Gray Davis, Governor
State of California
Business, Transportation and Housing Agency
320 West Fourth Street, Suite 880
Los Angeles, CA 90013-2234
213-576-7618 voice
213-576-7186 fax
jlarsen@dmhc.ca.gov

March 29, 2002

IN REPLY REFER TO FILE NO: 933 0308
CERTIFIED MAIL – RRR

FINAL REPORT

Maria Ina Cantor-Grable, Chairman of the Board
CALIFORNIA BENEFITS DENTAL PLAN
3611 S. Harbor Blvd., Ste. 150
Santa Ana, CA 92704

RE: ROUTINE EXAMINATION OF CALIFORNIA BENEFITS DENTAL PLAN

Dear Ms. Cantor-Grable:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of California Benefits Dental Plan (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 December 13, 2001. The Department received the Plan's response on January 31, 2002

This Final Report includes a description of the compliance efforts included in the Plan's January 31, 2002 response, in accordance with Section 1382(c).

Section 1382(d) states "If requested in writing by the plan, the commissioner 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 January 31, 2002 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 January 31, 2002 response did not adequately or fully respond to the deficiencies raised in the Preliminary Report issued by the Department on December 13, 2001. 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 this report. If the Plan fails to fully respond and resolve the deficiencies raised in the Final Report, then a referral will be made to the Office of Enforcement for appropriate administrative action for any remaining, unresolved deficiencies.

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: Jack Toney, Assistant Deputy Director, Office of Health Plan Oversight
Mark Wright, Chief, Division of Financial Oversight
Thomas Roedl, Examiner
Brian Bartow, Chief, Division of Licensing
Rachel Lawrence, Counsel

DEPARTMENT OF MANAGED HEALTH CARE

REPORT OF ROUTINE EXAMINATION

CALIFORNIA BENEFITS DENTAL PLAN

FILE NO.: 933 0308

DATE: MARCH 29, 2002

SUPERVISING EXAMINER: JOAN LARSEN
EXAMINER-IN-CHARGE: THOMAS ROEDL

BACKGROUND INFORMATION FOR CALIFORNIA BENEFITS DENTAL PLAN

Date Plan Licensed:	July 30, 1992
Organizational Structure:	California Benefits Dental Plan was incorporated under the laws of the State of California on August 9, 1991. It is a for-profit entity that is a wholly owned subsidiary of Dental Holdings, Inc. (the Parent). The Parent is a wholly owned subsidiary of GE Financial Assurance Holdings, Inc. (the Grandparent), which is a subsidiary of General Electric Corporation.
Type of Plan:	Specialized health care service plan providing dental services.
Provider Network:	Contracts with individual primary care providers on a capitation payment basis and provides specialist care on a fee-for-service payment basis.
Plan Enrollment:	A total of 31,520 enrollees were reported for the quarter ended March 31, 2001.
Service Area:	Designated portions of southern California counties of Los Angeles, Orange, Riverside, San Bernardino, San Diego and Ventura.
Date of Last Public Routine Financial Examination Report:	October 4, 1996

FINAL REPORT OF A ROUTINE EXAMINATION OF CALIFORNIA BENEFITS DENTAL PLAN

This is the Final Report of a routine examination of the fiscal and administrative affairs of California Benefits Dental Plan (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 December 13, 2001. The Department received the Plan's response on January 31, 2002.

This Final Report includes a description of the compliance efforts included in the Plan's January 31, 2002 response to the Preliminary Report, in accordance with Section 1382(c).

We examined the financial report filed with the Department for the quarter ended March 31, 2001, as well as other selected accounting records and controls related to the Plan's various fiscal and administrative transactions. Our findings are presented in this report as follows:

Section I.	Financial Statements
Section II.	Calculation of Tangible Net Equity
Section III.	Calculation of Administrative Costs
Section IV.	Compliance Issues
Section V.	Internal Control Issues
Section VI.	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. FINANCIAL STATEMENTS

A. BALANCE SHEET:

BALANCE SHEET
AS OF MARCH 31, 2001

ASSETS:	Balance per F/S @ 3-31-01		Debit		Credit	Balance per Exam @ 3-31-01
CURRENT ASSETS:						
Cash	595,380	Y1	240,277	Y2	19,389	
		A1	54,956	A2	23,180	
		Y6	1,979	Y3	7,590	842,433
Short-Term Investments	119,119			A1	50,726	68,393
Premiums Receivable	289,997			Y1	154,251	
				A3	38,778	
				A4	4,306	92,662
Prepaid Expenses	84					84
Aggregate Write-ins	158,382			A5	109,344	49,038
TOTAL CURRENT ASSETS	1,162,962		297,212		407,564	1,052,610
OTHER ASSETS:						
Restricted Assets	50,000					50,000
TOTAL OTHER ASSETS	50,000					50,000
PROPERTY & EQUIPMENT						
Furniture and Equipment	92,967					92,967
TOTAL PROPERTY & EQUIPMENT	92,967					92,967
TOTAL ASSETS	$1,305,929		$297,212		$407,564	$1,195,577

A.BALANCE SHEET (continue):

LIABILITIES:	Balance per F/S @ 3/31/01		Debit		Credit	Balance per Exam @ 3/31/01
CURRENT LIABILITIES:						
Accounts Payable	173,657	Y2	19,349	Y1	86,026	
		Y3	353	A10	90,396	
				Y7	102,165	432,542
Claims Payable	6,934	Y2	40			
		Y3	6,834	A6	7,684	7,744
Accrued Inpatient Claims	100			Y5	1,597	
				A7	3,783	5,480
Unearned Premiums	888,476	Y4	8,874			
		A8	198,325			
		A9	54,380			626,897
Aggregate Write-ins	(800)					(800)
TOTAL CURRENT LIABILITIES	1,068,367		288,155		291,651	1,071,863
NET WORTH:						
Capital	10,000					10,000
Paid in Surplus	695,880					695,880
Unassigned Surplus	(468,318)		**358,456		**263,558	
		A2	23,180	A1	4,230	(582,166)
TOTAL NET WORTH	237,562		381,636		267,788	123,714
TOTAL LIABILITIES & NET WORTH	1,305,929		669,791		559,439	1,195,577

** from Section I. B.

B. INCOME STATEMENT:

STATEMENT OF INCOME AND EXPENSE FOR THE QUARTER ENDED MARCH 31, 2001

	Balance per F/S @ 3/31/01		Debit		Credit	Balance per Exam @ 3/31/01
Premium	630,662	Y3	403	Y4	8,874	
		A3	38,778	A8	198,325	
				A9	54,380	853,060
Interest	10,029			Y6	1,979	12,008
Aggregate Write-Ins	19,482					19,482
TOTAL REVENUES	660,173		39,181		263,558	884,550
EXPENSES:						
Medical Expenses	262,850	Y5	1,597			
		A6	7,684			
		A7	3,783			275,914
Administration Expenses	353,564	Y7	102,165			
		A5	109,344			
		A10	90,396			
		A4	4,306			659,775
TOTAL EXPENSES	616,414		319,275			935,689
NET INCOME (LOSS)	43,759		*358,456		*263,558	(51,139)

* To Section I-A Balance Sheet

C. ADJUSTING JOURNAL ENTRIES

AJE #	ACCOUNT NAME	DEBIT	CREDIT
A1	Cash - Lockbox	$ 54,956	
	Unassigned Surplus		$ 4,230
	Short Term Investments		$ 50,726

To properly record a transfer from Short Term Investments to the Lockbox Account.

A2	Unassigned Surplus	$ 23,180	
	Cash – Operating Account		$ 23,180

To properly reflect the cash accounts.

A3	Premium Revenue	$ 38,778	
	Premium Receivable		$ 38,778

To reconcile premium receivables with the subsidiary schedule.

A4	Bad Debt Expense	$ 4,306	
	Allowance for Doubtful Accounts		$ 4,306

To properly recognize bad debt expense for premium receivable.

A5	Commissions	$ 109,344	
	Prepaid Commissions		$ 109,344

To properly record commission expenses.

A6	Specialty Referral Claims	$ 7,684	
	Accrued Claims		$ 7,684

To reconcile claims payable with the subsidiary schedule.

A7	Specialty Referral Claims	$ 3,783	
	Incurred But Not Reported		$ 3,783

To properly accrue the claim liability for incurred but not reported claims.

A8	Unearned Premium	$ 198,325	
	Premium Revenue		$ 198,325

To reconcile unearned premium (individual) to the subsidiary schedule.

A9	Deferred Income	$ 54,380	
	Premium Revenue		$ 54,380

To reconcile deferred income (group) to the subsidiary schedule.

A10	Bad Debt Expense	$ 90,396	
	Federal Income Tax Payable to Parent		$ 90,396

To write off a receivable from a former affiliate due to lack of evidence that the amount is collectable.

The Plan was required to provide assurance to the Department that the above adjustments were posted to the books or provide an explanation regarding their disposition.

The Plan responded that all requested audit adjustments, including both those of the Plan's auditors and those provided by the Department, were made on the books of the Plan, and were reflected in the Plan's filings with the Department for the month of December 2001.

The Department finds that the compliance efforts as set forth above satisfactorily responds to the deficiency cited and the corrective action required by the Department.

D. YEAR END AUDIT ADJUSTMENTS

ADJUSTMENT	ACCOUNT	DEBIT	CREDIT
Y1	Cash	$ 240,277	
	Accounts Receivables		$ 154, 251
	Consolidated Bill Suspense		$ 86,026
Y2	Claims Payable	$ 40	
	Accrued Expenses	$ 19,349	
	Cash		$ 19,389
Y3	Claims Payable	$ 6,834	
	Accrued Expenses	$ 353	
	Premium Revenue	$ 403	
	Cash		$ 7,590
Y4	Unearned Premium	$ 8,874	
	Premium Revenue		$ 8,874
Y5	Specialty Referral Claims Expense	$ 1,597	
	Accrued IBNR		$ 1,597

Y6	Cash	$ 1,979	
	Interest Income		$ 1,979
Y7	Income Taxes	$ 102,165	
	Income Tax Benefit		$ 102,165

The Plan recorded these audit adjustments for the year ended December 31, 2000 on July 1, 2001, except for audit adjustment Y7.

The Plan was required to provide assurance to the Department that audit adjustment Y7 was posted to the books or provide an explanation as to its disposition.

The Plan responded that all requested audit adjustments were made on the books of the Plan, and were reflected in the Plan's filing with the Department for the month of December 2001.

In addition, the Plan was required to explain why these audit adjustments were not recorded in its quarterly report for March 31, 2001.

The Plan responded that these audit adjustments were inadvertently omitted from the March 31, 2001 quarterly report. The Plan adopted a Corrective Action Plan regarding maintenance of employee's accounting skills and knowledge of generally accepted accounting principles as described later in this report, and submits that its implementation of this Corrective Action Plan will prevent future or similar errors.

The Department finds that the compliance efforts as set forth above satisfactorily responds to the deficiency cited and the corrective action required by the Department.

Section II. CALCULATION OF TANGIBLE NET EQUITY

Tangible Net Equity per examination at March 31, 2001	$ 123,714
Required TNE	68,245
Excess TNE	$ 55,469

Rule 1300.76 requires each health care service plan to at all times maintain tangible net equity ("TNE") in the amounts specified in this rule. The Plan is in compliance with the TNE requirement of Rule 1300.76 at March 31, 2001.

No response was required to this Section.

Section III. CALCULATION OF ADMINISTRATIVE COSTS

Revenues from subscribers and enrollees per examination (from Section I.B.)	$853,060
Administrative Costs per examination (from Section I. B.)	$659,775
Administrative Cost percentage as of March 31, 2001	77%

Rule 1300.78(b) requires that administrative costs incurred by the plan must be reasonable and necessary. This Rule states that should administrative costs of a plan that has been in operation for five years or more exceed 15% of subscriber revenue then such plan may be called upon to demonstrate that such costs are not excessive.

Our review of administrative costs, after our examination adjustments, indicated that administrative costs were 77% of subscriber revenue for the quarter ended March 31, 2001. The administrative cost percentage was higher than historically reported percentages due to our examination adjustments for the write off of prepaid commission and a tax benefit from an affiliate (See AJE#5& 10).

During our examination, the Plan provided a justification to support the Plan's administrative costs reported in their historical quarterly reports for June 30, 2000 through March 31, 2001, which ranged from 67% to 52%. However, we determined that this justification did not adequately identify the specific actions or procedures instituted by the Plan to reduce administrative costs.

The Plan was required to demonstrate that such administrative costs were not excessive within the meaning of Section 1378 and were justified under the circumstances; and/or provide a written statement as to the procedures or actions instituted to reduce administrative costs that are proving effective.

The Plan responded that the increase in it's administrative costs was due to the effects of adjustments to the Plan's financial statements required by the Department, and do not reflect any actual increase in the Plan's administrative costs. The Plan stated it has made substantial progress in reducing its administrative costs. In 1997, the year prior to the Plan's acquisition by Phoenix Mutual Home Life Insurance Company ("PHL"), the administrative costs were 73.42%. In 1998, the year the Plan was acquired by PHL (September 1, 1998), the administrative costs were reduced to 71.71%. In 1999, the Plan invested in personnel, technology and facilities to support the Plans five-year plan, which included the introduction of new benefits designed and underwritten for the California group marketplace. The Plan stated that this investment resulted in a temporary increase in administrative costs to 87.94%. However, the Plan further states that the year 2000 demonstrated the effectiveness and efficiencies of this investment and the Plan's efforts by reducing administrative costs to 68.94%. Based upon this trend, the Plan stated it expects its 2001 administrative costs to be nearer 50%.

Moreover, the Plan responded that it believes that its administrative expenses have not, and are not now, inappropriately high in light of the nature of the Plan's product lines. The Plan stated that historically it has provided services to individual subscribers who have purchased plans that covered a relatively narrow range of dental services and retained fairly substantial subscriber responsibility for the cost of specialized dental

services and procedures. The Plan indicated that the limited dental benefits provided by these plans kept their premiums relatively low, but did not materially reduce the Plan's cost of administration. As a result, the Plan's administrative costs, as a proportion of premium revenue, have historically been relatively high.

The Plan further stated it has designated and underwritten new benefits plans directed to and competitive for the California group marketplace. These new benefit plans generally include more comprehensive coverage for dental services and procedures. The Plan stated that the new plans have higher premiums than its older plans, due to the new plans' higher value, but do not involve increased administrative costs in proportion to the increase in premium. Therefore, the Plan indicated that as more of the Plan's business is comprised of these new plans, premium revenues would increase without a corresponding increase in administrative costs. As a result, the Plan expects its administrative costs, as a proportion of premium revenue, to drop significantly.

The Department finds that the compliance effort as set forth above satisfactorily responds to the deficiency cited and the corrective action required by the Department.

Section IV. COMPLIANCE ISSUES

A. ADMINISTRATIVE CAPACITY

Section 1367(g) requires a plan to have the organizational and administrative capacity to provide services to subscribers and enrollees. Rule 1300.67.3(a)(2) requires the plan to have staffing in fiscal and administrative services sufficient to result in the effective conduct of the plan's business.

To demonstrate adequate administrative capacity, a plan must have executive management and support staff sufficient to perform the necessary administrative functions of a health care service plan. A plan may make contractual arrangements for non-discretionary or ministerial services, but a Plan employee must perform functions requiring the exercise of any judgment, or decision-making, with the Plan's management having the ultimate responsibility. Furthermore, any non-discretionary functions that are delegated must be performed with oversight by the Plan's management.

Our examination disclosed that the Plan did not have administrative capacity as required by Section 1367(g) and Rule 1300.67.3(a)(2). The deficiencies noted throughout this report demonstrate a failure on the part of Plan management to understand its obligations to comply with the financial and compliance requirements placed on the Plan by the Knox-Keene Health Care Service Plan Act of 1975 ("Act") and the California Code of Regulations ("Rules").

The following are examples of the Plan's lack of administrative capacity.

1. The Plan relinquished control of some administrative functions of Plan operations, including accounting operations, to its parent and/or affiliates. The Plan provided the Department with one administrative services agreement, the operational status of which was uncertain. This was a transition services agreement with Phoenix Home Life Mutual Insurance Company ("Phoenix"). The agreement supported certain services provided by Phoenix during the transition period of the Plan's purchase by GE Corporation from Phoenix. Current services received by the Plan from its ultimate parent, GE Corporation, and GE affiliates, such as Union Fidelity Life Insurance Company, and GE Financial Assurance Holdings, Inc. were not supported by any administrative services agreements.

2. Delegated services provided to the Plan by its parent and/or affiliates were performed with no oversight by the Plan's executive or key management staff.

3. The Plan performs administrative services on behalf of its affiliate, GE Financial Assurance Holdings, Inc.—Employer Services Group, without benefit of an administrative services agreement. The Plan receives all premium checks from group subscribers which include both the Plan premium and amounts for other GE insurance and PPO products. The Plan staff identifies the funds due to other affiliates and makes payment to the appropriate affiliate on the first of the month following receipt of funds.

4. The Plan does not employ staff with sufficient accounting skills and an adequate knowledge of Generally Accepted Accounting Principles ("GAAP") to prepare adequate interim financial statements in accordance with GAAP, as required by Section 1345(r). Our examination disclosed many deficiencies in the financial statements and supporting records. This is evidenced by the number of adjusting journal entries presented in Section I of this report, which include the adjustments resulting from the Plan's previous year end audit not made until July 2001. Furthermore, it must be concluded that the Plan's affiliates do not employ staff with sufficient accounting skills and/or an adequate knowledge of GAAP, because our examination disclosed many deficiencies in the bank reconciliations prepared by an out of state affiliate. In addition, these reconciliations were not prepared in a timely manner.

5. The Plan substantially overstated its TNE position in its Orange Blank filing for the quarter ended March 31, 2001. The Plan reported excess TNE of $187,562. The proper TNE position was not evident until the examination adjustments were made (See Section I and Section II). The reason for this overstatement is because the financial statements were not prepared in accordance with GAAP.

6. The Plan's presentation of accounts payable in its Orange Blank filing for the quarter ended March 31, 2001 represents a "net" payable. The Plan offsets payables that include affiliate liabilities with receivables from affiliates. GAAP allows offsets to occur only between two parties that have a determinable obligation to each other, i.e. the Plan and one affiliate. (See Section IV. B.2.) As a result of the examination adjustment (AJE#10), the transactions with Plan affiliates resulted in payables.

7. The Plan's staff did not process claims in a manner that demonstrated substantial compliance with the requirements of the Act and Rules. (See Section IV. C.)

8. The records of Board of Director's meetings are presented as "Statutory written consent in lieu of meeting of Board of Directors". These records do not demonstrate that the Board is discussing the financial or operational issues of the Plan In addition, these records stated changes in Officers and Directors that were not reported to the Department.

The Plan was required to provide a detailed Corrective Action Plan ("CAP") to bring the Plan in compliance with Section 1367(g) and Rule 1300.67.3(a)(2). The CAP was to include the following elements:

- Administrative service agreements are to be executed between the Plan and each of the affiliates that provide services to the Plan. These agreements should be specific regarding the services to be performed by the affiliate. These services are to be ministerial in nature. Each agreement must state how the Plan will provide oversight for each delegated activity and how the performance of this oversight will be documented. In addition, the compensation arrangements should be fully disclosed and the Plan is to demonstrate that the compensation is fair and reasonable to the Plan and relates to the services provided.

- Administrative service agreement is to be executed between the Plan and <u>each</u> affiliate that the Plan provides services on behalf of or receives services from.

- A demonstration that the Plan has in its employment staff with sufficient accounting skills and adequate knowledge of GAAP to ensure that financial statements are prepared in accordance with GAAP.

- A demonstration that the Plan has adequate oversight of the affiliate providing bank reconciliation services to ensure that the affiliate's staff has sufficient accounting skills to properly prepare the reconciliations on a timely basis.

- A demonstration that Plan's executive and key management staff has adequate knowledge and understanding of the Act and Rules.

- A demonstration that the Plan has a Board of Directors that is actively involved in the financial and operational issues of the Plan.

The Plan was required to state the date on which the new administrative services contracts were filed with the Department and include a copy with its response. The CAP provided in response to this report should address the examples cited above and provide time frames for compliance for any corrective action that may take longer than the 45-day response time to the Preliminary Report. The Plan should demonstrate full compliance no later than 90 days from the date of the plan's receipt of the Preliminary Report. Status reports are to be provided to the undersigned 30 days, 60 days and 90 days for any corrective action not completed in the Plan's initial response to the Preliminary Report.

The Plan's response provided copies of its CAP that it adopted and implemented with respect to Administrative Services Agreements, Accounting Skills and Knowledge of Plan Personnel (to be implemented by March 31, 2002), Bank Reconciliations (implemented January 30, 2002), Knowledge and Understanding of Knox-Keene Act and Rules (implemented January 30, 2002), Involvement of Board of Directors

(implemented January 30, 2002). The Plan stated that the Chief Executive Officer is responsible for ensuring that each CAP is implemented and maintained.

The Plan filed in conjunction with its response a Shared Service and Expense Agreement between the Plan and three of its affiliates that provide administrative services to the Plan. The Plan stated that this agreement describes the services to be provided by these affiliates and provides explicitly that all such services are ministerial in nature and provided only to supplement the existing administrative capacity of the Plan. The Plan stated that the measures by which the Plan will maintain oversight of the management of these services are described in the Agreement. Additionally, the Plan added that it has reviewed the compensation arrangements and that they are fair and reasonable and specifically relate to the services provided to the Plan at its request.

The Plan responded that it would demonstrate to the Department there is sufficient accounting skills and adequate knowledge of GAAP in all future financial filings. The Plan stated that it has changed its accounting system as of January 1, 2002 to utilize the GE Oracle accounting system. The Plan added that these changes in its systems and processes, and its independent auditors, have contributed greatly to the Plan's augmentation of its administrative capacity. The Plan stated that its CAP regarding Accounting Skills and Knowledge of Plan Personnel shows the Plan's Vice President of Finance as responsible for filing and processing all financial records in accordance with GAAP as outlined in the American Institute of Certified Public Accountants' ("AICPA") Audit and Accounting Guide for Health Care Organizations. Furthermore, the Plan stated that to assure maintenance of the Vice President of Finance's knowledge and expertise in GAAP and related accounting matters, the Plan adopted a Reporting Requirements Training Plan set forth as an exhibit in its response.

The Plan responded that it no longer contracts for affiliates to perform bank reconciliations, and has resumed internal responsibility for its own bank account reconciling to ensure that the accounts are completed accurately and on a timely basis. The Plan further stated that should it resume having bank reconciliations performed by affiliates, it would make an appropriate filing of a written agreement pertaining thereto that will outline the bank reconciliation process, ownership, oversight and other parameters with specificity.

The Plan responded that it's Chief Executive Officer and Vice President of Finance, aided by the Plan's other personnel, are responsible for operating the Plan's business with knowledge and understanding of the Acts and Rules. The Plan stated that following the period described by the Preliminary Report, the Chief Executive Officer and Vice President of Finance have reviewed the requirements of the Acts and the Rules, and have adopted as a policy of the Plan to review those requirements and changes to those requirements from year to year on a regular basis. The Plan added that its President would continue to inform the Board of Directors of the Act and Rules as it applies to the Board of Directors' activity in the Plan's operations.

The Plan responded that its Board of Directors continues to be active in reviewing the financial and operational affairs of the Plan, and in determining the policies of the Plan. The Plan stated that its CAP for the Involvement of Board of Directors provides that the minutes of the proceedings of the Board of Directors would demonstrate that the Board reviews the reports of management not less frequently than quarterly, and that the Board acts specifically thereupon. In addition, the Plan stated that this CAP provides that the Plan will maintain all records of the meetings, Board actions and resolution at its main office.

The Plan provided a copy of a Shared Services and Expenses Agreement (Agreement) that it proposes to enter into with and among its affiliates, GE Group Life Assurance Company, GE Group Administrators, Inc., and GE Group Retirement, Inc.. The Plan further stated that these affiliates are forbidden to enter into this Agreement with the Plan until they have each received the approval of the Connecticut Department of Insurance. The Plan stated that the form of this Agreement was submitted to the Connecticut Department of Insurance and approval is anticipated shortly. The Plan added that it would report in writing to the Department, no less often than monthly, on the progress of the Connecticut Department of Insurance's review and approval of the Agreement. Upon receipt of approval by the Connecticut Department of Insurance, the Plan stated that it and its affiliates will enter into the Agreement and the Plan will file an executed copy thereof with the Department.

The Department finds that the compliance effort as set forth above is <u>not</u> fully responsive to the deficiency cited and the corrective action required by the Department, as follows:

- The Plan did not provide an administrative service agreement between <u>each</u> affiliate. The Plan provided an Exhibit to the Shared Services and Expenses Agreement that joins the Plan to an agreement with and among its affiliates and sets forth the services to be provided to the Plan or by the Plan. The descriptions of these services should be more detailed. The descriptions provided under "Accounts Payable" and "Cash Management" appears to include discretionary functions that are to be retained by the Plan. The agreement does not specifically address how the Plan will provide oversight for each delegated activity and how the performance of this oversight will be documented. The agreement does not specifically address the type of documentation to support the compensation arrangements (i.e., invoicing) or the settlement process.

  As required in the Preliminary Report, the Plan is again required to file separate administrative service agreements between the Plan and <u>EACH</u> affiliate that provide services to the Plan or for which the Plan provides services. These agreements are to be specific regarding the services to be performed by each affiliate. These services are to be ministerial in nature. Each agreement must state how the Plan will provide oversight for each delegated activity and how the performance of this oversight will be documented. In addition, the compensation arrangements should be fully disclosed. The Plan is required to provide an explanation as to why it did not comply with the Department's request to file separate agreements with each affiliate.

- The Plan's CAP provided for Shared Services and Expenses Agreements with Affiliates sets forth that the measures within this CAP will be implemented upon the approval of the administrative agreements by the Department of Insurance of the State of Connecticut, instead of including this Department. Such approval was not achieved at the time of the Plan's response to the Preliminary Report. Therefore, the Plan stated that it would report in writing to the Department, no less often than monthly, on the progress of the Connecticut Department of Insurance's review and approval of the Agreement. The Department has <u>not</u> received a status report as requested in the Preliminary Report, which should have been filed on March 1, 2002; nor has the Plan filed these agreements with the Department.

  The Plan is reminded that administrative agreements are also to be filed with and approved by this Department. The Plan is to provide a copy of the CAP that has been appropriately revised.

The Plan is again required to file appropriate administrative agreements with this Department in accordance with Section 1352 and Rules 1300.52 and 1300.52.1 with its response to this report. In addition, the Preliminary Report required that the Plan demonstrate full compliance with administrative capacity within 90 days from the date of the Plan's receipt of the Preliminary Report, which was March 17, 2002. The Plan is required to explain why it has not complied with its assurance to provide status reports and why it has not filed the required administrative service agreements.

- The Plan CAP regarding Accounting Skills and Knowledge of Plan Personnel provided with its response refers to an Exhibit A, Reporting Requirements Training Plan. This exhibit is to provide the means by which accounting skills and knowledge of GAAP for Plan personnel will be measured. However, this Exhibit was not located in the Plan's response. In addition, this CAP required that the Vice President of Finance complete the Reporting Requirements Training Program no later than March 31, 2002.

  The Plan is required to provide Exhibit A with its response to this report. The Plan is also required to demonstrate that the Vice President of Finance has completed the required training program and the date completed.

The Department continues to have concerns regarding the Plan's administrative capacity due to the Plan's failure to fully comply with the corrective actions required in our Preliminary Report, as presented throughout this report.

B. GENERALLY ACCEPTED ACCOUNTING PRINCIPLES

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

1. PREPAID COMMISSIONS

GAAP relating to commission expense of providers of prepaid health care services was originally established by AICPA Standards Board Statement of Position 89-5 (SOP 89-5), which discussed accounting for contract acquisition costs. In 1996, the AICPA published the Audit and Accounting Guide for Health Care Organizations ("the Guide"). With the publication of this guide, SOP 89-5 was superseded but the AICPA reaffirmed its position on contract acquisition costs by incorporating the provisions of SOP 89-5 verbatim in chapter 13 of the Guide. The relevant portions, sections 13.09 and 13.10, remain unchanged in the 2001 edition of the Guide. GAAP, as promulgated and set forth by the AICPA in the Guide, requires the expensing of contract acquisition costs, especially broker/agent fees and commissions, as they are incurred.

Our examination disclosed that the broker/agent commissions were not accounted for in accordance with GAAP. The Plan records prepaid commissions as an asset rather than expensing commissions as incurred as

required by GAAP. Adjusting journal entry A5 corrects the accounting for the prior years by adjusting retained earnings as of December 31, 2000 and through the current period ended March 31, 2001.

The Plan took corrective action and made journal entries to write off the prepaid commissions as of August 31, 2001. However, the adjustments included a journal entry creating a Goodwill account in the amount of $98,070. The Plan incorrectly reports this Goodwill on the Prepaid Expenses line item of the Orange Blank for the month ended September 30, 2001 and has not properly excluded it in the calculation of TNE for September 30, 2001.

The Plan was required to provide an explanation for recognizing a portion of this Prepaid Commission as Goodwill and support that this treatment is in accordance with GAAP.

If the Plan demonstrates that this treatment is in accordance with GAAP, then it must confirm with the Department that it will properly report Goodwill on line 13: Intangibles Assets & Goodwill of the Orange Blank in its future financial statement filings. In addition, the Plan must confirm that it will exclude Goodwill in its calculation of TNE as required by Rule 1300.76(e).

The Plan responded that it made an adjustment to Goodwill for the portion of Prepaid Commissions on the Plan's Balance Sheet as of October 31, 2000, the date on which the Plan came under the ownership of GE Financial Assurance Holdings, Inc. The Plan further stated that the remaining amount of Prepaid Commissions were expensed to its August 2001 Income Statement. The Plan provided the following TNE Calculation for the month of August 2001:

Net Equity At August 31, 2001	*527,233*
Add: Subordinated Debt	*0.00*
Less: Goodwill	*-98,070*
Tangible Net Equity	*429,163*
Required Tangible Net Equity	*55,178*
TNE Excess	*373,985*

The Plan provided the following journal entry for eliminating the Prepaid Commission asset:

Account	*Debit*	*Credit*
Prepaid Commissions		*111,838*
Commission Expense	*13,768*	
Goodwill	*98,070*	

The Plan confirmed that all future financial filings will properly report goodwill and will exclude it from its TNE calculations as required by 1300.76(e).

The Department finds that the compliance effort as set forth above is <u>not</u> fully responsive to the deficiency cited and the corrective action required by the Department, as follows:

- The Plan did not provide an adequate explanation for recognizing a portion of this Prepaid Commission as Goodwill, nor did it provide support that this treatment is in accordance with GAAP.

  The Plan is again required to provide this explanation and to provide support that this treatment is in accordance with GAAP.

- The Department has reviewed the monthly and quarterly financial filings submitted by the Plan for the periods ended August 31, 2001 through December 31, 2001. The Department finds that the Plan continued to report Goodwill incorrectly on the Prepaid Expenses line item of the Orange Blank for the period August 31, 2001 through November 30, 2001, but did deduct the goodwill in calculating its TNE compliance for the periods ended November 30, 2001 and December 31, 2001.

  The Plan is required to explain why its response states that the required corrective action was made in August 2001, when it was not.

2. <u>RIGHT OF OFFSET</u>

FASB Technical Bulletin No. 88-2 ("FTB 88-2"), superceded by FASB Interpretation No. 39 ("FIN 39") both address the offsetting of assets and liabilities. FIN 39 states "A right of offset is a debtor's legal right, by contract or otherwise, to discharge all or a portion of the debt owed to another party by applying against the debt an amount that the other party owes to the debtor…"

While both FTB 88-2 and FIN 39 do not require a written right of offset, they do require that this right of offset be enforceable at law. The Department has consistently required a plan to execute a written right of

offset where offsetting occurs as a means of strengthening and clarifying the relationship. This written right of offset provides evidence that all parties have agreed to the offset and identifies the amounts and accounts to be offset. In the absence of a written right of offset, intercompany receivables and payables must not be offset in preparing financial statements filed with the Department.

Our examination disclosed that the Plan does not have a written Right of Offset with its affiliates. The Plan's financial statements present a "net" accounts payable balance. The Plan offsets payables that include affiliate liabilities accounts with receivable balances. GAAP allows offsets to occur only between two parties that have a determinable obligation to each other. As a result of our examination adjustment (AJE#10), the transactions between the Plan and its affiliates resulted in a payable balance.

The Plan was required to file a Right of Offset with each affiliate, as appropriate, and file it as an amendment filing with the Department. A copy of this filing was to be included with the Plan's response to the Preliminary Report.

The Plan responded that it would obtain administrative services and support from its affiliates pursuant to the Shared Services and Expenses Agreement provided in response to Section IV. A. of this report. The Plan states that this agreement clearly provides for a right of offset, as will all future agreements for which offsets are to be taken.

The Department finds that the compliance effort as set forth above is responsive to the deficiency cited and the corrective action required by the Department.

C. CLAIMS

1. CLAIMS STATUS

Rule 1300.77.4 requires plans to "institute procedures whereby all claim forms received by the plan from providers of health care services for reimbursement are maintained and accounted for in a manner which permits the determination of the date of receipt of any claim, the status of any claim, the dollar amount of unpaid claims at any time, and rapid retrieval of any claim." Status categories include: to be processed; processed, waiting for payment; pending, waiting for approval or denial; pending, waiting for additional information; denied; paid; and, if appropriate, other. The procedures must use "either a claims log, claims numbering system, electronic data processing records, and/or any other method held unobjectionable by the Director."

Our examination disclosed that not all claims were date stamped with the date the claim was received. Only a sample of thirteen claims was reviewed during the examination, and three of these were not date stamped.

The Plan was required to demonstrate that the Plan has the capability to determine the status of all claims received, including the date received, as required by Rule 1300.77.4. The Plan's response was to include detailed procedures that address the date stamping of claims, the date these procedures were implemented, and identify the management position responsible for ensuring ongoing compliance with the Rule.

The Plan responded that it has the capacity to process claims through the HMO pro claims module, in accordance with Rule 1300.77.4, as follows:

- *Claims to be processed,*
- *Processed, waiting payment;*
- *Pending, waiting approval for payment or denial,*
- *Pending, waiting for additional information,*
- *Denied, and*
- *Paid, if appropriate*

The Plan provided in its response its referral and Claims Processing flowcharts and procedures, as previously filed with the Department, which detail the above process. The flowchart indicates the point at which the claim is date stamped. The Plan stated that it's Director of Compliance and Provider Relations has the management responsibility for ensuring ongoing compliance.

The Department finds that the compliance effort as set forth above is responsive to the deficiency cited and the corrective action required by the Department.

2. CLAIMS REIMBURSEMENT

Section 1371 requires a specialized health care service plan to reimburse claims within thirty (30) working days after receipt of the claim, unless the claim is contested or denied by the plan. Section 1371 also requires that if the claim is contested by the plan, the claimant shall be notified, in writing, that the claim is contested or denied within thirty (30) 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 disclosed that 9 out of 157 claims paid during the period January 1, 2001 through March 31, 2001 were paid late, i.e. the payment date was in excess of thirty (30) working days from the date of receipt of the claim. These claims were paid from 31 to 44 working days after the date of receipt of the claim.

The Plan was required to submit a corrective action plan that would describe the steps taken to ensure compliance with the reimbursement requirements of Section 1371 at all times. The Plan's corrective action was to include detailed procedures that address the monitoring for compliance with Section 1371, the date these procedures were implemented, and identify the management position responsible for ensuring ongoing compliance with this Section.

The Plan responded that it has adopted a CAP with respect to claims reimbursement and provided it as an exhibit to its response. The Plan stated that the Plan's Director of Compliance and Provider Relations would be responsible for the weekly, monthly and quarterly reporting and document payment compliance to the Plan's Chief Executive Officer.

The Department finds that the compliance effort as set forth above is not responsive to the deficiency cited and the corrective action required by the Department, because the corrective action plan for

claims reimbursement was not located within the Plan's response. The date the corrective action plan was implemented was also not provided.

The Plan is again required to submit a corrective action plan that describes the steps taken to ensure compliance with the reimbursement requirements of Section 1371 at all times, includes detailed procedures that address the monitoring for compliance with Section 1371, and provides the date these procedures were implemented.

3. PAYMENT OF INTEREST

Section 1371[2] further states that if an uncontested claim is not reimbursed within the thirty (30) working day period, interest shall accrue at the rate of fifteen percent (15%) per annum beginning with the first calendar day following the thirty (30) working day period. This Section also states that a Plan shall automatically include in its payment of the claim all interest that has accrued without requiring the claimant to submit a request for the interest amount and that any Plan failing to comply with this requirement shall pay the claimant a ten dollar ($10) fee.

Our examination disclosed that the Plan does not have policies or procedures in place for paying interest on uncontested claims that exceed the thirty (30) working day timeframe required by this Section. Our review of the Plan's claim payment process disclosed that the Plan does not pay interest on uncontested claims that are paid later than thirty (30) working days after the receipt of the claim.

The Plan was required to provide a corrective action plan that includes procedures for the timely identification of uncontested claims that have not been paid within thirty (30) working days, and to pay interest in accordance with Section 1371. In addition, the Plan is required to provide evidence that it has identified all claims since January 1, 1996 on which interest should have been paid and pay the interest and fee. The fee is applicable on all 2001 claims. If the payment of interest (and fee, if applicable) on late claims has not been completed at the time the response to this report is due, then provide a time frame in which the payments will be made.

The Plan responded that it completed a CAP and provided a list of all claims identified since January 1, 1996 through December 31, 2001 that were paid past 30 days and included a calculation of the interest and fee to be paid in accordance with Section 1371. The Plan provided detailed examples of the original paid claim and support. The Plan provided copies of the completed "Request for Check" for interest amounts to be paid to the providers including the $10.00 penalty fee. These payment requests indicate that checks were to be issued on January 31, 2002.

The Department finds that the compliance effort as set forth above is <u>not</u> fully responsive to the deficiency cited and the corrective action required by the Department, because a corrective action plan that addresses the procedures implemented to ensure compliance with Section 1371 was not located within the response.

---

[2] This section was amended January 1, 2001 to increase the interest rate and provide for minimum interest to be paid.

The Plan is again required to provide a corrective action plan that sets forth procedures for the timely identification of uncontested claims that have not been paid within thirty (30) working days, and to automatically pay interest and penalty fee in accordance with Section 1371. The Plan is also required to submit a sample of check copies to support that actual payment of interest and penalties was made to the providers on January 31, 2002, pursuant to the Request for Check forms.

4. INCURRED BUT NOT REPORTED CLAIMS

Section 1377(c) states that every plan which reimburses providers of health care services on a fee-for-service basis, or which directly reimburses its subscribers and enrollees to an extent exceeding ten per cent of its total payments for health care services, shall estimate and record in the books of account a liability for incurred and unreported claims.

Rule 1300.77.1 states that a plan that reimburses providers of health care services on a fee-for-service basis shall estimate its liability for incurred and unreported claims and record the estimate as an accrual in its books and records at least every month.

Rule 1300.77.2 states, in part, that each plan that reimburses providers of health care services on a fee-for-service basis shall calculate the estimate of incurred and unreported claims pursuant to a method held unobjectionable by the Director. Such method may include a lag study, an actuarial estimate, or other reasonable method of estimating incurred and unreported claims. The amount required by Section 1300.77.1 to be accrued in the plan's books and records must equal the estimated total of all claims incurred but not yet received as of the end of the month as calculated in working papers, schedules or reports prepared in support of the unobjectionable lag study, actuarial estimate, or other method of estimating incurred and unreported claims.

Our examination disclosed that the Plan reimburses specialized providers of health care services on a preauthorized/fee-for-service basis, but it does not accrue an appropriate estimate of incurred but not reported claims ("IBNR") on a monthly basis. The Plan reported a balance of $100 on the March 31, 2001 Orange Blank for "Accrued Referral Claims (Not Reported)". The Plan's independent CPA's recognized the inadequacy of the reserve, and recommended a year-end audit adjustment of $1,597 to increase this reserve at December 31, 2000. As mentioned previously in this report, the audit adjustments were not posted by the Plan until July 2001.

Our examination included a review of claims with a date of service March 31, 2001 and prior, which were received by the Plan on April 1, 2001 through June 30, 2001. Our review resulted in an examination adjustment (see AJE 7) to increase this reserve as at March 31, 2001.

Our examination also disclosed that the Plan has not established a method for estimating incurred and unreported claims that are supported through working papers, schedules or reports.

The Plan was required to provide a detailed description of the methodology that it would apply to calculate the IBNR liability in accordance with the requirements of the above Section and Rules. Also, the Plan was required to provide the procedures implemented to ensure that the Plan would properly accrue an IBNR liability in accordance with GAAP in all future financial statements.

Furthermore, the Plan was required to provide the management position responsible for the calculation and recording of the IBNR liability and for ensuring that the method of calculation is in compliance with Rule 1300.77.2(a).

The Plan responded that it adopted a CAP regarding incurred but not reported claims and provided it as an exhibit to its response. The Plan stated that pursuant to this CAP it would begin adjusting IBNR at least quarterly. The Plan added that it would base its IBNR estimates upon its own claim history, which permits the Plan to estimate unknown claims liability with statistical validity. The Plan provided extracted claims data formatted into a "lag study" as illustrated in Rule 1300.77.2.

The Plan stated that the Plan's Vice President of Finance has the responsibility for reporting the quarterly calculation and recording of the Plan's IBNR liability in accordance with Rule 1300.72 to Plan's Chief Executive Officer and Board of Directors.

The Department finds that the compliance effort as set forth above is <u>not</u> fully responsive to the deficiency cited and the corrective action required by the Department, because the corrective action plan that addresses the procedures implemented to ensure compliance with Section 1300.77.2 was not located within the Plan's response.

The Plan is again required to submit a corrective action plan that describes the procedures implemented to ensure compliance with Section 1300.77.2.

D. <u>INSURANCE</u>

1. <u>FIDELITY BOND</u>—Repeat Deficiency

Rule 1300.76.3(a) 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. The fidelity bond shall also provide for thirty (30) days' notice to the Director of the Department of Managed Health Care prior to cancellation.

The fidelity bond presented for our review does not comply with Rule 1300.76.3 as follows:

- The policy provided for our review lists the policyholder as General Electric Company, with the Plan as a named insured. However, our review of this policy did not demonstrate that the Plan has exclusive right to the minimum required coverage of $200,000.

- A specific endorsement to cover all officers, directors, trustees, partners, and employees of the Plan whether or not they are compensated was not located.

- Endorsement No. 12 provides for sixty (60) days notice for standard cancellation and fifteen (15) days notice for non-payment cancellation to the Department of Corporations' San Francisco office.

The Plan was required to provide a copy of a fidelity bond that contains the necessary endorsements to demonstrate compliance with Rule 1300.76.3. While the sixty (60) days notice for standard cancellation is more generous than required, the fifteen (15) days notice of cancellation for non-payment needs to be revised to comply with the required thirty (30) days notice. In addition, the cancellation notice needs to be sent to the Department of Managed Health Care at the Sacramento address. The Plan was also required to state the management position responsible for ensuring this corrective action and a description of the monitoring system implemented to ensure ongoing compliance with Rule 1300.76.3.

The Plan's failure to maintain the required endorsements to the fidelity bond was previously addressed in our Confidential Report of Examination dated August 26, 1996, following the routine examination for the quarter ended March 31, 1996.

The Preliminary Report required the Plan to explain why the corrective action taken in response to the prior examination report did not prevent this reoccurrence and what measures will be taken to prevent further recurrence of noncompliance. These measures should include the management position responsible to ensure continued compliance.

The Plan responded that Phoenix Home Life acquired it on September 1, 1998 and the appropriate Fidelity Bond was put in place at that time and remained in force until GE Financial Assurance acquired it on November 1, 2000. At that time, the Plan stated that a replacement Fidelity Bond was put in place that included coverage for the Plan together with the other divisions of GE. The Plan added that it understands the objection the Department has raised to this policy and obtained replacement coverage. A certificate evidencing the Plan's Fidelity Bond Certificate of Insurance was included in its response. The Fidelity Bond provides coverage in the amount of $1,000,000, includes coverage for all officer, directors, trustees, partners and employees of the Plan whether or not they are compensated. The policy has a provision for sixty (60) days notice for standard cancellation and fifteen (15) days notice for non-Payment cancellation to the Department of Managed Health Care's Sacramento office.

The Plan stated that its Chief Executive Officer has the management responsibility to ensure compliance.

The Department finds that the compliance effort as set forth above is <u>not</u> fully responsive to the deficiency cited and the corrective action required by the Department. The cancellation endorsement still contains a fifteen (15) days notice for non-payment cancellation, which needs to be revised to comply with the required thirty (30) days notice. The policy provided does not indicate whether there is a deductible or not. The Plan did not provide a description of the monitoring system implemented to ensure ongoing compliance with Rule 1300.76.3.

The Plan is again required to provide a copy of a fidelity bond that demonstrates compliance with Rule 1300.76.3. The Plan is again required to provide a description of the monitoring system implemented to ensure ongoing compliance with Rule 1300.76.3.

2. MALPRACTICE INSURANCE

Section 1351(o) requires that each plan maintain a policy of insurance to respond to claims for damages arising out of the furnishing of health care services.

An insurance policy documenting coverage for claims arising out of the furnishing of health care services was not provided during the examination. The Plan provided a Commercial General Liability Insurance policy in the name of an affiliate, General Electric Company. Our review of this policy found that it does not state expressly that claims arising from malpractice are covered. In addition, this policy does not provide exclusive coverage for the Plan. The "Separation of Insured" clause on page 15 of this policy says that it applies to each "insured" separately, except with respect to policy limits. Our review of the definitions of "insured" or "named insured" and the long list of named insured does not disclose clearly that the Plan is covered or covered exclusively, i.e. that coverage is exclusive to the Plan so that the Plan's coverage is not reduced by claims of other insured entities.

The Plan was required to provide a copy of a malpractice insurance policy that provides exclusive coverage to the Plan for claims arising out of the furnishing of health care services, as required by Section 1351(o). The Plan was also required to state the management position responsible for ensuring this corrective action and a description of the monitoring system implemented to ensure ongoing compliance with this Section.

The Plan responded that it has a policy that meets and exceeds the requirements as set forth in Section 1351(o). A copy of the Certificate of Insurance and endorsement was provided in the response.

The Department finds that the compliance effort as set forth above is not fully responsive to the deficiency cited and the corrective action required by the Department. The Plan did not state the management position responsible for ensuring this corrective action nor did it provide a description of the monitoring system implemented to ensure ongoing compliance with this Section.

The Plan is again required to state the management position responsible for ensuring corrective action and to provide a description of the monitoring system implemented to ensure ongoing compliance with this Section.

F. MATERIAL MODIFICATIONS AND AMENDMENTS

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

1. ADMINISTRATIVE SERVICES AGREEMENTS

Our examination disclosed that the Plan receives and/or provides administrative services to/from the following entities that were not supported by a written agreement or an agreement that was filed with the Department (See Section IV.A. for related comment):

- GE Corporation
- General Electric Company
- Dental Holdings, Inc.
- Phoenix Home Life Mutual Insurance Company
- Phoenix American Life Insurance Company
- Phoenix Group Services
- Union Fidelity Life Insurance Company
- GE Financial Assurance Holdings, Inc
- GE Financial Assurance Holdings, Inc.—Employer Services Group
- GE Group Life Assurance Company

The Plan was required to review their administrative arrangements with each of the above affiliates and enter into an administrative service agreement with each entity that is performing services for the Plan and with each entity for which the Plan provides services. The arrangements described in the agreements should include the elements noted in corrective action requested in Section IV.A. of this report. In addition, any tax sharing arrangements between the Plan and an affiliate are to be documented in an agreement and should include procedures for settlement on at least a quarterly basis.

These agreements were to be filed as an amendment with the Department, in accordance with the Section and Rule stated above.

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

Furthermore, the Plan was required to state the management position responsible for ensuring that all administrative arrangements are supported by a written administrative agreement and to provide a description of the monitoring system implemented to ensure ongoing compliance with the Section and Rule stated above.

The Plan provided a copy of its Services and Shared Expense Agreement as an exhibit within its response. The Plan stated that it adopted a CAP with respect to Administrative Services Agreements and provided a copy as an exhibit within its response. The Plan submits that these two exhibits demonstrate the Plan's correction of this deficiency.

The Plan added that it is an indirect subsidiary of General Electric Company ("GE) and like all other non-life insurance subsidiaries of GE, the Plan stated it is included in the consolidated federal income tax return of GE. The Plan stated that GE subsidiaries are subject to a tax-sharing arrangement, which allocates tax on a separate company basis, but provides group benefit for current utilization of losses and credits. The Plan

added that deferred taxes are allocated to individual subsidiaries by applying the asset and liability method of accounting for deferred incomes taxes. The Plan stated that such arrangements are permitted under the Internal Revenue Code and related Treasury regulations. The Plan further stated that this arrangement is not one that is a matter of contract rights of any GE subsidiary such as the Plan; and, therefore would be inappropriate for the Plan to seek to enter into a tax sharing agreement.

The Department finds that the compliance effort as set forth above is <u>not</u> fully responsive to the deficiency cited and the corrective action required by the Department. The Plan did not provide an administrative services agreement with each of the above affiliates that is performing services for the Plan and/or for which the Plan provides services. The Plan did not file these agreements as an amendment with the Department as required by the Preliminary Report.

The Plan is again required to review their administrative arrangements with each of the above affiliates and state whether the Plan will enter into an administrative service agreement with that entity. The Plan is also required to enter into a separate administrative service agreement with <u>each</u> entity that is performing services for the Plan and with each entity for which the Plan provides services. See related comments in Section IV.A. of this report. These agreements are to be filed as an amendment with the Department, in accordance with the Section and Rule stated above.

The Plan is also required to provide evidence (i.e., a copy) in its response to this report that the requested filing has been submitted to the Department within thirty (30) days after receipt of this report.

2. <u>CHANGES IN OFFICERS AND DIRECTORS</u>

Rule 1300.52.2 states, in part, that a plan shall file an amendment to its application in the form required by Section 1300.52, when there are any changes in personnel of the plan, or of any management company of the plan. Changes in personnel refer to the addition or deletion of a director, trustee, principal officer, general partner, general manager or principal management persons, or persons occupying similar positions or performing similar functions, or a substantial and material change in the duties of any such person.

Our review of the record of meetings of the Board disclosed changes in the Plan's directors and corporate officers that were not reported to the Department, as follows:

- On June 18, 2001, Gary Prizzia was elected as Treasurer
- On November 1, 2000, Marcia Ina Cantor-Grable was elected as Director and Chairman

The Plan was required to file these changes as an amendment with the Department, in accordance with the Section and Rule stated above.

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 Preliminary Report.

Furthermore, the Plan was required to state the management position responsible for ensuring that all changes in officers and directors are filed in a timely manner with this Department.

The Plan responded that in accordance with Rules 1300.52.2 and 1300.52 the Plan has filed with the Department on February 1, 2001 an amendment to Exhibit F-1-f (Individual Information Sheets) that provides the required information with respect to all voting members of the Plan's Board of Directors. The Plan also provided a copy in its response.

The Plan also stated that its Director of Compliance, reporting to Plan President, will have the management responsibility to file with the Department all future additions or deletions of directors, trustees, principal officers, general partners, general management persons, persons occupying similar positions or performing similar functions, or a substantial and material change in the duties of any such person within 5 business days as required.

The Department finds that the compliance effort as set forth above is responsive to the deficiency cited and the corrective action required by the Department. The amendment filing referenced by the Plan was received by the Department on February 7, 2002 and will be reviewed through the normal process.

G. SOLICITOR CONTRACTS

Contracts with solicitors are required to satisfy provisions of Rules 1300.67.12. This Rule includes the requirements that all funds received by the solicitor be segregated from the assets of the solicitor firm and promptly deposited to a trust account, and that all funds received by the solicitor firm for the account of the plan be transmitted to the plan within (5) five business days after such funds are received by the solicitor.

Rule 1300.76.2 requires a plan to monitor its solicitors that handle funds of the plan or subscribers, for certain financial requirements.

Our examination noted that the Plan has a solicitor arrangement with Vision Plan of America ("VPA"), another Knox-Keene licensed health care service plan. However, the Plan does not directly solicit VPA products. It has solicitor agreements with Americhoice and Americorp, which sell the VPA product along with the Plan's dental product. Americhoice and Americorp do not handle funds, but have the employer groups submit premium payments directly to the Plan. The premium amounts include the premium for VPA.

The solicitor contract between VPA and the Plan states that the Plan is not to handle funds, but should forward checks made payable to VPA to VPA by close of business on the day following the date of receipt. However, the Plan collects the premium, deposits it into the Plan's cash account, and sends a monthly check to VPA.

The Plan's contract with VPA provides for compensation to the Plan in the form of a "net rate", but the Plan does not receive any compensation.

Therefore, the solicitor contract between the Plan and VPA, and between the Plan and Americhoice and Americorp do not support the actual arrangements in place at the time of the examination.

The Plan was required to file an appropriate contract with the Department that supports the arrangement between the Plan and VPA, as well as between the Plan and Americhoice and Americorp. The filing should include a narrative explanation of the arrangement and be supported by relevant marketing materials and the disclosure provided to the subscriber groups.

The Plan was required to file the appropriate contract and supporting information as an amendment filing with the Department, pursuant to Section 1352 and Rule 1300.52. The Plan was required to provide evidence (i.e., a copy) with its response to this report that such filing was submitted to the Department.

Furthermore, the Plan was required to describe the corrective action implemented to ensure that all solicitor contracts are in compliance with the above Rules and to state the management position responsible for continued compliance.

The Plan responded that it filed with the Department on February 1, 2002 the appropriate contract. A copy of this filing was provided in the Plan's response. The Plan stated that its Chief Executive Officer is the management position responsible for continued compliance with this requirement. The Plan added that this agreement complies with the requirements of the Plan's CAP for Administrative Services Agreements attached as an exhibit to its response.

The Department finds that the compliance effort as set forth above is not fully responsive to the deficiency cited and the corrective action required by the Department. The Plan's corrective action plan for Administrative Services Agreements as provided in its response does not address solicitor contracts. The amendment filing referenced by the Plan was received by the Department on February 7, 2002 and will be reviewed through the normal process.

The Plan is again required to describe the corrective action implemented to ensure that all solicitor contracts are in compliance with the above Rules.

H. BOOKS AND RECORDS

Rule 1300.85 requires every Plan to maintain books and records on a current basis and requires the retention of specific records. Section 1385 requires that each Plan keep and maintain current such books of account and other records as the Director may by rule require for the purpose of this chapter. Rule 1300.85.1 requires every plan to preserve for a period of not less than five years, the last two years of which shall be in an easily accessible place at the offices of the plan, the books of account and other records required under the provisions of, and for the purposes of the Act.

Our examination disclosed that of a sample of thirteen claims reviewed, all had exceptions relating to inadequate documentation or missing documents, as follows:

- Copies of claims were not provided for 6 out of the 13 claims
- Claim Control Sheets did not include the claim number assigned by the Plan on 11 out of the 13 claims
- Copies of claim checks were not provided for 4 out of the 13 claims

The Plan was required to state the procedures that were implemented to address the above concerns, the date of implementation, and the management position responsible for compliance and the controls implemented for monitoring continued compliance.

The Plan responded that it provided additional training to all persons involved in referral/claims processing to correct the deficiencies noted by the Department. The Plan stated that it also installed additional file space specifically for the retention of referral/claim records. The Plan added that the management position responsible for compliance and monitoring of the referral/claim process is the Director of Compliance and Provider Relations.

The Department finds that the compliance effort as set forth above is responsive to the deficiency cited and the corrective action required by the Department.

I. FINANCIAL STATEMENT PRESENTATION

Rule 1300.84.2 sets forth the requirements for the filing of quarterly financial statements with the Department. The rule states that the quarterly financial statements (which need not be certified) are to be prepared in accordance with GAAP and on a basis consistent with the certified financial report furnished by the plan pursuant to Section 1384(c), unless the plan receives the written approval of the Director to vary from that basis and the variance is adequately noted in its report under this section. This rule also refers to Rule 1300.84.06(b) that sets forth the requirements for the supplemental information that is to accompany the Orange Blank filings.

Our examination noted the following concerns with the quarterly Orange Blank for March 31, 2001:

- The Plan did not properly execute the cover page. The affidavit is to be properly completed and be executed by the President, Secretary and Treasurer, not just the President.

- The Plan did not provide the previous period or year to date information requested in the balance sheet and statement of income and net worth.

- Footnote disclosure is to be updated for the period being reported upon. The Plan filed the footnotes for the year ended December 31, 2000, instead of for the quarter ended March 31, 2001.

- The supplemental information form is not completed for items 1 through 4. The Plan records a liability for incurred and unreported claims and an explanation of the method of calculating this liability is to be disclosed in item 1. The Plan has transactions with affiliates that may result in accounts receivable and/or donated services and should be disclosed in items 2 and 3.

- Numerous adjusting journal entries, as noted in Section I of this report, were needed to properly state the Plan's financial position at the quarter ended March 31, 2001. This indicates that the Plan is not preparing its interim financial statements on a basis consistent with GAAP or its annual audited report.

The Plan was required to state the corrective action taken to ensure that compliance with the above concerns was demonstrated in the quarterly financial statement for December 31, 2001 due to be filed on February 15, 2002. The Plan was also required to state the management position responsible for compliance and the controls implemented for monitoring continued compliance.

The Plan responded that it has adopted a corrective action as follows:

1. *The Plan will properly execute the Cover Page by having the signatures of the Plan President, Secretary and Treasurer.*
2. *The Plan will provide the previous period or year to date information on the balance sheet and statement of income and net worth.*
3. *The Plan will update the footnote disclosures for each period being reported upon.*
4. *The Plan will complete the supplemental information for, items 1-4 as appropriate.*
5. *The Plan will prepare its interim and annual financial statements on a basis consistent with GAAP.*

The Plan stated that it will demonstrate its execution of this corrective action plan in its filing of the financial statements for the quarter ended December 31, 2001. The Plan stated that the management position responsible for the compliance and controls implemented for monitoring compliance is the Vice President of Finance.

The Department finds that the compliance effort as set forth above is responsive to the deficiency cited and the corrective action required by the Department. However, our review of the supplemental information accompanying the quarterly financial statements for December 31, 2001, as submitted to the Department, disclosed that the Plan did not complete item 1.

The Plan is again required to confirm that it will provide an explanation of the method of calculating its IBNR claims liability in item 1 of the supplemental information beginning with its quarterly report for March 31, 2002.

SECTION IV. INTERNAL CONTROL STRUCTURE

Section 1384, 1345(s) and Rule 1300.45(q) include requirements for filing financial statements in accordance with generally accepted accounting principles 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 – designated 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.

Our examination disclosed deficiencies in the Plan's internal controls as follows:

A. CASH

Our examination disclosed the following concerns in regards to the Plan's cash accounts:

- The bank reconciliations are not prepared by plan personnel, but by employees of an affiliated company located outside of California. These reconciliations are not reviewed or supervised by a responsible employee of the Plan.
- The bank reconciliations were not prepared in a timely manner. The reconciliations for March 2001 were not prepared until August 2001.
- The bank reconciliations contained numerous adjustments that are not reviewed and corrected on a timely basis. Reconciling items were not posted promptly to the general ledger. As a result, our examination determined that cash was not properly stated and resulted in AJE 1 and 2. (See Section I.)
- The record of the Board dated November 1,2000 and Certificates of Delegation dated January 2, 2001 and January 29, 2001 gave authority to employees and officers of the plan's affiliate, GE Financial Assurance Holdings, Inc., over the Plan's bank accounts and investment accounts.

The Plan was required to state the policies and procedures implemented to correct each of the above deficiencies, the date of implementation, the management position responsible for compliance, and the controls implemented for monitoring continued compliance. In addition, the Plan was required to provide an assurance that all bank accounts will be reconciled routinely, and that Plan management now reviews and approves all bank reconciliations.

The Plan responded that it has adopted the CAP with respect to bank reconciliations that it provided as an exhibit to its response. The Plan stated that it and its affiliate companies understand the importance of proper bank account reconciliations. The Plan stated that it has thoroughly reviewed all prior bank reconciliations performed by an affiliate company and has reconciled its own bank accounts, by month, for the fourth quarter of 2001. The Plan added that all its bank accounts are reconciled.

The Plan further stated that it would continue to reconcile it own bank accounts until the proper affiliated company service agreements are filed with all interested agencies. The proper service agreements will contain provisions to guarantee accurate and timely account reconciliations. The Plan stated it would maintain all original bank records at its corporate office. The Plan added that control of the bank reconciliations would be such as to enable the Plan to accurately complete its financial documentation.

The Department finds that the compliance effort as set forth above is not fully responsive to the deficiency cited and the corrective action required by the Department. The Plan did not respond to the concern that the Plan gave authority to employees and officers of the plan's affiliate, GE Financial Assurance Holdings, Inc., over the plan's bank accounts and investment accounts. The Plan did not identify the management position responsible for compliance with the above. The Plan is reminded that the ministerial functions of the bank reconciliation process may be delegated through an administrative service agreement. However, the Plan must continue to maintain oversight of this delegated function through the review and approval of bank reconciliations.

The Plan is required to state the corrective action taken in regards to employees and officers of an affiliate having control over the Plan's bank and investment accounts. The Plan is again required to identify the management position responsible for compliance, and the controls implemented for monitoring continued compliance. In addition, the Plan is required to provide an assurance that upon delegation of this function to an affiliate that Plan management will retain proper oversight and approval of all bank reconciliations.

B. RECOGNITION OF ASSETS/LIABILITIES

Our examination disclosed that the Plan does not reconcile the general ledger accounts for premiums receivable, claims payable and unearned premium revenue with the supporting subsidiary schedules. The Plan's failure to reconcile these accounts resulted in the overstatement of premiums receivable and unearned premium revenues and the understatement of claims payable in the financial statements. Therefore, to properly present these accounts resulted in examination adjustments A3, A6, A8 and A9. In addition, an adequate provision for uncollectible premiums was not established and resulted in examination adjustment A4.

The Plan was required to describe the procedures implemented that will result in more reliable, effective, and efficient controls over the recognition of these assets and liabilities. These procedures were to include a description of the Plan's collection policy and recognition of a reserve for uncollectible accounts. In addition, the Plan was required to state the date these procedures were implemented, the management position responsible for ensuring compliance with and continued oversight of these procedures.

The Plan responded that it has modified its method of calculating Unearned Premium. The Plan stated that all premiums received for annual Plan membership is recorded as Unearned Premium and all refunds of premium are debited against Unearned Premium. The Plan stated that it uses its managed care system to calculate the amount of earned income each month and records it against Unearned Premium.

The Plan stated it would continue to use its managed care system to produce Group Premium Bills and record premium payments. The Plan stated it retains Aging Reports as of the end of each month. The Plan states that this procedure was implemented in November 2001. The Plan provided a brief description of its collection policy that has been in place since January 1, 1999. The Plan stated the management position responsible for ensuring compliance and oversight for collections would be the Vice President of Finance.

The Department finds that the compliance effort as set forth above is <u>not</u> fully responsive to the deficiency cited and the corrective action required by the Department. The Plan did not specifically address the actions taken to ensure that the general ledger accounts for premiums receivable, claims payable and unearned premium revenue are reconciled with the supporting subsidiary schedules. In addition, the Plan did not specifically indicate its policy to ensure an adequate reserve for uncollectible premiums is recognized on the books.

The Plan is again required to describe the procedures implemented that will result in more reliable, effective, and efficient controls over the recognition of these assets and liabilities. These procedures are to include a description of the Plan's recognition of a reserve for uncollectible premiums.

C. INTERCOMPANY ACCOUNTS

Our examination disclosed that the Plan does not reconcile the intercompany general ledger account balances on a periodic basis, settle the payroll account in a timely manner, or follow up on the collectibility of affiliate receivables. The Plan's failure to reconcile or settle these accounts resulted in examination adjustment AJE# 10 to properly present these accounts in the financial statement.

The Plan was required to describe the procedures implemented that will result in more reliable, effective, and efficient controls over the intercompany accounts. These procedures were to include a description of the Plan's settlement and collection policies with its affiliates. In addition, the Plan was required to state the date these procedures were implemented, the management position responsible for ensuring compliance with and continued oversight of these procedures.

The Plan responded that its policy for settlement and collections is being made part of the Services and Shared Expenses Agreement. The Plan stated the implementation date would be the same as the adoption date of the Services and Shared Expenses Agreement (see Section IV.A.). The Plan stated the management position for ensuring compliance and providing oversight is the Vice-President of Finance.

The Department finds that the compliance effort as set forth above is not fully responsive to the deficiency cited and the corrective action required by the Department. The Services and Shared Expense Agreement does not set forth specific policies and procedures for timely reconciliation, collection and settlement of intercompany accounts. This agreement provides for a reconciliation between actual costs and payments to be performed annually.

The Plan is again required to provide specific policies and procedures for timely reconciliation, collection and settlement of intercompany accounts. Reconciliation and settlement of these accounts should be performed on at least a quarterly basis. In addition, the Plan is again required to state the date these procedures were implemented.

SECTION V. OTHER ISSUES

REPRESENTATION LETTER FROM ATTORNEY

As part of our examination procedures, the Department sends out legal inquiry letters to each attorney who performed services for the plan during the current fiscal year. This letter requests that the attorney report on matters that existed at the examination date and from this date to the date of the attorney's response.

The Plan was requested to provide the Department with a letter from the Plan's attorneys during the examination. The requested letter was not received. Our examination is not considered complete without this letter.

The Plan was required to contact their law firm and advise them to submit the required response directly to the Department's Los Angeles office as soon as possible, but no later than forty-five (45) days after receipt of the Preliminary Report.

The Plan responded that it's law firm will submit the "Representation Letter From Attorney" to the Department's Los Angeles office under separate cover.

The Department finds that the compliance effort as set forth above is not responsive to the deficiency cited and the corrective action required by the Department. The required letter has not been received.

The Plan is again required to have its law firm submit the representation letter.

NONROUTINE EXAMINATION

The Plan is advised that the Department will conduct a nonroutine 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 is required to this Section.

CALIFORNIA BENEFITS DENTAL PLAN

GE Financial Assurance Employer Services Group

3611 S. Harbor Boulevard, Suite 150
Santa Ana, California 92704
(714) 540-4255
(800) 350-3999
FAX (714) 540-4754

April 11, 2002

Joan Larsen
Supervising Examiner
Office of Health Plan Oversight
Divisiion of Financial Oversight
Department of Managed Health Care
320 West Fourth Street, Suite 880
Los Angeles, CA 90013

Re: California Benefits Dental Plan; Response to Final Report of Routine Financial Examination (File No. 933-0308)

Dear Ms. Larsen:

On April 1, 2002, California Benefits Dental Plan (the "Plan") received the Department of Managed Health Care's March 29, 2002 Final Report of its December, 2001 Routine Examination of the Plan's fiscal and administrative affairs (the "Final Report"). This letter is the Plan's preliminary response to the Final Report, made pursuant to Section 1382(c) of the Health and Safety Code, made within 10 days of the Plan's receipt of the Final Report. Please append this response to all copies of the Final Report made available to the public.

The Final Report requires the Plan to provide additional information within 30 days following the Plan's receipt of the Final Report. The Plan is preparing this additional information (the "Detailed Response") and will provide the Detailed Response to the Department within the time required.

The following paragraph and section references correspond to those of the Final Report in which the Department requested additional information.

Section IV. Compliance Issues.

A. Administrative Capacity.

<u>Administrative Services Agreements</u>:

1. Request: The Department has requested that the Plan enter into and furnish copies of separate administrative services agreements with each affiliate.

Response: The Plan believes that the Shared Services and Expenses Agreement that it has provided to the Department on January 31, 2002 (the "January Response") has the same legal effect as a separate agreement with each affiliate (the "Administrative Services Agreements"). Nevertheless, the Plan will be reviewing this issue further and developing a new response to the Department's concerns. That response will be included in the Detailed Response.

2. Request: The Department has requested that the Plan's Administrative Services Agreements be more specific in the following respects:

- Description of services provided.
- Description of how the Plan will conduct oversight of affiliates' performance for each service.
- Description of documentation that will be provided to Plan to permit such oversight.
- Description of compensation methodology.

Response: The Plan will amend its Administrative Services to provide the additional specificity requested. The Plan's proposed amendments will be included in the Detailed Response.

3. Request: The Department has requested an explanation of why separate Administrative Services Agreements (*i.e.*, a separate agreement with each affiliate) have not yet been provided.

Response: The Plan believes that the Shared Services and Expenses Agreement provided in the January Response was responsive to the substance of the Department's request, *i.e.*, for legally binding agreements among the Plan and its affiliates regarding administrative services arrangements. The arrangements created under the Shared Services and Expenses Agreement have been adopted by the Plan's corporate parent and the Plan's other affiliates as a means to administer intra-corporate relationships efficiently and in a coordinated manner. The Plan believes it would be most efficient to participate in these arrangements under its parent's present structure. As stated above, the Plan will be reviewing this matter further and the Detailed Response will respond to the Department's concerns on this subject fully.

4. Request: The Department has requested that the Plan provide monthly status reports regarding progress in obtaining approvals from other regulatory agencies concerning Administrative Services Agreements, and an explanation for why such updates have not yet been provided.

Response: The Plan will include the requested status reports in the Detailed Response, and will provide updated status reports on a monthly basis thereafter. The omission of status reports for prior months was due to inadvertent oversight that the Plan has corrected. The Detailed Response will also include the Plan's corrective action plan with respect to the filing of required status reports.

5. Request: The Department has requested that the Plan amend its corrective action plan concerning Administrative Services Agreements so that it will apply also to the Plan's solicitor agreements.

Response: The Plan will provide a fully responsive amended corrective action plan in the Detailed Response.

6. Request: The Department has requested that the Plan provide a copy of the exhibit to its Corrective Action Plan for Accounting Skills and Knowledge of Plan Personnel (*i.e.*, "Reporting Requirements Training Plan"), which exhibit was not included in the Plan's earlier response.

Response: The requested exhibit was inadvertently omitted from the January Response. The Plan will provide the requested exhibit in the Detailed Response.

Officer Training

Request: The Department has requested that the Plan confirm that its Vice President of Finance completed the Reporting Requirements Training Program by March 31, 2002.

Response: The Plan's Vice President of Finance has undertaken extensive training that will be described in the Detailed Response.

B. Generally Accepted Accounting Principles

Prepaid Commissions

1. Request: The Department has requested that the Plan explain how recognizing a portion of prepaid commissions as goodwill is in accordance with generally accepted accounting principles and provide support for that explanation.

Response: The Plan has made a decision to modify its treatment of recognizing a portion of prepaid commissions as goodwill. The entire amount of prepaid commissions will be written-off in 2001 and the Plan will not carry goodwill on its books.

2. Request: The Department has requested that the Plan explain why the Plan has stated that goodwill was deducted from TNE starting in August, 2001, when the Plan continued to count goodwill through November, 2001.

Response: The Plan discovered a formula error in the TNE calculation portion of the spreadsheet in which the Orange Blanks are prepared. The Plan re-calculated TNE for its response to the Department's Preliminary Response and recognized the error in the November monthly Orange Blank.

C. Claims

Claims Reimbursement

1. Request: The Department has requested that the Plan adopt a more formal corrective action plan regarding claims reimbursement practices.

Response: The Plan is preparing a more formal corrective action plan and will include that plan in the Detailed Response.

2. Request: The Department has requested that the Plan explain when this corrective action plan was adopted.

Response: As explained above, the Plan is preparing the requested more formal corrective action plan and will provide that plan and the date of its implementation in the Detailed Response.

Payment of Interest

1. Request: The Department has requested that the Plan adopt a more formal corrective action plan regarding interest payment on claims that are not paid within the required period.

Response: The Plan is preparing a more formal corrective action plan and will include that plan in the Detailed Response.

2. Request: The Department has requested that the Plan explain when this corrective action plan was adopted.

Response: As explained above, the Plan is preparing the requested more formal corrective action plan and will provide that plan and the date of its implementation in the Detailed Response.

Incurred But Not Reported Claims

Request: The Department has requested that the Plan adopt a more formal corrective action plan regarding its calculation of incurred but not reported claims.

Response: The Plan is preparing a more formal corrective action plan and will include that plan in the Detailed Response.

D. Insurance

Fidelity Bond

1. Request: The Department has requested that the Plan have its fidelity bond coverage amended to provide notice to the Department of cancellation for nonpayment extended from 15 to 30 days.

Response: The Plan will comply with this request and will provide the corresponding amended certificate of coverage in the Detailed Response.

2. Request: The Department has requested that the Plan describe deductible that applies under its fidelity bond coverage.

Response: The Plan will provide an amended certificate of insurance, which describes the applicable deductible, in the Detailed Response.

Malpractice

Request: The Department has requested that the Plan adopt a more formal corrective action plan regarding the monitoring of insurance coverages obtained by its parent or other affiliates.

Response: The Plan is preparing a more formal corrective action plan and will include that plan in the Detailed Response.

I. Financial Statement Presentation

Request: The Department has requested that the Plan confirm it will complete Orange Blank Item 1 in reports commencing 3/31/02.

Response: The Plan confirms that by the Orange Blank for the quarter ending 3/31/02 all required information will be present and submitted appropriately.

Section V. Internal Control Structure

A. Cash

Request: The Department has requested that the Plan adopt a more formal Corrective Action Plan regarding maintenance of authority over accounts.

Response: The Plan is preparing a more formal corrective action plan and will include that plan in the Detailed Response.

B. Recognition of Assets/Liabilities

1. Request: The Department has requested that the Plan provide more detailed procedures for general ledger controls over recognition of assets/liabilities.

Response: The Plan has adopted the Parent Company's policy of reconciling all Balance Sheet accounts quarterly and will provide more detail in the formal corrective action plan that will be included in the Detail Response.

2. Request: The Department has requested that the Plan provide a more detailed description of its procedures to ensure the maintenance of an adequate reserve for uncollectible premiums.

Response: The Plan's reserve for uncollectible premium has so far been adequate. The Plan is however reviewing its premium collection history in order to develop a supportable method of setting reserves for uncollectible premiums. The progress will be reported in the Detailed Response and in subsequent thirty day reports to the Department until the new policy and procedure is implemented.

C. Intercompany Accounts

1. Request: The Department has requested that the Plan provide a more specific description of procedures for reconciliation, collection and settlement of intercompany accounts.

Response: Consistent with the Department's request for the Plan's Administrative Services Agreements to contain more detailed descriptions of the services provided thereunder, the amended agreements to be included in the Detailed Response will provide the specific descriptions of reconciliation procedures the Department has requested.

2. Request: The Department has requested that the Plan state the date on which those procedures were implemented.

Response: The Plan proposes to implement the procedures described in the revised Administrative Services Agreements upon the effectiveness of each such revised agreement. The Plan's proposal in this regard will be more specifically described in the Detailed Response.

Section VI. Other Issues

Request: The Department has requested that the Plan have its law firm provide the requested audit letter.

Response: The Plan has requested that its law firm provide the requested letter without delay.

Thank you for your attention to these materials. If you have any questions or comments prior to receiving the Detailed Response, please do not hesitate to call me.

Very truly yours,

CALIFORNIA BENEFITS DENTAL PLAN

By: _____

Valerie A. Clark
Chief Executive Officer