DEPARTMENT OF Managed Health Care

Edmund G. Brown Jr., Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
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June 17, 2016

Dong H. Ahn, Chairman of the Board
Access Dental Plan
8890 Cal Center Drive
Sacramento, CA 95856

FINAL REPORT OF ROUTINE EXAMINATION OF ACCESS DENTAL PLAN

Dear Mr. Ahn:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of Access Dental Plan (Plan), conducted by the Department of Managed Health Care (Department), pursuant to Section 1382(a) of the Knox-Keene Health Care Service Plan Act of 1975.[1] The Department issued a Preliminary Report to the Plan on March 8, 2016. The Department accepted the Plan's electronically filed response on April 30, 2016.

This Final Report includes a description of the compliance efforts included in the Plan's April 30, 2016 response, in accordance with Section 1382(c).

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

Please indicate within ten (10) days from the date of the Plan's receipt of this letter whether the Plan requests the Department to append its response to the Final Report. If so, please indicate which portions of the Plan's response shall be appended, and electronically file copies of those portions of the Plan's response excluding information held confidential pursuant to Section 1382(c). 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 April 30, 2016 response,

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in the 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 Chapter 2 of Division 1, Title 28, of the California Code of Regulations, beginning with Section 1300.43.

please provide the electronically filed documentation no later than ten (10) days from the date of the Plan's receipt of this letter through the eFiling web portal. Please file this addendum electronically via the Corrective Action Plan system (CAP system) within the Online Forms Section of the Department's eFiling web portal https://wpso.dmhc.ca.gov/secure/login/, as follows:

- From the main menu, select "eFiling".
- From the eFiling (Home) menu, select "Online Forms".
- From the Existing Online Forms menu click on the "Details" for the DFO Corrective Action Plan S15-R-318.
- Go to the "Messages" tab
  - Select "Addendum to Final Report" (note this option will only be available for 10 days after the Final Report has been issued)
  - Select the deficiency(ies) that are applicable
  - Create a message for the Department
  - Attach and Upload all documents with the name "Addendum to Final Report"
  - Select "Send Message"

As noted in the attached Final Report, the Plan's response of April 30, 2016 did not fully respond to the deficiencies raised in the Preliminary Report issued by the Department on March 8, 2016. Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any request for additional corrective action contained within the attached Final Report, within 30 days after receipt of the Report. If the Plan fails to fully respond and/or resolve the deficiencies addressed in the Final Report, then a referral will be made to the Office of Enforcement for appropriate administrative action for any remaining, unresolved deficiencies.

The Plan is hereby advised that any violations listed in this report may be referred to the Office of Enforcement for appropriate administrative action upon the completion of all remediation addressed in the Final Report.

The Department will also send the Plan an e-mail(s) requesting those items that are still outstanding. The e-mail(s) will contain a link to the CAP system for the Plan to file the response electronically.

Questions or problems related to the electronic transmission of the response should be directed to Susan Levitt at (916) 255-2443 or email at Susan.Levitt@dmhc.ca.gov. You may also email inquiries to wpso@dmhc.ca.gov.

The Department will make the attached Final Report available to the public in ten (10) days from the Plan's receipt of this letter through the eFiling system. The Report will be located at the Department's website at View Financial Examination Reports.

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

Sincerely,

ORIGINAL SIGNED BY

Bill Chang, CPA
Supervising Examiner
Office of Financial Review
Division of Financial Oversight
Telephone: (916) 255-2441
Email: bill.chang@dmhc.ca.gov

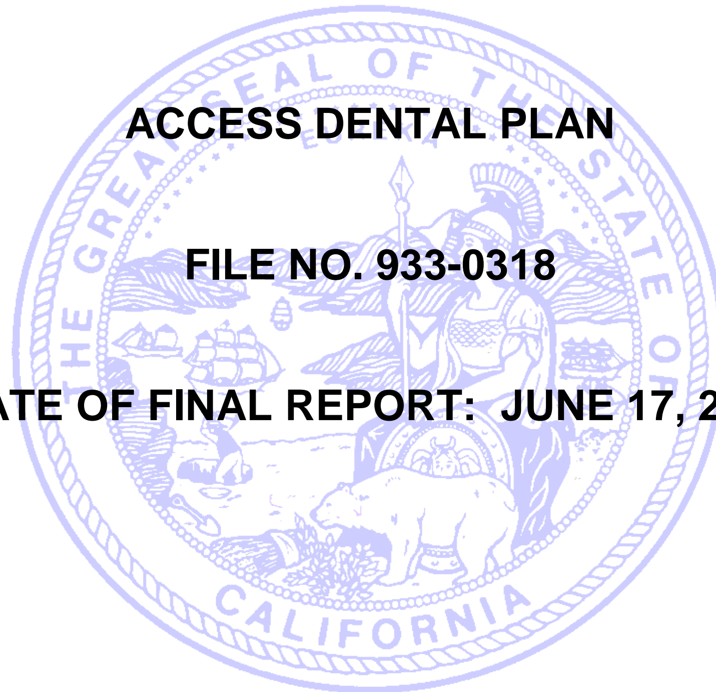
Cc: Candee Bolyog, President, Access Dental Plan
Gil Riojas, Deputy Director, Office of Financial Review
Steve Alseth, Examiner IV (Supervisor), Division of Financial Oversight
Nina Moua, Examiner, Division of Financial Oversight
Ashika Chiu, Examiner, Division of Financial Oversight
Danielle Cavallini, Attorney, Office of Plan Licensing
Laura Dooley-Beile, Chief, Division of Plan Surveys
Dan Southard, Health Program Manager III, Help Center
Paula Hood, Staff Services Manager I, Help Center

STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE

DIVISION OF FINANCIAL OVERSIGHT

FINAL REPORT OF ROUTINE EXAMINATION

OF



ACCESS DENTAL PLAN

FILE NO. 933-0318

DATE OF FINAL REPORT: JUNE 17, 2016

SUPERVISING EXAMINER: Bill Chang

OVERSIGHT EXAMINER: Steven Alseth

EXAMINER-IN-CHARGE: Nina Moua

FINANCIAL EXAMINERS: Anna Belmont, Eri Fukuda, Erica Short

BACKGROUND INFORMATION FOR ACCESS DENTAL PLAN

Date Plan Licensed:	December 22, 1993
Organizational Structure:	On August 1, 2014, First Commonwealth, Inc., a wholly owned subsidiary of Guardian Life Insurance of America, purchased all of the outstanding stock of the Plan. In Sacramento and Los Angeles Counties, the Plan operates as a dental health care service plan under the California Geographic Managed Care Program (GMC) and the Los Angeles Prepaid Health Plan (LAPHP), respectively. The GMC and LAPHP are administered by the California Department of Health Care Services and were created by the State legislature to ensure access, quality of care, and cost-effectiveness for beneficiaries of the Medi-Cal Program. The Plan also operates in various counties throughout California as a dental maintenance organization under the Healthy Families Program administered by the State of California.
Type of Plan:	Specialized Dental Plan.
Provider Network:	The Plan contracts with affiliated and non-affiliated dental clinics throughout California.
Plan Enrollment:	As of June 30, 2015, the Plan has total enrollment of 391,691.
Service Area:	All California Counties
Date of prior Final Routine Examination Report:	February 7, 2012

FINAL REPORT OF A ROUTINE EXAMINATION OF ACCESS DENTAL PLAN

This is the Final Report of a routine examination of the fiscal and administrative affairs of Access Dental Plan (Plan), conducted by the Department of Managed Health Care (Department) pursuant to Section 1382(a) of the Knox-Keene Health Care Service Plan Act of 1975.[1] The Department issued a Preliminary Report to the Plan on March 8, 2016. The Department accepted the Plan's electronically filed response on April 30, 2016.

This Final Report includes a description of the compliance efforts included in the Plan's April 30, 2016 response to the Preliminary Report, in accordance with Section 1382(c). The Plan's response is noted in *italics*.

The Plan is hereby advised that any violations listed in this report may be referred to the Office of Enforcement for appropriate administrative action upon the completion of all corrective actions required in response to this Report.

The Department examined the Plan's financial report filed with the Department for the quarter ended June 30, 2015 as well as other selected accounting records and controls related to the Plan's various fiscal and administrative transactions. The Department's findings are presented in this Report as follows:

Section I.	Financial Statements
Section II.	Calculation of Tangible Net Equity
Section III.	Compliance Issues
Section IV.	Non-routine Examination

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.

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[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in the 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 Chapter 2 of Division 1, Title 28, of the California Code of Regulations, beginning with Section 1300.43.

SECTION I. FINANCIAL REPORT

The Department's examination resulted in the following reclassifications to the Plan's financial statements for the quarter ended June 30, 2015, as filed with the Department. A copy of the Plan's financial statements can be viewed at the Department's website by typing the link http://wpso.dmhc.ca.gov/fe/search/#top and selecting Access Dental Plan on the second drop down menu.

LIABILITIES AND NET WORTH				
QE June 30, 2015				
	Bal. per F/S @	**Exam Adjustments**		**Bal. per Exam @**
	6/30/2015	**Dr**	**Cr**	**6/30/2015**
CURRENT LIABILITIES:				
Trade Accounts Payable	104,099			104,099
Claims Payable (Reported)	144,918		249,655	394,573
Incurred But Not Reported Claims	623,136		252,031	875,167
Unearned Premiums	8,478			8,478
Amounts Due To Affiliates - Current	690,759			690,759
Aggregate Write-Ins for Current Liabilities	3,761,790			3,761,790
TOTAL CURRENT LIABILITIES	**5,333,180**			**5,834,866**
TOTAL OTHER LIABILITIES				
TOTAL LIABILITIES	**5,333,180**			**5,834,866**
NET WORTH				
Common Stock	300,000			300,000
Preferred Stock				
Paid In Surplus	344,757			344,757
Retained Earnings (Deficit) Fund Balance	13,221,541	501,686		12,719,855
Aggregate Write-Ins for Other Net Worth Items				
TOTAL NET WORTH	**13,866,298**			**13,364,612**
TOTAL LIABILITIES AND NET WORTH	**19,199,478**			**19,199,478**

ADJUSTING JOURNAL ENTRIES

Primary Professional Services - Non-Capitated	$501,686	
Incurred But Not Reported Claims		252,031
Claims Payable (Reported)		249,655

To increase IBNR and to accrue unrecorded claims payable (effect on net income/loss is adjusted to Retained Earnings).

The Plan was required to provide written assurance that the above adjusting entries were posted to the books and records and/or provide an explanation regarding their disposition. The Plan was also required to identify the management position(s) responsible for ensuring continued compliance.

PLAN'S RESPONSE

The Plan responded that as of September of 2015, the Company implemented a process to accrue for specialty claims earned but not yet paid. This accrual was recorded as claims payable during the September 2015 close process. The Plan does not agree that IBNR should be impacted by this adjustment as their actuaries are aware of the timing and nature of these monthly specialty claim payments and had adjusted IBNR accordingly prior to year-end 2015.

The management position responsible for ensuring continued compliance is the Controller.

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

SECTION II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

Net Worth as of quarter Ended June 30, 2015	$13,365,194
Less: Intangible Assets and Goodwill-Net	689,355
Tangible Net Equity	12,675,839
Required TNE	511,530
TNE Excess per Examination quarter Ended June 30, 2015	$12,164,309

The Plan is in compliance with the TNE requirement of Section 1376 and Rule 1300.76 as of June 30, 2015.

No response required to this Section.

SECTION III. COMPLIANCE ISSUES

A. CLAIMS SETTLEMENT PRACTICES

Section 1371.37 (a) prohibits a health care service plan from engaging in an unfair payment pattern. Subsection (c) sets forth the claim settlement practices that are considered as an “unfair payment pattern”.

Rule 1300(a)(8) defines a “demonstrable and unjust payment pattern” or “unfair payment pattern” as any practice, policy or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims.

The Department’s examination found that the Plan failed to comply with the claim settlement requirements for the three-month period ending June 30, 2015, as summarized below:

1. PAYMENT ACCURACY

Section 1371 requires a specialized health care service plan to reimburse uncontested claims no later than 30 working days after receipt of the claim. This section also requires that if an uncontested claim is not reimbursed within 30 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 30 working day period.

Rule 1300.71(a)(8)(K) describes one unfair payment pattern as the failure to reimburse at least 95% of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three-month period.

Rule 1300.71(i) and (j) requires that all interest that has accrued shall be automatically included in the claim payment. The penalty for failure to comply with this requirement shall be a fee of ten ($10) dollars paid to the claimant.

The Department’s examination of paid claims disclosed that the Plan failed to reimburse claims accurately, including paying interest and penalty on 3 out of 50 paid claims (a compliance rate of 94%) for the three month period ending June 30, 2015. The deficiencies were noted in samples PD-6 (paid late with no interest), PD-14 (not paid according to contract [Plan corrected during examination]), and PD-47 (paid at lower of billed charges when provider contract does not provide for payment of lower of billed or contracted charges).

The Department’s examination of manual paid claims found that the Plan failed to reimburse claims accurately, including paying interest and penalty on 1 out of 10 manual paid claims (a compliance rate of 90%). According to the fee schedule the Plan had to pay $10 for procedure code 2160. The plan’s system automatically replaced all procedures for code 2160 with procedure code 2130 and did not pay the fee.

The Plan was required to pay interest and penalties on PD-6. The Plan was required to pay the remaining contracted fee schedule amount with interest on PD-47. The Plan was also required to set forth the corrective action to either pay the contracted fee schedule or change their provider contract to state if the provider bills lower than the fee schedule the Plan will pay the lower of the two. The Plan corrected the payment for PD-14 during the exam, so no further action is required.

The Plan was required to identify and pay all manual claims with procedure code 2160 which have been automatically replaced with procedure code 2130 and pay the fee, if applicable, in accordance with above Section and Rules.

In addition, the Plan was required to provide policies and procedures and provide the management position(s) responsible for compliance and a description of the monitoring system implemented to ensure continued compliance with section and rules listed above.

PLAN'S RESPONSE

The Plan responded that the Plan has correctly paid interest and penalties for PD-6. In addition the remaining contracted fee schedule amount with interest has been paid on PD-47.

The Plan will move forward with correcting the provider contract to state that the provider can bill up to their fee schedule and if the Provider bills less than their fee schedule the Plan will pay the lesser of the two. Until the provider contract change has been approved and implemented, the Plan will continue to pay based on the contracted fee schedule.

The Plan has identified 1,178 claims with procedure code 2160 that were paid at $0 due to the automatic replacement included in 2160 report. All others in the time period had been correctly paid. Incorrect payments have been corrected along with interest and penalty payments.

Updated Policies and Procedures have been provided to the Board and will be reviewed at the next Board Meeting on May 17, 2016. The Plan will submit evidence of Board approval with an amended response to the Department's preliminary report of examination by May 31, 2016.

The management position responsible for compliance with this finding is the Director of Claims.

The Plan recognizes that incorrect payments were due to a one-time coding conversion errors. The Plan has corrected this mapping error and developed additional systems testing to prevent such errors on future coding conversions on April 1, 2016.

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

2. PAYMENT OF INTEREST ON LATE CLAIM

Rule 1300.71(a)(8)(K) describes one unfair payment pattern as the failure to reimburse at least 95% of complete claims with the correct payment including the automatic payment of all interest and penalties due and owing over the course of any three month period.

Section 1371 requires a specialized health care service plan to reimburse uncontested claims no later than 30 working days after receipt of the claim. This section also requires that if an uncontested claim is not reimbursed within 30 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 30 working day period.

Section 1371 and Rule 1300.71(1)(2) and (j) requires that interest at the rate of 15 percent per annum for the period of time that the payment is late shall be automatically included in the claim payment of a complete claim. The penalty for failure to comply with this requirement shall be a fee of ten ($10) dollars paid to the claimant.

The Department's examination of late paid claims disclosed that the plan did not pay interest on 17 out of 50 late paid claims (a compliance rate of 66%) for the three month period ending June 30, 2015. The deficiencies were found in samples LP-2, LP-5, LP-7, LP-8, LP-11, LP-13, LP-14, LP-21, LP-22, LP-26, LP-34, LP-36, LP-45, LP-46, LP-49, LP-50, and LP-52.

The Department found that 11 out of 17 late paid claims were late due to the Plan placing the members' claims on hold for not receiving premium payments. According to the Plan's policy, if the Plan does not receive premium payments from the member, it places all the claims received for those members on a financial hold. The Plan incorrectly excluded days of financial hold from the interest calculation.

The Department's examination of manual late paid claims disclosed that the plan did not pay interest on 50 out of 50 manual late paid claims for the three month period ending June 30, 2015.

The Plan was required to submit a Corrective Action Plan (CAP) to substantiate the corrective actions implemented to comply with the above Sections and Rules. The CAP should address the deficiency cited above and include the following:

a) Identification of all late claims because of financial hold, for which interest was not correctly paid, from July 1, 2010 through the date corrective action was implemented by the Plan.

b) Identification of manual late claims for which interest and penalties were not correctly paid, from July 1, 2010 through the date corrective action was implemented by the Plan.

c) Evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in paragraphs "a" and "b", above. This evidence was to include an electronic data file (Excel or dBase) or schedule that identifies the following:

- Claim number
- Date of service
- Date original claim received
- Date new information received (date claim was complete)
- Total billed
- Total paid
- Paid date (mail date)
- Number of days late used to calculate interest
- Interest amount paid
- Date interest paid
- Penalty amount paid
- Additional interest amount paid if applicable
- Date additional interest paid if applicable
- Check Number for additional interest and penalty paid amount
- Provider name

d) Provide training to its staff and establish internal auditing procedures to ensure that policies and procedures are followed.

e) Policies and procedures implemented to ensure the correct payment of interest and penalty, if appropriate, on all late claims that result from the deficiency cited above, pursuant to Sections 1371.

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

The required data file and policies and procedures were to be filed with the Plan's response to this report. If the Plan was not able to complete the CAP or portions of the CAP in response to this report, then the Plan was required to submit with its response a matrix that outlines the specific steps required towards full compliance with specific dates for completing each step. The timeline was to commit the Plan to completion of the CAP within 90 calendar days from the receipt of this report. If the Plan was not able to meet this timeframe, it must provide a justification for completion of the CAP. The Plan was then required to submit a monthly status report until the CAP was completed.

PLAN'S RESPONSE

The Plan responded that it has identified all claims on financial hold from July 1, 2010 through December 31, 2015. All claims have been paid with interest and penalty accurately up to the date of implementation. The Plan has updated processes to include financial hold claims to accrue interest and penalties correctly. This has been implemented as of January 1, 2016. The Plan provided a list of claims identified and amount of interest and penalty paid as an attachment in its response.

All manual late claims have been identified from July 1, 2010 through December 31, 2015. All claims have been paid with interest and penalty accurately up to the date of implementation (January 1, 2016). Manual claims are no longer processed once per quarter but rather on a monthly basis to avoid interest and penalty. This report covers the period up to the change in process.

The Plan has provided staff training on Fair Claims Settlement as well as establishing internal audit processes to ensure policies and procedures are followed.

Updated Policies and Procedures have been provided to the Board and will be reviewed at the next board meeting on May 17, 2016. The Plan will submit evidence of Board approval with an amended response to the Department's preliminary report of examination by May 31, 2016.

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

3. INCORRECT INTEREST CALCULATION

Section 1371.35 states that a health care service plan, including a specialized health care service plan, shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the complete claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the complete claim by the health care service plan.

Section 1373.10(b) (1) states that a "health maintenance organization" or "HMO" means a public or private organization, organized under the laws of this state, which does all of the following: Provide or otherwise makes available to enrolled participants health care services, including at least the following basic health care services: usual physician services, hospitalization, laboratory, X-ray, emergency and preventive services, and out-of-area coverage.

The Department's examination of late paid claims disclosed that the Plan calculated interest after 45 working days. The Plan stated that they are a "health maintenance organization" or "HMO" plan. However, the Plan does not meet the basic requirements

for a HMO plan according to Section 1373.10 (b) (1). The Plan is required to calculate interest after 30 working days.

The Plan was required to submit a CAP to substantiate the corrective actions implemented to comply with the above Sections. The CAP should address the deficiency cited above and include the following:

a) Identification of all claims for which interest was paid using 45 days, and penalties were not correctly paid, from July 1, 2010 through the date corrective action was implemented by the Plan.

b) Evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in paragraph “a”, above. This evidence is to include an electronic data file (Excel or dBase) or schedule that identifies the following:

- Claim number
- Date of service
- Date original claim received
- Date new information received (date claim was complete)
- Total billed
- Total paid
- Paid date (mail date)
- Number of days late used to calculate interest
- Interest amount paid
- Date interest paid
- Penalty amount paid
- Additional interest amount paid if applicable
- Date additional interest paid if applicable
- Check Number for additional interest and penalty paid amount
- Provider name

c) Training provided to its staff and internal auditing procedures established to ensure that policies and procedures are followed.

d) Policies and procedures implemented to ensure the correct payment of interest and penalty, if appropriate, on all late claims that result from the deficiency cited above, pursuant to Section 1371.35.

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

The required data file and policies and procedures were to be filed with the Plan’s response to this report. If the Plan was not able to complete the CAP or portions of the

CAP in response to this report, then the Plan was required to submit with its response a matrix that outlines the specific steps required towards full compliance with specific dates for completing each step. The timeline is to commit the Plan to completion of the CAP within 90 calendar days from the receipt of this report. If the Plan was not able to meet this timeframe, it must provide a justification for completion of the CAP. The Plan was then required to submit a monthly status report until the CAP is completed.

PLAN'S RESPONSE

The Plan responded that it has identified all claims paid past 45 days from July 1, 2010 through March 31, 2016, and accurately recalculated interest and penalty based on 30 working days. The Plan provided a list of claims identified and amount of interest and penalty paid as an attachment in its response.

The Plan has made the change to the interest calculation to ensure late claims are calculated using the 30 working days on May 1, 2016. Until implementation the Late Payables report will be used to ensure correct interest calculation.

Updated Policies and Procedures have been provided to the Board and will be reviewed at the next Board meeting on May 17, 2016. The Plan will submit evidence of Board approval with an amended response to the Department's preliminary report of examination by May 31, 2016.

The management position responsible for compliance with this finding is the Plan Controller.

The Plan has provided staff training on Fair Claims Settlement as well as establishing internal audit processes to ensure policies and procedures are followed.

The Claims Department shall run a weekly Late Payables report. All Late Claims identified in the Late Payables report will be verified to ensure date correctness. Verified late claims shall be completed and the system will calculate interest. All verified and completed late claims shall have their EOB reviewed by the Claims Department to ensure interest and penalty was paid.

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

4. CLAIM ADJUSTMENT

Rule 1300.71(c) states that the plan and the plan's capitated provider shall identify and acknowledge the receipt of each claim, whether or not complete, and disclose the recorded date of receipt as defined by section 1300.71 (a)(6) in the same manner as the claim was submitted or provide an electronic means, by phone, website or another mutually agreeable accessible method of notification, by which the provider may readily

confirm the plan's or the plan's capitated provider's receipt of the claim and the recorded date of receipt.

Rule 1300.77.4 requires all plans to institute procedures whereby all claims received by the plan are maintained and accounted for in a manner which permits the determination of the date of receipt of any claims, the status of any claims, the dollar amount of unpaid claims at any time and the rapid retrieval of any claim.

Rule 1300.71(d)(1) states that a plan or a plan's capitated provider shall not improperly deny, adjust, or contest a claim. For each claim that is either denied, adjusted or contested, the plan or the plan's capitated provider shall provide an accurate and clear written explanation of the specific reasons for the action taken within the timeframes specified in sections (g) and (h).

The Department's examination of late paid claims disclosed that the plan either combined two claims with different dates of service into one claim or split one claim with multiple procedures into two claims on 6 out of 50 late paid claims (or 88% compliance rate). The claims sample reviewed were LP-7, LP-8, LP-13, LP-14, LP-45, and LP-52.

The Plan was required to provide additional training to claims processors to ensure that each complete claim is assigned its own claim number and to file evidence of this training. In addition, the Plan was requested to submit additional policies, procedures and oversight of processes implemented in compliance with the above Rules.

PLAN'S RESPONSE

The Plan responded that it has provided staff training on the changes to policies and procedures to ensure that each claim is assigned its own unique claims number. In the event the claim crosses two different benefit plans the system will automatically split the claim into their own unique identification numbers. This process shall ensure maximum benefits to the member.

Updated Policies and Procedures have been provided to the Board and will be reviewed at the next Board meeting on May 17, 2016. The Plan will submit evidence of Board approval with an amended response to the Department's preliminary report of examination by May 31, 2016.

The Plan has added this as part of their internal auditing process.

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

5. INCORRECT DATE OF RECEIPT

Rule 1300.77.4 requires all plans to institute procedures whereby all claims received by the plan are maintained and accounted for in a manner which permits the determination

of date of receipt of any claim, the status of any claim, the dollar amount of unpaid claims at any time and the rapid retrieval of any claim.

Rule 1300.71(a)(6) defines the date of receipt as the working day when a claim by physical or electronic means, is first delivered to either the plan's specified claims payment office, post office box, or designated claims processor or to the plan's capitated provider for that claim. This definition shall not affect the presumption of receipt of mail set forth in Evidence Code section 641. In the situation where a claim is sent to the incorrect party, the "date of receipt" shall be the working day when the claim, by physical or electronic means, is first delivered to the correct party responsible for adjudicating the claim.

The Department's examination disclosed that the date of receipt was not entered into the system correctly in the following samples:

- Four (4) out of fifty (50) late paid claims (a compliance rate of 92%). The claims sample reviewed were LP-8, LP-18, LP-45, and LP-52.

- Twenty-five (25) out of twenty-six manual paid claims (a compliance rate of 4%) were paid before the Plan's records indicated the claims were received. The claims sample reviewed were MPD-2, MPD-3, MPD-4, MPD-5, MPD-6, MPD-7, MPD-8, MPD-9, MPD-10, MPD-11, MPD-12, MPD-13, MPD-14, MPD-15, MPD-16, MPD-17, MPD-18, MPD-19, MPD-20, MPD-21, MPD-22, MPD-23, MPD-24, MPD-25, and MPD-26.

The Plan was required to submit a description of its process to ensure that the correct claim receipt date is being captured in compliance with the above Rules. The Plan was also required to provide the management position(s) responsible for compliance and a description of the monitoring system implemented to ensure continued compliance with these Rules.

PLAN'S RESPONSE

The Plan responded that it scans claims to a secure FTP (SFTP) site: the scanner dates the claims with a received date. The Plan attempted to compare the received date in the claim system to the received date imprinted by the scanner; however, the cited files were misplaced due to a one-time data migration that impacted the SFTP site. As a result, the Plan was unable to verify the received dates on the cited claims. While this data migration was a one-time occurrence, new system processes have also been implemented to ensure that files cannot be removed or deleted from the SFTP site utilized by the Plan's claim organization. In order to ensure claims are not misplaced from the SFTP site, all file permissions must be approved by the Director of Claims.

The management position responsible for compliance with this finding is the Director of Claims.

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

6. CLAIMS BOOKS AND RECORDS

Section 1381 (a) requires all records, books and paper of the plan shall be open to inspection during normal business hours by the director. Section 1381 (b) states that to the extent feasible, all such records, books, and papers described in subdivision (a) shall be located in this state.

Section 1385 and Rule 1300.58 requires each plan to keep and maintain current such books of account and other records as the Director may by rule require.

Rule 1300.85.1 requires that every plan 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 purpose of the Act. After such books and records have been preserved for two years, they may be warehoused or stored, or microfilmed, subject to their availability to the Director within not more than 5 days after request therefore.

During the Department's examination, the Plan was unable to provide the original claims for the following samples:

- Two out of 50 paid claims (a compliance rate of 96%). The misplaced original claims were samples PD-20 and PD-42.

- Twelve (12) out of fifty (50) denied claims (a compliance rate of 76%). The misplaced original claims were samples D-9, D-10, D-11, D-13, D-12, D-15, D-18, D-21, D-23, D-31, D-41, and D-52.

The misplacing of claims also resulted in the Department's inability to verify correct date of receipts for the above samples.

The Plan was required to describe in detail the CAP the Plan has implemented to ensure compliance with the above Sections and Rule and identify the management position(s) that has the responsibility for implementing the CAP and for ensuring ongoing compliance.

PLAN'S RESPONSE

The Plan responded that as stated in the response to Claim Deficiency #5, the Plan discovered that the cited claim files had been misplaced due to a one-time data migration that impacted the SFTP site. While this data migration was a one-time occurrence, new system processes have also been implemented to ensure that files cannot be removed or deleted from the SFTP site utilized by the Plan's Claim

organization. In order to ensure claims are not misplaced from the SFTP site, all file permissions must be approved by the Director of Claims.

The management position responsible for compliance with this finding is the Director of Claims.

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

B. PROVIDER DISPUTE RESOLUTION MECHANISM

1. WRITTEN DISPUTE

Rule 1300.71.38(a)(1)&(2) sets forth the procedures that a licensed health care service plan must follow when it receives a written dispute from a contracted or non-contracted provider.

The Department's examination disclosed that for 1 out of 8 provider disputes reviewed the Plan misclassified a claim as a written dispute (a compliance rate of 87%). The Plan denied the first claim. When the claim was resubmitted, the Plan initiated a formal dispute even though it had no indication of a written dispute. The deficiency was found in sample PDR- 7.

The Plan was required to submit policies and procedures to ensure the Plan processes only written disputes through its provider dispute resolution mechanism, in compliance with the above Rule. The Plan was also required to state the implementation date and the management position(s) responsible to ensure continued compliance.

PLAN'S RESPONSE

The Plan responded that the Plan has developed a Provider Dispute Memorandum to assist provider dispute processors to distinguish between an incoming claim and a provider dispute. In addition, the Plan has revised Policies and Procedures to incorporate this guidance. Updated Policies and Procedures have been provided to the Board and will be reviewed at the next Board meeting on May 17, 2016. The Plan will submit evidence of Board approval with an amended response to the Department's preliminary report of examination by May 31, 2016.

The management position responsible to ensure continued compliance is the Team Lead, Quality Management.

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

2. DATE OF RECEIPT FOR PROVIDER DISPUTES

Rule 1300.71.38 (a) (3) defines the “date of receipt” as the working day when the provider dispute or amended provider dispute, by physical or electronic means, is first delivered to the plan's designated dispute resolution office or post office box.

The Department’s examination disclosed that in 4 out of 8 provider disputes the date of receipt was not recorded correctly in the system (a compliance rate of 50%). This deficiency was found in samples PDR-1, PDR-2, PDR-6, and PDR-7.

The Plan was required to submit a description of its process to ensure that the correct claim receipt date is being captured in compliance with Rule 1300.71.38(a)(3). The Plan was also required to provide the management position(s) responsible for compliance and a description of the monitoring system implemented to ensure continued compliance with this Rule.

PLAN’S RESPONSE

The Plan responded the Plan has developed a Provider Dispute Memorandum to assist provider dispute processors to recognize and record the correct Company received date on incoming provider disputes. In addition, the Plan has revised Policies and Procedures to incorporate this guidance. Updated Policies and Procedures have been provided to the Board and will be reviewed at the next Board meeting on May 17, 2016. The Plan will submit evidence of Board approval with an amended response to the Department’s preliminary report of examination by May 31, 2016.

The management position responsible for compliance is the Team Lead, Quality Management.

The Department finds that the Plan’s compliance effort is responsive to the corrective action required.

3. PAST DUE PAYMENTS

Rule 1300.71.38(g) states if the provider dispute or amended provider dispute involves a claim and is determined in whole or in part in favor of the provider, the plan or the plan’s capitated provider shall pay any outstanding monies determined to be due, and all interest and penalties required under sections 1371 and 137.35 of Health and Safety Code and section 1300.71 of Title 28, within five (5) working days of the issuance of the Written Determination. Accrual of interest and penalties for the payment of these resolved provider disputes shall commence on the day following the expiration of “Time for Reimbursement” as forth in section 1300.71(g).

The Department’s examination found that in 2 out of 8 provider disputes reviewed the Plan did not pay the provider the outstanding monies determined to be due within five

(5) working days of the issuance of the Written Determination (a compliance rate of 75%). The deficiency was found in samples PDR-1 and PDR-2.

The Plan was required to submit policies and procedures implemented to ensure that additional payments resulting from a dispute are mailed out within five (5) days of the determination letter, the date of implementation, the management position responsible for compliance, and the controls implemented for monitoring continued compliance.

The Plan was also required to demonstrate that it provided training to its staff and established internal auditing procedures to ensure that policies and procedures are followed.

PLAN'S RESPONSE

The Plan responded the Plan has developed a Provider Dispute Memorandum to assist provider dispute processors to ensure that additional claims amounts approved as a result of the provider dispute resolution process are issued within five (5) working days of the date of the Written Determination. In addition, the Plan has included Policies and Procedures which incorporates this guidance. Updated Policies and Procedures have been provided to the Board and will be reviewed at the next Board meeting on May 17, 2016. The Plan will submit evidence of Board approval with an amended response to the Department's preliminary report of examination by May 31, 2016.

The management position responsible for compliance is the Team Lead, Quality Management.

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

4. DETERMINATION LETTER

Rule 1300.71(a)(8(f) states that the Plan's failure to inform a provider with an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim consistent with section (d)(1) at least 95% of the time for the affected claims over the course of any three-month period is an unfair payment pattern.

Rule 1300.71.38(f) requires a plan to issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 working days after the date of receipt of the provider dispute or amended provider dispute.

The Department's examination disclosed that the Plan did not give the correct determination for 1 out of 8 provider disputes reviewed (a compliance rate of 87%). The Plan's record indicated that the provider was given wrong information by the Plan's customer service representative. The Plan paid the claim as a goodwill payment. The Department found that the above mentioned Provider Dispute Resolution (PDR) is not a goodwill payment due to the Plan providing incorrect information.

The Plan was required to state the policies and procedures implemented to correct the above deficiency, the date of implementation, and the management position responsible for monitoring continued compliance.

PLAN'S RESPONSE

The Plan responded it updated Policies and Procedures to add that notification shall include "stating the pertinent facts and explaining the reasons." This updated Policy and Procedure was provided to the Board and implemented on April 1, 2016 in anticipation of Board approval. Updated Policies and Procedures will be reviewed at the next Board meeting on May 17, 2016. The Plan will submit evidence of Board approval with an amended response to the Department's preliminary report of examination by May 31, 2016.

The management position responsible to ensure continued compliance with this finding is the Director of Claims.

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

C. ANTIFRAUD PLAN

Section 1348(a) states that every health care service plan licensed to do business in this state shall establish an antifraud plan. The purpose of the antifraud plan shall be to organize and implement an antifraud strategy to identify and reduce costs to the plans, providers, subscribers, enrollees, and others caused by fraudulent activities, and to protect consumers in the delivery of health care services through the timely detection, investigation, and prosecution of suspected fraud. The antifraud plan elements shall include, but not be limited to, all of the following: the designation of, or a contract with, individuals with specific investigative expertise in the management of fraud investigations; training of plan personnel and contractors concerning the detection of health care fraud; the plan's procedure for managing incidents of suspected fraud; and the internal procedure for referring suspected fraud to the appropriate government agency.

Section 1348(c) states that every health care service plan that establishes an antifraud plan pursuant to subdivision (a) shall provide to the director an annual written report describing the plan's efforts to deter, detect, and investigate fraud, and to report cases of fraud to a law enforcement agency. For those cases that are reported to law enforcement agencies by the plan, this report shall include the number of cases prosecuted to the extent known by the plan. This report may also include recommendations by the plan to improve efforts to combat health care fraud.

The Department's examination found that the Plan's antifraud plan does not include the required language listed above in section 1348(a). The Plan did not file an annual antifraud report with the Department for 2013 and 2014.

The Plan was required to file the annual antifraud reports for year 2013 and 2014 that include required language in accordance with section 1348(a). In addition, the Plan was required to identify the management position(s) responsible for ensuring continued compliance with the above cited Sections.

PLAN'S RESPONSE

The Plan responded that 2013 and 2014 Anti-Fraud Reports have been filed on the portal. The management position responsible for ensuring continued compliance is the Dental Director.

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

D. ADMINISTRATIVE SERVICES AGREEMENT

Section 1351(d) states that applicant is required to provide a copy of any contract made, or to be made, between the applicant and any provider of health care services, or any person or organization agreeing to perform an administrative function or service for the plan.

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

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

Section 1352(a) and Rule 1300.52 and 1300.52.1 require all plans to file an amendment with the Department within thirty (30) days after any changes in the information contained in its application, other than financial or statistical information.

The Department's examination disclosed the following:

a. The Plan provides various administrative services to two affiliated companies, Access Dental Plan of Utah and Access Dental Service LLC (Delaware). However the Plan does not have a contract with either company.

b. The Plan has service or consulting agreements with Envoy LL (Emdeon) and National Electronic Attachment Inc. (NEA). However, the Plan did not file the agreements with the Department.

The Plan was requested to enter into administrative services agreements with Access Dental Plan of Utah and Access Dental Service LLC (Delaware) that specify the services to be provided by each entity, compensation terms, and right of offset arrangement, if applicable. The agreements are to be electronically filed with the Department as an amendment, in accordance with the Sections and Rules stated above. In addition, the Plan was requested to provide evidence (i.e., eFiling number) in its response to this report that the requested filing was submitted to the Department. The cover page for this amendment filing was to state that it was filed as a result of the recent financial examination.

The Plan was required to electronically file the aforementioned agreements with Envoy LL (Emdeon) and National Electronic Attachment Inc. (NEA), in accordance with Section 1352(a) and Rules 1300.52. The cover page for this filing should state that it is filed as a result of the recent financial examination.

The Plan was also required to state the policies and procedures implemented to ensure that administrative services agreements are filed with the Department, the date of implementation, and the management position(s) responsible for ensuring that all administrative arrangements are supported by a written administrative services agreement and filed with the Department in compliance with the Sections and Rules stated above.

PLAN'S RESPONSE

The Plan responded that it proposes to enter into an administrative services agreement with Access Dental Plan of Utah (THE PLAN (UT)) upon regulatory approval. The agreement was filed with the Department on March 31, 2016. The Plan also proposes to enter into an administrative services agreement with Access Dental Service LLC (Delaware) (ADS) upon regulatory approval. The agreement was filed with the Department on March 31, 2016. Both agreements specify the services to be provided by the Plan and the compensation terms.

The Plan filed with Envoy LLC (Emdeon) agreement on March 24, 2015, and the National Electronic Attachment Inc. (NEA) agreement on March 25, 2016.

Regarding the Policies and Procedures implemented to ensure that administrative services agreements are filed with the Department, the following has been implemented:

Effective as of March 23, 2016, the office of the President of Access Dental Plan is responsible for ensuring that all administrative arrangements are supported by a written administrative services agreement, and that all such administrative services agreements are timely filed with the Department. Furthermore, the Office of the President of Access Dental Plan maintains a log recording the dates that: (i) administrative services agreements are filed with the Department, (ii) comment letters, if any are issued by the

Department, and the related response deadlines: (iii) responses are filed by the Plan; (iv) approvals are issued by the Department, and (v) any agreed upon Undertakings.

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

E. UNASSIGNED ENROLLEES

The Plan does not have a written policy for assigning a provider to enrollees who have not selected a primary dentist. There are enrollees who have been enrolled since 2014 that do not have a primary care dentist.

The Plan was required to file a written policy for the assignment of enrollees to a provider. The policy was to require the Plan to accrue for and pay the newly assigned provider capitation retrospectively for a new member back to the effective date of enrollment. The Plan was also required to provide the date of implementation and the management position(s) responsible for ensuring continued compliance.

PLAN'S RESPONSE

The Plan responded that the Plan updated Policies and Procedures and implemented and the new procedures on April 4, 2016. The Policies and Procedures will be reviewed at the next Board meeting on May 17, 2016. The Plan will submit evidence of Board approval with an amended response to the Department's preliminary report of examination by May 31, 2016.

Provider Services will monitor a monthly unassigned report to ensure that members are being accurately assigned. As stated in the revised Policies and Procedures, some groups have the ability to prevent auto-assignment. The Plan does not auto-assign non-verified members.

The Management position responsible to ensure continued compliance with this finding is the Director of Provider Services.

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

F. MALPRACTICE INSURANCE

Section 1351(o) requires every plan to maintain at all times evidence of adequate insurance coverage or self-insurance to respond to claims for damages arising out of the furnishing of health care services.

The Department's examination disclosed that the Plan does not have malpractice insurance. The Dental Director has his own personal malpractice insurance.

The Plan was required to provide evidence that it obtained malpractice insurance as required by Section 1351(o). The Plan was also required to state the management position(s) responsible for ensuring continued compliance.

PLAN'S RESPONSE

The Plan responded that it continues to work diligently with its external broker to obtain the required coverage. To date the Plan has submitted all requested documentation in support of its application for coverage and awaits the broker's response. The Plan will submit evidence of coverage with an amended response to the Department's preliminary report of examination by May 31, 2016.

The Management position responsible for ensuring continued compliances is the Corporate Treasurer of Guardian.

The Department finds that the Plan's compliance effort is not fully responsive to the corrective action required in that the Plan has not submitted the evidence of malpractice insurance. The Plan is required to provide evidence that it obtained malpractice insurance as required by Section 1351(o).

G. FIDELITY BOND

Section 1351(q) and Rule 1300.76.3 state that each plan shall at all times maintain a fidelity bond covering each officer, director, trustee, partner and employee for the plan, whether or not they are compensated. The fidelity bond may be either a primary commercial blanket bond or a blanket position bond written by an insurer licensed by the California Insurance Director, and it shall provide for 30 days' notice to the Director prior to cancellation. The fidelity bond shall provide at least the minimum coverage for the plan, as required by the schedule in this Rule and may contain a provision for a deductible amount that is not in excess of 10 percent of the required minimum bond coverage, but in no event shall the deductible amount be in excess of $100,000.

The Department's examination disclosed that the Plan did not maintain fidelity bond coverage in accordance with the above Section and Rule for the quarter of June 30, 2015.

The Plan was required to provide evidence of fidelity bond coverage for the Plan in the amount of at least $2,000,000, with a deductible amount not in excess of $100,000. The fidelity bond needs to either be in the name of the Plan or the Plan needs to have exclusive rights. The fidelity bond must meet the requirements listed in the above Section and Rule. The Plan must maintain a fidelity bond at all times and have no lapse of coverage.

The Plan was required to describe the policies and procedures implemented and the date of implementation. Additionally, the Plan was required to provide the management position(s) responsible for overseeing and ensuring ongoing compliance with the Rule.

PLAN'S RESPONSE

The Plan responded that it notes that it had fidelity coverage during the review period through its parent company, First Commonwealth, Inc.; however, the Plan continues to work diligently with its external broker to obtain fidelity coverage that meets the requirements of Section 1351 (q) and Rule 1300.76.3. To date the Plan has submitted all requested documentation in support of its application for coverage and awaits the broker's response. The Plan will submit evidence of coverage with an amended response to the Department's preliminary report of examination by May 31, 2016.

The management position responsible for ensuring continued compliance is the Corporate Treasurer of Guardian.

The Department finds that the Plan's compliance effort is not fully responsive to the corrective action required in that the Plan has not submitted evidence of Fidelity Bond coverage. The Plan was required to provide evidence of Fidelity Bond coverage for the Plan in the amount of at least $2,000,000, with a deductible amount not in excess of $100,000.

H. SOLICITOR AGREEMENT

Rule 1300.67.12 (a) states that all funds received by the solicitor firm for the account for the plan shall at all times be segregated from the assets of the solicitor firm and shall be promptly deposited to a trust account in a state or federal bank authorized to do business in this state and insured by an appropriate federal insuring agency. "Promptly deposited" means deposited no later than the business day following receipt by the solicitor firm.

Rule 1300.67.12 (b) states that all funds received by the solicitor firm for the account of the plan shall be transmitted to the plan, or the person designated in the contract, net of actual commissions earned under the particular contract within (5) five business days after such funds are received by the solicitor firm.

The Department's examination found that Premier Access Inc., a solicitor of the Plan, sells and collects premium on behalf of the Plan. Premier Access Inc. did not transmit the premium within (5) five business days after receiving the funds.

The Plan was required to provide the policies and procedures implemented to ensure compliance with Rule 1300.76.2 (a) & (b), the date of implementation, the management position(s) responsible for implementation and compliance, and the controls implemented for monitoring continued compliance.

PLAN'S RESPONSE

The Plan responded that on a quarterly basis, Premier Access Insurance Company (PAIC) will calculate and advance two weeks of average premium receipts into the

Plan's bank account. The deposit will constitute advance premium for the Plan. Twice a month, PAIC will transfer actual premiums collected on behalf of the Plan into the Plan's bank account. The new process will be implemented, beginning May 1, 2016.

It should be noted that PAIC, not Premier Access, Inc., is performing the premium billing and collection function on behalf of the Plan, and neither PAIC nor Premier Access, Inc. is a solicitor of the Plan. As a result, the solicitors' agreement does not accurately reflect the relationship between PAIC and the Plan. Instead, the Plan is currently developing an intercompany administrative services arrangement detailing the premium billing and collection function, as well as the transmission of premiums from PAIC to the Plan as described above. The Plan will submit the proposed intercompany administrative services agreement for the Department's approval, as required, and supplement its response to the preliminary report accordingly.

As controls, the Group Financial Management organization (Finance) has implemented a cash log to monitor cash received by PAIC on behalf of the Plan, and has included a Quarterly Advance Premium calculation and settlement in the quarterly close schedule for the Plan and PAIC.

The management position responsible for implementation and compliance, and the controls implemented for monitoring continued compliance is the Controller.

The Department finds that the Plan's compliance effort is not fully responsive to the corrective action required. The Plan is required to submit the Administrative Services Agreement with PAIC, which will confirm the Plan's relationship with PAIC.

I. FINACIAL STATEMENT REPORTING

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 generally accepted accounting principles (GAAP) and on a basis consistent with the certified financial report furnished by the plan pursuant to Section 1384(c). This rule also refers to Rule 1300.84.06(b) that sets forth the requirements for the supplemental information that is to accompany the DMHC Reporting Format. The filing requirements are further supported by the "General Information, Definition and Instruction" guide that provides instructions by line item for proper completion of the DMHC Report Form.

The Department's examination disclosed the following concerns with the Plan's financial statement reporting:

- The Plan has special claims which they manually process. The Plan did not accrue and report the liabilities of the claims in their financial statement. This resulted in an understatement of Incurred but Not Reported Claims and Claims Payable (IBNR) accounts and overstatement in income.

- The accounting adjustments, as noted in Section I of this report, were needed to correctly report IBNR.

The Plan was required to state the policies and procedures implemented to correct the above deficiencies, the date of implementation, and the management position responsible for monitoring continued compliance.

PLAN'S RESPONSE

The Plan responded that it agrees that certain specialty claims that were manually processed were not accrued as of June, 30, 2015, and this resulted in an under accrual of Claims Payable. These specialty claims are paid once a month to Providers.

The Plan disagrees, however, that the under accrual of these specialty claims would have resulted in an understatement of IBNR. Our actuaries are aware of these manually processed claims and have adjusted the Plan's IBNR calculations accordingly.

On a monthly basis during the financial close, Finance will contact the Claims department to determine the amount of specialty claims earned for the month but not yet paid. Finance will account for this amount as claims payable. This new process will be implemented by September 30, 2015.

The management position responsible for continued compliance is the Controller.

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

J. ANNUAL AUDITED FINANCIAL REPORT DELINQUENT

Section 1384 (b) states that except as otherwise provided in this subdivision, each plan shall submit financial statements prepared as of the close of its fiscal year within 120 days after the close of the fiscal year. The financial statements referred to in this subdivision and in subdivisions (a) and (b) of this section shall be accompanied by a report, certificate, or opinion of an independent certified public accountant or independent public accountant. The audits shall be conducted in accordance with generally accepted auditing standards and the rules and regulations of the director. However, financial statements from public entities or political subdivisions of the state whose audits are conducted by a county grand jury shall be submitted within 180 days after the close of the fiscal year and need not include a report, certificate, or opinion by an independent certified public accountant or an independent public accountant, and the audit shall be conducted in accordance with governmental auditing standards.

The Department's examination disclosed that the Plan filed their annual audited financial statements 224 days after the required due date as listed above in section 1384(b).

The Plan was required to state the policies and procedures implemented to correct the above deficiency, the date of implementation, and the management position responsible for monitoring continued compliance.

PLAN'S RESPONSE

The Plan responded that the Plan has started the 2015 audit much earlier than prior year and will complete the audit in phases throughout calendar year 2016. The Plan is working with the external auditors to ensure that the audited financial statements are filed by the required due date. The 2016 audit will be aligned with Guardian's audit process, which is expected to reduce the effort required to complete the audit after year end. This new process has been implemented as of January 1, 2016.

The management position responsible for monitoring continued compliance is the Controller.

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

K. ACCESS TO BOOKS AND RECORDS

Section 1381 (a) requires that all records, books, and papers of a plan be open to inspection during normal business hours by the Director. Section 1381 (b) states that to the extent feasible, all such records, books, and papers described in subdivision (a) shall be located in this state. This subsection further states that in examining such records outside this state, the Director shall consider the cost to the plan, consistent with the effectiveness of the Director's examination, and may upon reasonable notice require that such records, books and papers, or a specified portion thereof, be made available for examination in this state, or that a true and accurate copy of such records, books and papers, or a specified portion thereof, be furnished to the Director.

Section 1385 requires each plan to keep and maintain current such books of account and other records as the Director may by rule require. Rule 1300.85.1 requires that every plan 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 purpose of the Act. After such books and records have been preserved for two years, they may be warehoused or stored, or microfilmed, subject to their availability to the Director within not more than 5 days after request therefore.

The Plan did not provide requested documents in a timely manner, prolonging the examination. Examples of not providing material and access to the Plan's books and records timely are:

- The Department requested that the Plan provide all claims samples and PDR samples the first day of the exam. The examination began November 30, 2015. The Department did not receive late claims samples until December 2, 2015.

- The Plan was requested to have a claims person meet with the examination team twice a day during the claims review. The claims person did not attend the scheduled meetings.

- The PDR samples provided on December 1, 2015, were incomplete and had to be returned for completion. The Department did not receive completed PDR samples until December 22, 2015.

- During the exam repeated requests were made to the Plan to provide minutes of board meetings conducted after the purchase of Access Dental Plan by Guardian. The Plan provided the board meeting minutes in February 2016 after the fieldwork was completed.

The Plan was required to describe in detail the CAP the Plan has implemented to ensure compliance with Section 1381(a) and (b), Section 1385, and Rule 1300.85.1 and identify the management position(s) that has the responsibility for implementing the CAP and for ensuring ongoing compliance with Section 1381(a) and (b), Section 1385, and Rule 1300.85.1.

PLAN'S RESPONSE

The Plan responded that the President of the Plan will designate an exam coordinator for future regulatory examinations. The exam coordinator will partner with the managers and designated subject matter experts of all affected operational areas, including claims and PDR, to ensure that sampled files are produced to examiners by established deadlines. The exam coordinator will ensure that a knowledgeable claim manager is assigned to meet with examiners as requested to respond to requests for additional information. The exam coordinator will also work with corporate partners to ensure that corporate records are produced to examiners by the established deadlines and contain all of the documentation requested for review.

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

SECTION IV. NONROUTINE EXAMINATION

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

No response required to this Section.