



Edmund G. Brown Jr., Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
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Telephone: 916-255-2444 | Fax: 916-255-2280

Via USPS Delivery and eFile

February 7, 2018

Dr. Richard Merkin, President
HERITAGE PROVIDER NETWORK, Inc.
8510 Balboa Boulevard, Suite 285
Northridge, CA 91325

FINAL REPORT OF ROUTINE EXAMINATION OF HERITAGE PROVIDER NETWORK, INC.

Dear Dr. Merkin:

Enclosed is the final report of a routine examination of the fiscal and administrative affairs of Heritage Provider Network, Inc. (Plan) for the quarter ended March 31, 2017 (Final Report). The examination was 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 November 22, 2017 (Preliminary Report). The Department accepted the Plan's electronically filed response on January 4, 2018.

This Final Report includes a description of the compliance efforts included in the Plan's January 4, 2018 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 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

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 Act of 1975 found within Title 28 of the California Code of Regulations.

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 Final Report or wishes to modify any information provided to the Department in its January 4, 2018, response, please provide the electronically filed documentation no later than 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://wps0.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 S17-R-357.
- 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 January 4, 2018 did not fully respond to the deficiencies raised in the Preliminary Report issued by the Department on November 22, 2017. Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department's request for additional corrective action described within the attached Final Report. The response is due within 30 days after receipt of the Final 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 the Final Report may be referred to the Office of Enforcement for appropriate administrative action for any remaining corrective actions required in response to the Final Report.

Please file the Plan's response electronically via the CAP system within the Online Forms section of the Department's eFiling web portal <https://wps0.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 S17-R-357.
- Go to the "Data Requests" tab:

- Click on the “Details” for each data request that does not have a status of “Complete.”
- Follow the Instructions and/or use the form shown to add the requested data (depending on the type of data requested: New Filing, Document Request, Claims Data, or Financial Statement refile).

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 Vijon Morales at 916-255-2447 or email at Vijon.Morales@dmhc.ca.gov. You may also email inquiries to wps@dmhc.ca.gov.

The Department will make the attached Final Report available to the public in 10 days from the Plan’s receipt of this letter through the eFiling system. The Report will be located at the Department’s web site at [View Financial Examination Reports](#).

If there are any questions regarding this Report, please contact me at 916-255-2444 or email me at Steven.Alseth@dmhc.ca.gov.

Sincerely,

Original Signed By

Steven J. Alseth
Senior Examiner (Supervisor)
Office of Financial Review
Division of Financial Oversight

cc: Jaya Kurian, Sr. Vice President, CFO, Heritage Provider Network, Inc.
Pritika Dutt, CPA, Deputy Director, Office of Financial Review
Nina Moua, Examiner, Division of Financial Oversight
Ping Han, Examiner, Division of Financial Oversight
Terence Sharp, Attorney, Office of Plan Licensing
Laura Dooley-Beile, Chief, Division of Plan Surveys
Paula Hood, Staff Services Manager I, Help Center

**STATE OF CALIFORNIA
DEPARTMENT OF MANAGED HEALTH CARE**

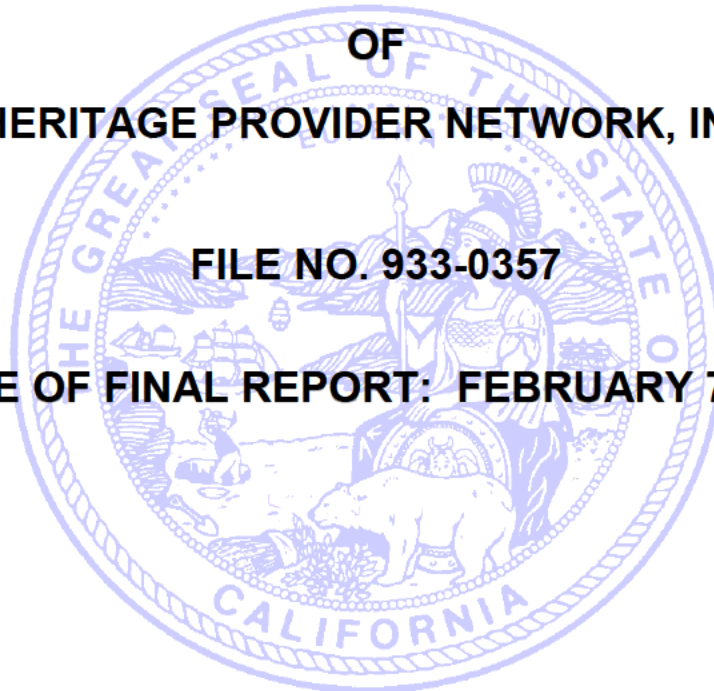
DIVISION OF FINANCIAL OVERSIGHT

FINAL REPORT OF ROUTINE EXAMINATION

**OF
HERITAGE PROVIDER NETWORK, INC.**

FILE NO. 933-0357

DATE OF FINAL REPORT: FEBRUARY 7, 2018



SUPERVISING EXAMINER: STEVEN J. ALSETH

EXAMINER-IN-CHARGE: NINA MOUA

FINANCIAL EXAMINERS:

ANNA BELMONT

ERI FUKUDA

ERICA SHORT

BACKGROUND INFORMATION FOR HERITAGE PROVIDER NETWORK, INC.

Date Plan Licensed:	February 7, 1997
Organizational Structure:	Heritage Provider Network, Inc. (Plan) and Heritage California Medical Groups (HCMG or Groups) are medical services organizations affiliated through common ownership. The seven entities comprising HCMG are High Desert Medical Corporation (a Medical Group), Bakersfield Family Medical Group, Inc., Desert Medical Group, Inc., Oasis Independent Medical Associates, Inc., Regal Medical Group, Inc., Sierra Medical Group, Inc., Lakeside Medical Organization, A Medical Group, Inc., and ADOC Acquisition Co. (A Medical Group, Inc.). These entities are owned and controlled by the sole shareholder. The Plan and the Groups were formed for the purpose of providing health care services to members of prepaid health service plans.
Type of Plan:	Full service health care plan limited to contracting with other licensed health plans through plan-to-plan contracts.
Provider Network:	The Plan arranges for health care services through contracts with hospital providers and with other ancillary health care providers
Plan Enrollment:	As of March 31, 2017 enrollment is 624,368
Service Area:	Imperial, Kern, Kings, Los Angeles, Orange, Riverside, San Luis Obispo, Santa Barbara, San Bernardino, San Diego, Tulare, and Ventura Counties
Date of last Final Routine Examination Report:	March 10, 2015

FINAL REPORT OF A ROUTINE EXAMINATION OF HERITAGE PROVIDER NETWORK, INC.

This is the final report (Final Report) of a routine examination of the fiscal and administrative affairs of Heritage Provider Network, Inc. (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 preliminary report to the Plan on November 22, 2017 (Preliminary Report). The Department accepted the Plan's electronically filed response on January 4, 2018.

This Final Report includes a description of the compliance efforts included in the Plan's January 4, 2018 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 Final Report may be referred to the Office of Enforcement for appropriate administrative action for any remaining corrective actions required in response to this Final Report.

The Department examined the Plan's financial report filed with the Department for the quarter ended March 31, 2017, 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's request for additional corrective action described within this Final Report. The response is due within 30 days after receipt of this Final Report

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 Act of 1975 found within Title 28 of the California Code of Regulations.

SECTION I. FINANCIAL STATEMENTS

The Department's examination resulted in the following reclassifications to the Plan's financial statements for the quarter ended March 31, 2017, 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://wps0.dmhc.ca.gov/fe/search/#top> and selecting Heritage Provider Network, Inc. on the second drop down menu.

BALANCE SHEET				
Quarter Ending March 31, 2017				
	Bal per G/L @	Exam Adjustments		Bal per Exam @
	3/31/2017	Dr	Cr	3/31/2017
ASSETS				
Cash and Cash Equivalents	\$280,378,032			\$280,378,032
Short-Term Investments	176,101,374			176,101,374
Premiums Receivable - Net	43,180,287			43,180,287
Other Health Care Receivables-Net	2,559,815			2,559,815
Prepaid Expenses	794,937			794,937
Aggregate Write-ins for Current Assets	5,890,992			5,890,992
TOTAL CURRENT ASSETS	508,905,437			508,905,437
Restricted Assets	14,732,495			14,732,495
Long-Term Investments	9,150,000			9,150,000
Intangible Assets & Goodwill-Net	26,540,632			26,540,632
Aggregate Write-ins for Other Assets	2,805,428			2,805,428
TOTAL OTHER ASSETS	53,228,555			53,228,555
Land, Building and Improvements	94,262			94,262
Furniture and Equipment - Net	1,464,004			1,464,004
Computer Equipment - Net	2,724,308			2,724,308
Leasehold Improvements - Net	10,037,071			10,037,071
Construction in Progress	695,813			695,813
TOTAL PROP & EQUIP	15,015,458			15,015,458
TOTAL ASSETS	\$577,149,450			\$577,149,450

	Bal per G/L @ 3/31/2017	Exam Adjustments		Bal per G/L @ 3/31/2017
		Dr	Cr	
LIABILITIES				
Trade Accounts Payable	\$4,237,470			\$4,237,470
Capitation Payable	115,293,713	115,293,713		0
Claims Payable (Reported)	201,874,865			201,874,865
Incurred But Not Reported Claims	108,641,846			108,641,846
POS Claims Payable (Reported)	2,534,678			2,534,678
POS Incurred But Not Reported Claims	336,597			336,597
Aggregate Write-ins for Current Liabilities	21,019,307		115,293,713	136,313,020
TOTAL CURRENT LIABILITIES	453,938,476	115,293,713	115,293,713	453,938,476
Loans and Notes Payable (Not Subordinated)	150,000			150,000
TOTAL OTHER LIABILITIES	150,000			150,000
TOTAL LIABILITIES	454,088,476	115,293,713	115,293,713	454,088,476
Common Stock	823,163			823,163
Paid in Surplus	81,712,362			81,712,362
Retained Earnings (Deficit)/Fund Balance	42,494,887			42,494,887
Aggregate Write-ins for Other Net Worth Items	1,969,438			1,969,438
TOTAL NET WORTH	123,060,974			123,060,974
TOTAL LIAB & NET WORTH	\$577,149,450	\$115,293,713	\$115,293,713	\$577,149,450

RECLASSIFYING JOURNAL ENTRY

Capitation Payable	\$115,293,713
Aggregate Write-Ins for Current Liabilities	\$115,293,713

The Plan reported aggregate risk settlement payable to other health plans as Capitation Payable. The Plan was required to reclassify \$115,293,713 as Aggregate Write-Ins for Current Liabilities

The Plan was required to provide evidence that it made the required journal entry listed above, and revise its March 31, 2017 quarterly report filed with the Department.

PLAN'S RESPONSE

The Plan confirmed that it reclassified for the risk settlement payable from "Capitation Payable" to the "Aggregate Write-ins for Current Liabilities". The Plan revised and resubmitted its March 2017 quarterly report with the Department.

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 reported by the Plan as of quarter of ended March 31, 2017	\$123,060,974
Less: Unsecured Affiliate Receivables – Current	<u>26,540,632</u>
Tangible Net Equity	96,520,342
Required Tangible Net Equity	<u>60,878,551</u>
TNE Excess per Examination	<u>\$35,641,791</u>

The Plan was in compliance with the TNE requirement of Section 1376 and Rule 1300.76 as of March 31, 2017.

No response is required to this section.

SECTION III. COMPLIANCE ISSUES

A. CLAIMS SETTLEMENT PRACTICES

1. PAYMENT ACCURACY

Rule 1300.71(a)(8)(K) describes one unfair payment pattern as the failure to reimburse at least 95 percent 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 and Rule 1300.71(i)(2) and (j) require a health care service plan to reimburse uncontested claims no later than 45 working days after the date of receipt of the claim by the plan, and require that if an uncontested claim is not reimbursed within 45 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after of 45 working day period. The penalty for failure to comply with this requirement shall be a fee of \$10 paid to the claimant.

The Department's examination disclosed that four out of 50 paid claims (a compliance rate of 92 percent) were not paid accurately. Three of the claims were paid incorrectly due to the Plan using the 2016 Medicare fee schedule instead of the 2017 Medicare fee schedule for claims with dates of service in 2017. One claim was paid incorrectly due to the Plan using an incorrect contract rate. The deficiencies were noted in the following sample numbers: PD-10, PD-35, PD-71 and PD-75.

In addition, the examination disclosed that the Plan's policy stated the Plan pays 100 percent of the Medicare Fee Schedule to non-contracted providers for its Exchange members. The Plan should have paid using its usual and customary rate for non-contracted providers. The deficiency was noted in denied sample number D-55.

The Plan was required to submit a CAP to address the deficiencies cited above. The CAP should have included the following:

- a. Identification of all paid claims processed from March 11, 2015 through the date corrective actions has been implemented by the Plan, where payments were made using an incorrect fee schedule.
- b. Evidence that payment, interest, and penalties, as appropriate, were paid retroactively for the claims identified in paragraph "a" above. This evidence was to include an electronic data file/schedule (Excel or dBase) that identifies the following:
 - Claims number
 - Date of service
 - Date original claim received
 - Date of receipt of new information
 - Date of receipt of complete claim
 - Total billed
 - Total paid
 - Paid date (mailed date)
 - Amount of original interest paid
 - Date interest paid
 - Penalty amount originally paid
 - Number of days late used to calculate interest
 - Total interest owned per claims (with formula)
 - Amount of additional interest paid in remediation (Total interest owned minus previous interest paid)
 - Penalty amount paid
 - Date additional interest and penalty paid, if applicable
 - Check number for additional interest and penalty paid amount
 - Provider name
 - Line of Business

- c. Training procedures to ensure that claim processors are properly trained on interest and penalty requirements.
- d. State the date of implementation of corrective action, the management position(s) responsible for ensuring compliance and the controls implemented for monitoring continued compliance.

Plan's Response

The Plan responded that based on the Department's findings, the Plan will instruct each of the groups found to be deficient to identify and adjust any claims processed from March 11, 2015 through the date of the implementation of its corrective action plans. The Plan will submit a Corrective Action Plan (CAP) within 90 calendar days and provide evidence that payment, interest and penalties were paid retroactively for the claims identified in paragraph "a" of the Preliminary Report in the manner requested by the Department. Furthermore, the Plan will require the Groups to show proof of appropriate training of the claim processors on interest and penalty requirements.

The Department finds that the Plan's compliance effort is not responsive to the corrective action required since the Plan has not completed the claims remediation. Furthermore, the Plan did not provide the following:

- a. **Training procedures to ensure that claim processors are properly trained on interest and penalty requirements.**
- b. **The date of implementation of corrective action, the management position(s) responsible for ensuring compliance and the controls implemented for monitoring continued compliance.**

The Plan is required to submit the CAP addressing the deficiencies cited above within 30 days upon receiving this Final Report.

2. INTEREST ON LATE CLAIM PAYMENT

Rule 1300.71(a)(8)(K) states that the failure to reimburse at least 95 percent 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 may constitute a basis for the finding that the plan has engaged in a demonstrable and unjust payment pattern.

Rule 1300.71(i)(1) and (2) state that late payment on a complete claim for emergency services and care, which is neither contested nor denied, shall automatically include the greater of \$15 for each 12-month period or portion thereof on a non-prorated basis, or interest at the rate of 15 percent per annum for the period of time that the payment is late. Late payments on all other complete claims shall automatically include interest at the rate of 15 percent per annum for the period of time that the payment is late.

Rule 1300.71(j) states that the penalty for failure to automatically include interest due on a late claim payment shall be a fee of ten (\$10) dollars paid to the claimant.

The Department's examination disclosed that the Plan failed to pay interest accurately on four out of 50 late claims (a compliance rate of 92 percent). The deficiencies were caused by processor errors such as: paying interest of \$15 for claims for emergency services instead of paying greater of \$15 or 15 percent per annum, stating that new information was received when no new information was received, and omitting interest payment. The deficiencies were noted in sample numbers: LP-30, LP-31, LP-42, and LP-81.

The Plan was required to submit a CAP to address the deficiencies cited above. The CAP should have included the following:

- a. Identification of all late claims processed from March 11, 2015 through the date corrective action was implemented by the Plan, where interest was not paid or underpaid.
- b. Evidence that payment, interest, and penalties, as appropriate, were paid retroactively for the claims identified in paragraph "a" above. This evidence was to include an electronic data file/schedule (Excel or dBase) that identifies the following:
 - Claims number
 - Date of service
 - Date original claim received
 - Date of receipt of new information
 - Date of receipt of complete claim
 - Total billed
 - Total paid
 - Paid date (mailed date)
 - Amount of original interest paid
 - Date interest paid
 - Penalty amount originally paid
 - Number of days late used to calculate interest
 - Total interest owned per claims (with formula)
 - Amount of additional interest paid in remediation (Total interest owned minus previous interest paid)
 - Penalty amount paid
 - Date additional interest and penalty paid, if applicable
 - Check number for additional interest and penalty paid amount
 - Provider name
 - Line of Business
- c. Training procedures to ensure that claim processors are properly trained on interest and penalty requirements.

- d. Audit procedures to confirm that the interest on claims is paid in accordance with Rule 1300.71(i)(1) and (2).
- e. State the date of implementation of corrective action, the management position(s) responsible for ensuring compliance and the controls implemented for monitoring continued compliance.

Plan's Response

The Plan responded that based on the Department's findings, the Plan will instruct each of the Groups to identify all late paid claims processed from March 11, 2015 through the date corrective action plans have been implemented by the Plan. The Plan will submit a CAP within 90 calendar days and provide evidence that payment, interest and penalties, as appropriate, were paid retroactively for the claims identified in paragraph "a" of the Preliminary Report. Furthermore, the Plan will require the Groups to show proof of appropriate training of the claim processors on interest and penalty requirements. Also, the Plan will audit the procedures to confirm that the interest on claims is paid in accordance with Rule 1300.71(i)(1) and (2).

The Department finds that the Plan's compliance effort is not responsive to the corrective action required since the Plan has not completed the claims remediation. Furthermore, the Plan did not provide the following:

- a. **Training procedures to ensure that claim processors are properly trained on interest and penalty requirements.**
- b. **Audit procedures to confirm that the interest on claims is paid in accordance with Rule 1300.71(1) and (2).**
- c. **The date of implementation of corrective action, the management position(s) responsible for ensuring compliance and the controls implemented for monitoring continued compliance.**

The Plan is required to submit the CAP addressing the deficiencies cited above within 30 days upon receiving this Final Report.

B. PROVIDER DISPUTE RESOLUTION ACKNOWLEDGEMENT

Rule 1300.71.38(e)(1) and (2) requires in the case of an electronic claim, identification and acknowledgment shall be provided within two working days of the date of receipt of the claim by the office designated to receive the claim. In the case of paper claim, identification and acknowledgment shall be provided within 15 working days of the date of receipt of the claim by the office designated to receive the claim.

The Department's examination disclosed that the Plan failed to send an acknowledgement letter within 15 working days of the date of receipt on three out of 50 PDRs. The deficiencies were noted in sample numbers: PDR-3, PDR-9, and PDR-41.

The Plan was required to implement policy and procedures to acknowledge written provider disputes within 15 working days of receipt in compliance with Rule 1300.71.38(e)(1) and (2). The Plan was also required to provide the date of implementation, 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 that based on the Department's finding, within the next 90 calendar days, the Plan will implement policy and procedures to acknowledge written provider disputes within 15 working days of receipt in the compliance with Rule 1300.71.38(e)(1) and (2). The Plan will also provide the date of implementation, the management position(s) responsible for compliance, and a description of the monitoring system implemented to ensure continued compliance with the rule.

The Department finds that the Plan's compliance effort is not responsive to the corrective action required. The Plan is required to submit the CAP addressing the deficiencies cited above within 30 days upon receiving this Final Report.

C. BOARD OF DIRECTORS OVERSIGHT – Repeat deficiency

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)(3) requires the plan to have written procedures for the conduct of the business of the plan, including the provisions of health care services, so as to provide effective controls.

The Department's examination disclosed that the oversight of the Plan's operations by the Board was not adequately documented in the Board of Directors minutes. The Board of Directors minutes did not indicate that the Board reviews and approves investment transactions.

The Plan was required to explain why the previously filed corrective action failed to correct the repeat deficiency. The Plan's was required to provide a description of the CAP taken to insure proper documentation of the Board of Directors' oversight activities, including review and approval of investment transactions. The Plan was required to state the date of implementation of the CAP, the management position(s) responsible for ensuring compliance and the controls implemented for monitoring continued compliance.

Plan's Response

The Plan responded that the investment transactions have been discussed at meetings of the Board Director. Starting January 2018, the Plan ensures to include oversight activities and documented in the Board of Director's minutes.

The Department finds that the Plan's compliance effort is not responsive to the corrective action required. The Plan did not provide a description of why the deficiency had not been corrected and the management position(s) for responsible for future compliance. The Plan is required to provide the reason for the deficiency not being corrected and the management position(s) responsible for future compliance within 30 days of receiving this Final Report.

D. UNCLAIMED PROPERTY

Section 1500 et seq. of the California Code of Civil Procedure, title 10, Chapter 7 for Unclaimed Property Law sets forth the requirements for submitting unclaimed funds to the Controller of the State of California. Funds unclaimed for three years or more should be escheated to the Controller's Office of the State of California

The Department's examination disclosed that the Plan's escheatment policy does not contain a provision to escheat checks three years and older to the California State Controller's Office.

The Plan was required to provide evidence that it revised its escheatment policy to include a provision for escheating outstanding credit balances aged more than three years to the California State Controller's Office, and to other states, in accordance with applicable unclaimed property laws and regulations. The Plan was also required to state the date of implementation of the policies and procedures, the management position(s) responsible for ensuring continued compliance with unclaimed property laws and regulations.

Plan's Response

The Plan responded that it updated the policy and procedure for the Unclaimed Fund / Escheatment effective as of January 1, 2018, and the Associate Vice President of Claims, will be responsible to ensure the compliance.

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

E. AMENDMENT FILING

Section 1352(a) states a licensed plan shall, within 30 days after any change in the information contained in its application, other than financial or statistical information, file an amendment thereto in the manner the director may by rule prescribe setting forth the changed information.

The Department's examination disclosed that the Plan did not file any of its affiliate/third party administrative service contracts.

During the course of the exam, the Plan filed its affiliate contracts and administrative service agreements (ASA) with the Department. The Plan was required to provide the policies and procedures implemented to ensure that ASAs are filed with the Department, the date of implementation, and the management position(s) responsible continued compliance with the Section stated above.

Plan's Response

The Plan responded that Plan has filed the administrative service agreement with the Department.

The Department finds that the Plan's compliance effort is not responsive to the corrective action required. The Plan did not provide the policies and procedures implemented to ensure that ASAs are filed with the Department, the date of implementation, and the management position(s) responsible continued compliance with the Section stated above. The Plan is required to file the requested documents within 30 days of receiving this Final Report.

SECTION IV. NON-ROUTINE EXAMINATION

The Plan is advised that the Department may conduct a non-routine examination, in accordance with Rule 1300.82.1, to verify representations made to the Department by the Plan in response to this Final 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.