



Gavin Newsom, Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
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September 17, 2020

Via eFile

Mr. Christopher Swanker
Chairman of the Board of Directors
Access Dental Plan
8890 Cal Center Drive
Sacramento, CA 95826

FINAL REPORT OF A ROUTINE EXAMINATION OF ACCESS DENTAL PLAN

Dear Mr. Swanker:

Enclosed is the final report (Final Report) of a routine examination for the quarter ended September 30, 2019 of the fiscal and administrative affairs of Access Dental Plan (Plan). The examination was conducted by the Department of Managed Health Care (Department) pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975.¹ The Department issued a preliminary report to the Plan on June 11, 2020. The Department accepted the Plan's electronically filed responses on July 24, 2020, August 26, 2020, and September 9, 2020 (Responses).

The Final Report includes a description of the compliance efforts included in the Plan's Responses, 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 Responses. If so, please indicate which portions of the Plan's Responses should be appended, and electronically file copies of those portions excluding information held confidential pursuant to Section 1382(c). If the Plan requests the Department to append a brief statement summarizing the Plan's Responses or wishes to modify any information provided to the Department in its Responses, please provide an addendum no later than 10 days from the date of the

¹ References to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in California Health and Safety Code Section 1340 et seq.

Plan's receipt of this letter. Please file this addendum electronically via the corrective action plan system (CAP system) within the Department's eFiling web portal at <https://wpso.dmh.ca.gov/secure/login/>, as follows:

- From the main menu, select "eFiling."
- From the eFiling menu, select "Online Forms."
- From the Online Forms menu, select "Details" for "CAP #S20-R-318."
- Go to the "Messages" tab, then:
 - o Select "Addendum to Final Report" (note this option will only be available for 10 days after the issuance of the Final Report).
 - o Select the deficiency(ies) that are applicable.
 - o Create a message for the Department.
 - o Attach and upload all documents with the name "Addendum to Final Report."
 - o Select "Send Message."

The Department finds that the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required. Therefore, no further response is required.

Questions or problems related to the electronic transmission of any addendum should be directed to Vijon Morales at 916-255-2447 or by e-mail at Vijon.Morales@dmhc.ca.gov. You may also e-mail inquiries to wpso@dmhc.ca.gov.

The Department will make the Final Report available to the public in 10 days from the Plan's receipt of this letter. The Final Report will be located at the Department's web site at <http://www.dmh.ca.gov/LicensingReporting/ViewFinancialExaminationReports.aspx>.

The Plan is hereby advised that any violations listed in the Final Report may be referred to the Department's Office of Enforcement for appropriate administrative actions.

If there are any questions regarding the Final Report, please contact me at 916-255-2432 or by e-mail at Evan.Lo@dmhc.ca.gov.

Sincerely,

SIGNED BY

Evan Lo
Corporation Examiner IV, Supervisor
Office of Financial Review
Division of Financial Oversight

cc: Jennifer Hatchett, Chief Compliance Officer, Access Dental Plan
Alisha Hightower, Director, Insurance Plan Compliance, Access Dental Plan
Steven Zep, Senior Accountant, Financial Reporting, Access Dental Plan
Pritika Dutt, CPA, Deputy Director, Office of Financial Review
Ned Gennaoui, Supervising Examiner, Division of Financial Oversight
Jasdeep Atwal, Examiner, Division of Financial Oversight
Ashika Chiu, Examiner, Division of Financial Oversight
Anna Green, Attorney III, Office of Plan Licensing
Laura Dooley Beile, Supervising Health Care Service Plan Analyst, Office of Plan Monitoring
Ben Carranco, Assistant Deputy Director, Help Center
Chad Bartlett, Staff Services Manager II, Help Center

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

**OFFICE OF FINANCIAL REVIEW
DIVISION OF FINANCIAL OVERSIGHT**

FINAL REPORT OF A ROUTINE EXAMINATION

OF

ACCESS DENTAL PLAN

FILE NO. 933 0318

DATE OF FINAL REPORT: SEPTEMBER 17, 2020

SUPERVISING EXAMINER: NED GENNAOUI

OVERSIGHT EXAMINER: EVAN LO

EXAMINER-IN-CHARGE: JASDEEP ATWAL

FINANCIAL EXAMINERS:

JOHN ATAMIAN

CHANTE BIAGAS

MICHAEL CEN

FRANCISCO GARCIA

VASILY LOPUGA

LORENA MEZA

BACKGROUND INFORMATION FOR ACCESS DENTAL PLAN

Date Plan Licensed:	December 22, 1993
Organizational Structure:	Access Dental Plan (Plan) is a for-profit, wholly owned subsidiary of First Commonwealth, Inc., which is in turn a wholly owned subsidiary of The Guardian Life Insurance Company of America. The Plan receives from and provides services to various affiliates pursuant to administrative services agreements.
Type of Plan:	The Plan is a specialized health care dental plan. It operates as a dental plan under the California Geographic Managed Care Program (GMC) in Sacramento County and under the Los Angeles Prepaid Health Plan (LAPHP) in Los Angeles County. The GMC and LAPHP are administered by the California Department of Health Care Services. The Plan also operates as a dental health maintenance organization for commercial and Covered California members.
Provider Network:	The Plan contracts with affiliated and non-affiliated dental clinics for the provision of dental care services.
Plan Enrollment:	As of September 30, 2019, the Plan reported total enrollment of 488,002 enrollees, consisting of 265,279 Medi-Cal, 196,435 individual, 17,216 large group, and 9,072 small group members.
Service Area:	The Plan operates in all counties in California.
Date of Prior Final Routine Examination Report:	June 17, 2016

FINAL REPORT OF A ROUTINE EXAMINATION OF ACCESS DENTAL PLAN

This is the final report (Final Report) for the quarter ended September 30, 2019 of a routine examination of the fiscal and administrative affairs of Access Dental Plan (Plan). The examination was conducted by the Department of Managed Health Care (Department) pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975.¹ The Department issued a preliminary report (Preliminary Report) to the Plan on June 11, 2020. The Department accepted the Plan's electronically filed responses on July 24, 2020, August 26, 2020, and September 9, 2020 (Responses).

This Final Report includes a description of the compliance efforts included in the Plan's Responses to the Preliminary Report, in accordance with Section 1382(c). The Plan's Responses are noted in italics within this Final Report.

The Plan is hereby advised that any violations listed in the Final Report may be referred to the Department's Office of Enforcement for appropriate administrative action.

The Department examined the Plan's financial report filed with the Department for the quarter ended September 30, 2019, 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 Final Report as follows:

- | | |
|-----------|------------------------------------|
| Part I. | Financial Statements |
| Part II. | Calculation of Tangible Net Equity |
| Part III. | Compliance Issues |

The Department finds that the Plan's compliance efforts are responsive to the deficiencies cited and the corrective actions required. Therefore, no further response is required.

¹ References to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as codified in California Health and Safety Code Section 1340 et seq. References to "Rule" are to regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act of 1975 contained within title 28 of the California Code of Regulations.

PART I. FINANCIAL STATEMENTS

The Department's examination did not result in any adjustments or reclassifications to the Plan's financial statements for the quarter ended September 30, 2019, as filed with the Department. A copy of the Plan's financial statements can be viewed by selecting "Access Dental Plan" on the second drop-down menu of the Department's financial statement database available at <http://wpso.dmh.ca.gov/fe/search/#top>.

No response is required to this Part.

PART II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

Net Worth as reported by the Plan as of quarter ended September 30, 2019	\$15,216,994
Less: Unsecured Affiliate Receivables - Current	<u>738,056</u>
TNE	14,478,938
Required TNE	<u>595,987</u>
TNE Excess per Examination	<u>\$13,882,951</u>

The Plan was in compliance with the TNE requirements of Rule 1300.76 as of September 30, 2019.

No response is required to this Part.

PART III. COMPLIANCE ISSUES

A. CLAIMS SETTLEMENT PRACTICES – “UNFAIR PAYMENT PATTERNS”

Section 1371.37 prohibits a health care service plan from engaging in an unfair payment pattern, and defines certain claim settlement practices as “unfair payment patterns.”

Rule 1300.71(a)(8) defines an "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 engaged in “unfair payment patterns” for the three-month period ended September 30, 2019, as follows:

1. PAYMENT ACCURACY OF INTEREST ON LATE CLAIMS – REPEAT DEFICIENCY

Section 1371 and Rule 1300.71(i)(2) require 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(j) states that the penalty for failure to comply with the requirements of Rule 1300.71(i)(2) shall be a fee of \$10 paid to the claimant for each late claim.

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.

The Department’s examination disclosed that the Plan failed to correctly pay interest on 14 out of 50 late paid claims reviewed (a compliance rate of 72 percent). This deficiency was noted in late paid claims sample numbers: 2, 12, 13, 19, 23, 26, 30, 31, 35, 37, 39, 41, 46, and 48. The Department determined that interest was incorrectly paid due to the claims payment processing system calculating the amount of interest based on the explanation of payment rather than the payment date.

The Plan’s failure to accurately pay interest on late paid claims was a repeat deficiency, as this issue was previously reported in the Department’s final report of examination dated June 17, 2016 for the quarter ended June 30, 2015 (Prior Examination). This examination disclosed that the Plan’s corrective actions implemented in response to the Prior Examination report were not effective at achieving compliance with the Section and Rules cited.

The Preliminary Report required the Plan to explain why the corrective actions implemented by the Plan to resolve the deficiency of failing to pay interest accurately, found in the Department’s Prior Examination, were not effective in ensuring continued compliance.

The Plan was also required to submit a detailed corrective action plan (CAP) to address the deficiency cited above, and to include the following:

- a. Training procedures, and date of implementation, to ensure that claim processors are properly trained on interest and penalty requirements in compliance with the above Section and Rules.
- b. Audit procedures, and date of implementation, to ensure that the Plan is monitoring the accurate payment of interest and penalties on late claim payments.
- c. Identification of all late paid claims for which interest and penalties were not correctly paid from January 1, 2016 (remediation implementation date for the

Prior Examination) through the date corrective action was implemented by the Plan.

- d. Evidence that interest and penalties, as appropriate, were paid retroactively for the claims identified in paragraph “c” above. This evidence was to include an electronic data file (Excel or Access) or schedule that identified the following:

- Claim number
- Date of service
- Date original claim received
- Date of receipt of new information
- Date of receipt for complete claim
- Total billed
- Total paid
- Paid date (mail date)
- Amount of interest paid
- Date interest paid
- Penalty amount paid, if applicable
- Number of late days used to calculate interest (with formula)
- Total interest owed per claim (with formula)
- Check number for interest and penalty paid amount
- Provider name

The data file was to provide the detail of all claims remediated, including the total number of claims and the total additional interest and penalties paid as a result of remediation.

- e. Management position responsible for ensuring continued compliance.

The Plan responded that the Prior Examination’s issues and corrective actions taken were unrelated to the issues raised by the Department in the current examination.

The Plan took the following corrective actions:

- *It implemented corrective actions for proper data entry of receipt date, calculation of interest based on the payment date, calculation of interest to allow for mailing time, and issuing explanations of payment indicating interest amount.*
- *It updated its claims desktop procedures for general claims handling on July 22, 2020. In addition, the Plan conducted bi-weekly training sessions with claims staff to review updated procedures, and conducted a formal refresher training on July 29, 2020.*
- *It modified its claims payment processing system logic to calculate interest correctly, and implemented updated claims audit protocols on June 9, 2020.*

- *It identified 3,157 claims that required remediation. The Plan submitted a remediation report to the Department, with a completion date of September 3, 2020. The remediation resulted in the payment of additional interest of \$563 and penalties of \$31,550.*
- *It identified the Plan's Claims Director as the management position responsible for continued compliance.*

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and corrective action required. Therefore, no further response is required.

B. SOLICITOR AGREEMENT – REPEAT DEFICIENCY

Section 1345(m) defines a solicitor as any person who engages in any presentation or advertising conducted by, or behalf of, a plan, where information regarding the plan is disseminated for the purpose of inducing persons to subscribe to the plan.

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 five business days after such funds are received by the solicitor firm.

The Department's examination disclosed that Premier Access Insurance Company (PAIC), a Plan affiliate, billed and collected premiums on behalf of the Plan, and provided marketing services to the Plan. PAIC did not deposit the collected premiums in a separate bank account nor transfer funds to the Plan within five business days.

The Plan's failure to comply with the requirements of Rule 1300.67.12 was a repeat deficiency, as this issue was previously reported in the Department's Prior Examination. This current examination disclosed that the Plan's corrective actions implemented in response to the Prior Examination report were not effective at achieving compliance with the Rule cited.

The Preliminary Report required the Plan to explain why the corrective actions implemented by the Plan to resolve the deficiency of failing to deposit Plan premiums in a separate bank account and to remit collected premiums within five business days to the Plan, found in the Department's Prior Examination, were not effective in ensuring continued compliance.

The Plan was also required to provide the policy and procedures implemented to ensure compliance with the above Rule, the date of implementation, the management position responsible for ensuring continued compliance.

The Plan responded that PAIC was not a solicitor. However, the Plan developed a new process to ensure that any premiums collected for the Plan were segregated from PAIC funds and timely deposited in the Plan's account within five business days of PAIC's receipt. The Plan updated and submitted to the Department its "Group Benefits Process Documentation, Settlement of DHMO Premiums" policy, which became effective July 1, 2020. The Plan identified the Plan's Controller as the management position responsible for continued compliance.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and corrective action required. Therefore, no further response is required.

C. FIDELITY BOND

Rule 1300.76.3(a) requires the Plan's fidelity bond to provide 30 days' notice to the director (Director) of the Department prior to cancellation.

The Department's examination disclosed that the Plan's fidelity bond policy did not include 30 days' notice to the Director prior to cancellation.

The Preliminary Report required the Plan to submit evidence (addendum to the fidelity bond) that included the 30 days' notice to the Director prior to cancellation.

The Plan was also required to describe the policy and procedures implemented, the date of implementation, and the management position responsible for ensuring continued compliance.

The Plan responded that it filed with the Department an amended fidelity bond policy, which provided 30 days' notice to the Department prior to cancellation (eFiling Number 20202969). This filing is currently under review by the Department. The Plan identified the Plan's Vice President of Treasury as the management position responsible for continued compliance.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and corrective action required. Therefore, no further response is required.

D. FINANCIAL STATEMENT REPORTING

Section 1384 states, in pertinent parts, that each plan shall submit financial statements, and the Department may make rules and regulations specifying the form and content of the reports and financial statements. Rule 1300.84.06 defines financial statements as

the DMHC Annual Financial Reporting Form (Financial Reporting Form), as updated on January 23, 2013.

The Department's examination disclosed that the Plan failed to accurately complete Report #4, Enrollment and Utilization Table, of the Financial Reporting Form. The Plan did not accurately report the membership "Additions During Period," "Terminations During Period," and "Cumulative Enrollee Months for Period" for the quarter ended September 30, 2019.

The Preliminary report required the Plan to correctly complete Report #4, Enrollment and Utilization Table, beginning with the Financial Reporting Form for the quarter ending June 30, 2020, and for all subsequent Financial Reporting Form filings.

The Plan responded that it would properly complete and file Report #4, Enrollment and Utilization Table, for the quarter ending June 30, 2020, and all subsequent Financial Reporting Form filings. The Financial Reporting Form filed with the Department for the quarter ended June 30, 2020 was properly completed.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and corrective action required. Therefore, no further response is required.

E. SPECIAL REPORTS

Section 1384(d) requires a plan to make any special reports to the Director as the Director may from time to time require.

The Department's examination disclosed that the Plan continued to have issues with its claims processing.

The Preliminary report required the Plan to complete and submit the following schedules of the Financial Reporting Form:

- Schedule G, Section III, Inventory of Claims to be Processed (Count); and
- Schedule H, Aging of All Claims (in Dollars).

The Plan was required to start filing these two schedules beginning with the Financial Reporting Form for the quarter ending June 30, 2020, and for all subsequent Financial Reporting Form filings.

The Plan responded that it would complete and file Schedules G and H for the quarter ending June 30, 2020, and for all subsequent Financial Reporting Form filings. The Financial Reporting Form filed with the Department for the quarter ended June 30, 2020 included properly completed Schedules G and H.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and corrective action required. Therefore, no further response is required.