BEFORE ALLAN L. MCVEY, INSURANCE COMMISSIONER
OF THE STATE OF WEST VIRGINIA

In the Matter of:

DELTA DENTAL OF WEST VIRGINIA, INC.

Administrative Proceeding No. 23-IC-158196

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER ADOPTING REPORT OF MARKET CONDUCT COMPLIANCE EXAMINATION AND DIRECTING CORRECTIVE ACTION AND ASSESSING A PENALTY

NOW COMES, Allan L. McVey, Insurance Commissioner of the State of West Virginia (hereinafter, "Commissioner"), who, after consideration of the *Report of Market Conduct Compliance Examination* (hereinafter, the "*Examination Report*") of Delta Dental of West Virginia, Inc. (hereinafter, "Delta Dental") for the examination period ending October 15, 2022, made the following findings of fact and conclusions of law and order.

FINDINGS OF FACT

1. The market conduct examination was a targeted examination due to an increase in frequency of complaints related to perceived discrepancies for In-Network versus Out-of-Network claims particularly concerning network access. The examination was conducted in accordance with *W. Va. Code* §33-2-9(c) by examiners duly appointed by the Commissioner and covered the period of April 1, 2021 through October 15, 2022.

2. On or about October 19, 2023, the examiner filed with the Commissioner, pursuant to *W. Va. Code* §33-2-9, the *Examination Report*.

3. A true copy of the *Examination Report* was provided to Delta Dental and Delta Dental was notified, pursuant to W.Va. Code §33-2-9(j)(2), that it had ten (10) days after receipt of the *Examination Report* to file a submission or rebuttals with the Commissioner. Delta Dental timely filed a submission/rebuttal to the *Examination Report*.

4. As set forth in the *Examination Report*, the examination focused on the methods used by Delta Dental to manage its operations for each of the areas examined, including whether and how Delta Dental complies with West Virginia's statutory and regulatory law.

5. The *Examination Report* is a report by test of company compliance with selected standards contained in the *NAIC 2022 Market Regulation Handbook* and standards approved by the Insurance Commissioner which are based on applicable West Virginia statutes and rules.

6. The Commissioner reviewed the *Examination Report* and considered Delta Dental's submissions/rebuttals prior to issuing these findings of fact, conclusions of law and order.

CONCLUSIONS OF LAW

1. The Commissioner has jurisdiction over the subject matter and the parties to this proceeding.

2. This proceeding is conducted pursuant to and in accordance with *W. Va. Code* §33-2-9.

3. The Commissioner is charged with the responsibility of verifying Delta Dental's continued compliance with West Virginia law.

4. Of the nineteen (19) standards reviewed, Delta Dental was predominantly compliant in seven (7) standards and non-compliant in three (3) standards.

5. As detailed in the *Examination Report*, Delta Dental failed to comply with provisions of West Virginia law as follows:

- Standard G7 – Delta Dental did not have adequate access to an In-Network specialist in five (5) claims as detailed in the *Examination Report* and the claims were handled as Out-of-Network.
- Standard G9 – All fifteen (15) individual retroactively denied claim files reviewed did not include in the denial notice the language required by W.Va. Code R. § 114-14-6.17.
- Standard G11 – In all fifteen (15) Out-of-Network paid claim files reviewed, Delta Dental did not honor Assignment of Benefits made by the covered person and failed to pay the provider directly in violation of W.Va. Code § 33-24-45.

6. The Commissioner has determined that Delta Dental should be assessed a penalty for violating the aforementioned standards.

ORDER

Pursuant to W.Va. Code §§ 33-2-9(j)(3)(A) and 33-3-11, following the review of the *Examination Report*, the examination work papers, and Delta Dental's response thereto, it is **ORDERED** as follows:

1. The referenced and attached *Examination Report* is hereby **ADOPTED** and **APPROVED** and by this reference, incorporated herein and made a part hereof;

2. Delta Dental shall endeavor to comply with the recommendations contained in the *Examination Report*;

3. Delta Dental shall continue to monitor its compliance with applicable West Virginia law.

4. Delta Dental shall specifically cure the violations and deficiencies identified in the *Examination Report* so as to bring itself into compliance and conformity with West Virginia law, as set forth hereinabove, to the extent such has not already been completed and/or accomplished;

5. Delta Dental shall file a Corrective Action Plan (CAP), subject to the approval of the Commissioner, which said CAP shall detail Delta Dental's changes to its procedures and/or internal policies to ensure compliance with West Virginia law and shall further incorporate all recommendations of the Commissioner's examiners and address all violations specifically cited in the *Examination Report*;

6. The CAP shall be submitted to the Commissioner for his approval within 30 days of the date this order is entered;

7. Delta Dental shall make reasonable changes to the CAP if and as directed by the Commissioner within 30 days of its receipt of the Commissioner's changes to, or disapproval of, the CAP;

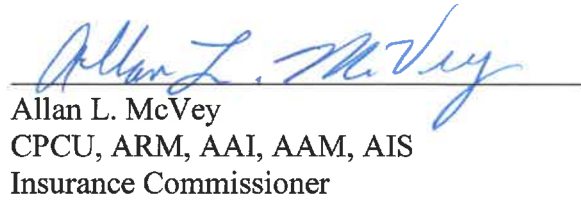
8. Delta Dental shall, within 90 days of its receipt of notice from the Commissioner of his final approval thereof, implement the CAP; and

9. Delta Dental shall pay an administrative penalty in the amount of Fifteen Thousand Dollars ($15,000.00) for its non-compliance with West Virginia law as set forth hereinabove, the assessment of which penalty is in lieu of any other regulatory penalty and shall be remitted within 30 calendar days of the date this order is entered.

10. Inasmuch as orders entered by the Commissioner are subject to judicial review in the Intermediate Court of Appeals as set forth in W.Va. Code §51-11-4(b)(4), any person aggrieved

by this Order may, within 30 days after the entry of the judgment being appealed, file an appeal as set forth in W.Va. Code §33-2-14 and W.Va. R.A.P., Rule 5(b).

Entered this 5th day of December, 2023.



Allan L. McVey
CPCU, ARM, AAI, AAM, AIS
Insurance Commissioner

Report of Market Conduct Compliance Examination

As of October 15, 2022

Delta Dental of West Virginia, Inc.
One Delta Drive
Mechanicsburg, PA 17055

NAIC COMPANY CODE: 12329
Examination Number: 22-IC-02424

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October 19, 2023

The Honorable Allan L. McVey, CPCU, ARM, AAI, AAM, AIS
West Virginia Insurance Commissioner
900 Pennsylvania Avenue
Charleston, West Virginia 25305

Dear Commissioner McVey:

Pursuant to your instructions and in accordance with West Virginia Code §§ 33-2-9 & 33-24-4, a Market Conduct examination has been made for the period of April 1, 2021 through October 15, 2022 on

Delta Dental of West Virginia
One Delta Drive
Mechanicsburg, PA 17055

hereinafter referred to as the "Company", "Issuer" or "DDWV". The following report of the findings of this examination is herewith respectfully submitted.

PURPOSE AND SCOPE OF THE EXAMINATION

Market conduct examiners with the West Virginia Offices of the Insurance Commissioner reviewed certain business practices of DDWV. The period covered by the examination was April 1, 2021 through October 15, 2022. W. Va. Code § 33-2-9 empowers the Commissioner to examine any entity engaged in the business of insurance. The findings in this report, including all work products developed in producing it, are the sole property of the West Virginia Offices of the Insurance Commissioner. West Virginia laws, regulations, and bulletins cited may be found at: https://www.wvinsurance.gov/Legal-Authority.

The purpose of this targeted examination was due to an increased frequency of complaints related to perceived discrepancies for In-Network versus Out-of-Network Claims particularly concerning network access and to determine the Company's compliance with West Virginia insurance laws. The conclusions and findings of this examination are public record.

The basic business areas that were reviewed and tested under this examination were:

- Claims Practices
- Complaint Handling
- Grievance/ Appeal Procedures
- Network Adequacy

Common abbreviations used herein after are as follows:

AOB	Assignment of Benefits
CWOP	Closed Without Payment
EOC	Evidence of Coverage
EOB	Explanation of Benefits
IN	In-Network
NAIC	National Association of Insurance Commissioners
OON	Out-of-Network
PPD	Policy Plan Documents
PRP	Preliminary Request Packet
RFI	Request for Information
W. Va. Code	West Virginia Code Annotated
W. Va. Code R	West Virginia Code of State Rules
WVOIC	West Virginia Offices of the Insurance Commissioner

EXECUTIVE SUMMARY

The preliminary company review began March 1, 2023. The Company did not grant the examiners remote access to their computer systems for the examination review. Instead, files were provided upon request through a secure site. The Company file review began May 9, 2023 and concluded on August 28, 2023.

A total of nineteen (19) standards were reviewed for compliance during this examination. Of those nineteen (19) standards, the Company was predominantly compliant in seven (7) and non-compliant in three (3) standards.

The market conduct examination revealed the following violations of the W. Va. Code or Regulations:

G7. PAID CLAIMS – The Examiner reviewed a total of thirty-five (35) OON Paid Claims to determine if the Company is handling OON Claims at an IN level when a participating provider is not available without unreasonable travel or delay. The Company's access report filed with the WVOIC, and the Company's online directory were used to determine compliance with W. Va. Code § 33-55-3(c)(1)].

- Four (4) of the OON Claims reviewed did not have an IN Periodontist within sixty (60) miles of the insured's zip code, all four (4) claims were handled as OON.
- One (1) OON Claim reviewed did not have an IN Orthodontist within fifty (50) miles of the insured's zip code. This claim was handled as OON.

G9. DENIED/CWOP CLAIMS – All fifteen (15) Individual Retroactively Denied Claim files reviewed did not include a denial notice giving claimants the option of contacting the WVOIC, or provide the claimants with its mailing address, telephone number, and website address as required by W. Va. Code R. § 114-14-6.17. The same issue was noted during the Group and Individual Denied/ CWOP Claims review. This is a systemic issue.

G11. PAID CLAIMS – The Company is cognizant of the legislation that went into effect in June of 2020 concerning AOB. Fifteen (15) OON Paid Claim files were reviewed specifically to determine if the Company is honoring AOB made by the covered person according to W.Va. Code § 33-24-45. All fifteen (15) claim forms reviewed were marked for the OON provider to be paid directly; however, all fifteen (15) claim payments were sent directly to the Insured. This is a systemic issue.

HISTORY AND PROFILE

DDWV is a West Virginia non-profit corporation incorporated in 1962. The Company has no employees or shareholders. The Company is licensed as a dental service corporation in West Virginia and regulated by the WVOIC. The Company sells and administers insured dental service contracts to West Virginia group purchasers and offers plans on and off the Federal Exchange (Exchange, FFM or Marketplace) in West Virginia under the Affordable Care Act.

The Company has a dental administration agreement with Delta Dental Insurance Company ("DDIC") to provide sales and administration of ASO dental service contracts for DDIC in West Virginia. The same agreement also has a management agreement with

Delta Dental of Pennsylvania ("DDP") under which DDP provides claims adjudication and other administrative services for DDWV insured contracts and carries out DDWV claim adjudication and other administrative services obligations to DDIC. The Company has a determination letter stating it is a tax-exempt organization described under IRS Section 501(c)(4). For West Virigina, the Company's group accident and health written premium reported for 2022 was $ 2,954,7705 with a market share of 2.211%, while the Company's direct written premium reported under Dental Only for 2022 was $ 29,547,705 with a market share of 66.34%.

METHODOLOGY

The examination was conducted in accordance with the standards and procedures established by the NAIC and West Virginia's applicable statutes and regulations. This is a report by test of company compliance with selected Standards contained in the *NAIC 2022 Market Regulation Handbook* and Standards approved by the WVOIC which are based on applicable West Virginia statutes and administrative rules, as referenced herein. Testing is based on guidelines contained in the *NAIC 2022 Market Regulation Handbook*. All tests applied are included in this report.

The examiners used the NAIC standards of 7% error ratio on claims tests (93% compliance rate) and 10% error ratio on all other tests (90% compliance rate) to determine whether an apparent pattern or practice of being compliant, predominantly compliant, or non-compliant existed for any given test. Due to the targeted nature of the examination, unless otherwise specified in the compliance table, the claim file samples reviewed consisted of fifteen (15) files for each of the following four (4) types of claims:

- Paid Group Claims
- Paid Individual Claims
- Denied/CWOP Group Claims
- Denied/CWOP Individual Claims

Herein after referred to as the "claim file sample".

Tests designed to measure the level of compliance with West Virginia statutes, rules and regulations were applied to the files. Each area of the examination has specific elements that were tested and are listed below. The examiners may not have discovered every unacceptable or non-compliant activity in which the Company is engaged. The failure to identify, comment on, or criticize specific practices does not constitute an acceptance of the practices by the WVOIC or its designee. A compliance table follows containing the results of each area of review with the compliance percentage for the Company and final examination results.

STANDARDS & REVIEW ELEMENTS

A1. RECORDS: Records are adequate, accessible, consistent and orderly and comply with state record retention requirements. (2022 NAIC Market Regulation Handbook Chapter 20, § A Standard 7)

- Are the records adequate and accessible? [W. Va. § 33-11-4 and W. Va. Code R. § 114-14-3 & 15-4]

A2. RECORDS: The regulated entity cooperates on a timely basis with the examiners performing the examination. (2022 NAIC Market Regulation Handbook Chapter 20, § A Standard 9)

- Did the Company provide records and cooperate with examiners on a timely basis? [W. Va. § 33-2-9 and W. Va. Code R. § 114-15-1 et seq.]

B1. COMPLAINTS: All complaints are recorded in the required format on the regulated entity's complaint register. (2022 NAIC Market Regulation Handbook Chapter 20, § B Standards 1)

- Is the Company recording, in a regulated complaint register, all complaints from both the consumer and the WVOIC? [W. Va. Code § 33-11-4(10)]
- Does the Company's complaint log clearly show the total number of complaints, the classification of each complaint by line of business, the nature of the complaint, the complaint disposition, and the complaint number assigned by the WVOIC when applicable? [W. Va. Code R. § 114-15-4.6]

B2. COMPLAINTS: The regulated entity has adequate complaint handling procedures in place and communicates such procedures to policyholders. (2022 NAIC Market Regulation Handbook Chapter 20, § B Standards 2)

- Does the Company have complaint procedures in place, and are they sufficient to satisfactorily handle complaints including tracking responses? [W. Va. § 33-11-4(10) and W. Va. Code R. § 114-14-5.2]

G1. CLAIMS: The Initial contact by the regulated entity with the claimant is within the required time frame. (2022 NAIC Market Regulation Handbook Chapter 20, § G Standard 1)

- Unless full payment or denial was made prior, was the claimant contacted within fifteen (15) working days (or mandated emergency order timeframe) from the date of the loss notice as required by W.Va. Code § 33-11-4(9)(b) and W. Va. Code R. § 114-14-5.1?

G2. CLAIMS: Timely investigations are conducted. (2022 NAIC Market Regulation Handbook Chapter 20, § G Standard 2)

- Did the investigation commence within fifteen (15) working days of any claim filed as required by W. Va. Code § 33-11-4(9)(c) and W. Va. Code R. § 114-14-6.2.a?
- Did the investigation continue more than thirty (30) calendar days? If so, was a notice of necessary delay sent within fifteen (15) working days after the thirty (30) calendar days AND if the investigation continued, were subsequent notices of necessary delay sent with forty-five (45) calendar days as required by W. Va. Code R. § 114-14-6.7?

G3. CLAIMS: Claims are resolved in a timely manner. (2022 NAIC Market Regulation Handbook Chapter 20, § G Standard 3)

- Did the Company affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed as required by W. Va. Code § 33-11-4(9)(e)?
- Are clean claims either paid or denied within forty (40) days of receipt if submitted manually and within thirty (30) days of receipt if submitted electronically? [W. Va. Code § 33-45-2(a)(1)]

G4. CLAIMS: Claim files are adequately documented. (2022 NAIC Market Regulation Handbook Chapter 20, § G Standard 5)

- Do the files contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed as required by W. Va. Code R. §§ 114-14-3, 114-15-4.2a & 114-15-4.4?
- Are the communications properly dated?

G5. PAID CLAIMS: Claims are properly handled in accordance with policy provisions and applicable statutes (including HIPAA), rules and regulations. (2022 NAIC Market Regulation Handbook Chapter 20, § G Standard 6)

- Are claims paid accurately and in accordance with applicable policy provisions and evidence of coverage? [W. Va. Code § 33-45-2 et seq]
- Is cost sharing applied as indicated by the policy plan?
- Are calendar year and lifetime maximums applied correctly?

G6. PAID CLAIMS: Claims are properly handled in accordance with policy provisions and applicable statutes (including HIPAA), rules and regulations. (2022 NAIC Market Regulation Handbook Chapter 20, § G Standard 6)

- Are In-Network Providers required to accept a specific amount/fee for dental services that are not a contracted/covered service? [W. Va. Code § 33-6-39(b)]

G7. PAID CLAIMS: Claims are properly handled in accordance with policy provisions and applicable statutes (including HIPAA), rules and regulations. (2022 NAIC Market Regulation Handbook Chapter 20, § G Standard 6)

- Are Out-Of-Network claims processed as In-Network when a participating provider is not available without unreasonable travel or delay? [W. Va. Code § 33-55-3(c)(1)]

G8. DENIED/CWOP CLAIMS: Denied and closed without payment claims are handled in accordance with policy provisions and state law. (2022 NAIC Market Regulation Handbook Chapter 20, § G Standard 9)

- Is the denial based upon specific policy provisions or exclusions, if so, is the reason included in the denial as required by W. Va. Code § 114-14-6.5?
- Is the claimant provided with a reasonable basis for the denial when required by statute or regulation as required by W. Va. Code § 33-11-4(9)(n)?

G9. DENIED/CWOP CLAIMS: Denied and closed without payment claims are handled in accordance with policy provisions and state law. (2022 NAIC Market Regulation Handbook Chapter 20, § G Standard 9)

- Do claim denial notices contain the Insurer's information, the claim processing address, and the claim number? [W. Va. Code R § 114-14-6.17]
- Is the claimant given the option of contacting the Commissioner's Office and provided with its mailing address, telephone number, and website address as required by W. Va. Code R. § 114-14-6.17?

G10. RETROACTIVELY DENIED CLAIMS: Denied and closed without payment claims are handled in accordance with policy provisions and state law. (2022 NAIC Market Regulation Handbook Chapter 20, § G Standard 9)

- As required by W. Va. Code § 33-45-2(a)(7), are previously paid claims only retroactively denied for the following reasons: the claim was fraudulently submitted, claim contains material misrepresentation, the provider was already paid, the provider was not entitled to reimbursement, service was not covered by the plan, or the insured was not eligible for reimbursement?

G11. PAID CLAIMS: Claim files are handled in accordance with policy provisions, HIPAA and state law. (2022 NAIC Market Regulation Handbook Chapter 24, § G Standard 1)

- Does the Company honor an assignment of benefit made in writing by the person covered under the policy as required by W. Va. Code § 33-24-45 et seq?
- Did the Company pay the provider directly when an assignment of benefit notice was in the claim file?

H1. GRIEVANCE PROCEDURES: The health carrier treats as a grievance any written complaint, or any oral complaint that involves an urgent care request, submitted by or on behalf of a covered person regarding: 1) the availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; 2) claims payment, handling or reimbursement for health care services; or 3) matters pertaining to the contractual relationship between a covered person and the health carrier. (2022 NAIC Market Regulation Handbook Chapter 24, § H Standard 1)

- Does the Company treat written and oral complaints regarding the availability, delivery or quality of care and claims payment, handling or reimbursements as a grievance?

H2. GRIEVANCE PROCEDURES: The health carrier documents, maintains and reports grievances and establishes and maintains grievance procedures in compliance with applicable statutes, rules and regulations. (2022 NAIC Market Regulation Handbook Chapter 24, § H Standard 2)

- The Company has implemented and maintains grievance procedures in compliance with W.Va. Code §33-55-3?
- Is the Company following the grievance procedures as implemented?

H3. GRIEVANCE PROCEDURES: A health carrier has implemented grievance procedures, disclosed the procedures to covered persons, in compliance with applicable statutes, rules and regulations, and files with the commissioner a copy of its grievance procedures, including all forms used to process a grievance. (2022 NAIC Market Regulation Handbook Chapter 24, § H Standard 3)

- Is the Company disclosing grievance procedures to covered persons as detailed in the Company's Access Plan filed with the WVOIC? [W.Va. Code §33-55-3]

I1. NETWORK ADEQUACY: The health carrier provides at enrollment a provider directory that lists all providers who participate in its network. It also makes available, on a timely and reasonable basis, updates to its directory. (2022 NAIC Market Regulation Handbook Chapter 24, § I Standard 8)

- As required by W.Va. Code §33-55-4:
    - Is the Company's provider directory updated at least monthly?
    - Is the Electronic version of the provider directory available to view without creating or accessing an account?
    - Does the Electronic version of the provider directory allow for certain information to be searched?
    - Does the provider directory list the provider's name, contact information, specialty, participating location, if the provider is accepting new patients, and language spoken if other than English?

- As required by W. Va. Code R. § 114-100-7:
  - Does the Company provide a printed copy of the provider directory within five (5) business days upon request?
  - Do both directories (printed and electronic) contain the proper disclosures and accommodate the communication needs of individuals with disabilities and/or limited English proficiency?
  - Are screen shots of the provider directory filed with the Company's access plan?
  - Are the directories audited at least three (3) times a year and all entries audited at least once every eighteen (18) months?

COMPLIANCE TABLE

Review Section	***# Pass***	***# Fail***	***Minimum Standard Compliance %***	***Compliance Result %***	***Examination Result***		
					Compliant	**Predominantly Compliant**	**Non-Compliant**
A1	N/A	N/A	N/A	N/A		X	
A2	N/A	N/A	N/A	N/A		X	
B1	N/A	N/A	N/A	N/A		X	
B2	N/A	N/A	N/A	N/A		X	
G1	60	0	93%	100	X		
G2	60	0	93%	100	X		
G3	64	0	93%	100	X		
G4	110	0	93%	100	X		
G5	29	1	93%	96.6		X	
G6	10	0	93%	100			
G7	30	5	93%	85.71			X
G8	45	0	93%	100	X		
G9	0	45	93%	0			X
G10	15	0	93%	100	X		
G11	0	15	93%	0			X
H1	7	0	90%	100	X		
H2	N/A	N/A	N/A	N/A		X	
H3	21	0	90%	100	X		
I1	N/A	N/A	N/A	N/A		X	

OBSERVATIONS

A1. RECORDS – The majority of the records received were adequate, accessible, consistent and orderly, and comply with state record retention requirements. Some of the documentation issues observed during the course of the examination are listed below:

- **Complaint Handling** – When asked to provide a list of consumer direct complaints the Company responded they did not receive any insurance department complaints during the scope of the examination. The WVOIC's complaint log has a record of three (3) complaints submitted to the Company from the WVOIC during the review period. When asked about the discrepancies in an RFI, the Company responded one (1) complaint was erroneously omitted during the data capture and the other two (2) complaints were out of the WVOIC's jurisdiction. All complaints submitted to the Company from the WVOIC should be listed on the Company's complaint log.

- **Claims** – The Examiner believed a deductible had been applied in error to diagnostic services for one (1) Individual Paid Claim file reviewed. The EOC submitted with the claim file revealed that the deductible is waived for Diagnostic and Preventative Services. A RFI was sent concerning the handling of the claim, the Company responded *"the EOC provided to the OIC with this claim originally was the 2023 form and attachment A… that contained this deductible exemption. This was an error and not effective during the date of service of the claim."* The Company then provided the Examiner with the correct PPD and EOC that was in effect for this claim on the date of service. The Examiner noted the entire Individual Paid Claims sample was sent with the incorrect PPD for the date of service. To continue the review in a timely manner, if the wrong PPD were sent with a remaining claim file sample the Examiner was able to access the correct PPD for review through the Company's SERFF (System for Electronic Rate and Form Filing) filings.

- **Claims –** During the claims review the Examiner noted some of the PPD reviewed have the WVOIC contact information listed incorrectly.

- **Claims** – Three (3) Retroactively Paid Claims processed as OON due to a credentialling issue. Once the issue was resolved, the claims were reprocessed as IN. No additional benefits were paid; however, two (2) of the claims had an adjusted EOB sent showing the amount owed the provider was adjusted to $0. One (1) claim had an adjusted EOB showing an amount still owed the provider, giving the impression that the IN provider could balance bill the member. A RFI was sent regarding the EOB, the Company responded *"DDWV first notes that the claim record provided for this sample was incomplete. We did not provide a second adjusted Explanation of Benefits (EOB) that correctly stated the Accepted Fee and the Maximum Contract*

Allowance." The Company also noted the claim was reprocessed under a different claim number, provided the corresponding EOB, and stated the provider was not allowed to balance bill the member.

- **Claims** – When the benefit payment and the EOB are sent directly to the member an EOB is not typically mailed to the OON provider; however, during the OON Paid Claims review the Examiner observed five (5) files with EOBs titled "Provider EOB" that were copies of the Member's EOB.

- **Claims** – Some of the claim forms reviewed had the date the claim was received stamped on the form. When asked in a RFI why all the claim forms were not date stamped the Company responded *they only stamp receipt dates on claims received by mail and the receipt date is stored electronically for electronically submitted claim forms.* The Examiner observed one (1) Orthodontic claim form that did not have a date stamp, the data information provided with the PRP showed it was not submitted electronically.

- **Paid Claims** – A RFI was sent requesting the Company's policy and procedures concerning the handling of AOB Claims. The Company provided screenshots for data entry purposes; however, no actual policy and procedures for handling AOB Claims. During the examination, additional information came to light concerning the handling of AOB Claims in which the Company stated they had implemented procedures for handling AOB Claims. A RFI was sent for the newly implemented written claims procedures mentioned in a complaint response letter dated May 15, 2023. Again, only screenshots for data entry were provided.

- **Grievance Procedures** – The majority of the Final Level Appeal Files were sent without EOB; however, many of the files have procedure details in the notes, allowing the Examiner access to most of the information that is needed for review when an appeal is made by a member concerning coverage, how a claim was paid, and/ or a coverage exception.

- **Grievance Procedures** – Two (2) grievance and three (3) appeal files were sent without the PPD for review.

- **Grievance Procedures** – One (1) Final Level Appeal selected by the Company for review was out of the WVOIC's jurisdiction.

- **Network Adequacy**- Upon request, the Company submitted provider directory audits for review. After one (1) follow-up RFI, one (1) email, one (1) conference call, and one (1) follow-up email; how the company presented the resulting data is still vague.

- The audit summary for both the PPO Network and for the Premier Network (dated October 2022 and performed in June 2021, April 2022, and July 2022) submitted with the initial RFI response have the same results, "*50 unique providers were suppressed from the directory across 117 unique locations until the information can be verified*", however, the total reviewed and total discrepancies/deficiencies amounts are different for each audit summary.

- The Excel workbook submitted for review with the directory audits was unclearly labeled. The workbook was labeled as a mailing list and consisted of four (4) excel worksheets. Also provided with the directory audits was a template letter. During the review of the Excel workbook the Examiner observed the same twenty-four (24) providers listed on all four (4) Excel worksheets, when the Company was asked for additional information concerning the provider list in a follow-up RFI the Company responded, *"For clarity, the lists provided are not mailing lists, these directory accuracy lists are used to conduct an auto dialer requesting the location to review their providers' directory information to ensure accuracy of the directory."*

- The Examiner requested the provider list for the audit that was performed in June of 2021, the Company responded *"Upon further review, we were unable to locate the provider list from this time period. During the initial audit, the provider list was not saved. After the initial audit, Delta improved the process to ensure all lists are saved in a central location."*

A2. RECORDS – The Company's representatives were cooperative and predominantly responded in a timely manner to the Examiner's request for preliminary claims data and the additional RFI. During the review, the Company requested twenty-two (22) extensions that were granted by the Examiner. Of those extension requests, four (4) had additional extension requests submitted by the Company and approved. Five (5) RFI responses were submitted untimely during the review, consisting of three (3) extension requests made after the initial due date and two (2) responses sent after the Company's requested extension deadline. [W.Va. Code R. § 114-15-4.9(a)]

B1. COMPLAINTS – Upon request, the Company provided an updated complaint log to include the one (1) erroneously omitted complaint. (Please reference A1. Complaint Handling for additional information.) The updated log did not give the nature of the complaint, or the complaint number assigned by the WVOIC, which are both required by W. Va. Code R. § 114-15-4.6.

B2. COMPLAINTS – The Company has complaint procedures in place; however, the Company's complaint handling procedures are mingled with the Company's appeal and grievance handling procedures.

G1. CLAIMS – All the files reviewed in the claim file sample were either paid or denied within fifteen (15) working days, a separate acknowledgment was not required by law.

- Although not technically a violation of Standard G1, the Examiner observed one (1) Orthodontic Claim where the remaining periodic payment processed Eighteen (18) working days after the one-year anniversary date. (When included in the policy plan, Orthodontic benefits have a lifetime maximum that pays half at the time of banding and the remaining half is paid one (1) year later. The information concerning Orthodontics was found in a group PPD.)

G2. CLAIMS – Investigation Delay letters were not required, many of the claims reviewed in the claim file sample were paid or denied within a week after receiving notice of the claim.

G3. CLAIMS – In addition to the claim file sample, one (1) Group Retroactively Paid Claim and three (3) Individual Retroactively Paid Claims were also reviewed to determine if clean claims are resolved in a timely manner. Several claims were paid or denied within a week of receiving notice of the claim. Please note that only four (4) of the twenty (20) Retroactively Paid Claims had actual supplementary benefits paid.

G4. CLAIMS– When the Examiner began the Retroactively Paid and Retroactively Denied Claim file review it became clear that the entire sample failed to include the pertinent event details that led to the retroactive adjustments. Separate RFI were sent to the Company asking for this additional information, updated claim files were then received from the Company.

G5. PAID CLAIMS – While performing the ***Individual*** Paid Claims review, the Examiner observed the Company pays Premier Providers at the PPO Fee Schedule and allows the Premier Providers to balance bill the member the difference between the PPO accepted fee and the Premier accepted fee. ***Individual*** PPD submitted and reviewed during the Market Conduct Examination support the Company's allowance of this type of balance billing; however, the 2022 Dentist Handbook the Examiner reviewed states '*Delta Dental Premier network dentists are "contracted" dentists in Delta Dental's fee-for-service plans, which allow enrollees to visit any licensed dentist but that offer advantages, such as no balance billing and the convenience of claims submission, when enrollees select a contracted Delta Dental Premier dentist.*'

One (1) ***Group*** Paid Claim was not paid accurately. A RFI was sent asking for an explanation regarding how the claim was paid, the Company responded, "*The accepted fee from the provider was $120 and therefore, the balance bill difference between the fee*

and contract max allowance is charged to the member." A follow-up RFI was sent asking why the Company allowed the PPO provider to balance bill. Company response: *"For this claim, the member required a resin filling (D2392) that was not covered. DDWV allowed this service as a coverage exception under an alternative procedure (D2150 – amalgam filling) so that the member could receive appropriate care. The provider billed $120 which DDWV agreed paid as the accepted fee for this claim."* Per The Company's response, the ***Group*** PPD submitted for review with the claim file, and the PPO fee schedule received with the Company's PRP response; the PPO provider should not have been allowed to balance bill for this service. See the following section copied from the **Group** PPD:

> **HOW CLAIMS ARE PAID**
> Payment for Services — PPO Provider
> Payment for covered services performed for you by a PPO Provider is calculated based on the Maximum Contract Allowance. PPO Providers have agreed to accept the Delta Dental PPO Contracted Fee as the full charge for covered services.

G6. PAID CLAIMS – The Examiner found no evidence during the Paid Claims review where the Company required IN providers to accept specific fees for dental services that were not covered. Also reviewed were the Company's PPO-Premier Dentist Agreement, Amendments, and the Dentist Handbook that were in force during the exam period. Review sample included five (5) IN Group Paid Claims and five (5) IN Individual Paid Claims.

G7. PAID CLAIMS – The Examiner reviewed a total of thirty-five (35) OON Paid Claims to determine if the Company is handling OON Claims at an IN level when a participating provider is not available without unreasonable travel or delay. The Company's access report filed with the WVOIC, and the Company's online directory were used to determine compliance.

- Four (4) of the OON Claims reviewed did not have a Periodontist within sixty (60) miles of the insured's zip code. All four (4) claims were paid at the IN level. However, they were processed as OON allowing the Periodontist to balance bill the member. A RFI was not sent due to the Company's access report, dated October of 2022, stating there are no IN Periodontist for the entire state of WV. Please note that members living in bordering counties may have access to an IN Periodontist in another state.

- One (1) OON Group Paid Claim reviewed did not have an IN Orthodontist within fifty (50) miles of the insured's zip code. A RFI was sent concerning the Orthodontist Claim, the Company responded, *"There are no in-network Orthodontists within a 50 mile radius of the member's residence." and " Yes, the plan would have been paid differently if an in-network provider would have been used. Because an out-of-network provider was used, the member would have been responsible for any difference between the in-network allowed*

amount for the service and the amount charged by the out-of-network dentist." Examiner note, policy plans that cover Orthodontic services have a lifetime maximum that members are made aware of in the PPD.

(It appears the Company is aware of network access issues in the state of WV given the decision letters reviewed during the Appeal and Grievance file review.

- Two (2) Grievance files reviewed were specific to limited access to an IN Periodontist. The Company was able to refer one (1) member to an IN Periodontist in a neighboring state, the other member received a decision letter admitting to a *"limited number of dental offices in your immediate area; however, we are actively recruiting in that location."*

- One (1) Final Level Appeal reviewed was concerning the request for an exception due to access of care for an IN Endodontist. The member received a decision letter advising *"we are unable to make that exception, and you would need to contact your group to have that exception reviewed. You would be responsible for the amount indicated on your explanation of benefits as the exception was not made prior to receiving the service. For future services, please request an exception from the group if there are no providers within reasonable distance due to access of care."* The Examiner was unable to locate in the PPD, received with the file, where the member was made aware of this opportunity prior to the decision letter.

G8. DENIED/CWOP CLAIMS – All Denied and Retroactively Denied Claim files reviewed had denial notifications given to the claimant that provided the reason for denial.

G9. DENIED/CWOP CLAIMS – All fifteen (15) Individual Retroactively Denied Claim files reviewed did not include a denial notice giving claimants the option of contacting the WVOIC, or provide the claimants with its mailing address, telephone number, and website address as required by W. Va. Code R. § 114-14-6.17. A RFI was sent concerning the denial notices. The Company responded, *'After review of the EOB notices sent associated with the samples reviewed by the OIC in the Individual Retroactively Denied Claim files, Delta Dental of West Virginia (DDWV) has determined these EOB documents do not "state that the claimant has the option of contacting the Commissioner" or provide "the Commissioner's mailing address, telephone number and web site address." DDWV further states that these EOB notices do include the "basis for denial, claim number, name of the Insurer and the claim processing address" as required by W. Va. Code R §114-14-6.17'.* The same issue was noted during the Group and Individual Denied/ CWOP Claims review, additional RFI were not sent due to the response given for the Individual Retroactively Denied Claims. This is a systemic issue.

G10. RETROACTIVELY DENIED CLAIMS – Fifteen (15) Individual Retroactively Denied Claims were requested for review to ensure the Company is handling Retroactively Denied Claims according to West Virginia state law. All fifteen (15) claims were previously denied. Once additional/ missing information was received concerning the claim,

adjustments/ recalculations were made. All fifteen (15) claims were still appropriately denied.

G11. PAID CLAIMS – The Company is cognizant of the legislation that went into effect in June of 2020 concerning AOB. Fifteen (15) OON Paid Claim files were reviewed specifically to determine if the Company is honoring AOB made by the covered person according to W.Va. Code §33-24-45. All fifteen (15) claim forms reviewed were marked for the OON provider to be paid directly; however, all fifteen (15) claim payments were sent directly to the Insured. When asked about this issue, the Company responded *that they became aware of a system configuration issue concerning AOB Claims which prompted a claims system modification and an internal manual procedure which were both implemented in May of 2022 allowing for new system capabilities to pend claims arriving with an AOB notification and assign them to a claims adjustor for manual processing.* During this examination, the Company discovered an additional issue that caused AOB Claims to be paid incorrectly. An additional fix was implemented on June 9, 2023, with post-implementation monitoring being performed to ensure the issue was fully remediated. DDWV is in the process of identifying all the claims that were impacted by this system issue and are contacting the impacted OON providers to determine any missing payments. Missing payments will then be sent out with late payment interest. This is a systemic failure.

H1. GRIEVANCE PROCEDURES – DDWV is domiciled and licensed in West Virgina as a dental service corporation and provides only limited scope dental benefits on a standalone basis. The regulatory requirements of West Virginia's Health Plan Issuer Internal Grievance Procedures specifically apply to health benefit plans offered by issuers as defined under W.Va. Code R. § 114-96-2.18 and therefore excludes limited scope dental benefits and issuers. Although excluded from the specific requirements under W.Va. Code R. § 114-96-1 et seq, the Company is required to file grievance procedures under W.Va. Code § 33-55-3. The Company's policy and procedures define an **appeal** as: A request by an enrollee or Provider to reconsider denial or delay of services rendered or enrollment in coverage and a **grievance** as: any expression of dissatisfaction from an enrollee, received by the enterprise through any channel. A grievance may include dissatisfaction regarding the enterprise and / or a provider, including quality of care.

During the review, the Examiner observed six (6) of the seven (7) grievances being handled concurrently as an appeal. When the Company was asked about the simultaneous handling, they responded that *"if multiple issues are identified within the complaint (e.g., an appeal and a grievance), two separate "child" cases will be created as part of the workflow in our appeals processing system".* The Company also gave an example, *"if a member communicates both an appeal from a denied claim and a quality-of-care complaint (i.e., a "grievance"), these matters will be handled separately within their system so that two different teams can analyze, document, and respond to them".* The Examiner was unable to find mention of this specific process in the Company's policy

and procedures and noted most of the grievance files reviewed were requesting the claim be reprocessed/reconsidered. Some of these requests were due to limited access to IN providers.

H2. GRIEVANCE PROCEDURES – The Company has implemented and maintains appeal and grievance procedures as required by W.Va. Code § 33-55-3. These procedures include handling appeals and grievances timely, equitably, and with sensitivity to enrollee's needs. More specifically these procedures include a written acknowledgement sent to the enrollee within five (5) calendar days following receipt of the appeal or grievance, a written decision sent to the enrollee within thirty (30) days of receipt of the appeal or grievance and accommodating the needs of individuals with limited English proficiency and/or disabilities by listing multiple language options and TTY info on acknowledgement and decision letters.

The Examiner noted four (4) instances during the review where the Company is not following its appeal and grievance procedures as implemented.

- One (1) Acknowledgement Letter stated the Company would respond to the enrollee within thirty-one (31) days not thirty (30) as stated in the Company's procedures.

- One (1) Decision Letter was sent thirty-five (35) days after receipt instead of thirty (30) days per the Company's written procedure. When asked about the decision letter in a RFI, the Company acknowledged *they failed to send the member/ member's representative a written notice of the decision within thirty (30) days and have implemented controls to monitor.*

- While reviewing Final Level Appeal files, the Examiner observed a note in two (2) separate files *stating the Acknowledgement Letter was not printed and mailed due to an identified system error and the decision letter was sent before the error was caught.*

- PPD specific to one (1) WV group policy plan states *if after review DDWV continues to deny the claim you will be notified in writing, the notice will state your options including the right to receive free of charge access to all documents and records relevant to the claim, and the right to bring action under ERISA, ADR options, and right to contact regulatory agency.* However, Decision letters sent only give the option *"If you have any questions regarding this matter, please contact the Grievance and Appeals Dept at 877-335-8273, Monday through Friday from 7am to 5 pm Pacific time."* A RFI was sent asking for additional information, the Company responded *"After review of the plan document..., we have determined that the language included in the EOC is incorrect. The EOC*

document was erroneously published with the incorrect appeals language statement for the West Virginia policy. The grievance decision letters examined in this exam contain language compliant with West Virginia law but, are not consistent with the incorrect language in this policy form." The Company also noted that the form is no longer in use, the group plan terminated June 30, 2023.

H3. GRIEVANCE PROCEDURES – The Company discloses grievance and appeal procedures to its members as detailed in the Company's Access Plan filed with the WVOIC.

I1. NETWORK ADEQUACY – During the review of the Company's Online and Printed Directories the Examiner observed the following:

- Two (2) different online directories were accessible, each with different formatting, available information, and disclosures. One (1) was accessed using the website listed on the Printed Directory and the PPD, Deltadentalins.com (https://www1.deltadentalins.com/), the other was found via google search - https://www.deltadental.com/us/en/member/find-a-dentist/

- The online directory is available to view without requiring account access and has mandatory search capabilities. One (1) of the searches the Examiner performed was by provider name which requires an address or zip code to perform the search.

- The Printed Directory provided with the RFI response does not specifically say if the providers are PPO, Premier, or both. Many of the Providers contracted with DDWV are both PPO and Premier providers and from the title of the directory sent, ***DR_PPO_WV_06.2023***, the Examiner was able to deduce that the directory is for PPO providers.

- One (1) exception was found. The Examiner called the Company on June 16, 2023 around 9:35am to request a copy of the printed provider directory to be mailed. As of August 14, 2023, a copy of the directory had not been received. On June 28, 2023 around 2:30pm, the Examiner-in-Charge went online and requested a printed provider directory be mailed and as of August 14, 2023 a copy had not been received. On July 12, 2023, a RFI was sent to the Company requesting a printed copy of the provider directory. A provider directory was received on July 19, 2023, within the required five (5) business days.

RECOMMENDATIONS

A1. RECORDS – [W. Va. § 33-11-4 and W. Va. Code R. § 114-14-3 & 15-4]

- **Complaint Handling** – All complaints submitted to the Company, whether direct from the WVOIC or indirect, should be listed on the Company's complaint log.
- **Claims** – The Company should have procedures in place to guarantee claim files sent for review are adequate and contain all notes, documents, and detailed information needed to reconstruct pertinent events.
- **Claims** – The Company needs to review all PPD to ensure information given to members is correct.
- **Claims** – The Company must be consistent with date stamping claim forms to ensure compliance with W. Va. Code R. § 114-15-4.4.c.
- **Paid Claims** – The Company should have written policy and procedures specific to the handling of AOB Claims and ensure implementation.
- **Grievance Procedures** – It is important that the Company has safeguards in place that prevent incomplete files from being sent for review. The EOB and PPD should be included when a request to appeal a claim decision is made. (e.g., requests for coverage to be reconsidered, an exception made, and/ or a claim be reprocessed.)
- **Network Adequacy** – The Company must ensure that the provider directories are not only audited, but that the data results can be explained in layman's terms.

A2. RECORDS – It is imperative that the Company responds to all examination inquiries and requests timely and efficiently to reduce potential delays during the examination. In the future, allowing examiners remote access to the Company's systems, in most cases, helps reduce delays while the examination is being performed. [W. Va. § 33-2-9 and W. Va. Code R. § 114-15-1 et seq.]

B1. COMPLAINTS – The Company's complaint, appeal, and grievance logs need to be updated to include all required information in accordance with W. Va. Code R. § 114-15-4.6.

B2. COMPLAINTS – As a better business practice, the Company should separate its complaint, appeal, and grievance handling policy and procedures.

G5. PAID CLAIMS – The Company must ensure all claims are paid accurately and in accordance with applicable PPD, EOC, Provider Agreements, and Dentist Handbook. [W. Va. Code § 33-45-2 et seq]

G7. PAID CLAIMS – The Company needs to continue recruiting not only General Dentist but also dentist that specialize in Endodontics, Oral Surgery, Orthodontics, Pediatric Dentistry, and Periodontics for the entire state of West Virginia to help ensure members have adequate access to care. Also, as required by W.Va. Code §33-55-3 the Company needs to inform all covered persons of the process used to request access to a covered benefit from a non-participating provider when diagnosed with a condition or disease that requires specialized care and the Company is unable to provide reasonable access to a participating provider without unreasonable travel or delay. One (1) way to advise members of their available options when reasonable access to an IN Provider is a concern, is to include the options in all PPD given to members. The Examiner believes the Company may be in the process of implementing this requirement, one (1) Individual PPD reviewed during the examination had a section called ***Network Adequacy Exception***. The Company could also add information to the PPD noting border county residents have the option of visiting an IN provider in other states.

G9. DENIED/CWOP CLAIMS – The Company must ensure that all claimants are given the option of contacting the WVOIC, and provide its mailing address, telephone number, and website address as required by W. Va. Code R. § 114-14-6.17.

G11. PAID CLAIMS – The Company needs to continue monitoring AOB Claims to safeguard proper handling and payment of all AOB Claims in accordance with W.Va. Code § 33-24-45.

H1. GRIEVANCE PROCEDURES – As a better business practice the Company should be following their filed policy and procedures by handling a complaint as a grievance, appeal, or inquiry.

H2. GRIEVANCE PROCEDURES – The Company should be following its appeal and grievance procedures as filed with the WVOIC.

I1. NETWORK ADEQUACY – The Company needs to implement policy and procedures to ensure directories are provided within five (5) business days of request. [W. Va. Code R. § 114-100-7]

EXAMINER'S SIGNATURE AND ACKNOWLEDGEMENT

The Examiner would like to acknowledge the cooperation and assistance extended by the Company during the examination.

In addition to the undersigned, the examination was overseen by Desiree D. Mauller, CIE, CWCP, MCM, Examiner-in-Charge.

Jean E. Tincher, APIR, MCM
Examiner

EXAMINER'S AFFIDAVIT AS TO STANDARDS AND PROCEDURES USED

State of West Virginia

County of Kanawha

I, Jean E. Tincher, being duly sworn, states as follows:

1. I have the authority to represent West Virginia in the examination of Delta Dental of West Virginia.
2. The examination of Delta Dental of West Virginia was performed in a manner consistent with the standards and procedures required by West Virginia.

The affiant says nothing further.

Jean E. Tincher, APIR, MCM

Subscribed and sworn before me by Jean E. Tincher on this 19 day of October 2023.

Notary Public

My commission expires: March 23, 2024