

MARKET CONDUCT EXAMINATION
of
WASHINGTON STATE HEALTH INSURANCE
POOL

P.O. BOX 269
BOW, WA 98232-0269

January 1, 2006 – April 30, 2007



Order No. 08-0160
Exhibit A

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The Honorable Mike Kreidler
Washington State Insurance Commissioner
302 14th Avenue SW
P.O. Box 40258
Olympia, Washington 98504-0258

Dear Commissioner Kreidler:

Pursuant to your instructions and in compliance with the statutory requirements of RCW 48.41.070 and procedures promulgated by the National Association of Insurance Commissioners and the Office of the Insurance Commissioner (OIC), an examination of the market conduct affairs has been performed of:

Washington State Health Insurance Pool
P.O. Box 269
Bow, WA 98232-0269

In this report, Washington State Health Insurance Pool is referred to as "WSHIP" or the "Pool".

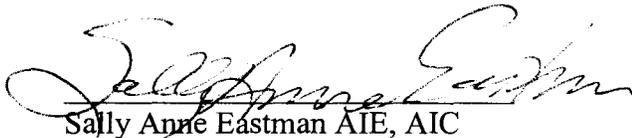
This report of examination is respectfully submitted.

CHIEF EXAMINER'S REPORT CERTIFICATION and ACKNOWLEDGEMENTS

This examination was conducted in accordance with Office of Insurance Commissioner and National Association of Insurance Commissioners market conduct examination procedures. Sandy Ray, CIE, CPCU, Gary Stephenson, AIE, AIRC and Juanita M Labosier, CPA of the Washington State Office of Insurance Commissioner performed this examination and participated in the preparation of this report.

The examiners wish to express appreciation for the courtesy and cooperation extended to them by WSHIP as well as by the personnel of Benefit Management, Inc. during the course of this market conduct examination.

I certify that this document is the report of the examination, that I have reviewed this report in conjunction with pertinent examination work papers, that this report meets the provisions for such reports prescribed by the Office of Insurance Commissioner and that this report is true and correct to the best of my knowledge and belief.



Sally Anne Eastman AIE, AIC
Chief Market Conduct Examiner
Office of the Insurance Commissioner
State of Washington

FOREWORD

This examination was completed by applying tests to each examination standard. Each test applied during the examination is stated in this report and the results are reported. Exceptions are noted as part of the comments for the applied test. Throughout the report, where cited, RCW refers to the Revised Code of Washington, and WAC refers to Washington Administrative Code.

Scope

Time Frame

The examination covered the Companies' operations from January 1, 2006 through April 30, 2007. This is the second market conduct examination of the Washington State Health Insurance Pool. This examination was performed both in the Seattle OIC office and on-site at Benefit Management, Inc. offices in Great Bend, Kansas.

Prior Examination Summary

The prior examination of WSHIP was adopted in 2003. The prior exam was a combined financial and market conduct examination. WSHIP was issued instructions on the following market conduct findings:

- Failure to submit amendments to the Plan of Operations to the OIC as the amendments are adopted.
- Failure to ensure that the existence of the Pool is advertised to the public in general and rejected applicants in particular.
- Failure of the Plan to require the administrator to regularly audit and reconcile its premium collection accounts.
- Failure of the application form to clearly describe that full, non-discounted premium is required with the application and that discounted premium will be effective after the applicant is approved for the premium discount.
- Failure of the Board to implement performance standards to assure accuracy and timeliness of premium collection and billing practices conducted by the administrator.
- Failure of the Board to take steps to ensure that claims are processed in a timely manner and pay penalties to WSHIP when performance standards are not met.
- Failure of the Board to direct the administrator to implement training and procedures to assure accuracy of customer service telephone inquiries.

Recurring findings will be identified in the appropriate section of the exam.

Matters Examined

The examination included a review of the following areas:

Company Operations and Management
Advertising
Underwriting
Claims
Contracts and Member Handbooks

Administrative Contracts
Complaints
Rate and Form Filing
Policy Administration

Sampling Standards

Methodology

In general, the sample for each test utilized in this examination falls within the following guidelines:

92 %	Confidence Level
+/- 5 %	Mathematical Tolerance

These are the guidelines prescribed by the National Association of Insurance Commissioners in the Market Conduct Examiners Handbook and the Market Regulation Handbook.

Regulatory Standards

Market conduct samples are tested for compliance with standards established by the OIC. The tests applied to sampled data will result in an error ratio, which determines whether or not a standard is met. If the error ratio found in the sample is, generally, less than 5%, the standard will be considered as met. The standards in the area of policy and form filings will not be met if any violation is identified. This will also apply when all records are examined, in lieu of a sample.

For those standards, which look for the existence of written procedures, or a process to be in place, the standard will be met based on the examiner's analysis of those procedures or processes. The analysis will include a determination of whether or not the company follows established procedures.

Standards will be reported as Passed (without Comment), Passed with Comment or Failed. The definition of each category follows:

Passed	There were no findings for the standard.
Passed with Comment	Errors in the records reviewed fell within the tolerance level for that standard.
Failed	Errors in the records reviewed fell outside of the tolerance level established for the standard.

POOL OPERATIONS AND MANAGEMENT

Pool History

The Washington State Health Insurance Pool (WSHIP) is a nonprofit entity that was created by the Washington State Legislature in 1987. The purpose of the Pool is to provide Washington residents who are denied health coverage by admitted carriers, access to health insurance. WSHIP coverage is also available to residents of Washington State counties where commercial, individual medical insurance is not available to the general public.

Any commercial insurer providing disability or stop loss insurance, any health care service contractor (HCSC) and any health maintenance organization (HMO) that accepts or denies health coverage to individual applicants in Washington participates in the operations of WSHIP. Self-funded multiple employer welfare arrangements, as well as the Washington State Health Care Authority as provider of the state uniform medical plan also participate. The participating carriers fund the operation of WSHIP through financial assessments based on each carrier's proportion of participation in the Pool. The requirements for assessments are outlined in RCW 48.41.090 and in the Pool's Plan of Operation.

Pool Management and Operations

WSHIP operations are governed by its Board of Directors (the Board). The Board is comprised of ten (10) members. Six (6) of the members are appointed by the Governor. Four (4) of the Governor's appointees are selected from lists of nominees submitted by statewide organizations representing health care providers, health insurance agents, small employers and large employers. Two (2) appointees are selected from a list of nominees submitted by statewide organizations representing health care consumers. The remaining four (4) members are elected by the companies that participate in the Pool. The elected members must include at least one (1) representative each of health care service contractors, health maintenance organizations and commercial insurers providing disability insurance. In addition, the Insurance Commissioner is a non-voting, ex-officio member. Board members serve three (3) year terms.

During the examination period the Board members were:

Board Member	Position/Representation (Governor Appointed)	Original Appointment Date	Term Expires
Michael Arnis	OIC / Ex Officio, Non-Voting	09/05/02	N/A
G. Robert Appel	Providers *	06/01/04	05/31/07
James Grazko	Carriers (HCSC)	01/01/06	05/3/09
Patti L. Carter	Small Business*	05/04/00	05/31/08
Sean Corry	Consumers*	05/08/00	05/31/06
Matthew Damon	Consumers*	06/01/06	05/31/09
Robert Jaffe, M.D.	Consumers*	05/01/04	05/31/07
Bernie Dochnahl	Business*	05/10/00	05/31/06
Dorothy Graham	Business*	06/01/06	05/31/09
Norman Seabrooks	Carriers (Disability)	07/01/05	05/31/08
William Perkins	Agents*	06/01/05	05/31/08
Robert Moore	Carriers (HMO)	02/01/98	05/31/07
Robert S. Kuecker	Carriers	09/05/02	05/3/09

The Board hired Kären Larson as WSHIP's Executive Director on May 14, 2001. The Executive Director supervises and controls the administrative business and affairs of the Pool. The Plan of Operations calls for the Board of Directors to select an administrator to conduct the day-to-day operations of the Pool. The administrator is selected through a competitive bidding processes every three (3) years, as outlined in RCW 48.41.080. Benefit Management, Inc. (BMI) is the current administrator. BMI's proposal to continue acting as administrator was unanimously accepted during the October 12, 2006 Board Meeting.

Eligibility for WSHIP coverage is based on the results of an individual's completed standard health questionnaire (SHQ) score. On May 11, 2006 the Board approved recertification of the SHQ effective October 1, 2006. The Board retained Milliman Consultants and Actuaries to develop the health questionnaire and scoring system. The Board directed BMI to issue letters to current enrollees encouraging them to reapply to a carrier for individual coverage as the new point threshold increased from 300 to 325.

The Board has a Tool Committee that is charged with implementing and recommending policy regarding the SHQ. The Committee works with the actuaries in determining that the SHQ meets the requirements of the law. During the recertification of the SHQ in 2006 by WSHIP, it was found that approximately 20% of denials by commercial carriers are subsequently overturned and coverage issued by the commercial carrier. The Committee suggested that an audit of carrier practices may be in order to investigate the reasons for the high rate of reversal. It was determined by the Executive Director that WSHIP does not receive the necessary information from applicants to perform SHQ audits, nor does WSHIP have the authority to

require it be provided. The statute governing WSHIP also does not include oversight authority with respect to implementation of the SHQ by carriers.

Findings

The following Plan Operations and Management Standards passed without comment:

	Compliance Operations and Management Standards	Reference
1	The Board of Directors is selected as required by statute.	RCW 48.41.040(2)
2	The Board shall submit to the commissioner a plan of operation for the Pool and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the Pool.	RCW 48.41.040(4)
3	The plan of operation contains all required provisions.	RCW 48.41.050
4	The Board selects an administrator to administer the Pool through a competitive bidding process. The administrator performs duties as assigned by the Board.	RCW 48.41.080
5	The Board shall designate or establish the standard health questionnaire to be used under RCW 48.41.100 and RCW 48.43.018, including the form and content of the standard health questionnaire and the method of its application.	RCW 48.41.060(1)(a)

GENERAL EXAMINATION STANDARDS

The examiners reviewed the Administrator's compliance with the requirements of the Administrative Service Agreement. They also reviewed the process in place for the Board to oversee the Administrative Service Agreement provisions.

During the examination period the Board received monthly reports from the Administrator concerning performance standards including:

- Enrollment Standards
- Billing Standards
- Claims Standards
- Customer Service Standards

The administrative contract between WSHIP and BMI includes a provision imposing a monetary penalty if BMI fails to meet one or more of the performance standards during a month. The contract also includes a bonus provision should BMI meet or exceed all performance standards during a month.

Findings

The following General Examination Standard passed without comment:

General Examination Standard	Reference
1 The Company does business in good faith, and practices honesty and equity in all insurance matters.	RCW 48.01.030
3 The Company may not discourage members from contacting the OIC and may not discriminate against those members that do contact the OIC.	WAC 284-30-572(2)

The following General Examination Standard failed:

General Examination Standard	Reference
2 The Company must facilitate the examination process by providing its accounts, records, documents and files to the examiners upon request.	RCW 48.03.030(1)

General Examination Standard 2: WSHIP's administrator BMI was unable to produce nine (9) underwriting files. Seven (7) of the nine (9) files represent in-force business written prior to BMI becoming WSHIP's administrator. BMI believes that these files were never received from Outsourced Administrative Systems, Inc. (OASYS), WSHIP's previous administrator.

The basement of the building in which BMI is located was flooded in April of 2007. Files stored in the basement incurred some water damage and some documents were destroyed in the flood.

Complaint file M21000222 referenced a written request to appeal a decision involving the policy termination date. This letter was not in the file and BMI could not locate the referenced correspondence.

See Appendix 1.

WSHIP also failed this standard in the prior examination adopted in 2003. The failure was because the examiners had difficulty working with WSHIP's previous administrator. This was not the case with the current administrator. It should be noted that this repeat failure was primarily restricted to record keeping problems with the previous administrator.

ADVERTISING

Requirements for WSHIP eligibility and procedures for enrollment are publicized through the WSHIP webpage, the application packet and information obtained from health carriers who have rejected an application for individual coverage.

Carriers send BMI a list of applicants rejected for individual coverage. BMI sends these individuals a follow-up letter reminding them about WSHIP.

WSHIP encourages the involvement in the application process by the agent and broker community. During 2006 35% of the applications received by WSHIP were completed by agents. The WSHIP web page lists agents who participate in a special training about the WSHIP application process. Agents are paid \$50.00 per each acceptable application submitted to the Pool. WSHIP also publishes a quarterly "Agent Bulletin" to update agents about product developments, changes to the Standard Health Questionnaire and other information.

Subsequent event: Beginning January 1, 2008 the fee paid to agents increased to \$75.00.

WSHIP hosts a monthly teleconference with consumer advocate groups Evergreen Health Insurance Program and the Northwest Kidney Center to keep them informed about WSHIP's policies and eligibility requirements.

Findings

The following Advertising Standards passed without comment:

#	Advertising Standards	Reference
1	The plan shall develop and implement a program to publicize the existence of the plan, the eligibility requirements and procedures for enrollment, and maintain public awareness of the plan.	RCW 48.41.050(8)
2	The administrator shall prepare a brochure outlining the benefits and exclusions of the Pool policy in plain language and make the brochure available to participants and potential participants.	RCW 48.41.110(2)

COMPLAINTS

Procedures

The examiners were provided with copies of the appeals, grievance and independent review organization (IRO) procedures in use during the examination period. Applicants and members can review the appeals and grievance process on WSHIP's website. The process is also outlined within the Application and Plan Description brochure as well as in the policy.

WSHIP offers three (3) levels of appeals. The first two (2) levels are internal. The first appeal goes to WSHIP's administrator, BMI. The second level goes to the WSHIP grievance committee. The third level of appeal is external and may be made to a designated independent review organization (IRO). The procedures detail steps that applicants and members need to take if they believe that mistakes were made either in the scoring and administration of the Standard Health Questionnaire (SHQ) or an action or decision made by WSHIP. The procedures provide a timeline showing when communication may be expected during the course of the appeal or grievance.

BMI also provided copies of its internal OIC Inquiry Processing and Complaint Processing procedures. The WSHIP Application and Plan Description does not have a separate section which deals specifically with complaints and refers to appeals as complaints. The appeals and grievance process calls for BMI to respond in writing within five (5) business days confirming receipt of an appeal request. Requests to appeal to WSHIP's grievance committee are also to be acknowledged within five (5) business days. If BMI considers the appeal to be something that can be resolved without much research being done it is handled as a complaint and no receipt confirmation letter is sent. The log of grievances and appeals provided by BMI did not identify any appeals as having been categorized as complaints. Eight (8) of the 55 appeals and grievance files reviewed did not include an acknowledgement within five (5) business days.

See Appendix 2.

The procedures require decisions on grievances and appeals to be made within 30 days of receipt of complete information. Six (6) of the 55 files reviewed did not have a decision rendered within the 30 day time frame.

See Appendix 3.

Complaint File Review

BMI provided the examiners with a log of 161 appeals and grievances received during the examination period. Four (4) cases were processed by Independent Review Organizations (IRO). The examiners selected a random sample of 51 files from the log and all four (4) IRO files for a total of 55 files. The following chart shows the reasons and dispositions of the 55 files reviewed:

Reason	Number	Upheld	Overtured
Benefits	6	2	5*
Claim Handling	19	8	11
Effective Date	1		1
Pre-existing Condition	1	1	
Premium / Billing	2	1	1
Reinstatements	26	1	25
Total	55	12	43

*One (1) appeal was partially overturned.

The reinstatement category was the largest and almost all of the initial decisions were overturned. This category also accounted for 48% of all complaints filed during the examination period. The majority of the reinstatement complaints were made on policies where a third-party payor, such as Evergreen Health Insurance Program (EHIP), was involved. An administrative policy directive for reinstatement of eligibility is in place for cases where a third party's actions, through no fault of the enrollee, have caused noncompliance with payment requirements.

The examiner found two (2) instances in which WSHIP's Executive Director personally made decisions regarding grievances.

- OIC 3 - Enrollee requested WSHIP authorize payment for treatment in Sweden. The enrollee followed the appeals and grievance procedure and requested involvement of an IRO as well. In each instance of the review process the treatment was found to be experimental or investigative and therefore not covered. The Executive Director overturned these decisions and made an administrative decision to authorize treatment.
- OIC 55 - Treatment for an enrollee was denied by WSHIP's utilization management administrator. The enrollee appealed the denial of treatment and the denial was upheld. The enrollee then requested review by the Grievance Committee. The Executive Director reviewed the file and approved payment for the requested treatment without review by the Grievance Committee.

The appeals and grievances policies and procedures in place do not allow for the Executive Director to make final determinations. WSHIP told the examiners that during the November 10, 2005 Board Meeting the Board gave the Executive Director authority to approve

reinstatements within certain parameters. The parameters, as outlined in the Board meeting minutes, are as follows:

- Cases where the enrollee's medical condition has deteriorated to the point that they were unable to comply with payment requirements; and
- Cases where a third party's actions, through no fault of the enrollee, have caused noncompliance with payment requirement.

The decisions made by the Executive Director did not involve reinstatement and fell outside of the Executive Director's authority.

BMI provided a second log of eleven complaints that had OIC involvement. Two (2) of the complaints involved WSHIP's Medicare Plan and were discarded from the sample. The remaining nine (9) complaints were tested for timely and substantial response to the OIC. WSHIP is not subject to WAC 284-30-360(2), WAC 284-30-650, and Technical Advisory T 98-4 but still responded to OIC inquiries within the 15 business day requirement.

Findings

The following Complaint Standard passed without comment:

#	Complaint Standard	Reference
1	The plan of operations establishes procedures under which applicants and participants may have grievances reviewed by an impartial body and reported to the Board.	RCW 48.41.050(9)

CLAIMS

Claims Processing Manual

BMI provided the examiners with the claims manual used to adjudicate WSHIP claims. The manual provided a description of workflow in the claims department. With the exception of the Coordination of Benefits (COB) procedures, the examiners found the manual to accurately describe the processes in place. The issue with COB is addressed under Claims Standard 5 below.

Claims Processing

WSHIP contracts with First Choice Health Network (FCHN) to provide its network to WSHIP participants. Provider claims are sent to FCHN for re-pricing to reflect the negotiated rate between FCHN and the contracted provider.

BMI started processing claims from a new system called LumineX on December 19, 2006. The system in place prior to LumineX was called the TPA System. All claims in the TPA System

were manually entered into LumineX. This includes claims that had been paid or denied prior to implementation of the new system. Board meeting minutes reflect that an audit to assure accuracy of the new system was scheduled for April 2007.

Subsequent Event: The Executive Director's Report dated November 5, 2007 states that Claim Technologies Incorporated (CTI) issued an audit report.

BMI does not auto adjudicate claims. The system does have the capability of auto adjudication however BMI believes it is more accurate to have examiners review all claims. During the examination period BMI was not receiving claims electronically from FCHN. Paper claims were manually input into the system. BMI contracted with JMS consulting to complete the inputting.

Subsequent Event: FCHN started sending BMI claims electronically on May 1, 2007.

BMI has five (5) examiners who handle WSHIP claims. Prior to the implementation of the new LumineX system between 120 and 150 claims were randomly selected for audit. Current audit procedures call for a review of 2% of claims. Claims are audited on a daily basis. A program in LumineX allows the percentage of claims to be audited to be set for each examiner and the system selects the claims that are to be audited. Claims examiners have payment authority levels and claims in excess of these limits are reviewed by supervisory staff prior to release. The authority levels for claim examiners range from \$2,000 to \$50,000; the Claims Analyst Supervisor has a \$75,000 processing limit and the Claims Operations Manager has a \$100,000 limit.

The TPA system provided an accumulated lifetime benefit which all customer service representative and claims examiners could access when giving benefits to providers. The LuminX system also tracks the benefits being accumulated towards the lifetime maximum. A lifetime medical accumulator report is run each month. WSHIP's prescription drug administrator, Medco, also runs a prescription lifetime accumulator report and sends the results to BMI. The two (2) accumulated amounts are then reported in the monthly service level report as the lifetime accumulated amount for those enrollees who have exceeded \$750,000.00.

Claims Review

BMI processed 83,792 claims during the examination period. The examiners reviewed 100 claims that were randomly selected. The claims transactions audited totaled payments of \$24,361.10. The claims were tested for the standards listed below as well as compliance with stated performance standards in the contract between WSHIP and BMI.

Medco processed 118,007 prescription drug claims during the examination period. The database of prescription drug claims was reviewed and analyzed using ACL auditing software.

Findings

The following Claims Standard passed without comment:

#	Claims Standards	Reference
1	The plan administrator shall administer claim payment functions relating to the Pool.	RCW 48.41.080(3)(a)
5	The plan administrator shall maintain clerical accuracy of claims processed at a percentage of 98% or greater. The accuracy percentage shall be based on a 2% claim audit during the reporting month.	Per the Terms of Administrative Services Agreement Effective April 1, 2007.
7	The plan administrator shall maintain financial accuracy of claims processed at a percentage of 99% or greater. The accuracy percentage shall be based on a 2% claim audit during the reporting month.	Per the Terms of Administrative Services Agreement Effective April 1, 2007.

The following Claims Standards passed with comment:

#	Claims Standards	Reference
2	The plan administrator shall perform the described necessary functions to assure timely payment of benefits to covered persons under the Pool.	RCW 48.41.080(3)(c)
6	The plan administrator shall maintain financial accuracy of claims processed at a percentage of 98% or greater.	Per the Terms of Administrative Services Agreement Effective November 25, 2003 to March 31, 2007.

Claims Standard 2: RCW 48.41.080(3)(c) does not stipulate what constitutes a timely payment. The contract between WSHIP and BMI does include a claim standard calling for 100% of all clean claims to be processed within 30 calendar days of receipt. Six (6) claims were not paid within the 30 calendar day timeframe. BMI was not able to determine the specific cause of delay for each claim. BMI states it moved from its legacy system to LumineX in December 2006 and as a result experienced delays in claim processing.

See Appendix 4.

The contract between WSHIP and Medco includes a direct claim turnaround performance guarantee. The standard calls for Medco to adjudicate 97% of claims within five (5) business days and 100% within an average of ten (10) business days. Medco's 2006 self audit shows that 94% of claims were closed within five (5) business days and 99% were closed within ten (10) business days. Medco did not meet its performance guarantee.

Claim Standard 6: The following are financial processing errors the examiners found:

- OIC 12 – This claim should have been denied due to a pre-existing condition. \$299.42 of the \$366.00 billed charges was allowed.

- OIC 28 – This claim should have been denied for untimely filing. Services were provided on 1/8/2005. This claim involved COB and was initially denied in 2005 because of non-receipt of an explanation of benefits from the primary carrier. The claim was received again on 1/24/2007. \$40.94 was paid on 2/23/2007.
- OIC 60 – This claim involved Coordination of Benefits (COB). As the last payor of benefits WSHIP should have paid \$34.65. This is WSHIP’s allowed amount of \$49.50 less \$14.85 which was the amount allowed and paid by the primary carrier. WSHIP underpaid this claim by \$19.80.
- OIC 62 – This claim also involves COB. WSHIP allowed \$79.17 which was applied to the member’s deductible. The primary carrier made a payment of \$50.00 on this claim; WSHIP should have applied \$29.17 to the member’s deductible.

Claims paid prior to the April 1, 2007 effective date of the revised Administrative Services Agreement totaled \$22,420.68. The above claims were all paid prior to April 1, 2007. BMI meet the standard with 98.3% financial accuracy.

The following Claims Standards failed:

#	Claims Standards	Reference
3	The Pool will be the last payor of benefits whenever any other benefit is available.	RCW 48.41.210
4	The plan administrator shall maintain clerical accuracy of claims processed at a percentage of 97% or greater	Per the Terms of Administrative Services Agreement Effective November 25, 2003 to March 31, 2007.

Claims Standard 3: In situations involving another carrier, WSHIP benefits payable should be reduced by all amounts paid or payable through any other health insurance, or health benefit plan. The claims procedure manual used by BMI does indicate that WSHIP will pay as secondary on the balance due up to 100% of the total allowable expense. The actual adjudication of claims involving a primary payor does not follow proper procedures. BMI pays the amount not covered by the primary payor.

- OIC 60 –As the last payor of benefits WSHIP should have paid \$34.65. This is WSHIP’s allowed amount of \$49.50 less \$14.85 which was the amount allowed and paid by the primary carrier. WSHIP underpaid this claim by \$19.80.
- OIC 62 – The primary carrier made a payment of \$50.00 on this claim; WSHIP should have applied \$29.17 to the member’s deductible. In this instance BMI did not follow its own procedures when it first handled the claim and applied the WSHIP allowable amount of \$79.17 to the member’s deductible. When questioned BMI incorrectly advised that the claim should have been processed with an allowable amount of \$60.64; the primary’s allowable amount of \$110.64 minus the \$50 payment made by the primary insurance.

Claims Standard 4: The following are clerical errors the examiners found:

- OIC 4 – This claim was correctly denied for being a duplicate claim. The denial code used incorrectly reflects that this was being denied due to the expense not being covered.
- OIC 17 – The receipt date of this claim was keyed into the system incorrectly. The re-pricing worksheet was received from FCHN on 8/21/2006. The system shows the received date as 8/31/2006.
- OIC 36 – The claim form and re-pricing worksheet both show a charge for procedure code 82272. The correct amount was paid however the procedure code was keyed into the system as 82273.

Eighty-one of the 100 sampled claims were paid prior to April 1, 2007 when the new service agreement went into effect. The above claims were all received and adjudicated in 2006. The 96.3% accuracy rate falls below the 97% agreed to in the Service Agreement.

RATE AND FORM FILING

The WSHIP Board is charged with developing rates for the plans offered by the Pool. During the exam period the Board retained the services of Leif Associates, Inc., a health care actuarial consulting firm, to develop rate scenarios from which the Board chooses. The Board approved 2006 rates during the November 10, 2005 Board meeting. The rates for 2007 were approved during the October 12, 2006 Board meeting. The rates were filed with the OIC for informational purposes. WSHIP is not required to submit its rates to the OIC for approval. RCW 48.41.200(1) requires that WSHIP determine the standard rate charged for coverage comparable to pool coverage by the five (5) largest carriers offering individual coverage in the state. WSHIP rates can be no lower than 110% of the standard risk rate and not more than 150%.

WSHIP is required to file its policy forms and obtain OIC approval prior to use. The examiners reviewed the filings and found that they had been properly filed with the OIC and approval obtained prior to being sold. During the examination period WSHIP offered three (3) plans, a standard plan, a network plan and Medicare plan.

Subsequent Event: Revisions to the standard and network plans were filed with the OIC and approved June 29, 2007.

Findings

The following Rate and Form Filing Standard passed:

1	The Board shall establish appropriate rates, utilizing appropriate risk factors in accordance with established actuarial underwriting practices as listed in RCW 48.44.022 and RCW 48.46.064.	RCW 48.41.060(1)(d)
2	All policy forms issued by the Pool shall be filed with and approved by the commissioner before they are used.	RCW 48.41.130
3	Rates may not change except on a class basis. The Pool's right to change rates must be clearly disclosed in the policy.	RCW 48.41.160(2)

UNDERWRITING

Underwriting Manuals and Procedures

The examiners reviewed the following documents used by BMI in the underwriting process:

- Plan 1 and Plan 3 Application Processing
- Low Income Application Processing
- Application Checklist
- WSHIP New Enrollment Form for Plan 1 and 3

The WSHIP application includes a checklist that states documentation requirements for participation in WSHIP and includes the BMI customer service phone number should applicants have any questions while completing the application.

Applications received by BMI are date stamped and applicant information is entered on to a WSHIP Enrollment Spreadsheet. A separate file is created and maintained for each applicant. The enrollment department verifies the applicant's eligibility and determines if the premium payment sent with the application is correct based on the applicants chosen plan, age and billing cycle selected. If the applicant is eligible for WSHIP coverage but required documentation is missing the application is pended and BMI sends the applicant a letter requesting the missing information. If no response is received after 14 days a second request letter is sent. If a response is not received within 30 days the application is denied.

Approved applications are set-up within the BMI computer system. A clerical accuracy audit is completed on each new application The information on the application is compared to what was entered into the system. The member's account is then set-up within the prescription vendor's system.

If the initial application includes a low income discount application, it is processed after all requirements of the Plan 1 and Plan 3 application processing procedures are completed. The enrollment department must confirm that the age of the member is between 50 and 64 and that the low income discount application and worksheet have been completed. If so, the application is then encrypted and sent electronically to the Health Care Authority (HCA) for review and approval.

Underwriting File Review

The random sample of files selected for review was pulled from the following population:

	Plan 1	Plan 3	Total	Sample Selected
New Business	217	1033	1250	50
In-Force	391	985	1376	30
Terminations	233	633	866	20

BMI was not able to locate one (1) new business file, one (1) terminated file and seven (7) in-force files. BMI was not able to locate the Certificate of Creditable Coverage for file OIC N22. Some of the documents may have been destroyed by the flood in 2007.

Findings

The following Underwriting Standards passed without comment:

1	The plan administrator shall administer eligibility functions relating to the Pool.	RCW 48.41.080(3)(a)
2	To be eligible for Pool coverage persons must be residents of Washington and meet eligibility standards outlined in RCW 48.41.100(1)(a) through RCW 48.41.100(1)(d)	RCW 48.41.100(1)
3	Any person who provides evidence within 90 days of a carrier's declination based on the standard health questionnaire is eligible for coverage.	RCW 48.41.100(1)(a)
4	Once a person is eligible for Pool coverage based on the results of the standard health questionnaire, that person will remain eligible until they no longer qualify for Pool coverage.	RCW 48.41.100(1)(b)
5	Eligibility for pool coverage is allowed because no carrier or surplus lines insurer offers other than catastrophic coverage in the applicant's county of residence.	RCW 48.41.100(1)(c)
6	A Medicare eligible person is eligible if they are rejected for a Medicare Supplement policy for the reasons listed in the statute.	RCW 48.41.100(1)(d)

7	The Pool may not reject an individual for coverage based upon preexisting conditions but will impose a 6-month waiting period. The preexisting condition waiting period shall not apply to prenatal care.	RCW 48.41.110(6)
8	The Pool shall credit any preexisting condition waiting period for a person who was enrolled at any time during the 63-day period immediately preceding the date of application for the new plan.	RCW 48.41.110(7)(a)

The following Underwriting Standard failed:

#	Underwriting Standard	Reference
9	If application is made as result of rejection, the date of application to the carrier, rather than to the Pool, should govern for purposes of determining preexisting condition credit.	RCW 48.41.110(8)

Underwriting Standard 9: The policies in use during the examination period state the following:

"If WSHIP receives Your application before the end of the month following the month You applied to an Insurance Carrier, the 63 days will be counted from the date the Insurance Carrier received a completed application and health questionnaire form if required."

The contract provision used is more restrictive than RCW 48.41.110(8).

BMI did not credit any pre-existing condition waiting period for file OIC N46. In calculating the 63-day period immediately preceding the date of application for a new plan BMI used the date the application was received by the Pool, not the date of application to a commercial insurance carrier.

CONTRACT AND MEMBER HANDBOOKS

The examiners reviewed the application forms and policies that were in use during the examination period. All of the forms and policies that were filed had been reviewed and approved by the OIC.

The following Contract and Member Handbooks Standards Passed without comment:

#	Contract and Member Handbooks Standard	Reference
1	The Pool shall offer one or more care management plans of coverage.	RCW 48.41.110(1)
2	Plan benefits shall include the described minimum coverage.	RCW 48.41.110(3)
3	The Board shall design and employ cost containment measures.	RCW 48.41.110(4)
4	The Pool benefit policy may contain benefit limitations, exceptions, and cost shares consistent with managed care products. No limitation, exception or reduction may be used to exclude coverage for any disease, illness, or injury.	RCW 48.41.110(5)
5	The contracts shall contain the deductible, coinsurance, out-of-pocket payments, and carryover requirements as defined.	RCW 48.41.120
6	Coverage for adopted and newborn children shall include care and treatment of medically diagnosed congenital defects and birth abnormalities.	RCW 48.41.140(1)
7	The Board shall offer a medical supplement policy for persons receiving Medicare Parts A and B.	RCW 48.41.150

POLICY ADMINISTRATION

The Administrative Services Agreement between WSHIP and BMI requires BMI to provide comprehensive administrative and management services needed to operate WSHIP's business.

The following policies and procedures were established by BMI and are used to help with the servicing of policies:

- Plan 1 and Plan 3 Application Processing
- Low Income Application Processing
- Termination Processing
- Premium Refund Check Processing
- Billing Statement Processing

The billing department is responsible for making sure that all changes to an insured's account are complete. With the exception of insured's who are on a monthly bank draft and receive no

statements, WSHIP invoices are printed and mailed on or around the 20th of each month. Printed billing statements are randomly audited for accuracy.

The termination provision in the WSHIP policies includes loss of residency as a reason for termination. BMI verifies residency at time of application and annually sends out eligibility verification forms. BMI estimates that approximately 60% of the members respond to the annual form with eligibility verification. There is no requirement that the form be returned in order to keep the policy in effect. BMI does follow-up for residency verification if there is any indication, such as a claim from an out-of-state provider, of a possible change in residency.

BMI's policies and procedures as well as the 23 in-force underwriting files and 19 terminations reviewed for the underwriting section of this exam were used to test compliance of the Policy Administration Standards.

Findings

The following Policy Administration Standards passed without comment:

#	Policy Administration Standards	Reference
1	The plan administrator shall establish a premium billing procedure for collection of premiums. Billings shall not be more frequent than monthly.	RCW 48.41.080(3)(b)
2	Coverage will not terminate for a dependent child if he/she is developmentally disabled.	RCW 48.41.140(2)
3	The policy shall contain provisions under which the Pool is obligated to renew the policy until the individual becomes eligible for Medicare.	RCW 48.41.160(1)
4	Upon the death of the individual in whose name the policy is issued, every other individual covered under the policy may elect to continue coverage under the same or different policy.	RCW 48.41.160(3)

ADMINISTRATIVE CONTRACTS

The examiners reviewed the following contracts WSHIP had with entities providing administrative services during the examination period:

- Benefit Management Inc. (BMI) – WSHIP Program Administrator
- Medco Health Solutions, Inc. (Medco) – Pharmacy Benefit Management
- First Choice Health Network, Inc. (FCHN) – Provider Network
- Health Integrated, Inc. (HI) – Care Management
- Qualis Health (Qualis) – Care Management

BMI

WSHIP has been contracting with BMI since April 1, 2004 to provide comprehensive administrative and management services needed to operate WSHIP's business. WSHIP's Board places this contract out for bid every three (3) years. The current agreement is effective until March 31, 2010.

The contract between WSHIP and BMI contains performance standards for the timely and accurate processing of applications and enrollment, premium billing and collection and claims. Customer service standards are also measured.

The contract includes provisions for a monthly penalty to be assessed for each failed standard and a monthly bonus if BMI meets or exceeds all performance standards during a month. BMI provides the Board with monthly reports detailing activity and the results of its compliance with the standards based on BMI's internal audit. No independent audits were performed of BMI during the examination period.

BMI received a bonus for meeting all standards 13 of 16 months in the examination period. In January 2006 BMI failed the 60 second average speed of answer criteria under the Customer Service Standards and the invoice for January included a performance penalty. A revised January invoice reverses the penalty and shows a bonus for the month of January. WSHIP's Executive Director told the examiner that WSHIP implemented its new supplement to Medicare, Basic Plus, a State Pharmacy Assistance Program (SPAP) which provides supplemental coverage to Medicare Parts A, B, and D in January 2006. The new program generated a large volume of questions and complaints. WSHIP's prescription drug administrator, Medco, was not able to respond accurately to calls and as a result the telephone call volume to BMI's customer service representatives increased. BMI's data shows that overall call volume in January was more than 20% over the monthly average. Pharmacy benefit questions were 604 for the month versus a monthly average of 142. The Executive Director deemed the calls to be beyond BMI's control and outside of their responsibility and felt it unfair to penalize them. The Executive Director made the decision to reverse the penalty. There are no notes in the Board meeting minutes or Executive Director Reports for this time period documenting that this was discussed or agreed upon by the Board.

Medco

The contract with Medco has been effective since September 1, 2004. An addendum to the agreement was added on January 1, 2006. Medco manages WSHIP's prescription drug program.

A number of performance standards and guarantees were added to the 2006 contract addendum. The contract calls for a maximum \$10,000 penalty per contract year for each standard that is not met. In 2006 Medco paid WSHIP \$30,000 in penalties. The following three (3) standards were not met:

- Direct Claim Turnaround
- Account Team Survey – Client Satisfaction
- Reporting Timeliness – Standard Management Reports

First Choice Health Network, Inc.

FCHN provides WSHIP with a network of providers, which have entered into agreements with FCHN. Under the contract FCHN also re-prices all provider claims to reflect the negotiated rate between FCHN and the provider.

Payment to FCHN is based on a percentage of network savings. The payment is billed and paid monthly. The agreement includes a provision allowing WSHIP to audit the books, records, and financial statements of FCHN that are in relation to this agreement.

Health Integrated, Inc.

HI provided Utilization Management services during 2006. Service included case management, behavioral case management and depression disease management. Performance measures included in the contract were monitored and reported by the HI contract administrator assigned to the contract. The reports were available to WSHIP through the HI website. The contract between WSHIP and HI allowed penalties to be assessed if performance measures were not met; the contract did not include a provision for bonuses. No penalties were assessed to HI during the examination period.

The Executive Director's Report dated September 6, 2005 states that the HI contract has been in place for two (2) years as of April 15 2005 and suggests that the Board Schedule and Work Plan for 2006 include a request for proposal (RFP) for care management. The RFP was developed and Qualis was selected as new vendor during the October 12, 2006 Board meeting.

Qualis Health

Qualis replaced HI as WSHIP's care management vendor effective January 1, 2007. Services to be provided by Qualis include utilization management, case management, disease management and specialty review.

The agreement has a set of performance standards and Qualis can earn a bonus or be penalized depending on performance. With the exception of the utilization management review measures, all performance measures are monitored and reported by the Quality Health Contract Administrator assigned to the contract. For the three (3) utilization management review measures, Qualis samples 100% of all WSHIP cases directly from its software database using an algorithm developed by its IT project team. That data is periodically reviewed for integrity and completeness by Qualis and then transmitted to WSHIP. There were no bonus payments paid or penalties assessed during the examination period.

INSTRUCTIONS

#	Instructions	Page #
1	The Pool is instructed to require the administrator to comply with RCW 48.03.030(1) and retain complete underwriting and complaint files in order to be able to better facilitate future examinations and provide all records.	10
2	The Pool is instructed to be the last payor of benefits in accordance with RCW 48.41.210.	17
3	The Pool is instructed to calculate prior coverage for the purposes of calculating a pre-existing condition credit by using the date of application to the commercial carrier. The Pool is instructed to review its records to ensure that pre-existing condition credits have been calculated appropriately and that claims have not been improperly denied. RCW 48.41.110(8)	21

RECOMMENDATIONS

#	Recommendation	Page #
1	It is recommended that the Pool define the difference between a complaint and an appeal and provide applicants and members with a written procedures outlining how each will be handled.	12
2	It is recommended that the Pool follow its written procedures and respond to all appeals within 5 days of receipt of the appeal.	12
3	It is recommended that the Pool follow its written procedures and resolve all appeals and grievances within 30 days of receipt of complete information.	12

#	Recommendation	Page #
4	It is recommended that the Board not allow the Executive Director to make decision on appeals and grievances outside the scope of her authority.	13, 14
5	It is recommended that the Board require the Pool administrator implement audit procedures that will ensure timely payment of claims.	16, 17
6	It is recommended that the Board conduct regular audits of its administrators to assure that contractual obligations are met.	16, 17
7	It is recommended that BMI be required to follow-up on members who do not return annual eligibility verification forms.	23
8	It is recommended that any decisions regarding payments and penalties assessed to administrators that are contrary to the administrators contract with WSHIP be fully discussed with the Board and documented in the Board meeting minutes.	24, 25

SUMMARY OF STANDARDS

Company Operations and Management Standards:

#	STANDARD	PAGE	PASS	FAIL
1	The Board of Directors is selected as required by statute. Reference: RCW 48.41.040(2)	9	X	
2	The Board shall submit to the commissioner a plan of operation for the Pool and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the Pool. Reference: RCW 48.41.040(4)	9	X	
3	The plan of operation contains all required provisions. Reference: RCW 48.41.050	9	X	
4	The Board selects an administrator to administer the Pool through a competitive bidding process. The administrator performs duties as assigned by the Board. Reference: 48.41.080	9	X	
5	The Board shall designate or establish the standard health questionnaire to be used under RCW 48.41.100 and 48.43.018, including the form and content of the standard health questionnaire and the method of its application. Reference: RCW 48.41.060(1)(a)	9	X	

General Examination Standards:

#	STANDARD	PAGE	PASS	FAIL
1	The Company does business in good faith, and practices honesty and equity in all insurance matters. Reference: RCW 48.01.030	10	X	
2	The Company must facilitate the examination process by providing its accounts, records, documents and files to the examiners upon request. Reference: RCW 48.03.030(1)	10		X
3	The Company may not discourage members from contacting the OIC and may not discriminate against those members that do contact the OIC. Reference: WAC 284-30-572(2)	10	X	

Advertising Standards:

#	STANDARD	PAGE	PASS	FAIL
1	The plan shall develop and implement a program to publicize the existence of the plan, the eligibility requirements and procedures for enrollment, and maintain public awareness of the plan. Reference: RCW 48.41.050(8)	11	X	
2	The administrator shall prepare a brochure outlining the benefits and exclusions of the Pool policy in plain language and make the brochure available to participants and potential participants. Reference: RCW 48.41.110(2)	11	X	

Complaint Standards:

#	STANDARD	PAGE	PASS	FAIL
1	The plan of operations establishes procedures under which applicants and participants may have grievances reviewed by an impartial body and reported to the Board. Reference: RCW 48.41.050(9)	14	X	

Claims Standards:

#	STANDARD	PAGE	PASS	FAIL
1	The plan administrator shall administer claim payment functions relating to the Pool. Reference: RCW 48.41.080(3)(a)	16	X	
2	The plan administrator shall perform the described necessary functions to assure timely payment of benefits to covered persons under the Pool. Reference: RCW 48.41.080(3)(c)	16	X	

#	STANDARD	PAGE	PASS	FAIL
3	The Pool will be the last payor of benefits whenever any other benefit is available. Reference: RCW 48.41.210	17		X
4	The plan administrator shall maintain clerical accuracy of claims processed at a percentage of 97% or greater. Reference: Terms of the Administrative Services Agreement	17		X
5	The plan administrator shall maintain clerical accuracy of claims processed at a percentage of 98% or greater. The accuracy percentage shall be based on a 2% claim audit during the reporting month. Reference: Terms of the Administrative Services Agreement.	16	X	
6	The plan administrator shall maintain financial accuracy of claims processed at a percentage of 98% or greater. Reference: Terms of the Administrative Services Agreement	16	X	
7	The plan administrator shall maintain financial accuracy of claims processed at a percentage of 99% or greater. The accuracy percentage shall be based on a 2% claim audit during the reporting month. Reference: Terms of the Administrative Services Agreement	16	X	

Rate and Form Filing Standards:

#	STANDARD	PAGE	PASS	FAIL
1	The Board shall establish appropriate rates, utilizing appropriate risk factors in accordance with established actuarial underwriting practices as listed in RCW 48.44.022 and RCW 48.46.064. Reference: RCW 48.41.060(1)(d)	19	X	
2	All policy forms issued by the Pool shall be filed with and approved by the commissioner before they are used. Reference: RCW 48.41.130	19	X	
3	Rates may not change except on a class basis. The Pool's right to change rates must be clearly disclosed in the policy. Reference: RCW 48.41.160(2)	19	X	

Underwriting Standards:

#	STANDARD	PAGE	PASS	FAIL
1	The plan administrator shall administer eligibility functions relating to the Pool. Reference: RCW 48.41.080(3)(a)	20	X	
2	To be eligible for Pool coverage persons must be residents of Washington and meet eligibility standards outlined in RCW 48.41.100(1)(a) through RCW 48.41.100(1)(d). Reference: RCW 48.41.100(1)	20	X	
3	Any person who provides evidence within 90 days of a carrier's declination based on the standard health questionnaire is eligible for coverage. Reference: RCW 48.41.100(1)(a)	20	X	
4	Once a person is eligible for Pool coverage based on the results of the standard health questionnaire, that person will remain eligible until they no longer qualify for Pool coverage. Reference: RCW 48.41.100(1)(b)	20	X	
5	Eligibility for pool coverage is allowed because no carrier or surplus lines insurer offers other than catastrophic coverage in the applicant's county of residence. Reference: RCW 48.41.100(1)(c)	20, 21	X	
6	A Medicare eligible person is eligible if they are rejected for a Medicare Supplement policy for the reasons listed in the statute. Reference: RCW 48.41.100(1)(d)	21	X	
7	The Pool may not reject an individual for coverage based upon preexisting conditions but will impose a 6-month waiting period. The preexisting condition waiting period shall not apply to prenatal care. Reference: RCW 48.41.110(6)	21	X	
8	The Pool shall credit any preexisting condition waiting period for a person who was enrolled at any time during the 63-day period immediately preceding the date of application for the new plan. Reference: RCW 48.41.110(7)(a)	21	X	
9	If application is made as result of rejection, the date of application to the carrier, rather than to the Pool, should govern for purposes of determining preexisting condition credit. Reference: RCW 48.41.110(8)	21		X

Contract and Member Handbook Standards:

#	STANDARD	PAGE	PASS	FAIL
1	The Pool shall offer one or more care management plans of coverage. Reference: RCW 48.41.110(1)	22	X	

#	STANDARD	PAGE	PASS	FAIL
2	Plan benefits shall include the described minimum coverage. Reference: RCW 48.41.110(3)	22	X	
3	The Board shall design and employ cost containment measures. Reference: RCW 48.41.110(4)	22	X	
4	The Pool benefit policy may contain benefit limitations, exceptions, and cost shares consistent with managed care products. No limitation, exception or reduction may be used to exclude coverage for any disease, illness, or injury. Reference: RCW 48.41.110(5)	22	X	
5	The contracts shall contain the deductible, coinsurance, out-of-pocket payments, and carryover requirements as defined. Reference: RCW 48.41.120	22	X	
6	Coverage for adopted and newborn children shall include care and treatment of medically diagnosed congenital defects and birth abnormalities. Reference: RCW 48.41.140(1)	22	X	
7	The Board shall offer a medical supplement policy for persons receiving Medicare Parts A and B. Reference: RCW 48.41.150	22	X	

Policy Administration Standards:

#	STANDARD	PAGE	PASS	FAIL
1	The plan administrator shall establish a premium billing procedure for collection of premiums. Billings shall not be more frequent than monthly. Reference: RCW 48.41.080(3)(b)	23	X	
2	Coverage will not terminate for a dependent child if he/she is developmentally disabled. Reference: RCW 48.41.140(2)	23	X	
3	The policy shall contain provisions under which the Pool is obligated to renew the policy until the individual becomes eligible for Medicare. Reference: RCW 48.41.160(1)	23	X	
4	Upon the death of the individual in whose name the policy is issued, every other individual covered under the policy may elect to continue coverage under the same or different policy. Reference: RCW 48.41.160(3)	23	X	

APPENDIX 1

General Examination Standard 2: The Company must facilitate the examination process by providing its accounts, records, documents and files to the examiners upon request. Reference: RCW 48.03.030(1)

OIC #	Effective Date	Termination Date	Comment
OIC N07	02/01/2006		WSHIP unable to provide file for review.
OIC I03	04/01/2004		WSHIP unable to provide file for review.
OIC I10	04/01/2004		WSHIP unable to provide file for review.
OIC I11	04/01/2004		WSHIP unable to provide file for review.
OIC I12	04/01/2004		WSHIP unable to provide file for review.
OIC I15	11/01/2004		WSHIP unable to provide file for review.
OIC I25	10/01/2005		WSHIP unable to provide file for review.
OIC I26	01/01/2005		WSHIP unable to provide file for review.
OIC T08	04/01/2004	03/31/2007	WSHIP unable to provide file for review.
OIC 05			Complaint file. Written request to appeal is not in the file.

APPENDIX 2

Appeals not acknowledged within five (5) days of receipt.

Appeal/ Grievance	Date Received	Date Acknowledged / Resolved	# of Business Days	Comment
OIC 2	01/30/06	02/14/06	11	Request for reinstatement was not acknowledged. Decision to deny appeal was sent 2/14/2006.
OIC 3	03/02/06	03/10/06	6	Initial appeal acknowledged in six (6) days.
OIC 3	05/30/06	06/09/06	8	Request for review by the grievance committee acknowledged in eight (8) days.
OIC 8	04/24/06	05/10/06	11	Appeal was not acknowledged. A letter was sent 5/10/2006 outlining the final decision.
OIC 16	03/26/07	04/04/07	7	Appeal was not acknowledged. A letter was sent 4/4/07 outlining the final decision.
OIC 18	02/26/07	03/06/2007	6	Appeal was not acknowledged within five (5) days of receipt.
OIC 34	01/02/07	01/12/07	8	Appeal was not acknowledged within five (5) days of receipt.
OIC 35	11/20/06	12/01/06	9	Appeal was not acknowledged within five (5) days of receipt.
OIC 46	02/15/06	03/03/06	12	Appeal was not acknowledged. A letter was sent on 03/03/06 outlining the final decision.

APPENDIX 3

Grievances and Appeals not resolved within 30 days of complete information.

Appeal / Grievance	Date additional information was received	Date Resolved	# of Calendar Days	Comment
OIC 9	06/02/06	07/10/06	36	Appeal was not resolved within 30 days of WSHIP receiving complete information.
OIC 11	02/27/06	04/04/06	36	Appeal was not resolved within 30 days of WSHIP receiving complete information.
OIC 14	01/08/07	03/29/07	80	The member was notified of the decision to pay the claim 01/07/08. The delay in notification was due to an error.
OIC 20	01/20/06	03/02/06	39	Appeal was not resolved within 30 days of WSHIP receiving complete information.
OIC 22	07/10/06	08/16/06	37	Appeal was not resolved within 30 days of WSHIP receiving complete information.
OIC 23	03/24/06	05/01/06	36	Appeal was not resolved within 30 days of WSHIP receiving complete information.

APPENDIX 4

Claims Standard 2: The plan administrator shall perform the described necessary functions to assure timely payment of benefits to covered persons under the Pool. Reference: RCW 48.41.080(3)(c)

OIC #	Date Received	Date Processed	Number of Days
OIC 39	03/17/2006	07/21/2006	124
OIC 77	11/20/2006	12/31/2006	41
OIC 79	12/19/2006	01/26/2007	38
OIC 83	01/18/2007	02/23/2007	36
OIC 84	01/22/2007	04/12/2007	80
OIC 93	02/23/2007	04/10/2007	46