MARKET CONDUCT EXAMINATION

of

PREMERA BLUE CROSS
LIFEWISE HEALTH PLAN OF WASHINGTON

7001 220th ST SW
MOUNTLAKE TERRACE, WA 98043

January 1, 2004 – December 31, 2005

Order No. G 07-0341
Premera Blue Cross
Lifewise Health Plan of Washington
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 48.44.145 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 on the following Companies:

Premera Blue Cross	NAIC 47570
LifeWise Health Plan of Washington	NAIC 52633

In this report, the above entities are collectively referred to as the Companies. In addition, Premera Blue Cross is also referred to as "Premera". LifeWise Health Plan of WA is referred to as "LifeWise".

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 and Jeanette M. Plitt, CLU 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 by the personnel of Premera Blue Cross and LifeWise Health Plan of Washington 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.

Leslie A. Krier, AIE, FLMI
Market Conduct Oversight Manager
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, 2004 through December 31, 2005. In some instances the review period was extended to cover a more current time frame. These areas are noted in the report. This was the first market conduct examination of Premera Blue Cross and LifeWise Health Plan of Washington. This examination was performed in both the Companies' office in Mountlake Terrace Washington and in the Seattle Office of the Insurance Commissioner.

Matters Examined

The examination included a review of the following areas:

Company Operations and Management
Agent Activity
Complaints
Underwriting
Network Adequacy
Advertising
Claims
Rate and Form Filing
Provider Activity
Administrative Contracts

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 agent licensing and appointment, and 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.

COMPANY OPERATIONS AND MANAGEMENT

Company History

Premera Blue Cross was originally incorporated as Washington Hospital Service Association on May 9, 1945 and was registered as a health care service contractor under Washington State law on July 8, 1948. On March 24, 1969 its corporate name was changed to Blue Cross Washington-Alaska, Inc. On April 11, 1978 Blue Cross Washington-Alaska, Inc. reincorporated as a nonprofit corporation and changed its name to Blue Cross of Washington and Alaska (BCWA).

In 1985, BCWA purchased Chelan County Medical Service Corporation, a Blue Shield Plan operated in North Central Washington. In 1994 BCWA affiliated with Medical Service Corporation of Eastern Washington (MSC) to form an upstream nonprofit holding company, PREMERA. BCWA and MSC continued to operate separately until June 1998 when BCWA merged with MSC and changed its name to Premera Blue Cross.

On December 22, 2000 one of Premera Blue Cross's affiliated companies, Premera HealthPlus, was merged into Premera Blue Cross. Premera HealthPlus was a nonprofit Washington corporation formed in 1981 and was licensed as a health maintenance organization in Washington and Idaho.

LifeWise Health Plan of Washington (LifeWise) operates as a health care service contractor in Washington and principally sells individual subscription contracts. On November 19, 1998, LifeWise was incorporated as Premera Health Care, Inc., a for-profit corporation. On January 12, 1999 the Company changed its name to Premera Healthcare, Inc.

On May 2, 2000 the Company filed Articles of Amendment of Restated Articles of Incorporation for LifeWise changing from a for-profit corporation to a non-profit corporation. The Company also changed its corporate name to Premera Healthcare. On August 31, 2000 the Company received its certificate of registration to operate as a health care service contractor in Washington. On January 8, 2001 the Company changed its name to Premera LifeWise Health Plan. On July 11, 2002 the Company changed its name to LifeWise Health Plan of Washington.

Company Operations and Management

Premera Blue Cross is managed by a Board of Directors (BOD) made up of no less than twelve and no more than fourteen members. All are subject to the approval of Premera's sole voting member; PREMERA. The BOD holds its annual meeting in the second quarter of every year and meets no less than four (4) times each calendar year.

The following individuals were Directors of Premera Blue Cross during the exam period:

Board Member	Affiliation	Original Appointment Date	Term Expiration Date
Paula E. Boggs	Starbucks Coffee Company	05/27/2004	05/27/2007
Richard D. Ford	Kirkpatrick & Lockhart Preston Gates & Ellis	08/12/1998	05/09/2007
John G. Golhofer, MD	Rockwood Clinic	05/15/2002	05/04/2008
William N. Lampson	Lampson, Inc	05/17/2000	05/03/2009
John Thomas Rulon, MD	Spokane Ear, Nose & Throat Clinic	05/27/1999	05/04/2008
Eleanor L. Andrews	The Andrews Group	05/15/2002	05/04/2008
Patrick M. Fahey	Retired	10/06/1998	05/27/2007
Richard P. Fox	Consultant	05/17/2000	05/03/2009
Sarah M.R. Jewell	REI	04/20/1995	05/03/2006
Maria M. Pope	Pope & Talbot, Inc	08/08/2001	05/27/2007
Thomas A. Waltz, MD	Scripps Clinic	05/09/2001	05/27/2007
John Leinen	Retired	05/01/1995	05/27/2004

LifeWise HealthPlan of Washington is managed by a Board of Directors which may consist of not less than three (3) directors nor more than fifteen directors. Directors are elected annually at the annual membership meeting.

The following individuals were Directors of LifeWise HealthPlan during the exam period:

Board Member	Affiliation	Original Appointment Date	Term Expiration Date
H.R. Brereton Barlow	Premera Blue Cross	02/11/1999	06/21/2006
Jeffrey E. Roe	Premera Blue Cross	11/25/2002	04/18/2005
Kent S. Marquardt	Premera Blue Cross	02/11/1999	03/16/2008
Brian E. Ancell	Premera Blue Cross	11/25/2002	03/16/2008
Heyward Donigan	Premera Blue Cross	03/01/2004	03/16/2008
Darryl Price	Premera Blue Cross	04/18/2005	03/19/2007

Territory of Operations

During the exam period the Companies offered health plans throughout Washington State. LifeWise Health Plan of Washington primarily writes individual coverage in addition to providing group coverage for employees who are members of five (5) associations located in Clark County. Premera Blue Cross provides plans in all Washington counties excluding Clark. Pursuant to an agreement between Premera Blue Cross and Regence Blue Cross Blue Shield of

Oregon, Clark County, Washington is within the service area of Regence Blue Cross Blue Shield of Oregon. Accordingly, Premera Blue Cross does not issue contracts in that County, instead all plans sold in Clark County are issued and sold by LifeWise Health Plan of Washington.

Findings

The following Company Operations and Management Standards passed without comment:

#	Company Operations and Management Standard	Reference
1	**The Company is required to be registered with the OIC prior to acting as a health care service contractor in the State of Washington.**	**RCW 48.44.015(1)**
2	**The Company is required to report to the OIC any changes to the registration documents, including Articles of Incorporation, Bylaws, and Amendments at the same time as submitting such documents to the Secretary of State.**	**RCW 48.44.013**
3	**When the Company registers with the OIC, it is required to state its territory of operations.**	**RCW 48.44.040**

GENERAL EXAMINATION FINDINGS

The Companies records and operations were reviewed to determine if the Companies do business in accordance with the requirements of this state.

Findings

The following General Examination Standard passed without comment:

#	General Examination Standard	Reference
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 passed with comment:

#	General Examination Standard	Reference
1	**The Company does business in good faith, and practices honesty and equity in all transactions.**	**RCW 48.01.030**

General Examination Standard 1: The examiners found several areas during the review in which errors may have caused confusion or disparate treatment of members and providers.

- Correspondence in two (2) complaint files did not properly identify the correct writing Company. Complaint files OIC 68 and 79 contained correspondence using both Premera and LifeWise letterhead. These appear to be isolated instances and do not indicate a trend.
- Complaint file OIC 87 involved the improper adjudication of a claim which was due to incorrect pricing information in the Companies' claim system. The complaint was resolved and the system was updated with correct pricing information, however the Companies did not initiate a search to identify other claims which may have been affected by the incorrect pricing information.

Subsequent Event: The Companies ran reports on 2/7/2007 to identify other affected claims. The Companies identified 4 additional claims that had not been adjudicated correctly. The Companies reprocessed the claims on 02/13/2007 and paid a total of $10,246.95 in additional benefits.

- During the exam period the Companies transitioned existing members to its newly filed Dimensions products from discontinued plans. Individual members were advised that their plans were being replaced and were given the option to choose from among the different Dimension plans being offered effective October 1, 2005. Most of the discontinued individual plans did not have a separate pharmacy deductible; benefits were subject to the plan's medical calendar year deductible. All of the new individual plans feature a separate pharmacy benefit calendar year deductible. While the benefit brochures for the new plans did include information on the pharmacy deductible, a letter sent to enrollees advising them of their choices for conversion policies included the following statement which the examiners find to be misleading because the old plans do not have a separate pharmacy deductible:

  "To help you with these changes, we have reviewed your current coverage. The following plan most closely matches your current benefits. ***Your deductible will not change.*** *" (Emphasis added)*

  The Companies decided on 9/30/2005 to offer a one-time 4th quarter 2005 pharmacy carryover to address this issue. The Companies identified 2,317 members as needing to have deductible amounts manually carried over from October 2005 to January 2006.
- In a letter responding to a member complaint filed with the OIC Premera advised that 9,848 enrollees were moved to new Individual plans. Premera was not able to provide the number of enrollees who elected to switch coverage that had credits to their new policy deductible; nor was the Company able to provide the number of enrollees who did not have their original policy deductible credited to their new policy. In the letter, Premera acknowledges that in a few instances deductibles were not credited to enrollees' new policies due to system errors and Premera was manually making corrections as members advised that deductible credits were not occurring.

Subsequent Event: The Companies assert that the information provided in the letter referenced above was incorrect. They maintain that affected members' claims were adjusted and members received refunds. Their records now indicated that 9,845 members asked to change to a new plan; errors occurred and were fixed on 26 of the records. 6,209 members had some part of their old deductible carried over and credited on their new Dimensions product; 3,630 had not satisfied any dollar amount toward their old deductible.

- The Companies contracted with a third party, Alternare, to provide the alternative care provider network and process alternative provider claims. In 2005 American Whole Health Network (AWHN) assumed the Alternare business. The transition from Alternare to AWHN caused a number of erroneous claim denials and late payments to providers. On July 15, 2005 providers received a broadcast fax regarding the Alternare transition to AWHN. The fax acknowledged that the Alternare and AWHN process of integration had created some issues for a limited number of providers and the transition was taking longer than planned. The fax also stated that Alternare and AWHN were aware that some aspects of its new claims processing configuration resulted in delays. The OIC consumer division conducted a conference call on August 3, 2005 with the Companies, including a representative from its provider relations department, and was told that the Companies had not heard of any problems with AWHN. As outlined in WAC 284-43-300 the Companies are ultimately responsible for the prompt and fair claim payments to all of its providers and should have been aware of the issue as soon as it came to the attention of its third party provider.

Subsequent Event: Effective August 18, 2007, AWHN no longer has any involvement with claim activities on behalf of the Companies.

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 48.44.145(2)**

General Examination Standard 2: The Companies were unable to produce one (1) provider contract, two (2) underwriting files, and fourteen applications.

A number of the Companies' individual Medicare supplement plans state that the approved application is considered part of the contract. However, the Companies standard business practice does not call for retention of applications beyond a seven (7) year retention limit. Eleven of the fourteen missing applications represent Medicare supplement plans. See Appendix 1.

ADVERTISING

Advertising Policy and Procedures Manuals

There are four (4) departments within the Companies' Advertising and Marketing division.

- Document Administration Department - responsible for all external and internal document advertisements, forms, contracts, etc.
- Paid Media Advertising - responsible for all radio, television, newspaper, magazine, and other paid advertisements.
- Request for Proposal (RFP) Department - responsible for the preparation of all marketing and sales proposals.
- E-Business Department - responsible for the design and implementation of the Companies' website.

Each of the four (4) advertising departments demonstrated adequate procedures were in place to monitor, review, document, maintain, and track creation and distribution of advertising materials. No single system or individual is responsible for maintaining a complete file of all printed, published or prepared advertisements; this is addressed under Standard 5.

Advertising Process

The initial process of requesting a new advertising piece, or change to an existing advertisement begins with a work order. The process of creating, maintaining, and distributing advertisements is outlined in the Companies' "Create, Maintain, and Distribute Sales Collateral" document.

In 2002 the Companies implemented a computerized system, IMTS, to track all standardized advertisements prepared by the Companies. The system tracks the complete history of a document including, but not limited to, the inception date, change request information, date approved by legal, date of implementation, form numbers, and filings where appropriate. Currently only the Document Administration Department and the E-Business Department are linked though the IMTS system. The Paid Media Advertising Department tracks its pieces manually with information compiled monthly within a Media Notebook. The RFP Department maintains all large group quotes provided since 2000 on disk. Quotes completed within the last rolling twelve months are maintained in original presentation format within notebooks and are stored in the Department in addition to being on disk.

Advertising File Review

The Companies initially reported that they had 989 advertisements in use during the exam period.

- 647 Premera Advertisements
- 287 LifeWise Advertisements
- 55 Medicare Supplement Advertisements

A total of 50 advertising pieces were randomly selected for review. The sample included 35 Premera and 15 LifeWise pieces. A separate sample of 28 randomly selected Medicare Supplement advertisements was also requested for review.

The Companies provided the requested samples and advised the examiners that the initial advertising log included advertisement pieces that were cancelled or never produced in final form and therefore not in use during the exam period. Consequently, the following Premera pieces were eliminated from the sample:

- PAD 23 Hot Sheet Hometown - cancelled; never released
- PAD 25 CDHP Interactive Sales Tool - cancelled
- PAD 29 HRA Product Sheet - cancelled; never produced

The following Advertising Standards passed without comment:

#	Advertising Standards	Reference
1	**The Company cannot advertise a plan to prevent illness or promote health unless a) the clinical preventive benefits are the same as the basic health plan; b) it monitors and reports annually to enrollees on standards of health care and satisfaction of enrollees; c) makes available its plan to identify and manage the most prevalent diseases within its enrolled population on request.**	**RCW 48.43.510(5), WAC 284-43-820(5)**
2	**No advertising may contain any false, deceptive or misleading information.**	**RCW 48.44.110**
3	**The Company cannot make misleading comparisons with other companies to induce the consumer to change from another HCSC.**	**RCW 48.44.140**
6	**The Company must comply with all health plan disclosures as required by regulation.**	**WAC 284-43-820(1) through WAC 284-43-820(3)**
7	**The Company cannot misrepresent the terms, benefits, or advantages of the contract.**	**RCW 48.44.120**
8	**The Company cannot guarantee future dividends or future refunds except in group contracts with an experience refund provision.**	**RCW 48.44.130**

The following Advertising Standard passed with comment:

#	Advertising Standards	Reference
5	**The Company maintains a complete advertising file.**	**WAC 284-50-200**

Advertising Standard 5: The Companies maintain four (4) separate advertising files. The examiners found that each file contained the required information. However, the Companies do not maintain a single complete file of all advertisements.

The following Advertising Standard failed:

#	Advertising Standards	Reference
4	**The Company complies with the practices stated in the referenced regulations.**	**WAC 284-50-050 through WAC 284-50-190**

Advertising Standard 4: An omission noted in one (1) piece of advertising was found to be misleading and in violation of WAC 284-50-060. Four (4) advertising pieces quoted statistics without identifying the source of the statistics in violation of WAC 284-50-110. See Appendix 2.

Medicare Supplement

The examiners found that the Companies were following the required and filed marketing procedures during the exam period.

The sample of Medicare Supplement files reviewed was reduced by three (3) files. These were withdrawn after being filed with the OIC. Six (6) of the files reviewed were filed and approved but were never printed or placed into use by the Companies.

The following Medicare Supplement Advertising standards passed without comment:

#	Medicare Supplement Advertising Standards	Reference
1	**Every form of Medicare Supplement advertising must be submitted to the OIC thirty days prior to use.**	**WAC 284-66-300(1)**
2	**All Medicare Supplement advertising shall comply with the standards of the Washington disability advertising regulations (WAC 284-50-010 through WAC 284-50-230) and must include the full name of the issuer and the location of its home office.**	**WAC 284-66-300(2)**
3	**All Medicare Supplement advertising must comply with the standards for marketing outlined in regulation WAC 284-66-330.**	**WAC 284-66-330(1) (a) through (e)**

COMPLAINTS

Complaint Policies and Procedures

The Companies provided the examiners with the following documents for review:

- Operations Procedure Complaints and Appeals: Contracted Providers PR.OP.CS.0077
- Provider Appeals PR.OP.RA.0013
- Operations Procedure Complaints and Appeals: Members PR.OP.CS.0003
- Corporate Operations Policy Complaint Handling and Resolution CP.OP.CS.002.v1.2
- Corporate Operations Policy Member Appeal Handling and Resolution CP.OP.CS.001.v1.4

The procedures were reviewed in conjunction with Premera's filed Practitioner Agreement and the following inconsistencies were found:

- The Practitioner Agreement outlines that neither the Plan nor the Participant shall seek a refund or appeal of a denial of a claim more than 365 calendar days after final adjudication of the claim. The provider appeals procedure states in part that when the plan issues a remittance, the 365-day period begins five (5) days after the date on the remittance.
- The Practitioner Agreement stipulates that the Plan is under no obligation to consider a request received, other than a billing dispute, by the Plan later than 60 days after Plan's action from which the Participant wishes to appeal. The Companies policy has always been to allow 365 days, plus the days for receipt, following the date on the provider explanation of payment or the date of the Companies response to the complaint.

Subsequent Event: The newly-filed provider contracts reflect the actual policies the Companies follow.

- The definition of Level II Appeal within the Companies' procedures state that a provider has 15 calendar days from the Level I Appeal notification letter date to issue a Level II Appeal Request. The practitioner agreement allows for 15 days after the participant's receipt of the Plan's response.

Subsequent Event: The Companies have revised the language in their procedure documents to match that of the Practitioner Agreement.

Complaints that can't be resolved by Customer Service are forward to Research Analysts in the Complaints and Appeals Department for additional investigation. The Department is comprised of two teams of Research Analysts; one handling provider complaints and the other responsible for member complaints. Complaints dealing with internal payment processes,

policies and refunds are sent to the Correspondence Department for handling. Some complaints, due to the complexity of the issues are routed from the Correspondence Department to Complaints and Appeals for resolution.

For the purposes of determining timely filing the Companies should be using the date that a complaint or appeal is initially received. During review of the sample files the examiners noted that the date of receipt for the following files is the date the complaint was received by the Complaints and Appeals Department:

- OIC 18 PA 040607071869P Date of appeal recorded as 6/7/2004 which is the date the appeal was received by the Complaints and Appeals Department. The complaint was received by Premera on 6/1/2004.
- OIC 26 PA 041222075837P The appeal was received by the Complaints and Appeals Department on 12/22/04. This is the official recorded receipt date. The appeal letter was dated 11/19/04 and was received in customer service. It is not clear why there was such a delay in forwarding the appeal to the appropriate department.
- OIC 68 050610000001 The member complaint was received by customer service on 2/17/05, the complaint receipt date is recorded as 2/21/05 which was the date Complaints and Appeals received information from customer service.

Subsequent Event: The Companies' procedures currently reflect that the mailroom receipt date is the date specified as the initiation date. The procedure was reinforced with the staff in the Complaints and Appeals Department and they were counseled on the need to ensure compliance.

File Review

The Companies were transitioning from the Legacy claims systems to the Facets system during the examination period. The complaint data provided to the examiners was pulled from multiple claim systems in use during the examination period. The Companies reported a total of 17,942 complaints during the exam period.

- Complaints pulled from Non-Facets (Legacy) systems
  - Member Complaints 52
  - Provider Complaints 4,614
  - Complaints filed with OIC 230
- Complaints pulled from Facets system
  - Member Complaints 264
  - Provider Complaints 11,439
  - Other (OIC, Legal etc.) 1,331

The examiners reviewed a total of 100 complaints which included nine (9) complaints received by the OIC.

The following Complaints Standards passed without comment:

#	Complaints Standards	Reference
1	**The Company has filed a copy of its procedures for review and adjudication of complaints with the OIC.**	**RCW 48.43.055**
2	**The Company maintains a fully operational, comprehensive grievance process.**	**RCW 48.43.530, WAC 284-43-615**
3	**The Company provides enrollees access to independent review services to resolve disputes.**	**RCW 48.43.535**
4	**Response to communications from the OIC must be within 15 business days of receipt of the correspondence. The response must contain the substantial information requested by the OIC.**	**WAC 284-30-650, Technical Advisory T 98-4**
5	**The Company complies with procedures for health care service review decisions.**	**WAC 284-43-620**

Medicare Supplement

The Companies do not have a separate process for handling Medicare Supplement complaints; they use the same policies and procedures in place for all products.

Medicare Supplement Standards two (2) through five (5) do not apply since the Companies do not write any Medicare Select Policies.

The following Medicare Supplement Complaints Standard passed without comment:

#	Complaints Standards	Reference
1	**Response to communications from the OIC must be within 15 business days of receipt of the correspondence. The response must contain the substantial information requested by the OIC.**	**WAC 284-30-650, Technical Advisory T 98-4**

CLAIMS

In 2000 the Companies made a decision to purchase one platform, Facets, to administer and adjudicate claims for all products. Products were transitioned into the new claims processing system at renewal. The first groups began transitioning on 1/1/2003. Most individuals had transitioned by October 2004 and by January 2006 most Medicare Supplement policies had

transitioned as well. During the transition the Companies also introduced the new Dimensions products and began the process of moving members to the new products.

The Companies' Legacy systems continue to support claims processing during the system conversion period. The Legacy systems and the products supported within them are as follows:

Old Claims System	Products
PBC - BlueCHIP	Commercial (group and individual)
PBC - CSC 8.1	HeathPlus
PBC - Amisys	PrimeCare and MSC Care
LifeWise - NorthStar (NS) GBAS	Commercial (group and individual)

Claims Processing

The Companies provided claims processing procedures for BlueChip, Facets and LifeWise claims for review. The procedures are encompassing and detailed. The procedures for the CSC 8.1 and Amisys systems were not reviewed since no new claims were adjudicated on the systems during the exam period.

During the exam period the Companies received 68.5% of all claims electronically. 21% were received as paper files which were scanned into the system. The remaining 10.5% of claims were received as paper files and keyed into the system manually. The average auto-adjudication rate for 21 months of the exam period is 73.4%. Due to systems issues, the Companies were unable to provide statistics for January and February of 2004 or for April 2005.

Claims Review

The Companies reported processing 28,627,447 claims during the 24 month exam period. This averages to 1,192,810 claims processed per month. The examiners requested that the Companies pull a random sample of 200 claims for review after excluding all pharmacy claims (10,782,813) and all claims between $0.01 and $100 (9,668,437). From the population of 8,176,197 claims the Companies used the following methodology to select the sample:

- A list of claim numbers was created
- A random number was assigned to each claim number
- All claims were sorted in ascending order by the generated random number
- The first 200 claims in the sorted list were provided for review.

The sample included claims from the following systems:

- CSC 8.1 HealthPlus - 6 claims
- NorthStar (NS) GBAS - 6 claims
- BlueChip - 26 claims
- Facets - 162 claims

The examiners noted the following issues with the claims processing systems and operations:

- Claim OIC 67 was reprocessed to reflect that the member's stop loss had been reached. Examiners requested more information as to why the stop loss information was not in the system when the claim was initially adjudicated. Premera was unable to verify if accumulators had been updated for stop loss or if edits failed for a time period.

Subsequent Event: Due to the unique nature and variables involved in the processing of this claim the Company did not deem it feasible to attempt to identify if other claims were affected. While the Companies can't identify the cause of the system failure, it maintains that a fix was implemented in November 2004 and now edits are in place to update the system when the member has reached the stop loss maximum.

- Due to the system's program logic certain categories of providers were not correctly identified as being contracted. This error resulted in members being balance billed (OIC 160).

Subsequent Event: The Companies believe that the system logic errors started on 1/16/03. Premera discovered the error and the issue was resolved on 7/13/2004. New IT functionality was developed so that liability would apply correctly. There were 195 providers involved and Premera reprocessed 1,170 claims that had negatively impacted members.

- Three (3) of the complaints reviewed involved the denial of codes 70551 and 70553 due to bundling issues. The examiners noted that in all cases the initial denials were overturned and the claims were paid upon appeal. One (1) complaint reviewed was from a facility that simultaneously appealed the denial of 24 claims with total charges of $38,847 due to the bundling issue; all of the denials were overturned. The Companies have advised that the initial denials were appropriate and an error was made in allowing the services upon appeal. There was a time frame in which these appeals were overridden, resulting in claims being allowed in error. (OIC 72, OIC 74, OIC 92)

Subsequent Event: At examiners request, the Companies have reviewed a report of all claims reprocessed involving CPT codes 70551 and 70553. The Companies determined that the total dollar impact of reversing the initial denials was $167,287.48. The Companies comment that not all claims represented in the given dollar amount were reviewed and therefore claims could be represented that were appealed and chart notes were reviewed.

See Appendix 3.

- Examiners reviewed a complaint received by the OIC for a member from group 1005804. In reviewing the complaint, the Companies realized that the group's 2004 benefit booklet stated that sterilization would be covered at a $25 copay in an office visit setting. This was not the group's intent and the group's benefits were configured in the system to match the Companies' standard benefit for the procedures with coverage subject to both the deductible and coinsurance. Coverage decisions and claim adjudication were made based on contract forms that had not been filed and approved by the OIC.

Subsequent Event: The Companies' research shows that this was an error that was limited to standard booklets for 51+ groups that were new or renewed 1/1/2004 through 6/30/2004. All claims were paid based on the benefits purchased by the groups. The Companies do not believe that members who gave no indication of being aware of the booklet language, or having relied on it in deciding whether to have the service performed, are entitled to benefit from the mistake.

Prior to paying claims the Companies attempt to gather all relevant data needed to determine liability. The Companies' other party liability investigation procedure requires that members be sent an Incident Questionnaire (IQ) in cases when the Companies suspect that another party may have liability in the claim. The following instances were noted during claims review where the payment of claims was delayed due to the liability investigation:

- OIC 5 claim 800326541200 - Company received the claim on 10/31/03; claim routed to the subrogation department for further investigation on 11/8/03; IQ was sent on 11/19/03, member called on 1/8/04 and informed customer service that the injury was not due to an accident. Providers called on 2/13/2004 and 3/5/004 to check on status and claim was paid on 3/22/2004.
- OIC 6 Claim 801394089800 - This claim was the result of a motor vehicle accident however the member was at fault and did not have personal injury protection coverage so coverage by Premera was appropriate. An IQ was sent in a timely manner however due to the severity of the member's injury he was not able to return the questionnaire in a timely manner resulting in several claims being denied. Premera ultimately paid in excess of $184,000. Given the circumstances it is not clear why the Companies were not able to provide assistance in the completion of the questionnaire.
- OIC 193 Claim 502100047 - An IQ was sent to the member in response to a claim filed in 2003. The claim under review was the result of treatment received in 2005. No new IQ was sent; the claim was denied and closed after ten days due to the original IQ sent in 2003 not having been returned.

The following Claims Standards passed without comment:

#	Claims Standards	Reference

#	Claims Standards	Reference
1	The Company shall provide no less than urgent and emergent care to a child who does not reside in the Company's service area.	RCW 48.01.235(3)
2	All plans must provide female enrollees direct access to women's health care services.	RCW 48.42.100, WAC 284-43-250
4	All plans shall cover emergency services necessary to screen and stabilize a covered person.	RCW 48.43.093
5	Decisions concerning maternity care and services are to be made between the mother and the provider.	RCW 48.43.115
6	The Company shall not deny benefits for any service performed by a denturist if the service performed was within the lawful scope of such person's license, and the agreement would have provided benefits if services were performed by a dentist.	RCW 48.43.180, RCW 48.44.500
7	The Company maintains a documented utilization review program and conducts utilization review within the prescribed format defined.	RCW 48.43.520, WAC 284-43-410
8	The Company shall not retrospectively deny emergency or nonemergency care that had prior authorization.	RCW 48.43.525(1)
9	All plans must provide coverage for the formula necessary for the treatment of phenylketonuria (PKU).	RCW 48.44.440, WAC 284-44-450
10	The Company shall not retrospectively deny an individual prescription drug claim that had prior authorization.	RCW 48.44.465
12	The denial of any claim must be communicated to the provider or facility with the specific reason claim denied.	WAC 284-43-321(4)

The following Claims Standards passed with comment:

#	Claims Standards	Reference
3	All plans must include every category of provider.	RCW 48.43.045 WAC 284-43-205
11	The Company shall pay or deny claims subject to the required minimum standards. The Company pays interest on undenied and unpaid clean claims that are more than 61 days old.	WAC 284-43-321(2)
13	The Company administers Coordination of Benefits provisions as required.	Chapter 284-51 WAC

Claim Standards 3 and 11: The Companies' vendor for alternative provider networks and claims transactions functions was Alternare which was purchased by American Whole Health Network (AWHN). The transition from Alternare to AWHN caused the following problems:

- A number of CPT codes were not programmed to accept coding within the scope of practice for many providers, such as codes within the naturopathic scope of practice. The initial denial of claims was in violation of RCW 48.43.045 and WAC 284-43-205 requiring plans to include every category of provider.
- Remediation of the programming issue, as well as administrative challenges of the transition from Alternate to AWHN, caused delays in claim payments. The OIC is aware of one instance, complaint case number PA051013079633M, in which the Companies provided a cash advance of $10,000 to a provider while working to resolve claim payment issues. While it is commendable that the Companies agreed to cash advances in those instances where claim payments were well past 30, 60 and 90 days due, the examiners did not find evidence of this occurring uniformly for all providers.

Claim Standard 13: The Companies told the examiners that it generally does not investigate other coverage on its own subscribers until they are of Medicare age. The Companies' contracts state "All of the benefits of this plan are subject to coordination of benefits." The Companies cannot comply with Chapter 284-51 WAC Standards for Coordination of benefits without investigating other insurance in all cases. Failure to coordinate in all instances can result in members potentially receiving improper reimbursement amounts and not receiving COB savings due to them. Conversely the Companies may also be over-paying claims in reimbursing providers as the primary carrier when in fact it is the secondary carrier.

Medicare Supplement

The Companies' policies and procedures for handling Medicare Supplement claims appear to be complete and detailed.

Medicare Supplement Standards six (6) and seven (7) do not apply since the Companies do not write any Medicare Select Policies.

Eight (8) of the 26 claims pulled from the BlueChip system involved Medicare Supplement Claims.

The following Medicare Supplement Claims Standards passed without comment:

#	Medicare Supplement Claims Standards	Reference
1	**Company must accept a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form.**	**WAC 284-66-270 (1) (a)**

#	Medicare Supplement Claims Standards	Reference
2	Company must notify participating physician or supplier and the beneficiary of the payment determination.	WAC 284-66-270(1) (b)
3	Company must pay the participating physician or supplier directly.	WAC 284-66-270(1) (c)
4	Company must pay user fees for claim notices that are transmitted electronically or otherwise.	WAC 284-66-270 (1) (e)
5	A Medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than three months from the effective date of coverage because it involved a preexisting condition.	RCW 48.66.130(1) WAC 284-66-063(1) (a)

AGENT ACTIVITY

Agent Licensing and Appointment Procedures

Agent Activity Review

The Companies provided the examiners with procedures for agent licensing and appointment. The procedures are detailed and comprehensive. The Companies quote generation system is designed to give a warning when the writing agent or agency is not appointed with the Companies.

There were 2,028 active agents and brokers soliciting business on behalf of the Companies as of 12/31/2005. There were also 146 licensed sales and marketing associates employed by the Companies to handle direct response sales. The Companies reported 581 agent terminations during the exam period.

Using the sample files pulled for the underwriting section of the exam the examiners selected 115 applications for review. The sample included 48 Premera Blue Cross, 19 Premera Medicare Supplement and 48 Lifewise applications.

Findings

Note: Standards #1 and #2 have a zero tolerance level.

The following Agent Activity Standard Passed with Comment:

#	Agent Activity Standard	Reference
3	The Company must provide the agent with written notice of termination of appointment and send a copy to the OIC.	RCW 48.17.160(3)

Agent Activity Standard 3: One (1) termination letter to an agent was not retained by the Companies. (OIC 11)

The following Agent Activity Standards failed:

#	Agent Activity Standard	Reference
1	**The Company requires that agents and brokers are licensed for the appropriate line of business with the State of Washington prior to allowing them to solicit business or represent the Company in any way.**	**RCW 48.17.060(1) RCW 48.17.060(2) RCW 48.44.011(2)**
2	**The Company ensures that agents are appointed to represent the Company prior to allowing them to solicit business on behalf of the Company.**	**RCW 48.17.160 RCW 48.44.011(2)**

Agent Activity Standard #1: Two (2) applications for in-force policies were not retained by the Companies making it impossible for the examiners to verify proper licensing of the individual writing the business. (OIC 11, OIC 17)

Agent Activity Standard #2: There was one (1) group file where the agent was not appointed with the Companies at the time of sale. (OIC 49)

Medicare Supplement

Nineteen Medicare Supplement policies were reviewed for this section. The Companies were not able to provide the original applications for 11 of the policies; they were able to produce the writing agent names for the nine (9) policies that were sold by external agents. The remaining policies were written via direct sales with no external agent involvement.

The examiners noted two (2) instances during review in which the Companies' records did not reflect the correct writing agent.

- OIC 16 - The agent of record and the agent signing the application both worked for the same agency. The signing agent was never issued a Premera specific number so the Companies' records reflect the name of another agency employee as writing agent.
- OIC 28 - The writing agent put the wrong agent number on the application; the Companies assume that agents will properly list their own numbers and if the number they list is a valid number, that is the number entered into the system.

The following Medicare Supplement Agent Activity Standards passed without comment:

#	Medicare Supplement Agent Activity Standard	Reference
1	**The Company requires that agents and brokers are licensed for the appropriate line of business with the State of Washington prior to allowing them to solicit business or represent the Company in any way.**	**RCW 48.17.060(1) RCW 48.17.060(2)**
2	**The Company ensures that agents are appointed to represent the Company prior to allowing them to solicit business on behalf of the Company.**	**RCW 48.17.160**
3	**The Company must provide the agent with written notice of revocation of appointment and send a copy to the OIC.**	**RCW 48.17.160(3)**
4	**The Company may not, directly or indirectly, provide commission to an agent for the solicitation, sale, servicing, or renewal of a Medicare supplement policy or certificate that is delivered or issued for delivery to a resident within this state unless the commission is identical as to percentage of premium for every policy year as long as the coverage under the policy or certificate remains in force with premiums being paid, or waived by the Company, for the coverage.**	**WAC 284-66-350(1)(a)**
5	**Each commission payment must be made by the issuer no later than sixty days following the date on which the premiums that are the basis of the commission calculated were paid.**	**WAC 284-66-350(1)(b)**
6	**Where an issuer provides a portion of the total**	**WAC 284-66-350(1)(c)**

#	Medicare Supplement Agent Activity Standard	Reference
	commission for the solicitation, sale, servicing, or renewal of a Medicare supplement policy or certificate to a general agent, sales manager, district representative or other supervisor who has marketing responsibilities, while such portion of total commissions continues to be paid it must be identical as to percentage of premium for every policy year as long as coverage under the policy or certificate remains in force with premiums being paid, or waived by the issuer, for the coverage.	

RATE AND FORM FILING

The Companies provided a listing of all rates, forms and contracts in use during the exam period. The examiners cross-referenced this listing to the records maintained by the OIC.

The examiners also reviewed the Companies' procedures and found that they do not document the OIC filed form numbers within their administration system. The Companies identify contracts issued by product name and by the internally generated codes or member group codes. Policyholders are initially sent a "Welcome Kit" which contains their benefit booklet. The Kit is assembled by the Fulfillment Department based on the product name; the Companies lack controls to assure that the policyholder is receiving the correct, and most recently filed, version of a contract.

During review the examiners were given LifeWise individual product benefit booklets for review and found that the 2004 booklets for the Preferred 80 Plan, Preferred 70 Plan, Share Preferred Plan and Shared Traditional Plan each contained the wrong product name, Choice 70 Plus, on pages two (2) through seven (7) of the booklets. The Companies could not confirm if prior versions of the booklet contained the same product name error, how long the incorrect booklets were in circulation, or how many policyholders received them.

Rate and Form Filing Review

The examiners selected forms and rates attached to the 100 new and in-force contracts used in the Underwriting sample for the rate and form filing review. The Companies were unable to produce one (1) LifeWise Individual file.

Findings

Note: Standards #1 and #2 have a zero tolerance level.

The following Rate and Form Filing Standard passed:

#	Rate and Form Filing Standard	Reference
3	**All contract forms and rates have been filed with the OIC on transmittal forms prescribed by and available from the Commissioner.**	**WAC 284-43-925**

The following Rate and Form Filing Standards failed:

#	Rate and Form Filing Standard	Reference
1	**All contract forms have been filed with the OIC prior to use.**	**RCW 48.44.040, WAC 284-43-920**
2	**All rates have been filed with the OIC prior to use.**	**RCW 48.44.040, WAC 284-43-920**

Rate and Form Filing Standard 1: Nine (9) groups were issued contracts not filed and approved by the OIC. The Companies filed contracts with the OIC listing specific contract numbers. When issuing contracts the Companies list the filed contract number on the Cover Page however a different number is then listed on the inside cover pages of the contract. The Companies assert that the numbers listed on the inside cover pages are for internal use only however these numbers also mirror contract numbers filed with the OIC. In some instances the plan chosen by a group represented a product filed only under the contract number listed on the inside cover pages. In addition, the contract verbiage did not mirror what had been filed and approved by the OIC. Two (2) negotiated groups were issued contracts not filed and approved by the OIC.

Rate and Form Filing Standard 2: Two (2) groups were written using rates not filed and approved by the OIC.

See Appendix 4.

Medicare Supplement

Twenty-five underwriting files were identified as being Medicare Supplement files. All of the Companies' Medicare Supplement contracts were filed and approved by the OIC prior to the examination period.

The following Medicare Supplement Rate and Form Filing standards pass without comment:

#	Medicare Supplement Rate and Form Filing Standard	Reference
1	**All Medicare Supplement insurance policy or certificate forms or application forms, riders or endorsements must be filed with and approved by the OIC prior to use.**	**RCW 48.66.035(1), WAC 284-66-243(1) and (2)**
2	**All Medicare Supplement rates, or modifications of rates, must be filed with and approved by the OIC prior to use.**	**RCW 48.66.035(2), WAC 284-66-243(3)**
3	**The Medicare Supplement outline of coverage as defined by WAC 284-66-092 must be filed with the OIC prior to use.**	**WAC 284-66-080(2)**
4	**The Medicare Supplement replacement notice as defined by WAC 284-66-142 must be filed with the OIC prior to use.**	**WAC 284-66-130(4) and (5)**
5	**On or before May 31 of each calendar year, an issuer of standardized Medicare supplement policies and certificates issued according to WAC 284-66-063, must file rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the commissioner on the form provided at subsection (6) of this section.**	**WAC 284-66-203(3)**
6	**Every issuer providing group Medicare supplement insurance benefits to a resident of this state must file with the commissioner, within 30 days of its use in this state, a copy of the master policy and any certificate used in this state, according to the filing requirements and procedures that apply to Medicare supplement policies issued in this state.**	**WAC 284-66-250**

UNDERWRITING

Underwriting Manuals

The Companies provided the examiners with underwriting guidelines as well as underwriting procedures for review. The examiners found the procedures to be detailed and comprehensive. The Companies maintain a file of both federal and state regulatory policies for reference during the underwriting process.

The Companies do not generally maintain underwriting records past their internal seven (7) year retention period. The Companies were not able to produce three (3) applications for business that was still in-force; however, the examiners were able to complete review of the files with the information retained in the Companies systems.

Underwriting File Review

The following is a breakdown of the total population during the examination period and random samples selected for review:

Type of Business	Total Population	Sample Selected
New Business - Individual	47,690	25
New Business - Group	14,585	9
Inforce Business - Individual	98,424	53
Inforce Business - Group	21,990	13
Quotes - Group	18,160	25
Lapsed / Terminated Business - Individual	42,502	39
Lapsed / Terminated Business - Group	10,746	11
Declined	4,059	25
Total	**258,156**	**200***

* The Companies were unable to provide two (2) of the files selected for review, reducing the number of files reviewed to 198. Failure to produce these files is addressed under General Examination Findings.

Findings

The following Underwriting Standards passed without comment:

#	Underwriting Standard	Reference
1	**The Company complies with the prescribed requirements for enrollment and coverage of a child under the health plan of the child's parent.**	**RCW 48.01.235**
2	**The Company appropriately reduces preexisting condition exclusions, limitations, or waiting periods in it large group, small group and individual plans by applying time covered by the preceding health plan coverage.**	**RCW 48.43.015 WAC 284-43-710**
3	**An individual is not required to complete the standard health questionnaire if stated criteria are met.**	**RCW 48.43.018(1)**
4	**The Company shall provide written notice of its decision not to accept an individual's application for enrollment to both the applicant and WSHIP within 15 business days of receipt of a completed application.**	**RCW 48.43.018(2)(b)**
5	**The Company may not reject an individual for health plan coverage in a large or small group based upon preexisting conditions of the individual. The Company may not deny,**	**RCW 48.43.025 RCW 48.43.035(1) WAC 284-43-720**

#	Underwriting Standard	Reference
	exclude, or limit coverage for an individual's preexisting health conditions. The Company shall accept any state resident within the group and within the Company's service area.	
6	Eligibility to purchase a health benefit plan must be extended to all small employers and small group as defined in RCW 48.43.005(24).	RCW 48.43.028
7	Dependent children cannot be terminated from an individual or group plan because of developmental disability or physical handicap.	RCW 48.44.200 RCW 48.44.210
8	All plans shall cover newborn infants and congenital anomalies from the moment of birth.	RCW 48.44.212(1)
9	No plan may deny coverage solely on account of race, religion, national origin, or the presence of any sensory, mental, or physical handicap.	RCW 48.44.220
10	An individual may return an individual health care contract for a full refund within ten (10) days of its delivery if not satisfied with the contract for any reason.	RW 48.44.230
11	All cancellations, denials, or non-renewals of an individual plan must be in writing and include the reason for such action.	RCW 48.44.260
12	Each group contract shall offer coverage for chiropractic care on the same basis as any other care.	RCW 48.44.310
13	All plans must include coverage for diabetes.	RWC 48.44.315
14	The Company may not refuse, cancel, or decline coverage solely because of a mastectomy or lumpectomy more than five (5) years prior.	RCW 48.44.335
15	Eligible group plans must offer optional supplemental coverage for mental health treatment for the insured and the insured's covered dependents.	RCW 48.44.340(1) and (3) WAC 284-43-810
16	Dependents shall have the right to continue coverage in the event of loss of eligibility by the principal enrollee.	RCW 48.44.400
17	Adoptive children shall be covered on the same basis as other dependents.	RCW 48.44.420
18	A rider will be cancelled upon application by the enrollee if, at least five (5) years after its issuance, no health care services have been received by the enrollee for the condition specified in the rider.	RCW 48.44.430
20	The Company shall produce and provide certificates of coverage to the employer for distribution to each covered employee.	WAC 284-44-050

The following Underwriting Standard passed with comment:

#	Underwriting Standard	Reference
19	**All plans shall offer optional coverage for the treatment of temporomandibular joint disorders (TMJ) and maintain proof of offer as required.**	**RCW 48.44.460, WAC 284-44-042**

Underwriting Standard 19: One (1) association file involving two (2) employer groups, OIC 38 and 39, did not include a copy of the offer of TMJ.

Medicare Supplement

The Companies provided their Medicare Supplement Pre-Screening Operations Procedures for review.

Medicare Supplement Underwriting Standards 12, 13 and 14 do not apply since the Companies do not write any Medicare Select Policies.

The following Underwriting Medicare Supplement Standards passed without comment:

#	Medicare Supplement Underwriting Standard	Reference
1	**No Medicare supplement insurance policy may use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.**	**RCW 48.66.050(2)**
2	**The Company must accept as "eligible persons" those applicants replacing Medicare Supplement coverage as defined by RCW 48.66.055(3), who apply to enroll within 63 days of termination of the prior coverage.**	**RCW 48.66.055(1)**
3	**No Medicare Supplement carrier may deny or restrict coverage for an eligible person because of health status, claims experience, receipt of health care, or medical condition; or impose an exclusion of benefits based on a preexisting condition under a prior Medicare Supplement policy.**	**RCW 48.66.055(2)**
4	**All Medicare Supplement polices must be guaranteed renewable and may not provide that the policy may be cancelled or nonrenewed solely on the grounds of deteriorating health. The Company shall not cancel or nonrenew for any reason other than nonpayment of**	**RCW 48.66.090**

#	Medicare Supplement Underwriting Standard	References
	premium or material misrepresentation.	
5	A Medicare Supplement outline of coverage as defined by WAC 284-66-092 shall be provided to the applicant at the time of application with an acknowledgement of receipt from the applicant retained.	RCW 48.66.110 WAC 284-66-080(1)
6	If a Medicare Supplement outline of coverage is provided at the time of application and the subsequently issued policy or certificate is revised, an appropriate outline of coverage must accompany the policy or certificate when delivered and contain the required statement immediately above the Company name.	WAC 284-66-080(3)
7	Every Medicare Supplement insurance policy issued after January 1, 1982 shall have prominently displayed on the first page stating that the person whom the policy or certificate is issued shall be permitted to return the policy or certificate within 30 days of its delivery to the purchaser and to have the premium refunded if the purchaser is not satisfied with it for any reason.	RCW 48.66.120
8	If there is a replacement of existing Medicare Supplement coverage which has been in effect for at least 3 months, the replacing carrier must waive all time periods for preexisting conditions, waiting periods, elimination periods, and probationary periods.	RCW 48.66.130(4), WAC 284-66-170(2),
9	If a group Medicare Supplement policy is replaced by another Medicare Supplement policy purchased by the same policyholder, the issuer of the replacement policy must offer coverage to all persons covered under the old group policy on its termination date. The new policy may not contain any exclusion for pre-existing conditions that would have been covered under the group policy being replaced.	WAC 284-66-063(1)(c)(v)
10	If completion of a medical history is required for acceptance of the application the medical history must be completed by the applicant, a relative of the applicant, a legal guardian of the applicant, or a physician.	RCW 48.66.140
11	An issuer must make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic "core" benefits, as defined in WAC 284-66-063(2) of this regulation.	WAC 284-66-066(1)

#	Medicare Supplement Underwriting Standard	Reference
16	Application forms must include the listed questions designed to elicit information as to whether, as of the date of the application, the applicant currently has another Medicare, Medicaid, or other disability policy and is intended to replace any other policy of an HCSC, HMO, disability insurer or fraternal benefit society presently in force. A supplementary application or other form to be signed by the applicant and agent containing the questions and statements, may be used: if the coverage is sold without an agent, the supplementary application must be signed by the applicant.	WAC 284-66-130(1)
17	Agents must list any other medical or health insurance policies sold to the applicant and must list policies sold that are still in force and policies that have been sold in the past five years that are no longer in force.	WAC 284-66-130(2)
19	If there is a replacement of existing Medicare Supplement coverage the replacing carrier must furnish to the applicant the replacement notice as defined by WAC 284-66-142 prior to issuance or delivery of the policy or certificate and retain a signed copy of the replacement notice in the issuer's files.	WAC 284-66-130(4)
21	If there is a replacement of existing Medicare Supplement coverage the replacing carrier must waive all time periods for preexisting conditions, waiting periods, elimination periods, and probationary periods to the extent such time was spent under the original policy.	WAC 284-66-170(1)
22	Effective after January 1, 1990, except for riders and endorsements that bring a policy into compliance, an amendment to a Medicare Supplement insurance policy or certificate that increase the premium must be requested or accepted by the policy holder in writing.	WAC 284-66-260(2)(a)
23	All Medicare Supplement issuers must comply with Omnibus Budget Reconciliation Act of 1987 by furnishing to the enrollee, at the time of enrollment, a card listing the policy name, number, and a central mailing address to which notices from a Medicare carrier may be sent.	WAC 284-66-270(1)(d)
24	An issuer may not issue a Medicare Supplement policy or certificate to an individual enrolled in Medicare Part 'C' unless the effective date of the coverage is after the termination date of the individual's Part 'C' coverage.	WAC 284-66-340(3)

The following Medicare Supplement Underwriting Standards failed:

#	Medicare Supplement Underwriting Standard	Reference
15	**All issuers of policies that provide benefits for persons eligible for Medicare must provide to all applicants at the time of application the prescribed "Guide to Health Insurance for People with Medicare," and acknowledgement of receipt from the applicant must be in the issuer's files.**	**WAC 284-66-110(1), (2) and (3)**
18	**In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, must be returned to the applicant by the insurer upon delivery of the policy.**	**WAC 284-66-130(3)**
20	**A true copy of the application for a Medicare Supplement insurance policy issued by a health maintenance organization or health care service contractor must be attached to or otherwise physically made a part of the policy when issued and delivered.**	**WAC 284-66-130(7)**

Medicare Supplement Underwriting Standard 15: The Companies' procedures state that the "Guide to Health Insurance for People with Medicare" is provided only upon request and the Companies do not maintain an acknowledgement of receipt from the applicants who have requested the guide.

Medicare Supplement Underwriting Standard 18: The Companies acknowledge not returning copies of the completed, signed application to new Individual Medicare Supplement members, except by their request.

Medicare Supplement Underwriting Standard 20: During discussions of procedures, the Companies acknowledged that there is not a procedure to return copies of the application with the contracts.

Subsequent Event: The Companies have initiated a manual process in Membership and Billing whereby the application will be mailed under separate cover to ensure receipt by the new subscriber.

PROVIDER ACTIVITY

Provider Contracting Process

The Companies' Credentialing program is part of the quality management program. Before a contract is effective, a provider must be credentialed and approved. Recredentialing occurs every three (3) years. The Companies' credentialing policies and procedures for 2004 and

2005 were provided for review as well as the Companies' documents outlining contracting procedures, standard contract process flow, and the process for updating current provider information. The examiners found all the procedures to be detailed and comprehensive.

Provider Manuals

Provider reference manuals dated January 2004, August 2005 and December 2005 were provided for review. The manuals reviewed were comprehensive and appeared complete.

Provider Activity Review

The Companies were unable to provide a searchable database of active providers during the exam period. Because of this, the examiners expanded the scope of the exam for this section and reviewed providers taken from a July 2006 download of the Companies' website listing of providers. The current website listing included 111,603 providers from which the examiners selected a sample of 100 providers. The Companies were unable to locate one (1) provider contract, reducing the sample to 99. This issue is discussed under General Examination Standards on page eleven.

Findings

The examiners reviewed two (2) sample files (OIC P57 and P100) which included elements of both a facility agreement as well as a practitioner agreement. Each of the agreements includes a Facility Agreement Compensation Exhibit B effective June 1, 2004 - May 31, 2007. The underlying agreements provided with the Facility Agreement Compensation Exhibit are PremeraFirst Practitioner Agreements. The Companies were unable to identify for the examiners if the agreements should be categorized as facility or practitioner agreements.

The following Provider Activity Standards passed without comment:

#	Provider Activity Standard	Reference
1	**All provider contract forms shall contain procedures for the fair resolution of disputes arising out of the contract.**	**RCW 48.43.055 WAC 284-43-320(11) WAC 284-43-322**
2	**All plans must allow enrollees to select a primary care provider who is accepting new patients from a list of participating providers.**	**RCW 48.43.515, WAC 284-43-251**
3	**All provider contracts shall contain language holding the enrolled participant harmless should the Company fail to pay for health care services.**	**RCW 48.44.020(4) WAC 284-43-320(2)**
5	**Company standards for selection of participating providers and facilities do not result in risk avoidance or**	**WAC 284-43-310(1)(a) and (b)**

#	Provider Activity Standard	Reference
	discrimination by excluding providers or facilities specializing in specific treatments or located in high risk geographic areas.	
6	**The Company establishes a mechanism by which its participating providers can obtain eligibility and benefits information.**	**WAC 284-43-320(1)**
8	**The Company does not preclude the provider from informing the patient of care required and whether such case is consistent with medical necessity, medical appropriateness, or covered by the plan.**	**WAC 284-43-320(5)(a)**
9	**The Company does not preclude or discourage providers from discussing the merits of other carriers even if critical of a carrier.**	**WAC 284-43-320(5)(b)**
10	**The Company and the provider will provide at least 60 days written notice to each other before terminating the contract without cause.**	**WAC 284-43-320(7)**

The following Provider Activity Standards failed:

#	Provider Activity Standard	Reference
4	**All provider contract forms must be filed with and approved by the OIC prior to use.**	**RCW 48.44.070** **WAC 284-43-330**
7	**The Company notifies all providers of their responsibilities regarding the Company's administrative policies and programs.**	**WAC 284-43-320(4)**

Provider Activity Standard 4: Fifty-seven practitioner agreements were issued on contracts not filed with the OIC. Two (2) facility agreements were issued on contracts not filed with the OIC. Additionally 19 providers were identified as LifeWise Health Plan of Washington providers however no provider contracts were filed with the OIC in the name of LifeWise Health Plan of Washington. See Exhibit 5.

Provider Activity Standard 7: The Companies could not provide documentation showing that they notified contracted participating providers of changes to agreements affecting health care service delivery. The Companies filed changes to their grievance language when they filed their May 2002 contract. The 35 providers in the sample with contracts issued prior to May 2002 were not notified of the changes in the grievance procedures.

ADMINISTRATIVE CONTRACTS

The examiners reviewed the following administrative contracts the Companies had in place during the exam period:

- Intercompany Agency Agreement between Premera and PremeraFirst, Inc.
- Intercompany Agency Agreement between Premera LifeWise Health Plan and PremeraFirst, Inc.
- Medical Consultant Agreement between PBC, LifeWise and a consultant.
- Emergis Network Access Agreement between Premera Blue Cross and BCE Ermergis Corporation and its affiliates and subsidiaries, Alternare of Washington, Inc. and Alternare of Oregon Inc. Emergis was named in the original contract however Emergis sold Alternare to Multiplan, which then sold it to American WholeHealth Networks (AWHN) which has been acquired by Axia.
- Care Enhancement Services Agreement between Premera and American Healthways Services, Inc. (AHSI)
- PrmeraFirst, Inc. Health Plan Service Agreement between Premerafirst, Inc. and Health Care Exchange Ltd. Dba DenteMax.
- Subscriber Services Agreement between Private Healthcare Systems, Inc. (PHCS) and LifeWise Health Plan of Arizona, Inc., LifeWise Health Plan of Oregon, Inc., and LifeWise Health Plan of Washington, Inc.
- Pharmacy Benefit Management Agreement between Medco Health Solutions and LifeWise.
- Calypso Healthcare Solutions agreement between PBC and LifeWise.
- Administrative Services Agreement between Premera and LifeWise, per this agreement Northstar Administrators Inc., an affiliate of PBC provided administrative and claims services to LifeWise.
- Administrative Services Agreement between NorthStar Administrators and LifeWise

The contracts were reviewed for reporting, privacy, hold-harmless and audit provisions. The examiners found that the Intercompany agency agreements between PremeraFirst, Inc and Premera and LifeWise respectively do not contain auditing provisions. During the exam period it was noted that the Companies' claims processing was impacted by the transition from Alternare to AWHN however AWHN was not assessed any performance penalties during the exam period, as would have been allowed per the agreement between the Companies and AWHN. The Companies were not able to produce minutes or agenda from the quarterly meetings they held with AWHN. The Examiners requested prompt pay statistics from the Companies after review of their contract with Medco; the requested data was compiled by Medco. No evidence was provided to indicate that the Companies performed their own audits. It is the sole responsibility of the Companies to ensure that all relevant statutes and regulations are met; the Companies cannot affectively confirm compliance in all areas if they do not monitor the activities of entities that contractually assume a business function for the Companies.

During review of the advertising the examiners noted that a relationship exists between LifeWise and HSA Bank. LifeWise is acting as an administrator for employee owned HSA accounts and remitting initial forms and payments received from employees directly to HSA bank; the examiners found this process to be in place prior to the Companies having an administrative contract in place with HSA Bank.

NETWORK ADEQUACY

The Companies were in the process of transitioning members to the new Dimensions products during the exam period. The Companies offered a number of new plan options to both individuals and groups while maintaining existing plans during the transition period. Each of the new plans matched to either a single network or a combination of networks.

The examiners noted the use of a Global Network by the Companies and found that the Premera website described the Global Network as offering access to any licensed provider or physician in Washington. The Companies maintain that the Global Network encompasses only contracted providers however the Global plans allow members to receive the in-network benefit level from the Global network as well as from providers with whom it does not contract. WAC 284-43-130 (20) defines network as "a group of participating providers and facilities providing health care services to a particular health plan....". WAC 284-43-130 (22) defines a participating provider or facility as "a facility or provider who, under contract with the health carrier or with the carrier's contractor or subcontractor, ..." (emphasis added). The Companies' reference to a "network" that includes any licensed provider in Washington State does not meet this definition.

Subsequent Event: The Companies have provided a listing of materials that refer to the Global network and plan to have all items amended by June 1, 2007. They also filed the Global Network with the OIC.

The Companies have acknowledged a number of systems issues impacting their Provider Network Form A filings during the exam period so the decision was made to expand the scope of the exam for this section to include current network filings.

The following Network Adequacy Standard passed without Comment

#	Network Adequacy Standard	Reference
2	**A health carrier must describe each of its networks in an access plan as prescribed by WAC 284-43-210.**	**WAC 284-43-220(1)**

The following Network Adequacy Standard passed with comment:

#	Network Adequacy Standard	Reference
1	**A health carrier shall maintain each plan network in a**	**WAC 284-43-200(1)**

#	Network Adequacy Standard	Reference
	manner that is sufficient in numbers and types of providers and facilities to assure that all health plan services to covered persons will be accessible without unreasonable delay.	
4	**A carrier must prepare an electronic report showing the total number of covered persons who were entitled to health care services during each month of the year.**	**WAC 284-43-220(3)**

Network Adequacy Standard 1: The examiners reviewed a random sample of 100 providers reported on Premera's August 2006 Provider Network Form A filing for its Heritage Network and found that four (4) of the providers were either no longer in practice or no longer with the listed facility. The Companies have noted that inconsistencies do occur in-between credentialing periods as providers do not always report changes. As noted previously in the exam, the Companies vendor for alternative provider networks, Alternare, was purchased by American Whole Health Network (AWHN). The Companies have noted that a number of discrepancies were due to AWHN and that they have no control over when AWHN corrects its system. The examiners maintain that the ultimate responsibility for accurate data rests with the Companies.

Subsequent Event: In May 2006 the Companies enhanced their provider update process so that it now collects more detailed information about providers. The Companies have also initiated the implementation of a project to capture updates for provider records midway during credentialing cycles. The process will cause claims inactivity by a specific provider during any 18-month period to trigger a verification process so that the Companies can identify situations such as retirement, relocation, and other reasons for which they would update their records to remove providers from their network listing.

Network Adequacy Standard 4: The Companies submitted a Network Enrollment Form B filing indicating 18,807 large group members were enrolled in December 2005 under the MSC Traditional Network. When questioned about the applicable filings for these groups the Companies determined that individual Medicare Supplement members were erroneously reported in the large group member category.

Members in the MSC Preferred Individual and MSC Traditional Participating Individual networks were erroneously reported as being enrollees of the PBC Prudent Buyer and PBC Participating networks in the Companies year end 2003 Network Enrollment Form B filing.

The following Network Adequacy Standards failed:

#	Network Adequacy Standard	Reference
3	**A carrier must file an electronic report of all participating providers by network.**	**WAC 284-43-220(2)**

#	Network Adequacy Standard	Reference
5	**A carrier must file an electronic or hard copy paper report meeting the standards set forth in the WAC.**	**WAC 284-43-220(4)**

Network Adequacy Standard 3: The Companies did not file the required reports for the Global Network during the exam period.

Examiners reviewed the reports submitted during the exam period and the following issues were identified:

- Changes initiated by American Whole Health Network in the summer of 2005 caused provider data mismatches between AWHN records and Premera records causing errors in the information provided to the OIC in the required reports.
- In March 2005 the Companies introduced new specialty mapping to synchronize their reports with the OIC. In this process, general surgeons were inadvertently mapped to abdominal surgeons, for which there is no separate specialty category.
- The May 2006 Provider Network Form A filing was affected by technical problems that resulted in several provider categories being understated in the Companies' reports to the OIC as compared to its internal database.

Subsequent Event: The Companies have been submitting the required reports for the Global Network as of February 2007.

Network Adequacy Standard 5: The Companies did not file a prescribed report in 2004 for their MSC Preferred Individual Network or their MSC Traditional Participating Individual Network. The Companies did not file the required report in 2005 for their Global Network.

INSTRUCTIONS AND RECOMMENDATIONS

#	Instruction	Page #
1	The Companies are instructed to comply with RCW 48.44.145(2) and retain complete underwriting files for all in-force business in order to be able to better facilitate future examinations and provide all records.	11
2	The Companies are instructed to comply with WAC 284-50-060 and include complete information in all advertising so that members are aware of all coverage options.	14
3	The Companies are instructed to comply with WAC 284-50-110(3) and cite the source of statistics in all advertising materials.	14
4	The Companies are instructed to identify all members who received the benefit booklet stating that sterilization would be covered at a $25 copay in an office visit setting and provide refunds to those members who did not have their claims adjudicated in accordance with this provision. Reference: RCW 48.44.040, WAC 284-43-920.	20
5	The Companies are instructed to comply with Chapter 284-51 WAC and coordinate on all claims or eliminate the COB provision from filed contracts.	22
6	The Companies are instructed to comply with RCW 48.17.060(1) and (2) and ensure that all agents and brokers are licensed in the appropriate line of business before allowing them to solicit business or represent the Companies in any way.	24
7	The Companies are instructed to comply with RCW 48.17.160 and ensure that all agents are appointed with the Companies prior to allowing them to solicit business for the Companies.	24
8	The Companies are instructed to develop policies and procedures that require the filing of all changes to contracts prior to use and that eliminate any confusion if multiple form numbers are used within a single policy. Reference: RCW 48.44.040 and WAC 284-43-920.	27
9	The Companies are instructed to comply with RCW 48.44.040 and WAC 284-43-920 and file all rates with the OIC prior to use.	27
10	The Companies are required to comply with WAC 284-66-110(1), (2) and (3) and provide all applicants at the time of application the prescribed "Guide to Health Insurance for People with Medicare" and retain acknowledgement of receipt from the applicant in its files.	34
11	The Companies are required to comply with WAC 284-66-130(3) when selling Medicare Supplement policies directly and return a copy of the application or supplemental form, signed by the applicant, and acknowledged by the Companies to the applicant upon delivery of the policy.	34
12	The Companies are required to comply with WAC 284-66-130(7) and	34

#	Instruction	Page #
	attach a true copy of the Medicare Supplement application to the policy when issued and delivered.	
13	The Companies are required to comply with RCW 48.44.070 and WAC 284-43-330 and file all provider contracts prior to use.	36
14	The Companies are required to comply with WAC 284-43-320(4) and notify their providers of their responsibilities regarding the Companies' administrative policies and programs, such as changes to grievance procedures.	36
15	The Companies are instructed to comply with WAC 284-43-220(2) and file accurate electronic reports of all participating providers by network.	40
16	The Companies are instructed to comply with WAC 284-43-220(4) and file a report for all networks meeting the standards set forth in the WAC.	40

#	Recommendation	Page #
1	It is recommended that the Companies continually monitor and audit procedures, as well as the actions of its third party administrators, to ensure that all errors are investigated and corrected timely and in a manner that is equitable.	11
2	While it seems appropriate that each unit that creates and implements advertising materials keeps a record of its materials, it is also important for the Companies to demonstrate control over the materials that are required under WAC 284-50-200. It is recommended that a central repository for all advertising materials be created and one department be responsible for oversight of the advertising log.	14
3	It is recommended that the Companies establish policies and procedures to correctly record the date of receipt of all complaints and appeals.	16
4	It is recommended that the Companies institute audit and control procedures to ensure that systems contain correct benefit information so that members are not assessed a larger member responsibility than appropriate or have claims inappropriately denied.	19
5	It is recommended that the Companies review the policies concerning handling of incident questionnaires to ensure that procedures and practices do not unnecessarily delay claim payments.	20
6	It is recommended that the Companies test and audit any program changes to ensure that all CPT codes are recognized within the appropriate scope of practice for applicable providers.	22
7	It is recommended that the Companies develop a system to identify claim payment delays during any changes to claims systems or changes in third party administrators and if problems arise to apply immediate resolutions uniformly to all members and providers.	22

#	Recommendation	Page #
8	It is recommended that the Companies develop procedures for the retention of all termination letters sent to agents and periodically perform audits to ensure that procedures are being followed.	24
9	It is recommended that the Companies develop policies and procedures to ensure that the correct writing agents for Medicare Supplement policies are captured in its system and commissions and being paid appropriately.	25
10	It is recommended that the Companies automate their procedure for issuing policies so as to be able to track the contract number and edition date of contract sent to members and groups.	26
11	It is recommended that the Companies create procedures to ensure that appropriate proof of the offer of TMJ coverage is being retained in their files.	31
12	It is recommended that the Companies create a procedure so that on a regular basis audits are conducted on those companies providing administrative services to the Companies per contract provisions.	37
13	It is recommended that the Companies obtain administrative contracts with any and all entities and affiliates to ensure legal and financial protection.	38
14	It is recommended that the Companies develop policies and procedures for the continued monitoring of their provider networks in order to ensure that they have the most current provider information available so that it may accurately determine the adequacy of their networks. It is recommended that the procedures include audits of third party vendors so that the provider information received from vendors and used by the Companies is accurate and current.	39
15	It is recommended that the Companies institute a review process prior to submitting data to the OIC so that Form B reports are accurate and show the total number of covered persons who are entitled to health care services during each month of the year.	39

SUMMARY OF STANDARDS

Company Operations and Management Standards:

#	STANDARD	PAGE	PASS	FAIL
1	The company is required to be registered with the OIC prior to acting as a health care service contractor in the State of Washington. Reference: RCW 48.44.015(1).	9	X	
2	The company is required to report to the OIC any changes to the registration documents, including Articles of Incorporation, Bylaws, and Amendments at the same time as submitting such documents to the Secretary of State. Reference: RCW 48.44.013.	9	X	
3	When the company registers with the OIC, it is required to state its territory of operations. Reference: RCW 48.44.040.	9	X	

General Examination Standards:

#	STANDARD	PAGE	PASS	FAIL
1	The company does business in good faith, and practices honesty and equity in all transactions. Reference: RCW 48.01.030.	9	X	
2	The company must facilitate the examination process by providing its accounts, records, documents and files to the examiners upon request. Reference: RCW 48.44.145(2).	11		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).	9	X	

Advertising Standards:

#	STANDARD	PAGE	PASS	FAIL
1	The Company cannot advertise a plan to prevent illness or promote health unless a) the clinical preventive benefits are the same as the basic health plan; b) it monitors and reports annually to enrollees on standards of health care and satisfaction of enrollees; c) makes available its plan to identify and manage the most prevalent diseases within its enrolled population on request. Reference: RCW 48.43.510(5), WAC 284-43-820(5)	13	X	
2	No advertising may contain any false, deceptive or misleading information. Reference: RCW 48.44.110	13	X	
3	The Company cannot make misleading comparisons with other companies to induce the consumer to change from another HCSC. Reference: RCW 48.44.140	13	X	
4	The Company complies with the practices stated in the	14		X

#	STANDARD	PAGE	PASS	FAIL
	referenced regulations. Reference: WAC 284-50-050 through WAC 284-50-190			
5	The Company maintains a complete advertising file. Reference: WAC 284-50-200	14	X	
6	The Company must comply with all health plan disclosures as required by regulation. Reference: WAC 284-43-820(1) through WAC 284-43-820(3)	13	X	
7	The Company cannot misrepresent the terms, benefits, or advantages of the contract. Reference: RCW 48.44.120	14	X	
8	The Company cannot guarantee future dividends or future refunds except in group contracts with an experience refund provision. Reference: RCW 48.44.130	14	X	

Medicare Supplement Advertising Standards:

#	STANDARD	PAGE	PASS	FAIL
1	Every form of Medicare Supplement advertising must be submitted to the OIC thirty days prior to use. Reference: WAC 284-66-300(1)	14	X	
2	All Medicare Supplement advertising shall comply with the standards of the Washington disability advertising regulations (WAC 284-50-010 through WAC 284-50-230) and must include the full name of the issuer and the location of its home office. Reference: WAC 284-66-300(2)	15	X	
3	All Medicare Supplement advertising must comply with the standards for marketing outlined in regulation WAC 284-66-330. Reference: WAC 284-66-330(1) (a) through (e)	15	X	

Complaint Standards:

#	STANDARD	PAGE	PASS	FAIL
1	The Company has filed a copy of its procedures for review and adjudication of complaints with the OIC. Reference: RCW 48.43.055	17	X	
2	The Company maintains a fully operational, comprehensive grievance process. Reference: RCW 48.43.530, WAC 284-43-615	17	X	
3	The Company provides enrollees access to independent review services to resolve disputes. Reference: RCW 48.43.535	17	X	
4	Response to communications from the OIC must be within 15 business days of receipt of the correspondence. The response must contain the substantial information requested by the OIC. Reference: WAC 284-30-650, Technical Advisory T 98-4	17	X	

#	STANDARD	PAGE	PASS	FAIL
5	The Company complies with procedures for health care service review decisions. Reference: WAC 284-43-620	17	X	

Medicare Supplement Complaint Standards:

#	STANDARD	PAGE	PASS	FAIL
1	Response to communications from the OIC must be within 15 business days of receipt of the correspondence. The response must contain the substantial information requested by the OIC. Reference: WAC 284-30-650, Technical Advisory T 98-4	18	X	
2	A Medicare SELECT issuer must have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures must be aimed at mutual agreement for settlement and may include arbitration procedures. Reference: WAC 284-66-073(11)	N/A		
3	Grievances must be considered in a timely manner and must be transmitted to appropriate authority for investigation. Reference: WAC 284-66-073(11)(c)	N/A		
4	If a grievance is found to be valid, corrective action must be taken promptly and all concerned parties must be notified about the results of a grievance. Reference: WAC 284-66-073(11)(d) and (e)	N/A		
5	The Company must provide a report of grievances, in the prescribed format, to the OIC no later than March 31 of each year. Reference: WAC 284-66-073(11)(f)	N/A		

Claims Standards:

#	STANDARD	PAGE	PASS	FAIL
1	The company shall provide no less than urgent and emergent care to a child who does not reside in the company's service area. Reference: RCW 48.01.235(3).	21	X	
2	All plans must provide female enrollees direct access to women's health care services. Reference: RCW 48.42.100, WAC 284-43-250	21	X	
3	All plans must include every category of provider. Reference: RCW 48.43.045, WAC 284-43-205	22	X	
4	All plans shall cover emergency services necessary to screen and stabilize a covered person. Reference: RCW 48.43.093	21	X	
5	Decisions concerning maternity care and services are to be made between the mother and the provider. Reference: RCW 48.43.115	21	X	

#	STANDARD	PAGE	PASS	FAIL
6	The Company shall not deny benefits for any service performed by a denturist if the service performed was within the lawful scope of such person's license, and the agreement would have provided benefits if services were performed by a dentist. Reference: RCW 48.43.180, RCW 48.44.500.	21	X	
7	The Company maintains a documented utilization review program and conducts utilization review within the prescribed format defined. Reference: RCW 48.43.520, WAC 284-43-410	21	X	
8	The Company shall not retrospectively deny emergency or nonemergency care that had prior authorization. Reference: RCW 48.43.525(1)	21	X	
9	All plans must provide coverage for the formula necessary for the treatment of phenylketonuria (PKU). Reference: RCW 48.44.440, WAC 284-44-450	21	X	
10	The Company shall not retrospectively deny an individual prescription drug claim that had prior authorization. Reference: RCW 48.44.465	21	X	
11	The Company shall pay or deny claims subject to the required minimum standards. The Company pays interest on undenied and unpaid clean claims that are more than 61 days old. Reference: WAC 284-43-321(2).	22	X	
12	The denial of any claim must be communicated to the provider or facility with the specific reason the claim was denied. Reference: WAC 284-43-321(4).	22	X	
13	The Company administers Coordination of Benefits provisions as required. Reference: Chapter 284-51 WAC.	22	X	

Medicare Supplement Claims Standards:

#	STANDARD	PAGE	PASS	FAIL
1	Company must accept a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form. Reference: WAC 284-66-270(1)(a)	23	X	
2	Company must notify participating physician or supplier and the beneficiary of the payment determination. Reference: WAC 284-66-270(1)(b)	23	X	
3	Company must pay the participating physician or supplier directly. Reference: WAC 284-66-270(1)(c)	23	X	
4	Company must pay user fees for claim notices that are transmitted electronically or otherwise. Reference: WAC 284-66-270 (1)(e)	23	X	

#	STANDARD	PAGE	PASS	FAIL
5	A Medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than three months from the effective date of coverage because it involved a preexisting condition. Reference: RCW 48.66.130(1), WAC 284-66-063(1)(a)	23	X	
6	A Medicare SELECT policy or certificate may not restrict payment for covered services provided by non-network providers if emergency care is required for unforeseen illness, injury, or condition and it is not reasonable to obtain the services through a network provider. Reference: WAC 284-66-073(7)(a) and (b)	N/A		
7	A Medicare SELECT policy or certificate must provide payment for full coverage under the policy for covered services that are not available through network providers. Reference: WAC 284-66-073(8)	N/A		

Agent Activity Standards:

#	STANDARD	PAGE	PASS	FAIL
1	The Company requires that agents and brokers are licensed for the appropriate line of business with the State of Washington prior to allowing them to solicit business or represent the Company in any way. RCW 48.17.060(1), RCW 48.17.060(2), RCW 48.44.011(2).	24		X
2	The Company ensures that agents are appointed to represent the Company prior to allowing them to solicit business on behalf of the Company. RCW 48.17.160, RCW 48.44.011(2).	24		X
3	The Company must provide the agent with written notice of revocation of appointment and send a copy to the OIC. Reference: RCW 48.17.160(3).	24	X	

Medicare Supplement Agent Activity Standards:

#	STANDARD	PAGE	PASS	FAIL
1	The Company requires that agents and brokers are licensed for the appropriate line of business with the State of Washington prior to allowing them to solicit business or represent the Company in any way. Reference: RCW 48.17.060(1) RCW 48.17.060(2)	25	X	
2	The Company ensures that agents are appointed to represent the Company prior to allowing them to solicit business on behalf of the Company. Reference: RCW 48.17.160	25	X	
3	The Company must provide the agent with written notice of	25	X	

#	STANDARD	PAGE	PASS	FAIL
	revocation of appointment and send a copy to the OIC. Reference: RCW 48.17.160(3)			
4	The Company may not, directly or indirectly, provide commission to an agent for the solicitation, sale, servicing, or renewal of a Medicare supplement policy or certificate that is delivered or issued for delivery to a resident within this state unless the commission is identical as to percentage of premium for every policy year as long as the coverage under the policy or certificate remains in force with premiums being paid, or waived by the Company, for the coverage. Reference: WAC 284-66-350(1)(a)	25	X	
5	Each commission payment must be made by the issuer no later than sixty days following the date on which the premiums that are the basis of the commission calculated were paid. Reference: WAC 284-66-350(1)(b)	25	X	
6	Where an issuer provides a portion of the total commission for the solicitation, sale, servicing, or renewal of a Medicare supplement policy or certificate to a general agent, sales manager, district representative or other supervisor who has marketing responsibilities, while such portion of total commissions continues to be paid it must be identical as to percentage of premium for every policy year as long as coverage under the policy or certificate remains in force with premiums being paid, or waived by the issuer, for the coverage. Reference: WAC 284-66-350(1)(c)	26	X	

Rate and Form Filing Standards:

#	STANDARD	PAGE	PASS	FAIL
1	All contract forms have been filed with the OIC prior to use. Reference: RCW 48.44.040, WAC 284-43-920.	27		X
2	All rates have been filed with the OIC prior to use. Reference: RCW 48.44.040, WAC 284-43-920.	27		X
3	All contract forms and rates have been filed with the OIC on transmittal forms prescribed by and available from the Commissioner. Reference: WAC 284-43-925.	27	X	

Medicare Supplement Rate and Form Filing Standards:

#	STANDARD	PAGE	PASS	FAIL
1	All Medicare Supplement insurance policy or certificate forms	28	X	

#	STANDARD	PAGE	PASS	FAIL
	or application forms, riders or endorsements must be filed with and approved by the OIC prior to use. Reference: RCW 48.66.035(1), WAC 284-66-243(1) and (2)			
2	All Medicare Supplement rates, or modifications of rates, must be filed with and approved by the OIC prior to use. Reference: RCW 48.66.035(2), WAC 284-66-243(3)	28	X	
3	The Medicare Supplement outline of coverage as defined by WAC 284-66-092 must be filed with the OIC prior to use. Reference: WAC 284-66-080(2)	28	X	
4	The Medicare Supplement replacement notice as defined by WAC 284-66-142 must be filed with the OIC prior to use. Reference: WAC 284-66-130(4) and (5)	28	X	
5	On or before May 31 of each calendar year, an issuer of standardized Medicare Supplement policies and certificates issued according to WAC 284-66-063, must file rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the commissioner on the form provided at subsection (6) of this section. Reference: WAC 284-66-203(3)	28	X	
6	Every issuer providing group Medicare Supplement insurance benefits to a resident of this state must file with the commissioner, within 30 days of its use in this state, a copy of the master policy and any certificate used in this state, according to the filing requirements and procedures that apply to Medicare Supplement policies issued in this state. Reference: WAC 284-66-250	28	X	

Underwriting Findings:

#	STANDARD	PAGE	PASS	FAIL
1	The Company complies with the prescribed requirements for enrollment and coverage of a child under the health plan of the child's parent. Reference: RCW 48.01.235.	29	X	
2	The Company appropriately reduces preexisting condition exclusions, limitations, or waiting periods in it large group, small group and individual plans by applying time covered by the preceding health plan coverage. Reference: RCW 48.43.015 WAC 284-43-710	29	X	
3	An individual is not required to complete the standard health questionnaire if stated criteria are met. Reference: RCW 48.43.018(1)	29	X	

#	STANDARD	PAGE	PASS	FAIL
4	The Company shall provide written notice of its decision not to accept an individual's application for enrollment to both the applicant and WSHIP within 15 business days of receipt of a completed application. Reference: RCW 48.43.018(2)(b)	29	X	
5	The Company may not reject an individual for health plan coverage in a large or small group based upon preexisting conditions of the individual. The Company may not deny, exclude, or limit coverage for an individual's preexisting health conditions. The Company shall accept any state resident within the group and within the Company's service area. Reference: RCW 48.43.025, RCW 48.43.035(1), WAC 284-43-720	29	X	
6	Eligibility to purchase a health benefit plan must be extended to all small employers and small group as defined in RCW 48.43.005(24). Reference: RCW 48.43.028	30	X	
7	Dependent children cannot be terminated from an individual or group plan because of developmental disability or physical handicap. Reference: RCW 48.44.200, RCW 48.44.210.	30	X	
8	All plans shall cover newborn infants and congenital anomalies from the moment of birth. Reference: RCW 48.44.212(1).	30	X	
9	No plan may deny coverage solely on account of race, religion, national origin, or the presence of any sensory, mental, or physical handicap. Reference: RCW 48.44.220.	30	X	
10	An individual may return an individual health care contract for a full refund within ten (10) days of its delivery if not satisfied with the contract for any reason. Reference: RW 48.44.230	30	X	
11	All cancellations, denials, or non-renewals of an individual plan must be in writing and include the reason for such action. Reference: RCW 48.44.260	30	X	
12	Each group contract shall offer coverage for chiropractic care on the same basis as any other care. Reference: RCW 48.44.310	30	X	
13	All plans must include coverage for diabetes. Reference: RCW 48.44.315	30	X	
14	The Company may not refuse, cancel, or decline coverage solely because of a mastectomy or lumpectomy more than five (5) years prior. Reference: RCW 48.44.335	30	X	
15	Eligible group plans must offer optional supplemental coverage for mental health treatment for the insured and the insured's covered dependents. Reference: RCW 48.44.340(1) and (3), WAC 284-43-810	30	X	

#	STANDARD	PAGE	PASS	FAIL
16	Dependents shall have the right to continue coverage in the event of loss of eligibility by the principal enrollee. Reference: RCW 48.44.400.	30	X	
17	Adoptive children shall be covered on the same basis as other dependents. Reference: RCW 48.44.420.	30	X	
18	A rider will be cancelled upon application by the enrollee if, at least five (5) years after its issuance, no health care services have been received by the enrollee for the condition specified in the rider. Reference: RCW 48.44.430	30	X	
19	All plans shall offer optional coverage for the treatment of temporomandibular joint disorders (TMJ) and maintain proof of offer as required. Reference: RCW 48.44.460, WAC 284-44-042.	31	X	
20	The Company shall produce and provide certificates of coverage to the employer for distribution to each covered employee. Reference: WAC 284-44-050	31	X	

Medicare Supplement Underwriting Standards:

#	STANDARD	PAGE	PASS	FAIL
1	No Medicare Supplement insurance policy may use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions. Reference: RCW 48.66.050(2)	31	X	
2	The Company must accept as "eligible persons" those applicants replacing Medicare Supplement coverage as defined by RCW 48.66.055(3), who apply to enroll within 63 days of termination of the prior coverage. Reference: RCW 48.66.055(1)	31	X	
3	No Medicare Supplement carrier may deny or restrict coverage for an eligible person because of health status, claims experience, receipt of health care, or medical condition; or impose an exclusion of benefits based on a preexisting condition under a prior Medicare Supplement policy. Reference: RCW 48.66.055(2)	31	X	
4	All Medicare Supplement polices must be guaranteed renewable and may not provide that the policy may be cancelled or nonrenewed solely on the grounds of deteriorating health. The Company shall not cancel or nonrenew for any reason other than nonpayment of premium or material misrepresentation. Reference: RCW 48.66.090	32	X	
5	A Medicare Supplement outline of coverage as defined by	32	X	

#	STANDARD	PAGE	PASS	FAIL
	WAC 284-66-092 shall be provided to the applicant at the time of application with an acknowledgement of receipt from the applicant retained. Reference: RCW 48.66.110 WAC 284-66-080(1)			
6	If a Medicare Supplement outline of coverage is provided at the time of application and the subsequently issued policy or certificate is revised, an appropriate outline of coverage must accompany the policy or certificate when delivered and contain the required statement immediately above the Company name. Reference: WAC 284-66-080(3)	32	X	
7	Every Medicare Supplement insurance policy issued after January 1, 1982 shall have prominently displayed on the first page stating that the person whom the policy or certificate is issued shall be permitted to return the policy or certificate within 30 days of its delivery to the purchaser and to have the premium refunded if the purchaser is not satisfied with it for any reason. Reference: RCW 48.66.120	32	X	
8	If there is a replacement of existing Medicare Supplement coverage which has been in effect for at least 3 months, the replacing carrier must waive all time periods for preexisting conditions, waiting periods, elimination periods, and probationary periods. Reference: RCW 48.66.130(4), WAC 284-66-170(2),	32	X	
9	If a group Medicare Supplement policy is replaced by another Medicare Supplement policy purchased by the same policyholder, the issuer of the replacement policy must offer coverage to all persons covered under the old group policy on its termination date. The new policy may not contain any exclusion for pre-existing conditions that would have been covered under the group policy being replaced. Reference: WAC 284-66-063(1)(c)(v)	32	X	
10	If completion of a medical history is required for acceptance of the application the medical history must be completed by the applicant, a relative of the applicant, a legal guardian of the applicant, or a physician. Reference: RCW 48.66.140	32	X	
11	An issuer must make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic "core" benefits, as defined in WAC 284-66-063(2) of this regulation. Reference: WAC 284-66-066(1)	33	X	
12	Before the sale of a Medicare SELECT policy or certificate, a Medicare SELECT issuer must obtain from the applicant a	N/A		

#	STANDARD	PAGE	PASS	FAIL
	signed and dated form stating that the applicant has received the information provided under subsection (9) of this section and that the applicant understands the restrictions of the Medicare SELECT policy or certificate. Reference: WAC 284-66-073(10)			
13	At the time of initial purchase, a Medicare SELECT issuer must make available to each applicant for a Medicare SELECT policy or certificate the opportunity to purchase any Medicare Supplement policy or certificate otherwise offered by the issuer. Reference: WAC 284-66-073(12)	N/A		
14	At the request of an individual insured under a Medicare SELECT policy or certificate, the issuer must make available the opportunity to purchase a Medicare Supplement policy or certificate offered by the issuer that has comparable or lesser benefits and does not contain a restricted network provision. The issuer must make the policy available without requiring evidence of insurability after the Medicare Supplement policy has been in force for three months. Reference: WAC 284-66-073(13)(a)	N/A		
15	All issuers of policies that provide benefits for persons eligible for Medicare must provide to all applicants at the time of application the prescribed "Guide to Health Insurance for People with Medicare," and acknowledgement of receipt from the applicant must be in the issuer's files. Reference: WAC 284-66-110(1), (2) and (3)	34		X
16	Application forms must include the listed questions designed to elicit information as to whether, as of the date of the application, the applicant currently has another Medicare, Medicaid, or other disability policy and is intended to replace any other policy of an HCSC, HMO, disability insurer or fraternal benefit society presently in force. A supplementary application or other form to be signed by the applicant and agent containing the questions and statements, may be used: if the coverage is sold without an agent, the supplementary application must be signed by the applicant. Reference: WAC 284-66-130(1)	33	X	
17	Agents must list any other medical or health insurance policies sold to the applicant and must list policies sold that are still in force and policies that have been sold in the past five years that are no longer in force. Reference: WAC 284-66-130(2)	33	X	
18	In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and	34		X

#	STANDARD	PAGE	PASS	FAIL
	acknowledged by the insurer, must be returned to the applicant by the insurer upon delivery of the policy. Reference: WAC 284-66-130(3)			
19	If there is a replacement of existing Medicare Supplement coverage the replacing carrier must furnish to the applicant the replacement notice as defined by WAC 284-66-142 prior to issuance or delivery of the policy or certificate and retain a signed copy of the replacement notice in the issuer's files. Reference: WAC 284-66-130(4)	33	X	
20	A true copy of the application for a Medicare Supplement insurance policy issued by a health maintenance organization or health care service contractor must be attached to or otherwise physically made a part of the policy when issued and delivered. Reference: WAC 284-66-130(7)	34		X
21	If there is a replacement of existing Medicare Supplement coverage the replacing carrier must waive all time periods for preexisting conditions, waiting periods, elimination periods, and probationary periods to the extent such time was spent under the original policy. Reference: WAC 284-66-170(1)	33	X	
22	Effective after January 1, 1990, except for riders and endorsements that bring a policy into compliance, an amendment to a Medicare Supplement insurance policy or certificate that increase the premium must be requested or accepted by the policy holder in writing. Reference: WAC 284-66-260(2)(a)	33	X	
23	All Medicare Supplement issuers must comply with Omnibus Budget Reconciliation Act of 1987 by furnishing to the enrollee, at the time of enrollment, a card listing the policy name, number, and a central mailing address to which notices from a Medicare carrier may be sent. Reference: WAC 284-66-270(1)(d)	33	X	
24	An issuer may not issue a Medicare Supplement policy or certificate to an individual enrolled in Medicare Part 'C' unless the effective date of the coverage is after the termination date of the individual's Part 'C' coverage. Reference: WAC 284-66-340(3)	34	X	

Provider Activity Standards:

#	STANDARD	PAGE	PASS	FAIL
1	All provider contract forms shall contain procedures for the fair resolution of disputes arising out of the contract. Reference:	35	X	

#	STANDARD	PAGE	PASS	FAIL
	RCW 48.43.055, WAC 284-43-320(11), WAC 284-43-322			
2	All plans must allow enrollees to select a primary care provider who is accepting new patients from a list of participating providers. Reference: RCW 48.43.515, WAC 284-43-251.	36	X	
3	All provider contracts shall contain language holding the enrolled participant harmless should the Company fail to pay for health care services. Reference: RCW 48.44.020(4) WAC 284-43-320(2)	36	X	
4	All provider contract forms must be filed with and approved by the OIC prior to use. Reference: RCW 48.44.070, WAC 284-43-330.	36		X
5	Company standards for selection of participating providers and facilities do not result in risk avoidance or discrimination by excluding providers or facilities specializing in specific treatments or located in high risk geographic areas. Reference: WAC 284-43-310(1)(a) and (b).	36	X	
6	The Company establishes a mechanism by which its participating providers can obtain eligibility and benefits information. Reference: WAC 284-43-320(1)	36	X	
7	The Company notifies all providers of their responsibilities regarding the Company's administrative policies and programs. Reference: WAC 284-43-320(4)	36		X
8	The Company does not preclude the provider from informing the patient of care required and whether such case is consistent with medical necessity, medical appropriateness, or covered by the plan. Reference: WAC 284-43-320(5)(a)	36	X	
9	The Company does not preclude or discourage providers from discussing the merits of other carriers even if critical of a carrier. Reference: WAC 284-43-320(5)(b)	36	X	
10	The Company and the provider will provide at least 60 days written notice to each other before terminating the contract without cause. Reference: WAC 284-43-320(7)	36	X	

Network Adequacy Standards:

#	STANDARD	PAGE	PASS	FAIL
1	A health carrier shall maintain each plan network in a manner that is sufficient in numbers and types of providers and facilities to assure that all health plan services to covered persons will be accessible without unreasonable delay. Reference: WAC 284-43-200(1)	39	X	
2	A health carrier must describe each of its networks in an access	39	X	

#	STANDARD	PAGE	PASS	FAIL
	plan as prescribed by WAC 284-43-210. Reference: WAC 284-43-220(1)			
3	A carrier must file an electronic report of all participating providers by network. Reference: WAC 284-43-220(2)	40		X
4	A carrier must prepare an electronic report showing the total number of covered persons who were entitled to health care services during each month of the year. Reference: WAC 284-43-220(3)	39	X	
5	A carrier must file an electronic or hard copy paper report meeting the standards set forth in the WAC. Reference: WAC 284-43-220(4)	40		X

APPENDIX 1

General Examination Findings Standard 2: The Company must facilitate the examination process by providing its accounts, records, documents and files to the examiners upon request. Reference: RCW 48.44.145(2).

OIC File	Comments
OIC P83	Company unable to locate the provider contract.
OIC PBC 11	Underwriting file did not include application.
OIC PBC 15	Company unable to locate underwriting file (quote).
OIC PBC 17	Underwriting file did not include application.
OIC LWWA 18	Company unable to locate underwriting file.
OIC PBC 27	Underwriting file did not include application.
Medicare Supplement	The Companies' general rule for destruction of applications is seven (7) years.
OIC PBC 5	Underwriting file did not include application.
OIC PBC 6	Underwriting file did not include application.
OIC PBC 7	Underwriting file did not include application.
OIC PBC 8	Underwriting file did not include application.
OIC PBC 9	Underwriting file did not include application.
OIC PBC 13	Underwriting file did not include application.
OIC PBC 14	Underwriting file did not include application.
OIC PBC 15	Underwriting file did not include application.
OIC PBC 21	Underwriting file did not include application.
OIC PBC 26	Underwriting file did not include application.
OIC PBC 29	Underwriting file did not include application.

APPENDIX 2

Advertising Standard 4: The Company complies with the Washington Disability Insurance Advertising Regulations. Reference: WAC 284-50-050 through WAC 284-50-190

OIC ID #	FORM and FORM #	Comments
LWAD12	2005 Preferred Drug List 012801 (09-2004)	The statement on page 4 omits the possibility a "preferred" Tier 2 copay could be elected. (WAC 284-50-060)
PAD 07	Discover the real value in health care benefit solutions 015303 (06-2005)	Material contains the following statements: "Provider satisfaction with Premera is extremely high" "73% of the claims Premera receives are auto-adjudicated, which means faster turnaround on claims payments" -"..over 99% network retention annually" Company does not cite source of information used to claim that provider satisfaction is extremely high. The statistics quoted for network retention and auto-adjudication rate do not indicate the source of the statistics. (WAC 284-50-110)
PAD 09	Discover the real value in health care benefit solutions 015303 (10-2005)	Material contains the following statements: "Provider satisfaction with Premera is extremely high" "73% of the claims Premera receives are auto-adjudicated, which means faster turnaround on claims payments" -"..over 99% network retention annually" Company does not cite source of information used to claim that provider satisfaction is extremely high. The statistics quoted for network retention and auto-adjudication rate do not indicate the source of the statistics. (WAC 284-50-110)
PAD 17	Proposal Brown & Brown	Bullet points on page two of the executive summary state: "Cost - we have competitive administration fees with the deepest provider discounts" "Network - we provide access to the largest provider networks and our award winning Care Facilitation programs. " Company does not cite source of information or source of comparison. (WAC 284-50-110)
PAD 18	Networking for Value 013546 (06-2004)	Included within the advertisement is the statement: "Each of our dental plans offers access to a network that includes more than half the dental providers in Washington, including specialists." The Company does not cite the source of this statistic. (WAC 284-50-110)

APPENDIX 3

OIC Number	Comments
68	Copy of Certificate of Health Coverage dated 7/23/04 on Premera letterhead. Letter to member dated 2/25/05 on LifeWise letterhead; copy of LifeWise appeal process also included. Letter to member dated 3/7/05 on Premera letterhead.
79	Explanation of payment dated 10/10/05 on LifeWise letterhead. Letter to provider dated 11/14/05 on Premera Letterhead.
87	Claim involving code E0760 initially denied due to incorrect pricing information in the system. Once system was corrected Premera did not run a report to identify and reprocess other claims that may have been impacted.
72	CPT code 70551 initially denied due to bundling; denial reversed on appeal.
74	The appeal selected in our sample involved only one claim however the file referenced all of the following claims.
	CPT code 70551 initially denied due to bundling; denial reversed on appeal. Claim involved charge of $1,155.00
	CPT code 70553 initially denied due to bundling; denial reversed on appeal. Claim involved charge of $1,916.00
	CPT code 70553 initially denied due to bundling; denial reversed on appeal. Claim involved charge of $2,389.00
	CPT code 70551 initially denied due to bundling; denial reversed on appeal. Claim involved charge of $1,155.00
	CPT code 70553 initially denied due to bundling; denial reversed on appeal. Claim involved charge of $1,916.00
	CPT code 70553 initially denied due to bundling; denial reversed on appeal. Claim involved charge of $1,916.00
	CPT code 70553 initially denied due to bundling; denial reversed on appeal. Claim involved charge of $1,916.00
	CPT code 70551 initially denied due to bundling; denial reversed on appeal. Claim involved charge of $1,155.00
	CPT code 70551 initially denied due to bundling; denial reversed on appeal. Claim involved charge of $1,155.00
	CPT code 70551 initially denied due to bundling; denial reversed on appeal. Claim involved charge of $1,155.00
	CPT code 70553 initially denied due to bundling; denial reversed on appeal. Claim involved charge of $1,916.00
	CPT code 70553 initially denied due to bundling; denial reversed on appeal. Claim involved charge of $1,916.00
	CPT code 70551 initially denied due to bundling; denial reversed on appeal. Claim involved charge of $1,155.00
	CPT code 70553 initially denied due to bundling; denial reversed on appeal. Claim involved charge of $1,916.00
	CPT code 70553 initially denied due to bundling; denial reversed on appeal. Claim involved charge of $1,916.00
	CPT code 70553 initially denied due to bundling; denial reversed on appeal. Claim involved charge of $1,916.00
	CPT code 70551 initially denied due to bundling; denial reversed on appeal. Claim involved charge of $1,155.00

	CPT code 70553 initially denied due to bundling; denial reversed on appeal. Claim involved charge of $1,916.00
	CPT code 70553 initially denied due to bundling; denial reversed on appeal. Claim involved charge of $1,916.00
	CPT code 70551 initially denied due to bundling; denial reversed on appeal. Claim involved charge of $1,155.00
	CPT code 70553 initially denied due to bundling; denial reversed on appeal. Claim involved charge of $1,916.00
	CPT code 70553 initially denied due to bundling; denial reversed on appeal. Claim involved charge of $1,916.00
	CPT code 70551 initially denied due to bundling; denial reversed on appeal. Claim involved charge of $1,155.00
	CPT code 70551 initially denied due to bundling; denial reversed on appeal. Claim involved charge of $1,155.00
92	CPT code 70553 initially denied due to bundling; denial reversed on appeal.

APPENDIX 4

Rate and Form Filing Standard 1: All Contract forms have been filed with the OIC prior to use. Reference: RCW 48.44.040, WAC 284-43-920

OIC ID #	Comments
PBC 37	Effective February 1, 2005 issued contract form WASGDIMENSIONS (1-2005). Inside pages of contract all marked WADIM1MEDSG with no date. The Heritage +1 plan chosen by this group was filed with the OIC to be used with WADIM1MEDSG (01-2005). The following statement under "Examples of material changes that may require re-rating" was not included in the contract filed with the OIC but was added to the issued contract: "Fraud or intentionally false or misleading medical or other information." The filed contract indicates that the BlueCard program is available to enrollees who live or travel in Clark County Washington or outside Washington and Alaska; the contract issued makes no specific reference to Clark County. The contract filed with the OIC indicates that recovered amounts, under the BlueCard Program, will be applied as an adjustment to the claims experience used in setting rates for this plan. The verbiage in the issued contract states that recoveries will be applied as an adjustment to the Group's claims experience.
PBC 38	Group contract was issued prior to being filed with the OIC.
PBC 39	Group contract was issued prior to being filed with the OIC.
PBC 41	Effective August 1, 2004 issued contract form WASGDIMENSIONS (07-2004). Inside pages of contract all marked WADIM1MEDSG with no date. The following statement under "Examples of material changes that may require re-rating" was not included in the contract filed with the OIC but was added to the issued contract: "Fraud or intentionally false or misleading medical or other information." The filed contract indicates that the BlueCard program is available to enrollees who live or travel in Clark County Washington or outside Washington and Alaska; the contract issued makes no specific reference to Clark County. The contract filed with the OIC indicates that recovered amounts, under the BlueCard Program, will be applied as an adjustment to the claims experience used in setting rates for this plan. The verbiage in the issued contract states that recoveries will be applied as an adjustment to the Group's claims experience.
PBC 43	Effective January 1, 2005 contract WASGDIMENSIONS (1-2005) was issued. Inside pages of contract all marked WADIM1MEDSG with no date. Contract for plan group applied for was filed with the OIC under contract WADIM1MEDSG (01-2005). The Heritage +1 plan chosen by this group was filed with the OIC to be used with WADIM1MEDSG (01-2005). The following statement under "Examples of material changes that may require re-rating" was not included in the contract filed with the OIC but was added to the issued contract: "Fraud or intentionally false or misleading medical or other information." The filed contract indicates that the BlueCard program is available to enrollees who live or travel in Clark County Washington or outside Washington and Alaska; the contract issued makes no specific reference to Clark County. The contract filed with the OIC indicates that recovered amounts, under the BlueCard Program, will be applied as an adjustment to the claims experience used in setting rates for this plan. The verbiage in the issued contract states that recoveries will be applied as an adjustment to the Group's claims experience.
PBC 44	Effective April 1, 2005 contract WASGDIMENSIONS (1-2005) was issued. Inside pages of contract all marked WADIM1MEDSG with no date.

	The following statement under "Examples of material changes that may require re-rating" was not included in the contract filed with the OIC but was added to the issued contract: "Fraud or intentionally false or misleading medical or other information." The filed contract indicates that the BlueCard program is available to enrollees who live or travel in Clark County Washington or outside Washington and Alaska; the contract issued makes no specific reference to Clark County. The contract filed with the OIC indicates that recovered amounts, under the BlueCard Program, will be applied as an adjustment to the claims experience used in setting rates for this plan. The verbiage in the issued contract states that recoveries will be applied as an adjustment to the Group's claims experience.
PBC 45	Effective January 1, 2005 contract WASGDIMENSIONS (1-2005) was issued. Inside pages of contract all marked WADIM1MEDSG with no date. Contract for plan group applied for was filed with the OIC under contract WADIM1MEDSG (01-2005). The Heritage +1 plan chosen by this group was filed with the OIC to be used with WADIM1MEDSG (01-2005). The following statement under "Examples of material changes that may require re-rating" was not included in the contract filed with the OIC but was added to the issued contract: "Fraud or intentionally false or misleading medical or other information." The filed contract indicates that the BlueCard program is available to enrollees who live or travel in Clark County Washington or outside Washington and Alaska; the contract issued makes no specific reference to Clark County. The contract filed with the OIC indicates that recovered amounts, under the BlueCard Program, will be applied as an adjustment to the claims experience used in setting rates for this plan. The verbiage in the issued contract states that recoveries will be applied as an adjustment to the Group's claims experience.
PBC 47	Effective April 1, 2005 contract WASGDIMENSIONS (1-2005) was issued. Inside pages of contract all marked WADIM1MEDSG with no date. Contract for plan group applied for was filed with the OIC under contract WADIM1MEDSG (01-2005). The Heritage +1 plan chosen by this group was filed with the OIC to be used with WADIM1MEDSG (01-2005). The following statement under "Examples of material changes that may require re-rating" was not included in the contract filed with the OIC but was added to the issued contract: "Fraud or intentionally false or misleading medical or other information." The filed contract indicates that the BlueCard program is available to enrollees who live or travel in Clark County Washington or outside Washington and Alaska; the contract issued makes no specific reference to Clark County. The contract filed with the OIC indicates that recovered amounts, under the BlueCard Program, will be applied as an adjustment to the claims experience used in setting rates for this plan. The verbiage in the issued contract states that recoveries will be applied as an adjustment to the Group's claims experience.
PBC 48	Effective January 1, 2005 contract WASGDIMENSIONS (1-2005) was issued. Inside pages of contract all marked WADIM1MEDSG with no date. The following statement under "Examples of material changes that may require re-rating" was not included in the contract filed with the OIC but was added to the issued contract: "Fraud or intentionally false or misleading medical or other information." The filed contract indicates that the BlueCard program is available to enrollees who live or travel in Clark County Washington or outside Washington and Alaska; the contract issued makes no specific reference to Clark County. The contract filed with the OIC indicates that recovered amounts, under the BlueCard Program, will be applied as an adjustment to the claims experience used in setting rates for this plan. The verbiage in the issued contract states that recoveries will be applied as an adjustment to the

	Group's claims experience.
PBC 49	Effective July 1, 2004 contract WASGDIMENSIONS (1-2004) was issued. Inside pages of contract all marked WADIM1MEDSG with no date. Contract WASGDIMENSIONS (01-2005) was issued on the renewal effective July 1, 2005. Inside pages of contact all marked WADIM1MEDSG with no date. The following statement under "Examples of material changes that may require re-rating" was not included in the contract filed with the OIC but was added to the issued contract: "Fraud or intentionally false or misleading medical or other information." The filed contract indicates that the BlueCard program is available to enrollees who live or travel in Clark County Washington or outside Washington and Alaska; the contract issued makes no specific reference to Clark County. The contract filed with the OIC indicates that recovered amounts, under the BlueCard Program, will be applied as an adjustment to the claims experience used in setting rates for this plan. The verbiage in the issued contract states that recoveries will be applied as an adjustment to the Group's claims experience.
PBC 50	Effective August 1, 2004 WASGDIMENSIONS (1-2004) was issued. Inside pages of contract all marked WADIM1MEDSG with no date. The following statement under "Examples of material changes that may require re-rating" was not included in the contract filed with the OIC but was added to the issued contract: "Fraud or intentionally false or misleading medical or other information." The filed contract indicates that the BlueCard program is available to enrollees who live or travel in Clark County Washington or outside Washington and Alaska; the contract issued makes no specific reference to Clark County. The contract filed with the OIC indicates that recovered amounts, under the BlueCard Program, will be applied as an adjustment to the claims experience used in setting rates for this plan. The verbiage in the issued contract states that recoveries will be applied as an adjustment to the Group's claims experience.

Rate and Form Filing Standard 2: All rates have been filed with the OIC prior to use. Reference: RCW 48.44.040, WAC 284-43-920

OIC ID #	Comments
PBC 38	Rates used were not filed with the OIC prior to the effective date.
PBC 39	Rates used were not filed with the OIC prior to the effective date.

APPENDIX 5

Provider Activity Standard 4: All provider contract forms must be filed with and approved by the OIC prior to use. Reference: RCW 48.44.070, WAC 284-43-330

Company Contract	OIC ID #	Comments
PF98PRA5 (4/00) rev 5/00	P10, P24	Revisions to contract used were not filed with the OIC.
PF98PRA5 (4/00) rev 7/00	P02, P29, P35, P47, P50, P55, P56, P60, P65, P73, P82	Revisions to contract used were not filed with the OIC.
PF98PRA5 (4/00) rev 2/01	P36, P80	Revisions to contract used were not filed with the OIC.
PF98PRA5 (4/00) rev 6/01	P07, P12, P13, P22, P23, P25, P49, P52, P54, P58, P62, P64, P70, P74, P86, P88	Revisions to contract used were not filed with the OIC.
PF98PRA5 (4/00) rev 8/02	P21, P32, P76, P93	Revisions to contract used were not filed with the OIC.
PF98PRA5 (4/00) rev 11/02	P03, P06, P20, P26, P27, P28, P34, P39, P40, P43, P59, P63, P67, P71, P75, P78, P85, P87, P91, P92, P95, P97	Revisions to contract used were not filed with the OIC.
PF98FAC4 (4/00) rev 11/02	P04, P05	Revisions to facility contract used were not filed with the OIC.
Contract for PBCPAR Providers - LifeWise	P01, P08, P11, P15, P16, P18, P19, P42, P48, P61, P66, P69, P77, P81, P84, P89, P90, P96, P98.	Provider Contracts for LifeWise Health Plan of Washington were not filed with the OIC.

PREMERA | BLUE CROSS

VIA FACSIMILE & U.S. MAIL
360-586-2022

September 12, 2007

Mr. James T. Odiorne
Deputy Commissioner, Company Supervision
Office of Insurance Commissioner
Insurance 5000 Building
P.O. Box 40259
Olympia, Washington 98504-0259

Re: Response to Draft Report for Market Conduct Examinations of Premera Blue Cross and LifeWise Health Plan of Washington

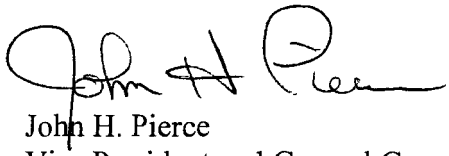
Dear Deputy Commissioner Odiorne:

The purpose of this letter is to furnish you with comments, on behalf of Premera Blue Cross and LifeWise Health Plan of Washington (collectively "the Companies"), on the Draft Report for Market Conduct Examinations dated August 9, 2007 ("Draft Report"). As you know, the Companies requested and the Office of Insurance Commissioner ("OIC") granted an extension until today, September 12, 2007, to provide comments on the Draft Report.

We would like to note with satisfaction the high number of standards that the Companies passed without comment and believe that such a result exemplifies the manner in which we perform our obligations in the market and focus on our customers. As indicated in various sections throughout the Draft Report, the Companies already completed or initiated mitigation efforts prior to the initiation of the examinations concerning many issues contained in the Draft Report. Thus, our comments are limited to factual inaccuracies in the narratives and additional comments, clarifications, subsequent event information about and recommended revisions to specific instructions and recommendations. You will find our comments outlined in Exhibit A to this letter. The Exhibit is organized to track the order of the sections contained in the Draft Report and captures the standard, if cited, relevant to each instruction or recommendation. To the extent you require additional information from the Companies or wish to discuss any of our comments in more detail, please contact me directly at (425) 918-6217.

Finally, we would like to acknowledge the collaborative efforts undertaken by the OIC's examiners, in working with our examination coordinator and other staff, during all phases of the examination and appreciate the comments made in the Draft Report on this subject. We also particularly appreciate the opportunities we have had to discuss the preliminary findings, and the resulting changes and clarifications reflected in the Draft Report. We respectfully urge your office to consider our comments contained herein in detail, and make further revisions to the Draft Report before it is adopted and made public. It is our understanding that our comments will, in any event, be part of the public record, even if requested changes are not made.

Sincerely,



John H. Pierce
Vice President and General Counsel

cc: Nabil Istafanous, Vice President, Compliance and Ethics Officer
Michael G. Watson, Chief Deputy Insurance Commissioner
Leslie Krier, Market Conduct Oversight Manager
Sandy Ray, Examiner in Charge

Enclosure

EXHIBIT A

COMPANIES' RESPONSE TO OIC'S
DRAFT MARKET CONDUCT EXAMINATION REPORT DATED 8/9/2007

COMPANY OPERATIONS AND MANAGEMENT

Companies' Response: At the bottom of page 7 of the Company Operations and Management subsection of the Draft Report, the first sentence should be amended to reflect that the Premera Blue Cross ("Premera") Board of Directors is made up of no less than twelve and no more than fourteen members. At the top of page 8 of the Draft Report, please change the reference to "PREMERA, Inc." to "PREMERA" to reflect its legal name. With respect to the chart listing Premera's Board of Directors, please correct Richard D. Ford's Term Expiration Date to May 9, 2007 and Sarah M. R. Jewell's Term Expiration Date to May 3, 2006. With respect to the chart listing LifeWise Health Plan of Washington's ("LifeWise") Board of Directors, please correct Darryl Price's Term Expiration Date to March 19, 2007.

GENERAL EXAMINATION FINDINGS

Standard #1: The Company does business in good faith, and practices honesty and equity in all transactions.

Recommendation #1: It is recommended that the Companies continually monitor and audit procedures, as well as the actions of its third party administrators, to ensure that all errors are investigated and corrected timely and in a manner that is equitable.

Companies' Response: RCW 48.01.030 requires, in pertinent part, that "all persons be actuated by good faith, abstain from deception, and practice honesty and equity in all insurance matters." In abiding by the principle, the Companies employ regular monitoring and audit procedures to assess compliance with applicable laws, regulations and contract terms. In the event that material errors are discovered, we strive to correct them timely. That being said, we do not believe that the statute requires continuous monitoring and auditing to "ensure that all errors" are investigated (emphasis added). The term "continually" can be read to imply unceasing monitoring or auditing and the term "all" can be read to imply monitoring and auditing of every conceivable error that may occur. Accordingly, we respectfully request the recommendation be revised to state, "It is recommended that the Companies regularly monitor and audit procedures, as well as the actions of its third party administrators, to ensure that errors are investigated and corrected timely and in a manner that is equitable.

In addition, a significant portion of the Draft Report narrative focused on the Companies' contract with American Whole Health Network ("AWHN"). Effective August 18, 2007, AWHN no longer has any involvement with claim activities on behalf of the Companies.

GENERAL EXAMINATION FINDINGS continued

Standard #2: The Company must facilitate the examination process by providing its accounts, records, documents and files to the examiners upon request.

Instruction #1: The Companies are instructed to comply with RCW 48.44.145(2) and retain complete underwriting files for all in-force business in order to be able to better facilitate future examinations and provide all records.

Companies' Response: RCW 48.44.145(2) requires that "every health care service contractor submit its books and records relating to its operations for...market conduct examinations and in every way facilitate them." We believe we met that standard by providing examiners access to documents requested. We do not dispute that the Companies could not locate one provider contract, two underwriting files and fourteen applications out of the thousands of documents requested during the examination process, despite our best efforts. Since the Draft Report does not suggest that this is a zero-tolerance standard, we request that this item be revised to a recommendation, in light of the insignificant percentage of items that were not located during the more than 12 months of examination time.

ADVERTISING

On page 12 of the Draft Report, the OIC incorrectly references the Companies' Document Administration Department as "Document Information." Please amend the Draft Report to reflect the correct name of the department.

Standard #5: The Company maintains a complete advertising file.

Recommendation #2: While it seems appropriate that each unit that creates and implements advertising materials keeps a record of its materials, it is also important for the Companies to demonstrate control over the materials that are generated to solicit business. It is recommended that a central repository for all advertising materials be created and one department be responsible for oversight of the advertising log.

Companies' Response: This standard, as stated, simply requires the Companies to maintain a complete file of advertising materials. It does not require that the materials be maintained in a single location, that they be monitored by a single department, or that the Companies maintain an "advertising log." We believe we have entirely complied with the standard, and therefore do not believe a recommendation is warranted. In particular, this recommendation implies that the Companies lack control over advertising materials simply because the "complete advertising file" is comprised of materials maintained in four departments. WAC 284-50-200 requires each health care service contractor to maintain a "complete file containing every printed, published, or prepared advertisement of its individual policies and typical printed, published, or prepared advertisements of its blanket, franchise, and group policies hereafter disseminated..." Given this definition, the file must include various types and formats of advertisements, and we believe it is not practical to consolidate all materials into a single repository. We note that neither the examiners' access to nor the completeness of requested advertising materials were

hampered by the physical locations of the Companies' records. Thus, we request that the recommendation be deleted. Additionally, the regulation does not use the terminology "materials that are generated to solicit business" and, therefore, if the recommendation remains in the report with that language, we request that language be replaced with "the materials required by WAC 284-50-200."

Standard #4: The Company complies with the practices stated in the referenced regulations.

Instruction #2: The Companies are instructed to comply with WAC 284-50-060 and include complete information in all advertising so that members are aware of all coverage options.

Companies' Response: This standard encompasses virtually all of the advertising regulations in WAC Chapter 284-50. Although this instruction does not reference the relevant subsection of WAC 284-50-060, we believe the only section potentially applicable is subsection (1). It provides that "no advertisement shall omit information...if the omission of such information...has the capacity, tendency, or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable."

This instruction results from one piece of advertising. Instead of focusing on an omission that may mislead or deceive purchasers, the instruction requires us to provide complete information about "all coverage options." We believe this is an overly broad interpretation of the regulation. We believe that when reading the document in its entirety, page 5 of the document provides the example that the OIC has deemed lacking—that is the circumstances when the lower-cost prescription drug tier may be available. Although repeating the exception on page 4 may have been helpful to the reader, the lack of repetition does not amount to an omission under the regulation. Thus, we respectfully request that this finding be deleted altogether.

Standard #4: The Company complies with the practices stated in the referenced regulations.

Instruction #3: The Companies are instructed to comply with WAC 284-50-110(3) and cite the source of statistics in all advertising materials.

Companies' Response: We understand, and have been reinforcing in our advertising review processes, that the source of statistics must be cited in advertising. Nonetheless, we also believe that your conclusion that the standard was failed is excessively harsh, given that only three distinct documents (two of the four documents cited in Appendix 2 were the same document with different print dates) did not contain source references and the majority of the statistics were self-evident as being internal (e.g., network retention statistics). We respectfully request that this instruction be amended to be a recommendation.

EXHIBIT A

COMPLAINTS

Recommendation #3: It is recommended that the Companies revise their practitioner agreements and procedures to mirror actual practices and policies to ensure that all practitioners are treated in an equitable and consistent manner.

Companies' Response: We have revised the applicable procedure to match the practitioner agreement with respect to the deadline for a Level 2 appeal request; we respectfully request that you add this as subsequent event information in the Draft Report.

CLAIMS

Instruction #4: The Companies are instructed to identify all members who received the benefit booklet stating that sterilization would be covered at a $25 copay in an office visit setting and to reprocess all claims that were not adjudicated in accordance with this provision. Reference: RCW 48.44.040, WAC 284-43-920.

Companies' Response: The instruction above does not appear to be related to a particular standard against which your office reviewed our market conduct, although the instruction itself contains references to state laws. Premera filed the affected group contracts and benefit booklets with the OIC as required by RCW 48.44.040 and WAC 284-43-920. As indicated previously, Premera believes it is obligated to process claims based on the benefit the group purchased, not on inadvertent errors in the benefit booklet that, to our knowledge, members did not rely upon. Neither Premera nor the OIC discovered the inadvertent inconsistency when the contracts were initially filed. However, for those members that did rely upon the benefit booklet and notified Premera, we did provide coverage based on the misinformation contained in the benefit booklet. We request that you delete this instruction as the company complied with the statute and regulation cited in the instruction.

Nonetheless, we continue to evaluate the feasibility of reprocessing all of these claims as directed in the instruction and believe that reimbursing the member directly for any amount paid to the provider above the $25 copay rather than reprocessing the claim may be less disruptive to providers (given the age of the claims and likelihood that coinsurance was already collected from the member) and less confusing to members. To the extent you are unwilling to delete this instruction, we respectfully request that it be amended to allow an equitable alternative to the actual reprocessing of the claims.

CLAIMS continued

Standard #13: The Company administers Coordination of Benefits provisions as required.

Instruction #5: The Companies are instructed to comply with Chapter 284-51 WAC and coordinate on all claims or eliminate the COB provision from filed contracts.

Companies' Response: We disagree with your characterization of the Companies' responses to examiners that the Companies do not "investigate other coverage on its own subscribers until they are of Medicare age." See page 22 of the Draft Report. The Companies' initial application forms request other coverage information, and if any is indicated, we determine order of liability, record that determination in our systems, and process claims accordingly. The Companies also use other mechanisms for identifying other coverage, including investigating other coverage information contained on subscriber claims, information obtained directly from subscribers, and other coverage inquiries completed by the subscriber or their dependents. The Companies have evaluated other large-scale mechanisms for updating other coverage information (or confirming the lack thereof). We determined that such activities are not fiscally prudent given the low likelihood of discovering other coverage that would be primary to ours compared to the expenditure of our members' time in responding to such inquiries and the Companies' resources in sending and evaluating such responses. We believe that our administrative procedure, under the current Washington COB rules, is reasonable and justifiable, and, therefore request that you remove the instruction.

Further, the Draft Report characterized Standard 13 as having "passed with comment," which resulted in recommendation in every other instance in the Draft Report; however in this instance it resulted in an instruction. At a minimum, we respectfully request that you revise this finding to a recommendation rather than an instruction.

AGENT ACTIVITY

Standard #1: The Company requires that agents and brokers are licensed for the appropriate line of business with the State of Washington prior to allowing them to solicit business or represent the Company in any way.

Instruction #6: The Companies are instructed to comply with RCW 48.17.060(1) and (2) and ensure that all agents and brokers are licensed in the appropriate line of business before allowing them to solicit business or represent the Companies in any way.

Companies' Response: Standard #1 references RCW 48.17.060(1), 48.17.060(2), and RCW 48.44.011(2). RCW 48.17.060(1) requires a person to be licensed by the commissioner in order to act as an agent, broker, solicitor, or adjuster. 48.17.060(2) provides that "an agent, solicitor, or broker may not solicit or take applications for, procure, or place for other any kind of insurance for which he or she is not then licensed." This statute places no obligation on a health care service contractor. RCW 48.44.011(2) provides that "no person shall act as or hold himself out to be agent of a health care service contractor unless...appointed by the health care service contractor on whose behalf solicitations are to be made." This finding results from the Companies' inability to produce two applications for in-force

AGENT ACTIVITY continued

policies. Given the lack of findings resulting from the other sampled applications, it is likely that the agents on these applications were appropriately licensed and appointed by the Companies. Because RCW 48.44.011(2) does not require retention of applications to evidence such appointments and our inability to produce these applications is already covered by Instruction #1 contained in the General Examination section, we request that Instruction #6 be deleted.

Standard #2: The Company ensures that agents are appointed to represent the Company prior to allowing them to solicit business on behalf of the Company.

Instruction #7: The Companies are instructed to comply with RCW 48.17.160 and ensure that all agents are appointed with the Companies prior to allowing them to solicit business for Companies.

Companies' Response: This instruction resulted from a finding of one application submitted by an agent under an agency appointed by Premera prior to that particular agent's appointment with that agency. WAC 284-17-475 states, "If an individual licensee is affiliated with a business entity licensee, the individual is not required to be directly appointed by the insurer." Therefore, Premera has no appointment obligation in this context. Further, neither that nor any other regulation places an obligation on a health care service contractor to ensure that the agency has fulfilled its obligation under WAC 284-17-473 to notify the OIC of the agents affiliated with the agency. We respectfully disagree that the Companies must ensure that an agency has properly appointed an individual agent for affiliation purposes when an application is submitted on agency paper and are unaware of any other health carriers that currently do so. We believe we properly relied on the agent's submission of the application, under the appointed agency's name, and that it was up to the agency, not Premera, to ensure that agency forms were used by agents only after they became affiliated with the agency.

RATE AND FORM FILING

Recommendation #11: It is recommended that the Companies automate their procedure for issuing policies so as to be able to track the contract number and edition date of contract sent to members and groups.

Companies' Response: The recommendation provided above does not appear to be related to a particular standard against which your office reviewed our market conduct. While we appreciate the comments in this context as intended to be helpful, we believe that it is appropriate to distinguish such comments from a recommendation that is derived from a specific statute and/or regulation, and we respectfully request that you delete this recommendation. Nonetheless, the Companies have instituted the recommended process for tracking contracts.

RATE AND FORM FILING continued

Standards #1: All contract forms have been filed with and approved by the OIC prior to use.

Instruction #8: The Companies are instructed to develop policies and procedures that require the filing of all changes to contracts prior to use and that eliminate any confusion if multiple form numbers are used within a single policy. Reference: RCW 48.44.040 and WAC 284-43-920.

Companies' Response: Both Standard #1 and Instruction #8 reference RCW 48.44.040 and WAC 284-43-920. Neither law requires that our contract forms need to be approved. In fact, the majority of our form filings are file-and-use, and are not subject to OIC approval, but only to disapproval. The only exceptions are certain provider agreement filings under RCW 48.44.070 and Medicare Supplement products under RCW 48.66.035. Therefore, the repeated references in this section to the lack of OIC approval should be deleted.

The receipt of the Draft Report was the first instance that the Companies learned about the finding that "[N]ine groups were issued contracts that were not filed." We believe this statement is overly broad as Appendix 4 clarifies the each of these group contracts were in fact filed but that each filing contained the same three inconsistencies when comparing the filed contracts with the contracts issued to the groups. The Companies previously discovered these unintentional inconsistencies when we prepared subsequent filings for these same groups in January 2006, corrected the language discrepancies, and installed a robust testing process for our contract production system to check for, and forestall, discrepancies between the filed document and the one issued. We request that you modify the finding in the Draft Report to "Nine (9) groups were issued contracts that did not exactly match the filed contracts." Finally, although neither RCW 48.44.040 nor WAC 284-43-920 prohibits the use of multiple form numbers within a single policy, we have discontinued such use as it caused confusion for the examiners. We request that both of these corrective actions be added as Subsequent Events to the Draft Report.

Standard #2: All rates have been filed with the OIC prior to use.

Instruction #9: The Companies are instructed to comply with RCW 48.44.040 and WAC 284-43-920 and file all rates with the OIC prior to use.

Companies' Response: This instruction results from our inability to produce copies of the filings of renewal contracts and rates for two large groups identified in Appendix 4. As these renewal contracts and rates would have been filed together as required by OIC protocol, we respectfully request that you combine Instructions #8 and #9, as listing them separately creates the appearance of more instances in which filings could not be substantiated than actually occurred.

UNDERWRITING

No Comments.

EXHIBIT A

PROVIDER ACTIVITY

Standard #4: All provider contract forms must be filed with and approved by the OIC prior to use.

Instruction #13: The Companies are required to comply with RCW 48.44.070 and WAC 284.43.330 and file all provider contracts prior to use.

Companies' Response: The Companies' provider contract forms at issue in this finding were, in fact, filed and approved prior to use as required by law. A contract form numbering misunderstanding by the OIC had lead to a categorization of a number of agreements as not having been filed. When we submitted specific addenda to our core provider agreement April 2001(form numbers PF01BSTPRAC (4/01) and PF01BSTFAC (4/01)), the core agreements were also supplied pursuant to OIC request (form numbers PF98PRA5 and PF98FAC4), and without transmittal forms, for ease of reference. These core agreements were subsequently revised based on OIC review comments, and approved on May 20, 2002. At that time, the Companies did not change the core agreement form numbers, and we were unaware that the addenda form numbers were captured in the OIC system as applicable to the core agreements. We continued to use the original core agreement numbers, with new revision dates, for the approved documents. Regardless of who caused the numbering error, the forms themselves were filed and approved as required, and we respectfully request that these contracts be removed from the finding.

In addition, LifeWise did submit provider contract forms. LifeWise submitted to the OIC the Agency Agreement between PremeraFirst, Inc. and LifeWise wherein PremeraFirst, Inc. acts as contracting agent for provider contracting purposes on behalf of LifeWise. The provider agreements at issue were approved on April 26 and June 20, 2001. Until this examination, we believed the OIC understood the nature of the Agency Agreement based on our course of dealing whereby Premera filed all subsequent PremeraFirst provider agreements for Premera and LifeWise. Nonetheless and based on this examination, PremeraFirst agreements for LifeWise are now being submitted separately. Based on the above, we respectfully request that Instruction #13 should be either deleted or revised to a recommendation.

Standard #7: The Company notifies all providers of their responsibilities regarding the Company's administrative policies and programs.

Instruction #14: The Companies are required to comply with WAC 284-43-320(4) and notify their providers of their responsibilities regarding the Companies' administrative policies and programs, such as changes to grievance procedures.

Companies' Response: Although WAC 284-43-320(4) does not require the retention of such notifications to providers, we provided ample evidence of our compliance with the notification requirement by providing examiners copies of a number of provider communications concerning changes to the Companies' administrative policies and programs. The Draft Report only references our inability to produce copies of notifications to 35 providers of changes to our grievance procedures. We respectfully request that this instruction be changed to a recommendation given the limited scope of this finding.

ADMINISTRATIVE CONTRACTS

Recommendation # 13: It is recommended that the Companies create a procedure so that regular audits of their affiliates are conducted.

Companies' Response: This recommendation does not appear to be related to a particular standard against which your office reviewed our market conduct. Again, while we appreciate the comments in this context as intended to be helpful, we believe that it is appropriate to distinguish such comments from a recommendation that is based on a specific statute and/or regulation. We respectfully request that you delete this recommendation. In addition, please note that neither AWHN nor Medco are affiliates of the Companies and that, effective August 18, 2007, AWHN no longer has any involvement with claim activities on behalf of the Companies.

Recommendation #14: It is recommended that the Companies obtain administrative contracts with any and all entities and affiliates to ensure legal and financial protection.

Companies' Response: This recommendation does not appear to be related to a particular standard against which your office reviewed our market conduct. While we appreciate the comments in this context as intended to be helpful, we believe that it is appropriate to distinguish such comments from a recommendation that is based on a specific statute and/or regulation. Additionally, the Draft Report indicates that this recommendation stems solely from LifeWise's relationship with HSA Bank. LifeWise has a marketing relationship with HSA Bank wherein HSA Bank does not perform any administrative tasks on behalf of LifeWise. It was the Companies' impression, based on discussions during the February 20, 2007 exit conference, that the examiners' comments on this subject were going to be dropped from the Draft Report. Further, the Recommendation is drafted very broadly to require administrative contracts with "any and all entities," which we do not believe is required by law. Consequently, we respectfully ask that the recommendation be deleted.

EXHIBIT A

NETWORK ADEQUACY

Standard #1: A health carrier shall maintain each plan network in a manner that is sufficient in numbers and types of providers and facilities to assure that all health plan services to covered persons will be accessible without unreasonable delay.

Recommendation #15: It is recommended that the Companies develop policies and procedures for the continued monitoring of their provider networks in order to ensure that they have the most current provider information available so that it may accurately determine the adequacy of their networks. It is recommended that the procedures include audits of third party vendors so that the provider information received from vendors and used by the Companies is accurate and current.

Companies' Response: Please note, as described above under the General Examination Findings, that we are in the process of our own contracting for those categories of providers for which AWHN was responsible in the past, thus ensuring better control of accuracy and consistency of our provider data.

APPENDICES

Some portions of the Draft Report's appendices contain "protected health information" as defined 45 CFR 164.501, such as claim numbers, subscriber numbers, and appeal numbers. In order to protect the privacy of our members, we respectfully request that such information be redacted prior to making the report public.