MARKET CONDUCT EXAMINATION

of

REGENCE BLUESHIELD
ASURIS NORTHWEST HEALTH

100 SW Market Street, 15th Floor
Portland, OR 97207

January 1, 2010 – June 30, 2011

Order No. 13-0286
Regence BlueShield
Asuris Northwest Health
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 48.37.060 and 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:

Regence BlueShield	NAIC 53902
Asuris Northwest Health	NAIC 47350

In this report, the above entities are collectively referred to as the Company or Companies. In addition, Regence BlueShield is also referred to as "RBS". Asuris Northwest Health is referred to as "ANH".

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. Jeffrey Moser, CIE, CCP, FLMI, CEBS; Carla Bailey, CPCU, CLU, FLMI, CIE, MCM, CCP, AIRC, CICSR; Steve Schelin, SCLA; and Michael Vaughan, AIE, CPCU of the Washington State Office of Insurance Commissioner performed this examination and participated in the preparation of this report. Also participating in this examination was former examiner Ann Frasier.

The examiners wish to express appreciation for the courtesy and cooperation extended by the personnel of Regence BlueShield and Asuris Northwest Health 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.

Jeanette Plitt, AIE, CLU, MCM
Chief Market Conduct Examiner
Office of the Insurance Commissioner
State of Washington

FOREWORD

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

Time Frame

The examination covered the Companies' operations from January 1, 2010 through June 30, 2011. This was the second market conduct examination of Regence BlueShield and Asuris Northwest Health. The prior examination covered the period from July 1, 2001 through December 31, 2002. This examination was performed both in the Companies' office in Seattle 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
Complaints and Appeals
Claims
Rate and Form Filing
Underwriting
Provider Contracting
Network Adequacy

SAMPLING STANDARDS

Methodology

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

95 %	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. At times, alternate tolerance levels are applied. When this occurs, it is noted in the appropriate section.

Random samples were developed utilizing the NAIC approved ACL® sampling program. The sample files were reviewed against the applicable standards for each section of the examination.

REGULATORY STANDARDS

Market conduct samples are tested for compliance with standards established by the OIC. The tests applied to sampled data results 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. If an alternate standard is applied, then the tolerance levels will be stated in that section.

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 examiners' analysis of those procedures or processes. The analysis will include a determination of whether or not the Companies follow 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.

EXECUTIVE SUMMARY

Background

The Office of the Insurance Commissioner (OIC) began monitoring market conduct events for Regence BlueShield and Asuris Northwest Health through the Continuum process in 2010. By July 2011, the increased number of events and the significant impact each event had upon consumers became a concern to regulators.

The OIC called a market conduct examination of Regence BlueShield and Asuris Northwest Health for the period of January 1, 2010 through June 30, 2011. OIC staff became aware of issues concerning RBS and ANH through multiple channels and felt that because of the varied nature of the issues, it was appropriate to call a targeted market conduct examination. The issues causing concern were:

- IT Controls for testing and implementation of system changes.
- Timely notification of issues impacting policyholders/customers.
- Implementation of timely and appropriate corrective actions.
- Adequate complaint documentation, appropriate steps to finalize and close complaints in accordance with state regulations.
- Handling of claim payments. This included processes such as timely/untimely claim payments, claim denials, improper coordination of benefits, accident investigations and quality control reviews.
- Rates and forms filings, timely and appropriate policyholder/customer notification

Examination Approach

Under the authority of Chapter 48.37, RCW, the OIC called a targeted Market Conduct Examination of Regence BlueShield, and Asuris NW Health on July 7, 2011. The examination was focused on the following operational areas:

Company Operations and Management
Complaint Activity
Claims
Provider Contracting
Rate and form filing
Underwriting
Network Adequacy

The NAIC Market Regulation Handbook was used as a guide for determining examination methodology. Interviews were conducted with executive leadership, departmental managers and supervisors, key home office personnel, subject matter experts, and IT representatives.

A targeted, statistical sampling of claims, complaints and appeals, underwriting files for individual, small and large groups, rates and forms, and provider contracts were tested for compliance with Washington state laws and regulations. The Examiners requested and received information from the Companies concerning areas being examined. Company responses were reviewed to determine compliance.

Examination Findings

The Examiners noted deficiencies and issues with the Companies oversight of insurance operations, complaint handling practices, claims handling practices, rate and form filings, and underwriting practices. Other areas examined found no violations of laws or regulations.

Company Operations and Management

Systems:

The examiners had difficulty in accessing appropriate systems. As a result, it was difficult for the examiners to complete auditing some areas due to lack of information available or to the need to wait for additional information to be provided.

- The examiners found that operational areas do not communicate with each other and often maintain separate systems and record keeping processes that are not compatible across the companies. It creates a silo effect within the companies and they are not able to share data or issues with each other. This carried over into use of systems and other procedural areas, and creates artificial barriers to open communication among divisions.
- The Companies had difficulty in providing requested records and files in a timely fashion. In multiple instances responses to communications from the OIC were beyond the requested due dates.
- The operational units store information differently and often on different systems. The Companies systems did not always align making communication across operating units difficult. Delays occurred because data was either inadequate or inaccurate, and had to be requested more than once.
- Use and storage of data within software systems varied by the different operational units and in some cases within operational units, creating inconsistencies in how and where data was stored. Retrieval of specific documentation required multiple searches to capture the varied methods. For example in "Radar", the Companies electronic

document and image storage system, Explanation of Benefits (EOB) could be found in one of 3 locations dependent upon who entered the data.

- The Companies on more than one occasion attempted to provide the Examiners with encrypted information after having been told the OIC cannot receive encrypted information.
- The data bases requested in the initial call letter were typical, standardized examination requests. The Company was given more than three months to provide the initial information, however once on site the Examiners still did not have all the information requested.
- Much of the initial data and information received was either incomplete or inaccurate. The Companies had adequate time to question the initial data content and format.

Complaint Activity

The Companies have a very narrow definition of "complaint", and as a result show that they don't receive many complaints. There are 4 Company established criteria that must be met in order for the call to be considered a complaint.

1. Rude treatment of a member by a Regence employee.
2. Incorrect information given a member by a Regence employee.
3. Failing to advise a member about required additional paperwork needed to complete their transaction.
4. Any other situation that does not result in an appeal or an exception.

As a result of this definition, 0.02% of the calls received during the examination period rose to the level of a complaint. This is problematic because the Companies do not have sufficient information to review complaint trends to use in Management discussions about training needs or other issues.

Claims

Just prior to and during the examination period, the Companies migrated to a new computer system. Because claims were on two systems, it was difficult for the Companies to produce the requested claim samples and other data in a timely and accurate fashion. This resulted in delays and multiple requests for the same data. This item is discussed in more detail in the General Examination Standards section of this report.

The other issue of concern in this section is an observation by the examiners that there continue to be problems with the way that Facets, the new administration system, handles claims. Throughout the examination period and subsequently into 2013, administrative functions under the old system were not carried through to the new system. This caused several payment problems.

The most significant issues concerning claims payments found during the examination were:

- WAC 284-43-321 requires prompt payment of claims. This rule provides that, for each provider under contract, 95% of clean claims must be processed within 30 days for each provider. All claims must be processed within 60 days. A review of individual provider claims for five separate months indicated the Companies are not able to create a single monthly claims report by provider. Provider identifiers on the Legacy systems are not the same as the provider identifiers on the Facets systems. The Companies cannot determine prompt pay standards based on all monthly claims by provider, by carrier. The Companies calculate prompt pay compliance based on performance in each system in each company.

- In addition, the prompt pay minimum standards require a carrier who fails to pay claims within the minimum standards to pay interest on undenied and unpaid clean claims more than sixty days old. If the underlying reports fail to meet prompt pay standards the question of accounting for clean claims beyond 60 days where interest must be paid, is questionable.

- Coordination of Benefits (COB) were not paid properly as the Facets system does not accumulate or use COB Savings without manual intervention. The Companies did initiate a manual process to track COB Savings and to pay claims using COB savings. The Companies are reviewing claims since 2009 that are eligible for savings and making payments accordingly.

Provider Contracting

The examiners reviewed provider contracting procedures, the provider manual and a sample of provider contracts to ensure that the Companies are using the correct, filed forms. There were no violations in this area.

Rate and Form Filing

The Companies failed to file two rate changes. In two instances, the Companies didn't file rates that had been in effect for 18 months, as required by WAC 284-43-920(1)(b). In this instance, two small group contracts which were never modified were not refiled as required by this rule.

The Companies failed to file Spanish language forms with the OIC and certify their translation.

Underwriting

The Companies passed all but one of the underwriting standards reviewed. The Companies failed to 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.

COMPANY OPERATIONS AND MANAGEMENT

History of the Companies

RBS is a taxable nonprofit corporation organized pursuant to Chapter 24.03 RCW and is registered as a Health Care Service Contractor pursuant to Chapter 48.44 RCW. RBS was originally incorporated as King County Medical Service Corporation (KCMSC) in 1933. KCMSC was issued a Certificate of Registration by the OIC on September 5, 1947. On November 23, 1970, KCMSC changed its name to King County Medical Blue Shield (KCMBS). Between 1983 and 1995, KCMBS merged with seven other medical bureaus:

- Lewis County Medical Services
- Pierce County Medical Bureau
- Cowlitz Medical Service
- Thurston County Medical Bureau
- Snohomish County Physicians Corporation
- Grays Harbor Medical Bureau
- Clallam County Physicians Service, Inc.

KCMBS changed its name on April 1, 1997 to Regence Washington Health and on April 16, 1998 to Regence BlueShield (RBS). On January 1, 2000, RBS merged with Northwest Washington Medical Bureau. The surviving entity was RBS.

Separately, RBS, RBS-OR and RBS-ID agreed to unite under the common control of The Regence Group in the Plan and Agreement of Affiliation signed in 1995. In 1997, another Plan and Agreement of Affiliation was executed to add RBS-UT to the affiliation. RBS, RBS-OR, RBS-ID and RBS-UT are referred to collectively as "plan parents."

The Regence Group (TRG)

TRG is an Oregon nonprofit public benefit corporation. TRG is the sole voting member of RBS, RBS-OR, and RBS-UT. As the sole voting member, TRG has authority to approve elections to the governing Board of Directors (BOD) of these three affiliates, and to discharge members of the governing BOD at any time, with or without cause. In addition, TRG manages RBS-ID under the terms of the Management and Administrative Service Agreement dated May 25, 1995.

Subsequent Event: On November 7, 2011 TRG changed its name to Cambia Health Solutions, Inc. Regence BlueShield, Regence BlueCross BlueShield of Oregon, Regence BlueShield of Idaho, and Regence BlueCross BlueShield of Utah are the four independent licensees of the Blue Cross and Blue Shield Association under the parent and holding company. Asuris

Northwest Health is also a health insurance company under the holding company Cambia Health Solutions, Inc.

Asuris Northwest Health (ANH)

ANH was originally incorporated in Washington as Walla Walla Valley Medical Service, a taxable nonprofit corporation in 1933, and was issued a Certificate of Registration as a health care service contractor under RCW 48.44 by the OIC on September 5, 1947. ANH was acquired by RBS in November 1994. The name was changed to Regence Northwest Health in 1997 and to ANH in September 2002. ANH is a Health Care Service Contractor and is a wholly owned subsidiary of Regence BlueShield.

Intercompany Agreements

Each Company is a party to various intercompany agreements with affiliates. As of December 31, 2010, the Companies had several intercompany agreements in force.

Regence Administrative Services Agreement
On December 28, 2007, TRG entered into the Regence Administrative Services Agreement (ASA) with RBS-OR, RBS-UT, and RBS. The agreement includes RBS subsidiaries, ANH, Commencement Bay Life Insurance Company, and Regence Life and Health Insurance Company. The ASA was filed with the OIC on January 11, 2008, and resubmitted to the OIC on February 28, 2008 to include a provision addressing settlement timing in compliance with Statement of Statutory Accounting Practice (SSAP) No. 25(6)

Plan and Agreement of Affiliation
The Plan and Agreement of Affiliation was entered into in May 1995. Under this agreement, RBS, RBS-OR, and RBS-ID agreed to unite under common control of TRG. In July 1997, another Plan and Agreement of Affiliation was executed to add RBS-UT to the affiliation.

TRG & Subsidiaries Consolidated Federal Income Tax Agreement
This agreement is between TRG and its affiliates and subsidiaries (including both RBS and ANH). The agreement became effective for the tax year ended December 31, 1997. The agreement sets forth the arrangement to allocate consolidated tax liability among the parties.

"Regence" Service Mark and Trade Name License Agreement
The "Regence" Service Mark and Trade Name License Agreement, between TRG and RBS, was effective October 1, 1999. Under the agreement, TRG charges RBS a fee for use of the name "Regence."

Subsequent Event: The Regence Service Mark and Trade Name License Agreement terminated effective December 31, 2011.

Management and Administrative Agreement

The Management and Administrative Services Agreement was entered into on May 25, 1995 between RBS-ID and TRG and was amended in 1998, 2001 and last amended on July 28, 2011. It allows TRG to manage RBS-ID for an initial term totaling 20 years, and allows for the allocation of TRG costs to RBS-ID for those services performed by TRG on its behalf. RBS signed the agreement for the purpose of guaranteeing payment of damages in case of breach of contract. Otherwise RBS is not part of this agreement.

Ownership

The Articles of Incorporation under each Company state that the corporations shall not have or issue shares of capital stock. There is a single member of the Corporation, which is TRG, an Oregon nonprofit corporation (the "Sole Member"). The Sole Member has all rights, powers and privileges to manage RBS.

Regence BlueShield (RBS)

A Board of Directors governs Regence BlueShield. Directors are elected at the first meeting of the year or upon vacancy by the full Board, subject to final approval by The Regence Group (TRG). The directors serve staggered 3-year terms. The RBS Board meets on a quarterly basis to discuss issues and to conduct oversight of operations of RBS. Minutes from all meetings are maintained in the corporate and legal departments in the Portland, Oregon offices of TRG.

The Company's By-Laws require no less than five and no more than seven Board Members. The Company's By-Laws also require more Outside Directors than Inside Directors and the only permitted Inside Directors are CEO of the Sole Member and the President of the Corporation. The Company had seven Board Members throughout the examination period, five of whom were Outside Members. As of June 30, 2011, the members of the Board of Directors for Regence BlueShield were:

Board Member	Affiliation	Original Appointment Date	Term Expiration Date
Mark C. Adams, M.D.	Franciscan Health Systems	06/02/2009	06/02/12
Mark B. Ganz	Cambia Health Solutions, Inc. (formerly TRG)	09/19/2004	Perpetual Term
M. Jonathan Hensley	Regence BlueShield	08/08/2008	Perpetual Term
Mark L. Hogans	M.L. Hogans, LLC	Re-Appointed	06/28/2014

Board Member	Affiliation	Original Appointment Date	Term Expiration Date
	Consulting Services and Puget Sound BOLD Initiative	06/28/2011 Previous Appointment June 2008	
Michael G. Koppel	Nordstrom, Inc.	Re-Appointed 06/29/2010 Previous Appointment June 2009	06/29/2013
Katherine G. Lindemann	Savers, Inc.	Re-Appointed 06/28/2011 Previous Appointment June 2009	06/28/2014
Jack G. Strother	Graham & Dunn	Re-Appointed 06/28/2011 Previous Appointment June 2010	06/28/2012

Asuris Northwest Health (ANH)

The Asuris Northwest Health Board of Directors is elected by RBS, as the sole shareholder of Asuris Northwest Health, at the ANH Annual Shareholder's Meeting. The directors serve staggered 3-year terms. The members of the current Board of Directors for Asuris Northwest Health are:

Board Member	Affiliation	Original Appointment Date	Term Expiration Date
Mark C. Adams, M.D.	Franciscan Health Systems	06/02/2009	06/02/12
Mark B. Ganz	Cambia Health Solutions, Inc. (formerly TRG)	09/19/2004	Perpetual Term
M. Jonathan Hensley	Regence BlueShield	08/08/2008	Perpetual Term
Mark L. Hogans	M.L. Hogans, LLC Consulting Services and Puget Sound BOLD Initiative	Re-Appointed 06/28/2011 Previous Appointment June 2008	06/28/2014

Michael G. Koppel	Nordstrom, Inc.	Re-Appointed 06/29/2010 Previous Appointment June 2009	06/29/2013
Katherine G. Lindemann	Savers, Inc.	Re-Appointed 06/28/2011 Previous Appointment June 2009	06/28/2014
Jack G. Strother	Graham & Dunn	Re-Appointed 06/28/2011 Previous Appointment June 2010	06/28/2012

Corporate Records

The Articles of Incorporation, Bylaws, Certificates of Registration, and minutes of the BOD and Committees were reviewed for the period under examination. All BOD meetings were conducted with a quorum present.

Territory and Plan of Operation

The Companies are registered as health care service contractors in the state of Washington. Their authorized lines of business are: Comprehensive (Hospital and Medical), Medicare Supplement, Dental, Federal Employees Health Benefit Plan, Medicare, and Medicaid. Approximately 75 percent of the business comes from the comprehensive hospital and medical line of business.

RBS, RBS-OR, RBS-UT, and RBS-ID, consolidated many aspects of operations while still maintaining local presences in targeted markets. Overall, TRG operates 29 multi-function facilities, sales or subsidiary offices throughout the states of Washington, Oregon, Utah, and Idaho. A large number of employees of RBS and ANH telecommute from home. The Companies also utilize the services of Third Party vendors outside of the United States.

During the examination period, RBS operated in 22 counties in Washington State: Clallam, Columbia, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Klickitat, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Skamania, Snohomish, Thurston, Wahkiakum, Walla Walla, Whatcom, and Yakima. Providers are also available to plan members in contiguous counties: Benton, Garfield, Grant, and Kittitas.

During the examination period, ANH operated in Adams, Asotin, Benton, Chelan, Douglas, Garfield, Grant, Ferry, Franklin, Lincoln, Kittitas, Okanogan, Pend, Oreille, Spokane, Stevens, and Whitman counties.

The examiners noted that while Asuris is licensed to do business in all Washington counties, it only actively markets and sells policies in the counties listed above. Asuris began marketing individual insurance in Asotin and Garfield counties August 1, 2010 (when Regence BlueShield of Idaho discontinued in those counties).

The examiners did not find any evidence that the Companies are operating outside of the stated territory of operation.

Internal Audit

The examiners conducted a review of the audits completed by The Regence Group's Internal Audit (IA) Department during the examination period. The IA auditing activities focused on the adequacy of internal controls to mitigate the identified risk through very specific objectives and scope. The audits were not specific to Washington statutes or regulations.

The Regence Group provided a list of the 19 IA Reports issued during the Exam period. From this list, the examiners requested 17 reports which were delivered to the examiners in a timely fashion.

The examiners reviewed the IA Audits for impacts on sections under review in this exam. In general, the examiners found that the review indicated:

- TRG classifies the findings by assigning one of three labels:
    - Red - Ineffective Controls with significant improvements required,
    - Yellow - Control Environment with average improvements required and
    - Green- Effective control environment with minor improvements required.
- Of the 17 IA Reports reviewed, 3 were classified as Red (18%), 12 classified as Yellow (71%) and 2 classified as Green (12%).

The examiners met with IA Department Management to gather an overview of the IA structure, process and its impact on other departments in the organization. Generally:

- Project Prioritization: IA Projects come from a variety of sources including an annual survey and interview process of Director Level and above staff. Also, known deficiencies and "re-audits" are factored into the department's plan. As technology is so important the annual Top 10 "Hot Topics" are also an input into the Project identification and prioritization process. Approximately 20% of the IA department's

hours are not assigned to specific projects so as to accommodate ad hoc or special requests that inevitably materialize. (Enterprise Risk Assessment)

- IA follow-up on Management Action Plans (MAPs): The IA unit works with appropriate Management to validate findings develop a plan to address identified deficiencies, and follow-up quarterly to verify the plan has been executed. The status of the activities is reported to the Audit Compliance Committee on a regular basis.
- Process Risk determination: Ultimately the conclusion is subjective, but the department has guidelines to drive consistent assignment of risk over all the projects. Factors considered include: frequency, severity, financial impact, compliance issues, and overall significance of the identified control deficiency in the process or activity.

The examiners reviewed 5 Internal Audit Reports related to the IA function. IA created and maintained spreadsheets that clearly define Action Plans, Responsibilities, timelines and task completion dates for the projects reviewed. The Internal Audit department reviews relevant and important activities and functions, deficiencies are corrected and re-audits are performed as necessary. The IA processes, activities and output appear robust.

Information Technology

The examiners conducted a review of the Companies' Information Technology department. The IT Review was general in nature addressing the structure, role or requirements of the Companies' IT processes or infrastructure for The Regence Group as a whole.

The Companies initially provided a series of systems diagrams. The diagrams included a broad overview for context as well as more focused illustrations that provide targeted details in support of specific business units, the lines of business as well as the interfaces between the systems.

The examiners met with the Companies' IT representative to gather an overview of the department as well as to address specific processes and methodologies used in systems changes and upgrades.

- The conversion to the Facets processing program started with Idaho and Utah in 2000. The Companies reported that the Idaho conversion was a success but some problems were encountered with the Utah conversion. The Companies indicated that they resolved those problems and began converting all states and all products to the Facets CPSS (Common Process Single System) platform. However, in checking with the Departments of Insurance for Idaho and Utah, issues were noted in both states. The result was to pull Facets in both states until 2010 when the system was implemented for all companies.

- The Legacy Mainframe support is provided by an outside vendor, Computer Associates. The Companies have extensive processes in place to manage the vendor's performance to the Service Level Agreements (SLAs), including weekly and monthly reports as well as semi-annual "true-up" meetings.

- The Companies have a formal process for Configuration Management and Change Control, following ITIL (Information Technology Infrastructure Library), a framework of Best Practice guidance.

- The Companies state their IT Department uses "Agile" Project Management methodology. "Agile" methodology is an alternative to traditional IT project management that helps teams respond to unpredictability through incremental, iterative work cadences.

- The Business units affected by a system change are key players in testing the change. Formal testing plans are incorporated into all system changes. Integration management is important as the Companies usually buy software products and then integrate into existing systems instead of writing code from scratch.

- Facets is a vendor product provided by Trizetto.

- The test approach taken by the Companies is documented in a Master Testing Approach document specific to Facets upgrades. Several approaches are taken to testing.

    - Unit testing
    - Assembly testing
    - Integration testing
    - User Acceptance testing
    - Performance testing and,
    - End to end testing (The end to end testing plan includes a team represented by each business unit, which ensures no units are overlooked).
    - If any portion of the testing fails the upgrade is not implemented and Trizetto is notified.

In an effort to review how the IT department functions and its impact on the organization, the examiners requested the following: organization charts, project log for items implemented in the Exam period, including hardware, TRG created software and Vendor created software, procedure documentation related to testing and software implementation, Management Action Plans for Internal Audit reports, and Vendor Management documentation for the IBM Legacy system.

The Companies provided complete responses regarding systems to all examiner requests. The IT Department provided confirmation that written processes and procedures are in place

concerning the acquisition, testing and implementation of hardware and software upgrades. Of concern to the Examiners however is the testing approaches outlined in the Master Testing Approach do not appear to include all business units, or cross operational lines. Communication and coordination between operating units is not apparent, however necessary in achieving corporate strategic objectives.

By way of example, in March of 2011 the Companies decided to move all Medigap policies from one system to another. At the same time the Companies elected to synchronize all anniversary dates. Changes were made to the monthly draft payment options, reducing the option to a single draft date in an effort to reduce administrative costs. Policies on multiple month billing modes were billed for the balance of their modal premium to coincide with the revised anniversary date. In some situations this resulted in the collection of more than 12 months premium in a policy year. Lastly adequate notification of the changes was not communicated to the consumer as required by Washington law.

The decision of the Companies to move policies from one system to another is not the issue. At issue is how each change impacted the policyholders. Effective communication and coordination between the operating units and IT prior to the change would have lessened the impact to policyholders, and increased the Companies' ability to achieve an integrated solution. In this example considerable time, personnel, and expense was incurred by the Company in reviewing the policies involved in the conversion, rectifying billings issues, and explaining the Companies' actions to consumers. The lack of communication between divisions negatively impacts the work process and compromises the Companies' ability to offer effective solutions.

Findings

The Companies Passed Without Comment all four Company Operations and Management Standards. (See page 53 for a list of these standards.)

GENERAL EXAMINATION STANDARDS

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

Obstacles encountered during the Market Conduct Examination

The examiners encountered obstacles in obtaining access to various systems used by the Companies, as well as obstacles in obtaining data to conduct the Market Conduct Examination.

This was primarily evident in areas of Complaints, Claims, Underwriting, and Policy Administration. The original call letter sent to the Companies included the information that was to be ready for examiner review when the on-site work began. This information was not ready when the examiners required it. Delays occurred because the data was often inadequate or the Companies were unable to produce accurate and complete data.

In addition, the examiners found that each operational area has a unique protocol for storing data and documents. Because of this, it was not possible to get uniform data across the company. For any data that crossed operational areas, such as complaints, the company would have to access the information in each area and then try to find a way to consolidate the data into a single report. This was frustrating for both the company personnel and for the examiners as it resulted in multiple requests for data and time delays in providing the data. It also impairs the Companies from gathering, monitoring and evaluating data on performance.

Findings

The Companies Passed Without Comment General Examination Standards 1, 3 and 5.

The Companies Failed 3 of the 6 of the General Examination Standards:

#	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) RCW 48.37.070**
4	**The Company maintains full and adequate accounts and records of its assets, obligations, transactions and affairs.**	**RCW 48.05.280**
6	**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, WAC 284-37-030(2)**

See APPENDIX 1

General Examination Standard 2:

- The Companies repeatedly sent communication to the OIC examiners via a secured, encrypted email service. The examiners advised the Companies on each occasion that the examiners could not accept encrypted email. Repeatedly asking the Companies' to resubmit the communication/data via other methods delayed the process for as long as 10 days. This was critical because often the Companies would wait until the due date to send materials to the examiners and this would further delay the receipt of those materials.
- There were several situations where the examiners did not have access to the appropriate systems.
    - At the onset of the exam, the Companies were advised of the operational areas that the examiners would be auditing. Delays occurred because either no system access to appropriate systems was available to examiners at the start of an audit section or because incomplete system access had been given to them. For example, the examiners asked for access to all appropriate systems in the original call letter. Two of those systems were Legacy and Facets. The call letter was dated 7/15/2011 with a due date of 10/15/2011. On 12/20/2011, the examiners followed up with the Companies because they did not yet have access. The examiners were provided access to these systems on 4/9/2012.
    - During the examination, the exam team found that one of their members was having trouble accessing certain information. The Companies researched the problem and it was discovered that the examiner had been given remote access while the rest of the team had internal access.
    - It appeared to the exam team that the exam contact was not aware of the entire scope of system access that was needed in any area until the subject matter experts (SME) became involved in the process. Usually this was during training. This delayed the examination process while the SME, exam contact and IT staff figured out what systems were needed and what access could or could not be given to the examiners. In some cases, the Companies found that they were not able grant access to the examiners at all in certain systems. Materials either needed to be downloaded to thumb drives for access by examiners or even converted to printed form. This further delayed the examination process.

General Examination Standard 4: The Company maintains full and adequate accounts and records of its assets, obligations, transactions and affairs:

- The conversion to the Facets processing program started with Idaho and Utah in 2000. The Companies reported that the Idaho conversion was a success but some problems were encountered with the Utah conversion. The Companies indicated that they resolved those problems and began converting all states and all products to the Facets CPSS (Common Process Single System) platform. However, in checking with Idaho

and Utah, there were problems in both states and as a result of those issues, Facets was pulled in both states until 2010 when the system was implemented for all companies.

- The Companies' complaints process is not comprehensive as it limits the definition of a complaint. In addition, the examiners were advised that the Companies' Customer Service Departments for RBS and ANH do not log a call as a complaint unless/until a member actually advises that he/she would like to submit a complaint. During the exam period 865,388 calls were logged with only 177 logged as complaints.
- The examiners could not reconstruct all the facts on three complete complaint files: OICC62; CC89; and CC102.
- The Companies indicated that groups of 50+ (large groups) require a peer underwriting review on every group whether it is a standard large group or a negotiated large group. The Peer and/or Management review serves as a "control" on each underwriting file to ensure compliance with the companies' underwriting policies. The examiners requested peer reviews done by the Company for 10 large group policies. The companies could not produce 6 of the 10 peer reviews requested.
- The Companies acknowledge an inability since 2009, of their systems to accurately pay or track coordination of benefit savings when the Companies are secondary payers.
- The Companies now have acknowledged that issues exist with the Legacy system as well and are working on resolution of the issue within the systems. The solution is not anticipated until the end of 2013. In the meantime a quarterly summary report is run and a review of all COB claims is preformed.
- The Companies acknowledged provider prompt pay minimum standards are not tracked in accordance with WA regulations.

General Examination Standard 6:

In general, the Companies responded by either the original due date or a due date that had been extended by the examiners. However, there were instances where the Companies exceeded the due date.

There were frequent cases where the information given to the examiners in response to an information request was incomplete or inaccurate. The result of this was delay of the examination process because the examiners had to review the materials, decide if the material was accurate and complete, and then file another information request for the missing information. This would start the cycle over again, delaying the examination process for a minimum of 15 business days. The Companies asked for extensions on numerous information requests.

See charts below.

Examples of this are:

Claims

Four (4) Information Request responses (a total of 200 files) were provided in minimized screen size despite repeated requests to provide full size screens, as was done with the samples. Even examiners with generally good eyesight had to use magnifiers to work on the files, creating unnecessary delays.

In many cases, the day after requests were made the examiners received a request for a due date extension. In other cases the examiners were simply being told a day or two before the deadline that the materials would be late. Several responses were not received by the date due, others were received timely but were incomplete, as noted below:

Information Request Number	Original Due Date	Follow-up Requests	Date Received
IR 014CB	2/22/2012	2	3/6/2012
IR 047CB	7/31/2012	1	8/11/2012
IR 050CB	8/8/2012	1	8/11/2012
IR 058CB	9/13/2012	2	10/23/2012
IR 060CB	11/5/2012	0	11/7/2012
IR 065CB	12/3/2012	0	12/10/2012
IR 068CB	1/17/2013	0	1/21/2013
IR 073CB	3/22/2013	0	04/04/2013

The computer Claims training materials we were provided were not specific to the exam period as requested, and contained revisions made after June 30, 2011.

Group Underwriting Process and Procedure Manuals

The initial call letter requested a copy of the Group Underwriting Process and Procedure manuals in use during the examination period. The Companies' response to this request was due on October 15, 2011. A complete manual was not included with that response. The examiners made multiple attempts throughout the examination to obtain a copy of this manual for review and it was provided over one year beyond the original due date on 10/31/2012.

Underwriting Databases

The Companies provided a listing of Individual, Group, and Medicare Supplement policies as part of the initial MCE data call. The requested policy lists had the following characteristics:

- Active policies as of June 30, 2011
- Declined applications during the Exam period
- Quotes produced during the Exam period

- Terminations and lapses that occurred during the Exam period

The initial Individual and Group response from the Companies lacked the necessary data elements to proceed with meaningful sampling. As such the examiners worked with and requested from the Companies revised databases suitable for sampling. Information requests included written correspondence, emails, and documented verbal requests. Final databases were provided by the Companies as follows:

Line of Business	Original Due Date	Follow up requests	Complete Date
Individual – Active	October 15, 2011	3	March 29, 2012
Individual – Declined	October 15, 2011	3	March 29, 2012
Individual – Quotes	October 15, 2011	1	March 23, 2012*
Individual – Term/Lapse	October 15, 2011	2	June 15, 2012
Medicare Supplement – Active	October 15, 2011	3	March 29, 2012
Medicare Supplement – Declined	October 15, 2011	3	March 29, 2012
Medicare Supplement – Quotes	October 15, 2011	1	March 23, 2012*
Medicare Supplement – Term/Lapse	October 15, 2011	2	June 15, 2012
Group – Active	October 15, 2011	2	April 6, 2012
Group – Declined Quotes	October 15, 2011	1	April 6, 2012
Group – Quotes	October 15, 2011	0	October 17, 2011
Group – Term/Lapse	October 15, 2011	2	June 15, 2012
Group Dental – Active	October 15, 2011	2	April 6, 2012
Group Dental – Declined	October 15, 2011	1	April 6, 2012
Group Dental – Quotes	October 15, 2011	0	October 17, 2011
Group Dental – Term/Lapse	October 15, 2011	2	June 15, 2012

*** The date the Companies confirmed that quote information is not stored and therefore a quote database was not available.**

COMPLAINTS AND APPEALS

The examiners conducted a review of the Companies' Complaints and Appeals practices. The examiners reviewed complaints and appeals for compliance with Title 48 RCW and Title 284 WAC.

The examiners reviewed the Companies' complaint procedures, a listing of all complaints received during the examination period and copies of internal complaint audits performed during the examination period.

The Companies' complaint and appeal handling procedures were reviewed and the examiners noted that procedures exist for both complaints and appeals. These Policies and Procedures vary by department. The examiners noted that while the Companies' definition of an appeal is sufficient, the definition of a complaint is not. The definition of a complaint limits a complaint to four criteria (Please see Findings below for additional details).

Complaints and Appeals File review

Processes and procedures were reviewed as part of the complaint exam process. As with other sections in this examination, the Companies had difficulty in providing the information requested by the exam team. Part of this was because the records and procedures concerning complaint handling are not centralized but are spread throughout the Companies' departments. The procedures are not always consistent among those departments. The other part of the problem is that the subject matter experts (SME) assigned to work with the examiners often did not have complete information needed to respond to the examiners' requests. This delayed the examination process because incomplete information was relayed to the exam team necessitating additional time and other people's involvement to complete requests.

A total of 238 complaints and appeals out of 1,920 were reviewed by the examiners. The examiners looked at response time, thoroughness of investigations and responses, and communication to the complainant. The Companies only keep trending information on appeal cases, so the examiners reviewed the trending reports on the appeals. The sample files included:

- 84 OIC Complaints, out of a total population of 433 OIC Complaints. Both the Companies' records and OIC records show 433 OIC Complaints during the examination period.
- 50 Complaints filed directly with the Companies from consumers, out of a total population of 177, per the Companies' records.

- 104 Appeals recorded by the Companies, out of a total of 1,310 as recorded in the Companies' records.

Findings:

The Companies Passed Without Comment Complaint and Appeal Standards 1 and 3.

The Companies Passed 3 Standards with Comment. **See APPENDIX 2**

#	Complaint Standards	Reference
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, WAC 284-30-340**
5	**The Company must adopt and implement a comprehensive process for the resolution of covered persons' grievances and appeals of adverse determinations.**	**WAC 284-43-620**
6	**The Company complies with procedures for health care service review decisions.**	**WAC 284-43-620, RCW 48.43.530(5)(a), RCW 48.43.530(5)(c), RCW 48.43.530(5)(g)**

During the examination process the following issues were identified:

- Two percent (2%) of the 84 OIC random sample complaint files reviewed did not meet the standard of WAC 284-30-650; response time to communications from the OIC must be within 15 business days of receipt of correspondence.
- Four percent (4%) of the 50 random sample Company complaint files did not meet the standard of WAC 284-30-650; response must contain the substantial information requested by the OIC.
- Four percent (4%) of the 50 random sample Company complaint files reviewed did not meet the standard of WAC 284-43-620; implementing procedures for registering and responding to oral and written grievances in a timely and thorough manner including notification of the covered person that a grievance or appeal has been received.
- Four percent (4%) of the 104 random sample Company appeal files reviewed did not meet the standards of RCW 48.43.530 and WAC 284-43-520; comprehensive grievance and appeal process, reconsider adverse determinations and notify covered person if its decision within fourteen days of receipt of the appeal unless the carrier notifies the covered person that an extension is necessary.

The review results were found within tolerance level, however the issues identified impact covered persons and the overall process for the resolution of grievances and appeals.

The Companies Failed 1 of 5 Complaint and Appeal Standards:

#	Complaint Standards	Reference
2	**The Company maintains fully operational, comprehensive grievance and appeals of adverse determinations processes.**	**RCW 48.43.530, WAC 284-43-615**

- Overall noncompliance with RCW 48.43.530(1) and WAC 284-43-615(1): Each carrier and health plan must have fully operational, comprehensive grievance and appeal processes, and for plans that are not grandfathered, fully operational, comprehensive, and effective grievance and review of adverse benefit determination processes. For purposes of this examination, a grievance is defined as a complaint, per the definition in this rule.
- The Companies' complaints process is not comprehensive as it limits the definition of a complaint to the following four criteria:
    - Rude treatment of a member by a Regence employee
    - Incorrect information given a member by a Regence employee
    - Failing to advise a member about required additional paperwork
    - Any other situation that does not result in an appeal or exception
- In addition, the examiners were advised that the Companies' Customer Service Departments for RBS and ANH do not log a call as a complaint unless/until a member actually advises that he/she would like to submit a complaint.
- Overall noncompliance with RCW 48.43.530(2) and WAC 284-43-615(2)(c): The Companies must process an enrollee's dissatisfaction about customer service or quality or availability of care as a complaint. Procedures must be implemented for registering and responding to oral and written complaints in a timely manner.
    - The Companies have a process in place for recording complaints. However, that process is limited in scope and the Companies cannot provide proof that all dissatisfaction was processed as a complaint.

There is a discrepancy between the number of phone calls that customer service received and the expected number of those calls classified as complaints. During the exam period the following was determined:

- 865,388 phone calls received by customer service.
- 177 logged by the Companies as complaints.
    - The number of complaints logged by RBS and ANH do not pass the reasonableness test.
    - A similar sized Health Carrier during a recent examination logged 13,500 complaints over an 18 month period.
- 433 complaints were received by the OIC during the examination period.
    - The Companies created a separate log for OIC complaints.

    - OIC complaints were not logged until they were sent to the Companies.
- The Companies' Provider, Applicant and Member Appeals Annual Report 2011 indicated that Provider Appeals Timeliness from Q3 2010 through Q2 2011 was at or below the 95% acceptable threshold for each quarter.
- While the Companies provided documentation demonstrating trend analysis of appeals, the Companies advised verbally and in writing that trending regarding complaints does not occur. WAC 284-43-615 (2)(j) requires the Companies evaluate trends.

Subsequent Event: Mid 2013 the Companies expanded their customer service complaint log to meet the NAIC definition of a complaint. The Companies will review complaint data on a quarterly basis to identify trends and potential issues. The Companies first aggregate report will be completed at the close of the third quarter 2013.

CLAIMS

The examiners conducted a review of the Companies' Claims handling practices. The examiners reviewed claims for compliance with Title 48 RCW and Title 284 WAC.

During the exam period the Companies were transitioning from their Legacy claim processing system to a new system, Facets.

Claims Processing

The Companies have 130 employees responsible for Washington claims. Of those, 80 work from home. These "cottage" workers are subject to the same security standards as employees working in the office, and their security access does not allow printing of any documents from the system. Claims examiners may have specialized areas of claim processing. Claims are assigned to examiners with appropriate areas of expertise, but general claims can be assigned to any examiner. In addition to being assigned by area of expertise, examiners also have dollar threshold limits and claims are assigned accordingly. Clean claims are auto-adjudicated up to $5,000 for individual providers and $10,000 for institutional providers. Claims over these thresholds are assigned to claim examiners for processing.

The Companies did not have paper procedure manuals available. Process and procedures are found exclusively online through the Companies' intranet.

During the exam period approximately 13% of claims were received on paper, and entered by a vendor electronically into the claims system. The remaining claims were submitted directly by providers through an electronic submission.

The Companies do not keep or produce 30 day and 60 day claim aging reports. The Companies do keep this information by provider however separate reports by carrier are run based upon the system in which the claims were paid. For the purpose of calculating prompt pay standards a single monthly report by provider for a carrier is required. The Companies failed to comply with the WA state prompt pay minimum standards under WAC 284-43-321.

Claim File Review

The Companies were requested to provide the following sample claims:

- 130 Individual Paid Claims
- 120 Group Paid Claims
- 50 Medicare Supplement Paid Claims
- 50 Dental Paid Claims
- 100 Denied Claims

These claims were from both Regence BlueShield and Asuris, and from both processing systems, Legacy and Facets.

Coordination of Benefits (COB)

In July of 2011, the Companies legal department advised the OIC of a problem with processing COB claims on the Facets system. The system failed to track COB savings accumulations when the Companies were secondary payors.

The Companies stated that the problem occurred in 2009 and impacted all companies with business on Facets. The first lines to be administered on Facets in 2009 were new and renewing small groups. In 2010, all lines in all companies moved to Facets. They did not detect the problem with COB savings accumulations and payouts until July 2011.

In July 2011 the Companies reviewed all COB claims, from 2009 through July 2011. The Companies provided the OIC with the following information concerning this issue:

Year	Report Date	#Members Impacted	$ Total Savings	Maximum Savings	Minimum Savings
2009	07/02/2011	184	$ 28,998		
2010	09/28/2011	460	$ 79,973	$ 2,965	$ 0.66

They were not able to provide the 2011 data.

To correct these problems, beginning in July 2011 on a go-forward basis the Companies developed a process to identify claims in Facets where the Companies are not primary:

- Claims with a COB flag are pended in Facets and directed to a Claims Analyst for review.
- The Analyst reviews the COB claim and manually enters the appropriate COB information for the claim.
- Facets calculate the claim based on the primary payment information and processes the claim through the payment batch cycle.
- At the same time Facets calculates savings and identifies the savings amount in the COB adjustment field of the claim.
- The COB adjustment field acts only as a COB indicator. Savings accrued per claim are not paid as part of the initial payment process.

- The Companies Facets system is not currently programmed to pay COB savings in the adjustment field, or track savings accumulations from prior claims.

Effective October, 2011 to activate COB savings adjustments, at the end of each quarter the Companies run a report, the Health Informatics (HI) report. The HI report is run against Facets and extracts all COB claims with accumulator field adjustments in the members' history at the claim line level. The report is run quarterly; however it pulls in all applicable claims for the calendar year.

A series of calculations are run against the report comparing savings and eligible out of pocket expenses to determine reimbursable amounts. Previously paid savings are subtracted to determine the final payable amount. The results are captured in a HI report Summary.

The Companies prepare a script from the HI report Summary which they then send to their Facets vendor, Trizetto. Trizetto runs the script through an automated process which creates a "forced on claim" within Facets that is payable to the member for COB savings. Trizetto returns the completed script document to the Companies. The script contains a list of the claim IDs created and their status; pended in Facets or ready for payment.

The question of calendar year reports was raised to the Companies as claims can be submitted up to one year after the date of service. The Companies advised they do generate run-out reports, the calendar year plus 12 months.

During the examination period the Companies indicated no COB claims processed through the Facets system accounted for COB savings accumulations correctly or accurately.
The Companies were asked to provide an accounting of all Facets COB claims during the examination period. The initial data provided did not capture all of the COB codes correctly.

Information requested, by market	Definition	Dental	Medicare (Med Adv)	Group	Ind.	Totals
Claims Processed (paid and denied)	# of Claims paid & denied	150,433	530,619	5,188,385	513,593	6,383,030
COB claims #	# of Claims where RBS/ANH coordinated with primary carrier	2,356	250	210,258	3,501	216,635

Information requested, by market	Definition	Dental	Medicare (Med Adv)	Group	Ind.	Totals
COB Claims Generated Savings #	# of Claims with a savings accumulation	798	N/A	28,868	400	30,066
COB Claims Generated Savings $	$ for claims with a savings accumulation	$137,941	N/A	$9,188,390	$261,041	$9,587,372
Claims with accrued savings applied #	# of Claims generated to reimburse for OOP exp Does "not" include $ for ind claims with OOP exp. reimbursed from savings. (ie, 239 savings reimbursement checks	239	N/A	1,856	51	2,146
Claims with accrued applied savings $	$ reimbursed for OOP exp. Incurred. Does "not" include $ for ind claims with OOP exp. Reimbursed from savings	$12,563	N/A	$226,176	$926,675	$24,800,592
Total Population of Members	# of Washington members	Included in Individual and Group accounts	64,059	600,851	144,185	809,096
Total # COB flags set to "yes" at enrollment	# of Washington members with other coverage that is primary	800	5,471	8,944	708	15,923

During the April 4, 2013 interview with the Companies regarding Facets COB savings issues, the Companies indicated possible COB savings issues existed with the Legacy system. Previously the companies indicated there were no issues with the Legacy COB claims savings.

The Companies were asked to provide an accounting of Legacy COB claims during the examination period, and identify the issues that impacted the COB claims. The Companies provided the following information, but never identified the issues:

Year	Number of Members Impacted	Total To Be Reimbursed
2010	224	$ 15,192.67
2011	165	$ 12,177.85

Findings

The Companies Passed Without Comment Claim Standards 1 through 9 and Claim Standard 13..

The Companies Failed 3 of the 14 Claim Standards.

#	Claims Standard	Reference
10	**A carrier shall pay providers and facilities as soon as practical but subject to the following minimum: 95% of the monthly volume of clean claims shall be paid within thirty days of receipt.**	**WAC 284-43-321(2)(a)(i) WAC 284-43-321(5)**
11	**A carrier shall pay providers and facilities as soon as practical but subject to the following minimum: 95% of the monthly volume of all claims shall be paid or denied within sixty days of receipt, except as agreed to in writing by the parties on a claim-by-claim basis.**	**WAC 284-43-321(2)(a)(ii) WAC 284-43-321(5)**
14	**Coordination of benefits must be processed in compliance with Washington law with respect to apportionment, investigation and timeliness.**	**WAC 284-51-195 WAC 284-51-205(4) WAC 284-51-215 WAC 284-51-220 WAC 284-51-225 WAC 284-51-230WAC 284-51-235 WAC 284-51-240**

Claim Standard 10: A carrier shall pay providers and facilities as soon as practical but subject to the following minimum: 95% of the monthly volume of clean claims shall be paid within thirty days of receipt,

A report run by the Companies for 5 separate months within the examination period confirmed the Companies do not have the ability to run a single montly claims report for a provider for a carrier. The Companies run the monthly claims reports for a provider based upon the system in which the claims were paid by the carrier.

Providers and facilities in Legacy are identified by using a combination of the provider's tax ID and a 4-6 digit provider suffix. Practitioners and facilities in Facets are identified by using a unique 12 digit identifier. The Companies indicated the identifiers for both systems are usually unique to a specific location.

The Companies could not provide the examiners a merged report of all monthly claims for a provider, for a carrier. The Companies failed to comply with the WA state prompt pay minimum standards under WAC 284-43-321.

See APPENDIX 3

A second report provided by the Companies showed in June, 2011 (the last month of the exam period) only 85.17% of clean claims were closed within 30 days. While this rule relates to individual provider results, the combined provider figure shows how serious the overall late payment problem is.

Claim Standard 11: A carrier shall pay providers and facilities as soon as practical but subject to the following minimum: 95% of the monthly volume of all claims shall be paid or denied within sixty days of receipt, except as agreed to in writing by the parties on a claim-by-claim basis.

A report run by the Companies for 5 separate months within the examination period confirmed the Companies do not have the ability to run a single monthly claims report by provider for a carrier. The Companies run the monthly claims reports for a provider based upon the system in which claims were paid by the carrier.

Providers and facilities in Legacy are identified by using a combination of the provider's tax ID and a 4-6 digit provider suffix. Practitioners and facilities in Facets are identified by using a unique 12 digit identifier. The Companies indicated the identifiers for both systems are usually unique to a specific location.

The Companies could not provide the examiners a merged report of all monthly claims for a provider, for a carrier. The Companies failed to comply with the WA state prompt pay minimum standards under WAC 284-43-321.

See APPENDIX 3

Subsequent event: The Legacy system was closed for RBS and ANH on December 31, 2011 for commercial lines and on June 30, 2012 for Medicaid.

Standard # 14: Coordination of benefits must be processed in compliance with Washington law with respect to apportionment, investigation and timeliness.

The companies acknowledged as early as 2010 continuing through the examination period, COB claims failed to track COB savings correctly when the companies were secondary payors.

Subsequent event: The Legacy system was closed for RBS and ANH on December 31, 2011 for commercial lines and on June 30, 2012 for Medicaid.

RATE FILING

The examiners conducted a review of the Companies' Rate Filings. The examiners reviewed rate filings for compliance with Title 48 RCW and Title 284 WAC.

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

From the database provided, the examiners obtained a random sample of rate filings to establish a file request list. Two sample lists were obtained. One list was for individual, small group policies and large groups less than 100 members (Merit groups), and the other for large group negotiated policies. The Individual, Small Group and Merit group sampling included 12 rate filings. The Large Group sample consisted of 104 negotiated policy rate filings. Standards related to rates and rate filings are subject to a zero tolerance for violations. The 5% tolerance does not apply to this section.

Rate Filing Review

The examiners selected rates attached to the new and active contracts used in the Underwriting sample for the rate filing review.

The examiner's review indicated the Companies were compliant with Washington rules and statutes relating to rate filing requirements with only minor exception during the Market Conduct Examination period. Information requests were responded to in a timely manner. The examiners tested the Companies adherence to Washington laws and rules concerning rate filings. In most cases, the examiners found that the Companies were compliant, as shown in the detail findings below.

- A total of 116 rate filings were identified for review for Standards 1 – 3:
  - 12 individual/small group
  - 104 negotiated large group rate filings.

A total of 320 actual rates were reviewed for Standard 4:

- 119 Individual
- 91 Medigap
- 110 Group

Findings

The Companies Passed Without Comment 3 of the 5 Rate Filing Standards.

The Companies Failed 2 of the 5 Rate Filing Standards.

#	Rate Filing Standard	Reference
2	**Carriers must file with the commissioner every contract form and rate schedule and modification of a contract form and rate schedule within thirty days after the end of an eighteen-month period during which a previous filing has remained unchanged for such period, including contract forms filed prior to the effective date of this regulation.**	**WAC 284-43-920(1)(b)**
4	**No registrant shall change any rates, modify any contract or offer a new contract until they have filed a copy of the changed rate schedule, modified contract or new contract with the insurance commissioner.**	**RCW 48.44.040**

See APPENDIX 4, APPENDIX 5

Rate Filing Standard 2:

Two (2) of the filings on the database did not meet the re-file requirement for unchanged rates after 18 months: OIC # NEG 31 and OIC # NEG 69. These are violations of Standard #2 WAC 284-43-920(1)(b).

Rate Filing Standard 4:

The review of Small Group files OIC # 13 & 15 revealed that the vision base rates used by the Companies were not the same as vision base rates filed with the OIC. The Companies confirmed the use of outdated rates (slightly lower than rates filed) during the period from January 1, 2010 through June 30, 2010.

- A total of 1,820 policies were affected by the vision rating errors.
- Total monthly premium volume was $170,496.59.
- The filed amount is 11.13% higher than billed amounts.
- Undercharged amount was approximately $18,976.28 each month
- Total undercharges during the 6 month period noted above was approximately $113,857.60

FORM FILING

The examiners conducted a review of Form Filings. The examiners reviewed form filings for compliance with Title 48 RCW and Title 284 WAC.

The examiners requested a database of form filings in effect during the examination period. The request included forms for all Individual plans, Small and Large Group plans in the State of Washington.

Form Filing Review

The examiners selected forms attached to the 921 new and active contracts used in the Underwriting sample for the rate and form filing review.

A total of 119 form filings were identified for review for standards #1 - 3. The examiners note that 1 filing was a legal notice (although properly filed, it was not applicable to this review), and 1 filing was an advertisement, also filed and not subject to Standards #2 and #3.

The examiners also reviewed policy contracts for standards #4 – #26. Examiners reviewed one sample of each type of contract issued from RBS and Asuris. Contracts selected were from the underwriting databases.

In addition, the examiners reviewed a total of 146 Spanish forms. Of the 146 reviewed 143 required filing to certify translations.

Individual Forms:

The examiners compared filed Individual policy contracts with those issued to members. The examiners found no errors.

Examiners' note: In the exclusions portion of all individual contracts reviewed, there was an exclusion included for Orthognathic Surgery. The exclusion is confusing and contradictory within itself.

The exclusion reads:

> *"Services and supplies for orthognathic surgery. By "orthognathic surgery", we mean surgery to manipulate facial bones, including the jaw, in patients with facial bone abnormalities resulting from an injury, congenital anomaly or abnormal development to restore the proper anatomic and functional relationship to the facial bones. This exclusion does not apply to orthognathic surgery due to injury, sleep apnea or congenital anomaly."*

Medicare Supplement Forms:

The examiners compared filed Medigap policy contracts with those issued to members. The examiners found no errors.

Initially there was a concern that policy language in the Medicare Part J plan (4.2.2), was not the same as RCW requirements. The policy states, *"as of the day after."* WAC 284-64-64(1)(d)(vii) requires *"as of the day of termination."* This difference was discussed with the OIC's Rates and Forms department and it was concluded that the interpretation of both wordings mean the same thing. The intent of the RCW is to prevent a gap in coverage. The wording on the policy differs, but still provides for no gap in coverage.

Group Forms:

The examiners compared filed Group policy contracts with those issued to members. The examiners found no errors.

Examiners' note: The Companies use the following Transplant policy language in both Small Group and Large Group contracts with less than 100 members: *"for a patient who receives a transplant during the course of a longer hospital stay, through 90 days after the transplant are applied to the Member Lifetime maximum."* However, RCW 48.43.680 requires: *"for a patient who receives a transplant during the course of a longer hospital stay, through one hundred days."*

Group Dental Forms:

The examiners compared filed Group Dental policy contracts with those issued to members. The examiners found no errors.

Findings

The Companies Passed Without Comment 25 of the 26 Form Filing Standards.

The Companies Failed 1 of the 26 Form Filing Standards.

#	Form Filing Standard	Reference
3	**All translated forms must be filed with the OIC and certified by the American Translators Association (ATA) or comparable organization.**	**WAC284-44A-120(1)(a), WAC 284-44A-120(2)(b)(i)(ii)**

Filing Standard 3:
During an initial interview with the Companies February 14, 2012, the Companies indicated that no foreign language policy forms were in use. The examiners discovered during a form filing review, evidence that some forms were being translated to Spanish. The examiners reported this to the Companies. This discovery led to the examiners' request from the company, of a list of all forms translated to Spanish. On April 4, 2012, the Companies stated they were researching the Spanish Forms issue. Shortly thereafter the Companies stated they were self disclosing that Spanish forms were not filed. The Company provided 146 documents that had been translated into Spanish by the Companies during the examination period. None of those documents had been filed with the OIC. Of the 146 documents reviewed 143 were required to be filed to certify the translations by ATA or a comparable organization. The list provided to the OIC is available upon request. The company confirmed that no other forms are in use for any other foreign language.

UNDERWRITING

INDIVIDUAL UNDERWRITING

The examiners conducted a review of Individual Underwriting files. The examiners reviewed the files for compliance with Title 48 RCW and Title 284 WAC.

In the initial data request submitted to the Companies with the examination call letter, the examiners asked the Companies to provide the following:

- Active policies as of June 30, 2011
- Declined applications during the Exam period
- Quotes produced during the Exam period

The Companies' initial Response was incomplete. This required the examiners to request additional data in order to select a sample of underwriting files for review. The chart below represents each data request and the time it took the Companies to respond with complete data.

Line of Business	Original Due Date	# follow up requests	Complete Date
Individual – Active	October 15, 2011	3	March 29, 2012
Individual – Declined	October 15, 2011	3	March 29, 2012
Individual – Quotes	October 15, 2011	1	March 23, 2012*

* The date the Companies confirmed that quote information is not stored and therefore a quote database was not available.

Quotes:

No file review was performed by the examiners as the Companies do not save quotes for the Individual and Medicare Supplement markets.

Final Valid Individual Underwriting databases received from the Companies on the following dates:

- Active: 3/29/2012
- Declined applications: 3/29/2012

The examiners had access to most of the Companies' systems and received basic systems training in order to navigate and use the systems to facilitate the file review. The examiners were not granted access to the StepWise Underwriting system due to the Companies' inability to grant "read only" access to the examiners. When requested, the Companies provided relevant supporting documentation from RUS and Stepwise.

Individual Underwriting File Review

Active policies as of June 30, 2011:

- The examiners reviewed 119 active policies.
- The examiners noted no violations of applicable Underwriting Standards.

Declined applications during the Exam period:

- The examiners reviewed 119 Declined Applications.
- The examiners noted no violations of Underwriting Standards # 1.0, 2.0, 4.0, 5.0,6.0, and 7.0 However, the Companies were in violation of Standard 3.0 (RCW 48.43.018(2)(b) - WSHIP notification.

Individual Underwriting Procedures Manual

The Individual Underwriting Process and Procedure documentation is electronic. It is housed on the Companies' intranet sites in the Underwriting Toolbox section. The toolbox contains Underwriting Guidelines, General Updates, Training Guides and Desk procedures.

The examiners reviewed each document in the Underwriting Toolbox. The documents appear to be robust in nature and contain all processes needed to underwrite an application.

Findings

The Companies Passed Without Comment Individual Underwriting Standards 1, 2 and 4 - 7.

The Companies Failed 1 of the 7 Individual Underwriting Standards.

#	Underwriting Standard	Reference
3	**Individual Market: 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)**

See APPENDIX 6

Underwriting Standard #3.0 addresses the Companies' notification requirements and responsibilities when an applicant is declined due to a Standardized Health Questionnaire (SHQ) score of 325 or more.

RCW 48.43.018(2)(b) requires 3 things on an application that is SHQ declined:

- Written notice within 15 days to the applicant.
- Notification to the applicant that coverage might be available through WSHIP.
- Written notice within 15 days to WSHIP.

The examiners verified that the Companies were compliant with points 1 and 2. However, the Companies were not compliant with point 3. Written notice to WSHIP is uploaded monthly at the beginning of the month only. This means that if a declination was processed in the first part of the month, it took longer than 15 days for the notification to reach WSHIP.

Specifically, the examiners identified the following files as noncompliant:

- OIC #17, 23, 31, 34, 41, 44, 75, 88, 89, 90, 94, 98, 101, 112.

Out of the Random Sample of 119 files WSHIP was not notified within the required 15 days on 14 files, or 11.76% of the population.

MEDICARE SUPPLEMENT UNDERWRITING

The examiners conducted a review of Medicare Supplement Underwriting files. The examiners reviewed the files for compliance with Title 48 RCW and Title 284 WAC.

The Medicare Supplement product is filed and approved (with the WA OIC) as an Individual and not a Group product. The Companies, with a limited exception, utilizes the Individual Underwriting infrastructure to process and service the Medicare Supplement line of business.

The Companies' initial Response was incomplete. This required the examiners to request additional data in order to select a sample of underwriting files for review. The chart below represents each data request and the time it took the Companies to respond with complete data.

Line of Business	Original Due Date	# follow up requests	Complete Date
Medicare Supplement – Active	October 15, 2011	3	March 29, 2012
Medicare Supplement – Declined	October 15, 2011	3	March 29, 2012
Medicare Supplement – Quotes	October 15, 2011	1	March 23, 2012*

* The date the Companies confirmed that quote information is not stored and therefore a quote database was not available.

Medicare Supplement Underwriting File Review

Medicare Supplement active policies as of June 30, 2011:

- A total of 119 policies were reviewed in the Medicare Supplement active policy Random Sample.
- The examiners noted no violations of applicable Underwriting Standards.

Declined Medicare Supplement applications during the Exam period:

- A total of 119 samples were obtained. 64 of the 119 quotes were reviewed in the Declined Quotes Random Sample.
- A total of 64 policies were reviewed in the Medicare Supplement Declined application Random Sample.
- The examiners noted no violations of applicable Underwriting Standards.

Findings

The Companies Passed Without Comment all 16 Medicare Supplement Underwriting Standards. (See page 59)

GROUP UNDERWRITING

The examiners conducted a review of Group Underwriting files including Group Dental. The examiners reviewed the files for compliance with Title 48 RCW and Title 284 WAC.

In the initial data request submitted to the Companies with the examination call letter, the examiners asked the Companies to provide the following:

- Active policies as of June 30, 2011 (policies issued and or renewed during the exam period)
- Declined quotes during the Exam period

The Companies initial Response was incomplete. This required the examiners to request additional data in order to select a sample of underwriting files for review. The chart below represents each data request and the time it took the Companies to respond with complete data.

Line of Business	Original Due Date	# follow up requests	Complete Date
Group – Active	October 15, 2011	2	April 6, 2012
Group – Declined Quotes	October 15, 2011	1	April 6, 2012
Group – Quotes	October 15, 2011	0	October 17, 2011
Group Dental – Active	October 15, 2011	2	March 22, 2012
Group Dental – Decline	October 15, 2011	1	March 9, 2012
Group Dental – Quotes	October 15, 2011	0	October 17, 2011

Group Underwriting File Review

Active policies as of June 30, 2011:

A total of 119 policies were reviewed in the active policy sample.

- The examiners noted no violations of applicable Underwriting Standards.

Declined Quotes during the Exam period:

A total of 119 samples were obtained. 65 of the 119 quotes were reviewed in the Declined Quotes Random Sample.

- The examiners noted no violations of applicable Underwriting Standards therefore the review was suspended at 65.

Quotes produced during the Exam period:

A total of 119 quotes were reviewed in the Random Sample.

- The examiners noted no violations of applicable Underwriting Standards.

Group Dental Underwriting File Review

A total of 60 randomly selected policies, were reviewed in the active policy Random Sample. The examiners noted no Violations of applicable Underwriting Standards. Additionally, the examiners reviewed all nine Association Trust accounts written by the Companies during the Exam period. The examiners noted no Violations of applicable Dental Underwriting Standards.

Group Underwriting Procedures Manual

In the Companies' response to the OIC's initial Information Request, the Companies provided a collection of ten "how to" documents. In discussions with the companies, the examiners determined that unless a computer has an edit for a specific issue, there are no formal procedures that are used on a regular basis in either small or large group underwriting.

The Companies did find one manual that was last updated in 2010. However, the manual was not widely used by any underwriting group. The manual was not company specific and appeared to apply to all TRG companies. It should be noted that the examiners requested this manual in July 2011, and it was not provided until October 2012. The examiners note that although the manual exists, the fact that the Companies could not locate it and it had not been updated indicates that the Companies do not use this resource. When the exam team met with the Companies to discuss the issue of manuals, the Companies pointed out that they do have processes and procedures. Some are system driven; some are through peer review and some through management review. However, after repeated requests to view or discuss these processes, the Companies did not provide the required information.

The examiners found that groups of 50+ (large groups) require a peer underwriting review on every group whether it is a standard large group or a negotiated large group. The Companies indicated that there is a Peer and/or Management review as a "control" on each underwriting file to ensure compliance with the companies' underwriting policies. The examiners requested peer reviews on 10 large group cases. The companies provided evidence of a peer review process on only 4 of the 10 cases. (See General Exam findings.)

Findings

The Companies Passed Without Comment all 13 Group Underwriting Standards. (See page 62)

POLICY ADMINISTRATION

The examiners did not perform a total review on the Policy Administration process as it was not part of the original call letter. The examiners' efforts focused on the Membership department's role in the new business end to end process and the handling of terminations and lapses.

Terminated and Lapsed policies (Individual, Medicare Supplement, Group):

The Companies' initial response lacked the necessary data elements to proceed with meaningful sampling. As such, Information Requests produced on February 2, 2012 requested additional information on the Termination and Lapse database.

The examiners were in weekly contact with the Companies concerning the difficulties and delays the Companies were encountering with the request. On March 19, 2012 the Companies delivered the requested database and within 5 minutes the examiners ascertained the data did not pass the reasonableness test and was not credible, prompting the OIC to question all previously submitted Underwriting databases.

On May 29, 2012 the Companies provided the requested information and a review showed the data appeared reasonable and the numbers aligned with other information received. After repeated attempts to utilize the ACL program to run random samples, the examiners approached the Companies' Internal Audit department and requested assistance with the files. On June 15, 2012 ACL Random Samples and supporting documentation were delivered by the Companies.

The Companies advised that the protracted delay (basically April and May) was due to problems with the Legacy portion of the data that is controlled by a Regence vendor located offshore.

The Companies defined "problems" as: Time zone delays, communication problems, repeated narrowing of data "parameters" and obviously flawed data coming to the Companies and detected during the Companies' analysis of the data.

Term/Lapse Database	Original Due Date	# follow up requests	Complete Date
Individual	October 15, 2011	2	June 15, 2012
Medicare Supplement	October 15, 2011	2	June 15, 2012
Group	October 15, 2011	2	June 15, 2012
Group Dental	October 15, 2011	2	June 15, 2012

Membership Department:

The Companies' initial response did not include Membership department specific process and procedure documentation. As the Exam unfolded, the examiners realized the role of the Membership department in the business process flow. The examiners requested and received access to the Membership Information Tool (MIT) located on the Companies' intranet.

The examiners noted a robust tool with an abundance of Procedures, Policies, Job Aids and training materials to drive consistent and compliant processing for both the Individual health and Medicare Supplement markets.

Individual Terminations and lapses that occurred during the Exam period:

- A total of 119 policies were reviewed in the Termination and Lapse random sample.
- The examiners noted no Violations of applicable Underwriting Standards.

Medicare Supplement Terminations & lapses that occurred during the Exam period:

- A total of 119 policies were pulled for the random sample, 64 of the 119 policies were reviewed in the Medicare Supplement Terminations and lapsed policy Random Sample.
- The examiners noted no Violations of applicable Underwriting Standards.

Group: Terminations and Lapses that occurred during the Exam period

- A total of 119 policies were reviewed in the active policy Random Sample.
- The examiners noted no Violations of applicable Underwriting Standards.

Findings

The Companies Passed Without Comment all 21 Policy Administration Standards (3 Individual, 16 Medicare, and 2 Group). (See page 63)

PROVIDER CONTRACTING

The examiners conducted a review of Provider Contracts. The examiners reviewed provider contracts for compliance with Title 48 RCW and Title 284 WAC.

The examiners requested a database of provider agreements in effect during the examination period. The request included all providers in all networks for all categories of providers in the state of Washington.

From the database provided, the OIC obtained a random sample of agreements. The list included 119 providers. The Companies provided all of the provider agreement information requested including agreements, access to Choreo (Online Provider Agreement Contract System), and Provider Administrative Manuals.

File Review

The examiners requested a sample of 119 of the Companies' 1,788 provider agreements and all 6 negotiated agreements listed in the Companies' provider directory. When the examiners received the documents from the Companies, one provider agreement file was an addendum agreement and was excluded from the sample.

From the 124 providers randomly selected for review, the examiners contacted 29 providers to compare their contracting information with that on file with the Companies. 8 responded. All responses matched the Companies' records.

The examiners' review of the 124 provider files did not find any issues.

Findings

The Companies Passed Without Comment all 15 Provider Activity Standards. (See page 67)

NETWORK ADEQUACY

The examiners conducted a review of Network Adequacy. The examiners reviewed network adequacy filings (Form "A" and Form "B") for compliance with Title 48 RCW and Title 284 WAC.

The examiners requested a copy of all network provider directories as part of the initial data call. In a subsequent request, the examiners requested copies of Form "A" and Form "B" filings for each network for the examination period. Geographical Access Reports for RBS & ANH were also requested.

The Companies Network Adequacy Access Plans, Communication Tracking System (CTS) Information, Member Touchpoint Measures Study (MTM), Member Satisfaction Study/Inquiry Satisfaction Survey, and Consumer Assessment of Health Plans Surveys (CAHPS®) were requested for the examination period as well.

File Review

During the examination period, there were no significant changes requiring the Companies to solicit new providers in any specialty. The examiners confirmed the Companies are in compliance with filing of Form A and Form B for each network.

Findings

Networks Reviewed:

- RBS – Preferred, Traditional (Participating), Selections, and Healthy Options
- ANH – Preferred. Participating, and Healthy Options

Examiners' note: Network Adequacy Access Plans are in place. However, the Companies listed CTS data as a source for determining customer satisfaction with providers when CTS data only measures general customer satisfaction with the Companies.

The examiners tested the Companies adherence to Washington laws and rules concerning Network Adequacy filings. The examiners found that the Companies were compliant with the standards listed below.

The Companies Passed Without Comment all 9 Network Adequacy Standards. (See page 67)

INSTRUCTIONS AND RECOMMENDATIONS

#	Instructions	Page #
1	The Companies are instructed to comply with RCW 48.44.145(2) and RCW 48.37.070 and facilitate the examination process by providing their accounts, records, documents and files to the examiners upon request.	21
2	The Companies are instructed to comply with RCW 48.05.280 and maintain full and adequate accounts and records of its assets, obligations, transactions and affairs.	21
3	The Companies are instructed to comply with WAC 284-30-650, and WAC 284-37-030(2) and respond to communications from the OIC within 15 business days of receipt of the correspondence. The response must contain the substantial information requested by the OIC.	21
4	The Companies are instructed to comply with RCW 48.43.530(1) and (2) and WAC 284-43-615 and implement a comprehensive process for the resolution of covered persons' grievances and appeals of adverse determinations. The Companies must process as a complaint an enrollee's expression of dissatisfaction about customer service or the quality or availability of a health service. The companies must implement procedures for registering and responding to oral and written complaints in a timely and thorough manner.	28
5	The Companies are instructed to comply with WAC 284-43-321(2)(a)(i), WAC 284-43-321(5) requiring prompt payments of amounts owed to providers or facilities in accordance with the minimum standard; ninety-five percent of the monthly volume of clean claims shall be paid within thirty days of receipt by the Companies.	34
6	The Companies are instructed to comply with WAC 284-43-321(2)(a)(ii) and WAC 284-43-321(5) requiring prompt payments of amounts owed to providers or facilities in accordance with the minimum standard; ninety-five percent of the monthly volume of all claims shall be paid or denied within sixty days of receipt by the Companies	34
7	The Companies are instructed to process Coordination of Benefits in compliance with Washington law with respect to apportionment, investigation and timeliness. WAC 284-51-195, WAC 284-51-205(4), WAC 284-51-215, WAC 284-51-220, WAC 284-51-225, WAC 284-51-230, WAC 284-51-235,WAC 284-51-240	34
8	The Companies are instructed to file with the Insurance Commissioner every contract form and rate schedule and modification of a contract form and rate schedule within thirty days after the end of an eighteen-month period during which a previous filing has remained unchanged for such period, including contract forms filed prior to the effective date of this regulation. WAC 284-43-920(1)(b)	38

#	Instructions	Page #
9	The Companies are instructed not to change any rates, modify any contract, or offer a new contract until it has filed a copy of the changed rate schedule, modified contract or new contract with the Insurance Commissioner. RCW 48.44.040	38
10	The Companies are instructed that all translated forms must be filed with the OIC and certified by the American Translators Association (ATA) or comparable organization. WAC 284-44A-120(1)(a) and WAC 284-44A-120(2)(b)(i)(ii)	40
11	The Companies are instructed to provide written notice of their decisions 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)	43

#	Recommendation	Page #
1	It is recommended the Companies consider an integrated, cross divisional planning and testing approach when implementing process changes or infrastructure changes to their systems and software.	18

SUMMARY OF STANDARDS

Company Operations and Management:

#	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. RCW 48.44.015(1)	20	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. RCW 48.44.013	20	X	
3	When the Company registers with the OIC, it is required to state its territory of operations. RCW 48.44.040	20	X	
4	The Company shall not advertise or display its certificate of registration for use as an inducement in any solicitation. RCW 48.44.150	20	X	

General Examination:

#	STANDARD	PAGE	PASS	FAIL
1	The Company does business in good faith, and practices honesty and equity in all transactions. RCW 48.01.030	21	X	
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) and RCW 48.37.070	21		X
3	The Company does business in its own legal name. RCW 48.05.190(1)	21	X	
4	The Company maintains full and adequate accounts and records of its assets, obligations, transactions and affairs. RCW 48.05.280	21		X
5	The Company may not discourage members from contacting the OIC and may not discriminate against those members who do contact the OIC. WAC 284-30-572(2)	21	X	
6	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 and WAC 284-37-030(2)	21		X

Complaints and Appeals:

#	STANDARD	PAGE	PASS	FAIL
1	Each Health Carrier must file a copy of its procedures for review and adjudication of complaints initiated by healthcare providers with the OIC. RCW 48.43.055	27	X	
2	The Company maintains fully operational, comprehensive grievance and appeals of adverse determinations processes. RCW 48.43.530 and WAC 284-43-615	28		X
3	An enrollee may seek review by a certified independent review organization of a carrier's decision to deny, modify, reduce, or terminate coverage of or payment for a health care service. RCW 48.43.535	27	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. WAC 284-30-650	27	X	
5	The Company must adopt and implement a comprehensive process for the resolution of covered persons, grievances and appeals of adverse determinations RCW 48.43.530	27	X	
6	A covered person or the covered person's representative may appeal an adverse decision. The carrier must reconsider the adverse determination and notify the covered person of its decision within 14 days. WAC 284-43-620	27	X	

Claims:

#	STANDARD	PAGE	PASS	FAIL
1	An issuer and an employee welfare benefit program, whether insured or self funded…may not deny enrollment of a child under the health plan of the parent on the grounds that the child is born out of wedlock, not claimed as a dependent, or the child does nor reside with the parent. RCW 48.01.235(3)	34	X	
2	Plans must provide female enrollee's direct access to women's health care; Unfair practices regarding prescriptions for contraceptives. RCW 48.42.100; WAC 284-43-250; WAC 284-43-822; and RCW 48.43.115	34	X	
3	All plans must include every category of provider. RCW 48.43.045 and WAC 284-43-205	34	X	
4	A Health carrier must cover emergency services to screen and stabilize a covered person if a prudent layperson would have believed that an emergency medical condition existed. RCW 48.43.093	34	X	

#	STANDARD	PAGE	PASS	FAIL
5	Carriers that offer a health plan shall maintain a documented utilization review program description and written utilization review criteria based on reasonable medical evidence. RCW 48.43.520 and WAC 284-43-410	34	X	
6	Benefits shall not be denied there under for any service performed by a Denturist licensed under chapter 48.18.30 RCW if the service was performed was within the lawful scope of such person's license. RCW 48.44.500; RCW 48.43.180; and WAC 284-44-042	34	X	
7	A Health carrier shall not retrospectively deny coverage for emergency and non-emergency services that had prior authorization. RCW 48.43.525(1)	34	X	
8	Any contract for health care services must provide coverage for the formula necessary to treat PKU. RCW 48.44.440 and WAC 284-44-450	34	X	
9	Health care service contractors who through an authorized representative have first approved, by any means, any prescription claim as eligible may not reject the claim at a later date. RCW 48.44.465	34	X	
10	A carrier shall pay providers and facilities as soon as practical but subject to the following minimum: 95% of the monthly volume of clean claims shall be paid within thirty days of receipt. WAC 284-43-321(2)(a)(i)	34		X
11	A carrier shall pay providers and facilities as soon as practical but subject to the following minimum: 95% of the monthly volume of all claims shall be paid or denied within sixty days of receipt, except as agreed to in writing by the parties on a claim-by-claim basis. WAC 284-43-321(2)(a)(ii)	34		X
12	Any carrier failing to pay claims within the standards established shall pay interest on undenied and unpaid clean claims more than 61 days old. WAC 284-43-321(2)(d)	34	X	
13	Denial of a claim must be communicated to the provider or facility and must include the specific reason why the claim was denied. WAC 284-43-321(4)	34	X	
14	Coordination of benefits must be processed in compliance with Washington law with respect to apportionment, investigation and timeliness. WAC 284-51-195; WAC 284-51-205(4); WAC 284-51-215; WAC 284-51-220; WAC 284-51-225; WAC 284-51-230 WAC 284-51-235; and WAC 284-51-240	34		X

Rate Filing:

#	STANDARD	PAGE	PASS	FAIL
1	Carriers must file with the commissioner every contract form and rate schedule and modification of a contract form and rate schedule before sale to the public and before the rate schedule is used. WAC 284-43-920(1)(a)	38	X	
2	Carriers must file with the commissioner every contract form and rate schedule and modification of a contract form and rate schedule within thirty days after the end of an eighteen-month period during which a previous filing has remained unchanged for such period, including contract forms filed prior to the effective date of this regulation. WAC 284-43-920(1)(b)	38		X
3	If the company issues standardized Medicare Supplement Policies it must file rates, rating schedule and supporting documentation with the OIC annually or on May 31st. WAC 284-66-203(3)	38	X	
4	No registrant shall change any rates, modify any contract or offer a new contract until it has filed a copy of the changed rate schedule, modified contract or new contract with the insurance commissioner. RCW 48.44.040	38		X
5	All rate schedules have been filed through SERFF using prescribed transmittal forms required by the commissioner. WAC 284-44A-050(1)	38	X	

Form Filings:

#	STANDARD	PAGE	PASS	FAIL
1	All contract forms have been filed and approved prior to use, submitted with the contents required by the commissioner electronically through SERFF. WAC 284-44A-050(1)	40	X	
2	Each form has a unique identifying number to distinguish it from other versions of the same form. Correct editions of forms used. WAC 284-44-030(3)	40	X	
3	All translated forms must be filed with the OIC and certified by the American Translators Association (ATA) or comparable organization. WAC284-44A-120(1)(a) and WAC 284-44A-120(2)(b)(i)(ii)	40		X
4	Colorectal cancer examination and laboratory tests – Required benefits or coverage. RCW 48.43.043	40	X	

#	STANDARD	PAGE	PASS	FAIL
5	Every carrier that provides coverage for maternity services must provide notice to policyholders regarding the coverage required under this section. RCW 48.43.115 (5)	40	X	
6	Lifetime limit on transplants. RCW 48.43.680	40	X	
7	State Registered domestic partnerships covered. RCW 48.43.904	40	X	
8	All plans shall cover newborn infants with congenital anomalies from the moment of birth. RCW 48.44.212 (1)	40	X	
9	An individual may return an individual health care contract for a full refund within 10 days of its delivery if not satisfied. RCW 48.44.230	40	X	
10	Mammograms – Insurance coverage. RCW 48.44.325	40	X	
11	Prostate Cancer Screening. RCW 48.44.327	40	X	
12	Mental health service requirements for all health benefit plans delivered, issued for delivery, or renewed on or after 7/1/2010. RCW 48.44.341 (2)(c)(i)(ii)	40	X	
13	Modification of basis of agreement, endorsement required. RCW 48.44.390	40	X	
14	Women's rights to access Health Care Services – notification requirements in Enrollee handbook. WAC 284-43-250 (4)	40	X	
15	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)	40	X	
16	Every Medicare supplement insurance policy issued after January 1, 1982 shall have prominently displayed on the first page a statement that the person to 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	40	X	
17	A Medicare supplement policy with benefits for outpatient prescription drugs may not be issued after December 31, 2005. WAC 284-66-050 (6)	40	X	

#	STANDARD	PAGE	PASS	FAIL
18	Every issuer [of a Certificate] must make available a policy or certificate including only the basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic "core" package, but not in place of the basic "core" package. Pre 6/1/10: WAC 284-66-066 (1) Post 6/1/2010: WAC 284-66-064 (1)	40	X	
19	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)	40	X	
20	Effective January 1, 1990, subject to RCW 48.66.050(2), and except for riders and endorsements issued according to subsection (2) of this section, no rider, endorsement, waiver, or any other means of modifying contractual benefits may be used by an issuer to exclude, limit, or reduce the coverage of benefits of a Medicare supplement insurance policy or certificate issued to a resident of this state. Only riders or endorsements that increase benefits or coverage may be used in this state. WAC 284-66-260 (1)	40	X	
21	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 increases the premium must be requested or accepted by the policy holder in writing. WAC 284-66-260 (2) (a)	40	X	
22	Where separate additional premium is charged for a rider, endorsement, or other amendment to the contractual benefits of a Medicare supplement insurance policy or certificate, the premium charged must be set forth in the policy. WAC 284-66-260 (2) (b)	40	X	

#	STANDARD	PAGE	PASS	FAIL
23	Each group health benefit plan or group dental plan that provides dental coverage must cover medically necessary general anesthesia services. RCW 48.43.185 (2)	40	X	
24	Dental Only: Temporomandibular joint disorder – Specified offer of coverage required – terms of specified offer defined. WAC 284-44-.042 (1)(b)	40	X	
25	Medical and Dental combined: Temporomandibular joint disorder – Specified offer of coverage required – terms of specified offer defined. WAC 284-.44-.042 (1)(c)	40	X	
26	Denturist services shall be covered. RCW 48.44.500	40	X	

Individual Underwriting:

#	STANDARD	PAGE	PASS	FAIL
1	The Company may not deny enrollment of a child under plan of the parent on the grounds that the child was born out of wedlock, not claimed as a tax dependent, or does not reside with the parent or in the service area. RCW 48.01.235(1)	41	X	
2	The Company shall provide no less than urgent and emergent care to a child living outside the service area. RCW 48.01.235(3)	43	X	
3	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)	43		X
4	Rules related to prior coverage and pre-existing wait period for the Individual Market. (See code for complete text.) RCW 48.43.015(4) and RCW 48.43.015(5)	43	X	
5	All individual health plans shall contain or incorporate by endorsement a guarantee of the continuity of coverage of the plan. RCW 48.43.038	43	X	
6	Dependent children cannot be terminated from an individual health plan because of developmental disability or physical handicap. RCW 48.44.210	43	X	
7	The Company may not refuse to issue, cancel, or decline to renew coverage solely because of a mastectomy or lumpectomy more than five (5) years prior. RCW 48.44.335	43	X	

Medicare Supplement Underwriting:

#	STANDARD	PAGE	PASS	FAIL
1	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 not later than 63 days after termination of the prior coverage. RCW 48.66.055 (1)	45	X	
2	No Medicare Supplement carrier may deny or restrict coverage or discriminate in pricing for an eligible person because of health status, claims experience, receipt of healthcare, 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)	45	X	
3	A Medicare Supplement outline of coverage as defined by WAC 284-66-080 (2) must be provided to the applicant at the time of application with an acknowledgement of receipt of the outline from the applicant. RCW 48.66.110 and WAC 284-66-080	45	X	
4	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 preexisting conditions that would have been covered under the group policy being replaced. RCW 48.66.130(4) and Pre 6/1/10: WAC 284-66-063(1) (d) (v) Post 6/1/10: WAC 284-66-064 (1) (d) (v)	45	X	
5	The medical history of an applicant must be completed by the applicant, a relative of the applicant, a legal guardian of the applicant, or a physician. RCW 48.66.140	45	X	
6	Before the sale of a Medicare SELECT policy or certificate, a Medicare SELECT issuer must obtain from the applicant a 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. WAC 284-66-073 (10)	45	X	

#	STANDARD	PAGE	PASS	FAIL
7	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. WAC 284-66-073 (12)	45	X	
8	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. WAC 284-66-073 (13) (a)	45	X	
9	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)	45	X	
10	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); WAC 284-66-110(2); and WAC 284-66-110(3)	45	X	
11	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)	45	X	
12	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)	45	X	
13	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 the time was spent under the original policy. WAC 284-66-170 (1)	45	X	

#	STANDARD	PAGE	PASS	FAIL
14	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)	45	X	
15	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)	45	X	
16	Effective May 21, 2009, except as provided in subsection (3) of this section, an issuer of a Medicare supplement insurance policy or certificate must not deny or condition the issuance of effectiveness of the policy or certificate and must not discriminate in the pricing of the policy or certificate of an individual on the basis of the genetic information with respect to any individual. WAC 284-66-068 (1)	45	X	

Group Underwriting:

#	STANDARD	PAGE	PASS	FAIL
1	The Company may not deny enrollment of a child under plan of the parent on the grounds that the child was born out of wedlock, not claimed as a tax dependent, or does not reside with the parent or in the service area. RCW 48.01.235(1)	47	X	
2	The Company shall provide no less than urgent and emergent care to a child living outside the service area. RCW 48.01.235(3)	47	X	
3	The Company shall reduce any preexisting condition exclusion, limitation, or waiting period in a group plan in accordance with HIPAA. RCW 48.43.015(1)	47	X	
4	Group Other than a small group: If the applicant's immediately preceding coverage ceased between 90 and 64 days before the application date, with continuous coverage for 3 months, there is no waiting period. If the coverage was not in force for the prior 3 months, the carrier shall credit the time covered under the immediately preceding plan towards any pre-existing condition waiting period under the new plan. RCW 48.43.015(2)(a) (b)	47	X	
5	Small Group: If the applicant's immediately preceding coverage ceased between 90 and 64 days before the application date, with continuous coverage for 9 months, there is no waiting period. If the coverage was in force less than 9 months, the carrier shall credit the time covered under the immediately preceding plan towards any pre-existing condition waiting period under the new plan. RCW 48.43.015(3) (a) (b)	47	X	
6	Group Other than a small group: The Company may not reject an individual or deny, exclude or limit coverage based on preexisting conditions of the individual. (3 month waiting period is OK if preexisting occurred within 3 months of effective date of coverage.) RCW 48.43.025(1)	47	X	
7	Small Group: The Company may not reject an individual or deny, exclude or limit coverage in a small group plan based on preexisting conditions of the individual. (9 month waiting period is OK if preexisting occurred within 6 months of effective date of coverage.) RCW 48.43.025(2)	47	X	
8	The Company shall accept for enrollment any state resident within the group and within the carrier's service area. RCW 48.43.035(1)	47	X	

#	STANDARD	PAGE	PASS	FAIL
9	Small Group: Eligibility to purchase a health benefit plan must be extended to all small employers and small groups as defined in RCW 48.43.005. RCW 48.43.028	47	X	
10	Group Dental: General anesthesia service for dental procedures. RCW 48.43.185(2)	47	X	
11	Dental Only: Temporomandibular joint disorder – Specified offer of coverage required – terms of specified offer defined. WAC 284-44-042(1)(b)	47	X	
12	Medical & Dental Combined: Temporomandibular joint disorder – Specified offer of coverage required – terms of specified offer defined. WAC 284-44-042(1)(c)	47	X	
13	Group Dental: Denturist services covered. RCW 48.44.500	47	X	

Policy Administration Individual:

#	STANDARD	PAGE	PASS	FAIL
1	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	49	X	
2	Dependants shall have the right to continue coverage in the event of loss of eligibility by the principle enrollee. RCW 48.44.400	49	X	
3	A rider will be cancelled upon application of the enrollee if, at least five (5) years after issuance, no health care services have been received by the enrollee for the condition specified in the rider. 48.44.430	49	X	

Policy Administration Medicare Supplement:

#	STANDARD			
1	The company must notify an individual losing coverage or benefits due to the termination of a contract, agreement, policy, or plan of their rights to continue coverage. The notice must be communicated contemporaneously with the notification of termination. RCW 48.66.055(5)(a)	49	X	
2	The company must notify an individual who ceases enrollment under a contract, agreement, policy, or plan, of their rights and the obligations of the company in regard to the cessation of coverage. The notice must be communicated within 10 working days of the issuer receiving notification of disenrollment. RCW 48.66.055(5)(b)	49	X	

#	STANDARD			
3	All Medicare Supplement policies must be guaranteed renewable and may not provide that the policy may be cancelled or nonrenewed solely on the grounds of health status. The issuer shall not cancel or nonrenew for any reason other than nonpayment of premium or material misrepresentation. RCW 48.66.090; Pre 6/1/10: WAC 284-66-063 (1)(d)(i) and (ii) Post 6/1/10: WAC 284-66-064 (1)(d)(i) and (ii)	49	X	
4	Subject to WAC 284-66-063(1)(c), a Medicare supplement policy with benefits for outpatient prescription drugs in existence before January 1, 2006, must be renewed for current policyholders who do not enroll in Part 'D' at the option of the policyholder. WAC 284-66-050(5)	49	X	
5	After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part 'D' unless: the policy is modified to eliminate coverage and premiums are adjusted to reflect the eliminated coverage. WAC 284-66-050(7)(a) and WAC 284-66-050(7)(b)	49	X	
6	A Medicare supplement policy or certificate may not provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. Pre 6/1/10 : WAC 284-66-063(1) (c) Post 6/1/10: WAC 284-66-064(1)(c)	49	X	
7	If the Medicare supplement policy is terminated by the group policy holder or the individual, the issuer must offer continuation of coverage under such policy. Pre 6/1/10: WAC 284-66-063 (1)(d)(iii) and (iv) Post 6/1/10: WAC 284-66-064 (1)(d)(iii)	49	X	
8	Termination of a Medicare supplement policy or certificate must be without prejudice to any continuous loss that began while the policy was in force, but the extension of benefits beyond the period that policy was in force may be conditioned upon the continuous total disability of the insured, limited to duration of the policy benefit period, or payment of maximum benefits. Pre 6/1/10: WAC 284-66-063(1)(e) Post 6/1/10: WAC 284-66-064(1)(d)(vi)	49	X	

#	STANDARD			
9	A Medicare supplement policy or certificate must provide that benefits and premiums under the policy or certificate be suspended at the request of the policyholder or certificate holder for the period (not to exceed 24 months) that the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to the assistance. Pre 6/1/10: WAC 284-66-063(1)(g)(i) Post 6/1/10: WAC 284-66-064(1)(d)(vii)(A)	49	X	
10	If the suspension occurs and if the medical assistance entitlement is lost, the policy or certificate must be automatically reinstated effective as of the date termination of the entitlement notice is provided within 90 days after the date of the loss and pays the premium attributed to the period. Pre 6/1/10: WAC 284-66-063(1)(g)(ii) Post 6/1/2010: WAC 284-66-064(1)(d)(vii)(B)	49	X	
11	Each Medicare supplement policy must provide that benefits and premiums under the policy will be suspended (for any period that may be provided by federal regulation) at the request of the policy holder if the policy holder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policy holder or certificate holder loses coverage under the group plan, the policy must be automatically reinstated (effective as of the date of loss of coverage within 90 days after the date of the loss). Pre 6/1/10: WAC 284-66-063(1)(g)(iii) Post 6/1/10: WAC 284-66-064(1)(d)(vii)(C)	49	X	
12	Reinstitution of the coverage may not provide for any waiting period with respect to treatment of preexisting conditions. Pre 6/1/10: WAC 284-66-063(1)(h)(i) Post 6/1/10: WAC 284-66-064(1)(d)(viii)(A)	49	X	
13	Reinstitution of the coverage must provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of the suspension. Pre 6/1/10: WAC 284-66-063(1)(h)(ii) Post 6/1/10: WAC 284-66-064(1)(d)(viii)(B)	49	X	

#	STANDARD			
14	Reinstitution of the coverage must provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied had the coverage not been suspended. Pre 6/1/10: WAC 284-66-063(1)(h)(iii) Post 6/1/10: WAC 284-66-064(1)(d)(viii)(C)	49	X	
15	As soon as practicable, but no later than 30 days before the effective date of any Medicare benefit changes, every insurer providing Medicare supplement insurance coverage to a resident of this state must notify its insured of modifications to Medicare supplement policies. WAC 284-66-160	49	X	
16	On or before March 1st of each year, an issuer must report to the commissioner the policy and certificate number and the date of issue for every individual resident of this state for which the issuer has in force more than one Medicare supplement policy or certificate on a form approved by the commissioner (WAC 284-66-323). The report must include policy and certificate number and date of issuance. The items must be grouped by individual policyholder. WAC 284-66-320(1) and WAC 284-66-320(2)	49	X	

Policy Administration Group:

#	STANDARD			
1	Dependent children cannot be terminated from a group plan because of developmental disability or physical handicap. RCW 48.44.210	49	X	
2	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	49	X	

Provider Activity:

#	STANDARD	PAGE	PASS	FAIL
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); and WAC 284-43-322	50	X	
2	Health Carrier selection standards for participating providers and facilities shall be consistent with rules or standards established by the State Department of Health or other regulatory authority. WAC 284-43-310(1)	50	X	
3	All individual provider and facility contracts shall be in writing and available for review upon request of the OIC. WAC 284-43-310(4)	50	X	
4	Every insurer shall conduct business in its own legal name. RCW 48.05.190	50	X	
5	Enrollees can select a PCP from a list of participating providers. RCW 48.43.515 and WAC 284-43-251	50	X	
6	Provider contract forms contain language holding enrolled participant harmless should the Company fail to pay for health care services. RCW 48.44.020(4) and WAC 284-43-320(2)	50	X	
7	Each Contract shall include hold harmless and insolvency language as approved by the commissioner. WAC 284-43-320(2)	50	X	
8	Provider contract forms must be filed and approved. RCW 48.44.070 and WAC 284-43-330	50	X	
9	Providers have a mechanism for obtaining eligibility information from the Company. WAC 284-43-320(1)	50	X	
10	Carrier shall notify providers of their responsibilities regarding carrier's administrative policies and programs including confidentiality. Providers and facilities must be given 60 days notice of changes that affect provider, compensation, and health care service delivery. WAC 284-43-320(4)	50	X	
11	Carrier may not preclude provider from informing patient of care required and whether care is consistent with medical necessity, medical appropriateness, or covered by plan. WAC 284-43-320(5)(a)	50	X	
12	Carrier may not preclude or discourage providers from discussing with patients merits of other carriers even if critical of the carrier. WAC 284-43-320(5)(b)	50	X	

#	STANDARD	PAGE	PASS	FAIL
13	A Health Carrier must cover services of a PCP whose contract is terminated without cause for 60 days following notice of termination. RCW 48.43.515(7)	50	X	
14	Carrier and provider shall provide at least 60 days written notice to each other before terminating contract without cause. WAC 284-43-320(7)	50	X	
15	The audit of medical records should only be limited to pertinent information of covered persons, and should not be burdensome to provider. If a carrier obtains the right to audit a provider, the provider obtains rights to audit carrier denials. WAC 284-43-324	50	X	

Network Adequacy:

#	STANDARD	PAGE	PASS	FAIL
1	Maintain each plan network to ensure services are available to covered persons without unreasonable delay. WAC 284-43-200(1)	51	X	
2	Each covered person will have adequate choice among each type of health provider. WAC 284-43-200(1)	51	X	
3	Emergency services are available 24 hours a day 7 days a week. WAC 284-43-200(1)	51	X	
4	When an insufficient number of providers or facilities exist, if a provider/facility is used through referral of PCP within proximity of covered person, charges will not exceed those of a network provider/facility. WAC 284-43-200(3)	51	X	
5	The Health Carrier shall maintain adequate arrangements to ensure reasonable proximity of network providers. WAC 284-43-200(4)	51	X	
6	The Health Plan provides coverage for treatments and services by every category of provider. WAC 284-43-205(1)	51	X	
7	A carrier must file an electronic report of all participating providers by network, updated monthly, (Provider Network Form A) WAC 284-43-220(1) and RCW 48.44.080	51	X	
8	A carrier must prepare an electronic report showing the total number of covered persons who are entitled to Health Care Services during each month of the year, excluding nonresidents	51	X	

#	STANDARD	PAGE	PASS	FAIL
	for each network by line of business, (Network Enrollment Form B). WAC 284-43-220(2)			
9	A carrier may not exclude or limit access to women's health care services offered by a particular type of health care practitioner in a manner that would unreasonably restrict access to that type of provider or covered service. WAC 284-43-250(1)(b)	51	X	

APPENDIX 1

General Examination Findings Standard 6: 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 and WAC 284-37-030(2)

Issue/Situation	Comments
Incomplete/Inaccurate Responses to Information Requests	See Charts Below

Claims:

Information Request Number	Original Due Date	Follow-up Requests	Date Received
IR 014CB	February 22, 2012	2	March 6, 2012
IR 047CB	July 31, 2012	1	August 11, 2012
IR 050CB	August 8, 2012	1	August 11, 2012
IR 058CB	September 13, 2012	2	October 23, 2012
IR 060CB	November 5, 2012	0	November 7, 2012
IR 065CB	December 3, 2012	0	December 10, 2012
IR 068CB	January 17, 2013	0	January 21, 2013
IR 073CB	March 22, 2013	0	April 4, 2013

Underwriting:

Initial Call Letter Line of Business	Original Due Date	Follow up requests	Complete Date
Individual – Active	October 15, 2011	3	March 29, 2012
Individual – Declined	October 15, 2011	3	March 29, 2012
Individual – Quotes	October 15, 2011	1	March 23, 2012*
Individual – Term/Lapse	October 15, 2011	2	June 15, 2012
Medicare Supplement – Active	October 15, 2011	3	March 29, 2012
Medicare Supplement – Declined	October 15, 2011	3	March 29, 2012
Medicare Supplement – Quotes	October 15, 2011	1	March 23, 2012*
Medicare Supplement – Term/Lapse	October 15, 2011	2	June 15, 2012

Group – Active	October 15, 2011	2	April 6, 2012
Group – Declined Quotes	October 15, 2011	1	April 6, 2012
Group – Quotes	October 15, 2011	0	October 17, 2011
Group – Term/Lapse	October 15, 2011	2	June 15, 2012
Group Dental – Active	October 15, 2011	2	April 6, 2012
Group Dental – Declined	October 15, 2011	1	April 6, 2012
Group Dental – Quotes	October 15, 2011	0	October 17, 2011
Group Dental – Term/Lapse	October 15, 2011	2	June 15, 2012

*** The date the Companies confirmed that quote information is not stored and therefore a quote database was not available.**

APPENDIX 2

Complaint Standard 4: Passed with comment. 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, WAC 284-30-340

Complaint Standard 5: Passed with comment. The Company must adopt and implement a comprehensive process for the resolution of covered persons' grievances and appeals of adverse determinations. WAC 284-43-620

Complaint Standard 5: Passed with comment. The Company complies with procedures for review and appeal of adverse determinations. WAC 284-43-620, RCW 48.43.530(5)(a), RCW 48.43.530(5)(c), RCW 48.43.530(5)(g)

Complaint or Appeal #	Finding	Code Violation
OICC24	Response to the OIC one day beyond OIC's requested due date	WAC 284-30-650
OICC62	Response to the OIC was incomplete	WAC 284-30-650
CC102	Incomplete file documentation	WAC 284-30-340
CC109	Incomplete file documentation	WAC 284-30-340
CC117	62 day response time	WAC 284-43-620
CC134	50 day period with no activity	WAC 284-43-620
CC17	Appeal was not resolved in 30 days and signed time extension request was not included in the file.	RCW 48.43.530(5)(c) WAC 284-43-620(1)
CC40	Provider generated appeal, member notified via EOB. Appeal was not resolved in 30 days and signed time extension request was not included in the file.	RCW 43.43.530(5)(a) (g) WAC 284-43-620(1)
CC88	Appeal was not resolved in 30 days and signed time extension request was not included in the file.	RCW 48.43.530(5)(a) WAC 284-43-620(1)
CC89	Appeal was not resolved in 30 days and signed time extension request was not included in the file.	RCW 48.43.530(5)(a) WAC 284-43-620(1)
CC100	Appeal was not resolved in 30 days and signed time extension request was not included in the file.	RCW 48.43.530(5)(a) WAC 284-43-620(1)

APPENDIX 3

Violations of Claims Standard 10 - Clean Claim Payments Over 30 Days
As provided by Companies

	REGENCE CPS - Legacy				REGENCE CPSS - Facets		
Month	**Total # of Providers Paid**	**# of Providers Paid Untimely**	**% of Providers Paid Untimely**		**Total # of Providers Paid**	**# of Providers Paid Untimely**	**% of Providers Paid Untimely**
January, 2010	24,982	5,184	20.75 %		21,772	2,096	9.62 %
July, 2010	24,087	1,592	6.61 %		22,397	1,107	4.94 %
January, 2011	23,064	1,411	6.11 %		24,664	4,393	17.81 %
April, 2011	18,269	578	3.16 %		30,471	6,600	21.65 %
May, 2011	15,782	549	3.47 %		29,693	5,698	19.18 %

	ASURIS CPS - Legacy				ASURIS CPSS - Facets		
Month	**Total # of Providers Paid**	**# of Providers Paid Untimely**	**% of Providers Paid Untimely**		**Total # of Providers Paid**	**# of Providers Paid Untimely**	**% of Providers Paid Untimely**
January, 2010	3,655	293	8.01 %		3,406	218	6.50 %
July, 2010	3,349	782	23.35 %		3,694	59	1.59 %
January, 2011	3,373	249	7.38 %		3,976	1,381	34.73 %
April, 2011	2,480	46	1.85 %		5,533	1,518	27.43 %
May, 2011	1,919	70	3.64 %		5,284	1,060	20.05 %

Violations of Claims Standard 11 - All Claim Payments Over 60 Days
As provided by Companies

	REGENCE CPS - Legacy				REGENCE CPSS - Facets		
Month	Total # of Providers Paid	# of Providers Paid Untimely	% of Providers Paid Untimely		Total # of Providers Paid	# of Providers Paid Untimely	% of Providers Paid Untimely
January, 2010	26,893	223	.83%		22,204	517	2.32%
July, 2010	26,006	183	.70%		22,927	804	3.505
January, 2011	25.424	210	.82%		25,115	1,288	5.12%
April, 2011	21,447	140	.65%		30,702	3,133	10.20%
May, 2011	18,809	98	.52%		29,923	1,391	4.74%

	ASURIS CPS - Legacy				ASURIS CPSS – Facets		
Month	Total # of Providers Paid	# of Providers Paid Untimely	% of Providers Paid Untimely		Total # of Providers Paid	# of Providers Paid Untimely	% of Providers Paid Untimely
January, 2010	4,341	54	1.24%		3,601	76	2.11%
July, 2010	4,039	37	.91%		3,948	170	4.30%
January, 2011	4,097	77	1.87%		4,157	410	9.86%
April, 2011	3,223	18	.55%		5,700	948	16.63%
May, 2011	2,617	10	.38%		5,427	384	7.07%

APPENDIX 4

Rate Filings Standard 2: Carriers must file with the commissioner every contract form and rate schedule and modification of a contract form and rate schedule within 30 days after the end of an eighteen-month period during which a previous filing has remained unchanged for such period, including contract forms filed prior to the effective date of this regulation.
Reference: WAC 284-43-920(10)(b)

OIC ID #	Comments
NEG 31	Filing Due 07-01-10 Filed 08-23-10 – 53 days
NEG 69	Filing Due 1-1-10 Filed 2-7-10 – 37 days

APPENDIX 5

Rate Filings Standard 4: No registrant shall change any rates, modify any contract until it has filed a copy of the changed rate schedule, modification contract or new contract with the insurance commissioner.
Reference: RCW 48.44.040

OIC ID #	Company ID #	Comments
Sm Gr 13	10003252	Vision rates filed were not the same as rates actually used
Sm Gr 15	10003954	Vision rates filed were not the same as rates actually used

APPENDIX 6

Individual Underwriting Standards 3: 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)

OIC ID #	Comments
Indiv. Und #17, 23, 31, 34, 41, 44, 75, 88, 89, 90, 94, 98, 101, 112.	Written notice to WSHIP is uploaded monthly at the beginning of the month only. This means that if a declination was processed in the first part of the month, it took longer than 15 days for the notification to reach WSHIP.