State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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Jorge Gomez, *Commissioner*

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Notice of Adoption and Filing of Examination Report

Take notice that the proposed report of the market conduct examination of the

Blue Cross Blue Shield of Wisconsin
401 West Michigan Street
Milwaukee WI 53203

dated November 4-12, 2003, and served upon the company on April 28, 2004, has been adopted as the final report, and has been placed on file as an official public record of this Office.

Dated at Madison, Wisconsin, this 2nd day of September, 2004.

Jorge Gomez
Commissioner of Insurance

STATE OF WISCONSIN
OFFICE OF THE COMMISSIONER OF INSURANCE

MARKET CONDUCT EXAMINATION

OF

BLUE CROSS BLUE SHIELD OF WISCONSIN
MILWAUKEE, WISCONSIN

NOVEMBER 4-12, 2003

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December 15, 2003

Honorable Jorge Gomez
Commissioner of Insurance
125 S Webster Street
Madison, WI 53702

Commissioner:

Pursuant to your instructions and authorization, a targeted market conduct examination was conducted November 4 to November 12, 2003 of:

BLUE CROSS BLUE SHIELD OF WISCONSIN
Milwaukee, Wisconsin

and the following report of the examination is respectfully submitted.

I. INTRODUCTION

Blue Cross Blue Shield of Wisconsin (BCBSWI) was organized as a nonstock, not-for-profit hospital service insurance corporation until June 14, 1999, when BCBSWI filed an application with Office of the Commissioner of Insurance (OCI) to convert from a nonprofit service insurance corporation to a stock insurance corporation. Effective March 21, 2001, BCBSWI converted to a stock insurance corporation and organized pursuant to ch. 611, Wis. Stat. On March 23, 2001, BCBSWI became a wholly owned subsidiary of Cobalt Corporation (Cobalt) through a combination of BCBSWI and Cobalt.

Cobalt finalized a merger agreement with Wellpoint Health Networks Inc., in June, 2003 and OCI approved the agreement September 19, 2003. Wellpoint Health Networks, Inc. filed a merger request on December 17, 2003, to merge with Anthem, Inc.

BCBSWI is a domestic insurer that markets only in Wisconsin. It offers managed care plans, such as preferred provider plans, and group, individual, Medicare supplement and dental policies. For 2001, it ranked 5th as a group accident and health writer with 6.7% of the business. It ranked 1st as an individual accident and health writer with 25.9% of the business. For 2002, it ranked 1st for Medicare supplement business. It ranked 3rd for small employer business with 7.7% of the market.

For 2002, BCBSWI reported it had 150,832 PPO enrollees and 166,210 indemnity enrollees. It contracts with provider networks that cover all areas of the state.

The following table summarizes the premium written and incurred losses in Wisconsin for 2001 and 2002.

Premium and Loss Ratio Summary

	2002			
Line Of Business	**Direct Premiums Earned**	**% of Total Premium**	**Direct Losses Incurred**	**Pure Loss Ratio**
Comprehensive Health	$343,150,000	57.6%	$319,358,000	89%
Medicare Supplement	100,456,000	17%	78,917,000	74%
Dental only	26,712,000	4.3%	22,563,000	83%
Federal Employees Health Benefits	127,536,000	20%	126,306,000	99%
Title XVIII Medicare	946,000	0%	0	n/a
Other	2,058,000	0%	2,171,000	105%
I Total	$600,859,000	100%	$549,315,000.00	91%

	2001			
Line Of Business	**Direct Premiums Earned**	**% of Total Premium**	**Direct Losses Incurred**	**Pure Loss Ratio**
Comprehensive Health	$321,505,000	54.3%	$288,973,000	90%
Medicare Supplement	91,455,000	15%	62,460,000	68%
Dental only	27,632,000	5%	21,614,000	78%
Federal Employees Health Benefits	79,369,000	14%	73,642,000	93%
Title XVIII Medicare	69,606,000	12%	70,008,000	100%
Other	2,866,000	1%	5,583,000	195%
Total	$592,433,000.00	100%	$522,280,000.00	88%

Complaints

The Office of the Commissioner of Insurance received 632 complaints against the company between January 1, 2002 through June 30, 2003. A complaint is defined as "a written communication received by the Commissioner's Office that indicates dissatisfaction with an insurance company or agent." The company ranked 21st on the 2002 complaint summary for group accident and health insurance, with 207 complaints and a complaint ratio of .07 compared to a Wisconsin average of .04 complaints per $100,000 of written premium. The company ranked 21st on the complaint summary for 2001, with 243 complaints and a complaint ratio of .06 compared to a Wisconsin average of .05 complaints per $100,000 of written premium. The majority of the complaints involved claim handling issues, including delays in claim payment and unsatisfactory settlements. Fifty-four percent of the complaints involved the company's PPO products.

The following table categorizes the complaints received against the company by type of policy and complaint reason for the last two years. There may be more than one type of coverage and/or reason for each complaint.

2002						
Reason Type	**Total**	**Underwriting**	**Marketing and Sales**	**Claims**	**Policyholder Service**	**Other**
Coverage Type	**No.**	**No.**	**No.**	**No.**	**No.**	**No.**
Individual A&H	69	23	3	40	3	0
Group A&H	35	2	1	30	2	0
PPO	168	21	1	140	3	3
Medicare Supplement	44	0	1	31	12	0
Total	316	46	6	241	20	3

2001						
Reason Type	**Total**	**Underwriting**	**Marketing and Sales**	**Claims**	**Policyholder Service**	**Other**
Coverage Type	**No.**	**No.**	**No.**	**No.**	**No.**	**No.**
Individual A&H	52	20	2	25	5	0
Group A&H	0	0	0	0	0	0
PPO	205	22	6	162	10	5
Medicare Supplement	51	11	1	27	10	2
Total	308	53	9	214	25	7

Grievances

The company submitted annual grievance summary reports to OCI for 2001 and 2002. A grievance is defined as "any dissatisfaction with the provision of services or claims practices of an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing to the insurer by, or on behalf of, an insured."

The grievance report for 2002 indicated the company received 254 grievances, 148 or 58% were reversed. The majority of the grievances filed with the company were related to benefit denials involving non-covered benefits. The grievance report for 2001 indicated the company received 228 grievances, 83 or 36% were reversed. The majority of the grievances received were related to benefit denials involving non-covered benefits.

The following tables summarize the grievances for the company for the last two years:

2002	
Category	**No.**
Access to Care	0
Continuity of Care	0
Drug & Drug Formulary	11
Emergency Services	0
Experimental Treatment	1
Prior Authorization	51
Not Covered Benefit	158
Not Medically Necessary	24
Other	9
Plan Administration	0
Plan Providers	0
Request for Referral	0
Total	254

Year	Plan Administration	Benefit Denial	Total
2002	0	254	254
2001	0	228	228

II. PURPOSE AND SCOPE

A targeted market conduct examination was conducted to determine whether the company's practices and procedures comply with the Wisconsin insurance statutes and rules. The examination focused on the period from January 1, 2002 through June 30, 2003. In addition, the examination included a review of any subsequent events deemed important by the examiner-in-charge during the examination.

The scope of the examination was limited to a review of the company's group health insurance operations in claims, company operation/management, complaints/grievances, managed care, small employer, electronic commerce, producer licensing, rates and policy forms and privacy activities. The examiners did not review the company's individual or Medicare supplement business. The examination included a review of compliance with the market conduct examination recommendations in the May 1999 report.

The report is prepared on an exception basis and comments on those areas of the company's operations where adverse findings were noted.

III. PRIOR EXAMINATION RECOMMENDATIONS

The previous market conduct examination of the company, as adopted May 31, 2000, contained 22 recommendations. Following are the recommendations and the examiners' findings regarding the company's compliance with each recommendation.

Marketing and Advertising

1. It is recommended that the company revise the manner in which it maintains its advertising files to include specific information on the manner and extent of distribution of the advertisement and the form number of the policy advertised as required by s. Ins 3.27 (28), Wis. Adm. Code.

   Action: Compliance

Claims Administration

2. It is recommended that the company correct the EOB programming problem as regards the proper calculation of remaining annual benefit limits and remaining deductible amounts stated on its EOBs and advise OCI of the corrective action taken within 90 days of the adoption of the examination report.

   Action: Compliance

Grievance and Complaint Procedures

3. It is again recommended that the company revise its procedures and provide staff training to ensure that extension notices are sent to grievants for grievances that are not resolved within 30 days as required by s. Ins 3.48 (7) (c), Wis. Adm. Code.

   Action: Compliance

4. It is again recommended that the company revise its procedures and provide staff training to ensure that medical records needed to consider grievances are requested from providers in a timely manner and that grievances are not closed in those situations where the company has not received copies of the medical records requested as required by s. Ins 3.48 (7), Wis. Adm. Code.

   Action: Compliance

5. It is recommended that the company revise its procedures and provide staff training to ensure that grievance hearing invitation letters are sent to grievants as required by s. Ins 3.48 (7) (d), Wis. Adm. Code.

   Action: Compliance

6. It is again recommended that the company incorporate language in its provider agreements requiring the prompt release of any medical records requested, and to enforce this language in grievance situations.

   Action: Non-Compliance

7. It is recommended that the company revise its procedures and provide staff training to ensure that grievances are date stamped upon receipt.

   Action: Compliance

8. It is recommended that the company handle grievances involving UCR and remaining balance issues as it would any other grievance as required by s. Ins 3.48 (7), Wis. Adm. Code.

   Action: Compliance

9. It is recommended that the company file with OCI amended grievance reports for 1997 and 1998 to include those grievances handled by Meridian Managed Care Inc., and that beginning in the year 2000 the company file one annual grievance report as required by s. 609.15, Wis. Stat., that includes all grievances handled by both Meridian and BCBSUW.

   Action: Compliance

10. It is recommended that the company count and handle as grievances all grievances received involving claim payment issues due to the company's claim backlog problem as required by s. Ins 3.48 (7), Wis. Adm. Code.

    Action: Compliance

11. It is recommended that the company amend its claim appeal/grievance procedure manual to include specific language with regard to the handling of urgent care grievances as required by s. Ins 3.48 (7) (e), Wis. Adm. Code.

    Action: Compliance

12. It is recommended that the company cease including grievances received for ASO plans in the annual grievance report to OCI.

    Action: Compliance

13. It is recommended that the company revise its procedures to ensure that complaints forwarded to the company by OCI are handled as directed and that the company contacts the complainant within 10 days of receiving the complaint and attempt to resolve the problem.

    Action: Compliance

Small Employer Health Insurance

14. It is recommended that the company improve its procedures to ensure that the notice required by s. Ins 8.44 (2), Wis. Adm. Code, is provided when coverage is issued to small employers.

    Action: Compliance

15. It is recommended that the company update its underwriting guidelines and agent product portfolio to reflect the current definition of small employer in s. 635.02 (7), Wis. Stat.

    Action: Non-Compliance

16. It is recommended that the company revise the provision in its underwriting guidelines regarding late enrollees/special enrollment periods to comply with the requirements of s. 632.746, Wis. Stat.

    Action: Compliance

17. It is recommended that the company revise the definition of eligible employee in its agent product portfolio to comply with the definition of eligible employee in s. 632.745 (5), Wis. Stat.

    Action: Compliance

Small Employer Health Insurance Rating

18. It is recommended that when the company makes substantial changes to its rates or rating factors that these changes have one effective date for all groups.

    Action: Compliance

19. It is recommended that until the company uses a broad experience base to evaluate all of its industry factors, the company either cease using these adjusted industry factors or count the rate differences due to these factors with health status factors instead of case characteristics.

    Action: Compliance

20. It is recommended that when submitting future actuarial certifications, should any groups be found to have rates which do not comply with the rating regulations that the company provide OCI details concerning the nature of the errors, corrective action taken to prevent future errors, and information concerning retroactive rate adjustments for groups that were rated higher than allowed. Groups rated too low should be brought into compliance at renewal.

    Action: Compliance

21. It is recommended that the company correct rates of any group rated higher than allowed by s. Ins 8.52, Wis. Adm. Code, refunding any overpayment in premium back to the effective date of the incorrect rate and adopt this corrective procedure for any groups that are incorrectly rated in the future.

    Action: Compliance

Miscellaneous

22. It is recommended that the company develop and distribute to contracted providers a comprehensive provider manual similar to the manual used by Compcare Health Services Insurance Corporation.

    Action: Compliance

IV. CURRENT EXAMINATION FINDINGS

Claims

The examiners reviewed the company's response to the claims interrogatory, claims administration processes and procedures, explanation of benefit (EOB) and remittance advice (RA) forms, and claim adjustment (ANSI) codes. Blue Cross Blue Shield of South Carolina (BCBSSC) provides to the company, and other Cobalt subsidiaries, information system services for claim processing and other related services. The company contracts with The Alliance and WPPN networks to provide pricing on claims from these networks' providers. The networks then refer their providers' claims to the company for processing.

The examiners reviewed the company's procedures for calculating and paying interest on delayed claims. The examiners found that the company's written procedures regarding payment of interest on delayed claims did not clearly reference that the company's payment was calculated based on the date the checks are mailed. The company indicated it would reword its written procedures to clarify that interest is calculated on the date the check is mailed in order to document compliance with s. 632.46 (1), Wis. Stat.

The examiners requested a random sample of 100 paid and 100 denied claims. The examiners found that the initial samples provided by the company contained claims for insureds who lived in Wisconsin, but were covered by other Blue Cross association companies. The examiners requested a second random sample of 100 paid and 100 denied claims. The second sample of paid claims contained two claims for insureds who were not BCBSWI insureds. The sample of denied claims contained 34 duplicates and 23 Medicare supplement claims. No exceptions were found involving the medical claim sample

The examiners requested for review a random sample of 25 paid and 25 denied mental health claims. The examiners requested a second sample due to the number of Blue Cross association insureds included in the original sample. The examiners found the company denied two claims for mental health benefits referencing EOB status code and

descriptions “R6023 This is not a contract benefit” although this description of the reason for denying the claim did not accurately describe to the insured the reason for denial. The company explained that the claims were from mental health providers who had not been set up as mandated providers in its system. The company further explained that reason code R6023 is hard coded logic in the claims processing system. In order for BCBSWI to use the proper ANSI code, the company would have to submit a change sheet to BCBSSC and it would be charged for the change to the claim processing system. The examiners found that the company’s description on its EOBs of the reason for denying claims for mental health services did not accurately describe to the insured member the reason for denial. The examiners also found the company did not have a process in place for identifying the mandated mental health claims that were denied for this reason to ensure that the claims were adjusted when and if the company determined that the providers had current licensure information to document status as a mandated provider. Section 632.89 (2), Wis. Stat., requires that group insurance policies issued by an insurer shall provide coverage of nervous and mental disorders and alcoholism and other drug abuse problems. Coverage of these conditions may be subject to exclusions or limitations, including deductibles and copayments, that are generally applicable to other conditions covered under the policy. Coverage includes minimum coverage of inpatient hospital, outpatient and transitional treatment arrangements; minimum coverage of inpatient hospital services; minimum coverage of outpatient services and minimum coverage of transitional treatment arrangements. Section Ins 6.11 (3), Wis. Adm. Code, provides that it is an unfair claim settlement practice to fail to make provision for adequate claims handling personnel, systems and procedures to effectively service claims in this state incurred under insurance coverage issued or delivered in this state.

1. **Recommendation:** It is recommended that the company develop and implement a process to ensure that mental health claims that are denied because providers’ contracting files do not have evidence of current licensure status be automatically processed when the providers’ licensure status is updated in order to comply with s. 632.89 (2), Wis. Stat..

2. **Recommendation:** It is recommended that the company change the status code and description on its EOBs for denying mental health claims due to the licensing status of providers in order to more accurately reflect the reason for denial and in order to comply with s. 632.89, Wis. Stat., and s. Ins 6.11 (3), Wis. Adm. Code.

The examiners requested for review a random sample of 25 paid and 25 denied chiropractic claims. The examiners requested a second sample due to the number of BlueCross association insureds included in the sample. The examiners requested a third sample of denied chiropractic claims because of the number of duplicates in the second sample. The denied chiropractic claims sample contained 14 duplicates. The company reported that the duplicates involved claims that providers submitted in paper form and also submitted electronically, and claims that providers submitted with an attached vendor pricing sheet, that the pricing vendor also submitted electronically with the pricing already applied. The company reported that its claim system did not allow duplicate claims to attach to the original claim.

The examiners reviewed the 45 denied chiropractic claims selected from the third sample and found 14 duplicates, four Medicare supplement claims and one non BCBSWI insured in the sample. The examiners found that the company's health policy department policy and procedure manual did not clearly document the company's process for chiropractic consultant review. The examiners found that the company denied three chiropractic claims, but did not document that it sent letters to the patient and treating chiropractor indicating than an independent evaluation had been conducted. The examiners found that effective May 1, 2002, the company implemented a review process for therapy services, including chiropractic and osteopathic services to determine medical necessity if the intended course of treatment would exceed ten visits. The company reported that it paid chiropractic claims consistent with physician claims and reviews medically necessary claims with an independent reviewer. Section 632.87 (3) (b), Wis. Stat., provides that no policy, plan or contract covering diagnosis and treatment of a condition or complaint by a licensed chiropractor within the scope of the chiropractor's professional license, may restrict or terminate coverage for the treatment of a

condition or a complaint by a licensed chiropractor within the scope of the chiropractor's professional license on the basis of other than an examination or evaluation by or a recommendation of a licensed chiropractor or a peer review committee that includes a licensed chiropractor.

3. **Recommendation:** It is recommended that the company maintain documentation that if it denies a claim for chiropractic services related to medical necessity, it sends a letter to the patient and treating chiropractor indicating that an independent evaluation had been conducted providing the information required by s. 632.875 (2), Wis. Stat.

4. **Recommendation**: It is recommended that the company document its process, including written procedures, for an examination or evaluation by or a recommendation of a licensed chiropractor or a peer review committee that includes a licensed chiropractor when it restricts or terminates coverage for the treatment of a condition or a complaint by a licensed chiropractor in order to document compliance with s. 632.87 (3) (b), Wis. Stat.

5. **Recommendation:** It is recommended that the company file a report with OCI within 90 days of the adoption of the examination report of its plan for compliance with the requirements of s. 632.87 (3), Wis. Stat.

The examiners found three paid chiropractic claims and seven denied medical claims did not include the correct ANSI code on the EOB. The examiners also found that the company's EOB forms provided to insureds did not consistently use American national standards institute (ANSI) codes. The company reported that it did not use the correct ANSI codes due to the fact that the BCBSSC system limited its ability to record on its EOBs those ANSI codes outside range 1 to 100, either numerically or alphabetically. Section Ins 3.651 (5), Wis. Adm. Code, states that an insurer shall use the claim adjustment reason codes provided by the Office of the Commissioner of Insurance by no later than the first day of the 4th month beginning after being notified that an updated list of codes is available.

6. **Recommendation:** It is recommended that the company include on its EOB forms ANSI codes, including the semi-annual updates, that comply with the requirements of s. Ins 3.651 (5), Wis. Adm. Code.

7. **Recommendation:** It is recommended that the company file within 90 days of the adoption of the examination report its plan for compliance with the requirements of s. Ins 3.651 (5), Wis. Adm. Code.

Electronic Commerce

The examiners reviewed the company's response to the electronic commerce interrogatory, including provider listings and information for agents. The company reported that four of its departments were involved in updating the contents of the company's website; group marketing, IP marketing, human resources and corporate communications. The company also reported that all changes to its website require management and legal department approval.

The examiners found that BCBSWI's website was a resource for members and providers. The site contained provider directories, pharmacy formularies, plan details, applications, and copies of contracts, health library, and various other tools that members could read and download. The company indicated that the internet provider directories were updated weekly and the printed directories were reprinted twice a year.

The examiners found that BCBSWI did have a process for reviewing agent websites for company advertising. The examiners also found that the company's agent agreements included language that required agents to obtain approval of all advertising before use.

Managed Care

The provisions of 2001 Wisconsin Act 16 (SB 55) and the 2001-2003 Biennial Budget amended the provisions of ch. 609, Wis. Stat. Effective on September 1, 2001, ch. 609, Wis. Stat., was amended to replace the term "managed care plan" with the term "defined network plan," throughout the chapter. The act relaxed some of the requirements applicable to preferred provider plans, but only if preferred provider plans did not require or impose financial incentives related to referrals for access to a participating or non-participating provider. In addition, a preferred provider plan that imposed material exclusions, deductibles, maximum limits or other conditions that are uniquely applied to out of network provider services, and that results in significant limits on out of network benefits compared to in-network benefits, is a defined network plan. The act provided that a preferred provider plan that was also a defined network plan was required to meet statutory requirements.

The examiners reviewed the company's response to the managed care interrogatory, its policies and procedures regarding plan administration, compliance program, credentialing and recredentialing. The company reported that its QI program committees ultimately report to the Board via the executive policy committee. The executive policy committee provides administrative and clinical oversight for all activities. The Medical Director presents the QI program descriptions, assessments and annual plans to the Board annually for its review and final approval. The company reported that it did not plan to seek accreditation from the National Committee for Quality Assurance (NCQA).

The examiners determined that the company's policy forms and certificates of coverage did not include referral requirements and material exclusions, deductibles or limits that resulted in significant limits on out of network benefits compared to in-network benefits. The examiners found that the company offered plans that met the definition of preferred provider plans that were not also defined network plans.

The company reported that it contracted with 10 PPO networks, including WPPN, Alliance, Oakleaf Medical Network, Preferred Health, Prevea, Premium HealthCare Inc., Network Health, HCC, Health Tradition, and Bellin Health.

Although the company referenced the fact that the plans it offered did not meet the definition of defined network plans and that at the time of the examination it was not required to develop the comprehensive quality assurance standards, the company did provide a copy of its 2003-2004 QI program description and its 2003-2004 work plan. Section 609.32 (1m), Wis. Stat., requires that a preferred provider plan shall develop a procedure for to address quality problems, including written procedures for taking appropriate corrective action. The examiners found that the company met this requirement.

As the company's PPO plans did not meet the definition of defined network plans, it was not required at the time of the examination to develop a process for selecting participating providers, including written policies and procedures for review and approval of providers, the company had a credentialing and recredentialing process that it utilized in conjunction with Compcare Health Service Insurance Corporation, another Cobalt subsidiary.

Although the company's PPP policies were exempt from the requirements of s. 609.34, Wis. Stat., that require defined network plans to have a medical director, the company did have a medical director. The medical director was responsible for the oversight of utilization review and utilization management activities; the credentialing of network practitioners and facilities; the panel of independently contracted consulting medical directors and the development and implementation of medical necessity and experimental/investigational for health insurance policies.

The examiners reviewed the company's plan administration activities included a review of its organization charts, provider directories and provider agreements. The examiners requested from the company a list of providers terminated within the six months prior to the examination, in order to verify that the terminated providers had been deleted from the

company's electronic provider directories. The company provided a list identifying 50 terminated providers. The examiners found that the names of the 50 had been deleted from the provider directories on the company's website. The company reported that it update its website lists weekly.

The examiners reviewed the company's procedures regarding access to care. The company used the standards developed by Cobalt Corporation to address network access and availability for health plan members. The standards address availability of network services, travel and distance to contracted network providers, primary care physician office capacity, and appointment availability.

As the company offered plans that met the definition of preferred provider plans that were not also defined network plans, it is required to have a compliance program. The examiners found that the company did not have in place a compliance program and procedures to verify compliance with the defined network plans statutes. The company acknowledged that it did not have a compliance plan that meets the requirements of s. Ins 9.42, Wis. Adm. Code. The company reported that it did have an informal procedure of auditing internal processes to ensure compliance with state and federal insurance laws, but it had not maintained any of the auditing paperwork related to these various internal audits. Section Ins 9.42 (2), Wis. Adm. Code, provides that all insurers shall establish and operate a compliance program that provides reasonable assurance that the insurer is in compliance with ss. 609.22, 609.24, 609.30, 609.32, 609.34, 609.36, and 632.83, Stats., this subchapter and other applicable sections including, but not limited to s. Ins 9.07; Wis. Adm. Code, that violations are detected and timely corrections are taken. Section Ins 9.42 (3), Wis. Adm. Code, provides that an insurer's compliance program shall include regular internal audits, including regular audits of any contractors or sub-

contractors who perform functions relating to compliance with ss. 609.22, 609.24, 609.30, 609.32, 609.34, 609.36, and 632.83, Stats., this subchapter and other applicable sections including but not limited to s. Ins 9.07.

8. **Recommendation:** It is recommended that the company create, implement and maintain documentation that it has a compliance plan conforming to all of the requirements of s. Ins 9.42, Wis. Adm. Code.

Grievance and IRO

Effective March 1, 2000, the market conduct requirements previously contained in s. Ins 3.50, Wis. Adm. Code, were incorporated in subchapter III of ch. 9, Wis. Adm. Code. Effective December 1, 2001, s. Ins 9.33, Wis. Adm. Code, was repealed and recreated as subchapter II of ch. 18, Wis. Adm. Code, titled grievance procedures. This report references cites in the administrative code as currently drafted.

The examiners reviewed the company's response to the grievance interrogatory, grievance procedure, independent review organization (IRO) process and procedures, policy and certificate of coverage language, sample EOB forms and benefit denial letters, and annual OCI grievance reports for 2001 and 2002.

Grievance

The examiners reviewed a random sample of 50 grievance files. The examiners found 11 grievance files that included copies of acknowledgment letter that were not sent within five days of receipt of the grievances, and one where it was not sent. Section Ins 18.03 (4), Wis. Adm. Code, states that an insurer, within 5 business days of receipt of a grievance, deliver or deposit in the mail, a written acknowledgment confirming receipt of the grievance.

9. **Recommendation:** It is recommended that the company develop written procedures and safeguards to ensure that grievance acknowledgement letters are mailed in a timely basis in order to comply with s. Ins 18.03 (4), Wis. Adm. Code.

The examiners found eight grievances that were not resolved within 60 days as required by s. Ins 18.03 (6) (b), Wis. Adm. Code. If the insurer is unable to resolve the grievance within 30 calendar days, the time period may be extended an additional 30 calendar days if the insurer provides a written notification.

10. **Recommendation:** It is recommended that the company develop and implement a procedure to ensure that grievances for fully insured plans are completed within 60 calendar days to comply with s. Ins 18.03 (6) (b), Wis. Adm. Code.

The examiners found six files that did not include documentation that the extension letter was sent to the grievant, and nine files in which the letter did not contain information

providing notification that the review was being extended. The company reported that although it did provide staff training, a regional office had not used the extension letter required by its procedure manual. Section Ins 18.03 (6) (b), Wis. Adm. Code, provides that if the insurer is unable to resolve the grievance within 30 calendar days, the time period may be extended an additional 30 calendar days if the insurer provides a written notification of all of the following: 1. that the insurer has not resolved the grievance, 2. when resolution of the grievance may be expected and 3. the reason additional time is needed. The company responded that the letters were not sent because of job turnover and high work volume.

11. .**Recommendation:** It is recommended that the company develop safeguards to ensure that when warranted it sends grievance extension letters, and that the extension letters meet the requirements of s. Ins 18.03 (6) (b), Wis. Adm. Code.

Independent Review

The independent review organization (IRO) process required under Wisconsin law became operational on June 15, 2002. It gave individuals who had received an adverse determination or an experimental treatment determination on or after December 1, 2000, and prior to June 15, 2002, a retroactive right to request an independent review.

The examiners found that the company's IRO procedure manual stated an insured must have completed the grievance process in order to qualify for an independent review. Section 632.835 (2) (d), Wis. Stat., states that an insured may not be required to exhaust the internal grievance process if either of the two situations in the statute applies.

12. **Recommendation:** It is recommended that the company modify its IRO procedure manual to allow the insured to bypass its internal grievance process if both the insured and the company agree or if the insured's health condition requires an expedited review in order to comply with s. 632.835 (2) (d), Wis. Stat.

The examiners found that the company's IRO procedure manual did not include a written process to handle an independent review request on an expedited basis. Section 632.835 (3) (g), Wis. Stat., requires an insurer to submit the required information to the IRO in a

shortened time period if the IRO determines that the health condition of the insured is such that following the standard procedure would jeopardize the life or health of the insured.

13. **Recommendation:** It is recommended that the company document its procedure to provide information to an IRO within the time periods required by s. 632.835 (3) (g), Wis. Stat., if an IRO determines that a review should be completed on an expedited basis.

The examiners found that the IRO procedure manual did not include a written process to provide additional information in response to a request from an IRO. Section 632.835 (3) (c), Wis. Stat., requires an insurer to provide the information requested or to provide an explanation of why the information is not being submitted within 5 business days of a request for additional information from an IRO.

14. **Recommendation:** It is recommended that the company document its process to provide additional information within 5 business days of a request from an IRO, as required by s. 632.835 (3) (c), Wis. Stat.

The examiners found that the company's corporate grievance unit did not have internal procedures that described when it should send the notice explaining the right to request an independent review would be sent out. Section Ins 18.11, Wis. Adm. Code, requires an insurer to establish procedures to notify an insured of the right to request an independent review each time it makes an adverse determination or an experimental treatment determination.

15. **Recommendation:** It is recommended that the company develop and implement a procedure to provide insureds with a notice of the right to request an independent review that includes all of the information required by s. Ins 18.11 (2), Wis. Adm. Code, each time a grievance resolution results in an adverse determination or an experimental treatment determination.

Marketing, Sales & Advertising

The examiners' reviewed the company's response to the marketing, sales, and advertising interrogatory, its marketing, sales and advertising activities and advertising file. The company has multiple departments responsible for marketing, sales and advertising that include the Individual Products Marketing and Product Development department, Individual Product Sales Department, Individual Product Agency Sales Department, and the Corporate Marketing and Product Development Department.

The examiners reviewed 34 of the company's Medicare supplement advertisements and conducted a match of the forms with those maintained by OCI in its rates and forms database. The examiners also reviewed 11 general advertisements in the company's advertising file. No exceptions were noted regarding the advertising file.

Policyholder Service & Complaints

The examiners reviewed the company's policyholder service and complaints interrogatory and its complaint handling policies and procedures, complaint logs, and complaint reports.

The examiners requested a copy of the company's complaint log in order to select a random sample for review. The company provided separate listings, one for OCI complaints and another for all other complaints maintained in the customer service processing system. The company indicated that the listing from the customer service processing system included contacts identified as complaints in the system as well as contacts identified as usual and customary (UCR) payment review and timely filing exceptions. The company reported that it did not have formal procedures (other than the appeals and grievance procedures) specific to complaints that were not OCI complaints, grievances, or appeals. Section Ins 18.06 (1), Wis. Adm. Code, provides that an insurer offering a health benefit plan shall record each complaint submitted to the insurer and retain the record for a period of at least 3 years. The records shall be maintained at the insurer's home office or principal office and shall be available for review during examinations.

16. Recommendation: It is recommended that the company revise its procedures and provide staff training to ensure that it records and maintains all complaints in order to document compliance with s. Ins 18.06 (1), Wis. Adm. Code.

The examiners selected and reviewed a random sample of 100 files that the company identified in response to OCI's complaint data request. As stated above, the data only included files the company identified as OCI complaints, grievances or appeals. The examiners found that four of the files identified as complaints met the definition of a grievance. However, the complaints were processed as grievances by the company. The examiners also found that these files were included in the annual grievance report submitted to OCI.

Producer Licensing

The examiners reviewed the company's response to the producer licensing interrogatory, including its agency agreement**s** and policies and procedures regarding producer licensing, listings, terminations and training.

The examiners requested from BCBSWI a listing of all Wisconsin agents that represented the company as of the end date of the period under review. The original data received from the company was a listing of all Cobalt subsidiary insurance company producers and not BCBSWI producers as requested. The examiners made a second and third request for the producer data, before they were able to select a file sample for review. The company reported that it contracted with Peoplesoft, a software vendor, to convert its existing producer files from EDS to the new agent software system. The conversion began on January 1, 2002, and was completed January 1, 2003. The examiners found that the company had not completed reconciliation or auditing its data.

17. **Recommendation**: It is recommended that the company file a report with OCI within 90 days of the adoption of the examination report including documentation that it has audited and reconciled its current producer files with data maintained by OCI.

The examiners conducted a data match of the company's files with those maintained by OCI. On December 10, 2003, the examiners notified the company that they had found 261 agents who were listed in the OCI database as company agents, but were not included in the listing provided by BCBSWI. The company responded that it had not requested the correct data from its system.

The examiners found 57 agents whose listings did not match with the information maintained by OCI. The examiners found that all were conversion errors that the company corrected during the examination.

The examiners identified six agent listings that included an incorrect social security number. The company reported that it corrected the social security numbers during the review.

18. **Recommendation:** It is recommended that the company institute a process for scheduled periodic audit of its agent system to ensure that its records accurately show all active and terminated agents of BCBSWI in order to document compliance with the requirements of s. Ins 6.57 (1) and (2), Wis. Adm. Code.

Although the company reported that that it did match the annual renewal billing sent by OCI to its database to make sure all agents are listed, but has no written procedures to ensure that it is done.

19. **Recommendation:** It is recommended that the company carefully review and compare the annual renewal billing sent by OCI to its company records, promptly initiate an investigation into the reason(s) an agent does not appear on the annual renewal billing and take appropriate corrective action to ensure compliance with s. Ins 6.57, Wis. Adm. Code.

The examiners reviewed a random sample of 50 terminated agent files. The examiners found two agent files contained OCI termination form 11-011 that was not dated within 30 calendar days of the termination date as required by s. Ins 6.57 (2), Wis. Adm. Code. The company reported that two of its departments are involved in the termination of agent, and that its sales department had terminated the agent, but failed to notify the licensing department in a timely manner.

20. **Recommendation**: It is recommended that the company develop and implement a process to document communication between its departments involved in terminating agents, to ensure that information regarding terminated agents is correct, consistent and timely in order to comply with s. Ins 6.57 (2), Wis. Adm. Code.

Small Employer

The examiners reviewed the company's response to the small employer interrogatory, its underwriting requirements, participation requirements, rating methodology, new business rates, renewal system, actuarial certifications, small group qualification documents and employer submission guidelines.

The examiners requested an explanation of compliance with the recommendation from the 1999 market conduct examination regarding use of the current definition of small employer in the company underwriting guidelines as required by s. 635.02 (7), Wis. Stat. The company responded that the underwriting manual was updated March 28, 2002, to include the new definition of small employer. The company's response dated September 1, 2000, to the compliance order for the 1999 examination indicated that the company had changed its underwriting guidelines to conform to the new definition. The examiners found that the company was not in compliance with the prior recommendation until two years after the compliance order was issued and for a portion of the period under review.

21. **Recommendation:** It is again recommended that the company audit its underwriting guidelines and practices to ensure that they are in compliance with the definition of a small employer as required by s. 635.02 (7), Wis. Stat.

The examiners requested a copy of the written disclosure of the rating factors and renewability, required by s. 635.11, Wis. Stat., and s. Ins 8.48 (1), Wis. Adm. Code. Section Ins 8.48, Wis. Adm. Code, requires that prior to the completion of an application for small employer health insurance, the employer must sign and receive a copy of a separate disclosure form that provides certain information regarding the manner in which the coverage will be rated and renewed. The company reported that effective January 1, 2002, it began including the rating and renewability disclosure information required by s. Ins 8.48 (1), Wis. Adm. Code, in the body of the employer application form. Prior to January 1, 2002, the company was using a separate rating and renewability disclosure form that complied with the requirements of the

regulation and completed by the agent with a copy being given to the employer prior to the application being completed. The examiners found that the company's current practice did not comply with the requirements of s. Ins 8.48, Wis. Adm. Code.

22. **Recommendation:** It is recommended that the company develop and use a separate rating and renewability disclosure form that complies with the requirements of s. Ins 8.48, Wis. Adm. Code.

The examiners reviewed a random sample of 50 issued small employer files. The company was unable to provide files for four of the sample groups. The company responded that during a realignment of its small employer underwriting, the company sent files to storage that were not reported accurately by box resulting in the company being unable to retrieve the files. The company reported it has established a new filing system as of July, 2003.

The examiners found that one group file did not contain supporting documentation. Section Ins 8.65 (1), Wis. Adm. Code, requires that a small employer insurer is to require a complete list of eligible employees and dependents of eligible employees and supporting documentation such as the state unemployment or workers compensation quarterly reporting forms to verify the information.

The examiners found that the company was not able to produce for review four small employer group files. Section 601.42, Wis. Stat., requires a company to provide information to OCI in reasonable form as requested by OCI. Section Ins 6.80 (4), Wis. Adm. Code, requires a domestic company to retain records of insurance company operations and other financial records reasonably related to insurance operations for the preceding 3 years.

23. **Recommendation:** It is recommended that the company revise existing procedures for the retention of small employer group files to ensure that records requested by OCI under s. 601.42, Wis. Stat., are readily retrievable and comply with s. Ins 6.80 (4), Wis. Adm. Code, for keeping files for 3 years.

The examiners requested a list of all company small employer quotes for the examination period in order to select a sample to verify the timeliness of quotes. The company responded that it did not record the dates the quotes were requested by the small employer or

agent. The company also reported that as of July, 2003, the underwriting area established an electronic process for receiving and processing small employer quotes.

24. **Recommendation:** It is recommended that the company include in its quoting system a method of recording dates the requests for a quotes are received to order to comply with s. 601.42, Wis. Stat.

The examiners reviewed the company small employer rating information and small employer insurer actuarial certification of calendar years 2001 and 2002. The company reported that two groups in 2001 and seven groups in 2002 were issued rates that were not in compliance with s. Ins 8.52, Wis. Adm. Code. Of the nine groups, five terminated their policy before the renewal date, so the incorrect rates were never implemented. Two groups were issued rates below the minimum rate band, which the company corrected upon renewal. Two of the groups were incorrectly reported as out of compliance, which the company determined after the actuarial certification was filed. No corrective action was required. The errors reported in the actuarial certification appear to have been a result of manual data entry errors. The company has since implemented a new renewal and rating system that gathers the necessary information automatically and relies less on data entry. This system has automated safeguards in place to ensure rates are calculated in compliance and the actuarial staff performs monthly checks to ensure the system is accurate.

Privacy and Confidentiality

Section 610.70, Wis. Stat., regarding medical records privacy, became effective June 1, 1999, and created restrictions on insurers regarding their collection and release of personal medical information that corresponded with the federal Health Insurance Portability and Accountability Act (HIPAA) requirements. Section Ins 25, Wis. Adm. Code, became effective July 1, 2001, to address the provisions of Gramm-Leach-Bliley, and is based on the National Association of Insurance Commissioners (NAIC) privacy of consumer financial and health information model regulation.

The examiners reviewed the company's response to the privacy of consumer financial and health information interrogatory, corporation privacy and confidentiality practices, employee confidentiality agreement, privacy notice, enrollment and disclosure information, provider, agent and vendor agreements. The examiners also interviewed the company's privacy officer. The company reported that its parent company, Cobalt, had established uniform privacy policies for all its subsidiaries to address privacy and HIPAA issues.

The company stated that its privacy officer reports to the Cobalt HIPAA Executive Steering Committee which reports to the Cobalt Board Ethics Committee. The Ethics Committee meets quarterly and reports to the Cobalt Board Audit Committee. The company has privacy contacts in every office for assistance in oversight of the policy.

The examiners found that the company has developed an internal audit schedule that began in the third quarter of 2003. The company reported that it had not issued any reports as a result of this audit, and that it had not been subject to an external privacy audit.

The examiners found that the company had developed a detailed privacy program for its employees. The company also had an orientation program for new employees that included general training regarding its compliance program. The company requires that employees sign a certification of review of code of conduct and code of ethics.

The examiners found that the company provided employees of small employers with a privacy information statement upon enrollment but provided the annual privacy statement only to the employer. The company stated that it provided the annual notice to its customer, which it defined as the employer. The company used the definition of customer from s. Ins 25.04 (9) and (10) (a), Wis. Adm. Code, which states that a customer means a consumer who has a customer relationship with a licensee. A customer relationship is a continuing relationship between a consumer and a licensee under which the licensee provides one or more insurance products or services to the consumer that are to used primarily for personal, family or household purposes. The company agreed to provide to both its subscribers and employers a copy of its annual privacy notice.

The examiners verified that the company's provider and vendor agreements included a provision regarding confidential and private health information. The examiners found that the company's vendor agreement for its document shredding service did not contain language that protected the documents confidentiality during pickup, transportation and destruction. The company indicated that it is amending this agreement during 2004.

Company Operations/Management

The examiners reviewed the company's response to the company operations and management interrogatory, provider agreements, and executive committee and board of directors meeting minutes.

The examiners reviewed a sample of 34 provider agreements for multiple individual providers. The examiners found that the company's agreements with ThedaCare Inc., Waukesha/Elmbrook, Medical College of Wisconsin, and Richland Medical Center, LTD, did not adequately meet the requirement that contracted providers promptly provide the insurer the information necessary to respond to complaints or grievances. The company acknowledged that the ThedaCare Inc., agreement, executed in 2002, did not contain a provision requiring that the contracted providers promptly provide the company information necessary to respond to complaints and grievances. The company maintained that the remaining three provider agreements included compliant provisions. Section Ins 18.03 (2) (c) 2. a., Wis. Adm. Code, requires that an insurer offering a preferred provider plan to include in each contract between its providers, provider networks and within each agreement governing the administration of provider services, a provision that requires the contracting entity to promptly provide the insurer the information necessary to respond to complaints or grievances.

25. **Recommendation**: It is again recommended that the company provide to OCI within 90 days of the adoption of the examination report, its plans for the review and revision of all of its provider agreements to include adequate language to satisfy the requirements of s. Ins 18.03 (2) (c) 2. a., Wis. Adm. Code.

The examiners' review of the company's operations and management activities, including claim functions, indicated that the company contracted for claim processing services that had both system limitations and charges associated with making enhancements to the system that the company was unwilling to pay. The examiners found that the company had not required modifications to the claim system that would meet the requirements of Wisconsin insurance law regarding mandates and claim adjustment reason codes. Section Ins 6.11 (3),

Wis. Adm. Code, defines certain claim adjustment practices which are considered to be unfair methods and practices in the business of insurance.

26. **Recommendation:** It is recommended that the company within 90 days of the adoption of the examination report provide to OCI its plans for identifying, implementing, and testing necessary enhancements to the information services system it utilizes to pay claims in order to demonstration compliance with Wisconsin insurance law.

V. CONCLUSION

The company is a domestic insurer that markets only in Wisconsin. The examiners found that Blue Cross Blue Shield of Wisconsin did not comply with two of the 22 recommendations that were adopted in 2000. This compliance examination resulted in 24 additional recommendations in the areas of claims, company operations and management, electronic commerce, managed care, producer licensing, small employer, grievance and IRO, marketing, sales and advertising, and policyholder services and complaints.

The examiners' experienced a delay in obtaining data in order to choose samples for review. The examination review identified certain activities for which the company needs to improve its oversight process. The examination report includes findings and recommendations regarding the company's occasional failure to comply with Wisconsin mandates and grievance requirements.

VI. SUMMARY OF RECOMMENDATIONS

Claims

Page 11 1. It is recommended that the company develop and implement a process to ensure that mental health claims that are denied because providers' contracting files do not have evidence of current licensure status be automatically processed when the providers' licensure status is updated in order to comply with s. 632.89 (2), Wis. Stat.

Page 12 2 It is recommended that the company change the status code and description on its EOBs for denying mental health claims due to the licensing status of providers in order to more accurately reflect the reason for denial and in order to comply with s. 632.89, Wis. Stat., and s. Ins 6.11 (3), Wis. Adm. Code.

Page 13 3. It is recommended that the company maintain documentation that if it denies a claim for chiropractic services related to medical necessity, it sends a letter to the patient and treating chiropractor indicating that an independent evaluation had been conducted providing the information required by s. 632.875 (2), Wis. Stat.

Page 13 4 It is recommended that the company document its process, including written procedures, for an examination or evaluation by or a recommendation of a licensed chiropractor or a peer review committee that includes a licensed chiropractor when it restricts or terminates coverage for the treatment of a condition or a complaint by a licensed chiropractor in order to document compliance with s. 632.87 (3) (b), Wis. Stat.

Page 13 5. It is recommended that the company file a report with OCI within 90 days of the adoption of the examination report of its plan for compliance with the requirements of ss. 632.87 (3), Wis. Stat.

Page 13 6. It is recommended that the company include on its EOB forms ANSI codes, including the semi-annual updates, that comply with the requirements of s. Ins 3.651 (5), Wis. Adm. Code.

Page 13 7. It is recommended that the company file within 90 days of the adoption of the examination report it plan for compliance with the requirements of s. Ins 3.651 (5), Wis. Adm. Code.

Managed Care

Page 18 8. It is recommended that the company create, implement and maintain documentation that it has a compliance plan conforming to all of the requirements of s. Ins 9.42, Wis. Adm. Code.

Grievance and IRO

Page 19 9. It is recommended that the company develop written procedures and safeguards to ensure that grievance acknowledgement letters are mailed in a timely basis in order to comply with s. Ins 18.03 (4), Wis. Adm. Code.

Page 19 10 It is recommended that the company develop and implement a procedure to ensure that grievances for fully insured plans are completed within 60 calendar days to comply with a s. Ins 18.03 (6) (b), Wis. Adm. Code.

Page 20 11. It is recommended that the company develop safeguards to ensure that when warranted it sends grievance extension letters and that the extension letters meet the requirements of s. Ins 18.03 (6) (b), Wis. Adm. Code.

Page 20 12. It is recommended that the company modify its IRO procedure manual to allow the insured to bypass its internal grievance process if both the insured and the company agree or if the insured's health condition requires an expedited review in order to comply with s. 632.835 (2) (d), Wis. Stat.

Page 21 13. It is recommended that the company document its procedure to provide information to an IRO within the time periods required by s. 632.835 (3) (g), Wis. Stat., if an IRO determines that a review should be completed on an expedited basis.

Page 21. 14. It is recommended that the company document their process to provide additional information within 5 business days of a request from an IRO, as required by s. 632.835 (3) (c), Wis. Stat.

Page 21 15. It is recommended that the company develop and implement a procedure to provide insureds with a notice of the right to request an independent review that includes all of the information required by s. Ins 18.11 (2), Wis. Adm. Code, each time a grievance resolution results in an adverse determination or an experimental treatment determination.

Policyholder Service and Complaint

Page 23 16. It is recommended that the company develop a process and procedures for recording and maintaining all complaints in order to document compliance with s. Ins 18.06 (1), Wis. Adm. Code.

Producer Licensing

Page 24 17. It is recommended that the company file a report with OCI within 90 days of the adoption of the examination report including documentation that it has audited and reconciled its current producer files with data maintained by OCI.

Page 25 18 It is recommended that the company institute a process for scheduled periodic audits of its agent system to ensure that its records accurately show all active and terminated agents of BCBSWI in order to document compliance with the requirements of s. Ins 6.57 (1) and (2), Wis. Adm. Code.

Page 25 19 It is recommended that the company carefully review and compare the annual renewal billing sent by OCI to its company records, promptly initiate an investigation into the reason(s) an agent does not appear on the annual renewal billing and take appropriate corrective action to ensure compliance with s. Ins 6.57, Wis. Adm. Code.

Page 25 20. It is recommended that the company develop and implement a process to document communication between its departments involved in terminating agents, to ensure that information regarding terminated agents is correct, consistent and timely in order to comply with s. Ins 6.57 (2), Wis. Adm. Code.

Small Employer

Page 26 21. It is again recommended that the company audit its underwriting guidelines and practices to ensure that they are in compliance with the definition of a small employer as required by s. 635.02 (7), Wis. Stat.

Page 27 22. It is recommended that the company develop and use a separate rating and renewability disclosure form that complies with the requirements of s. Ins 8.48, Wis. Adm. Code.

Page 27 23. It is recommended that the company revise existing procedures for the retention of small employer group files to ensure that records requested by OCI under s. 601.42, Wis. Stat. are readily retrievable and comply with s. Ins 6.80 (4), Wis. Adm. Code, for keeping files for 3 years.

Page 28 24. It is recommended that the company include in its quoting system a method of recording dates the requests for a quotes are received to order to comply with s. 601.42, Wis. Stat.

Company Operation/Management

Page 31 25. It is again recommended that the company provide to OCI within 90 days of the adoption of the examination report, its plans for the review and revision of all of its provider agreements to include adequate language to satisfy the requirements of s. Ins 18.03 (2) (c) 2. a., Wis. Adm. Code.

Page 32 26. It is recommended that the company within 90 days of the adoption of the examination report provide to OCI its plans for identifying, implementing, and testing necessary enhancements to the information services system it utilizes to pay claims in order to demonstration compliance with Wisconsin insurance law.

VII. ACKNOWLEDGEMENT

The courtesy and cooperation extended to the examiners during the course of the examination by the officers and employees of the company is acknowledged.

In addition, to the undersigned, the following representatives of the Office of the Commissioner of Insurance, state of Wisconsin, participated in the examination.

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Pam Ellefson	Senior Insurance Examiner
Jerry Zimmer	Insurance Examiner
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Respectfully submitted,

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Examiner-in-Charge