



THE OFFICE OF THE COMMISSIONER OF SECURITIES AND INSURANCE

MONTANA STATE AUDITOR

COMMISSIONER MONICA J. LINDEEN

AMENDED REPORT OF THE MARKET CONDUCT EXAMINATION

OF

**BLUE CROSS AND BLUE SHIELD OF MONTANA, INC. (NAIC 53686)
(NOW KNOWN AS CARING FOR MONTANANS, INC. AS OF JULY 31, 2013)**

HELENA, MONTANA

AS OF DECEMBER 31, 2010

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February 4, 2014

Honorable Monica J. Lindeen
Commissioner of Securities and Insurance
Montana State Auditor
840 Helena Ave.
Helena, MT 59601

Dear Commissioner Lindeen:

Pursuant to your authority delegated under the provisions of Mont. Code Ann. §§ 33-1-401, 33-30-105, and 33-31-401, and in accordance with the instructions of the Office of the Commissioner of Securities and Insurance, Montana State Auditor (CSI), a market conduct examination of the business practices and affairs has been conducted on:

**BLUE CROSS AND BLUE SHIELD OF MONTANA, INC.,
(NOW KNOWN AS CARING FOR MONTANANS, INC., AS OF JULY 31, 2013)**

P.O. Box 1165
Helena, Montana 59624

Blue Cross and Blue Shield of Montana, Inc., now known as Caring for Montanans, Inc., hereinafter referred to as "the Company," was a Montana domiciled non-profit health service corporation until July 31, 2013. The examination was performed as of December 31, 2010, at the Company's former home office in Helena, Montana.

The amended report of examination is herewith respectfully submitted.

EXAMINATION PURPOSE AND SCOPE

Risk & Regulatory Consulting, LLC, a subsidiary of RSM McGladrey, Inc. (RSM), an independent examination team, contracting with the CSI through the authority delegated under the provisions of Mont. Code Ann. §§ 33-1-401, 33-30-105, and 33-31-401, reviewed certain business practices of the Company in conjunction with the CSI (jointly referred to herein as Examiner). The findings in this report, including all work products developed in the production of this report, are the sole property of the Commissioner of Securities and Insurance, Montana State Auditor (Commissioner), and the CSI.

RSM performed a portion of this routine market conduct examination in order to assist the CSI in meeting its statutory examination requirements. The purpose of the examination was to determine the Company's compliance with Montana insurance laws, regulations and bulletins, selected federal laws and regulations, and generally accepted operating principles. Examination information contained in this report should serve only those purposes. The conclusions and findings of this examination are public record. The preceding statements are not intended to limit or restrict the distribution of this report.

This market conduct examination was conducted pursuant to the provisions of Mont. Code Ann. §§ 33-1-401, 33-30-105, and 33-31-401, and in accordance with procedures and guidelines outlined in the *May 2009 NAIC Market Regulation Handbook*. All procedures were performed under the management, control, and general supervision of the CSI. The Examiner relied primarily on records and materials maintained by the Company. However, it was deemed that some procedures were more efficiently addressed by prior CSI financial examinations. In those cases, the Examiner relied on procedures performed by the CSI's financial examination staff to the extent deemed necessary to ensure that the objective was adequately addressed. The examination covered the period from July 1, 2006, through December 31, 2010.

This examination included a review of the Company's practices in the areas listed below:

1. Operations and Management
2. CSI Complaint Handling
3. Appeal Handling
4. Independent Review Handling
5. Marketing and Sales
6. Producer Licensing and Commissions
7. Policyholder Services

- a. Billing, Policy Issuance, and Communications
- b. Pharmacy Services
- c. Consumer Collection Actions
- 8. Underwriting and Rating
 - a. Issued and Renewed Coverage
 - b. Declined Coverage
 - c. Canceled/Non-Renewed/Terminated Coverage
 - d. Creditable Coverage Certifications
 - e. Rescinded Coverage
- 9. Claims
 - a. Paid Claims
 - b. Denied Claims
- 10. Network Adequacy
- 11. Provider Credentialing
- 12. Quality Assessment and Improvement

This examination report is a report-by-exception. References to any practices, procedures, or files that contained no improprieties were omitted. As a result, the majority of the material reviewed may not be addressed in this report.

During the course of the Examiner's review, the Company was provided with "information requests" that addressed the Examiner's questions, concerns, and potential discrepancies. The file data provided, along with the Company's responses to the information requests, were used to determine compliance. If the Examiner believed the Company was potentially not in compliance with state and federal laws, legal agreements with the CSI, and/or generally accepted business practices, a "concern form" was issued outlining the potential non-compliance. Each concern form contained a section that allowed the Company to indicate if it agreed or disagreed with the information presented, and allowed the Company to clarify facts, as well as provide any additional information addressing the issues presented. The Company's concern form responses were reviewed and carefully considered when determining the exceptions that were included in this report.

The Examiner's findings may result in administrative action by the CSI. During the course of the examination, all unacceptable or non-compliant practices of the Company may not have been discovered. Failure to identify specific Company practices, however, does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any insurance product.

COMPANY HISTORY AND BACKGROUND

In 1929, a prepaid hospital plan was created at Baylor University in Texas. It was known as the Hospital Service Association (HSA). The Hospital Service Association entered Montana in 1940 and in 1964 became known as Blue Cross of Montana. Montana Physicians Service (MPS), a Blue Shield Company, was created in 1946 when 200 physicians agreed to accept MPS reimbursement as a payment-in-full for their services.

Blue Cross of Montana and MPS merged in 1986 to become Blue Cross and Blue Shield of Montana, Inc., an independent not-for-profit health services corporation. The Company was a locally operated independent licensee of the Blue Cross and Blue Shield Association.

During the 1990s, the Company was licensed to provide managed care services, and later offered point-of-service plans under this license. Therefore, it was licensed to offer both traditional insurance and managed care products in the state of Montana

During the examination period until November 30, 2006, the Company was the administrator for Medicare Parts A and B in Montana. In addition, it served as the lead carrier for the Montana Comprehensive Health Association (Montana's High Risk Pool and HIPAA Portability Pool).

On July 31, 2013, Health Care Service Corporation (HCSC) and the Company closed their statutorily approved asset purchase agreement. On that same day, it lawfully changed its name to Caring for Montanans, Inc. It continues to exist as a business entity following the transaction, but it does not operate as a health insurance business. Instead, the Company's business purpose is satisfying or otherwise discharging its remaining liabilities, including any fines arising from this examination. When all liabilities have been resolved or otherwise discharged, the Company will be wound down and dissolved in accordance with its July 31, 2013, Articles of Dissolution filed with the Montana Attorney General.

The Company served more than 230,000 customers in Montana and 140,000 Medicare beneficiaries.

The Company offered the following products/services in the state of Montana during the examination period:

1. Individual and Group PPO benefit plans.
2. Group Point-of-Service and Managed Care benefit plans.
3. Individual and Group High Deductible Health plans.

4. Short-term coverage.
5. Medicare Part "D" and Medicare Advantage plans.
6. Medicare Supplement plans.
7. Administrative Services for the Federal Employee Program.
8. Administrative Services for Self-insured Montana Employers.
9. Administrative Services for CHAMPUS/TriWest.
10. Administrative Services for the Healthy Montana Kids (HMK) program (formerly known as "Montana BlueCHIP"), sponsored by the Department of Health and Human Services for low-income families that are not eligible for Medicaid.
11. Administrator for the Montana Comprehensive Health Association, which is a high-risk pool for individuals who have no group coverage and are not eligible for non-group coverage for medical reasons. It also supplies access to health insurance for federally eligible individuals without preexisting conditions.
12. Administrator for both Medicare A and B for Montana until November 30, 2006.
13. Administered both the Montana State Employee Plan and Montana State University Plan.

The following table is a summary of the Company's annual premiums as reported on Schedule T of the Annual Statement.

Report Year	Accident & Health Premiums	Medicare Title XVIII	Federal Employees Health Benefits Program Premium
2006	\$380,462,556	\$1,447,194	\$100,098,151
2007	\$399,933,110	\$4,434,416	\$107,237,954
2008	\$396,764,533	\$4,464,297	\$117,892,623
2009	\$378,467,231	\$3,682,471	\$122,671,630
2010	\$399,135,540	\$4,318,306	\$126,939,454

The Company's officers as of December 31, 2010, include the following individuals:

1. Jerry E. Lusk, Chairman.
2. Michael E. Frank, President and CEO.
3. Fred Olson, M.D., Executive Vice President of Internal Operations and Chief Medical Officer.
4. Mark A. Burzynski, Chief Financial Officer and Treasurer.
5. Mary Belcher, Corporate Secretary and General Counsel.
6. Patrick Law, Chief Information Officer.
7. Shannon Marsden, Chief Marketing and Business Development Officer.

Members of the Company's upper management team who terminated employment between July 1, 2006, and December 31, 2010, include the following individuals:

1. Richard Miltenberger, Sr. Director of Underwriting – Voluntary Termination on October 6, 2006.
2. David Pfeifle, Director of Medicare Audit and Reimbursement – Retired with Benefits on November 30, 2006.
3. Michael Wagner, VP of Government Programs and Corporate Treasury – Retired with Benefits on January 5, 2007.
4. Jane DeLong, VP of Strategic Planning and Corporate Program Management – Retired with Benefits on January 5, 2007.
5. Tanya Ask, VP of Government Affairs – Voluntary Termination on April 27, 2007.
6. Mary Puckett, Director of Large Group Sales – Voluntary Termination on June 1, 2007.
7. Marianne Krpan, VP of Claims and Customer Service – Voluntary Termination on July 6, 2007.
8. James VanVig, AVP Actuarial and Reporting – Voluntary Termination on July 20, 2007.
9. Kirk Smith, VP and Chief Actuary - Long-Term Disability effective August 3, 2007.
10. Richard Lindeman, Director of Administrative Services – Retired with Benefits on December 14, 2007.
11. Eric Deeg, Sr. Director of Large Group Sales – Voluntary Termination on May 30, 2008.
12. Robert Reid, Administrator Actuarial and Underwriting Research – Retired with Benefits on July 1, 2008.
13. Linda McGillen, Director of Corporate Communications – Voluntary Termination on December 5, 2008.
14. Terry Cosgrove, Executive VP and General Counsel – Retired with Benefits on January 2, 2009.
15. Sheila Shapiro, Chief Operating Officer – Voluntary Termination on January 8, 2009.
16. Jared Short, Chief Marketing Officer – Voluntary Termination on July 16, 2009.
17. Christina Sharp, Director of Marketing and Consumer Sales – Voluntary Termination on November 20, 2009.
18. Eric Schindler, Chief Financial Officer – Voluntary Termination on February 19, 2010.
19. Gregory Gould, Associate General Counsel – Voluntary Termination on January 21, 2010.
20. Sherry Claodouhos, CEO – Retired with Benefits on November 30, 2010.

21. Judd Wagner, Director of Key Accounts – Voluntary Termination on December 10, 2010.
22. Paul Jelinek, Director of Sales, OPS and Ancillary Services – Voluntary Termination on December 30, 2010.

The Company did not have any acquisitions or mergers during the exam period, but acquired interest in the following companies:

- **BCS Financial Corp.** Stock Certificate dated January 1, 2007 (9,601 shares).
- **Blue Cross and Blue Shield Association.** Stock Certificate March 7, 2007 (208 shares; \$.01).
- **TriWest Alliance, Inc.** Stock Certificate dated May 15, 2008 (1,015.2100; Class A \$.01).
- **Prime Therapeutics LLC.** Stock Certificate dated January 20, 2009 (134 Units).
- **Plan's Holding Corporation.** Stock Certificate dated March 7, 2007 (208 shares Class A Common Stock; 208 shares Preferred Stock).

During the audit period, a membership and claims conversion from the mainframe LRSP system to the client server QNXT system was in progress with staggered conversions, each consisting of a mix of fully funded and self-funded group business. The staggered conversion dates for group business during the audit period were October 1, 2006, and again April 1, 2007. The individual line of business (excluding Medicare Supplement products) was converted separately and was completed on January 1, 2008. Prior to the beginning of the audit period (July 1, 2006), some group business had already been converted to the QNXT system. Medicare Supplement products (with the exception of the Simply Blue products which were converted on June 1, 2010) were converted on January 1, 2011, and thus processed solely on the mainframe LRSP system during the audit period. As with any system conversion, the Company has encountered several difficulties during the change-over process, including problems which restricted its ability to process and settle claims.

In addition to the above conversions, the Company completed a major version upgrade to the QNXT processing system in October 2009, which moved the system from the client server (V 2.6) to a web based platform (V 3.4).

OPERATIONS AND MANAGEMENT

The Company's policies and procedures relating to audit programs, controls, safeguards, record retention, and contracts with external entities were carefully evaluated to determine the completeness and appropriateness of those procedures.

Additionally, all standards were considered throughout each of the testing reviews performed as part of this Market Conduct Examination. General review results will be recorded in this section of the report, whereas any exceptions noted during the review of specific review areas will be recorded in the results section of the appropriate review area.

Seventeen (17) standards were evaluated to determine the Company's compliance with any applicable state and federal statutes, rules and regulations, National Association of Insurance Commissioners (NAIC) standards, contract provisions, and established policies and procedures. Exceptions to those standards are listed below.

Operations and Management Standard 7

Records are adequate, accessible, consistent, and orderly while complying with state record retention and production requirements. Mont. Code Ann. § 33-3-401.

POLICY AND PROCEDURE TESTING RESULTS

The Company has established record retention policies and procedures that allow for adequate record retention as required.

The Company provided most of the files, records, and other data requested during the examination, although some Company responses were incomplete and untimely. Upon further discussions with the company, the company dedicated more resources to provide more complete and timely responses.

Operations and Management Standard 9

The Company cooperates on a timely basis with the Examiner performing the examination. Mont. Code Ann. § 33-1-408.

POLICY AND PROCEDURE TESTING RESULTS

The Company representatives were very cooperative throughout the examination process. However, as identified in this report, based on the allocation of their resources, they were not always able to provide timely responses. Upon further discussions with the Company, the Company dedicated more resources to provide more timely responses.

CSI COMPLAINT HANDLING

The complaint handling review consisted of key personnel interviews, a review of the Company's policies and procedures, and the review of a randomly selected sample of files. In addition, the Examiner reconciled the CSI's complaint listing with the Company's listing and reviewed the Company's listing to determine whether it was complete and accurate.

Three (3) standards were evaluated to determine the Company's compliance with any applicable state and federal statutes, rules and regulations, NAIC standards, contract provisions, and established policies and procedures. Exceptions to those standards are listed below.

CSI Complaint Handling Standard 1

*All complaints are recorded in the required format on the Company's complaint register.
Mont. Code Ann. § 33-18-1001.*

Five (5) exceptions were identified in the reconciliation of the CSI's complaint listing to the Company's listing. The exceptions are as follows:

- Two (2) CSI complaints were not found in the Company's listing.
- Three (3) complaints were incorrectly recorded.

CSI Complaint Handling Standard 2

The Company takes adequate steps to finalize and dispose of complaints in accordance with applicable state and federal statutes, rules and regulations, and contract language. Mont. Code Ann. §§ 33-18-232, 33-22-121, 33-22-142, 33-22-151, 33-32-203, 33-37-102, Admin. R Mont. 37.108.305, 37.108.310, 37.108.315, 6.6.5079G.

SAMPLE FILE TESTING RESULTS

No. of Files Tested	No. of Files with Errors	Percentage of Errors
119	12	10%

Several of the complaint files with errors contained multiple exceptions involving the underlying claims and appeals, etc. The following were the exceptions noted in the testing for this standard:

- Six (6) files in which the Company failed to process the claim timely.
- Five (5) files in which Company errors delayed claim processing or payment.
- Three (3) files in which the Explanation of Benefits (EOB) contained inadequate, incomplete, or incorrect explanations.
- One (1) file in which the Company failed to respond to appeals.
- Three (3) files in which the Company failed to respond timely to an appeal.
- One (1) file in which the Company failed to send a notice of policy cancellation.
- One (1) file in which the Company failed to send a Certificate of Creditable Coverage upon cancellation of the coverage.

CSI Complaint Handling Standard 3

The Company addressed all issues raised in the CSI complaints in an accurate and timely manner. Mont. Code Ann. § 33-1-315.

SAMPLE FILE TESTING RESULTS

No. of Files Tested	No. of Files with Errors	Percentage of Errors
119	14	12%

The following exceptions were noted in this review:

- Eleven (11) CSI complaints in which the Company failed to respond within thirty (30) business days as requested by the CSI.
- Three (3) CSI complaints in which the Company failed to send an acknowledgement or respond within ten (10) work days as requested by the CSI.
- One (1) file of the fourteen (14) failed both the ten (10) and the thirty (30) day standard requested by the CSI.

POLICY AND PROCEDURE TESTING RESULTS

A review of the Company's CSI complaint register, in conjunction with the reconciliation of the register to the CSI's listing identified the following exception:

- Twelve (12) complaints in the Company register failed to record the time taken to process each complaint.

APPEAL HANDLING

The Appeal Handling review consisted of a review of the Company's policies and procedures, interviews of key personnel, and the review of a randomly selected sample of files.

It should be noted that it is the Company-provided inquiries, grievances, complaints, and appeals in the Examiner's population of complaints and appeals. As a result, sample files that were extracted from this population were subjected to review by the Examiner as a complaint and/or appeal.

Seven (7) standards were evaluated to determine the Company's compliance with any applicable state and federal statutes, rules and regulations, NAIC standards, contract provisions, and established policies and procedures. Exceptions to those standards are listed below. Additionally, the Examiner identified exceptions to other review area standards and those standards are listed in this section after the Appeal Handling standards.

Appeal Handling Standard 1

The Company acknowledges appeals within ten (10) days of receipt. Mont. Code Ann. § 33-31-303.

SAMPLE FILE TESTING RESULTS

No. of Files Tested	No. of Files with Errors	Percentage of Errors
119	1	1%

- One (1) appeal file of the one hundred nineteen (119) sample appeal files tested was identified as being covered by an HMO plan and, therefore, subject to Standard 1. It took the Company fifty (50) calendar days to issue a written acknowledgment in the form of an appeal response letter regarding its appeal determination.

Appeal Handling Standard 2

The Company resolves the appeal in a timely manner in accordance with applicable state and federal statutes, rules and regulations, contract provisions, and established policies and procedures. Mont. Code Ann. § 33-4-401.

In calculating the time it took the Company to resolve an appeal, the Examiner would use the date the Company was in receipt of the appeal and the date it issued a resolution or response letter. If an appeal resolution/response letter was not issued and it involved a claim, the Examiner would use the date an EOB was issued to the member in response to the appeal.

SAMPLE FILE TESTING RESULTS

No. of Files Tested	No. of Files with Errors	Percentage of Errors
119	1	1%

The first two bullets constitute non-statutory violation exceptions that were noted in the review for purposes of imparting CSI's expectations to insurers in timely resolving appeals:

- Nine (9) files took the Company between sixty-one (61) to eighty-five (85) days to resolve from the date it received all requested information.
- Two (2) files took the Company between one hundred fifty-five (155) days to one hundred eighty (180) days to resolve from the date it received all requested information.
- One (1) file was identified in which the Company could not provide a copy of the response letter.

Appeal Handling Standard 3

The Company's appeal responses address all issues raised in a complete and accurate manner according to applicable state and federal statutes, rules and regulations, contract provisions, and established policies and procedures. 29 CFR Sec. 2560.503-1(h). Mont. Code Ann. §§ 33-15-302, 33-18-1001.

SAMPLE FILE TESTING RESULTS

No. of Files Tested	No. of Files with Errors	Percentage of Errors
119	9	8%

The following exceptions were noted in this review:

- Five (5) files involved an incomplete response letter that did not adequately address all issues raised on the appeals.
- Two (2) files contained a response letter that referenced incorrect information regarding the effective dates or date of service.
- Two (2) files contained a response letter in the form of an updated EOB that was reprocessed at a different benefit level, and this information was not adequately identified or explained.

Appeal Handling Standard 4

The Company maintains complete documentation pertaining to the appeal in accordance with applicable state and federal statutes, rules and regulations, contract provisions, and established policies and procedures. Mont. Code Ann. § 33-3-401.

SAMPLE FILE TESTING RESULTS

No. of Files Tested	No. of Files with Errors	Percentage of Errors
119	1	1%

- One (1) file was identified in which the Company was unable to provide proof that it issued a response to an inquiry.

Appeal Handling Standard 5

The Company records and reports accurate appeal information in accordance with applicable state and federal statutes, rules and regulations, contract provisions, and established policies and procedures. Mont. Code Ann. §§ 33-18-1001, 33-31-303.

SAMPLE FILE TESTING RESULTS

No. of Files Tested	No. of Files with Errors	Percentage of Errors
119	44	37%

According to the Company, the date an appeal is resolved is the date a formal determination was issued to the member or the date of an updated EOB for appeals involving a claim. If an appeal involved a claim, the Company does not generally issue a formal appeal resolution notice; instead, the Company relies on the updated EOB to represent its appeal resolution notice. The date an appeal is resolved is the date an appeal determination is formally relayed to the member (i.e., appeal determination letter or updated EOB).

The following exceptions were noted in this review:

- Twenty-four (24) files were identified in which the reported resolved date did not match the date on the resolution notice.
- Twelve (12) files were identified in which the reported receipt and/or resolved date did not match the receipt date stamp on the appeal or the date on the resolution letter.
- Six (6) files were identified in which the reported resolved date for the appeal did not match the EOB.
- One (1) file was identified in which the reported receipt date did not match the date on the Appeal Form completed by the Company staff who received the verbal appeal.
- One (1) appeal was identified in which a receipt date was not recorded.

Appeal Handling Standard 7

The underlying processes (i.e., claims, underwriting, etc.) were in accordance with the terms of the policy as well as in compliance with applicable state and federal laws. Mont. Code Ann. § 33-18-201.

SAMPLE FILE TESTING RESULTS

No. of Files Tested	No. of Files with Errors	Percentage of Errors
119	3	3%

During the Examiner’s review of the one hundred nineteen (119) appeals sample population to determine the Company’s compliance to the Appeals test standards, the Examiner observed three (3) claim files which had several underlying issues and/or procedures beyond the Appeals test standards as listed:

INCORRECT AND/OR UNREASONABLE EXPLANATION OR BENEFITS

The following two (2) sample appeal files involved EOBs that appear to indicate incorrect information or provide unreasonable explanations:

- Two (2) files involved claims that were reprocessed with the out-of-network penalties removed, but this information was not adequately identified or explained.

The Examiner also observed that for several of the EOBs above, instead of referencing specific plan provisions, the Company provides broad statements directing the member to several general sections of the Member Guide, which has different coinsurance amounts and out-of-network penalties.

REASONABLE INVESTIGATION NOT CONDUCTED:

- One (1) sample involved an emergency service claim that was reprocessed as a valid emergency service; accordingly, the non-participating provider differential penalty was removed. However, the information that was reviewed during the appeal was no different than what was submitted when it was initially denied as a valid emergency service. Because this involved only one sample, Mont. Code Ann. § 33-18-201 does not apply to this bullet.

INDEPENDENT REVIEW HANDLING

The Examiner assessed the Company's Policies and Procedures, conducted interviews of key personnel, and evaluated a randomly selected sample of files in regard to Independent Review Handling. The Company segregated the Independent Review handling process, as defined under Mont. Code Ann. § 33-37-102, into two (2) distinct processes--Independent Reviews relating to the determination of medical necessity, and External Reviews relating to experimental or investigational service determinations. Both review processes are subject to the requirements of Mont. Code Ann. § 33-37-101 et seq. and Admin. R. Mont. 37.108.3.

The file reviews initially included forty-eight (48) randomly selected files identified by the Company as independent reviews.

Upon review of the complete file documentation provided by the Company, it was determined that twenty-three (23) of the forty-eight (48) files were not actually independent reviews under the terms of Mont. Code Ann. § 33-37-102. Of the remaining twenty-five (25) files, eight (8) were classified by the Company as Independent Reviews and seventeen (17) were classified as External Reviews.

Eight (8) standards were evaluated to determine the Company's compliance with any applicable state and federal statutes, rules and regulations, NAIC standards, contract provisions, and established policies and procedures. Exceptions to those standards are listed below.

Independent Review Handling Standard 1

The Company obtained approval of an alternative review entity from the individual requesting the independent review when Mountain Pacific Quality Health Foundation (MPQHF) did not perform the independent review. Mont. Code Ann. § 33-37-103, Admin. R Mont. 37.108.305.

SAMPLE FILE TESTING RESULTS

The original sample of forty-eight (48) files contained only seventeen (17) external reviews to which Standard 1 applied.

No. of Files Tested	No. of Files with Errors	Percentage of Errors
17	10	59%

The following exception was noted in this review:

- Ten (10) files were identified and involve the Company’s policies and procedures which allow independent review entities other than MPQHF to perform all independent reviews related to the denial of experimental or investigational services. The individual requesting the independent review is not provided with an opportunity to approve the review entity prior to the review, nor are they provided with an opportunity to have an additional review performed by MPQHF if they disagree with the outcome of the review performed by another review entity.

Independent Review Handling Standard 2

The Company provided the independent review entity the required documentation. Mont. Code Ann. § 33-37-102.

SAMPLE FILE TESTING RESULTS

No. of Files Tested	No. of Files with Errors	Percentage of Errors
25	17	68%

- Seventeen (17) files were identified and involve the Company's policies and procedures which do not provide for the submission of a separate list of each health care provider who has provided care to the enrollee and who may have medical records relevant to the appeal.

Independent Review Handling Standard 3

The Company submitted the required documentation to the independent review entity within three (3) business days of receipt. Mont. Code Ann. § 33-37-102.

SAMPLE FILE TESTING RESULTS

No. of Files Tested	No. of Files with Errors	Percentage of Errors
25	2	8%

- Two (2) files were identified in which the Company failed to submit the required documentation to the independent review entity within three (3) business days of receipt.

Independent Review Handling Standard 4

Company should communicate the independent review results to the review requester.

SAMPLE FILE TESTING RESULTS

No. of Files Tested	No. of Files with Errors	Percentage of Errors
25	2	8%

- Two (2) files were identified in which the Company did not communicate the independent review results to the review requester.

MARKETING AND SALES

The Marketing and Sales review consisted of the review of a random sample of sixteen (16) marketing and sales pieces used by the Company during the examination period.

Nine (9) standards were evaluated to determine the Company's compliance with any applicable state and federal statutes, rules and regulations, NAIC standards, contract provisions, and established policies and procedures. No exceptions were noted as a result of this review.

PRODUCER LICENSING AND COMMISSIONS

The producer licensing and commissions review consisted of a review of the Company's policies and procedures, interviews of key personnel, reconciliation of the Company records to the CSI records, and the review of all commissioned agent files.

Six (6) standards were evaluated to determine the Company's compliance with any applicable state and federal statutes, rules and regulations, NAIC standards, contract provisions, and established policies and procedures. Exceptions to those standards are listed below.

Producer Licensing and Commissions Standard 2

Producers are properly licensed and appointed. Mont. Code Ann. § 33-17-1103.

SAMPLE FILE TESTING RESULTS

No. of Files Tested	No. of Files with Errors	Percentage of Errors
119	19	16%

The following exceptions were noted in this review:

- Eighteen (18) files wherein the Company paid commissions to producers that were not appointed with the Company.
- One (1) file was identified wherein the Company paid commissions to an agency that was not licensed as an insurance producer in Montana.

Producer Licensing and Commissions Standard 5

The Company adequately documents reasons for terminations of its producers. Mont. Code Ann. §§ 33-3-401, 33-17-231, 33-17-237.

SAMPLE FILE TESTING RESULTS

The following were the exceptions noted in the testing for this standard:

No. of Files Tested	No. of Files with Errors	Percentage of Errors
54	10	19%

- Ten (10) files were identified for which the Company was unable to produce any file documentation.

No. of Files Tested	No. of Files with Errors	Percentage of Errors
40	24	60%

- Twenty-four (24) files were identified for which the Company was unable to provide producer termination notices for review.

No. of Files Tested	No. of Files with Errors	Percentage of Errors
40	6	15%

- Six (6) files were identified for which the Company provided inaccurate information to the CSI regarding the reason for producer terminations.

POLICY AND PROCEDURE TESTING RESULTS

The Company did not track the date the notification of producer terminations are provided to the CSI, and the producer files did not contain documentation of the date the notices were provided to the CSI. Therefore, the examiners were unable to independently verify the Company's compliance with Mont. Code Ann. § 33-17-237.

POLICYHOLDER SERVICES

A random sample of forty-eight (48) terminated policies were selected for review. Eleven (11) standards were evaluated to determine the Company's compliance with

any applicable state and federal statutes, rules and regulations, NAIC standards, contract provisions, and established policies and procedures. Exceptions to those standards are listed below.

Policyholder Service Standard 2

Evidence of creditable coverage is provided in accordance with the requirements of HIPAA and/or applicable statutes, rules, and regulations. Mont. Code Ann. § 33-22-142.

SAMPLE FILE TESTING RESULTS

No. of Files Tested	No. of Files with Errors	Percentage of Errors
48	5	10%

The following exceptions were noted in this review:

- Three (3) files were identified for which no certificate of creditable coverage was sent.
- One (1) file was identified in which a corrected certificate of creditable coverage was not sent out on time.

BILLING, POLICY ISSUANCE, AND COMMUNICATIONS

The billing, policy issuance, and communications review consisted of a review of the Company's policies and procedures, interviews of key personnel, and the review of a randomly selected sample of files. The sample populations were also used in evaluating the issued and renewed underwriting and rating standards; therefore, any exceptions identified are contained within the issued and renewed underwriting and rating portion of the report.

PHARMACY SERVICES

A risk assessment was performed in order to obtain a sufficient understanding of the inherent and residual risks in the Company's pharmacy services process in order to determine if claim file testing would be necessary.

The Examiner reviewed the contracts for all three (3) of the pharmacy benefit managers that were in place for fully insured businesses during the examination period in order to determine if the terms were appropriate and consistent with generally accepted business practices. The following items were also reviewed:

- Forms and marketing materials specific to the pharmacy benefits managers.
- A summary of all disputed pharmacy benefit claims, complaints, and appeals in addition to the name, claim number(s), service date(s), and the dispute reason(s).
- Results of member surveys and performance standard.

After evaluating the above information, it was determined that additional testing would not be performed. However, since the Company did not commission or perform any audits on its pharmacy vendors/benefit managers during the exam period, it is highly recommended that the Company conduct such audits.

CONSUMER COLLECTION ACTIONS

The Company's consumer collection actions were reviewed to obtain additional insight regarding retro-cancellations and pharmacy benefit services in order to determine if additional testing was warranted.

After evaluating summary data regarding all consumers that the Company turned over to collections during the examination period, it was determined that additional testing would not be performed.

UNDERWRITING AND RATING

ISSUED AND RENEWED COVERAGE

The issued and renewed coverage review consisted of a review of the Company's policies and procedures, interviews of key personnel, and the review of a randomly selected sample of files. The same sample populations were used in evaluating the billing, policy issuance, and communication policyholder services standards. Fourteen (14) standards were reviewed for Large Group, sixteen (16) standards for Small group, fourteen (14) standards for Individual, and six (6) for Medicare Supplement. All standards were used to determine the Company's compliance with any applicable state and federal statutes, rules and regulations, NAIC standards, contract provisions, and established policies and procedures. Exceptions to those standards are listed below.

INDIVIDUAL ISSUED AND RENEWED COVERAGE

POLICY AND PROCEDURE TESTING RESULTS

Individual Issued and Renewed Coverage Standard 3

Required documents and disclosures are issued timely. Mont. Code Ann. § 33-22-244.

The Company issued the outline of coverage as part of the contract and is unable to demonstrate an outline of coverage was issued at the time of application.

Individual Issued and Renewed Coverage Standard 14

All mandated disclosures are documented and in accordance with applicable statutes, rules and regulations. Mont. Code Ann. § 33-22-244.

Individual outlines of coverage did not contain a statement of the estimated periodic premium to be paid by the insured, a general description of the factors or case characteristics that the insurer may consider in establishing or changing the premiums and, if applicable, in determining the insurability of the applicant, nor did they contain a general description of the trend of premium increases or decreases for comparable policies issued by the insurer during the preceding four (4) years.

Individual Issued and Renewed Coverage Standard 14

All mandated disclosures are documented and in accordance with applicable statutes, rules, and regulations. Mont. Code Ann. § 33-15-303.

The Company provided an approved rate sheet with every individual policy that was issued. This general listing of rates did not provide premiums as required.

SMALL GROUP ISSUED AND RENEWED COVERAGE

Small Group Issued and Renewed Standard 5

Record retention of medical points. Mont. Code Ann. § 33-3-401.

SAMPLE FILE TESTING RESULTS

No. of Files Tested	No. of Files with Errors	Percentage of Errors
48	43	90%

- Forty-three (43) files were identified in which the Company utilized a system that involved the assignment of medical points as part of the underwriting and rating process. The Company did not retain records of the medical points initially assigned to each individual within a small group. Therefore, examiners were unable to independently verify compliance.

Small Group Issued and Renewed Standard 17

All mandated disclosures are documented and in accordance with applicable statutes, rules, and regulations. This finding also relates to operations and management testing Standard 5, contracts between the regulated entity and entities assuming a business function or acting on behalf of the regulated entity such as, but not limited to, managing general agents (MGAs), general agents, (GAs), third-party administrators (TPAs), and management agreements must comply with applicable licensing requirements, statutes, rules, and regulations. Mont. Code Ann. § 33-17-602.

SAMPLE FILE TESTING RESULTS

No. of Files Tested	No. of Files with Errors	Percentage of Errors
48	20	42%

- Twenty (20) files involved a third party vendor business entity that performed duties and services under administrative service agreements (ASAs) with and for certain trade association groups. Based upon its ASAs, the third party vendor acted in the capacity of a third-party administrator by determining eligibility, being tasked with the retention of original applications, processing changes, and performing billing functions. The third party vendor was not a member of the Company's workforce, yet it allowed these functions to be delegated to the third party administrator. The Company did not execute a written agreement with the third party vendor, who was not licensed as a TPA by the CSI.

Small Group Issued and Renewed Standards 14 and 15

Improper medical premium billing. Mont. Code Ann. §§ 33-18-212 and 33-18-208.

SAMPLE FILE TESTING RESULTS

No. of Files Tested	No. of Files with Errors	Percentage of Errors
48	20	42%

- Twenty (20) files were identified as being affected by the Company's decision to enter into a Billing Administration Services Agreement (BASA) with an Association in April 2009 that desired to leave its former third party vendor. The BASA facilitated the transition of COBRA administration, billing, and enrollment duties from the former third party vendor to the Company.

During the BASA negotiations, the Company learned that the former third party vendor was adding an Association member life insurance premium, an EAP premium, and an administrative fee to the Company's premium before sending the premium bill to the Association's groups. These added sums equaled approximately \$5.25 per contract per month ("pcpm"). The Company informed the Association it would not continue to include the \$5.25 pcpm amounts in the Company's medical premium. The Company did, however, agree to pay an additional .66 percent (later changed to .60 percent) in commission (equivalent to \$3.00 pcpm as opposed to \$ 5.25) to the Association's then current agency of record. These additional pcpm sums were included in the Company's medical premium as the additional commission.

The Company also billed approximately \$2.25 pcpm as a percentage of premium which was to be set aside for the Association's rate stabilization fund used to offset future premium rate increases. This one rate was referred to as "external rate" or "external rates." Upon the BASA's execution and continuing throughout the time period covered by the exam, the Company billed the "external rates" to the Association's groups as medical premium. The Company also developed and utilized "internal rates" which represented the actual cost of medical premium for which the Company was providing insurance benefits to the members, spouses, and dependents covered by the association plan.

Under the BASA, the Company paid the .60 percent commission to the Association's agent of record. The Company knew that the agency would pass on the .60 percent commission to the Association in order for it to pay for the Association's member life insurance premium, the EAP premium, and the administrative/marketing fee. The Company reported the entire commission paid to the agency/agent as commission on a reporting tax form.

Effective March 1, 2010, the Association's director terminated one of the three agents who had been receiving the .60 percent commissions. Thereafter, the Association directed the Company to increase the percentage of the commission paid to one of the two remaining agents. The Company agreed to do this and the arrangement continued beyond December 31, 2010.

The Company's BASA resulted in it collecting as medical premium sums in excess of the premium actually generated by the rates fixed by the Company for the current period. The Company did not report this to the CSI during the examination period.

In 2011, the Company determined that the .60 percent agent commission should not be included in the overall medical premium (premium + commission). Instead, the Company, with the Association's consent, itemized the \$3.00 pcpm (member life insurance premium, member EAP premium, and Association administrative fee) as separate line item components on its bills to the Association's groups.

The Company's BASA facilitated an arrangement whereby the additional commission was paid to the Association's agents which then paid the additional commission to the Association. The Company's payment of the additional commission under the BASA acted as an accommodation to the Association to continue to utilize the Company as the health benefits insurer for the Association's group health plan.

Small Group Issued and Renewed General Exam Standard and Producer Licensing Testing Standard 2

The regulated entity's producers are properly licensed and appointed. Mont. Code Ann. §§ 33-17-102, 33-17-236.

SAMPLE FILE TESTING RESULTS

No. of Files Tested	No. of Files with Errors	Percentage of Errors
48	1	2%

- One (1) file was identified in which the Company negotiated an agreement with a non-resident agency effective October 1, 2006, yet did not file written Notice of Agency Appointment with the CSI until July 14, 2010.

The identified file was found to have involved a circumstance in which the Company accepted business from several individuals working on behalf of the non-resident insurance agency. The individuals were not licensed as insurance producers in Montana, nor were they identified as being affiliated with the non-resident agency upon or after the submission of the Notice of Agency Appointment by the Company. These individuals are in addition to those noted in the Producer Licensing Sample Exceptions.

Small Group Issued and Renewed Underwriting and Rating Standard 12

Benefit/premium change notice provided timely. Mont. Code Ann. § 33-22-524.

SAMPLE FILE TESTING RESULTS

The original sample of forty-eight (48) files contained twenty-four (24) sample files involving Community Block groups. Exceptions to those files are listed below.

No. of Files Tested	No. of Files with Errors	Percentage of Errors
24	5	21%

- Five (5) files were identified in which the Company did not provide Notice of Product Discontinuation at least ninety (90) days prior to the discontinuation of Blue Choice and Blue Select products offered to employer groups within the Community Block.

POLICY AND PROCEDURE TESTING RESULTS

Small Group Issued and Renewed Underwriting and Rating Standard 7 and 12

Renewal notice issued timely, and underwriting and rating and benefit/premium change notice provided timely. Mont. Code Ann. § 33-22-107.

During the period from January 2009 and May 2009, the Company sent renewal and billing notice information for certain association groups to a third party vendor who, in turn, was responsible for distribution to the associations' employer groups.

Small Group and Large Group Underwriting and Rating Standard 15 and General Examination Standard 5

All forms, including contracts, riders, endorsement forms, and certificates, are filed with the insurance department, if applicable. Mont. Code. Ann. § 33-1-501.

The Company utilized a variety of forms that were integral parts of insurance contracts issued to certain associations and employer groups. These forms were specifically titled: "Full Retention Letter of Agreement," "Modified Retention Letter of Agreement," "Minimum Premium Agreement," and "Billing Administration Services Agreement." The forms were generally known as "Letters of Agreement," "Rate Stabilization Reserve," or "RSR agreement," and "Billing Administration Services Agreements." During the time period covered by the examination, the Company did not file any of the "Letters of Agreement," "Rate Stabilization Reserve Agreements," or "Billing Administration Services Agreements" with the CSI.

DECLINED, CANCELED, NON-RENEWED, AND TERMINATED COVERAGE

Individual and Large Group Declined Coverage

The individual and large group declined coverage review consisted of a review of the Company's policies and procedures, interviews of key personnel, and the review of all large group declinations, as well as a randomly selected sample of individual declinations processed during the examination period.

The Examiner evaluated three (3) standards for large group policies and four (4) standards for individual policies. All standards were used to determine the Company's compliance with any applicable state and federal statutes, rules and regulations, NAIC standards, contract provisions, and established policies and procedures. Exceptions to those standards are listed below.

Individual Declined Coverage Standard 1

Records are retained to demonstrate that decline reason was non-discriminatory and consistent with established policies and procedures. Mont. Code Ann. § 33-3-401.

SAMPLE FILE TESTING RESULTS

No. of Files Tested	No. of Files with Errors	Percentage of Errors
48	1	2%

- One (1) file was identified for which the Company was unable to provide any documentation; therefore, compliance with this standard could not be independently verified.

Individual Declined Coverage Standard 2 and Large Group Declined Coverage Standard 2

Appropriate Adverse Underwriting Determination Notice Issued. Mont. Code Ann. §§ 33-19-303, 33-3-401.

SAMPLE FILE TESTING RESULTS FOR LARGE GROUP COVERAGE

No. of Files Tested	No. of Files with Errors	Percentage of Errors
5	4	80%

The following exceptions were noted in this review:

- Two (2) files were identified in which the Company did not issue the appropriate adverse underwriting notification, as the adverse underwriting notification letter did not include the summary of rights required under Mont. Code Ann. § 33-19-303.
- Two (2) files were identified for which the Examiner was unable to independently verify that the appropriate adverse underwriting notice was issued.

Individual Declined Coverage Standard 3

Records are retained to demonstrate that funds return accurate and timely, consistent with established policies and procedures. Mont. Code Ann. § 33-3-401.

SAMPLE FILE TESTING RESULTS

No. of Files Tested	No. of Files with Errors	Percentage of Errors
48	1	2%

- One (1) file was identified for which the Company was unable to provide any documentation; therefore, compliance with this standard could not be independently verified.

Individual Declined Coverage Standard 4

Record retention of documentation maintained by the Company was adequate and allowed for independent verification of transactional compliance. Mont. Code Ann. § 33-3-401.

SAMPLE FILE TESTING RESULTS FOR INDIVIDUAL COVERAGE

No. of Files Tested	No. of Files with Errors	Percentage of Errors
48	1	2%

- One (1) file was identified for which the Company was unable to provide any documentation; therefore, compliance with this standard could not be independently verified.

MEDICARE SUPPLEMENT DECLINED COVERAGE

A random sample of forty-eight (48) declined Medicare supplement applications were selected for review. Five (5) standards were used to determine the Company's compliance with any applicable state and federal statutes, rules and regulations, NAIC standards, contract provisions, and established policies and procedures. Exceptions to those standards are listed below.

Medicare Supplement Declined Coverage Standard 6

The health carrier provides written notice of an adverse determination, in compliance with applicable statutes, rules and regulations. Mont. Code Ann. § 33-19-303.

SAMPLE FILE TESTING RESULTS FOR MEDICARE SUPPLEMENT DECLINED COVERAGE

No. of Files Tested	No. of Files with Errors	Percentage of Errors
48	1	2%

- One (1) file was identified in which the Company did not provide the applicant with the specific reason or reasons in writing for an adverse underwriting determination as required in Mont. Code Ann. § 33-19-303.

RESCINDED COVERAGE

The rescinded review consisted of a review of the Company's policies and procedures, interviews of key personnel, and the review of the fifty-six (56) policies that were rescinded during the examination period.

Four (4) standards were evaluated to determine the Company's compliance with any applicable state and federal statutes, rules and regulations, NAIC standards, contract provisions, and established policies and procedures. No exceptions were noted as a result of this review.

CLAIMS

PAID AND DENIED CLAIMS

The claims review consisted of a review of the Company's policies and procedures, interviews of key personnel, and the review of one hundred nineteen (119) randomly selected sample files involving paid claims and one hundred nineteen (119) denied claims which were evaluated to determine the Company's compliance with any applicable state and federal statutes, rules and regulations, NAIC standards, contract provisions, and established policies and procedures.

The Examiner evaluated eleven (11) standards for paid claims and ten (10) standards for denied claims. Exceptions to those standards are listed below.

Paid and Denied Claims Standard 1

Initial Contact with Claimant occurred within required time frame. Mont. Code Ann. § 33-18-232.

PAID CLAIMS TESTING RESULTS

No. of Files Tested	No. of Files with Errors	Percentage of Errors
119	1	1%

The following exceptions were noted in this review:

- One (1) file was identified in which the Company failed to pay or deny within 30 days and no request for additional information was issued.

Paid and Denied Claims Standard 2

Reasonable and timely claims investigation was conducted. Mont. Code Ann. § 33-18-232.

DENIED CLAIMS TESTING RESULTS

No. of Files Tested	No. of Files with Errors	Percentage of Errors
119	14	12%

The following exceptions were noted in this review:

- Four (4) of the denied claims were denied indicating the insured was not covered on the service date when, in fact, coverage was in effect.
- Three (3) files were not investigated timely.
- Three (3) claims were paid to either the wrong provider or sent to the wrong address.
- Two (2) claims were incorrectly denied as having exceeded the calendar year maximum benefit.
- One (1) accident report was requested when no third party liability was possible.
- One (1) file was denied because the insured gave the provider an old ID number. The Company maintained records of the member, including both old and new ID number, yet the claim was denied without regard to investigation of the available information.

Paid and Denied Claims Standard 3

The claim was resolved within required time frame. Mont. Code Ann. § 33-18-232.

PAID CLAIMS TESTING RESULTS

No. of Files Tested	No. of Files with Errors	Percentage of Errors
119	1	1%

The following exceptions were noted in this review:

- One (1) file was identified in which the Company failed to pay or deny within 30 days and no request for additional information was issued.

DENIED CLAIMS TESTING RESULTS

No. of Files Tested	No. of Files with Errors	Percentage of Errors
119	20	17%

The following exceptions were noted in this review:

- Ten (10) claims were denied incorrectly and never reprocessed.
- Three (3) claims were not denied timely.
- Three (3) claims for which additional information was not requested timely.
- Two (2) claims for which the Company issued an explanation of benefits form late.
- One (1) claim which was reprocessed late.
- One (1) claim which was neither paid nor denied.

Paid and Denied Claims Standard 5

File documentation maintained by the Company was adequate and allowed for independent verification of transactional compliance. Mont. Code Ann. § 33-3-401.

DENIED CLAIMS TESTING RESULTS

No. of Files Tested	No. of Files with Errors	Percentage of Errors
119	4	3%

The following exceptions were noted in this review:

- Four (4) files were identified in which the file documentation maintained by the Company was inadequate and did not allow for independent verification of transactional compliance.

Paid and Denied Claims Standard 7

The coverage under which payment is made is set forth in a statement accompanying such payment and/or reasonable explanations of denials are provided. Mont. Code Ann. § 33-18-201.

PAID CLAIMS TESTING RESULTS

No. of Files Tested	No. of Files with Errors	Percentage of Errors
119	77	65%

- Seventy-seven (77) files of the one hundred nineteen (119) sample paid claim files reviewed contained an inadequate coverage statement and/or denial explanation.

DENIED CLAIMS TESTING RESULTS

No. of Files Tested	No. of Files with Errors	Percentage of Errors
119	33	28%

- Thirty-three (33) files of the one hundred nineteen (119) sample denied claim files were identified as failing to comply with the standard.

POLICY AND PROCEDURE TESTING RESULTS FOR CLAIMS PAID AND DENIED

The Examiner requested and reviewed an additional sample of BlueCard Emergency claims for the fourth quarter of 2010. The sample contained non-participating provider claims with the emergency care code. The sample size consisted of claims for thirty-seven (37) members and approximately one hundred and sixty-five (165) claim lines.

The Examiner identified one claim in which the Company incorrectly reimbursed the claim at the non-network coinsurance rate of forty (40) percent instead of the in-network coinsurance rate of fifty (50) percent. The services were provided by a non-network provider; however, the services were for emergency care. The Company advised it was a business practice to allow claims originating from urgent care locations for emergency care to process at non-network benefit levels, unless appealed by the member. This business practice misrepresented the benefit level available relating to the coverages at

issue and neglected to provide adequate reimbursement. The Company took measures beginning October 2010 to discontinue this business practice.

During the Examiner's review of the paid claims sample population, the Examiner noted a systemic issue related to accumulation of plan deductibles that led to the underpayment of five (5) claims for a single insured.

NETWORK ADEQUACY

The network adequacy review consisted of an in-depth review of the Company's established policies and procedures.

Eight (8) standards were evaluated during the course of the review and no exceptions were noted.

PROVIDER CREDENTIALING

The provider credentialing review consisted of an in-depth review of the Company's established policies and procedures as well as a review of six (6) provider credentialing files.

Eight (8) standards were evaluated during the course of the review and no exceptions were noted.

QUALITY ASSESSMENT AND IMPROVEMENT

The quality assessment and improvement review consisted of an in-depth review of the Company's established policies and procedures.

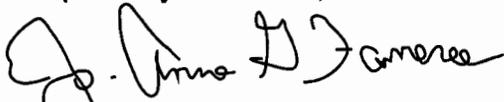
Seven (7) standards were evaluated during the course of the review and no exceptions were noted.

ACKNOWLEDGEMENT

The courtesy, assistance and cooperation extended by the Company during this examination was appreciated.

In addition to the undersigned, James P. Benham, CIE, MCM; Jann Goodpaster, CIE, CPCU, MCM Pat Neesham, CPA, CFE, MCM; Linh C. Nguyen, MPA:HA, RHU, MCM; Kim Hewitt, CIE, AMCM; and David Dachs, MCM, PIR participated on this examination.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Jo Anne G. Fameree". The signature is fluid and cursive, with the first name "Jo" being particularly prominent.

Jo Anne G. Fameree, MCM, CIE, FLMI, AIRC, ACS and Carol Roy, AIE, MCM

AFFIDAVIT OF EXAMINER

STATE OF ^{Illinois} MONTANA)
) ss.
COUNTY OF Cook)

Jo-Anne G. Fameree, MCM, CIE, FLMI, AIRC, ACS, being first duly sworn, deposes and says:

That she was one of the lead examiners representing the Commissioner of Securities and Insurance, Montana State Auditor, of the state of Montana. That pursuant to authority vested in me by Monica J. Lindeen, Commissioner of Securities and Insurance, Montana State Auditor, I performed a market conduct examination on Blue Cross and Blue Shield of Montana, Inc., renamed Caring for Montanans, Inc. as of July 31, 2013, Helena, Montana, for the period from January 1, 2006, to December 31, 2010.

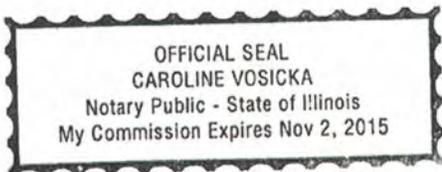
That to the best of their information, knowledge and belief, the attached amended report of the examination is a true and correct report of the proposed market conduct affairs and operations of the Company as of December 31, 2010.

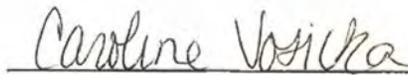
DATED this 10 day of February, 2014.



Jo-Anne G. Fameree, MCM, CIE, FLMI, AIRC,
ACS

SUBSCRIBED AND SWORN to before me this 10th day of February, 2014,
by Jo-Anne G. Fameree.





AFFIDAVIT OF EXAMINER

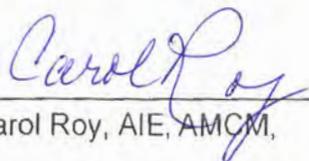
STATE OF MONTANA)
) ss.
COUNTY OF LEWIS + CLARK)

Carol Roy, AIE, MCM, being first duly sworn, deposes and says:

That she was one of the lead examiners representing the Commissioner of Securities and Insurance, Montana State Auditor, of the state of Montana. That pursuant to authority vested in me by Monica J. Lindeen, Commissioner of Securities and Insurance, Montana State Auditor, I performed a market conduct examination on Blue Cross and Blue Shield of Montana, Inc., renamed Caring for Montanans, Inc. as of July 31, 2013, Helena, Montana, for the period from January 1, 2006, to December 31, 2010.

That to the best of their information, knowledge and belief, the attached amended report of the examination is a true and correct report of the proposed market conduct affairs and operations of the Company as of December 31, 2010.

DATED this 10 day of FEBRUARY, 2014.



Carol Roy, AIE, AMCM,

SUBSCRIBED AND SWORN to before me this 10 day of FEBRUARY, 2014,
by Carol Roy.



