STATE OF UTAH INSURANCE DEPARTMENT

REPORT OF MARKET CONDUCT EXAMINATION

of

BLUE CROSS AND BLUE SHIELD OF UTAH

2455 Parley's Way
Post Office Box 30270
Salt Lake City, Utah 84130

NAIC Company Code: 54550

its subsidiary company

HEALTHWISE

NAIC Company Code: 95303

and its subsidiary agency

GROUP SERVICES, INC.

as of

December 31, 1995

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November 8, 1996

The Honorable Robert E. Wilcox, ASA, FCA, MAAA
Insurance Commissioner
Utah Insurance Department
State Office Building, Room 3110
Salt Lake City, Utah 84114

Dear Commissioner Wilcox:

In accordance with your instructions, an examination has been made of the market conduct practices of

BLUE CROSS & BLUE SHIELD OF UTAH
Salt Lake City, Utah 84130

a non-profit health service corporation, hereinafter referred to as the Company, as of December 31, 1995. The examination also included two wholly owned subsidiaries, HEALTHWISE, a health maintenance organization, and GROUP SERVICES, INC., a resident insurance agency. The report of such examination is herein respectfully submitted.

FOREWORD

The market conduct examination report is, in general, a report by exception. Reference to Company practices, procedures, or files subject to review may be omitted if no improprieties are encountered by the examiners.

SCOPE OF EXAMINATION

This examination was conducted by examiners representing the Utah Insurance Department in accordance with the Model Market Conduct Examination Handbook of the National Association of Insurance Commissioners and Utah Code Annotated (U.C.A.), Title 31A, Chapter 2. The period covered by the examination was January 1, 1992 to December 31, 1995. Where considered appropriate, transactions of the Company prior and subsequent to the examination period were reviewed.

The purpose of the examination was to determine if the Company was in compliance with the Utah Insurance Code (Title 31A, U.C.A.), and Utah Insurance Department Rules applicable to the Utah Insurance Code, and to determine if Company operations were consistent with public interest.

COMPANY PROFILE

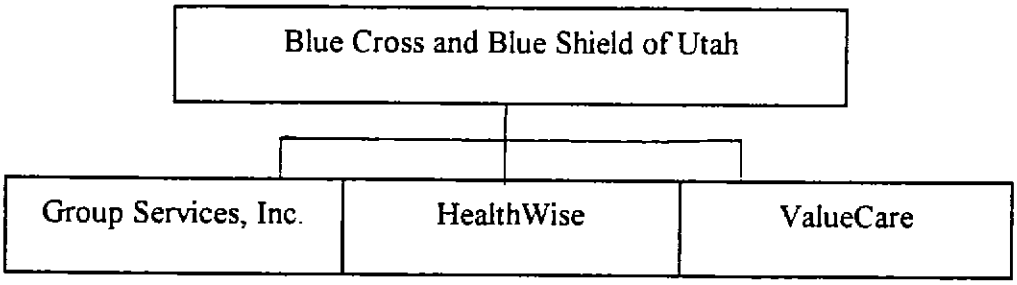
History

Blue Cross of Utah was organized December 22, 1944, as Intermountain Hospital Service Plan, a non-profit corporation providing hospital services to its subscribers. The corporate name was changed October 14, 1965 to Blue Cross of Utah.

Blue Shield of Utah was organized February 21, 1935, as Medical Service Bureau of the State Medical Association, Inc., a non-profit corporation providing hospital, medical-surgical, dental and other health care services to its subscribers. The corporation was inactive until August 16, 1946. The corporate name was changed September 22, 1966 to Blue Shield of Utah.

Blue Cross of Utah and Blue Shield of Utah consolidated January 1, 1982 into a single entity, Blue Cross and Blue Shield of Utah, a non-profit hospital, medical-surgical, dental and health service corporation.

Affiliated Companies



The Company has three active wholly owned subsidiaries as shown above. In addition, the Company is the sole member of the Utah Caring Foundation, Inc., a Utah non-profit corporation which funds health insurance for underpriviledged youth.

Group Services, Inc. was organized in July 1976 as a subsidiary insurance agency of Blue Shield of Utah in order to provide non-health care products to its subscribers. Group Services, Inc. became a wholly owned subsidiary of the newly consolidated Company in January 1982.

On April 22, 1981, an independent practice association model health maintenance organization was formed and commenced operations as a line of business of Blue Cross of Utah and Blue Shield of Utah. The health maintenance organization became a separate Utah domiciled insurer under the name HealthWise in September 1982, wholly owned by the Company. Under an operating agreement between the Company and HealthWise, the Company agreed to provide marketing consultation, advertising, public relations, accounting, investment counseling and electronic data processing services for HealthWise. The Company also agreed to provide office space, furniture, equipment, utilities, telephone service, office supplies and other services necessary for Healthwise to continue its operations.

ValueCare was organized by the Company in October 1984 as a preferred provider organization. Under an operating agreement between the Company and ValueCare, ValueCare agreed to permit the Company to utilize its preferred provider network for the Company's subscribers.

In January 1986, the Company became affiliated with BCSU Corporation, a holding company. In December 1986, ownership of Group Services, Inc., HealthWise and ValueCare was transferred to BCSU Corporation. After BCSU Corporation filed Articles of Dissolution in December 1987, ownership of Group Services, Inc., HealthWise and ValueCare reverted back to the Company.

The Company operates Group Services, Inc., HealthWise and ValueCare as if they were integral parts of the Company rather than as separate entities. Marketing, actuarial, underwriting, claims, administration, etc. are handled under the Company's direction.

Territory and Plan of Operations

Operating Jurisdictions

The Company has certificates of authority to transact business as a non-profit health service insurer in the States of Utah and Idaho. HealthWise has a certificate of authority to transact business as a health maintenance organization in the State of Utah. The Company issues contracts on which it accepts risk for hospital, medical and surgical costs, and administers health care plans for self funded groups. The Company uses the ValueCare network and discounts in administering workers compensation medical benefits to self funded accounts of over five hundred contracts.

The Company provides services to subscribers of other Blue Cross and Blue Shield companies and to national account groups, which are groups with subscribers residing in areas served by more than one Blue Cross and Blue Shield company. The Company participates in the BlueCard Program, a collection of policies and provisions supported by Inter-Plan Teleprocessing Services software and the Central Financial Agency, that enable "Home Plans" to process claims for health services received by their subscribers outside their service areas while capturing the "Host Plans'" provider discounts. The BlueCard Program is a required program under the Blue Cross and Blue Shield Association's membership standard for participation in national programs, replacing the prior Inter-Plan Reciprocal Benefit Program and the Inter-Plan Service Benefit Bank Program.

The Company participates in the Federal Employees Health Benefits Program, which provides employee and dependent coverage for federal civilian employees and their dependents residing in Utah. The Company is involved with the Medicare Program as a processor of Part A and Part B claims and as a provider of Medicare Supplement insurance policies. The Company also contracts with the state of Utah's Medicaid program, The Utah Comprehensive Health Insurance Pool and other Blue Cross and Blue Shield companies to provide services and process claims.

HealthWise provides benefits to its members through participating medical providers. Subscribers are served by providers in Salt Lake, Davis, and Weber counties and portions of Box Elder, Cache, Morgan, Summit, Tooele, Utah and Wasatch counties. A zip code listing of service areas is provided in the Subscriber Agreements.

Market Approach

The Company has used various methodologies over the years to market its products, including exclusive use of internal agents as employee account executives, exclusive use of external independent agents from the independent agency system and allowing Company subsidiaries to market their products separately. Currently the Company markets its products and those of its subsidiaries through Blue Cross and Blue Shield of Utah, using both internal employee agents and external independent agents. All group plans serviced by an external agent have an internal agent assigned to them. Through its subsidiary agency, Group Services, Inc., the Company includes ancillary insurance products in the employee benefit packages marketed to subscribing groups.

Major Lines of Business

The Company has designed and markets health insurance products to individuals, small groups of one to fifty subscribers, and large groups of fifty-one or more subscribers. Applicants for individual policies and individual subscribers within small groups are underwritten using individually specific medical information supplied by the applicant. Group products were designed for groups of one, such as a sole proprietor, groups of two through twenty-four, groups of twenty-five through fifty, groups of fifty-one through ninety-nine, and groups of one hundred or more.

The mix of group products includes: comprehensive major medical products with varying benefit levels and types provided by the Company; preferred provider organization products arranged by ValueCare and insured by the Company; health maintenance organization products provided by HealthWise; dental products provided by the Company; and ancillary group insurance products such as life, and long and short term disability, underwritten by other insurers and provided through Group Services, Inc. Many group products include minimum amounts of group life insurance. A variety of health insurance funding mechanisms, from full premium to complete self funding, are provided by the Company to groups with more than sixty employees.

The mix of non-group products include: comprehensive major medical individual and family health insurance products provided by the Company; preferred provider organization individual and family health insurance products arranged by ValueCare and insured by the Company; a two to four month short term interim individual and family health insurance product provided by the Company; a medicare supplement product provided by the Company; dental products provided by the Company; and a long term nursing home care product underwritten elsewhere and provided through Group Services, Inc.

Policy Forms and Rates

The Company has a variety of policy forms available to purchasers of its product lines. The forms vary in terms, benefits, deductibles, co-payment amounts and exclusions. The majority of the product forms are in the comprehensive major medical product line, which can be tailored to meet the requirements of the purchasing employer. The other product lines have several forms available, but the purchaser is required to choose between the forms offered rather than have the forms tailored to meet the purchaser's requirements. In addition to the health insurance policy forms, the Company offers several dental policy forms as a complement to the health insurance products.

The table below summarizes the various products available:

List of Products			
	Medical	HMO	Dental
Large Group (51 and over)	Blue Cross/Blue Shield of Utah ValueCare BlueNet HealthPoint	HealthWise HMOBlue	Blue Cross/Blue Shield of Utah ValueCare DentalWise
Small Group (1-50)	Blue Cross/Blue Shield of Utah ValueCare BlueNet HealthPoint	HealthWise HMOBlue	Blue Cross/Blue Shield of Utah ValueCare DentalWise
Individual	Blue Cross/Blue Shield of Utah (Qualifier) ValueCare (250/500 ded) ValueCare Premier (0 ded) InterimPlus Medicare Supplement		Blue Cross/Blue Shield of Utah
Low income	MedUtah (Medicaid)		
Uninsurables	Health Insurance Pool		
Federal workers	Federal Employee Program		
Medicare	process Medicare claims		

HealthWise is a federally qualified health maintenance organization, providing managed care on a fee-for-service basis. HMOBlue, a separate line of business under HealthWise, currently provides managed care on a fee-for-service basis, but ultimately on a capitation basis. ValueCare is a preferred provider organization. BlueNet is a managed care plan established specifically for Thiokol Corporation employees. HealthPoint is a point of service product with a swing out option. InterimPlus is a limited benefit, short term policy for use by employees during enrollment waiting periods. DentalWise is a fully capitated dental maintenance organization. MedUtah is the Company's Medicaid HMO.

The Company has separate rates for individual products, small group products and large group products.

Company Growth

The table below reports the growth in premium for the Company and HealthWise for the last six years. Numbers were taken from the their regulatory annual statements filed with the Utah Insurance Department.

Blue Cross and Blue Shield of Utah	
Year	Earned Premium
1995	*$229,822,222
1994	* 218,231,412
1993	* 202,724,473
1992	318,767,886
1991	304,651,071
1990	275,994,827

HealthWise	
Year	Premium & Related Revenue
1995	*$22,135,692
1994	* 20,029,709
1993	* 21,559,041
1992	29,405,935
1991	31,358,604
1990	30,587,378

* As of 1992, the Utah Insurance Department required the Administration Service Contracts and Minimum Premium Business to be reported as Administrative Service Only contracts. This resulted in the removal of premium income and claims expense relating to this business from the Income Statement and related schedules and in only reporting the administrative income as a reduction to administrative expenses.

PREVIOUS EXAMINATION FINDINGS

The previous market conduct examination report as of August 30, 1990 and financial examination reports as of September 30, 1992 of the Company and its subsidiaries, HealthWise and Group Services, Inc., were reviewed. Company responses to the findings and recommendations in those reports, pertaining to market conduct areas, were also reviewed. All of the recommendations were addressed and appropriate actions taken by the Company.

CURRENT EXAMINATION FINDINGS

Company Operations/Management

The Company has a valid internal audit program in place, which provides meaningful information to management concerning the Company and its subsidiaries. Audit recommendations are responded to in order to correct, modify and implement procedures. The Company has a fraud/abuse specialist function and routinely conducts fraud investigations. A new disaster recovery plan is being implemented, which was tested in 1995 and is expected to be fully operational by the end of 1996. The Company adequately provides for off-site backup storage and recovery and has appropriate controls, safeguards and procedures in place for protecting the integrity of computer information. The Company's management information services operational reports reflect a stable and productive computer environment during the examination period, with positive computer performance statistics. The Company and HealthWise are operating within their Certificates of Authority. Company policies and procedures manuals were requested with regard to each of the areas reviewed during the examination process. Policies and procedures manuals were not in place for several of the areas examined.

Producer Relationships

The Company has been authorized by Medical Life Insurance Company (Medical Life), Rocky Mountain Life Insurance Company (Rocky Mountain Life) and Trans-General Life Insurance Company (Trans-General Life) to contract and appoint all Utah agents for them, and to maintain all related files. Combined lists of producers contracted and appointed or designated as agents of the Company, HealthWise, Group Services, Inc., Medical Life , Rocky Mountain Life, and Trans-General Life were provided to the examiner. The lists included 269 agencies contracted, 1431 individuals contracted, and 50 agencies or individuals with restricted producer contracts. The lists provided by the Company were compared with Utah Insurance Department lists of appointed or designated producers for the above entities. In connection with this comparison, also reviewed were the above entities' producer contract files, producer contract language, commission reports and effective dates of business produced. The discrepancies encountered during this comparison and review are described in the following two paragraphs.

In two cases, the producer was licensed under one name, but contracted and paid commissions under a different name. In another case, the producer's license lapsed, resulting in the termination of his restricted contract with the Company. The license was later reinstated and the producer reappointed, but the producer's restricted contract was not reinstated. In all three of these cases, the error was pointed out by the examiner and corrected by the Company during the examination period. In another case, a Rocky Mountain Life contract was not signed by the producer. The producer was appointed to Rocky Mountain Life by the Company with no written contract in effect. These actions are violations of U.C.A. 31A-23-309.

The Rocky Mountain Life and Trans-General Life producer contracts require a broker license, not an agent license. However, in actual practice, most of the producers are licensed as agents and act in the capacity of agents, rather than brokers.

Provider Relationships

Provider lists of the Company's health maintenance organization, HealthWise, and of HMOBlue, a product line of HealthWise, were provided by the Company. From those lists of providers, provider contract files of health service providers, hospitals, physicians and practitioners were selected and reviewed. Also reviewed, in connection with the provider contract files, were provider relations materials, provider contract language, provider credentialing, provider malpractice insurance requirements, provider quality control procedures and provider complaint procedures. The discrepancies encountered during this review are described in the following four paragraphs.

In one case, the provider's name was listed in the HMOBlue provider directory, but the Company was unable to provide evidence of an in-force HMOBlue written contract. This is a violation of U.C.A. 31A-8-407(1).

One provider contract did not include the required hold harmless agreement. This is a violation of U.C.A. 31A-8-407(1).

Eleven provider contracts were incomplete, with either the provider's name or execution date of the contract not completed, or the effective date of coverage not specified.

Under the terms of the provider contracts, the Company required the providers to have malpractice insurance coverage in force. During most of the examination period the Company generally did not physically review the coverage nor require the providers to provide proof that the coverage was in effect. However, in late 1995, a full time position was added which, among other duties, reviews each provider's malpractice insurance documents every two years.

Marketing and Sales

Advertising for Company and affiliate products, including those of HealthWise, ValueCare and Group Services, Inc., is done under the Company's direction. The Company maintains all current advertising files. An advertising agency is retained by the Company to produce its advertising program. The advertising agency maintains the Company's historical advertising files. Advertising is done through various mediums, including television, radio, newspapers, bus signs, and direct mail.

Company marketing and sales materials were reviewed, including marketing plans, sales training materials, advertising, sales illustrations and other sales materials. Medicare Supplement advertisements were printed and distributed in Utah by the Company without providing a copy of the advertisements to the Utah Insurance Commissioner. Failure to provide a copy of a Medicare supplement advertisement intended for use in this state to the Utah Insurance Commissioner is a violation of U.C.A. 31A-22-620(7), and Utah Insurance Department Rule R590-146-18, Medicare Supplement Insurance Minimum Standards.

Company Forms/Required Filings

The Company has used various methods to file forms. In the past the Company has 1) had outside agencies file the forms, 2) had the Company, ValueCare and HealthWise file their own forms, and 3) centralized the forms filings responsibilities for all but HealthWise under the Benefits Communication Department, with responsibility for the HealthWise filings under the Legal Department. Currently, forms and other required filings for the Company and all subsidiaries are submitted by the Benefits Communication Department.

Utah Insurance Department Rule R590-167, Individual and Small Employer Health Insurance Rule, requires a separate rate manual be developed for each class of small employer group business, and a copy of the applicable rating manual be filed for every health benefit plan subject to that rule. This filing requirement is further clarified in Utah Insurance Department Bulletin 95-1, Small Employer Health Insurance. The Company has not yet filed a copy of the rate manuals for the health benefit plans subject to the rule. Failure to file a copy of the applicable rating manual for every small employer group health benefit plan subject to Utah Insurance Department Rule R590-167 is a violation of Utah Insurance Department Rule R590-167-12(B).

Utah Insurance Department Rule R590-167, Individual and Small Employer Health Insurance Rule, requires the small employer group health benefit plan counts as described in the rule be filed by March 15 of each year. This requirement is further clarified in Utah Insurance Department Bulletin 95-1, Small Employer Health Insurance. The Company did not file the required information until July 10, 1996. Failure to file the small employer health benefit plan counts as described in Utah Insurance Department Rule R590-167 by March 15 of each year is a violation of Utah Insurance Department Rule R590-167-12(D).

Underwriting/Rating

General

Health insurance benefits are provided to individuals, small groups of 1 to 50 employees, and large groups of 51 or more employees and their dependents. Individual applicants and individual subscribers within small groups and their dependents are medically underwritten on an individual basis, with more stringent guidelines for those in small groups of 1 to 24 than those in groups of 25 to 50. Newly hired subscribers and late applicant subscribers of small groups of 1 to 24 are also medically underwritten on an individual basis through a completed health statement supplied by the subscriber. Except in the case of late applicant subscribers, large group subscribers are not medically underwritten on an individual basis. Large groups are underwritten based on the medical experience of the group, premium history, and community and industry factors.

The following methods have been used by the Company to prevent providing benefits for pre-existing medical conditions to individual applicants and small group subscribers; excluding benefits by endorsement for pre-existing conditions for up to 9 months for small group subscribers and up to 12 months for individual applicants, excluding individuals or dependents, in rare cases, from individual policies and rejecting the entire group, except under open enrollment circumstances. Individual policy applicants may be rejected due to existing or past medical conditions, out of state residence, being over 65 years of age, not including all eligible family members, or if benefits are available to the applicant through Company group products.

The Company has separate rates for individual products, small group products and large group products. Rates, rating plans and rate manuals in use and/or under development during the examination period were reviewed. The Company has not yet filed a copy of the rate manuals for the health benefit plans subject to Utah Insurance Department Rule R590-167, Individual and Small Employer Health Insurance Rule (see Company Forms/Required Filings section above). However, Company rates subject to this rule were reviewed and were within the guidelines specified in the rule. No other discrepancies were noted.

Underwriting File Review

Individual, small group and large group underwriting files of the Company and HealthWise were reviewed. The combined available population of active policies in each of these categories and the sample selected and reviewed are shown in the following table. In addition, fourteen denied applications, twelve rescinded policies, and six canceled or non-renewed policies were also reviewed.

Active Policies Reviewed

Category	Available Population	Sample Selected and Reviewed
Individual	12,411	32
Small Groups	2,437	34
Large Groups	904	26

Of those files reviewed with new business dates initiated during the examination period, the average number of days from the date the last data was received by the Company to the date the underwriting decision was made by Company was approximately 4.14 days.

Review of Individual Underwriting Files

No material discrepancies were encountered.

Review of Small Group Underwriting Files

In two files, there was a name change of an insured group. However, the change form did not identify whether or not there was a change in ownership of the group, even though Company procedure requires a new signature if the name change corresponds with a change in ownership. In several files, additional information requested and subsequently received by the Company was not date stamped or logged upon receipt, and it was difficult for the examiner to determine when the information was received by the Company from the file documentation.

Review of Large Group Underwriting Files

No discrepancies were encountered.

Claims

General

The Company processes claims for itself and for HealthWise, as well as for other Blue Cross and Blue Shield entities, national accounts, Medicare Parts A and B, Medicaid and federal employee plans. During the examination period, the Company contracted with Blue Cross of Western Pennsylvania to process Pennsylvania claims using that company's system. The Company also processes Medicare claims for Blue Cross and Blue Shield of Montana and for Blue Cross and Blue Shield of Wyoming.

Approximately fifty percent of the claims are received electronically by the Company and fifty percent are received by mail. Those received by mail are sorted and batched by line of business, microfilmed and input into the computer system data base. Claim numbers are assigned as the claims are electronically or manually entered into the data base. Claims are then processed automatically by the computer system. They are generally processed and settled by the next day unless exceptions are discovered by the system. The exceptions are first resolved by a claim adjudicator and then the claim is again automatically processed until settled or discovery of any additional exceptions. Exceptions are encountered in about forty percent of the claims processed through the system.

The Company has one grievance procedure for itself and HealthWise, applicable to all their products. Claimants with grievances initiate the process by contacting the Customer Service Department by telephone or in writing. If the grievance cannot be resolved by telephone, it must be submitted in writing to the Customer Service Department. The second step is a written appeal by the claimant to the Claims Appeal Committee, which meets every two weeks. The third step is a written appeal by the claimant to the Company's general counsel. The final step in the grievance procedure appeals process is compulsory binding arbitration. Company literature describing this final step states, "Binding arbitration is the final step for the resolution of any dispute. When you enroll as a Member of BCBSU, you agree that any dispute will be resolved by binding arbitration, and you agree to give up the right to a jury or court trial for the settlement of such disputes." Although it does not appear the Company has, in practice, precluded dispute resolutions by Utah small claims courts having jurisdiction, the language in the compulsory binding arbitration provisions implies a claimant is precluded from seeking a resolution through any court, including a small claims court. Compulsory binding arbitration provisions containing language construed to preclude any dispute resolution by any small claims court having jurisdiction is a violation of Utah Insurance Department Rule R590-122-4(6), Permissible Arbitration Provisions.

Utah Insurance Department Rule R590-122-4(5), Permissible Arbitration Provisions, requires in each application or binder pertaining to insurance policies containing compulsory binding arbitration and, in the case of group insurance, in the certificate of insurance or other disclosure of benefits, it be prominently disclosed that the arbitration award may include attorney's fees if allowed by state law and may be entered as a judgement in any court of proper jurisdiction. The language used by the Company pertaining to this disclosure was not as clear as the rule requires. In addition, the rule requires it be prominently disclosed in each of the above documents that a copy of the rules of The American Arbitration Association or other recognized arbitrator is available upon request. The Company did not include this disclosure in each of those documents. Failure to prominently disclose this information is a violation of Utah Insurance Department Rule R590-122-4(5), Permissible Arbitration Provisions.

The Company's Internal Audit Department samples claims from all lines of business and all claims exceeding $10,000 processed during the previous week and audits them for accuracy and timeliness. Any discovered errors are verified or challenged by the claim unit supervisor. Upon

verification of payment errors, the claim is adjusted to correct the error. Collection of overpayment errors of less than $25 is not generally pursued.

Review of Claims

Samples of the Company's local (Utah) and HealthWise claims, including ValueCare claims, were selected for review from the Company's Internal Audit Department weekly samples. Claims selected and reviewed were from February, June and October 1994, and March, July and November 1995. The claims selected and reviewed are shown in the table below.

Claims Reviewed

Year	Company	Claims Population	Claims Available for Review from Weekly Internal Audit Samples	Sample Selected and Reviewed
1995	*BCBSU	502,773	702	53
	HealthWise	31,335	457	27
	Combined	534,108	1,159	80
1994	BCBSU	431,645	924	32
	HealthWise	28,772	418	18
	Combined	460,417	1,342	50
Total	BCBSU	934,418	1,626	85
	HealthWise	60,107	875	45
	Combined	994,525	2,501	130

* BCBSU = Blue Cross & Blue Shield of Utah

Claim File Review

Ninety-seven percent of the Company's claims reviewed and ninety-eight percent of HealthWise's claims reviewed met the Utah Insurance Department's guideline of settlement within thirty days of receipt of the claim. Those claims which were not settled within thirty days required additional research time to adjudicate the claim, and in each case the claimant was notified every thirty days of the status of the claim. The Company's average calendar days from receipt of the claim until settlement was twelve and the average for HealthWise was fifteen.

Utah Insurance Department Rule R590-89-10(A), Unfair Claims Settlement Practices Rule, requires acknowledgement of claims not settled within fifteen days of receipt. Nineteen percent of the Company's claims reviewed and twenty percent of HealthWise's claims reviewed did not

meet this acknowledgement requirement. Neither the Company nor HealthWise have procedures in place to ensure compliance with this requirement.

Utah Insurance Department Rule R590-89-12(B), Unfair Claims Settlement Practices Rule, requires that the first party claimant be advised of the denial of the claim by the insurer, and any basis for the denial of a claim to be communicated promptly and in writing to the claimant. Two Company claims reviewed did not meet this requirement. In each case, the claim was considered by the Company to be a "soft denial" due to missing information. The Comany's procedure is to send an "Explanation of Claims Processed" (EOCP) form to the insured with an explanation of the missing information still needed in order to process the claim. If the missing information is subsequently received by the Company, the claim is re-opened at that time. Upon sending the EOCP form, the claim is closed and considered denied. In each of the above two cases, the denial of the claim was not clearly communicated to the claimant on the EOCP form.

One Company claim and two HealthWise claims reviewed were adjudicated and paid incorrectly. In each case, the error was discovered by internal audit and subsequent adjustments were made to correct the errors.

Consumer Complaints

The Company maintains a consolidated consumer complaints register for itself and HealthWise. There have been a total of 133 consumer complaints filed with the Utah Insurance Department against the Company during the examination period, of which 15 were justified complaints. There were 7 complaints filed against HealthWise during the same period, of which 2 were justified. The following two tables show a population breakdown of these complaints, by year, and the number of complaint file samples selected and reviewed for each year.

Complaints against Blue Cross & Blue Shield of Utah

	1992	1993	1994	1995	Total
Justified Compaints	5	6	2	2	15
Other Complaints	41	33	27	17	118
Total Complaints	**46**	**39**	**29**	**19**	**133**
Samples Selected & Reviewed	0	13	13	13	39

Complaints against HealthWise

	1992	1993	1994	1995	Total
Justified Complaints	1	1	0	0	2
Other Complaints	2	3	0	0	5
Total Complaints	**3**	**4**	**0**	**0**	**7**
Samples Selected & Reviewed	0	3	0	0	3

Utah Insurance Department Rule R590-89, Unfair Claims Settlement Practices Rule, has specific time requirements for answering Utah Insurance Department inquiries respecting claims and for consumer complaints/inquiries requiring a response. In one of the forty-two consumer complaint files reviewed, the Company exceeded the fifteen day maximum response time requirement for answering a Utah Insurance Department inquiry respecting a claim. Failure to furnish the department with a substantive response within fifteen days is a violation of Utah Insurance Department Rule R590-89-10.

HMO Specific Requirements

In addition to the general regulatory requirements for insurers, health maintenance organizations have other specific regulatory requirements to comply with. The additional market conduct requirements are found in Chapter 8 of the Utah Insurance Code, Health Maintenance Organizations and Limited Health Plans, and in Utah Insurance Department Rule R590-76, Health Maintenance Organizations.

HealthWise operations were reviewed with regard to these additional specific regulatory requirements and the following discrepancy was noted. HealthWise did not prepare certified annual reports of the effectiveness of the organization's internal quality control, as required by U.C.A. 31A-8-404. Although the format for the report has not been specified by the Insurance Commissioner, lack of a prescribed format does not negate the organization's requirement to prepare the report. HealthWise was informed of this requirement in their most recent market conduct examination report issued by the Utah Insurance Department. In that report, HealthWise was instructed to use a format "the Company deems best" in lieu of a format prescribed by the Insurance Commissioner. Failure to prepare the annual reports is a violation of U.C.A. 31A-8-404.

Policyholder Service

Policyholder service was generally timely and correct. Except as already noted in this report, no discrepancies related to policyholder service were encountered.

SUMMARIZATION

Summary

Comments included in this report which are considered to be significant and requiring special attention are summarized below:

1. Company policies and procedures manuals were requested with regard to each of the areas reviewed during the examination process. Policies and procedures manuals were not in place for several of the areas examined. The examiner recommends the Company prepare policies and procedures manuals covering all areas of Company operations. **(OPERATIONS/MANAGEMENT)**

2. In two cases, the producer was licensed under one name, but contracted and paid commissions under a different name. In one case, the producer's license lapsed, resulting in the termination of his restricted contract with the Company. The license was later reinstated and the producer reappointed, but the producer's restricted contract was not reinstated. In all three cases, the error was pointed out by the examiner and corrected by the Company during the examination period. In another case, the Rocky Mountain Life contract was not signed by the producer. The producer was appointed to Rocky Mountain Life by the Company with no written contract in effect. These actions are violations of U.C.A. 31A-23-309. The examiner recommends procedures be implemented or changed to ensure, in all cases, producers are not appointed by the Company unless a written contract is in effect, and that they are contracted and paid under the same name in which they are licensed. **(PRODUCER RELATIONSHIPS)**

3. The Rocky Mountain Life and Trans-General Life producer contracts require a broker license, not an agent license. However, in actual practice, most of the producers are licensed as agents and act in the capacity of agents, not brokers. The examiner recommends the producer contracts be amended to require the producers to have an agent license if the producer will be acting in the capacity of an agent. **(PRODUCER RELATIONSHIPS)**

4. A providers' name was listed in the HMOBlue provider directory, but the Company was unable to provide evidence of an in-force HMOBlue written contract. This is a violation of U.C.A. 31A-8-407(1). The examiner recommends procedures be implemented or changed to ensure that non-contracted providers are not included in printed provider directories. **(PROVIDER RELATIONSHIPS)**

5. One provider contract did not include the required hold harmless agreement. This is a violation of U.C.A. 31A-8-407(1). The examiner recommends the provider contract be properly amended to include the required hold harmless agreement. **(PROVIDER RELATIONSHIPS)**

6. In eleven cases, the provider contracts were incomplete, with either the provider's name or execution date of the contract not completed, or the effective date of coverage not specified. The examiner recommends the Company review all existing provider contracts and implement or change Company procedures to ensure that all provider contracts are properly completed and executed. **(PROVIDER RELATIONSHIPS)**

7. The Company printed and distributed Medicare Supplement advertisements in Utah without providing a copy of the advertisements to the Utah Insurance Commissioner. This is a violation of U.C.A. 31A-22-620(7), and Utah Insurance Department Rule R590-146-18, Medicare Supplement Insurance Minimum Standards. The examiner recommends the Company provide a copy of any Medicare Supplement advertisement intended for use in Utah to the Utah Insurance Department prior to distributing the advertisement. **(MARKETING AND SALES)**

8. The Company has not filed a copy of the applicable rating manual for every health benefit plan subject to Utah Insurance Department Rule R590-167, Individual and Small Employer Health Insurance Rule. Failure to file a copy of the applicable rating manual for every health benefit plan subject to Utah Insurance Department Rule R590-167 is a violation of Utah Insurance Department Rule R590-167-12(B). The examiner recommends the Company file a copy of each such rating manual. **(COMPANY FORMS/REQUIRED FILINGS)**

9. The Company did not file, in a timely manner, the small employer health benefit plan counts as described in Utah Insurance Department Rule R590-167, Individual and Small Employer Health Insurance Rule. Failure to file the small employer health benefit plan counts by March 15 of each year is a violation of Utah Insurance Department Rule R590-167-12(D). The examiner recommends the Company file the required health benefit plan counts by March 15 of each year. **(COMPANY FORMS/REQUIRED FILINGS)**

10. When there is a name change of an insured group, Company procedure is to require a new signature if the name change corresponds with a change in ownership of the group. However, the form used for requesting a name change does not identify whether or not there is a change in ownership. The examiner recommends procedures be implemented or changed to document whether or not there is a corresponding change in ownership whenever there is a name change of an insured group. **(UNDERWRITING/RATING)**

11. Additional information requested and subsequently received by the Company was often not date stamped or logged upon receipt, and it was difficult for the examiner to determine when the information was received by the Company. The examiner recommends procedures be implemented or changed to identify when requested information is received by the Company. **(UNDERWRITING/RATING)**

12. Language in the Company's compulsory binding arbitration provisions could be construed to preclude dispute resolution through small claims courts. Compulsory binding arbitration provisions containing language construed to preclude any dispute resolution by any small claims court having jurisdiction is a violation of Utah Insurance Department Rule R590-122-4(6), Permissible Arbitration Provisions. The examiner recommends the Company change the language in its compulsory binding arbitration provisions to specifically not preclude dispute resolution by small claims courts having jurisdiction. **(CLAIMS)**

13. Utah Insurance Department Rule R590-122, Permissible Arbitration Provisions, requires in each application or binder pertaining to insurance policies containing compulsory binding arbitration and, in the case of group insurance, in the certificate of insurance or other disclosure of benefits, it be prominently disclosed that the arbitration award may include attorney's fees if allowed by state law and may be entered as a judgement in any court of proper jurisdiction. The language used by the Company was not as clear as the rule requires. In addition, the rule requires it be prominently disclosed in each of the above documents that a copy of the rules of The American Arbitration Association or other recognized arbitrator is available upon request. The Company did not include this disclosure in each of those documents. Failure to prominently disclose this information is a violation of Utah Insurance Department Rule R590-122-4(5). The examiner recommends the Company include the required disclosures, in clear and prominent language, in all future printings of the applicable applications, binders, and certificates. **(CLAIMS)**

14. Nineteen percent of the Company's claims reviewed and twenty percent of HealthWise's claims reviewed did not meet the fifteen day acknowledgement requirement identified in Utah Insurance Department Rule R590-89-10(A), Unfair Claims Settlement Practices Rule. Neither the Company nor HealthWise have procedures in place to ensure compliance with this requirement. The examiner recommends the Company and HealthWise implement procedures to ensure compliance with this requirement. **(CLAIMS)**

15. Utah Insurance Department Rule R590-89-12(B), Unfair Claims Settlement Practices Rule, requires that the first party claimant be advised of the denial of the claim by the insurer, and any basis for the denial of a claim to be communicated promptly and in writing to the claimant. Two Company claims reviewed did not meet this requirement. In each case, the claim was considered by the Company to be a "soft denial" due to missing information. Upon sending an "Explanation of Claims Processed" (EOCP) form to the insured with an explanation of the missing information still needed in order to process the claim, the claim was closed and considered denied. However, in each case, the denial of the claim was not clearly communicated to the claimant. The examiner recommends procedures be implemented or changed to ensure, in all cases, the claimant be clearly advised of the denial of the claim and the basis for the denial be communicated promptly and in writing to the claimant. **(CLAIMS)**

16. HealthWise did not prepare certified annual reports of the effectiveness of the organization's internal quality control. Failure to prepare the reports is a violation of U.C.A. 31A-8-404. The examiner recommends HealthWise prepare the required report each year, using a format HealthWise deems best, and submit the report to the appropriate authority. **(HMO SPECIFIC REQUIREMENTS)**

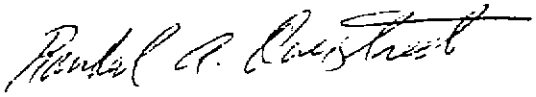
Examiner's Comments Refence Policyholder Treatment

Except as otherwise noted in this report, policyholders appear to have been treated correctly and fairly by the Company and HealthWise. Underwriting practices appear to be fair and consistent. Claims appear to be investigated promptly and settled as soon as proper documentation is received from the claimants. Complaints were generally handled in an expeditious manner and policyholder service appears to be timely and correct.

ACKNOWLEDGMENT

The cooperation and assistance rendered by the officers and employees of the Company during this examination is hereby acknowledged and appreciated.

In addition to the undersigned, John E. "Mickey" Braun, Jr., CIE, CLU, ChFC, Senior Market Conduct Examiner, assisted in the examination.



Randal A. Overstreet, MBA, CIE
Market Conduct Examiner
Examiner-in-Charge
Utah Insurance Department