

Report on
Market Conduct Examination

of

Blue Cross Blue Shield of North Carolina
Chapel Hill, North Carolina

by Representatives of the
North Carolina Department of Insurance

as of

May 27, 2014

TABLE OF CONTENTS

SALUTATION 1

FOREWORD2

SCOPE OF EXAMINATION2

 Previous Examination Findings3

EXECUTIVE SUMMARY3

UTILIZATION MANAGEMENT4

 Policies and Procedures.....4

 Medical Necessity Reviews5

 Appeal Records Review8

PROVIDER CREDENTIALING 11

 Policies and Procedures..... 11

 Credentialing Files 11

POLICYHOLDER TREATMENT 13

 Policies and Procedures..... 14

 Member Grievance Records Review 15

 Consumer Complaints..... 17

MARKETING 18

 Producer Appointment Files 18

 Sales and Advertising.....20

UNDERWRITING PRACTICES21

 Employer Group Underwriting21

 Individual Medicare Supplement Declined.....22

DELEGATED OVERSIGHT	23
Intermediary Contracts and Management Agreements.....	23
Review of Actual Monitoring and Oversight.....	24
CONCLUSION.....	26

Raleigh, North Carolina
May 27, 2014

Honorable Wayne Goodwin
Commissioner of Insurance
Department of Insurance
State of North Carolina
Dobbs Building
430 N. Salisbury Street
Raleigh, North Carolina 27603

Honorable Commissioner:

Pursuant to your instructions and in accordance with the provisions of North Carolina General Statute (NCGS) 58-2-131 through 58-2-134 and 58-67-100, a compliance examination has been made of the market conduct activities of the Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), and Indemnity lines of business for

**Blue Cross Blue Shield of North Carolina
(NAIC #54631)**

NAIC Exam Tracking System Exam Number: NC299-M42
Chapel Hill, North Carolina

hereinafter generally referred to as the Company, at the Company's home office located at 1830 US 15-501 North, Chapel Hill, North Carolina and at the North Carolina Department of Insurance (Department) office located at 11 S. Boylan Avenue, Raleigh, North Carolina. A report thereon is respectfully submitted.

FOREWORD

The examination reflects the North Carolina insurance activities of Blue Cross Blue Shield of North Carolina. The examination is, in general, a report by exception. Therefore, much of the material reviewed will not be contained in this written report, as reference to any practices, procedures, or files that revealed no concerns were omitted.

SCOPE OF EXAMINATION

The examination commenced on October 28, 2013, and covered the period of January 1, 2011, through December 31, 2012, for all lines of business, with analyses of certain operations of the Company being conducted through May 14, 2014. All comments made in this report reflect conditions observed during the period of the examination.

The examination was conducted in accordance with the North Carolina Department of Insurance and the National Association of Insurance Commissioners (NAIC) Market Regulation Handbook procedures, including analyses of Company operations and accordingly included tests of utilization management, provider credentialing, policyholder treatment, marketing, underwriting practices, and delegated oversight.

It is the Department's practice to cite companies in violation of a statute or rule when the results of a sample show errors/non-compliance at or above the following levels: 0 percent for utilization review determinations, grievances (including quality of care), sales and advertising, producers who were not appointed and/or licensed, the use of contract forms that were neither filed with nor approved by the Department, the listing of a provider/facility in the provider/facility directory prior to being fully credentialed, and use of unapproved underwriting methodology and factors; 7.0 percent for claims practices, provider and facility credentialing, and the content of quality management and utilization management review notification letters; and 10.0 percent for all other areas reviewed.

Previous Examination Findings

A general examination covering the period January 1, 2005, through December 31, 2007, was performed on the HMO. A compliance examination covering the period January 1, 2006, through December 31, 2007, was also performed on PPO and indemnity lines of business. A comprehensive report dated February 12, 2010, was issued. The HMO general examination report identified violations in the areas of utilization management, provider credentialing, policyholder treatment, marketing, underwriting practices, and delegated oversight. The PPO compliance examination report identified violations in the areas of utilization management, provider credentialing, and policyholder treatment. The Indemnity compliance examination report identified violations in the areas of policyholder treatment, marketing, and underwriting practices. Specific violations relating to these areas are listed within the appropriate sections of this report.

EXECUTIVE SUMMARY

This market conduct examination revealed concerns with Company procedures and practices in the following areas:

Utilization Management – HMO: Failure to communicate the retrospective review determination within 30 days; and Failure to notify the member and/or provider of the retrospective review decision. *PPO:* Failure to communicate the retrospective review determination within 30 days; Failure to notify the member and/or provider of the retrospective review decision; Failure to include the professional qualifications and licensure of the medical director who reviewed the appeal in both the standard and expedited appeal determination letters; Failure to send an appeal acknowledgement letter within three business days of receipt; Failure to process and communicate expedited appeal decisions within four days of receipt; and Failure to handle expedited second-level appeal requests as required by statute.

Provider Credentialing – HMO: Failure to conduct facility recredentialing activities at least every three years.

Policyholder Treatment – HMO and PPO: Failure of member/appeal grievance policy to adequately address the required provisions for processing expedited second-level grievance procedures. *PPO:* Failure to process member grievances in accordance with statutory requirements, including non-compliant decision notification letters and acknowledgement letters sent in excess of three business days. *Indemnity:* Consumer complaints: Failure to maintain a copy of the initial Departmental complaint.

Marketing – Indemnity: Sales and Advertising: Failure to include correct statistical footnotes.

Delegated Oversight – HMO: Failure to receive and/or receive timely the quarterly updated provider listings from five delegated credentialing entities; and Failure of the Company's intermediary services agreement to meet the required regulatory provisions regarding the submission of updated lists of providers as it permits the submissions to exceed the quarterly timeframe requirement.

Specific violations related to each area of concern are noted in the appropriate sections of this report. All North Carolina General Statutes and rules of the North Carolina Administrative Code cited in this report may be viewed on the North Carolina Department of Insurance Web site www.ncdoi.com by clicking "INSURANCE DIVISIONS" then "Legislative Services".

This examination identified various statutory violations. The Company is directed to take immediate corrective action to demonstrate its ability and intention to conduct business in North Carolina according to its insurance laws and regulations.

All statutory violations may not have been discovered or noted in this report. Failure to identify statutory violations in North Carolina does not constitute acceptance of such violations. Examination report findings that do not reference specific insurance laws, regulations, or bulletins are presented to improve the Company's practices and provide consumer protection.

UTILIZATION MANAGEMENT

Policies and Procedures

The Company's policies and procedures and form letters for utilization management were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

The previous HMO and PPO examinations revealed the following:

- The Company was deemed to be in violation of the provisions of NCGS 58-50-61(f) as its Utilization Management policy entitled "Utilization Management Timeliness Standards" (including iterations effective 9/16/04, 5/31/05, 4/20/06, and 6/28/07) includes a timeframe for prospective review notification which potentially allows greater than three business days for issuance of a written noncertification to the covered person.

- The Company was deemed to be in violation of the provisions of NCGS 58-50-61(j) as its Utilization Management policy entitled “Appeal/Grievance Process for All Product Lines” (all iterations) does not state that each appeal denial shall be evaluated by a medical doctor licensed to practice medicine in North Carolina. Instead, the policy references a “health care professional with appropriate training”. In addition, this policy references the Managed Care Patient Assistance Program (MCPAP) in “Addendum 8”; however, there are portions of the policy that do not reference “Addendum 8” within the items listed to be included in the written decision to the member. This includes the expedited appeal adverse decision letter, which is deemed to be in violation of the provisions of NCGS 58-50-61(l), as well as the level II grievance acknowledgment letter, deemed to be in violation of the provisions of NCGS 58-50-62(f)(1)(c), and the level II adverse decision letter, deemed to be in violation of the provisions of NCGS 58-50-62(h)(9).
- The Company has outlined a process for second-level appeals in which an Executive Review Committee (ERC) conducts an initial administrative review prior to scheduling/conducting an external review panel second-level review. The policy entitled “Appeal/Grievance Process for All Product Lines” (all iterations) does not document the process for cases in which the ERC approves the appeal. The Company was instructed to document this process within the policy by including a provision that states when the ERC approves the appeal, that the meeting of the second-level grievance review panel (as required by the provisions of NCGS 58-50-62(f)(2)) is not scheduled and does not occur. In addition, this policy does not reference a timeframe requirement for issuing the approval decision when the ERC overturns the first-level decision. It was noted that in these cases the approval letter provides notification of the member’s right to review by an External Panel.

The current HMO and PPO examinations revealed the following:

The Company’s policies and procedures and form letters for utilization management were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules. No adverse trends or unfair trade practices were observed in this section of the examination.

Medical Necessity Reviews

The previous HMO examination revealed the following:

- The Company completed a total of 10,111 prospective review requests during the examination period. A random sample of 100 prospective review files was examined. Within one file (1.0 percent error ratio), the determination was not communicated within three business days after receiving all necessary information, a deemed violation of the provisions of NCGS 58-50-61(f).

- The Company completed a total of 3,391 retrospective review requests during the examination period. A random sample of 50 retrospective review files was examined. Within three files (6.0 percent error ratio), the determination was not communicated within 30 days after receiving all necessary information, a deemed violation of the provisions of NCGS 58-50-61(g).

The current HMO examination revealed the following:

The Company completed a total of 508 prospective review requests during the examination period. A random sample of 50 prospective review files was examined. All files were found to be completed in accordance with the provisions of NCGS 58-50-61(f). No adverse trends or unfair trade practices were observed in this section of the examination.

The Company completed a total of 202 retrospective review requests during the examination period. A random sample of 50 retrospective review files was examined. The Company was again deemed to be in violation of the provisions of NCGS 58-50-61(g) as well as its own policies and procedures for the following:

- Within three files (6.0 percent error ratio) the determination was not communicated within 30 days after receiving the retrospective review request and/or requested additional information.
- One file (2.0 percent error ratio) did not contain notification of the reviewer's decision to the member or the provider.

The average service time to review and send notification of a retrospective review decision was eight calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	30	60.0
8 - 14	11	22.0
15 - 21	2	4.0
22 - 30	4	8.0
Over 30	3	6.0
Total	50	100.0

The previous PPO examination revealed the following:

The Department reviewed random samples of both concurrent and retrospective review files to ascertain compliance with the provisions of NCGS 58-50-61. The Company was again deemed to be in violation of the provisions of NCGS 58-50-61 as the review revealed the following:

- A review of 100 concurrent review files from a total population of 34,138 revealed that in one file (1.0 percent error ration), the determination was not communicated within three business days after receiving all necessary information. The Company was again deemed to be in violation of the provisions of NCGS 58-50-61(f).
- A review of 100 retrospective reviews files from a total population of 12,863 revealed that in one file (1.0 percent error ratio), the determination was not communicated within 30 days after receiving all necessary information, and the Company was again deemed to be in violation of the provisions of NCGS 58-50-61(g). In addition, one file (1.0 percent error ratio) did not contain a notice of noncertification and the Company was deemed to be in violation of the provisions of NCGS 58-50-61(h).

The current PPO examination revealed the following:

The Company completed a total of 18,885 concurrent review requests during the examination period. A random sample of 100 concurrent review files was examined. All files were found to be completed in accordance with the provisions of NCGS 58-50-61(f). No adverse trends or unfair trade practices were observed in this section of the examination.

The Company completed a total of 20,518 retrospective review requests during the examination period. A random sample of 100 retrospective review files was examined. The Company was again deemed to be in violation of the provisions of NCGS 58-50-61(g) as well as its own policies and procedures for the following:

- Within ten files (10.0 percent error ratio), the determination was not communicated within 30 days after receiving the retrospective review request and/or requested additional information.
- One file (1.0 percent error ratio) did not contain notification of the reviewer's decision to the member or the provider.

The average service time to review and send notification of a retrospective review decision was 11 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	53	53.0
8 - 14	17	17.0
15 - 21	13	13.0
22 - 30	7	7.0
Over 30	10	10.0
Total	100	100.0

Appeal Records Review

The Company's appeal process was reviewed for compliance with regulatory requirements as to member notification of the results of the review.

The previous HMO examination revealed the following:

The Company received a total of 300 member appeals during the examination period. A random sample of 50 appeal files was reviewed to assess the Company's timeliness and compliance with the provisions of NCGS 58-50-61 and 58-50-62, as well as its own policies and procedures. The following issue was noted:

- In one file (2.0 percent error ratio), the Company skipped the first-level appeal process and conducted a second-level appeal review, a deemed violation of the provisions of NCGS 58-50-61(j) and (k). The statute specifically outlines the process required for first-level and second-level appeal stages.

Twenty-one first-level appeals were escalated to second-level grievance reviews. Upon review of the second-level grievances, it was noted that within three files (15.0 percent error ratio), the decision letter did not contain information regarding the availability of the Commissioner's office for assistance or the availability of assistance from the Managed Care Patient Assistance Program (MCPAP), a deemed violation of the provisions of NCGS 58-50-62(f).

The Company received a total of three expedited appeals during the examination period. A review of these expedited appeals was conducted and revealed that in one expedited appeal file (33.0 percent error ratio), the review was not completed and the decision communicated

within four days of receiving the information, a deemed violation of the provisions of NCGS 58-50-61(l).

The current HMO examination revealed the following:

The Company completed a total of ten member appeal reviews, as well as a total of two expedited member appeal reviews during the examination period. The total populations of ten appeal files and two expedited appeal files were examined. All files were found to be completed in accordance with the provisions of NCGS 58-50-61. No adverse trends or unfair trade practices were observed in this section of the examination.

The average service time to review and send notification for a standard appeal decision was 26 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
15 - 21	1	10.0
22 - 30	9	90.0
Total	10	100.0

The previous PPO examination revealed the following:

The Department reviewed a random sample of 50 noncertification appeal files from a total population of 2,098. The review revealed that in one appeal file (2.0 percent error ratio), the acknowledgement letter was not sent within three business days of receipt of the appeal and written notification of the decision to the insured was not completed and sent within 30 days of receipt of the appeal request. The Company was again deemed to be in violation of the provisions of NCGS 58-50-61(k).

Twelve first-level appeals were escalated to second-level grievance reviews. Upon review of the second-level grievances, the following issues were noted:

- In one file (8.3 percent error ratio), the acknowledgement letter was not sent within ten business days of receipt of the appeal. The Company was deemed to be in violation of the provisions of NCGS 58-50-62(f).

- In one file (8.3 percent error ratio), the required 15-day advance notice of the review panel meeting date was waived in order to meet the statutory requirement that a review meeting be held within 45 days after receiving a request for a second-level review. The Company was deemed to be in violation of the provisions of NCGS 58-50-62(f)(g).

The current PPO examination revealed the following:

The Company completed a total of 1,881 UM appeal reviews during the examination period. A random sample of 50 appeal files was examined, including five files which were escalated to a second-level review request. Six appeal files (12.0 percent error ratio) contained issues as detailed below and were again deemed in violation of the provisions of NCGS 58-50-61:

- The determination letter within one appeal file (2.0 percent error ratio) did not state the professional qualifications and licensure of the medical director reviewing the appeal.
- The acknowledgement letter was not sent within three business days of receipt for five appeal files (10.0 percent error ratio).

The average service time to review and send notification for a standard appeal decision was 26 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	1	2.0
8 - 14	2	4.0
15 - 21	6	12.0
22 - 30	41	82.0
Total	50	100.0

The Company completed a total of 180 expedited appeal reviews during the examination period. A random sample of 50 expedited appeal files was examined, including 21 files which were escalated to a second-level review request. Four expedited appeal files (8.0 percent error ratio) contained issues as detailed below and were again deemed in violation of the provisions of NCGS 58-50-61 and/or 58-50-62:

- The determination letter within one expedited appeal file (2.0 percent error ratio) did not state the professional qualifications and licensure of the medical director reviewing the appeal.
- The review was not completed and communicated within four days of receipt for one expedited appeal file (2.0 percent error ratio).
- Two expedited appeal files (4.0 percent error ratio), which were escalated to a second-level review request, were not handled as expedited second-level reviews, and hence were erroneously subjected to standard appeal review timeframes.

PROVIDER CREDENTIALING

Policies and Procedures

The previous HMO and PPO examinations revealed the following:

The Company was deemed to be in violation of the provisions of 11 NCAC 20.0405 as its facility credentialing policies, which were utilized throughout the entire examination period, did not address the following items:

- The policy did not adequately address the termination guidelines of the credentialing process, if all information for the application has not been received or verified within 60 days after receipt of the application;
- The policy did not indicate that within 15 days after receipt of an incomplete application, the Company will notify the applicant in writing of all missing or incomplete information or supporting documents; and
- The policy did not indicate that if the Company chooses not to include an applicant in its network, for reasons that do not require review of an application, then they shall provide written notice to the applicant of that determination within 30 days after receipt of the application.

The current HMO and PPO examinations revealed the following:

No adverse trends or unfair trade practices were observed in this section of the examination.

Credentialing Files

The previous HMO examination revealed the following:

The Department reviewed a random sample of 100 provider credentialing files from a total population of 14,056. The following results indicate the level of adherence to the

Company's guidelines and to the provisions of 11 NCAC 20.0406 which require the Company to maintain centralized files on each individual provider making an application and to retain on file documentation of compliance with 11 NCAC 20.0404, 20.0405, and 20.0407.

- In 11 files (11.0 percent error ratio), the Company had not conducted recredentialing activities every 3 years and the Company was deemed to be in violation of the provisions of 11 NCAC 20.0407.
- In addition to the 11 files which were not credentialed in accordance with the provisions of 11 NCAC 20.0407, the Company had 27 additional files for which it had not conducted recredentialing activities within 33 months as required by its credentialing plan; therefore, the Company was in violation of its own policies and procedures.
- In two files (2.0 percent error ratio), the board certification date was not current and the Company was deemed to be in violation of the provisions of 11 NCAC 20.0404(1)(d).

The current HMO examination revealed the following:

The Department reviewed a random sample of 100 provider credentialing files from a total population of 13,222. The file sample reflects initial credentialing and any subsequent recredentialing that occurred during the examination period.

The average service time to initially credential providers was 43 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
22 - 30	5	15.2
31 - 60	28	84.8
Total	33	100.0

The previous HMO examination revealed the following:

The Department reviewed a random sample of 50 facility credentialing files from a total of 1,122. The review revealed the following:

- In five files (10.0 percent error ratio), the Company had not conducted recredentialing activities every three years and the Company was deemed to be in violation of the provisions of 11 NCAC 20.0407.
- In addition to the five files which were not credentialed in accordance with the provisions of 11 NCAC 20.0407, the Company had eight additional files for which it had not conducted recredentialing activities within 33 months as required by its credentialing plan; therefore, the Company was in violation of its own policies and procedures.
- In five files (10.0 percent error ratio), the application was processed in excess of the 60-day timeframe. The Company was deemed to be in violation of the provisions of 11 NCAC 20.0405.

The current HMO examination revealed the following:

The Department reviewed a random sample of 50 facility credentialing files from a total population of 118 files during this examination. The Department's review revealed that in nine facility credentialing files (18.0 percent error ratio), the Company had not conducted recredentialing activities every three years as required by regulation. Therefore, the Company was again deemed to be in violation of the provisions of 11 NCAC 20.0407.

The average service time to initially credential facilities was 23 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	1	25.0
15 - 21	1	25.0
22 - 30	1	25.0
31 - 60	1	25.0
Total	4	100.0

POLICYHOLDER TREATMENT

The Company's member services activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

Policies and Procedures

The Department reviewed the Company's policies and procedures and form letters addressing standard grievances.

The previous HMO and PPO examinations revealed the following:

- The Company's policy entitled "Appeal/Grievance Process for All Product Lines, Excluding Federal Employee Program and State Health Plan – CMS32" was deemed to be in violation of the provisions of NCGS 58-50-62(f)(1)(c) as it does not state that a second-level acknowledgement letter must include the availability of the Managed Care Patient Assistance Program (MCPAP), including the telephone number and address of the program.
- The Company was also deemed to be in violation of the provisions of NCGS 58-50-62(h) as this same policy does not state that the second-level determination letter will be issued within seven business days of the review panel meeting. Instead, the Company's policy states that the determination shall be sent within seven business days of the date the determination was rendered. Based on the Company's policy, the Chair of the External Grievance Community Panel communicates the recommendation to the Executive Review Committee to render the final decision. The policy does not require the communication from the Panel Chair to the Executive Review Committee to occur on the same day; therefore, the policy allows the issuance of the determination letter to exceed the seven business day timeframe from the date of the review panel.
- The Department also notes that although the grievance policy provides MCPAP information in the "Forms" section of the policy, it does not require notice of the availability of MCPAP, including the required contact information, when enumerating the requirements for the first-level grievance decision letter. This could result in uncertainty of the statutory requirements for decision letters prepared for members.

The current HMO and PPO examinations revealed the following:

The Company's policy "Appeal/Grievance Process for All Product Lines, Excluding Federal Employee Program and State Health Plan" (all iterations) does not adequately address provisions for expedited second-level procedures as outlined in section (i) of the statute, as it fails to address that an expedited second-level review can take place by way of a telephone conference call or through the exchange of written information. Therefore, the Company is again deemed to be in violation of the provisions of NCGS 58-50-62, as the policy is noncompliant with various statutory provisions in the previous examination.

Member Grievance Records Review

The previous HMO examination revealed the following:

The Company received a total of 484 member grievances during the examination period. A random sample of 50 grievances was reviewed to assess the Company's timeliness and compliance with the provisions of NCGS 58-50-62 and its own policies and procedures. This review revealed one or more of the following violations of the provisions of NCGS 58-50-62 and/or the Company's policies and procedures:

- Four files (8.0 percent error ratio) contained decision letters which did not include all of the required statutory provisions, a deemed violation of the provisions of NCGS 58-50-62(e)(2).
- Three files (6.0 percent error ratio) contained an acknowledgment letter which was not sent within three business days of receipt of the grievance, a deemed violation of the provisions of NCGS 58-50-62(e)(1).
- In three files (6.0 percent error ratio), resolution and written notification to the insured of the decision was not completed within 30 days of receipt, a deemed violation of the provisions of NCGS 58-50-62(e)(2).
- In four files (8.0 percent error ratio), the Company failed to meet its established timeframe for sending an authorization form to individuals who are filing a grievance on behalf of a member, a deemed violation of its own policies and procedures.
- One file (2.0 percent error ratio) contained an initial Explanation of Benefits (EOB) with an inadequate denial code, as it did not reflect the good faith reason for the denial and did not reference that medical records were necessary for a complete review.

Fourteen first-level grievances were escalated to second-level grievance reviews. Upon review of the second-level grievances, it was noted that one acknowledgement letter (7.1 percent error ratio) did not contain all of the required statutory provisions, and three determination letters (21.4 percent error ratio) did not contain all of the required statutory language, including the availability of the Commissioner's office for assistance and the contact information as well as the required information regarding the MCPAP. Therefore, the Company was deemed in violation of the provisions of NCGS 58-50-62(h).

The current HMO examination revealed the following:

The Company completed a total of ten member grievance reviews during the examination period. The total population of ten member grievance files was examined, none of which were escalated to a second-level grievance request. All files were found to be completed in accordance with the provisions of NCGS 58-50-62. No adverse trends or unfair trade practices were observed in this section of the examination.

The average service time to process a first-level member grievance was 26 calendar days.

A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
8 - 14	1	10.0
22 - 30	9	90.0
Total	10	100.0

The previous PPO examination revealed the following:

The Company received a total of 2,236 member grievances during the examination period. A random sample of 50 grievances was reviewed to assess the Company's timeliness and compliance with the provisions of NCGS 58-50-62 and its own policies and procedures. This review revealed one or more of the following deemed violations of the provisions of NCGS 58-50-62 and the Company's policies and procedures.

- In two files (4.0 percent error ratio), resolution and written notification to the insured of the decision was not completed within 30 days of receipt. The Company was again deemed to be in violation of the provisions of NCGS 58-50-62.
- In seven files (14.0 percent error ratio), the acknowledgement letter was not sent within three business days of receipt of the grievance. The Company was again deemed to be in violation of the provisions of NCGS 58-50-62.

The current PPO examination revealed the following:

The Company completed a total of 1,859 member grievance reviews during the examination period. A random sample of 50 member grievance files was examined, including

two files which were escalated to a second-level grievance request. Two grievance files (4.0 percent error ratio) contained issues as detailed below and were again deemed in violation of the provisions of NCGS 58-50-62.

- The determination letter within one grievance file (2.0 percent error ratio) did not contain a statement advising the member of the right to request a second-level grievance review and the procedure for submitting one.
- The acknowledgement letter was not sent within three business days of receipt within one grievance file (2.0 percent error ratio).

The average service time to process a first-level member grievance was 25 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
8 - 14	4	8.0
15 - 21	4	8.0
22 - 30	42	84.0
Total	50	100.0

Consumer Complaints

The Company's procedures for complaint handling were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

The previous Indemnity examination revealed the following:

- The Company was deemed to be in violation of the provisions of 11 NCAC 1.0602 as 2.0 percent of the Departmental complaints required more than seven calendar days to respond to the Department and no extension was requested or granted.

A random sample of 50 complaint files from a population of 435 was reviewed. **The current Indemnity examination revealed the following:**

The following table displays the type of complaints received for each year of the examination:

Type	2011	2012
Administrative Related	8	9
Claim Related	12	19
Underwriting Related	2	0
Total	22	28

The consumer complaint register was provided for the examiners' review. The register was found to be in compliance with the provisions of 11 NCAC 19.0103.

Six complaint files (12.0 percent error ratio) did not contain a copy of the initial Departmental complaint. The Company was deemed to be in violation of the provisions of 11 NCAC 19.0102(a). Three complaints were responded to in excess of seven calendar days. However, extensions were requested and granted for those complaints.

The average service time to respond to a Departmental complaint was six calendar days. A chart of the Company's response time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	47	94.0
8 - 14	2	4.0
15 - 21	1	2.0
Total	50	100.0

MARKETING

The Company's sales and marketing activities were reviewed for adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

Producer Appointment Files

The previous HMO examination revealed the following:

A random sample of 50 producer appointment files from a population of 610 was reviewed. The review revealed the following:

- Ten files (20.0 percent error ratio) contained insufficient documentation to demonstrate compliance with the provisions of NCGS 58-33-40, as the files did not contain the effective date of the producer services agreement, contained an

incomplete producer services agreement, and/or did not contain documentation to demonstrate formal notification to the producer of his/her appointment, a deemed violation of the provisions of 11 NCAC 19.0102 and 19.0106.

- In five files (10.0 percent error ratio), the Company did not initially provide complete producer appointment records to the Department, and the Company was deemed to be in violation of the provisions of 11 NCAC 19.0106(f). Additionally, in one of these files, the Sales Director did not completely document on the form his/her review of the pre-appointment questionnaire and subsequent approval of the producer's appointment, a deemed violation of the Company's policies and procedures.

The current HMO examination revealed the following:

A random sample of 50 producer appointment files from a population of 795 was reviewed. The review revealed the following:

- In four files (8.0 percent error ratio), the Company did not initially provide complete producer appointment records to the Department.
- In one file (2.0 percent error ratio), the Company failed to document that a complete background check had been conducted, a deemed violation of the Company's policies and procedures.
- In one file (2.0 percent error ratio), there was no documentation of the manager's approval of the initial appointment on the "Designation of Product" form, a deemed violation of the Company's policies and procedures.

Additionally, in 20 files, the producer appointment date submitted to the Department was not consistent with the documented effective date of appointment in the producer agreement. It was further noted that the Company's "Producer Licensing and Appointment Policy" effective during the examination period failed to address the use of a consistent appointment effective date. The Department also noted that in ten files, a producer contract, which had been signed in advance (March 9, 2009) by a Company representative, had been countersigned by Farm Bureau producers during the 2011-2012 examination period. In each of these cases, the Company representative signed the agreement years prior to the actual completion of the appointment process. In February 2014, the Company amended its processes to require electronic signatures for producer agreements, thereby eliminating the use of countersigned agreements.

Sales and Advertising

The Company's sales and advertising files and internet site, <http://www.bcbsnc.com>, were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

The previous Indemnity examination revealed the following:

- The Company was deemed to be in violation of the provisions of 11 NCAC 12.0525 for the following advertisements:
 1. Blue Advantage web advertisement indicating that it was the most popular individual plan in the state. It did not contain the required footnote and reference to where the statistic could be located.
 2. Blue Options HRA advertisement U3330a 6/06 contains an incorrect amount of claim reimbursement that would be paid. This advertisement was corrected by the Company and replaced by advertisement U3330a 02/07.

All advertising materials used by the Company during the examination period were reviewed. **The current Indemnity examination revealed the following:**

The Company maintains its sales and advertising file pursuant to the provisions of 11 NCAC 12.0533.

The following advertisements were again deemed to be in violation of the provisions of 11 NCAC 12.0525:

- Blue Options - U4691 - The following statements were not supported by correct statistical references:
 1. "With nearly 100% of all doctors and hospitals in our network"
 2. "99% of all hospitals in the nation"
 3. "87% of all rural hospitals nationwide"
- Monthly prospecting letter - U7513b: There was no footnote to the statistical reference under "Guaranteed Rate Cap" stating rates will not increase more than 6%. The Company provided data showing two employer groups had increases greater than 6%.

UNDERWRITING PRACTICES

The Company's premium rate setting and underwriting activities were reviewed for adherence to Company guidelines and compliance with applicable North Carolina statutes and rules.

Employer Group Underwriting

The previous HMO examination revealed the following:

A random sample of 100 employer group underwriting files from a total of 8,836 files containing initial and renewal information was reviewed for compliance with rating practices. Included in this sample were 97 small employer groups and three large employer groups. The review revealed the following deemed violations of statutory and/or regulatory provisions:

- In ten files (10.0 percent error ratio), the Company used an incorrect rate filing which resulted in an overcharge of premium rates totaling \$14,337.24, a deemed violation of the provisions of NCGS 58-67-50. The Company self-reported this error to the Department in January 2008 and was instructed to implement immediate corrective action. The corrective action included an adjustment to the second quarter 2008 block of renewals in the percentage equal to the maximum impact that would have been realized by any group (2.38 percent for small group and 0.25 percent for medium group). The adjustments made for the quarter totaled \$785,363.00 for small groups and \$12,149.00 for medium groups. The Company also implemented additional internal control measures to ensure that only rate filings approved for the corresponding quarter are used.
- In five files (5.0 percent error ratio), an input error with the drug plan code resulted in a slight undercharge of the premium rate, a deemed violation of the provisions of NCGS 58-67-50.
- In three files (3.0 percent error ratio), the Company quoted the actual premium rate, instead of the filed percentage change, to the employer group based on a rate filing which had not yet been approved by the Department, a deemed violation of the provisions of NCGS 58-67-50 and Bulletins 96-B-1 and 98-B-2.
- In one file (1.0 percent error ratio), an incorrect mental health benefit factor was applied, resulting in an annualized premium rate undercharge of \$118.00 to the employer group, a deemed violation of the provisions of NCGS 58-67-50. At the Department's request, the Company reported that in an additional 21 files the employer group was also undercharged during the examination period due to an incorrect application of the mental health benefit adjustment factor. The total amount undercharged to all 22 groups totaled \$2,315.00.

- In one file (1.0 percent error ratio), the group was erroneously allowed to renew on medical and chiropractor benefit plans which were not included in the fourth quarter rate filing, a deemed violation of the provisions of NCGS 58-67-50.
- In one file (1.0 percent error ratio), the Company could not locate the 2005 renewal packet documentation.

Additionally, in five files (5.0 percent error ratio), the Department noted that the Company's rate validation tool was not rounding in the same manner as the rating system, and therefore, the Department was not able to validate the accuracy of the quoted rates. The rounding inconsistencies between the two systems also allowed the input errors to go undetected by the Company. The input errors were discovered during this examination. Therefore, the Company has been instructed to prepare a guidance document which demonstrates at what point and to what extent the system is rounding for each step in the rate calculation process. The Company has also been instructed to use this document consistently between the Company's rating system and rate validation tool.

The current HMO examination revealed the following:

Of the total 786 employer group underwriting files containing initial and renewal information, a random sample of 50 files was reviewed for compliance with rating practices. All files in the sample included small employer groups. No adverse trends or unfair trade practices were observed in this section of the exam.

Individual Medicare Supplement Declined

The Company's underwriting procedures were reviewed to determine adherence to Company guidelines and compliance with North Carolina statutes and rules.

The previous Indemnity examination revealed the following:

- The Company was again deemed to be in violation of the provisions of 11 NCAC 19.0102(a), 19.0104, and 19.0106(g)(h) as 26.0 percent of the application files were not provided.

A random sample of 50 application files from a population of 388 was reviewed. **The current Indemnity examination revealed the following:**

One application file (2.0 percent error ratio) was incomplete as it did not contain a copy of the declination letter.

The average service time to underwrite and decline an application was seven calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	32	64.0
8 - 14	12	24.0
15 - 21	1	2.0
22 - 30	4	8.0
31 - 60	1	2.0
Total	50	100.0

DELEGATED OVERSIGHT

Intermediary Contracts and Management Agreements

The previous HMO examination revealed the following:

Review of the Company's executed contracts with delegated entities revealed the following violations and/or concerns regarding the agreements:

- The Company executed an agreement with American Imaging Management, Inc. on July 1, 2006 but the agreement did not contain a date of execution. The effective date of the agreement was prior to the Department's approval of the form which occurred on September 29, 2006. The Company provided other related agreements which were executed after the approval of the master agreement form; however, these documents were not sufficient to demonstrate definitively that the master agreement form was executed concurrently with these documents. Therefore, the Company was deemed in violation of the provisions of NCGS 58-67-30(a) as the Department could not ascertain the execution date of the master agreement form to determine compliance with statutory requirements. Additionally, the Department noted the executed form did not contain the designated form number as submitted to and approved by the Department.
- On August 1, 2006, prior to receiving approval from the Department, the Company executed an addendum to its Pharmacy Benefit Agreement with Medco Health Solutions, Inc., which contained a material change. Therefore, the Company was deemed in violation of the provisions of 11 NCAC 20.0203. Additionally, the Department noted the executed form did not contain the designated form number as submitted to and approved by the Department.

- The Company executed a contract with Merck-Medco Managed Care, LLC for the provision of pharmacy benefit services effective August 18, 1999, through September 30, 2005. This contract contained a form number different from the form number which had been approved by the Department. In addition, the Company executed an addendum on January 1, 2007 to the Medco Health Solutions, Inc. contract (effective October 1, 2005, through December 31, 2007) which delegated activities related to member services, drug utilization review, and recall that had not been approved by the Department, a deemed violation of the provisions of 11 NCAC 20.0203.

The current HMO examination revealed the following:

No adverse trends or unfair trade practices were observed in this section of the examination.

Review of Actual Monitoring and Oversight

The previous HMO examination revealed the following:

A review was made of the Company's oversight and monitoring of all intermediary and other contracted entities performing delegated functions. The Company conducted oversight and monitoring activities of entities to which activities have been delegated, with the following exceptions:

- The Company conducted a follow-up audit of Magellan Behavioral Health's executed provider contracts on July 26, 2005, but did not conduct reviews of provider contracts again until February 2007.
- The Company did not receive an updated list of providers from Carolinas Physicians Network in the fourth quarter of 2006, and was deemed to be in violation of the provisions of 11 NCAC 20.0410(2).
- From 2005-2007, the Company received updated lists of providers during each quarter from the remaining entities to which it delegated credentialing; however, for three of the entities (ECU, UNC, DUAP), the lists were not received during regular intervals, which resulted in some listings far exceeding a 3-month time interval while some listings were received after only two weeks had elapsed. While the updated provider listings were received during each quarter, the inconsistent time intervals between receipt of the listings should be addressed.
- The Company's "Delegation of QM, UM, Credentialing, Appeals, and Pharmacy Functions" policy utilized throughout the examination period states that the

Credentialing Committee will review and approve the list of physicians credentialed and re-credentialed by the delegated entity at least quarterly. The policy further states that the approval will be documented in the Credentialing Committee minutes. However, the Credentialing Committee did not review and approve the delegated credentialing/recredentialing lists, and the Company was deemed to be in violation of its own policies and procedures.

- Due to insufficient documentation, the Department was unable to ascertain that the Company conducted ongoing monitoring and review of the credentialing verification plans, policies, procedures, and forms of seven delegated entities to which it delegated credentialing activities; therefore, the Company was deemed to be in violation of the provisions of 11 NCAC 20.0410(1).

The current HMO examination revealed the following:

The Company was again deemed to be in violation of the provisions of 11 NCAC 20.0410(2) as it did not receive and/or did not receive a timely, updated list of providers at least quarterly from the following entities to which credentialing activities were delegated:

- Wake Forest University Physicians – In 2011, fourth quarter (32 days late). In 2012, fourth quarter (26 days late).
- MBC of North Carolina, LLC dba Magellan Behavioral Health - In 2012, third quarter (23 days late).
- Duke University Physicians and Affiliated Providers – In 2012, first quarter (70 days late).
- University of North Carolina Physicians and Associates – In 2011, third quarter (60 days late). In 2012, (no second quarter update received), third quarter (27 days late), fourth quarter (13 days late).
- Choice Health, Inc. – In 2012, third quarter (14 days late).

In addition, the Company's intermediary services agreement form (Exhibit 2.11), which addresses the submission of updated lists of providers, does not meet the required provisions of 11 NCAC 20.0410(2) as it permits the submissions to exceed the quarterly timeframe requirement.

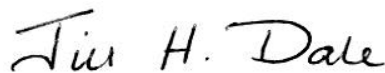
CONCLUSION

A compliance examination has been conducted on the market conduct affairs of Blue Cross Blue Shield of North Carolina's HMO, PPO, and Indemnity lines of business for the period of January 1, 2011, through December 31, 2012, with analysis of certain operations of the Company being conducted through May 14, 2014.

This examination was conducted in accordance with the North Carolina Department of Insurance and the National Association of Insurance Commissioners Market Regulation Handbook procedures, including analyses of Company operations in the areas of utilization management, provider credentialing, policyholder treatment, marketing, underwriting practices, and delegated oversight.

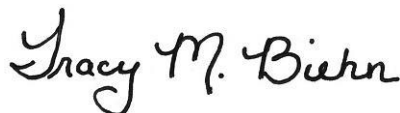
In addition to the undersigned, Tanyelle Byrd, MBA, MHA, Brian Dearden, CLU, ChFC, FLMI, ALHC, ACS, AIRC, AIAA, RHU, REBC, Scott Grindstaff, HIA, MHP, Kim D. King, HIA, MHP, PAHM, and Lalita Wells, JD, CPM, AIAA, ACS, North Carolina Market Regulation Examiners, participated in this examination and the preparation of this report.

Respectfully submitted,



Jill H. Dale, PAHM, HIA, MHP
Examiner-In-Charge
Market Regulation Division
State of North Carolina

I have reviewed this examination report and it meets the provisions for such reports prescribed by this Division and the North Carolina Department of Insurance.



Tracy M. Biehn, LPCS, MBA
Deputy Commissioner
Market Regulation Division
State of North Carolina