REPORT OF
MARKET CONDUCT EXAMINATION
OF

HIGHMARK INC.
Harrisburg, Pennsylvania

AS OF
February 10, 2009

COMMONWEALTH OF PENNSYLVANIA

INSURANCE DEPARTMENT
BUREAU OF MARKET CONDUCT

Issued: March 11, 2009

HIGHMARK, INC.

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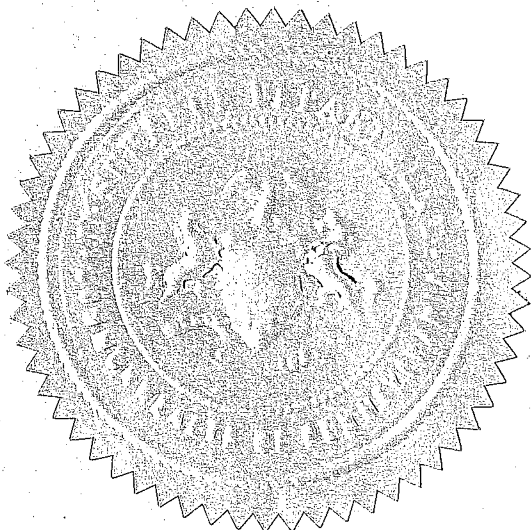
BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 22ND day of July, 2008, in accordance with Section 905(c) of the Pennsylvania Insurance Department Act, Act of May 17, 1921, P.L. 789, as amended, P.S. § 323.5, I hereby designate Ronald A. Gallagher, Deputy Insurance Commissioner, to consider and review all documents relating to the market conduct examination of any company and person who is the subject of a market conduct examination and to have all powers set forth in said statute including the power to enter an Order based on the review of said documents. This designation of authority shall continue in effect until otherwise terminated by a later Order of the Insurance Commissioner.



Joel S. Ario
Insurance Commissioner

Highmark Inc. Market Conduct Examination as of the close of business on February 10, 2009	Docket No. MC09-03-007

ORDER

A market conduct examination of Highmark Inc. (referred to herein as "Respondent") was conducted in accordance with Article IX of the Insurance Department Act, 40 P.S. § 323.1, et seq., for the period January 1, 2005, through December 31, 2007. The Market Conduct Examination Report disclosed exceptions to acceptable company operations and practices. Based on the documentation and information submitted by Respondent, the Department is satisfied that Respondent has taken corrective measures pursuant to the recommendations of the Examination Report.

It is hereby ordered as follows:

1. The attached Examination Report will be adopted and filed as an official record of this Department. All findings and conclusions resulting from the review of the Examination Report and related documents are contained in the attached Examination Report.

2. Respondent shall comply with Pennsylvania statutes and regulations.

3. Respondent shall comply with the recommendation contained in the attached Report.

4. Respondent shall file an affidavit stating under oath that it will provide each of its directors, at the next scheduled directors meeting, a copy of the adopted Report and related Orders. Such affidavit shall be submitted within thirty (30) days of the date of this Order.

The Department, pursuant to Section 905(e)(1) of the Insurance Department Act (40 P.S. § 323.5), will continue to hold the content of the Examination Report as private and confidential information for a period of thirty (30) days from the date of this Order.

BY: Insurance Department of the Commonwealth of Pennsylvania

(March 11, 2009)

Ronald A. Gallagher, Jr.
Deputy Insurance Commissioner

I. INTRODUCTION

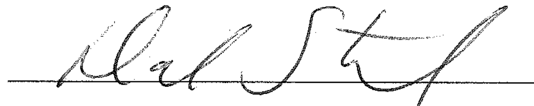
The Market Conduct Examination was conducted on Highmark, Inc.; hereafter referred to as "Company," at the Company's office located in Camp Hill, Pennsylvania, May 19, 2008, through August 22, 2008. Subsequent review and follow-up was conducted in the office of the Pennsylvania Insurance Department.

Pennsylvania Market Conduct Examination Reports generally note only those items, to which the Department, after review, takes exception. A violation is any instance of Company activity that does not comply with an insurance statute or regulation. Violations contained in the Report may result in imposition of penalties. Generally, practices, procedures, or files that were reviewed by Department examiners during the course of an examination may not be referred to in the Report if no improprieties were noted. However, the Examination Report may include management recommendations addressing areas of concern noted by the Department, but for which no statutory violation was identified. This enables Company management to review these areas of concern in order to determine the potential impact upon Company operations or future compliance.

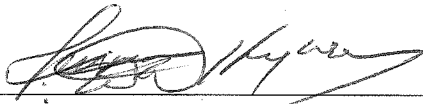
Throughout the course of the examination, Company officials were provided status memoranda, which referenced specific policy numbers with citation to each section of law violated. Additional information was requested to clarify apparent violations. An exit conference was conducted with Company officials to discuss the various types of violations identified during the examination and review written summaries provided on the violations found.

The courtesy and cooperation extended by the Officers and Employees of the Company during the course of the examination is acknowledged.

The undersigned participated in the Examination and in the preparation of this Report.



Daniel Stemcosky, MCM, AIE, FLMI
Market Conduct Division Chief



Frank W. Kyazze, MCM, AIE, FLMI, ALHC
Market Conduct Examiner

Michael Vogel, MCM
Market Conduct Examiner

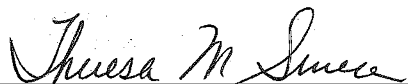
Verification

Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. §4903 (relating to false swearing).

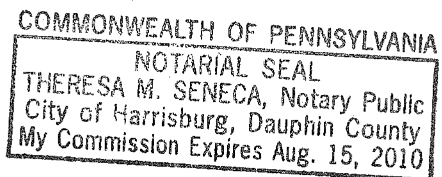
Frank W. Kyazze, MCM, AIE, ALHC, FLMI
[Examiner in Charge]

Sworn to and Subscribed Before me

This 23 Day of January , 2009



Notary Public



II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted pursuant to the authority granted by Sections 903 and 904 (40 P.S. §§323.3 and 323.4) of the Insurance Department Act and covered the experience period of January 1, 2005, through December 31, 2007, unless otherwise noted. The purpose of the examination was to ensure compliance with Pennsylvania insurance laws and regulations.

The examination focused on the Company's operation in areas such as: Forms, Underwriting Practices and Procedures and Claim Handling Practices and Procedures.

The Company was requested to identify the universe of files for each segment of the review. Based on the universe sizes identified, random sampling was utilized to select the files reviewed for this examination.

During the course of the examination, for control purposes, some of the review segments identified in this Report may have been broken down into various sub-categories by line of insurance or Company administration. These specific sub-categories, if not reflected individually in the Report, would be included and grouped within the respective general categories of the Examination Report.

III. COMPANY HISTORY AND LICENSING

Highmark, Inc. (Highmark) is a Pennsylvania nonprofit corporation formed on December 6, 1996 upon the consolidation of Veritus Inc. (d/b/a Blue Cross of Western Pennsylvania) and Medical Services Association of Pennsylvania (d/b/a Pennsylvania Blue Shield). Highmark holds certificates of authority from the Pennsylvania Insurance Department to operate both a nonprofit professional health services plan and a nonprofit hospital plan in the Commonwealth of Pennsylvania.

Under this authority, Highmark offers full-service traditional indemnity, or "fee for service", health care coverage, on both an insured and a self-funded basis, to individuals and groups in the 29 western-most counties of Pennsylvania and in 21 counties of central Pennsylvania and the Lehigh Valley. Through joint operating agreements, Highmark also provides professional health services coverage in conjunction with hospital coverage provided by Hospital Service Association of Northeastern Pennsylvania (d/b/a Blue Cross of Northeastern Pennsylvania) in northeastern Pennsylvania and Independence Blue Cross in southeastern Pennsylvania. In addition to its indemnity coverage, Highmark offers health care coverage in 49 of Pennsylvania's 67 counties through a non-Medicare preferred provider organization program.

Highmark is the ultimate controlling entity of a group of related companies comprising an insurance holding company system. Through its subsidiaries, Highmark offers various other health care coverage options to individuals and groups (including the Medicare population) in Pennsylvania and West Virginia.

As an independent licensee of the national Blue Cross Blue Shield Association, which owns the familiar Blue Cross and Blue Shield names and marks, Highmark operates as Highmark Blue Cross Blue Shield in the 29 western-most counties of Pennsylvania and as Highmark Blue Shield in the remaining counties of the Commonwealth.

Highmark's total statutory net premium income for 2007, as reported in its filed annual statement, was $5,205,550,441. Its total annual member months as reported for the year was 22,797,262.

IV. FORMS

The Company was requested to provide a list and copies of all forms used during the experience period. The forms provided were reviewed to ensure compliance with pertinent state insurance laws and regulations including, but not limited to: Insurance Company Law, Section 354; Title 18, Pennsylvania Consolidated Statutes, Section 4117(k), Fraud Warning Notice; the Accident and Health Reform Filing Act, No. 159 (40 P.S. §3803); and the Quality Health Care Accountability and Protection Act No. 68, Section 2136 (40 P.S. §991.2136), Required Disclosure. In addition, contracts were reviewed for inclusion of the following state mandated coverages:

- Alcohol/Substance Abuse
- Conversion
- Chemotherapy/Cancer Hormone Treatment
- Childhood Immunizations
- Dependent Children
- Diabetic Supplies and Education
- Emergency Reimbursement
- Gynecological Examination/Pap Smear
- Mammography Screenings
- Mastectomy/Reconstructive Surgery
- Maternity
- Medical/Nutritional Foods
- New Born Children
- Physically Handicapped/Mental Retarded Child

No violations were noted.

V. UNDERWRITING

The Underwriting review was sorted and conducted in three (3) general segments.

A. Group Policies Terminated
B. Group Certificates Terminated
C. Group Conversions

Each segment was reviewed for compliance with underwriting practices and procedures and applicable issuance, conversion and underwriting statutes and regulations. Subsequent to the onsite examination, the Department discovered that the Company had modified the administration of newborn eligibility under Act 81, specifically medically underwriting newborn baby care. Through a self audit program and coordinated efforts with the Department, the impact of the modification was revealed, resolved and remediated.

A. Group Policies Terminated

The Company was requested to provide a list of all group policies terminated during the experience period of January 1, 2007, through December 31, 2007, for accident and health coverage. The Company identified a universe of 4,590 group policies terminated. A random sample of 50 files was requested, received and reviewed. The policy files were reviewed to ensure compliance with contract provisions, termination laws and regulations, and proper return of any unearned premium. No violations were noted.

B. Group Certificates Terminated

The Company was requested to provide a list of all Pennsylvania residents holding a certificate of coverage terminated during the experience period of January 1, 2007, through December 31, 2007, for accident and health coverage. The Company identified a universe of 217,870 group certificates terminated. A random sample of 75 certificate files was requested, received and reviewed. The files were reviewed to ensure that terminations were not the result of any discriminatory underwriting practice and that the certificate holders were provided the required notice of conversion to an individual plan of coverage. No violations were noted.

C. Group Conversions

The Company was requested to provide a list of all applications for conversion of group coverage to individual coverage for the experience period of January 1, 2007, through December 31, 2007, for accident & health coverage. The Company identified a universe of 10,092 certificate holders converting their group health coverage upon termination to an optional individual plan. A random sample of 50 conversion files was requested, received and reviewed. The files were reviewed to ensure compliance with applicable issuance, conversion and underwriting statutes and regulations. No violations were noted.

VI. CLAIMS

The Company was requested to provide copies of all procedural guidelines used in handling alcohol and substance abuse claims and mental illness claims during the experience period including, but not limited to: all training manuals, internal audit examination manuals, company memorandums, and any other instructions concerning claims handling. The Company provided the following documentation for review:

1. Educational Material Manuals
2. Magellan Behavioral Health Agreements
3. Behavioral Health Utilization Management Service Agreement
4. Community Behavioral Healthcare Cooperative Of Pennsylvania Delegation Agreement
5. Behavioral Health Service Agreement
6. Suspensions Processing
7. County Access Guidelines – Behavioral Health Services
8. Alcohol and Drug Claims Guidelines
9. Mental Illness Claims Guidelines
10. Psychiatric /Psychological Guidelines
11. Alcohol and Drug Rehabilitation Guidelines
12. Behavioral Health Services Guidelines
13. Accumulator Descriptor Codes
14. Special Bulletins
15. Bulletin Releases
16. Network Provider News
17. Modifiers
18. Screen Information
19. MTM Direct Measures Program Guide – Claims Accuracy
20. Performance Measurement & Reporting Quality/Audit Procedures

The claim procedural guidelines were reviewed for any inconsistencies, which could be considered discriminatory, specifically prohibited by statute or regulation, or unusual in nature. No violations were noted.

The claim file review consisted of 6 areas:

A. Blue Cross Blue Shield Alcohol and Drug Denied Claims
B. Blue Shield Alcohol and Drug Denied Claims
C. Blue Cross Blue Shield Alcohol and Drug Denied Services
D. Blue Shield Alcohol and Drug Denied Services
E. Blue Cross Blue Shield Mental Health Denied Claims
F. Blue Shield Mental Health Denied Claims

All claim files were reviewed for compliance with requirements of the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171); Section 602-A of the Insurance Company Law (40 P.S. §908-2), Alcohol/Drug Abuse and Dependency Mandated Policy Coverage and Options; Title 31, Pennsylvania Code, Section 89.612, Minimum covered services; Section 635.1 of the Insurance Company Law (40 P.S. §764g), Coverage for Serious Mental Illnesses and Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

A. Blue Cross Blue Shield Alcohol and Drug Denied Claims

The Company was requested to provide a list of all denied claims finalized during the experience period of January 1, 2005, through December 31, 2006, for alcohol and drug rehabilitative services. The Company identified a universe of 978 Blue Cross Blue Shield denied claims finalized in calendar year 2005, and 1,728 denied claims finalized in calendar year 2006. From the original universe of claims for 2005 and 2006, the Department utilizing an audit program, extracted claims that had denial codes that were considered most susceptible for non-compliance with the Alcohol and Drug mandated benefit. The extracted universe of denied claims for 2005, was 58 claims and for 2006, the extracted universe was 70 claims. Of the 58 denied claims and the 70 denied claims, random samples of 25 and 50 respectively, were requested,

received and reviewed. The files were reviewed to ensure that the Company's claims adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent state insurance laws and regulations. No violations were noted.

B. Blue Shield Alcohol and Drug Claims Denied

The Company was requested to provide a list of all denied claims finalized during the experience period of January 1, 2005, to December 31, 2006, for alcohol and drug rehabilitative services. The Company identified a universe of 416 Blue Shield denied claims finalized in calendar year 2005, and 705 denied claims finalized in calendar year 2006. From the original universe of claims for 2005 and 2006, the Department utilizing an audit program, extracted claims that had denial codes that were considered most susceptible for non-compliance with the Alcohol and Drug mandated benefit. The extracted universe of denied claims for 2005, was 57 claims and for 2006, the extracted universe was 3 claims. Of the 57 denied claims for 2005, a random sample of 25 claims and all 3 claims for 2006, were requested and received. The files were reviewed to ensure that the Company's claims adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent state insurance laws and regulations. No violations were noted.

C. Blue Cross Blue Shield Alcohol and Drug Services Denied

The Company was requested to provide a list of all services denied during the experience period of January 1, 2005, to December 31, 2006 for alcohol and drug rehabilitative services. The Company identified a universe of 3,043 Blue Cross Blue Shield alcohol and drug services denied in calendar year 2005, and 5,055 alcohol and drug services denied in calendar year 2006. From the original universe of services denied for 2005 and 2006, the Department utilizing an audit program, extracted files that had denial codes that were considered most susceptible for non-compliance with the Alcohol and Drug mandated benefit. The extracted universe of denied services for 2005, was 490 and for 2006, the extracted universe was 498. Of the 490 denied services for 2005, and the 498 denied services for 2006, random samples of 25 and 50 respectively, were requested, received and reviewed. The files were reviewed to ensure that the Company's adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent state insurance laws and regulations. The following violation was noted.

1 Violation - Insurance Company Law, Section 2166 (40 P.S. §991.2166), Prompt Payment of Provider Claims

(A) A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim.

The claim noted was not paid within the required 45 days.

D. Blue Shield Alcohol and Drug Services Denied

The Company was requested to provide a list of all services denied during the experience period of January 1, 2005, to December 31, 2006 for alcohol and drug rehabilitative services. The Company identified a universe of 2,124 Blue Shield alcohol and drug services denied in calendar year 2005, and 2,547 alcohol and drug services denied in calendar year 2006. From the original universe of services denied for 2005 and 2006, the Department utilizing an audit program, extracted files that had denial codes that were considered most susceptible for non-compliance with the Alcohol and Drug mandated benefit. The extracted universe of denied services for 2005, was 390 and for 2006, the extracted universe was 200. Of the 390 denied services for 2005, and the 200 denied services for 2006, random samples of 25 and 50 respectively, were requested, received and reviewed. The files were reviewed to ensure that the Company's adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent state insurance laws and regulations. No violations were noted.

E. Blue Cross Blue Shield Mental Health Claims Denied

The Company was requested to provide a list of all claims denied during the experience period of January 1, 2006, to December 31, 2006, for mental illness services. The Company identified a universe of 7,009 Blue Cross Blue Shield mental illness claims denied. From the original universe, the Department extracted files that had denial codes that were considered most susceptible for non-compliance with the Mental Illness mandated benefit. The extracted universe of denied claims was 482

claims. Of the 482 denied claims, a random sample of 50 claim files was requested, received and reviewed. The files were reviewed to ensure that the Company's claims adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent state insurance laws and regulations. The following violation was noted:

1 Violation - Insurance Company Law, Section 2166 (40 P.S. §991.2166), Prompt Payment of Provider Claims

(A) A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim.

The claim noted was not paid within 45 days.

F. Blue Shield Mental Health Claims Denied

The Company was requested to provide a list of all claims denied during the experience period of January 1, 2006, to December 31, 2006, for mental illness services. The Company identified a universe of 5,470 Blue Shield mental illness claims denied. From the original universe, the Department extracted files that had denial codes that were considered most susceptible for non-compliance with the Mental Illness mandated benefit. The extracted universe of denied claims was 171 claims. Of the 171 denied claims, a random sample of 25 claim files was requested, received and reviewed.

The files were reviewed to ensure that the Company's claims adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent state insurance laws and regulations. No violations were noted.

VII. RECOMMENDATIONS

The recommendation made below identifies corrective measures the Department finds necessary as a result of the number of some violations, or the nature and severity of other violations, noted in the Report.

1. The Company must implement procedures to ensure compliance with requirements of Section 2166 of the Insurance Company Law of 1921 (40 P.S. §991.2166), relating to prompt payment of provider claims.

VIII. COMPANY RESPONSE

March 4, 2009

Daniel A. Stemcosky, AIE, FLMI, MCM
Market Conduct Division Chief
Office of Market Regulation
Bureau of Market Conduct – Life and Health Division
1227 Strawberry Square
Harrisburg, PA 17120

Re: Examination Warrant Number: 07-M27-058

Dear Mr. Stemcosky:

We hereby acknowledge receipt of the certified Report of Examination of Highmark, Inc., made as of the close of business December 31, 2008.

The attached Exhibit A contains our responses to your Recommendation on page 17 of the report.

Sincerely,

Elizabeth A. Farbacher
Senior Vice President & Chief Audit Executive

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Attachment A

Report of Examination
PA Market Conduct Study – Highmark Inc.
As of December 31, 2008
Responses to Recommendations

Current Examination

1. It is recommended that the Company must implement procedures to ensure compliance with requirements of Section 2166 of the Insurance Company Law of 1921 (40 P.S. §991.2166), relating to prompt payment of provider claims.

   Response from Highmark Inc.: It should be noted that the Company continually monitors claims inventory to be finalized within 45 days of receipt. The Company uses aging reports that show inventory of unprocessed claims by claim receipt date to monitor aging of claims. Claims are routed to staff for handling in age order to ensure that claims will be finalized within the 45 day time frame. The Company also shifts resources within areas to manage inventories that have increased or aged. The Company will continue to utilize these methods to ensure compliance with Section 2166 of the Insurance Company Law of 1921 (40P.S. §991.2166).

   The 2 claims noted as violations in the audit report were both finalized incorrectly, resulting in denials when the claims were initially processed. These claims were finalized within 45 days of receipt, consistent with our normal business practice of managing the claims inventory to finalize all claims within 45 days of receipt. The fact that these claims should have been paid, rather than denied, became known only pursuant to this examination, so the routine process and controls used to ensure compliance with Section 2166 of the Insurance Company Law of 1921 (40 P.S. §991.2166), relating to prompt payment of provider claims, would not apply. Upon determination that these claims had been finalized in error, adjustments were initiated and the claims, with interest, have been paid.