pennsylvania
INSURANCE DEPARTMENT

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT

MARKET CONDUCT
EXAMINATION REPORT

OF

HIGHMARK INC.
CAMP HILL, PA

As of: March 8, 2013
Issued: May 3, 2013

MARKET ACTIONS BUREAU
LIFE AND HEALTH DIVISION

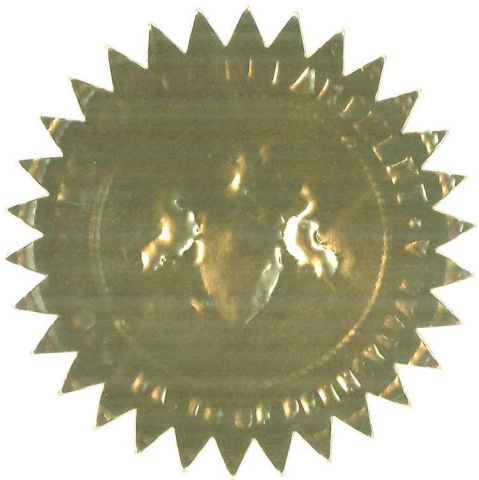
HIGHMARK INC.

TABLE OF CONTENTS

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 27th day of April, 2011, 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.



Michael F. Consedine
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
HIGHMARK, INC.	:	Section 904(b) of the Insurance
1800 Center St.	:	Department Act, Act of May 17, 1921,
Camp Hill, PA 17089	:	P.L. 789, No. 285 (40 P.S. §323.4)
	:	
	:	Section 5(a)(10)(i)(ii)(iii)(iv)(v)(vi)(xii)
	:	(xiv) of the Act of July 22, 1974 (P.L.)
	:	589, No 205) (40 P.S. §1171.5(a)(10)(i)
	:	(ii)(iii)(iv)(v)(vi)(xii)(xiv))
	:	
	:	
Respondent.	:	Docket No. MC13-04-017

CONSENT ORDER

AND NOW, this 3rd day of May, 2013, this Order is hereby issued by the Insurance Department of the Commonwealth of Pennsylvania pursuant to the statutes cited above and in disposition of the matter captioned above.

1. Respondent hereby admits and acknowledges that it has received proper notice of its rights to a formal administrative hearing pursuant to the Administrative Agency Law, 2 Pa.C.S. § 101, et seq., or other applicable law.

2. Respondent hereby waives all rights to a formal administrative hearing in this matter, and agrees that this Consent Order shall have the full force and effect of an order duly entered in accordance with the adjudicatory procedures set forth in the Administrative Agency Law, supra, or other applicable law.

3. Respondent neither admits nor denies the Findings of Fact and Conclusions of Law contained herein. Respondent denies violating any Pennsylvania law or regulation.

FINDINGS OF FACT

4. The Insurance Department finds true and correct each of the following Findings of Fact:

(a) Respondent is Highmark, Inc., and maintains its address at 1800 Center St., Camp Hill, PA 17089.

(b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from April 16, 2010, through January 18, 2011.

(c) On March 8, 2013, the Insurance Department issued a Market Conduct Examination Report to Respondent.

(d) A response to the Examination Report was provided by Respondent on April 5, 2013.

(e) On April 15, 2013, the Insurance Department issued a revised Market Conduct Examination Report to Respondent.

(f) The Examination Report notes violations of the following:

(i) Section 904(b) of the Insurance Department Act, Act of May 17, 1921 (40 P.S. § 323.4), which requires every company or person from whom information is sought, its officers, directors and agents must provide to the examiners appointed under subsection (a) timely, convenient and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the company being examined. The officers, directors, employees and agents of the company or person must facilitate such examination and aid in such examination so far as it is in their power to do so. The refusal of any company, by its officers, directors, employees or agents, to submit to examination or to comply with any reasonable written request of the

examiners shall be grounds for suspension or refusal of, or nonrenewal of any license or authority held by the company to engage in insurance or other business subject to the department's jurisdiction. Any such proceedings for suspension, revocation or refusal of any license or authority shall be conducted pursuant to 2 Pa.C.S. (relating to administrative law and procedure);

(ii) Section 5(a)(10)(i)(ii)(iii)(iv)(v)(vi)(xii)(xiv) of the Unfair Insurance Practices Act, (40 P.S.§1171.5(a)(10)), which requires fair claim settlement or compromise practices;

(iii) Section 5(a)(10)(i) of the Unfair Insurance Practices Act, (40 P.S. §1171.5(a)(10)), which prohibits misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue;

(iv) Section 5(a)(10)(ii) of the Unfair Insurance Practices Act, (40 P.S. §1171.5(a)(10)), which prohibits failing to acknowledge and act promptly upon written or oral communications with respect to claims arising under insurance policies;

(v) Section 5(a)(10)(iii) of the Unfair Insurance Practices Act, (40 P.S. §1171.5(a)(10)), which prohibits failing to adopt and implement

reasonable standards for the prompt investigation of claims arising under insurance policies;

(vi) Section 5(a)(10)(iv) of the Unfair Insurance Practices Act, (40 P.S. §1171.5(a)(10)), which prohibits refusing to pay claims without conducting a reasonable investigation based upon all available information;

(vii) Section 5(a)(10)(v) of the Unfair Insurance Practices Act, (40 P.S. §1171.5(a)(10)), which prohibits failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative;

(viii) Section 5(a)(10)(vi) of the Unfair Insurance Practices Act, (40 P.S. §1171.5(a)(10)), which prohibits not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear;

(ix) Section 5(a)(10)(xii) of the Unfair Insurance Practices Act, (40 P.S. §1171.5(a)(10)), which prohibits delaying the investigation or payment of claims by requiring the insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions

contain substantially the same information;

(x) Section 5(a)(10)(xiv) of the Unfair Insurance Practices Act, (40 P.S. §1171.5(a)(10)), which prohibits failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

CONCLUSIONS OF LAW

5. In accord with the above Findings of Fact and applicable provisions of law, the Insurance Department makes the following Conclusions of Law:

(a) Respondent is subject to the jurisdiction of the Pennsylvania Insurance Department.

(b) Respondent's violations of Section 5(a)(10)(i)(ii)(iii)(iv)(v)(vi)(xii)(xiv) of the Unfair Insurance Practices Act, (40 P.S. §1171.5(a)(10)(i)(ii)(iii)(iv)(v)(vi)(xii)(xiv)), which requires fair claim settlement or compromise practices, are punishable by the following under Section 9 of the Unfair Insurance Practices Act (40 P.S. §§ 1171.9):

(i) cease and desist from engaging in the prohibited activity;

(ii) suspension or revocation of the license(s) of Respondent.

(c) In addition to any penalties imposed by the Commissioner for Respondent's violations of the Unfair Insurance Practices Act (40 P.S. §§ 1171.1 – 1171.5), the Commissioner may, under Sections 10 and 11 of the Unfair Insurance Practices Act (40 P.S. §§ 1171.10, 1171.11) file an action in which the Commonwealth Court may impose the following civil penalties:

(i) for each method of competition, act or practice which the company knew or should have known was in violation of the law, a penalty of not more than five thousand dollars ($5,000.00);

(ii) for each method of competition, act or practice which the company did not know nor reasonably should have known was in violation of the law, a penalty of not more than one thousand dollars ($1,000.00).

ORDER

6. In accord with the above Findings of Fact and Conclusions of Law, the Pennsylvania Insurance Department orders and Respondent consents to the following:

(a) Respondent shall cease and desist from engaging in the activities described herein in the Findings of Fact and Conclusions of Law.

(b) 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.

(c) Respondent shall pay Fifty Thousand Dollars ($50,000.00) to the Commonwealth of Pennsylvania, Pennsylvania Insurance Department in settlement of all violations contained in the Report.

(d) Payment of this matter shall be made by check payable to the Pennsylvania Insurance Department. Payment should be directed to Cherie Leese, Bureau of Market Actions, 1321 Strawberry Square, Harrisburg, Pennsylvania 17120. Payment must be made no later than thirty (30) days after the date of this Order.

7. In the event the Insurance Department finds that there has been a breach of any of the provisions of this Order, based upon the Findings of Fact and Conclusions of Law contained herein may pursue any and all legal remedies available, including but not limited to the following: The Insurance Department may enforce the provisions of this Order in the Commonwealth Court of Pennsylvania or in any other court of law or

equity having jurisdiction; or the Department may enforce the provisions of this Order in an administrative action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

8. Alternatively, in the event the Insurance Department finds that there has been a breach of any of the provisions of this Order, the Department may declare this Order to be null and void and, thereupon, reopen the entire matter for appropriate action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

9. In any such enforcement proceeding, Respondent may contest whether a breach of the provisions of this Order has occurred but may not contest the Findings of Fact and Conclusions of Law contained herein.

10. Respondent hereby expressly waives any relevant statute of limitations and application of the doctrine of laches for purposes of any enforcement of this Order.

11. This Order constitutes the entire agreement of the parties with respect to the matters referred to herein, and it may not be amended or modified except by an amended order signed by all the parties hereto.

12. This Order shall be final upon execution by the Insurance Department. Only the Insurance Commissioner or a duly authorized delegee is authorized to bind the Insurance Department with respect to the settlement of the alleged violations of law

contained herein, and this Consent Order is not effective until executed by the Insurance Commissioner or a duly authorized delegee.

BY: Highmark, Inc., Respondent

President / Vice President

Secretary / ~~Treasurer~~

COMMONWEALTH OF PENNSYLVANIA
By: 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 starting on February 2, 2012, through March 2, 2012 and then at the Wilkes Barre, Pennsylvania location starting on March 26, 2012 through May 3, 2012. 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 following examiners participated in the Examination and in the preparation of this Report.

Yonise A. Roberts Paige
Market Conduct Division Chief

Michael A. Jones
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).

Michael A. Jones, Examiner in Charge

Sworn to and Subscribed Before me

This 16th Day of April , 2013

Notary Public

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
LINDY McMILLEN, Notary Public
City of Harrisburg, Dauphin County
My Commission Expires March 23, 2014

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 for major medical claims processed from April 16, 2010, through December 17, 2010 and for the post system remedy of December 18, 2010 to January 18, 2011 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: Claim Handling Practices and Procedures.

The Company was requested to identify, for each segment of the review, the universe of files that denied with the code of S5232 *(In order to process this claim, additional information is needed from your provider. The provider has been contacted and asked to resubmit the claim with the correct information).* 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 History

Highmark Inc. ("Highmark") was incorporated on December, 6, 1996 as the result of the consolidation between Blue Cross of Western Pennsylvania and Pennsylvania Blue Shield. Highmark is a Pennsylvania nonprofit corporation licensed by the Pennsylvania Insurance Department ("Department") to operate a nonprofit hospital plan and a nonprofit professional health services plan pursuant to the Health Plan Corporations Act, 40 Pa. C.S. 6101-6127, 6301-6335 ("HPCA").

Highmark is also an independent licensee of the Blue Cross Blue Shield Association ("BCBSA"), which owns the "Blue" names and marks, and is one of four "Blue" plans in Pennsylvania. Under its BCBSA licenses, 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. As a party to joint operating agreements, Highmark provides professional health services coverage in conjunction with hospital coverage provided by Blue Cross of Northeastern Pennsylvania in northeastern Pennsylvania and by Independence Blue Cross ("IBC") in southern Pennsylvania. Highmark also offers jointly underwritten Major Medical Products with Blue Cross of Northeastern Pennsylvania and Independence Blue Cross. Administrative services performed by the companies are set forth in separate Administrative Service Agreements.

Highmark has several subsidiaries and affiliates that are engaged in offering health insurance, dental insurance, vision services, workers compensation insurance, stop-loss insurance, real estate management services and other administrative services.

As of the Company's December 31, 2010, annual statement for Pennsylvania, Highmark Inc., reported total revenues for Comprehensive Hospital and Medical Health Insurance in the amount of $3,746,763,075 and total revenues for Medicare Supplement Insurance in the amount of $361,398,572.

IV. CLAIMS & CLAIMS MANUALS

The Company was requested to provide copies of all claims procedural guidelines including all manuals, memorandums, directives and any correspondence or instructions used for processing claims during the experience period. The Company provided the following claim manuals:

Claims Manuals

- Introduction
- Member Searches
- Claims Viewing
- Benefit Viewing
- Authorizations
- Major Medical Claims Processing Overview

Misc Manuals

- Product Overview
- OSCAR Tools
- Services (claims information)
- Claims Timeliness Guide - 2010 MTM Program Guide (*BCBS Guidelines*)

How to/ Training Manuals

Package 1

- Product Overview Section
- Indemnity Section
- Managed Care Section

Package 2

- OSCAR Tools Section

Package 3

- Services Section

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

A. Health Insurance Claims

Based on a consumer complaint, the Pennsylvania Insurance Department became aware of a problematic upgrade of the Highmark Oscar System that lead to approximately 20,521 claims that contained the S5232 denial code from April 16, 2010 through December 18, 2010. The Company identified a universe of 20,520 professional health insurance claims and 1 facility claim received for major medical consideration. The Department requested a random sample of 100 professional health claims received prior to submission for major medical consideration. All 100 claims files were requested, received and reviewed. The provider submitted claim files were reviewed for compliance with Act 205, (40 P.S. §1171.5) Unfair Methods of Competition and Unfair or deceptive acts or practices to insure that prior to submission to major medical, Highmark's processing of the claims was in compliance. The following violations were noted:

6 Violations - Act 205, (40 P.S. §1171.5) Unfair methods of competition, unfair or deceptive acts or practices defined

(a) " Unfair Methods of Competition " and " unfair or deceptive acts or practices " in the business of insurance means:

(10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices:

(ii) Failing to acknowledge and act promptly upon written or oral communications with respect to claims arising under insurance policies.

(iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

(v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative. The Company failed to acknowledge and act promptly within a reasonable time after proof of loss statement have been completed and communicated to the Company or its representative in the 6 noted claim files.

B. Health Insurance Major Medical Claims not Manually Processed, Unpaid and Non-Duplication

The Company was requested to provide a list of major medical claims denied with the code of S5232 that had been scrubbed by the Company and were non-duplicative (e.g., same claimant/insured, different procedure code, different diagnosis code, different date of service, different amount billed and different provider). In addition, the claims denied between April 16, 2010 and December 17, 2010 and that were not manually processed and unpaid. The Company identified a universe of 18,084 health insurance claims. A random sample of 50 claims was requested, received and reviewed. The files were reviewed to determine compliance with Act 205, (40 P.S. §1171.5) Unfair Methods of Competition and Unfair or deceptive acts or practices defined. The following violations were noted:

1 Violation - Insurance Department Act, Section 904 (40 P.S. § 323.4)

(b) Every company or person from whom information is sought, its officers, directors and agents must provide to the examiners appointed under subsection (a) timely, convenient and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the company being examined. The officers, directors,

employees and agents of the company or person must facilitate such examination and aid in such examination so far as it is in their power to do so. The refusal of any company, by its officers, directors, employees or agents, to submit to examination or to comply with any reasonable written request of the examiners shall be grounds for suspension or refusal of, or nonrenewal of any license or authority held by the company to engage in insurance or other business subject to the department's jurisdiction. Any such proceedings for suspension, revocation or refusal of any license or authority shall be conducted pursuant to (2 Pa.C.S.) relating to administrative law and procedure. Verification that an explanation of benefits was provided to the provider or member could not be established in the noted claim file.

25 Violations - Act 205, (40 P.S. §1171.5) Unfair methods of competition, unfair or deceptive acts or practices defined

(a) " Unfair Methods of Competition " and " unfair or deceptive acts or practices " in the business of insurance means:

(10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices:

(i) Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.
(iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.
(iv) Refusing to pay claims without conducting a reasonable investigation based upon all available information.

(vi) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear.

The processing times used were inconsistent with the standards set forth in the Company's guidelines used for the 25 noted claim files.

C. Health Insurance Major Medical Claims Manually Processed, Paid and Non-Duplication

The Company was requested to provide a list of major medical claims denied with the rejection code of S5232 that has been scrubbed by the Company that contains non-duplicative (e.g. same claimant/insured, different procedure code, different diagnosis code, different date of service, different amount billed and different provider) claims denied between April 16, 2010 and December 17, 2010 that were manually processed and paid. The Company identified a universe of 8,736 health insurance claims. A random sample of 50 claims was requested, received and reviewed. The files were reviewed to determine compliance with Act 205, (40 P.S. §1171.5) Unfair Methods of Competition and Unfair or deceptive acts or practices defined. The following violations were noted:

1 Violation - Insurance Department Act, Section 904 (40 P.S. § 323.4)
(b) Every company or person from whom information is sought, its officers, directors and agents must provide to the examiners appointed under subsection (a) timely, convenient and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the company being examined. The officers, directors, employees and agents of the company or person must facilitate such examination and aid in such examination so far as it is in their power to do so. The refusal of any company, by its officers, directors, employees or agents, to submit to examination or to comply with any reasonable written request of the examiners shall be grounds for suspension or refusal of, or nonrenewal of any license or authority held by the company to engage in insurance or other business subject to the department's jurisdiction. Any such proceedings

for suspension, revocation or refusal of any license or authority shall be conducted pursuant to 2 Pa.C.S. (relating to administrative law and procedure). Verification that the reviewed line item was properly adjudicated could not be established in the noted claim file.

21 Violations - Act 205, (40 P.S. §1171.5) Unfair methods of competition, unfair or deceptive acts or practices defined

(a) " Unfair Methods of Competition " and " unfair or deceptive acts or practices " in the business of insurance means:

(10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices:

(i) Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.
(iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.
(iv) Refusing to pay claims without conducting a reasonable investigation based upon all available information.
(vi) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear.
The processing times used were inconsistent with the standards set forth in the Company’s guidelines for the 21 noted claim files.

D. Health Insurance Major Medical Claims not Manually Paid due to Duplication

The Company was requested to provide a list of major medical claims denied with the code of S5232 that contains duplicates (e.g. same claimant/insured, different procedure code, different diagnosis code, different date of service, different amount billed and different provider) claims denied between April 16, 2010 and December 17, 2010 that were not manually paid because it was a duplicate claim. The Company identified a universe of 2,903 health insurance claims. A random sample of 50 claims was requested, received and reviewed. The files were reviewed to determine compliance with Act 205, (40 P.S. §1171.5) Unfair Methods of Competition and Unfair or deceptive acts or practices defined. The following violations were noted:

10 Violations - Insurance Department Act, Section 904 (40 P.S. § 323.4) (b) Every company or person from whom information is sought, its officers, directors and agents must provide to the examiners appointed under subsection (a) timely, convenient and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the company being examined. The officers, directors, employees and agents of the company or person must facilitate such examination and aid in such examination so far as it is in their power to do so. The refusal of any company, by its officers, directors, employees or agents, to submit to examination or to comply with any reasonable written request of the examiners shall be grounds for suspension or refusal of, or nonrenewal of any license or authority held by the company to engage in insurance or other business subject to the department's jurisdiction. Any such proceedings for suspension, revocation or refusal of any license or authority shall be conducted pursuant to 2 Pa.C.S. (relating to administrative law and procedure). Verification that a complete explanation of benefits was provided to the provider and or the member could not be established in the 14 noted claim files.

20 Violations - Act 205, (40 P.S. §1171.5) Unfair methods of competition, unfair or deceptive acts or practices defined

(a) " Unfair Methods of Competition " and " unfair or deceptive acts or practices " in the business of insurance means:

(10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices:

(i) Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.
(iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.
(iv) Refusing to pay claims without conducting a reasonable investigation based upon all available information.
(vi) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear.
The processing times used were inconsistent with the standard set forth in the Company's guidelines for the 20 noted claim files.

E. Health Insurance Major Medical Claims Electronically Processed and Paid Post-System Remedy

The Company was requested to provide a list of major medical claims denied with the code of S5232 and were denied between April 16, 2010 and December 17, 2010 that were electronically processed and paid post-remedy. The Company identified a universe of 10,778 health insurance claims. A random sample of 50 claims was requested, received and reviewed. The files were reviewed to determine compliance with Act 205,

(40 P.S. §1171.5) Unfair Methods of Competition and Unfair or deceptive acts or practices defined. The following violations were noted:

46 Violations - Act 205, (40 P.S. §1171.5) Unfair methods of competition, unfair or deceptive acts or practices defined

(a) " Unfair Methods of Competition " and " unfair or deceptive acts or practices " in the business of insurance means:

(10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices:
(i) Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.
(ii) Failing to acknowledge and act promptly upon written or oral communications with respect to claims arising under insurance policies.
(iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.
(iv) Refusing to pay claims without conducting a reasonable investigation based upon all available information.
(v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.
(vi) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear.
(xii) Delaying the investigation or payment of claims by requiring the insured, claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(xiv) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement. The processing times used were inconsistent with the standard set forth in the Company's guidelines for the 46 noted claim files.

F. Health Insurance Major Medical Claims Electronically Processed Denial Upheld and Non-Duplication

The Company was requested to provide a list of major medical claims denied with the code of S5232 that has been scrubbed by the Company that contains non-duplicative (e.g. same claimant/insured, different procedure code, different diagnosis code, different date of service, different amount billed and different provider) claims denied between April 16, 2010 and December 17, 2010 that were electronically processed and the denial was upheld and Non-Duplication. The Company identified a universe of 7,548 health insurance claims. A random sample of 50 claims was requested, received and reviewed. The files were reviewed to determine compliance with Act 205, (40 P.S. §1171.5) Unfair Methods of Competition and Unfair or deceptive acts or practices defined. No violations were noted.

V. RECOMMENDATIONS

The recommendations made below identify 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 review and revise procedures to ensure that its officers, directors and agents provide to the examiners appointed under subsection (a) timely, convenient and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the company being examined to ensure compliance with Section 904(b), (40 P.S. §323.4) of the Insurance Department Act.
2. The Company must implement procedures to ensure compliance with the requirements of Insurance Department Act of 1921 "Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance – Act 205, Section 5 (40 P.S. §1171.5).

VI. COMPANY RESPONSE

April 5, 2013

Ms. Yonise Roberts Paige, Chief
Life, Accident and Health Division
Market Actions Bureau
Commonwealth of Pennsylvania
Insurance Department
1321 Strawberry Square
Harrisburg, PA 17120

RE: Highmark Inc.
Examination Warrant Number: 11-M25-018
Experience Period: April 16, 2010 to January 18, 2011
Response to Final Examination Report

Dear Ms. Roberts Paige:

Thank you for the opportunity to respond to the Pennsylvania Insurance Department's ("Department") Report on the Examination of Highmark Inc. ("Company") covering the period of time from April 16, 2010 through January 18, 2011.

As you are aware Highmark Inc. and its affiliates serve approximately 4.9 million customers across three (3) states. As a result, the Company processes approximately 84.7 million claims per year. The Company prides itself on timely and accurate claims processing and compliance with all laws and regulations. The Company strives for excellence through self-evaluation and necessary improvements.

To that end, the Company acknowledges that the market conduct examination process is a useful process in identifying potential problem areas and provides a vehicle for the Company to reexamine its business processes and internal controls in order to identify areas where improvements may be made.

The following is Highmark's Response to the Department's findings and recommendations:

SECTION IV. CLAIMS & CLAIMS MANUALS

Findings: No Findings.

Company Response: *Company agrees with the Department's Findings.*

A. Health Insurance Claims

Findings: The Company failed to acknowledge and act promptly within a reasonable time after proof of loss statement had been completed and communicated to the Company or its representative in the eight (8) noted claims files.

Company Response: *The Company respectfully disagrees with the Department's findings. The eight (8) initial claims, which were subject to review, were processed and finalized well within the Company's thirty (30) day claims inventory guidelines. The Company responded to these eight (8) alleged violations on March 27, 2012. A response was sent to the reviewer via e-mail. The Company explained to the Department that six (6) of the initial claims had processed and finalized correctly and within a timely manner. However, these same claims were then resubmitted for processing due to a mass adjustment that was mandated by the Centers for Medicare and Medicaid Services' ("CMS'") Fee Schedule Change that began in August of 2011.*

The Company was legally required to make this mass adjustment and reprocess these claims. Adjusted claims, as explained previously, fall outside of the Company's thirty (30) day timely processing guidelines because adjustments generally require manual intervention and additional research. The amount and type of intervention and research varies based upon the individual claim. This distinction between the timeframe for processing of initial claims and the timeframe that applies when adjustments are made to claims previously processed was explained to the Department earlier. The Company believed that based upon the information supplied to the Department that these alleged violations had been removed. The other two claims that were designated as violations did not require readjudication and had processed and paid within thirty (30) days in accordance with the Company's guidelines. Please note that within the thirty (30) day

time frame, claims that require no manual intervention will process more quickly than others.

B. Health Insurance Major Medical Claims not Manually Processed, Unpaid and Non-Duplicative

Findings: The Department could not verify that an explanation of benefits was provided to the provider or member for one (1) claim.

Company Response: *The Company agrees with the Department's finding. Highmark is currently in the process of reevaluating its internal processes and procedures related to the issuance and retention of member and provider notifications.*

Findings: The processing times used were inconsistent with the standards set forth in the Company's guidelines used for the twenty five (25) noted claims.

Company Response: *The Company respectfully disagrees with the Department's findings. The Company provided to the Department a copy of its claims processing guidelines and a copy of the Blue Cross Blue Shield Association's ("BCBSA's") Member Touchpoint Measures Guidelines ("MTM Guidelines"). Both the internal guidelines and the MTM Guidelines establish that initial claims and readjudicated claims are subject to different timely processing guidelines. The MTM Guidelines in Section 4.2 Population Claims Timeliness, Subsection b) Exclusions, Paragraph iii specifically excludes "Adjustments to a previously processed claim." An initial claim must be processed and finalized within thirty (30) days. "Finalized" means that the claim must pay or deny. Once the claim is finalized, the clock stops. If a claim is submitted for readjudication, as these claims were, a new clock starts. As such, it is the Company's position, that all of these claims initially processed and finalized in a timely manner and that the readjudicated claims processed correctly and finalized within the Company's guidelines as well.*

C. Health Insurance Major Medical Claims Manually Processed , Paid and Non-Duplicative

Findings: The Department was unable to establish that one (1) claim was properly adjudicated.

Company Response: *The Company respectfully disagrees with the Department's finding. The Company did provide the Department with a copy of the explanation of benefits that was issued to the member. Pursuant to the Company's guidelines, an explanation of benefits, however, was not issued to the provider because the provider was a non-participating provider. Payments for services rendered by a non-participating provider are issued only to the member. As a result, the member was the proper recipient of the explanation of benefits.*

Findings: The processing times used were inconsistent with the standards set forth in the Company's guidelines for the twenty one (21) noted claim files.

Company Response: *The Company respectfully disagrees with the Department's findings. The Company provided to the Department a copy of its claims processing guidelines and a copy of the Blue Cross Blue Shield Association's ("BCBSA's") Member Touchpoint Measures MTM Program Guidelines ("MTM Guidelines"). Both the internal guidelines and the MTM Guidelines establish that initial claims and readjudicated claims are subject to different timely processing guidelines. The MTM Guidelines in Section 4.2 Population Claims Timeliness, Subsection b) Exclusions, Paragraph iii specifically excludes "Adjustments to a previously processed claim." An initial claim must be processed and finalized within thirty (30) days. "Finalized" means that the claim must pay or deny. Once the claim is finalized, the clock stops. If a claim is submitted for readjudication, as these claims were, a new clock starts. As such, it is the Company's position, that all of these claims initially processed and paid finalized correctly in a timely manner and that the readjudicated claims processed correctly and finalized within the Company's guidelines as well.*

D. Health Insurance Major Medical Claims not Manually Paid Due to Duplication

Findings: The Department could not verify that a complete explanation of benefits was provided to the provider or the member for ten (10) noted claims files.

Company Response: *The Company agrees with the Department's finding. The Company is currently in the process of reevaluating its internal processes and procedures related to the issuance and retention of member and provider notifications.*

Findings: The processing times used were inconsistent with the standard set forth in the Company's guidelines for twenty (20) noted claim files.

Company Response: *The Company respectfully disagrees with the Department's findings. The Company provided to the Department a copy of its claims processing guidelines and a copy of the Blue Cross Blue Shield Association's ("BCBSA's") Member Touchpoint Measures MTM Program Guidelines ("MTM Guidelines"). Both the internal guidelines and the MTM Guidelines establish that initial claims and readjudicated claims are subject to different timely processing guidelines. The MTM Guidelines in Section 4.2 Population Claims Timeliness, Subsection b) Exclusions, Paragraph iii specifically excludes "Adjustments to a previously processed claim." An initial claim must be processed and finalized within thirty (30) days. "Finalized" means that the claim must pay or deny. Once the claim is finalized, the clock stops. If a claim is submitted for readjudication, as these claims were, a new clock starts. As such, it is the Company's position, that all of these claims initially processed and paid finalized correctly in a timely manner and that the readjudicated claims processed correctly and finalized within the Company's guidelines as well.*

E. Health Insurance Major Medical Claims Electronically Processed and Paid Post-System Remedy

Findings: The Company's processing times were inconsistent with the standard set forth in the Company's guidelines for the forty six (46) noted claims files.

Company Response: *The Company respectfully disagrees with the Department's findings. The Company provided to the Department a copy of its claims processing guidelines and a copy of the Blue Cross Blue Shield Association's ("BCBSA's") Member Touchpoint Measures MTM Program Guidelines ("MTM Guidelines"). Both the internal guidelines and the MTM Guidelines establish that initial claims and readjudicated claims are subject to different timely processing guidelines. The MTM Guidelines in Section 4.2 Population Claims Timeliness, Subsection b) Exclusions, Paragraph iii specifically*

excludes "Adjustments to a previously processed claim." An initial claim must be processed and finalized within thirty (30) days. "Finalized" means that the claim must pay or deny. Once the claim is finalized, the clock stops. If a claim is submitted for readjudication, as these claims were, a new clock starts. As such, it is the Company's position, that all of these claims initially processed and paid finalized correctly in a timely manner and that the readjudicated claims processed correctly and finalized within the Company's guidelines as well.

Health Insurance Major Medical Claims Electronically Processed
Denial Upheld and No-Duplication

Findings: No Findings.

Company Response: *The Company agrees with the Department's Findings.*

SECTION V. RECOMMENDATIONS

1. The Company must review and revise procedures to ensure that its officers, directors and agents provide to examiners appointed under subsection (a) timely, convenient and free access at all reasonable hours at its offices to all books, records, accounts, papers documents and any or all computer or other recordings relating to the property, assets business and affairs of the company being examined to ensure compliance with Section 904(b), (40 P.S. §33.4) of the Insurance Department Act.

   Company's Response: *The Company prides itself on transparency and candor with the Department. The Company also takes compliance matters very seriously. Highmark strives to comply with any requests for documentation within a timely manner. As stated previously, the Company is in the process of reevaluating its processes and procedures related to the issuance and retention of member and provider notifications.*

2. The Company must implement procedures to ensure compliance with the requirements of Insurance Department Act of 19231 "Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of Insurance—Act 205, Section 5 (40 P.S. § 1171.5).

Company Response: *The Company will review its procedures, however the Company believes that the Company adhered to its guidelines and processed and finalized both initial and readjudicated claims in accordance with the appropriate processing guidelines. Company respectfully disagrees that it engaged in any business practices that violated Act 205.*

Thank you for the opportunity to review and respond to the Final Report. Should you have any additional questions, please feel free to contact me.

Sincerely,

Melissa M. Anderson

Melissa M. Anderson, Executive Vice President
Chief Auditor & Compliance Officer
Highmark Inc.