



identifying the year as 2005, however, the notary public, Cheryl Karnowski, has appeared before the director and stated that the correct date of the signature by Ms. Haley was May 31, 2006.) The verified Report of Examination was filed with the Department effective May 31<sup>st</sup>, 2006, and is attached hereto and incorporated herein as Exhibit A, consisting of a total of 77 pages including cover, table of contents, and signature page.

### **RESPONSE**

A Waiver form, along with the verified Report of Examination, was transmitted to Jack Alan Myers, Sr. Vice-President and CFO of the Company on May 31, 2006 electronically (e-mail) and by U.S. certified mail. As required by statute (see § 41-227(4) Idaho Code), BCI was afforded a reasonable opportunity of not more than thirty (30) days to make a written submission or rebuttal with respect to matters contained in the examination report. The Company chose not to execute the Waiver form. However, the Company made a written submission containing responses to the examination report in a signed letter received electronically (fax) on June 29, 2006, and executed by Mr. Myers. Further, the Company requested that the written submission become part of the public record of the Department. BCI's written submission is attached hereto and incorporated herein as Exhibit B, consisting of 8 pages including fax coversheet.

### **ORDER**

NOW THEREFORE, after carefully reviewing the above described Report of Examination, attached hereto and incorporated herein as Exhibit A, and good cause appearing therefor, it is hereby ordered that the above described report, which includes and supplements the findings, conclusions, comments and recommendations supporting this order, is hereby ADOPTED pursuant to Idaho Code § 41-227(5)(a) as the final

examination report and as an official record of the Department. The Company's written submission and response, attached hereto and incorporated herein as Exhibit B, is noted and hereby made a part of this order.

### **NOTIFICATION OF RIGHTS**

This is a final order of the agency. Any party may file a motion for reconsideration of this final order within fourteen (14) days of the service date of this order. The agency will dispose of the petition for reconsideration within twenty-one (21) days of its receipt, or the petition will be considered denied by operation of law. See Section 67-5246(4), Idaho Code.

Pursuant to Sections 67-5270 and 67-5272, Idaho Code, any party aggrieved by this final order or orders previously issued in this case may appeal this final order and all previously issued orders in this case to district court by filing a petition in the district court of the county in which:

- i. A hearing was held,
- ii. The final agency action was taken,
- iii. The party seeking review of the order resides, or operates its principal place of business in Idaho, or
- iv. The real property or personal property that was the subject of the agency action is located.

An appeal must be filed within twenty-eight (28) days (a) of this final order, (b) of an order denying any petition for reconsideration, or (c) the failure within twenty-one (21) days to grant or deny a petition for reconsideration, whichever is later. See Section

67-5273, Idaho Code. The filing of an appeal to district court does not itself stay the effectiveness or enforcement of the order under appeal.

DATED and EFFECTIVE at Boise, Idaho this 30<sup>th</sup> day of June, 2006.



Shad Priest, Acting Director  
IDAHO DEPARTMENT OF INSURANCE

**CERTIFICATE OF SERVICE**

I hereby certify that on this 30<sup>th</sup> day of June, 2006, I caused to be served the foregoing document on the following parties in the manner set forth below:

Raymond Ralph Flachbart, President & CEO	_____	certified mail
Blue Cross of Idaho Health Service, Inc.	_____	first class mail
3000 E. Pine Ave.	_____	hand delivery
Meridian, Idaho 83642	_____	facsimile
rflachbart@bcidaho.com	<u>  X  </u>	e-mail

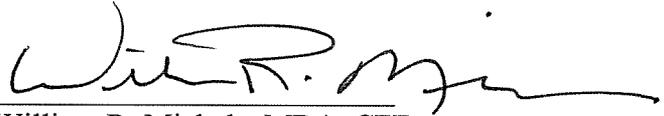
Jack Alan Myers, Sr. Vice-President & CFO	<u>  X  </u>	certified mail
Blue Cross of Idaho Health Service, Inc.	_____	first class mail
3000 E. Pine Ave.	_____	hand delivery
Meridian, Idaho 83642	_____	facsimile
jmyers@bcidaho.com	<u>  X  </u>	e-mail

David Wayne Slonaker, Director of Finance	_____	certified mail
Blue Cross of Idaho Health Service, Inc.	_____	first class mail
3000 E. Pine Ave.	_____	hand delivery
Meridian, Idaho 83642	_____	facsimile
dslonaker@bcidaho.com	<u>  X  </u>	e-mail

Carol Mulder, Sr. Statutory Accountant	_____	certified mail
Blue Cross of Idaho Health Service, Inc.	_____	first class mail
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cmulder@bcidaho.com	<u>  X  </u>	e-mail

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<input type="checkbox"/>	certified mail
<input type="checkbox"/>	first class mail
<input type="checkbox"/>	hand delivery
<input type="checkbox"/>	facsimile
<input checked="" type="checkbox"/>	e-mail



William R. Michels, MBA, CFE  
Examinations Supervisor  
IDAHO DEPARTMENT OF INSURANCE

EXHIBIT A

DEPARTMENT OF INSURANCE

STATE OF IDAHO

REPORT OF EXAMINATION

of

BLUE CROSS OF IDAHO HEALTH SERVICE, INC.

(a domestic mutual insurer)

(NAIC Company Code 60095)

as of

December 31, 2004

<b>FILED</b>	<u>5/31/06</u>	<u>ceh</u>
	date	initial
<b>ADOPTED</b>	<u>6/30/06</u>	<u>ceh</u>
	date	initial
<b>STATE OF IDAHO</b> Department of Insurance		

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*State of Idaho*  
**DEPARTMENT OF INSURANCE**

**DIRK KEMPTHORNE**  
Governor

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**GARY L. SMITH**  
Director

Meridian, Idaho  
May 31, 2006

The Honorable Gary L. Smith  
Director of Insurance  
State of Idaho  
700 West State Street  
Boise, Idaho 83720

Dear Sir:

Pursuant to your instructions, in compliance with Section 41-219(1), Idaho Code, and in accordance with the practices and procedures promulgated by the National Association of Insurance Commissioners (NAIC), we have conducted an examination as of December 31, 2004, of the financial condition and corporate affairs of:

Blue Cross of Idaho Health Service, Inc.  
3000 E. Pine Avenue  
Meridian, Idaho 83642

hereinafter referred to as the "Company," at its offices in Meridian, Idaho. The following Report of Examination is respectfully submitted.

## SCOPE OF EXAMINATION

This examination covered the period January 1, 2000, through December 31, 2004, and included such prior transactions and any material transactions and/or events occurring subsequent to the examination date and noted during the course of this examination. The scope of this examination includes the Company's managed care line of business former division, Blue Cross of Idaho Coordinated Care, Inc., former subsidiary Health Ventures Corporation, and market conduct issues set forth in the target market conduct examination of the Company. These items were the subject of separate prior examination reports, which will be addressed in more detail under the captions, *PRIOR EXAMINATION* and *HISTORY AND DESCRIPTION*.

The examination was conducted in accordance with Section 41-219(1), Idaho Code, the National Association of Insurance Commissioners (NAIC) *Financial Condition Examiners Handbook*, and the NAIC *Accounting Practices and Procedures Manual*. We performed our testing in order to achieve a confidence level commensurate with the risk assessed through utilization of the NAIC *Financial Condition Examiners Handbook*. Verification and valuation of assets, determination of liabilities and reserves, and an analysis and review of such other accounts and records as appropriate to the examination were also performed.

The actuarial review of reserves, related liabilities, and other actuarial items was performed by Taylor-Walker and Associates, Inc., consulting actuaries, for the Idaho Department of Insurance. The results of the actuarial review are discussed under the caption, *ACCOUNTS AND RECORDS* and Note 5 to the Financial Statements. A review of the Company's information systems and risk assessment was performed by Regulatory Associates, Inc. Those findings are also discussed under the caption, *ACCOUNTS AND RECORDS*.

There was some reliance on the 2004 independent Certified Public Accountant's statutory audit report and workpapers in this examination.

A letter of representation attesting to the Company's ownership of all assets and to the nonexistence of unrecorded liabilities or contingent liabilities was signed by and received from management.

## PRIOR EXAMINATION

The prior financial examination of the Company was conducted by the Idaho Department of Insurance covering the period January 1, 1996 through December 31, 1999. Concurrent examinations were conducted on Blue Cross of Idaho Coordinated Care Services for the period January 1, 1996 through December 1999 and Health Ventures Corporation covering the period February 11, 1999 through December 31, 1999. In addition, a target market conduct examination of the Company was performed covering the period January 1, 2000 through January 1, 2003.

Recommendations contained in the respective prior examination reports and management's responses to those recommendations (noted in italics) were as follows:

Blue Cross of Idaho Health Service, Inc.

1. Contracts and Agreements-Lease. It was determined that the Company had changed the amount of office space leased to Health Ventures Corporation. During 1999, the Company had increased the space from 7,402 sq. ft. to approximately 19,993 sq. ft. and increased the monthly cost approximately \$19,935. As the Company varied from the agreement without prior notice to the Director, the Company was in violation of Section 41-3807(2) (d), Idaho Code. It is recommended that the Company file transactions or amendments with the Idaho Department of Insurance, as required by 41-3807(2) (d), Idaho Code.

In a letter to the Department dated January 7, 2002, management stated that:

*Due to the December 27, 2001 buy-out of Health Ventures Corporation by the Company, there is no need to amend the lease agreement.*

2. Contract and Agreements-Third Party Administrators-Dental. The Company was not able to provide evidence that Idaho Benefit Association, Inc. and WellPoint Health Networks, Inc. were licensed in the State of Idaho as third party administrators. It is recommended that the Company verify that its third party administrators are licensed in the State of Idaho, in accordance with Section 41-913(1), Idaho Code.

*The Company will be filing for a third party administrator's license for Idaho Benefits Association during the first quarter of 2002.*

3. Contracts and Agreements-Third Party Administrators-Dental. The Company management indicated that the compensation that the Company pays Idaho Benefit Association has changed; however, the Company was not able to provide a copy of the amendment nor that the amendment was filed with the Idaho Department of Insurance 30 days prior to its effective date, as required by Section 41-3807(2)(d), Idaho Code. It is recommended that the Company file all amendments to affiliated agreements in accordance with the provisions of the Idaho Code.

*The Company will be filing an amendment to the Idaho Benefit Association agreement during the first quarter 2002 addressing the compensation that the Company pays the Idaho Benefit Association.*

4. Contracts and Agreements-Third Party Administrators-Prescription Drugs. The Company was unable to provide documentation that WellPoint Pharmacy Management Inc. was licensed in the State of Idaho as a third party administrator. It is recommended that the Company verify that its third party administrators are licensed as such in the State of Idaho, in accordance with Section 41-913(1), Idaho Code.

*As per a letter from Wellpoint Pharmacy dated December 6, 2001, they are in the process of filing the application and plan to have it completed by the end of February 2002.*

5. Articles of Incorporation and Bylaws. It is recommended that the Company amend its Articles of Incorporation to reflect the Company's current location.

*The Company will comply with this request and file an amendment to the Articles of Incorporation.*

6. Reinsurance. During the review of the reinsurance agreements, it was noted in several instances that provisions in the agreement did not correspond with the actual practices. It is recommended that the reinsurance agreements and the practices implemented by the parties be brought into conformity. It is also recommended that the reinsurance agreements be brought into compliance with Idaho Code, especially in regard to items 3 and 4.

*The Company will comply with this request and will follow the practices defined in the agreements until the expected Health Ventures Corporation dissolution within the next 60 days.*

7. Complaint Register. It was noted that two Company employees, whom the Department addresses complaints to, are no longer employed by the Company. It is recommended that the name of one person be given to the Department so that only that person logs in the complaint and then forwards the complaint to the appropriate section for response.

*The Company agrees with this recommendation and requests all Idaho Department of Insurance inquires and complaints be addressed to Lynda Hartley, Manager of Quality Review.*

8. Complaint Register. In comparing the listings of complaints from the Insurance Department to that of the Company, it was noted that the information provided made the comparison difficult. It is recommended that when an Insurance Department complaint is logged, that the information includes the Department's file number.

*The Company will comply with this recommendation and has added the Idaho Department of Insurance's file number to the log.*

9. Complaint Register-Direct Consumer Complaints. From the samples taken for Direct Consumer Complaints, it was noted that a few of the files or documentation could not be provided by the Company, which is a possible violation of Section 41-1330, Idaho Code. It is recommended that the Company be more diligent in maintaining files or copies of responses made to a complaint.

*The Company will comply with this recommendation and has developed a new Administrative Policy Bulletin that outlines the process for the acceptance of member appeals and the appeals reporting process.*

10. Complaint Register-Electronic Complaints. A one-page form entitled Customer Services Procedure was provided that addressed responding to the Web Site Email; however, it does not include a procedure for handling email complaints. It is recommended that the Company include a procedure for the handling and logging of email complaints in the administrative memo described under the report caption Complaint Procedures Manual.

*The Company will comply with this recommendation and will have the Complaint Procedures Manual updated to include a section that outlines how to handle email complaints.*

11. Complaint Register-Complaint Procedures Manual. During the examination period, the Company did not maintain a complaint procedure manual. It is recommended that the Company maintain a complaint procedure manual.

*The Company will comply with this recommendation and has instructed each department within the Company that handles complaints to develop departmental procedures to ensure compliance with all state and federal regulations related to the handling and logging of appeals, complaints, and grievances.*

12. Complaint Register-Timeliness of Complaint Response. A review was made of the timeliness of complaint response. The review indicated the majority of the responses were within 30 days; however, approximately 10 percent were responded to in excess of 30 days. It is recommended that all complaints be responded to within 30 days.

*The Company will make every effort to comply with this recommendation and see that complaints are responded to within the 30 day timeframe.*

13. Marketing and Sales-Producer Licensing-Active and Terminated Appointments. A comparison was made between the active and terminated agents' listings of the Department of Insurance and the Company, which revealed many discrepancies between the listings. It is recommended that the Company conduct a thorough review and update the Department on any inaccuracies.

*The Company will comply with this recommendation and has committed to a comprehensive review of our records during the first quarter of 2002.*

14. Marketing and Sales-Producer Licensing-Terminated Appointment Notices. During the review of the terminated agents' files, it was noted that some of the terminated agents' files did not contain the termination notice. It is recommended that the Company retain copies of the agent's termination notices in each terminated agent's file.

*The Company will comply with this recommendation and has developed a new procedure to ensure that proper documentation will be maintained in the agent's files.*

15. Marketing and Sales-Producer Licensing-Commission Review. During the agent's commission review, it was noted that the agents producing the managed care business were paid by Health Ventures Corporation on Health Ventures Corporation's check stock. Health Ventures Corporation has no appointed agents and did not write any business directly. This is a violation of Section 41-1063(1), Idaho Code. Subsequent to January 1, 2000, it is recommended that all commission payments be made on the Company's check stock.

*Effective September 1, 2001, and continuing forward, all commissions paid for managed care business were/will be issued on the Company's check stock.*

16. Underwriting and Rating-Individual Underwriting & Rate Review. During the individual underwriting and rate review, one exception was noted. A married male applicant was applying for coverage for himself only. He listed no medical problems, but did indicate that his spouse smoked tobacco. Even though his spouse was not applying for coverage, he was rated up. This may be a possible violation of Section 41-5206(1) (f), Idaho Code.

*As stated in our May 30, 2001 letter to Claudia Schwartz, the Company believes that we are in compliance with Idaho Code Section 41-5206(1) (f). Idaho Code states that an individual carrier shall not use case characteristics, including tobacco use without prior approval of the director; however, the Company considers tobacco use to be a health risk rather than a case characteristic. The referenced applicant was a non-smoker, however, resided in a smoking household and therefore exposed to second-hand smoke.*

17. Underwriting and Rating-Declined New Business. During the review of declined new business, several exceptions were noted. The Company had a checklist, which would indicate why an application was being returned; however, the form was not completed or not available for review for three applications. It is recommended that the Company retain copies of applications, the date the application is returned to the branch office or directly to the applicant, plus reasons as to why the application was returned.

*The Company will comply with this recommendation and has begun maintaining a declined business log in June 2001.*

18. Underwriting and Rating-Declined New Business. Also, the review of declined new business indicated a refund was not mailed to the applicant for nearly 60 days after the application was declined. It is recommended that the Company be more diligent in refunding funds submitted with the application, when it is declined.

*The Company will comply with this recommendation and has implemented a procedure for refunding application cash in no more than ten (10) days from the date we receive notice coverage was declined.*

19. Underwriting and Rating-Declined New Business. Another applicant appeared to have her application withdrawn/cancelled by the agent; however, sufficient documentation supporting the cancellation could not be provided. It is recommended that the Company maintain records of such requests and letter of acknowledgement that would accompany the declined application requests.

*The Company will comply with this recommendation and will make every effort to maintain appropriate documentation in our files.*

20. Accounts and Records-General Accounting. During the examination, the Company could not readily provide supporting documentation for some of their assets and liabilities. It is recommended that the Company maintain and have readily available the detailed documentation for their asset and liability accounts.

*The Company will comply with this recommendation and has implemented new procedures to assure all proper documentation is maintained.*

21. Accounts and Records-General Accounting. The Company could not provide detail of paid claims that would reconcile to the general ledger and the annual statement amounts. It is recommended that the Company have a system in place to provide a total detail of claims paid that would balance to the Company's general ledger and annual statement.

*The Company will comply with this recommendation and will develop a system to provide the detail of paid claims balancing between the general ledger and the annual statement.*

22. Accounts and Records-General Accounting. During the examination period, Blue Cross of Idaho Coordinated Care Services produced the managed care business and ceded 100 percent to Health Ventures Corporation. Effective January 1, 2000, the Company produced the managed care business and ceded 100 percent to Health Ventures Corporation. However, neither Blue Cross of Idaho Coordinated Care Service nor the Company reflected the managed care business in their general ledger and did not account for the cession of the business on a monthly basis and complete monthly reinsurance settlement statements. It is recommended that the Company record all activity regarding the managed care business in its general ledger on a monthly basis and complete monthly settlement statements as prescribed by the Idaho Department of Insurance.

*The Company will comply with this recommendation until the expected dissolution of Health Ventures Corporation within the next 60 days.*

23. Bonds. It is recommended that the Company make certain each of the custodial agreements with the banks include the NAIC recommended safeguards. Since the Company has several accounts at each bank, it is also recommended that each bank's custodial agreement include the account numbers that are associated with the agreement. This reference should be amended each time an account is either added or terminated.

*The Company will comply with this recommendation and will ensure that the account numbers are included in the custodial agreements.*

24. Common Stocks. The total of all the overstatements was \$460,114. This amount was immaterial to the Company; however, since the examination adjustment was a material change to Health Ventures Corporation and Health Ventures Corporation is a subsidiary, the adjustment was made to the Company's balance sheet for the total overstatement.

*The Company made an estimate of the statutory value of the Health Venture Corporation investment on its annual statement; subsequently, Health Ventures Corporation revised its statement which was immaterial to the Company's books. In the future, the Company will make every effort to keep the two statements in balance.*

25. Investment Amortization. The above-captioned asset represents the amount of negative goodwill/deferred gain the Company has amortized for its investment in Health Ventures Corporation. During 1999, the Company established a value of \$9,000,000 as negative goodwill/deferred gain to allow Health Ventures Corporation to use the Blue Cross/Blue Shield Association trademark. This negative goodwill/deferred gain was set up as part of the Company's contribution to Health Ventures Corporation. According to Idaho Code, Section 41-603(1), goodwill, trade names and other like intangible assets are considered assets specifically not allowed.

In December 2000 the Idaho Department of Insurance (the Department) reviewed whether or not to allow the amortization of the negative goodwill/deferred gain as an admitted asset. The Department's conclusion was that the \$206,250 write-in asset (investment amortization) would be non-admitted as an examination adjustment.

*Subsequent to the Idaho Department of Insurance's review of the amortization reporting, the Company began non-admitting the asset as requested.*

26. Accident and Health Premiums Due and Unpaid. A review of the Company's delinquent premium report did not disclose any significant exceptions; however, it is recommended that the Company include due dates in its delinquent premium reports in order to ascertain that all premiums due and unpaid qualify as admitted assets.

*The Company will comply with the recommendation and will create a report that includes due dates for the delinquent premiums.*

27. Investment Income Due and Accrued. It is recommended that in the future that the Company use the appropriate NAIC Valuation of Securities diskette for reporting declared but unpaid dividends.

*The Company will comply with this recommendation and will use appropriate valuations.*

28. Provider/Plan Receivables. It is recommended that the Company should not admit all balances in the miscellaneous receivables that are in excess of ninety days past due.

*The Company will comply with this recommendation and will ensure all receivables over 90 days are non-admitted.*

29. Policy and Contract Claims: Accident and Health. During the review of the methods used by the Company's actuarial department, it was noted that the Company used an estimated claims reserve of \$400,000 for its stop-loss coverages. It is recommended that a more precise method be used to calculate the stop-loss claims reserve.

As the difference between the reported claims reserve and the claims run-out is minimal, the reserve does not provide any margin for adverse contingencies. It is recommended for future year-end annual statements that the Company include in its claims reserve an amount for adverse contingencies of approximately 5 percent of estimated unpaid claims.

*The Company will comply with this recommendation. The actuarial department reviews large claims cases to help estimate and calculate the stop-loss claims reserve. Annual statements now include in the claims reserve an amount for adverse contingencies of at least 5 percent of estimated unpaid claims.*

#### Blue Cross of Idaho Coordinated Care Services (BCICCS)

1. The review of BCICCS' reinsurance agreements indicated several discrepancies. It is recommended that the reinsurance agreements and the practices implemented by the parties (currently BCI and HVC) be brought into conformity.

In a letter to the Department dated January 7, 2002, management stated that:

*Effective January 1, 2000, BCICCS voluntarily surrendered its certificate of authority; consequently, BCICCS is no longer a party to the reinsurance agreements. (The reinsurance discrepancies are discussed in the BCI and HVC responses to their Comments and Recommendations.)*

2. The supporting documentation for four grievances and appeals could not be provided, which is a violation of Section 41-3918(2), Idaho Code, which states "Every managed care organization shall maintain records of grievances filed with it concerning health care services...". It is recommended that BCICCS, the direct writer of the managed care business, retain copies of grievance files and any appeals in accordance with Section 41-3918(2), Idaho Code.

*Effective January 1, 2000, BCICCS voluntarily surrendered its certificate of authority; consequently, BCI will be more diligent in this area and has developed a new Administrative Policy Bulletin that outlines the process for the acceptance of member appeals and the appeals reporting process.*

3. There was no evidence in the grievance file that indicated that any grievance letters concerning quality of care or service of a physician or facility were ever referred to such persons with a copy to the director. It is recommended that BCICCS attach a dated interoffice memo or other documentation to the grievance file when a grievance is forwarded to the credentialing administrator so that documentation of any action taken may be traced to its conclusion. It is also recommended that a copy of any grievances received by BCICCS' administrator, HVC, be sent to the Director in compliance with Section 41-3918 (2).

*Effective January 1, 2000, BCICCS voluntarily surrendered its certificate of authority; consequently, Managed Care customer service operations, including the processing of grievances, are now being handled by BCI. Departmental procedures are currently being developed to ensure compliance with all state and federal regulations related to the logging and documentation of action taken related to the resolution of appeals, complaints, and grievances.*

4. BCICCS' managed care administrator, HVC, provided a copy of their Health Ventures Policies & Procedures in response to a request for written information on the provider grievance program. These policies and procedures appeared to meet the requirements of the Code. However, this was dated August 2000, subsequent to the examination period. A request was made for any information for 1999 and prior as well as the date when a provider grievance program was first established for the managed care policies. A copy of Contract Interpretation Bulletin (CIB) #108 was provided, but this mostly pertained to traditional lines. For managed care, (CIB) #108 referred to Administrative Policy Bulletin (APB) #86. A copy of (APB) #86, which was executive staff approved on January 20, 1998, was provided. However, this was not a procedure or guideline for a provider grievance program but, rather, its purpose was to have each department director approve and implement desktop procedures, which meet Quality Management policy guidelines. A copy of any such departmental guidelines could not be provided. This is a violation of Section 41-3927(3), Idaho Code. It is recommended that BCICCS maintain a grievance system for providers. Furthermore, as previously indicated, this is a violation of Section 41-3909(1)(2)(3), Idaho Code, with regard to the retention of records.

*Effective January 1, 2000, BCICCS voluntarily surrendered its certificate of authority; consequently, BCI is in the process of developing a procedure to track all provider grievances, and will incorporate the proper record retention requirements.*

5. HVC contracts with six different physicians networks. The same network contracts are used for all networks. In reviewing the contract between the Network and HVC for Primary Care Physician (PCP) services, it was noted that Attachment B, entitled Quality Incentive Payment System (QIPS), reflected certain provisions for an incentive bonus. The QIPS program indicates that the primary care physician must meet the standard performance measures plus two optional performance measures in order to qualify for an end of year incentive bonus. The performance measures place specific benchmarks on prescribing drugs and the number of radiology tests, laboratory/pathology tests and physical therapy procedures per 1,000 members per year. If the physician meets the

criteria, he qualifies for the incentive bonus. The Company was asked to explain why the incentive program was not in violation of Section 41-3928(1), Idaho Code.

BCICCS responded that it “does not think it was in violation, as options are neither specific to any one member nor specific to a group of members with similar medical conditions. Radiology, laboratory, and physical therapy services are provided to a variety of members for a variety of medical conditions. In addition, other QIP's options are related to Preventive Medicine. These options are to provide an incentive to PCP's to assure members receive these services. Cancer screening is specific to a medical condition, but the QIPS program does not offer incentives to deny, reduce, limit, or delay services but encourages primary care physicians to provide these services.”

*Effective January 1, 2000, BCICCS voluntarily surrendered its certificate of authority; furthermore, BCI has chosen to discontinue the QIP's Program.*

6. HVC has its own contracts with participating providers and contracts with six major Provider Networks in Idaho. BCI may or may not have a contract with the same physicians. The NAIC Market Conduct Examiners Handbook states that, when there is a contract between a health carrier and an intermediary, a health carrier shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons. BCI/BCICCS does not retain that right nor does it have to approve any provider with whom HVC may wish to contract. It is recommended that BCI/BCICCS retain the right to approve or disapprove the participation status of an HVC subcontracted provider.

*Effective January 1, 2000, BCICCS voluntarily surrendered its certificate of authority; additionally, due to the December 27, 2001 buy-out of HVC by BCI, BCI will be the sole contractor with all providers.*

7. To the best of their knowledge, the company does not send out any notice and most of the large groups set their own open enrollment and notify their employees. This does not appear to be in compliance with the language of the group contract and is a violation of the requirements of Section 41-3919(2), which states:

...every managed care organization shall have an annual open enrollment period of at least one (1) month during which it accepts members, without restrictions up to the limits of its capacity...

It appears that, if the open enrollment period occurs 30 days prior to renewal of the group contract, that BCICCS and, subsequently, BCI, had an obligation to ensure that the open enrollment period took place; to notify and remind the employer annually; and seek confirmation from the employer of any new enrollments during the open enrollment period or that no new enrollments had taken place. It is recommended that BCICCS/BCI notify employers and verify that open enrollment takes place on an annual basis.

*Effective January 1, 2000, BCICCS voluntarily surrendered its certificate of authority. Effective with April group renewal (currently in process), BCI will send a reminder to all groups. BCI does have procedures in place to process all applications for the open enrollment period. We will process all applications received 30 days prior to, and 30 days after the group's renewal date.*

8. A number of requested records, reports, minutes, etc. for the managed care business, could not be provided for the examination time period of 1996 through 1999. This is a violation of Section 41-3911(2), Idaho Code, which states:

Every such organization shall upon the director's request submit its books and records relating to its affairs and operations to such examination and shall facilitate the examination.

Additionally, Idaho Code Section 41-3807(1)(d), transactions with affiliates-standards, states that:

The books, accounts, and records of each party shall be so maintained as to disclose clearly and accurately the precise nature and details of the transaction, including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties.

It is recommended that BCICCS and BCI maintain any and all records that are subject to examination in compliance with Idaho Code.

*Effective January 1, 2000, BCICCS voluntarily surrendered its certificate of authority; however, BCI will comply with this recommendation, and has implemented new procedures to assure all proper documentation is maintained.*

9. Although the claim checks were processed by HVC, they were written on BCICCS checks through December 31, 1999. HVC continued to use BCICCS check stock to pay claims until May 2000 even though BCICCS ceased to exist as of December 31, 1999. As of May 2000, HVC began using its own HVC checks to pay the managed care claims, which is a violation of Section 41-341(2) Idaho Code, which states:

(2) In all transactions between the insurer and its parent corporation, or involving the insurer and any subsidiary or affiliated person, full recognition shall be given to the paramount duty and obligation of the insurer to protect the interests of policyholders, both existing and future.

HVC has been delegated the responsibility of processing and payment of claims, however, they are not a party to the contract between the policyholder and Blue Cross of Idaho Health Service, Inc. As the direct writer of the managed care policies, it is BCI that would be ultimately liable for the payment of any eligible claims. Therefore, BCI's name should appear on the claim checks in order to "protect the interests of policyholders, both existing and future." It is recommended that all managed care claim

checks, including Medicare risk programs, have the name of Blue Cross of Idaho Health Service, Inc. on them as the insurer.

*Effective January 1, 2000, BCICCS voluntarily surrendered its certificate of authority. Effective August 1, 2001, the managed care claims checks had both the BCI and HVC names printed on the checks (for non-Medicare claims). The Medicare claims checks were also converted to contain both the BCI and HVC names and logos.*

10. BCICCS reported Premiums Receivable of \$1,162,490 and no balance for not admitted premiums over 90 days past due. Pursuant to Section 41-601(5), Idaho Code, the amount of \$7,728 represented balances not admitted. As the amount is immaterial no change has been made on the balance sheet of this report; however, it is recommended that BCICCS not admit balances of 90 days past due in accordance with Section 41-601(5).

*Effective January 1, 2000, BCICCS voluntarily surrendered its certificate of authority; consequently, BCI will comply with this request and will generate a report showing the premiums over 90 days past due (which will then be non-admitted assets on the statutory statements).*

#### Health Ventures Corporation (HVC)

1. During 1999, David Barnett and Edwin Dalhberg met as members of the Executive Committee. Meetings were held on August 18, 1999 and November 15, 1999; as evidenced by its minutes; however, the Executive Committee was not established and approved by the Board of Directors. Upon inquiry, the Assistant Secretary for HVC indicated that Barnett and Dalhberg have continued to meet but no minutes of their meeting are being taken, as the Executive Committee was not approved by the Board of Directors. It is recommended, that if the Executive Committee continues to meet, the Board of Directors approve the committee and minutes of the Executive Committee meetings be recorded.

In a letter to the Department dated January 7, 2002, management stated that:

*Due to the December 27, 2001 buyout of HVC by BCI, there is no need for the Board of Directors to approve an Executive Committee.*

2. HVC relies on BCI's conflict of interest statements, as HVC does not have any employees. With regard to the directors and officers affiliated with St. Luke's Regional Medical Center, there were no procedures in effect. It is recommended that HVC establish its own conflict of interest procedure, including its questionnaire, to be completed by all of its officers and directors.

*Due to the December 27, 2001 buyout of HVC by BCI, there is no need to establish a conflict of interest procedure.*

3. It was determined that the Company had changed the amount of office space leased to HVC. During 1999, the Company had increased the space from 7,402 sq. ft. to approximately 19,993 sq. ft. and increased the monthly cost approximately \$19,935. As the Company varied from the agreement without prior notice to the Director, the Company was in violation of Section 41-3807(2)(d), Idaho Code. It is recommended that the Company file transactions or amendments with the Department of Insurance, as required by 41-3807(2)(d), Idaho Code.

*Due to the December 27, 2001 buyout of HVC by BCI, there is no need for an amended lease agreement.*

4. It was noted that HVC's investment transactions were not mentioned or approved by its Board of Directors. Therefore, HVC is not in compliance with Sections 41-704 and 41-705, Idaho Code. It is recommended that HVC incorporate procedures that will bring it into compliance with Sections 41-704 and 41-705, Idaho Code.

*An HVC Statement of Investment Policy was presented to and approved by the Board of Directors on May 21, 2001; therefore, HVC was in compliance prior to the December 27, 2001 buyout of HVC by BCI.*

5. HVC's bylaws indicate that the annual meetings of the shareholders be held on the fourth Thursday of March or such other date selected by the Board and such date shall be 60 days, but not more than 180 after HVC's fiscal year-end. Written notice of changing the date and time of the meetings was not available for review. It is recommended that, if meetings are not held in accordance with the bylaws, written notice of the change be attached to the minutes and included in the corporate minutes book.

*Due to the December 27, 2001 buyout of HVC by BCI, there is no need to document meeting changes.*

6. Article IV, Section 1 of HVC's bylaws indicates that its officers shall consist of a Chairman of the Board, Vice Chairman, President, Secretary and Treasurer. Officers are to be elected annually. The minutes for 1999 and 2000 were silent with regard to the election of the Office of President. It is recommended that HVC reflect the election of all the required officers in HVC's minutes of the Board of Directors' meetings.

*Due to the December 27, 2001 buyout of HVC by BCI, there is no need to reflect election results in the meeting minutes.*

7. There were several provisions in HVC's reinsurance agreements that were not consistent with the practices employed by the parties. It is recommended that the reinsurance agreements and the practices implemented by the parties be brought into conformity.

*BCI will comply with this request and will follow the practices defined in the agreement until the expected HVC dissolution within the next 60 days.*

8. It is recommended HVC readily maintain and have available the support documentation for various accounts. The support should consist of a detailed listing or worksheet indicating the individual components (i.e. listing of individual personnel, checks, invoices, policy numbers, or claim numbers) of particular asset or liability accounts.

*Due to the December 27, 2001 buyout of HVC by BCI, there is no need for HVC to maintain documentation; however, BCI will maintain and have available all documentation necessary for account reconciliation.*

9. HVC was paying the agents' commissions on the managed care business, which was written by BCICCS and, subsequent to December 31, 1999, by BCI. As HVC was not a direct writer and has no licensed and appointed agents, the payment of commission of HVC check stock is a violation of Section 41-1063(1), Idaho Code. It is recommended that HVC come into compliance with Idaho Code and cease paying commissions on its own check stock.

*Effective September 1, 2001 and continuing forward, all commissions paid for managed care business were/will be issued on BCI check stock.*

10. Note 1-Claims Adjustment Payable. HVC underestimated the liability for claims adjustment expenses. The liability was increased \$870,000. It is recommended that HVC use current data to calculate the claims adjusting expense ratio in order to determine a more accurate liability.

*The liability for claims adjustment expenses was understated due to incorrectly processed capitated claims, as well as, system problems at year-end. Procedures have been developed for processing capitated claims and the system problems have been corrected.*

Blue Cross of Idaho Health Service, Inc. (target market conduct examination)

1. For the Small Employer group renewal business in 2000, BCI was not in compliance with Idaho Code 41-4706(1) (c) (I). For renewal business in 2001 and forward, BCI meets the criteria set forth in Idaho Code Section 41-4706(1)(c)(I). The situation corrected itself and no recommendation is made.

In a letter to the Department dated January 14, 2004, management stated:

*The first item in the summary regards a situation that has been rectified, and no recommendation was made.*

2. The Blue Value POS plan is not filed as a limited benefit plan; therefore, this is a violation of Idaho Code Section 41-4706(1)(b).

*Blue Cross of Idaho (BCI) agrees with the finding. BCI discontinued the rating practice that was in violation of the Code as soon as it became aware that it was out of compliance.*

3. It is recommended that all Small Employer rating methodologies comply with Idaho Code Section 41-4706(1)(c) and the language of the "sum of." The Company may use whatever rating methodology it chooses so long as the ultimate rating result does not exceed the maximum increase allowed by Idaho Code Section 41-4706(1)(c).

*BCI will change its rate formulas to comply with the "Sum of" limitation as interpreted by the Department of Insurance. We will change the formulas by March 1 for groups renewing with a May 1 effective date. System complications may require a one-month delay to this timetable.*

4. It is recommended that BCI utilize one operating mode for all groups from 2 through 50 members.

*BCI currently uses age specific billing for groups of 2 to 19 employees, and composite billing for groups with 20 to 50 employees. We would like to discuss this recommendation further with the Department of Insurance, for three reasons.*

*1. While regulation 41-4706 does not expressly allow differing billing practice by group size, it does not expressly prohibit. 41-4706 regulates the rates the health care carrier can charge the small employer. The rates that Blue Cross charges a group on renewal with identical age/gender composition and benefits is the same regardless of whether age specific billing or composite billing is used.*

*2. Varying premium billing practice by group size meets the needs of both our smaller and larger groups. When Blue Cross of Idaho initially used an age-rated basis for billing groups with 20 or more employees, our customer response was very negative, and after a year we changed to the current composite billing method for larger groups. Carriers that use composite rates for the smallest small groups have found that it causes two problems. Groups can be very dissatisfied with large renewal rate increases due to an increase in the age of the group members. Small groups that replace older workers with younger workers and are composite rated are forced to choose between maintaining the high composite rate and switching to a different carrier in order to get a rate that reflects the younger worker. This leads to instability in the marketplace, and selection problems for the insurers.*

*3. Finally, BCI is concerned with the market dynamics of either using composite billing or age specific billing exclusively for all sizes of groups subject to Title 41, Chapter 47. It is our understanding that other carriers have rating practices similar to our current practice, and changing unilaterally will adversely affect both our underwriting results and our market share.*

The recommendations and comments contained in the prior examination report were addressed by the Company, except for those noted within the body of this report.

## HISTORY AND DESCRIPTION

### General

The Company was formed as a non-profit entity on December 31, 1977. Its incorporation and formation was the result of a consolidation of Blue Cross of Idaho, Inc. and South Idaho Medical Service Bureau, Inc., who had maintained separate operations in Idaho since 1945 and 1962, respectively. The Company was formed under Title 41, Chapter 34, Idaho Code, and operated as a hospital and professional service corporation. In 1995, the Company converted to a nonprofit mutual insurer under Title 41, Chapter 28, Idaho Code.

Beginning in 1987, the Company became subject to Federal income taxes. Prior thereto it had been exempt under Section 501(c)(4), Internal Revenue Code.

Prior to the Company's mutualization, it was exempt from Idaho State Premium Taxes, State Corporation Taxes, and participation in the Life and Health Guaranty Association. State taxation in lieu of Idaho premium taxes was provided under Section 41-3427, Idaho Code, which required assessment of four cents per subscriber contract per month.

As a result of mutualization in 1995, the Company's lines of business, with the exception of its administrative service contract business, are no longer exempt from Idaho premium taxes and participation in the Life and Health Guaranty Association. In addition, the Company's Annual Statement reporting form was changed from a hospital, medical, dental and indemnity form to a Life, Accident and Health blank.

Beginning with 1994, the Company's managed care line of business, Idaho Preferred Healthcare, was no longer required to file a separate Annual Statement. Idaho Preferred Healthcare's line of business was to be reported in the Company's Annual Statement separately as to premium income, claims, administrative expenses and enrollment in the same manner as required for the other lines of business. Idaho Preferred Healthcare was reported in the Company's 1994 and 1995 Annual Statements.

The Department, by a letter dated March 12, 1996, notified the Company that, effective with the quarterly statement as of March 31, 1996, Idaho Preferred Healthcare was to begin filing separate statements. Although Idaho Preferred Healthcare did not operate as a separate legal entity, it was required to file a separate statement, since it operated under a separate certificate of authority and its business and operations were clearly distinguishable from the other types of insurance offered by the Company.

In August 1996, the name of Idaho Preferred Healthcare was changed to Blue Cross of Idaho Coordinated Care Services. As noted in the preceding paragraph, Blue Cross of

Idaho Coordinated Care Services was not a corporation or legal entity, but was operated concurrently with the operations of the Company and was considered a separate and distinct division within the Company, in accordance with Section 41-3406 (4), Idaho Code.

Effective February 11, 1999, Health Ventures Corporation received its Certificate of Authority to operate as a managed care organization under Title 41, Chapter 39, Idaho Code. Prior to this, Health Ventures Corporation was incorporated as a third party administrator for the Company's Medicare managed care line of business, which was written by Blue Cross of Idaho Coordinated Care Services. Health Ventures Corporation changed to an insurer on February 11, 1999 and effective this date became the 100 percent reinsurer of the Blue Cross of Idaho Coordinated Care Services' group managed care and Medicare Choice lines of business. Health Ventures Corporation was owned equally by the Company and St. Luke's Regional Medical Center. Health Ventures Corporation owned 50 percent of Triad Limited Liability Company while Eastern Idaho IPA, PLLC owned the remaining 50 percent.

On January 1, 2000, Blue Cross of Idaho Coordinated Care Services voluntarily surrendered its certificate of authority and ceased writing business. Consequently, Blue Cross of Idaho Coordinated Care Services' assets, liabilities, equity, and all managed care products were absorbed within the Company. The Company's Certificate of Authority was re-issued on January 3, 2000 to include managed care business.

Health Ventures Corporation executed surplus note agreements with the Company and St. Luke's Regional Medical Center on June 29, 2000. During 2000 surplus notes in the amount of \$3,250,000 each were issued to the Company and to St. Luke's.

In December 2001, the Company acquired St. Luke's Regional Medical Center's interest in Health Ventures Corporation for \$7,000,000 in cash in exchange for St. Luke's shares and surplus notes receivable of \$3,250,000. The Board of Directors authorized the transaction on November 30, 2001. The Plan of Dissolution was submitted to the Idaho Department of Insurance and in a letter dated December 27, 2001, the Department indicated it had no objections to the acquisition. Pursuant to the Plan, Health Ventures Corporation was dissolved on February 26, 2002 and voluntarily surrendered its Certificate of Authority on February 28, 2002. Health Ventures Corporation's share of Triad Limited Liability Company was transferred to the Company. The surplus notes issued to St. Luke's were surrendered and the Company became the owner of Health Ventures' assets and liabilities.

Blue Cross of Idaho Foundation for Health, Inc. was incorporated as a non-profit entity on December 28, 2001. The Board of Directors approved the establishment of the Foundation on November 13, 2001. The purpose of the foundation was to promote health improvement initiatives to Idaho residents. The Company donated \$1,000,000 and \$500,000 to the Foundation during the years ended December 31, 2004 and 2003, respectively. The Board of Directors approved the 2003 contribution on November 21, 2003 and the 2004 contribution on November 9, 2004.

The Company changed its reporting format from the NAIC Life, Accident and Health blank to the Health blank effective January 1, 2004.

The Company is a member of the Blue Cross and Blue Shield Association. The Association serves as a national non-affiliated advisory organization for all Blue Cross and Blue Shield Plans in the United States.

### Surplus Debentures

As previously reported, the Company, along with St. Luke's Regional Medical Center, entered into a surplus loan agreement with Health Ventures Corporation effective June 29, 2000. The surplus loan agreements provided for the Company and St. Luke's to contribute funds to Health Ventures in the amount of \$7,500,000 or \$3,750,000 each. On the same day, the Company and St. Luke's made an initial contribution to Health Ventures in the amount of \$4 million, which was split \$2,000,000 each.

The surplus notes accrued interest at the rate of five percent per annum (365 day per year basis). Prior to the payment of interest or repayment of principal, Health Ventures was required to obtain written approval from the Director of the Idaho Department of Insurance and the payment shall be made from surplus over and above the minimum required.

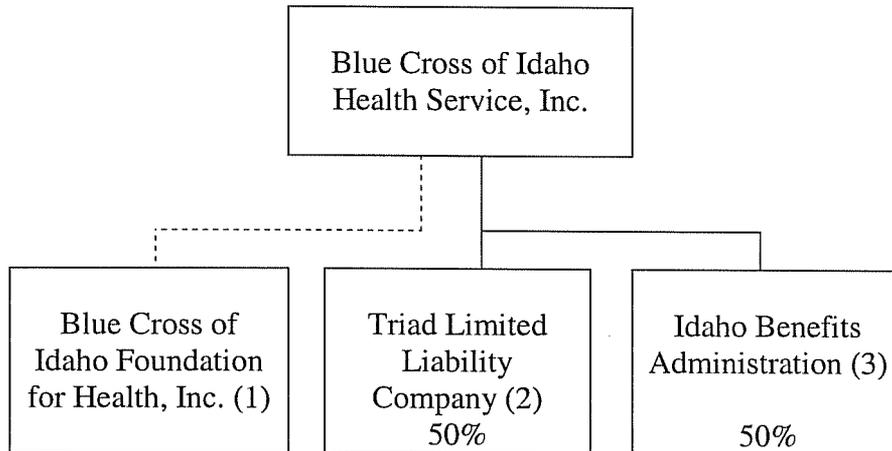
Including the initial \$4 million contributed, the Company and St. Luke's agreed to make advances totaling \$7,500,000 or \$3,750,000 each. During the year 2000, the Company and St. Luke's contributed \$3,250,000, for a total of \$6,500,000 to Health Ventures.

Also previously reported, the Company acquired St. Luke's interest in Health Ventures in December 2001, for \$7,000,000 cash. The surplus notes issued to St. Luke's in the amount of \$3,250,000 were then surrendered. After acquisition and in accordance with the Plan of Dissolution, Health Ventures Corporation was subsequently dissolved and the Company became the owner of Health Venture's assets and liabilities.

## MANAGEMENT AND CONTROL

### Insurance Holding Company System

The Company was a member of an insurance holding company system and was the ultimate controlling person, as depicted in the following organizational chart:



(1) As previously reported, the Company contributed \$1,000,000 and \$500,000 to the Blue Cross of Idaho Foundation for Health, Inc. during the years ended December 31, 2004 and 2003, respectively. The Company was the majority contributor to the Foundation, thus creating a related party relationship. Subsequent to the examination date, the Company contributed \$2,000,000 to the Foundation. The contribution was approved by the Board of Directors on November 8, 2005.

(2) Eastern Idaho IPA, PLLC had a 50 percent interest in Triad Limited Liability Company. According to management, Triad LLC is in the process of being dissolved.

(3) Idaho Benefits Administration, Inc. was a joint venture with WellPoint Health Networks, Inc., which owned the remaining 50 percent. The Company contracted with Idaho Benefits Administration, Inc. for administrative services for its dental products. See *Contracts and Agreements* for additional discussion.

The Form B Insurance Holding Company System Registration Statements for the years 2000 and 2001 were reviewed. The Company received an exemption from filing the Form B filings for the years 2002 and 2003. According to the 2004 statutory audit performed by Deloitte & Touche LLP, the Company received an exemption from the Department on filing Form B for year 2004. A copy of a written exemption from the Department was not reviewed.

## Contracts and Agreements

The following significant contracts and agreements were in effect as of the examination date:

### Lease Agreements

The Company entered into various lease agreements for its district offices located in Coeur d'Alene, Idaho Falls, Lewiston, Pocatello, and Twin Falls, Idaho. The terms of the lease agreements varied by location. The leases were all long term, except for the Pocatello office, which was on a month-to-month basis.

### Third Party Administrator Agreements

1. Vision Care Subscriber Agreement. Effective February 1, 1993, the Company entered into a Vision Care Subscriber Agreement with Idaho Vision Services, dba as Vision Service Plan. Idaho Vision Services, Inc. was the former name of Vision Service Plan of Idaho. The agreement provided for Vision Service Plan to arrange and provide covered services as described in Attachment A and as described in the Company's group contracts and certificates. Vision Service Plan was a prepaid program and covered services were provided at no out-of-pocket cost, other than the insured's copayment. Vision Service Plan paid the member doctor directly for covered services. A member may elect to obtain covered services from any licensed optometrist, ophthalmologist, or optician. Vision Service Plan reimbursed the member for covered services per Attachment A. For this service the Company paid Vision Service Plan scheduled amounts set forth in Attachment B.

The Company indicated that Attachments A and B were not amended during the examination period. However, the Vision Care Subscriber Agreement was amended effective June 24, 2003 to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-64).

Vision Service Plan was licensed in Idaho as a hospital and professional services company; and therefore, met the requirements of Section 41- 901(3), Idaho Code.

2. Dental. Effective March 31, 1997, the Company entered into a Development and Management Agreement with Idaho Benefits Administration, Inc., a related party, and WellPoint Health Networks Inc. The agreement provided that Idaho Benefits Administration, Inc. (i) develop a national accounts program for the benefit of WellPoint Health Networks Inc. and the Company, (ii) develop a dental program to be offered by the Company, (iii) provide comprehensive management services to the Company regarding the dental program, and (iv) carry out other benefit coverage, management and administrative services arrangements. Idaho Benefits Administration, Inc. was supported in the management of the dental program by WellPoint Health Networks Inc. pursuant to the terms of an Administrative Services

Agreement between WellPoint Health Networks Inc. and Idaho Benefits Administration, Inc.

The management services provided by Idaho Benefits Administration, Inc. included the following:

- assistance in development of premium rates and underwriting standards for the dental program.
- provision of support to the sales and marketing staff of the Company, who were responsible for the dental products.
- assistance in the preparation of appropriate financial and regulatory reports.
- agreed-upon system support.

The Company was responsible for the billing and collection of premiums attributed to the dental program, except for national accounts serviced by WellPoint Health Networks Inc. The original agreement provided for Idaho Benefits Administration, Inc. to settle claims. Compensation was on a per member per month basis for the use of WellPoint's claims processing system, plus administration costs. According to management, there have been no changes to the per member per month rates during the examination period.

The Development and Management Agreement was amended effective January 1, 2003 whereby the following management services previously provided were deleted:

- assistance in enrollment of members into the Company dental program.
- administration of claims and customer service function and grievance process applicable to the dental program.
- utilization management relating to the dental program, including assistance in development of policies and procedures.

The agreement with Idaho Benefits Administration and WellPoint Health Networks Inc. was amended effective October 8, 2003 to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-64).

The Administrative Services Agreement referenced above was also amended effective January 1, 2003.

In the prior examination report, the per member per month rate set forth in the Development and Management Agreement was changed. However, the Company was not able to provide a copy of an amendment or evidence that any amendment was filed with the Idaho Department of Insurance 30 days prior to its effective date, as required by Section 41-3807(2)(d), Idaho Code. As noted above, the agreement was amended effective January 1, 2003 and October 8, 2003. The Company did not provide prior notice to the Department. Therefore, it is again recommended that the Company file all amendments to affiliated agreements in accordance with the provisions of the Idaho Code.

Subsequent to the examination date, the amendments to the Development and Management Agreement and the Administrative Services Agreement effective January 1, 2003 were filed with the Idaho Department of Insurance.

Professional Claim Services, Inc. dba WellPoint Inc., West Hills, California was a licensed third party administrator in compliance with Section 41- 913(1), Idaho Code.

3. Prescription Drugs. Effective January 1, 1999, the Company entered into a Pharmacy Benefit Management Services Agreement with WellPoint Pharmacy Management Inc.; whereby, WellPoint Pharmacy Management Inc. provided clinical pharmacy management, claims processing, and pharmacy network management services to the Company. For these services, the Company paid WellPoint Pharmacy Management Inc. the cost of the claim, an administration fee, plus the cost of using ReViewPoint® software. The administrative fee that the Company paid WellPoint Pharmacy Management Inc. was based on a per claim processing fee, a clinical services fee based on per member per month, plus a retention and a flat monthly fee for usage of ReViewPoint® software. These fees were amended during the current examination period.

The agreement between the Company and WellPoint Pharmacy Management Inc. was amended effective February 21, 2003 to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-64).

The term of the agreement was extended to November 1, 2007 by an amendment effective September 21, 2004.

Professional Claim Services, Inc. dba WellPoint Inc., West Hills, California was a licensed third party administrator in compliance with Section 41- 913(1), Idaho Code.

#### Indemnification Agreements

In 2004, the Company's Board of Directors entered into Indemnification Agreements with the Company. Under the agreements, the Company agreed to hold harmless and indemnify the Directors to the full extent authorized or permitted by law, the Company's articles of incorporation, or its bylaws and against all liability incurred in connection with any claim of the Company.

The agreements are continuous during the period the Director is a director of the Company and shall continue thereafter so long as the Director is subject to any possible threatened, pending, or completed action, suit or proceeding, arising out of or related to the fact that the Director is or was director, officer, fiduciary, employee or agent of the Company. On April 25, 2003, the Board of Directors approved the Corporate Resolution authorizing the President and Chief Executive Officer of the Company to enter into the Indemnification Agreements with Directors and senior executives.

At their meeting of October 20, 2003, the Board authorized management to modify the Board Indemnification Agreement to be suitable for physicians who serve on committees at the Company's request.

### Directors

The Company was a mutual organization with each policyholder being a member of the corporation. The members annually elected Company directors to three-year terms. The directors' terms were arranged so that approximately one-third of the terms expired annually. There were three classes of directors: physicians, hospital administrators, and public directors, with the majority being public directors.

The governing body of the Company was its Board of Directors and consisted of no less than 5 nor more than 25 members, which was provided by the requirements of Section 41-2835(5), Idaho Code. Article II, Section 1 of the Company's Bylaws provided that the number of directors at the beginning of the 1996 annual meeting shall be 21, at the beginning of the 1998 annual meeting the number of directors shall be 19, and at the beginning of the 2000 annual meeting the number of directors shall be 17. The Board of Directors approved a proposal to reduce the Board from 17 to 13 Directors at their meeting on July 29, 2000. As of December 31, 2004, the number of directors was 13, which consisted of 3 physician representatives, 3 hospital representatives, and 7 public representatives.

The following persons were the duly elected members of the Board of Directors at December 31, 2004:

<u>Name</u>	<u>Principal Occupation</u>
<u>Physician Representatives:</u>	
Michael John Adcox, M.D.	Idaho Nephrology Associates
Stephen Arthur Sherman, M.D.	Pocatello Radiology Associates
Samuel Milton Summers, M.D.	Family Medical Clinic
<u>Hospital Representatives:</u>	
Sandra Bennett Bruce	President & Chief Executive Officer, Saint Alphonsus Regional Medical Center
Jess Bradford Hawley III	Administrator, Syringa General Hospital
Joseph Edward Morris III	Chief Executive Officer, Kootenai Medical Center
<u>Public Representatives:</u>	
Joanne Stringfield Arnold	Vice President of Human Resources, Micron Technology, Inc.
Raymond Ralph Flachbart	President & Chief Executive Officer, Blue Cross of Idaho Health Service, Inc.
Jack Wynn Gustavel	Chairman & Chief Executive Officer, Idaho Independent Bank
Norman Charles Hedemark	Executive Vice President & Chief Operating Officer, Intermountain Gas Company
Kenlon Porter Johnson	President, Forde Johnson Oil Company, Inc.
Ward Douglas Parkinson	Director, Ovonyx, Inc.
Michael James Shirley	President & General Manger, Bogus Basin Mountain Resort

Subsequent to the examination date, Norman Charles Hedemark submitted a letter of resignation. The Board of Directors asked Mr. Hedemark to serve the balance of his current term until the Annual Meeting in April 2007.

Officers:

The following persons were serving as Officers of the Company at December 31, 2004:

Raymond Ralph Flachbart	President & Chief Executive Officer
Gary Miles Dyer	Executive Vice President & Chief Operating Officer
Jack Alan Myers	Senior Vice President & Chief Financial Officer
David James Hutchins	Vice President & Actuary
Richard Merle Armstrong	Senior Vice President, Sales/Services
Thomas Bruce Bassler	Senior Vice President, General Counsel
Michael Dennis Cannon	Vice President, Information Services
Douglas William Dammrose, M.D.	Senior Vice President, Medical Director
Drew Shelton Forney	Vice President, Benefits/Member Service
Debra Marie Henry	Vice President, Human Resources
Jerome Anthony Dworak	Senior Vice President, Chief Marketing Officer

In addition to the Board of Directors, an Executive Staff governed the Company. Each of the executives was responsible for the operations of a division, which reported directly to them. Division directors were responsible for the various department operations and participated on the Management Advisory Committee. They met on a regular basis and discussed operational, benefit and personnel policies and made recommendations to the Executive Staff. Executive Staff and Management Advisory Committee members are listed below:

Executive Staff

Richard Merle Armstrong	Senior Vice President, Sales/Services
Thomas Bruce Bassler	Senior Vice President, General Counsel
Michael Dennis Cannon	Vice President, Information Services
Douglas William Dammrose, M.D.	Senior Vice President, Medical Director
Jerome Anthony Dworak	Senior Vice President, Chief Marketing Officer
Gary Miles Dyer	Executive Vice President & Chief Operating Officer
Raymond Ralph Flachbart	President & Chief Executive Officer
Drew Shelton Forney	Vice President, Benefits/Member Service
Debra Marie Henry	Vice President, Human Resources
David James Hutchins	Vice President & Actuary
Mary Kelley	Executive-Assistant to the President
Jack Alan Myers	Senior Vice President & Chief Financial Officer

Management Advisory Committee

Bill Agler	Process Improv/Systems Integration
Steve Brocksome	Pharmacy Management
Brenda Bruns, M.D.	Medical Director
Jeff Couch	Provider Services
Drew Hall	Benefits Administration
Terrie Havis	Sales Support Services
Connie Kent	Member Services
Mary Jo Kleinfeldt	Medical/Quality Management
Jeanie Phillips	Medicare + Choice Administration
Scott Riebe	IS-Systems and Programming
Carol Rosebrock	Marketing Services
David Slonaker	Finance Administration
Rod Stiller	Internal Audit/Corporate Compliance
Julie Taylor	Legal Services-Governmental Affairs
Dennis Warren	Sales-Major & National Accounts
Rex Warwick	Sales-General Sales

Subsequent to the examination date, Brenda Bruns, M.D. resigned as Medical Director of the Company.

Committees:

The revised Bylaws dated July 30, 1994 provided for the Board of Directors to appoint from among its own members an Executive Committee and a Nominating Committee. The Board may also appoint from time to time, from among its members, such other Committees as may be authorized by resolution passed by a majority of the Board.

The following schedule lists the Committees and the chairperson(s) serving as of the examination date:

<u>Committee</u>	<u>Chairman</u>
Executive	- Jack Wynn Gustavel
Audit	- Norman Charles Hedemark
Hospital & Physician Affairs	- Joseph Edward Morris III & Samuel Milton Summers, M.D.
Investment	- Michael James Shirley
Marketing & Customer Services	- Jess Bradford Hawley III
Nominating	- Gary Leroy Mahn
Compensation Subcommittee	- Norman Charles Hedemark

Subsequent to the examination date, Norman Charles Hedemark became chairperson of the Nominating Committee.

In addition to the above, there were various internal committees that met regularly to review Company operations, such as the IS Steering Committee.

In 2000, the Board established a Compliance Committee to assist the Corporate Compliance Officer in achieving the Company's compliance objectives.

#### Conflict of Interest

The Company had a conflict of interest policy in place that required the directors, officers, management employees, and other employees in key areas to disclose annually, on a prescribed written form, any outside personal interests, activities or affiliations that conflicted or may potentially conflict with their official duties with the Company.

Conflict of interest statements that were completed for the period January 1, 2000, through December 31, 2004 appeared to appropriately disclose any possible conflicts of interest.

## CORPORATE RECORDS

### Articles of Incorporation and Bylaws

The Company's records indicated that the Articles of Incorporation and the Bylaws were not amended during the period under examination.

### Minutes of Meetings

A review of the minutes of the meetings of the Policyholders, the Board of Directors, and the various committees for the period January 1, 2000 through December 31, 2004 and subsequent thereto, indicated compliance with the Articles of Incorporation and Bylaws with respect to the election of the Board of Directors and Officers, and the election or appointment of Committee members.

This review of the minutes also indicated that a quorum was present at all Board of Directors' meetings held during the examination period and that significant Company transactions and events were properly authorized. Specifically, investment transactions were approved by the Board of Directors or the Executive Committee, as required by Section 41-704, Idaho Code. Furthermore, the Company maintained records of its investments in conformity with Section 41-705, Idaho Code.

The Board of Directors certified that they had received a copy of the Company's December 31, 1999 Report of Examination and Order Adopting the Report of Examination.

The Board of Directors reviewed the target Market Conduct Examination Report as of January 1, 2003 at their meeting on January 30, 2004. As noted in the minutes, each Board member received a copy of the full report and signed an affidavit acknowledging receipt of the report.

## FIDELITY BOND AND OTHER INSURANCE

Insurance coverage for the protection of the Company was maintained through the period under examination. Coverage in effect as of December 31, 2004, is summarized as follows:

The Company had a financial institution bond which covered fidelity or employee dishonesty; on premises loss of property; in transit loss of property; forgery or alteration; counterfeit currency; computer systems fraud; and destruction of data or programs by hacker and/or virus losses up to \$1,000,000. The deductible for all coverages was \$50,000.

The financial institution bond coverage maintained by the Company did not meet the suggested minimum limits recommended by the NAIC *Financial Condition Examiners*

*Handbook*, adopted pursuant to Section 41-223, Idaho Code. The NAIC suggested a minimum of \$1,250,000 based on 2004 net admitted assets and gross income. However, coverage under the Company's financial institution bond was \$1,000,000. Therefore, it is recommended that the Company obtain the minimum limits recommended by the NAIC.

Other insurance maintained by the Company included director and officers liability; errors and omissions liability; managed care organization liability; employment practice liability; commercial property; general liability; business automobile; fiduciary liability; and umbrella excess liability coverages.

The insurance carriers providing coverages to the Company were licensed or otherwise authorized in the State of Idaho.

## PENSION, STOCK OWNERSHIP AND INSURANCE PLANS

### Defined Benefit Plan

The Company participated in a noncontributory defined benefit retirement plan administered by the Blue Cross and Blue Shield Association National Employee Benefit Administration covering substantially all of its employees. Benefits were based on years of service and employees' final coverage compensation. The Company contributed \$4,000,000 to its pension plan for the year ended December 31, 2004.

### Deferred Compensation 401(k) Plan

The Company had a 401(k) salary deferred compensation plan that covered all employees who have attained age 18 and have completed 90 days of continuous service. The Company made matching contributions equal to 60 percent of the employee's deferral up to 6 percent of the employee's annual salary. The Company's matching contributions were approximately \$706,000 in 2004.

### Postretirement Benefit Plans

The Company also provided health and life insurance benefits for retired employees and, health insurance, to their eligible dependents. Benefits were provided once the employee became eligible by satisfying plan provisions including certain age and/or service and participation requirements. Participants in the plans were required to contribute 10 percent to 100 percent of the premiums for covered dependents. The Company's post-retirement benefit plans, other than pension plans, were not funded.

### Employee Insurance Plans

The Company provided a non-contributory long term disability program for regular full-time and eligible part-time employees. The Company also provided a group health care, dental and vision plan for which the employee contributed part of the premium. Group

life and accidental death and dismemberment were provided for which the employee contributed part of the premium. Additional voluntary group accidental death and dismemberment coverage and group universal life plans were also made available to the employees at their own expense.

A flexible spending account was also made available to Company employees to pay eligible health related, dependent care expenses, or group health care expenses as qualified by Section 125 (d) of the Internal Revenue Code.

### Executive Plans

The Company had three corporate whole life par policies in effect for highly compensated key personnel. The policies were established in trust as a deferred compensation and supplemental retirement plan for employed corporate officers. The Rabbi trust was originally established in 1993 and the Company was the beneficiary and owner of the policies. The policies remained in force as of December 31, 2004.

In December 1994 the Company established the non-contributory retirement program for certain Company employees. The program was adopted for those employees whose retirement benefits would be reduced as a result of the benefit limitations of Sections 401 (a)(17) and 415 of the Internal Revenue Code. The Board of Directors approved amending the definition of earnings for the Company's qualified and non-qualified retirement and long-term disability programs to be effective January 1, 2003.

On June 11, 2002, the Company established the Blue Cross of Idaho Health Service, Inc. Executive Non-qualified Deferred Compensation Plan. In this connection, a Rabbi trust was established between the Company and Fidelity Management Trust Company, as well as a recordkeeping agreement between the Company and Fidelity Investments Institutional Operations Company, Inc. The purpose of the plan was to attract, motivate and retain valuable key executives. The participants had the right to direct the investment of their plan account into the registered investment companies advised by Fidelity Management & Research Company.

### Incentive Plans

The Company had corporate incentive and director incentive plans. The object of the plans was to improve performance and productivity and reward the individuals that helped to accomplish the agreed upon goals. The incentive plans were based upon annual performance with the exception of the Claims and Customer Service incentive plans which were based on quarterly results. The incentives were based on a range to determine percentage, which was multiplied by the participant's salary, with the exception of the Federal Employees Program incentive. The Federal Employees Program incentive consisted of a dollar amount that was determined by the national program, which was then divided between eligible participants.

## TERRITORY AND PLAN OF OPERATION

The Company was licensed only in the State of Idaho as a mutual insurer authorized to write disability insurance, including managed care. In addition to the home office located in Meridian, Idaho, the Company maintained five district offices located throughout the State of Idaho in the cities of Coeur d'Alene, Idaho Falls, Lewiston, Pocatello, and Twin Falls. The primary functions of the district offices were marketing, policyholder service, and writing new business. Claims processing was performed in the home office located in Meridian.

The Company marketed its insurance products through commissioned individually appointed producers and agencies and utilized a field force of approximately 1,300 appointed agents and agencies. This does not include those licensed agents that were registered to operate through their respective agency appointments. The Company indicated there were approximately 1,800 active agents and/or agencies.

The Company provided health care services to group and individual subscribers utilizing participating/contracting providers as a means of fulfilling their contractual obligations. In addition, the Company provided administrative services to approximately 45 companies, which have self-funded a portion of their employees' health care claims, and the Federal government employee plans.

During the examination period, the Company provided traditional individual major medical and Medicare supplement plans, small and large group plans, Preferred Provider Organization plans, Managed Care plans and also administered Administrative Service Contracts for self-funded plans. The managed care business was written by Blue Cross of Idaho Coordinated Care Services up to January 1, 2000. On that date, Blue Cross of Idaho Coordinated Care Services voluntarily surrendered its certificate of authority. The Company amended its certificate of authority to include managed care business.

The Company's key lines of business included hospital and medical; Medicare supplement; dental; Federal Employee Health Benefit Plan; Title XVII Medicare; and stop loss products.

Agencies produced business pursuant to Independent Production Agreements – Agency. There was a separate Independent Production Agreement for individual agents. An Addendum to Agreement with Business Associate, which was included as part of the Independent Production Agreement, specifically pertained to privacy issues and responsibilities. The Production Agreements contained standard language, such as Agency responsibilities, confidentiality, indemnification, hold harmless, and compensation information. The contract may be terminated by either party by written certified notice or personal delivery. The termination date will be effective 30 days after the date a written notice was mailed by either party.

During the prior examination period, the Department's listing of active and terminated agent appointments was compared to the Company's listing. Many discrepancies were noted between the listings; therefore it was recommended that the Company conduct a thorough review and update the Department on any inaccuracies.

In the current examination, numerous discrepancies were once more noted between the Department and Company listings. Therefore, it is again recommended that the Company conduct a thorough review of its active and terminated agents and update the Department on any inaccuracies.

### STATUTORY AND SPECIAL DEPOSITS

As of December 31, 2004, the Company had provided the following deposits in trust for the protection of all its policyholders and/or creditors:

<u>Description</u>	<u>Par Value</u>	<u>Statement Value</u>	<u>Market Value</u>
US Treasury Notes, 3.875%, Due 2/15/2013	<u>\$1,200,000</u>	<u>\$1,183,968</u>	<u>\$1,183,968</u>
Totals	<u>\$1,200,000</u>	<u>\$1,183,968</u>	<u>\$1,183,968</u>

The deposit met the general requirements and provisions of Sections 41-316A, 41-803 and 41-804, Idaho Code.

### GROWTH OF THE COMPANY

The Company's growth for the years indicated, as taken from the prior examination report and its Annual Statements, is shown in the following schedule:

<u>Year</u>	<u>Admitted Assets</u>	<u>Liabilities</u>	<u>Capital &amp; Surplus</u>	<u>Net Income(Loss)</u>
1999*	\$133,720,726	\$ 60,612,338	\$ 73,108,388	\$ 3,873,986
2000	143,987,056	70,370,058	73,616,998	8,454,986
2001	149,866,758	75,000,363	74,866,395	1,800,163
2002	163,255,429	91,199,336	72,056,093	4,967,603
2003	207,185,369	102,990,791	104,194,578	12,452,484
2004*	287,456,463	144,382,497	143,073,966	32,491,252

In general, assets, liabilities, and surplus have increased during the examination period. Net income has also increased as a result of membership growth and cost containment.

\*As determined by Examination.

## MORTALITY/LOSS EXPERIENCE

The ratios of benefits and expenses to premium shown in the following schedule were derived from amounts reported in the Company's Annual Statements:

<u>Year</u>	<u>Premiums Earned</u>	<u>Claims Incurred</u>	<u>Other Expenses Incurred</u>	<u>Total Claims Expenses</u>	<u>Ratio of Claims Incurred and Expenses to Earned Premium</u>
1999*	\$277,468,184	\$237,711,464	\$44,629,256	\$282,340,720	101.76
2000	306,045,868	254,972,344	47,383,200	302,355,544	98.79
2001	343,021,604	285,539,370	53,873,720	339,413,090	98.95
2002	455,827,850	382,651,259	71,266,284	453,917,543	99.58
2003	539,880,757	449,321,651	78,089,704	527,411,355	97.69
2004*	690,948,397	566,095,700	68,874,255	634,969,955	91.90

\*As determined by Examination.

## REINSURANCE

The Company did not assume or cede reinsurance with any third party insurance or reinsurance companies, except for the Idaho Individual High Risk Reinsurance Pool.

Under the Pool, the Company could submit high risk applicants to the pool if said applications were denied a preferred program, based on a health statement application, or if the premium for the preferred program was higher than the High Risk Program counterpart.

The Board of Directors of the Idaho Individual High Risk Reinsurance Pool were responsible for the design of the individual Basic, Standard, Catastrophic A and Catastrophic B high risk plans and also established the premium rates for the plans.

The Company had to meet a \$5,000 deductible per person per calendar year and was also responsible for 10 percent coinsurance of the next \$25,000 of benefit payments during a calendar year and the pool reinsured the remainder. Lifetime policy maximums were determined by the plan selected.

In 2005, Health Savings Account compatible health plans were also added to pool eligibility.

## INSURANCE PRODUCTS AND RELATED PRACTICES

### Policy Forms and Underwriting Practices

As previously reported, the Company wrote traditional individual major medical and Medicare supplement plans, small and large group plans, Preferred Provider Organization plans, Managed Care plans and also administered Administrative Service Contracts for self funded plans. The Company also made Dental and Vision coverage available to its policyholders. As of July 1, 2004, the Company became the health carrier for the State of Idaho Employees and Retirees health plans.

#### Policy Form and Rate Filings

The Company's and Department's listings of policy form filings were compared as to policy form numbers, revision dates and actions taken by the Department. Nothing exceptional was noted in this review.

The Company did not include rate form filings on its policy form filings. However, the Department's listings indicated that the Company had filed various Company plan rates with the Department, which were accepted as Filed Certified.

It was noted that the Company used the Idaho Individual Application IND-APP-12-2003 in accordance with Idaho Bulletin No. 04-1. The Company also used BCI form No. 3-397 (07-04), entitled *Individual Universal Application Cover Sheet*. *This form must accompany all Idaho Individual (Universal) Applications.*

Idaho Bulletin 04-1 indicated that the Company must file an intent to use the universal Idaho Individual Application. The Company did file an intent to use Idaho Individual Application IND-APP-5/98 and it was accepted as filed by the Department of Insurance on November 3, 2000. However, the forms that the Company was utilizing in late 2004 were Idaho Individual Application IND-APP-2003 and BCI cover sheet Form No. 3-397 (07-04). Neither the Department nor the Company had any record of these form filings. In addition, the Company provided an even newer BCI Universal Application Cover Sheet Form No. 3-397A(07-05).

It is recommended that the Company file Forms IND-APP-2003 and BCI Form No. 3-397(07-04) with the Department. The Company also needs to file BCI Form 3-397(07-05) if it has not yet been filed. The Company advised that it was filing the forms immediately.

The actuarially justified rates were filed with the Department annually. In addition, a rate review was performed by the Department during the target market conduct examination as of January 1, 2003 (see *PRIOR EXAMINATION*). The rates were sampled and tested during that examination and no exceptions were noted in the uniformity, calculation and application in the processing procedures. Based on the forgoing, a rate review for the current examination was waived.

Subsequent to the examination date, all Individual and Group policies were being replaced in 2005, except for the mandated plans. The existing policyholders have been or will be rolled into the new policies on their respective renewal dates. Policies would be transitioned from a calendar year to a benefit period basis.

#### Policy Form Review

Individual, Small and Large Group and Managed Care policy forms were reviewed as to content and mandatory provisions. The policies were in compliance with Section 41-2832(3), Idaho Code with respect to the Policyholders' annual meeting notice.

#### Underwriting Procedures and Manuals

The Company indicated it did not have a comprehensive underwriting manual but was compiling one with a target completion date of August 1, 2006. Instead, a variety of documents/manuals were utilized, such as the Broker Manual, application forms, monthly actuarial factor tables, trends, an excess loss program, medical underwriting points, and an Access database.

#### Declined Individual Business in 2004

A random sample of individual new business declined in 2004 was selected for review. The related individual and Medicare supplement applications were provided along with any necessary supporting documentation. Files were also reviewed as to actual enrollment, declinations for various acceptable reasons and subsequent offers of mandated plans to eligible applicants. Documentation provided for this review was adequate to support the denials and processing and/or that denials were handled in a timely manner.

Premium payment refunds arising from declined new business were also reviewed. Tracking refunds was difficult as the Company's procedure was to return the applicant's check with the denial letter and the denial letter did not include check information.

Two exceptional items were noted in this review. One was due to an oversight—the denial letter did not mention the returned premium refund and the other involved a Medicare application. The Company stated that no payment was received with this application. However, the Applicant's Statement and the Producer Checklist certification, which were part of the application, indicated \$128.10, was collected from the Medicare applicant. The Company's District Office indicated that it would have contacted the Company if there was an amount listed, but no accompanying check. None of the records provided for review indicated that the District Office had notified the Company of such. Based on information provided by Company and the District Office, it appears that money may have accompanied the application. However, there is no way to conclusively determine this.

It is recommended that the Company establish a control procedure to ensure that applications with and without refund payments are accurately tracked and monitored.

The Company subsequently advised that it had changed the application procedure since 2004. The Company indicated that all applications were considered quotes and no money was accepted initially and any checks received were sent back. The Company further indicated that requests for premium were made only after underwriting was complete and an offer had been made.

Due to the above exceptions, the scope of this review was expanded to include a second sample of forty-five individual new business declined in 2004. Thirteen applications in the sample indicated that premium payments were included. Some of the applications contained notations indicating the application was denied—some included check numbers and amounts, while others indicated only that the application was denied. The related denial letters were reviewed to determine if the premium deposit was returned to the applicant. The denial letters stated that the deposit was enclosed.

It is recommended that in order to strengthen internal controls, the Company implement procedures to track an applicant's premium payment by check number, amount and date returned, either by including this information within the denial letter or by another tracking method.

As noted above, the Company subsequently changed the application procedure whereby requests for premium were made only after underwriting was complete and an offer had been made.

#### Cancelled/Non-Renewed Policy Review

A random sample of individual cancelled/non-renewed policies was selected for review. The Company's Facets system was utilized to verify the type of policy, dates of cancellation/non-renewal and reasons for such. Substantially all of the reasons noted for cancellation and/or non-renewal were non-payment of premium or a member's request.

#### New Business Written in 2004

Statistical samples of New Business Individual and New Business Small Group contracts written in 2004 were selected using Audit Command Language software.

The sample of New Business Individual policies included various Company Preferred Provider Organization plans and Traditional individual products, Health Savings Account products, mandated individual products and Medicare Supplement policies. Applications were also reviewed through the Company's imaging system. Nothing exceptional was noted in this review.

The New Business Small Group review included an examination of documents such as enrollment verification, including census, small group applications, benefit selection questionnaires, individual employee applications and waivers of coverage.

To expedite this review, original underwriting files were requested, which should have contained all necessary documentation. However, the Company provided only copies, rather than originals and in some cases, not all of the requested documents were provided. This resulted in additional requests and numerous follow-ups. Ultimately, most of the records necessary to complete the small group review were provided, but a review of the timely delivery of the policy and employee handbooks could not be completed because the copied documents did not contain information necessary for review, and because the poor quality of some copied documents inhibited the examination process. Management was repeatedly advised that it was not necessary to make copies and that original files could be reviewed wherever located.

Despite these problems, it was determined there were no exceptions to the enrollment process.

Examination comment:

It should be noted that the underwriting files were in hard copy and not available through the Company's imaging system. A review of the original files would have eliminated the need for the Company to copy file documents, or in some cases the entire file, and thereby incurring additional unnecessary expense.

Another difficulty arose because needed documents were not initially copied from the original underwriting files. The failure to provide complete information resulted in numerous additional examination requests and follow-up.

Based on the foregoing, it is recommended that the Company provide access to the original underwriting files for future examinations. In addition, the Company should insure that signed waivers of coverage are included in the file for all those employees that are waiving the right to coverage according to the original census.

#### Certificates of Individual and Group Health Care Coverage

Upon termination of coverage the Company automatically issued a Certificate of Individual Health Care Coverage for individual and Short Term Blue Policies. Upon termination of an employee and/or dependents, the Company automatically issued a Certificate of Group Health Care Coverage along with a Statement of HIPAA Portability Rights. The forms were reviewed as to content and no exceptions were noted.

## Gramm-Leach-Bliley (GLB) and Health Insurance Portability and Accountability Act (HIPAA) - Privacy Policies and Procedures

The Company's notice of privacy practices was disseminated as follows:

1. To anyone who requested it.
2. To each individual who was a Company enrollee on the Privacy compliance date, April 14, 2003.
3. Thereafter, the Company would disseminate the Notice to each new enrollee at enrollment.
4. Upon any revisions when there was a material change to the uses and disclosure of Policyholder information.
5. At least once every three years, current enrollees would be notified that the Notice of Privacy Practices was available upon request.
6. The Notice of Privacy Practices would be prominently posted on any web site that the Company maintained that provided information about customer services or benefits.

The HIPAA notices were provided as set forth above. The annual GLB notices were sent out with the annual members' notices, with a copy provided.

The Company appears to be acting in accordance with HIPAA, GLB, Section 41-1334, Idaho Code, and IDAPA 18.01.48.

### Treatment of Policyholders

#### General Handling of Direct Complaints and Timeliness of Processing

The Company maintained a record of all complaints in a format that complied with Section 41-1330, Idaho Code.

A random sample of complaints filed directly with the Company was selected for review. The related complaint files were reviewed as to content, resolution and timeliness of processing. All complaints within the sample were processed, additional information requested, issues addressed and resolved and a closing response sent to the complainant within a maximum of nineteen business days. No exceptions were noted to general handling or timeliness of processing of direct complaints.

## General Handling of Department of Insurance Complaints and Timeliness of Processing

The Company maintained a system log of complaints filed with the Department, which were entered and maintained on a quarterly basis. The complaints were reviewed and compared to documentation provided by the Department. Minor differences that were noted were satisfactorily resolved. It was determined that the Company was tracking complaints with their system log in the format required by Section 41-1330, Idaho Code.

A random sample of complaints filed with the Department was selected for review. The related complaint files were reviewed as to content, resolution and timeliness of processing. All complaints within the sample were processed, additional information requested, issues addressed and resolved and a closing response sent to the Department within a maximum of thirteen business days. No exceptions were noted to general handling or timeliness of processing of complaints filed with the Department.

### Electronic Complaints

The Company maintained a web page that included a Customer Service area for submitting inquiries. The Company indicated that if an inquiry was determined to be a complaint, grievance and/or appeal, it was acknowledged and turned over to the appropriate area for processing and a written response. Therefore, complaints and/or grievances were accepted via the Internet; however, Company responses were not made over the Internet.

### Grievance Procedures

The Company maintained written instructions for a *Customer Service Grievance Procedure*. The procedures were for all lines of business except the Federal Employee Program.

## General Handling of Managed Care Grievances and Timeliness of Processing

Section 41-3918, Idaho Code provides that a grievance system should be established for managed care members. It also requires that an annual report be filed with the Director of the Department of Insurance containing the description of the managed care grievance procedures and a list of the managed care grievances filed. The following table documents the filing status of prior grievance reports:

<u>Year</u>	<u>Filing Status w/DOI</u>
2000	Filed
2001	Filed
2002	Not Filed
2003	Not Filed
2004	Filed

The 2004 Grievance Report identified a total of 17 grievances filed with the Company; however, only one entry listed was a bona-fide managed care item. Upon request, the Company produced a revised managed care grievance report which contained 109 managed care grievances communicated to the Company in 2004. Therefore, based on the revised report provided by the Company, the initial 2004 Grievance Report filed with the Department was deficient and was not in compliance with Section 41-3918, Idaho Code.

Further, grievance reports were not filed with the Department for calendar years 2002 and 2003; which is also a violation of Section 41-3918, Idaho Code. In reviewing Company records for these years, it was noted that approximately 200 and 172 managed care grievances were filed with the Company in 2002 and 2003, respectively.

Therefore, it is recommended that the Company provide the Department with an amended 2004 Grievance Report that complies with Section 41-3918, Idaho Code. It is also recommended that the Company file the delinquent Grievance Reports with the Department for calendar years 2002 and 2003. Furthermore, it is recommended that the Company develop a reporting system that accurately captures bona-fide managed care grievance items for annual filing with the Department of Insurance.

A random sample of managed care grievances filed in 2004 was selected for review. The related grievance files were reviewed as to content, resolution and timeliness of processing. The complaints within the sample were processed, additional information requested, issues addressed and resolved and a closing response sent to the complainant within a maximum of twenty business days. Other than the recommendation noted above, no exceptions were noted to general handling or timeliness of processing of the managed care grievances and appeals.

## Quality of Care Grievances

Quality of Care grievances are those that are made against other persons, such as medical providers. Section 41-3918(2), Idaho Code requires that grievances involving other persons shall be referred to such persons, with a copy to the director. There were no grievances of this nature noted during this examination.

The prior examination of Blue Cross of Idaho Coordinated Care Services recommended that a dated interoffice memo or other documentation be attached to the grievance file when a grievance is forwarded to the credentialing administrator so that documentation of any action taken may be traced to its conclusion. It was also recommended that a copy of any grievances received be sent to the Director in compliance with Section 41-3918 (2), Idaho Code.

Although there were no grievances of this nature noted during this examination, it is again recommended that the Company implement procedures for submitting quality of care grievances to the Director when received.

With respect to Advisory Panel meetings, the Company indicated that it did not need to have such meetings unless changes were made to the grievance procedures. The Company also indicated there were no changes made to the procedures during the current examination period. However, based on a review of the Managed Care Member Handbooks Form No. 12-1011 (01-03) and Form No. 12-1011 (08-05), the language setting forth the member's right to *appear or be heard, or both* before the grievance panel, in accordance with Idaho Code Section 41-3918(1) was deleted. Such language did appear the HMO Blue Member Handbook reviewed during the prior examination of Blue Cross of Idaho Coordinated Care Services. The Company did not provide sufficient evidence that this issue was reviewed or discussed by the Advisory Panel. The examination has determined that deleting this language is an important change to the managed care grievance procedures and therefore, is a violation of Sections 41-3916 and 41-3918(1), Idaho Code.

Therefore, it is recommended that when changes are made to the managed care grievance procedures that conflict with the Idaho Code, such changes shall be reviewed with the Idaho Department of Insurance. It is further recommended that the Company establish an alternative mechanism to fulfill the requirements of Section 41-3916, Idaho Code if Advisory Panel meetings are not held.

## Grievance system - Providers

The Company had a grievance system for providers in place, with nothing exceptional noted.

## Claims Training and/or other Procedures Manuals Review

Claims Procedures Manuals and training guides were available to the claims examiners at the Blue Cross Online Service Source external web site. Policies and Manuals, Administrative Policy Bulletins, Claim Administration Team memos, Contract Interpretation Bulletins, Contracts and HIPAA information, along with other guidance, were available on this website

## General Handling Paid Claims and Time Studies Review

Five categories of paid claims were reviewed: Individual & Medicare Supplement, Medium to Large Groups, Small Groups, Managed Care and State of Idaho claims. Statistical samples of each claim category were selected for review using Audit Command Language software. Claims were reviewed for eligibility, application of deductibles, co-insurance and co-payments, benefits and limitations of coverage including in or out of Network, and mathematical accuracy. No exceptions were noted.

## Timeliness of Processing and Payment of Paid Claims

A time study of the five categories of paid claims was also conducted. All of the sampled claims were paid in less than 30 days, with an overall average of 6.03 business days from date of receipt to payment. The average included claims that required additional information.

## Claims Closed without Payment other than Pre-existing

A statistical sample of claims closed without payment as other than pre-existing were selected and reviewed. The sample units selected included Individual-Medicare Supplement, Med-Large Group, Small Group, Managed Care and State of Idaho claims. This review indicated that the sampled claims were properly closed without payment and not declined in a discriminatory manner.

## Claims Denied as Pre-existing

A statistical sample of claims closed as Pre-existing were reviewed as to type of policy, eligibility of the claimant, effective dates of coverage, named pre-existing condition, and medical records, among other things. Applications and other pertinent documentation were reviewed for creditable coverage. Nothing exceptional was noted in the review of Claims Denied as Pre-existing.

## Litigated Claims Review

The Company provided a Litigated Claims Report for the Period January 1, 2000 through January 1, 2005. There were four claims on the list; three were dismissed in 2002 and one in 2004. No patterns or other exceptions were noted.

## Fraudulent Claim Reporting

The Company had established procedures to report fraudulent claims as required under Section 41-290, Idaho Code. During the examination period and subsequent thereto, the Company reported suspected fraudulent claims to the Department of Insurance in compliance with Idaho law.

## Advertising and Sales Material

The Company maintained an advertising file in accordance with IDAPA 18.01.24 (024.01). The advertisements consisted of telephone ads, periodical advertisements, sales brochures, member guides, policy outlines and descriptions of coverage, and other specific issue brochures for its traditional and managed care plans. The Company ran several radio spots in 2004. The Company required pre-approval of any advertisement run by agents and/or agencies utilizing the Company's name or logo in the advertisement.

Information about the Company and its products was available to the general public on the Company's website at [www.bcidaho.com](http://www.bcidaho.com).

The review of the Company's brochures, sales literature and advertisements and information available on the Internet were not deceptive or misleading.

## Certificate of Compliance

IDAPA 18.01.24 (024.02) requires that an insurer file a Disability Advertising Certificate of Compliance signed by an officer of the Company, along with the Annual Statement. The Certificate was filed for all years under examination.

## ACCOUNTS AND RECORDS

### General Accounting

The Company utilized an IBM 2003-246 mainframe computer and Micron computers during the examination period. Claims payment, processing, group administration, membership/billing administration, provider administration, customer service, medical/management, commissions, and benefits administration applications were performed on the Facets system. J.D. Edwards software was utilized for financial and human resource applications. Subsequent to the examination date, the Company converted to the Lawson system for its financial and human resource applications. On June 9, 2005, the Executive Committee of the Board of Directors approved conversion to the Lawson system.

The general ledger and supporting accounting records were maintained on a GAAP basis and then adjusted to a Statutory basis of accounting through adjusting journal entries. The Annual Statements were compiled utilizing the Sunguard software package, the NAIC *Annual Statement Instructions* and the NAIC *Accounting Practices and Procedures Manual*.

In general, the Company responded to documentation requests in a timely manner. However, certain records, specifically reconciliations of bonds and real estate, information necessary to independently test cash internal controls, and the 2000 and 2001 Form B filings, among other things were not provided until weeks or months after the initial requests for documents were made.

According to Section 41-223(3), Idaho Code, every person being examined shall make freely available the accounts, records, documents, files, and information relating to the examination to facilitate the examination. Furthermore, Section 41-247, Idaho Code states that every insurer being examined shall promptly furnish to the Director all requested information. Therefore, it is recommended that requested documents and records be provided in a more timely manner for future examinations.

### Evaluation of Controls and Information Systems

A limited examination of the Company's information systems and risk assessment was performed by Jenny Jeffers, Certified Information Systems Auditor (CISA) and Automated Examination Specialist (AES) of Regulatory Associates, Inc. The examination was performed in accordance with the guidelines and procedures set forth in the Exhibit C, Evaluation of Controls in Information Systems (IS) Questionnaire of the NAIC *Financial Condition Examiners Handbook*.

The scope of the information systems examination was as follows:

- Review the NAIC IS Questionnaire (Exhibit C) responses from the Company and follow up on any issues noted.
- Analyze a major system through which the Company's data is processed.
- Obtain or create a data flow for the financially significant systems which process the Company's business and feed the general ledger system for use by financial reporting.
- Examine the controls in place in each piece of this process and observe the data flowing through the system.
- Examine underlying data for reasonableness, consistency, and reliability.
- Review the process and reconciliation of the data that is loaded into the data warehouse.
- Review the security around the electronic data processing—including the clearinghouse claims transmissions for other entities.
- Observe the physical and system controls in place at the main computer facility.
- Review the system security measures regarding access to all major systems.
- Review the Disaster Recovery Plan.
- Participate in the request, receipt and validation of data to be used in completeness and accuracy testing.

The examination findings are noted below and are listed under captions that correspond to the respective sections of the Evaluation of Controls in Information Systems (IS) Questionnaire:

#### Section A. Management and Control

In its response to the Evaluation of Controls in Information Systems (IS) Questionnaire, management indicated that the IS Department was fully staffed. However, the Information Systems Specialist's extensive discussions with users indicated that several issues remained unsolved or unfixed each year due to staffing of the IS Division not being adequate to fulfill the needs of the Company. Management indicated that additional staff positions have been approved for the 2006 year and further indicated that the work load should be getting somewhat lighter with the completion of the very long and intense implementation of Facets for claims processing.

#### Examination Comment:

Whereas the Information Systems Specialist agreed that staffing was difficult and the goal was not to take on staff that will later have to be let go, it was the responsibility of the IS Division to provide adequate service to the users to enable business units to adequately and accurately perform the work of the Company. This should be the primary consideration.

## Section D. System and Program Development

In its response to the (IS) Questionnaire, management indicated there wasn't a control that ensured when modifications were made subsequent to initial program testing, they were also subject to appropriate program testing procedures. Management further indicated there wasn't a control that ensured that unauthorized changes cannot be made after the completion of program testing but before transfer into the live environment.

### Examination Comment:

The control deficiencies could be mitigated by the development of a protected testing environment. The addition of a Quality Assurance staff would greatly enhance the adequacy of the testing and the controls needed to ensure that all changes and new development processes are adequately tested, including regression testing and that no program was promoted that had been changed after testing had occurred.

## Section E. Operations

With respect to a question posed in the (IS) Questionnaire, management indicated that it provided data processing services for others and there was insurance to protect it from liability for errors and omissions. The Information Systems Specialist determined that the Company performed data clearinghouse operations on its system. Specifically, the Company performed clearinghouse processes for several providers (other than the Company), such as collecting bills and transmitting them to the appropriate payer (the Company being one payer). Some risk may be assumed and consequences may result if the process should be interrupted and services be curtailed for a period of time. The Disaster Recovery Plan for the Company was not adequate currently and this would exacerbate the possibility of a service interruption. The Company was also exposed to the risk of sending claims to an incorrect payer and therefore violating HIPAA rules.

It is recommended that the Company take steps to upgrade the Disaster Recovery Plan to adequately cover and mitigate the risk(s) of service interruptions. It is also recommended that the Company investigate how it might more effectively reduce the risk of sending claims to an incorrect payer and thereby violating HIPAA rules. (See a related recommendation in Section J. Contingency Planning).

## Section F. Processing Controls

The processing of checks was reviewed with Accounting staff. Basic processing controls were good and the end result manually monitored. However, the following internal control weaknesses or deficiencies were found and discussed with management:

- Check stock was kept in the printers at all times.
- Check type was printed on the bottom part of a check and the complete check page was sent to the mail room, leaving a blank check that could be cut and used.

- Some provider numbers were not correct on the data transmittals as the claim may be paid to a provider that was no longer in the current list. When this happened, the system left the field populated with the previous provider number. This could result in an inappropriate provider receiving the payment. Accounting staff manually read the data and look for these provider numbers that are repeated (some are correctly repeated as they are receiving multiple payments, so it is not an exact process). Accounting then manually changes the data to the correct provider number. This introduces the opportunity for error and the possibility for fraud. This has been reported to IS repeatedly and has not yet been fixed. The explanation is that the time it takes Accounting to monitor it and the cost to the Company does not warrant the time it would take IS to repair. This is not an acceptable approach. Subjecting an employee to being required to change data in check files or even allowed to change data in a check file does not provide adequate control.
- Some providers had payments automatically deposited into their bank accounts. The indicator for automatic deposits was continuously overwritten when the list (a list was maintained) was updated. This required Accounting staff to research which providers had automatic deposit, to go into each record to reset the indicator, and enter the bank number. Again, this has been reported repeatedly to IS and has not been fixed. This can also introduce the opportunity for error and fraud. Furthermore, it required an employee to change banking information directly.
- The balancing process done by Accounting staff required an employee to cut and paste lines from a data feed (data transmittals) into a spreadsheet. Accounting was required to look for the lines of business, separate the rows, paste them in and then determine whether the totals balanced. This process is inefficient and provides an inadequate control.

The Information Systems Specialist observed that IS had made an appointment with Accounting to observe the problems, but no additional information or update has been provided.

It is highly recommended that all of these issues be given top priority by the IS Department as they are an integral part of the reconciliation of checks to be printed.

#### Section I. Logical and Physical Security

In its response to the (IS) Questionnaire, management indicated that procedures provided for prompt cancellation of identification codes and passwords when the employment of the individual to whom they were assigned has been terminated.

The BCI Logical and Physical Security Policies Manual is available on BOSS (Blue Cross Online Service Source) and was reviewed in depth with IS. Additionally, this was discussed with IS and testing was done, with excessive exceptions noted. The risk was mitigated to a large degree by the fact that there were no exceptions for the network access termination. Therefore the risk was not great. However, the application access could be used by others in the Company so the timing must improve.

It is recommended that the group that maintains the access to the applications attend to doing the processing in a timely manner.

In its response to the (IS) Questionnaire, management indicated that periodic checks were carried out to confirm that employees' current application access was commensurate with their job responsibilities only for job changes or termination.

The Information Systems Specialist determined that no entitlement reviews were done by management. The current access for all users should be reviewed for appropriateness on a quarterly basis. This is not occurring and was not reported to be in the plans.

It is recommended that the current access for all users should be reviewed for appropriateness on a quarterly basis.

#### Section J. Contingency Planning

In its response to the (IS) Questionnaire, management indicated that it does not have a written agreement for use by IS of a specific alternate site and computer hardware to restore data processing operations after a disaster occurs.

This lack of a hot site contract or spare equipment at a remote site was verified by the Information Systems Specialist and is a problem as a rebuild, which is the current plan, is estimated to take one to two weeks prior to the restoration of the processing. This will not only affect the Company's processing, but also the processing for the clearinghouse function.

It is highly recommended that the development of a workable Disaster Recovery Plan be made the highest priority in 2006. (See related recommendation in Section E. Operations).

#### Data Completeness and Accuracy Validation

With respect to testing the accuracy and completeness of the data underlying claims paid, it was learned that the Company used a *dynamic* process to determine the line of business (market segment using Company terminology) that was associated with a given claim payment. Each month, the Company determined the lag triangle components for that month, such as January 2004, for the claim payments made during that month. The assignment of a claim reflected the line of business code for that claim during that month.

However, at a policy anniversary, a given group could move (migrate) from one line of business to another. For example, Small Group could migrate to Medium Group and vice versa, and Medium Group to Large Group and vice versa.

This meant that for a given claim producing incident, some of the claim payments could be recorded under one line, i.e., Small Group, such as during the first two months after the incident, and the remaining payments could be made under a different line, i.e. Medium Group, such as the payments in the following months, third and later.

The Company determined the lag triangle components each month, such as January 2004, for the claim payments made during that month. Therefore, these migrations would distort the determination of completion factors.

The Consulting Actuary tested any possible impact of the use of incorrect completion factors by running incurred but not reported (IBNR) estimates for Small Group and Medium Group combined, and for Medium Group and Large Group combined.

The Consulting Actuary found that the projected incurred but not reported for the groupings was only slightly greater than the original projections (2.36 percent greater). This difference was not considered to be material and the results did not change the examination's conclusion that the Company's reported Claims Unpaid liability was adequate. The total claims paid during 2005, whether in the *correct* line of business or not, was less than the reported 2004 Claims Unpaid Liability.

As noted in the scope paragraph of this report section, the Information Systems Specialist participated in the request, receipt and validation of data to be used in completeness and accuracy testing. The data was provided from the Company's data warehouse. The Information Systems Specialist reviewed the first set of data provided with management and found errors and missing data. Additional sets of data were provided as issues were found. The Company was asked to balance the data to the Annual Statement amounts. In trying to do this, management discovered additional issues with the data and sent a second *final version* of data to the Information Systems Specialist on November 11, 2005.

Using the *final version*, the Information Systems Specialist extracted the data that should make up the amounts in the cells selected for testing. The Information Systems Specialist tested the data further by reconciling the claims paid inventory that was provided by the Company (data extract) to the paid claims lag triangles. This inventory was not the inventory actually used by the Company's Actuarial Department to produce the paid claims lag triangles, but was characterized by the Company as being an accurate representation of claims paid. The results of this cell verification indicated numerous differences. The Company was asked to reconcile two of the larger differences, but was not able to do so. The Company stated that its inability to reconcile the warehouse data to the incurred but not reported data was a noticeable gap that had been highlighted by this exam and will be looked at in the future.

This data validation review demonstrated the general accuracy of the Company provided claims lag triangles: however, the Company's inability to reconcile its warehouse data to the IBNR data was a noticeable gap in its system. Management has indicated that it will work with its IS department to add a claim detail option to the IBNR data feed, will add a regular reconciliation audit between the warehouse and the IBNR feeds, and conduct semi-annual testing.

The lack of the ability to reconcile the data residing in the warehouse to the system data was also evident in other business units, such as Accounting—specifically, the monthly balancing of claims and check processing reports.

Based on the foregoing, it is strongly recommended that the Company include validation of the data in the data warehouse in its task list for 2006. It is also recommended that the Company adopt coding procedures to insure that the line of business assignment is consistent for all claims payments and to maintain a history of migrations to/from Small, Medium and Large groups.

### Conclusion

The Company had a secure environment for the data assets of the Company with the exceptions noted above. All of the comments and recommendations made in this report were discussed with the Company. The final evaluation of control risk of the information systems structure was: high intended reliance on internal controls and a medium level of risk identified. The original risk assessment determined in planning was: high intended reliance on internal controls and low level of risk identified. The Information Systems Specialist's assessment of a medium level of risk in the information systems structure was based on the following:

- The difficulty of obtaining data that the Consulting Actuary could tie to the 2004 Annual Statement.
- The examples observed and discussed with Accounting personnel of data errors in reports.
- Manual corrections required in the check processing function.
- Observation of the difficulty in reconciling the system data to the data residing in the data warehouse.

### Independent Accountants

The annual independent audits of the Company for the years 2000 through 2004 were performed by Deloitte & Touche LLP, Boise, Idaho. The financial statements in each report were on a statutory basis. There was some reliance on the 2004 audit report and workpapers in this examination of the Company.

### Actuarial Opinion

The Company submitted a statement of actuarial opinion of the claims unpaid and unpaid claims adjustment expenses. A separate statement of opinion of the provision for experience rating credits was also submitted.

The unpaid claims reserves and unpaid claims adjustment expenses were calculated by the Company and reviewed by Ross A. Laursen, FSA, MAAA, consulting actuary with Milliman, Inc. The December 31, 2004 statement of actuarial opinion issued stated that the amounts carried in the balance sheet:

*(I) are computed in accordance with accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles, based upon the relevant Standards of Practice and Compliance Guidelines as promulgated by the Actuarial Standards Board;*

*(ii) are based on actuarial assumptions relevant to contract provisions and appropriate to the purpose for which the statement was prepared;*

*(iii) meet the requirements of the insurance laws of the State of Idaho;*

*(iv) make good and sufficient provision for all unpaid claims and other actuarial liabilities of the Company guaranteed under the terms of its contracts and agreements;*

*(v) are computed on the basis of assumptions consistent with those used in computing the corresponding items in the annual statement of the Company for the preceding year-end; and*

*(vi) include provision for all related actuarial items which ought to be established.*

The identified actuarial items in the 2004 Annual Statement were as follows:

Claims unpaid, page 3, line 1	\$84,300,000
Unpaid claims adjustment expenses, page 3, line 3	2,475,000

This opinion was substantially in compliance with the NAIC *Annual Statement Instructions*. However, the opinion did not discuss the preparation of the Underwriting and Investment Exhibit - Part 2B and did not provide the actuary's mailing address or telephone number.

Experience refunds that were reported under *Aggregate health policy reserves* reported in page 3, line 4 were calculated by the Company and reviewed by David J. Hutchins, Vice President of Actuarial Services and Underwriting for the Company. The December 31, 2004 statement of actuarial opinion identified the following actuarial item:

Provisions for experience rating credits, page 3, line 4	\$ 2,609,861
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This opinion was very abbreviated and did not contain much of the wording required by the NAIC *Annual Statement Instructions*. Specifically, the scope paragraph did not disclose whether the actuary reviewed the underlying records or summaries, or whether he relied on data provided by another party. In addition, the opinion paragraph did not state whether (a) the amount was calculated in accordance with accepted actuarial standards, whether (b) the amount meets the requirements of Idaho law, and whether (c) the amount includes provision for all related actuarial items. Furthermore, the opinion did not provide the actuary's mailing address or telephone number.

Although the two actuarial opinions were generally prepared in accordance with the actuarial requirements of SSAP No. 54, paragraph 11 and the Actuarial Standards Board, the opinions did not contain all of the wording specified in the NAIC *Annual Statement Instructions*. Therefore, it is recommended that future actuarial opinions be prepared in accordance with statutory accounting principles, Actuarial Standards Board, and the NAIC *Annual Statement Instructions*.

Additional actuarial findings are discussed under Note 5 to the Financial Statements.

### FINANCIAL STATEMENTS

The financial section of this report contains the following statements:

Balance Sheet as of December 31, 2004

Statement of Revenue and Expenses, Year 2004

Capital and Surplus Account, Year 2004

Reconciliation of Capital and Surplus Account, December 31, 1999, through December 31, 2004.

Balance Sheet  
As of December 31, 2004

ASSETS

	<u>Assets</u>	Nonadmitted <u>Assets</u>	Net <u>Admitted</u>
Bonds (Note 1)	\$162,720,310	\$ 0	\$162,720,310
Common stocks (Note 1)	69,077,165		69,077,165
Real estate, properties occupied by the company (less \$10,409,148 encumbrances) (Note 2)	6,860,194	0	6,860,194
Cash, cash equivalents and short-term investments	25,369,432	0	25,369,432
Other invested assets	7,908	0	7,908
Investment income due and accrued	1,464,466	0	1,464,466
Uncollected premiums and agents' balances in the course of collection (Note 3)	6,257,968	0	6,257,968
Amounts receivable relating to uninsured plans	4,307,481	469,255	3,838,226
Current federal and foreign income tax recoverable and interest thereon	1,164,378	0	1,164,378
Net deferred tax asset	273,679	0	273,679
Electronic data processing equipment and software (Note 4)	16,046,265	11,246,638	4,799,627
Furniture and equipment, including health care delivery assets (Note 4)	2,215,214	172,394	2,042,820
Health care and other amounts receivable	2,823,718	284,894	2,538,824
Aggregate write-ins for other than invested assets:			
Non-qualified Exec Deferred Compensation	180,690	180,690	0
Prepaid Expenses and Misc Receivables	7,126,037	7,126,037	0
Cash Value Life Insurance	1,041,466	0	1,041,466
Rounding	<u>1</u>	<u>0</u>	<u>1</u>
Totals	<u>\$306,936,372</u>	<u>\$19,479,908</u>	<u>\$287,456,464</u>

Balance Sheet  
As of December 31, 2004 (Continued)

LIABILITIES, SURPLUS AND OTHER FUNDS

	<u>Covered</u>	<u>Uncovered</u>	<u>Total</u>
Claims unpaid (Note 5)	\$10,343,610	\$73,956,390	\$ 84,300,000
Accrued medical incentive pool and bonus amounts	3,411,220	0	3,411,220
Unpaid claims adjustment expenses (Note 5)	2,475,000	0	2,475,000
Aggregate health policy reserves (Note 5)	2,609,861	0	2,609,861
Premiums received in advance	18,942,938	0	18,942,938
General expenses due or accrued	30,258,758	0	30,258,758
Amounts withheld or retained for the account of others	500,053	0	500,053
Borrowed money (Note 2)	397,900	0	397,900
Amounts due to parent, subsidiaries and affiliates	52,568	0	52,568
Mortgage Interest Rate Swap (Note 6)	<u>1,434,199</u>	<u>0</u>	<u>1,434,199</u>
Total liabilities	<u>\$70,426,107</u>	<u>\$73,956,390</u>	<u>\$144,382,497</u>
Unassigned funds (surplus)			<u>\$143,073,966</u>
Total capital and surplus			<u>\$143,073,966</u>
Total Liabilities, capital and surplus			<u>\$287,456,463</u>

STATEMENT OF REVENUE AND EXPENSES

For the Year Ending December 31, 2004

	<u>Per Examination and Per Company</u>	
	<u>Uncovered</u>	<u>Total</u>
Net premium income		\$690,257,187
Change in unearned premium reserves and reserve for rate credits		(228,010)
Host Access Fees		1,493,564
Fixed Asset Disposal & Other Income		<u>(574,344)</u>
Total revenues		<u>\$690,948,397</u>
 <b>Hospital and Medical:</b>		
Hospital/medical benefits	\$318,313,965	\$382,526,791
Other professional services	35,673,866	39,353,651
Outside referrals	35,597,399	35,597,399
Emergency room and out-of-area	6,094,933	7,392,538
Prescription drugs	100,129,321	100,129,321
Incentive pool, withhold adjustments and bonus amounts	<u>0</u>	<u>1,096,000</u>
Subtotal	<u>\$495,809,484</u>	<u>\$566,095,700</u>
 <b>Less:</b>		
Total hospital and medical	\$495,809,484	\$566,095,700
Claims adjustment expenses, including \$5,797,975 cost containment expenses		23,448,027
General administrative expenses		<u>68,874,255</u>
Total underwriting deductions	<u>\$495,809,484</u>	<u>\$658,417,982</u>
Net underwriting gain		<u>\$ 32,530,415</u>
Net investment income earned		\$ 7,361,584
Net realized capital gains		<u>1,541,926</u>
Net investment gains		<u>\$ 8,903,510</u>
Net income before federal income taxes		\$ 41,433,925
Federal and foreign income taxes incurred		<u>8,942,673</u>
Net income		<u>\$ 32,491,252</u>

## CAPITAL AND SURPLUS ACCOUNT

For the Year Ending December 31, 2004

	<u>Per</u> <u>Company</u>	<u>Examination</u> <u>Changes</u>	<u>Per</u> <u>Examination</u>
Capital and surplus, December 31, 2003 (Note 7)	<u>\$104,194,578</u>	<u>\$ 0</u>	<u>\$104,194,578</u>
<b>GAINS AND LOSSES TO CAPITAL &amp; SURPLUS</b>			
Net income	\$ 32,491,252	\$ 0	\$ 32,491,252
Net unrealized capital gains and losses	3,776,845	0	3,776,845
Change in nonadmitted assets	1,473,072	0	1,473,072
Aggregate write-ins for gains or (losses) in surplus:			
Difference GAAP-SAP on Post- retirement	744,274	0	744,274
Other Comprehensive Income Adjustment	<u>393,942</u>	<u>0</u>	<u>393,942</u>
Net change in capital and surplus	<u>\$ 38,879,385</u>	<u>\$ 0</u>	<u>\$ 38,879,385</u>
Capital and surplus, December 31, 2004	<u>\$143,073,963</u>	<u>\$ 0</u>	<u>\$143,073,963</u>

RECONCILIATION OF CAPITAL AND SURPLUS ACCOUNT

December 31, 1999 Through December 31, 2004

	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>2004</u>
Capital and surplus, December 31, previous year	* <u>\$73,108,388</u>	<u>\$73,617,005</u>	<u>\$74,866,397</u>	<u>\$72,056,397</u>	<u>\$104,194,578</u>
Net income	8,454,986	1,800,163	4,967,603	12,452,484	\$32,491,252
Change in net unrealized capital gains or (losses)	(2,418,718)	197,212	(4,789,323)	6,425,390	0
Net unrealized capital gains and losses	0	0	0	0	3,776,845
Change in nonadmitted assets and related items	(7,102,490)	(763,850)	(3,935,701)	5,847,928	1,473,072
Change in asset valuation reserve	192,736	(591,880)	1,990,597	(2,301,858)	0
Cumulative effect of changes in accounting principles	0	(264,983)	0	0	0
Aggregate write-ins for gains or (losses) in surplus:					
Difference GAAP-SAP on Post- retirement	708,988	872,733	649,363	794,200	744,274
CCS Adjustment – Correction	(218,246)	0	0	0	0
Difference GAAP-SAP – Amortization of Goodwill	225,000	0	0	0	0
Prior year statutory examination adjustments booked this year	666,364	0	0	0	0
Rounding	(3)	(3)	1	(1)	(6)
SWAP – Mark to market	0	0	(1,692,540)	0	0
Other Comprehensive Income Adjustment	0	0	0	2,846,993	393,942
Conversion to Health Blank (Note 7)					
Interest Maintenance Reserve	0	0	0	2,902,564	0
Asset Valuation Reserve	0	0	0	3,170,488	0
Net change in capital and surplus	<u>\$ 508,617</u>	<u>\$ 1,249,392</u>	<u>\$(2,810,000)</u>	<u>\$ 26,065,135</u>	<u>\$ 44,952,431</u>
Capital and surplus, December 31, current year	<u>\$73,617,005</u>	<u>\$74,866,397</u>	<u>\$72,056,397</u>	<u>\$104,194,578</u>	<u>*\$143,073,963</u>

\*Per examination

## NOTES TO THE FINANCIAL STATEMENTS

Note (1) – Bonds	\$162,720,310
<u>Common stocks</u>	<u>69,077,165</u>

The following were noted during the review of bonds and common stocks:

1. Effective 2004, the Idaho Department of Insurance had approved the use of non-NAIC fair market values for the company's investments. It was determined that the differences in fair market value were immaterial to the statutory financial statements.
2. The Company had a custody agreement, dated November 15, 1999, with US Bank N.A. and a custody agreement with Wells Fargo Bank (formerly First Security Bank) effective September 28, 1992. These agreements did not contain the recommended safeguards or provisions suggested by the NAIC *Financial Condition Examiners Handbook*, which was adopted pursuant to Section 41-223, Idaho Code.

The agreements were in force during the prior examination period. The prior examination report recommended that the Company make certain the custodial agreements included the NAIC recommended safeguards. In a letter to the Department of Insurance dated January 7, 2002, the Company indicated it would comply with this request. However, this had not been done. Therefore, it is again recommended that the Company make certain that all custodial agreements with banks holding its securities include the NAIC recommended safeguards.

3. Certain bond and stock investments owned by the Company were held by the following brokerage firms or funds: Piper Jaffray, Vanguard Group, Evergreen Investments, Frontegra Funds, AMF Asset Management Fund, and SSGA S&P 500 Index Fund. A review of Company records indicated that custodial arrangements did not exist with these brokerage firms or funds.

NAIC guidance that was in effect during the examination period prohibited the use of brokerage firms to hold and maintain insurance company investments.

However, subsequent to the examination date, the NAIC issued new custodial agreement guidelines. The new guidelines permit broker/dealers as authorized custodians for insurance company securities, if certain conditions are met.

According to the confirmations reviewed and/or received by the examination, the investments held by the brokerage firms or funds were not maintained in the State of Idaho as required by Idaho law. Pursuant to Section 41-2839(2), Idaho Code, every domestic insurer shall have and maintain its assets in Idaho, with limited exceptions. Under Section 41-2839(4)(c), Idaho Code, the use of custodial arrangements for the holding of book-entry securities owned by the insurer is permitted, either in or outside of

Idaho, if the arrangements conform to rules adopted by the director for safeguarding the assets and facilitating the director's examination of insurers using such custodial arrangements.

As previously noted, custodial arrangements did not exist, therefore, at the examination date, the Company was not in compliance with Section 41-2839, Idaho Code.

Based on the foregoing, it is recommended that custodial agreements be executed between the Company and the various broker/dealers noted above. It is further recommended that the custodial agreements contain the most recent safeguards set forth by the NAIC.

4. A sample of bond and stock purchases made in 2004 were traced to supporting documentation, which indicated numerous errors in trade dates, number of shares of stock, and the total acquisition cost. From the sample of purchases, the Company, in many cases, recorded the settlement date as the acquisition date, instead of using the trade date. This is contrary to SSAP No. 26, paragraph 4 for bonds, SSAP Nos. 30 and 32, paragraphs 5 and 10 for common and preferred stocks, respectively, and SSAP No. 43, paragraph 6 for loan-backed and structured securities.

It is recommended that the Company record the trade date as the date acquired for all of its investments. It is further recommended that the Company be more diligent in recording the investment transactions in its investment records and general ledger.

Note (2) – Properties occupied by the company (less \$10,409,148 encumbrances)	\$6,860,194
<u>Borrowed money</u>	<u>\$ 397,900</u>

The Company had the following outstanding liabilities for loans at December 31, 2004:

Notes Payable - Mortgage:	\$10,409,148
Notes Payable - Noncollateral:	<u>397,900</u>
Total:	<u>\$10,807,048</u>

The notes payable - mortgage related to the encumbrance on the Company's home office property. The original construction loans amounted to \$19,975,000. Upon completion of the building, the construction loans were converted to term loans. The encumbrance on the building was originally \$15,375,000 and the unsecured note was \$4,600,000. The loans were established for 15 years for the building encumbrance and 7 years for the unsecured loan.

The interest rate for the encumbrance on the building was established at 2.35 percent less than the prime established by the bank. The unsecured loan rate was 2.05 percent less than prime. However, when the Company originally requested the loans, it signed an interest rate swap agreement for 7.77 percent (see Note 6). In essence, the interest rates

on both loans had a fixed interest rate of 7.77 percent. The purpose of the interest rate swap was to minimize cash flow exposures to fluctuations in interest rates for the notes payable.

The notes payable agreements contained certain financial covenants, including current ratio, debt-to-reserve ratio and debt service coverage. The independent auditors tested the covenants and concluded that the Company was in compliance at December 31, 2004. The examination tested, verified, and relied upon their work in this regard.

The encumbrance on the home office property is due December 1, 2012, payable in monthly installments including interest at variable rates equal to the lender's prime rate less 2.35 percent (2.9 percent at December 31, 2004), collateralized by the building. The encumbrance on the building was properly reported as an offset to the book value in accordance with SSAP No. 40, paragraph 4.

The unsecured note was payable in monthly installments including interest at variable rates equal to the lender's prime rate less 2.05 percent (3.2 percent at December 31, 2004). The unsecured note was reported as *Borrowed money* in the financial statements.

The interest paid date was January 1, 2005. Therefore, it was not reasonable for the Company to accrue an interest expense at year end. The independent auditors reviewed the accounts payable detail noting the expense was properly excluded from the balance.

The unsecured note matured July 1, 2005. The balance of \$66,305.00, plus accrued interest of \$218.26 was paid on June 16, 2005.

The independent auditors confirmed the loan balances and interest rates, among other things at December 31, 2004.

Note (3) – Uncollected premiums and agents' balances in the course of collection	<u>\$6,257,968</u>
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The Company had established an uncollectible premium receivable reserve of \$272,000 in the general ledger. The reserve was based on estimated uncollectible amounts, as well as specific past due balances. The past due balances that were specifically identified totaled \$107,241 and were included within the reserve of \$272,000. Uncollected premiums were appropriately reduced by the reserve, however, the specifically identified past due balances were not disclosed as nonadmitted assets in the 2004 Annual Statement.

The NAIC *Annual Statement Instructions* for Health companies are silent with respect to reporting nonadmitted assets. However, the Health insurance annual statement blank has a column to present nonadmitted assets, and therefore implies that nonadmitted assets should be disclosed in page 2, column 2, Nonadmitted assets.

Therefore, it is recommended that the Company properly classify any specifically identified past due balances in the *nonadmitted* column of future Annual Statements.

Note (4) – Electronic data processing equipment and software	\$4,799,627
<u>Furniture and equipment, including health care delivery assets</u>	<u>2,042,820</u>

Pursuant to Section 41-601(11), Idaho Code, electronic and mechanical machines constituting a data processing and accounting system are defined as assets if the cost of such system is at least \$25,000. The cost of electronic data processing equipment and software exceeded \$25,000 at December 31, 2004, therefore, the Company was in compliance with current Idaho law. However, according to SSAP No. 16, paragraph 4, the aggregate amount of admitted EDP equipment and operating system software (net of accumulated depreciation) shall be limited to three percent of the reporting entity's capital and surplus, excluding EDP equipment and operating system software, net deferred tax assets and net positive goodwill.

The Company depreciated data processing equipment three to seven years according to its capitalization policy. Pursuant to Section 41-601(11), Idaho Code, the cost of electronic and mechanical machines shall be amortized in full over a period not to exceed ten calendar years. Although the Company was in compliance with Idaho law, depreciation periods greater than three years are contrary to SSAP 16, paragraph 3.

Under Section 41-601(12), Idaho Code, all office equipment, office furniture, private passenger automobiles deemed necessary for conduct of insurance business (subject to limitations), are considered admitted assets. SSAP No. 19, paragraph 2 states that undepreciated portions of furniture, fixtures and equipment shall be reported as nonadmitted assets and charged against surplus.

The Company did not disclose the above differences between Idaho law and SSAP No. 16, paragraphs 3 and 4 and SSAP No. 19, paragraph 2 in Note 1.A. to the 2004 Annual Statement. According to NAIC *Annual Statement Instructions*, departures from the NAIC *Accounting Practices and Procedures Manual* that affect net income statutory surplus or risk-based capital should be disclosed in the financial statements.

It is recommended that the Company disclose departures from the NAIC *Accounting Practices and Procedures* manual that affect net income, statutory surplus, or risk-based capital in future financial statements.

Note (5) – Claims unpaid	\$84,300,000
Unpaid claims adjustment expenses	2,475,000
<u>    Aggregate health policy reserves</u>	<u>2,609,861</u>

As previously reported, the actuarial review of claims unpaid, unpaid claims adjustment expense, and aggregate health policy reserves was performed by Taylor-Walker and Associates, Inc., Consulting Actuary, for the Idaho Department of Insurance. The following was noted in their review of the actuarial items:

1. The Company should adopt coding procedures to insure that the line of business assignment is consistent for all claims payments. A recommendation was made under *ACCOUNTS AND RECORDS, Data Completeness and Accuracy Validation*.

2. The Company should use a ratio of paid claims adjustment expenses to paid hospital and medical expenses that is consistent with Company experience when determining its unpaid claims adjustment expenses (UCAE) liability.

It is recommended that the Company use a ratio of paid claims adjustment expenses to paid hospital and medical expenses that is consistent with Company experience.

3. The Company's actuarial opinions should include all of the required wording as specified in the Annual Statement instructions. A recommendation was made under *ACCOUNTS AND RECORDS, Actuarial Opinion*.

4. The Company did not provide Claims Adjustment Expenses (CAE) workpapers; therefore, the Contract Actuary was unable to obtain an understanding of the type of expenses included within CAE in accordance with SSAP No. 85. However, a review of the Annual Statement showed that the level of reported CAE were within industry norms.

In the future, it is recommended that the Company provide all documents requested for the examination in compliance with Sections 41-223(3) and 41-247, Idaho Code.

5. The Consulting Actuary reviewed the Company's calculation of Claims Adjustment Expenses (CAE) reserves. The Company's calculation of the Unpaid Claims Adjustment Expenses liability did not take into account all relevant CAE expenses. Although the Company's calculation methodology understated the reported liability by approximately \$1,600,000, the reported liability was not adjusted for purposes of the examination.

It is recommended that the Company's calculation of Unpaid Claims Adjustment Expenses liability take into account all relevant CAE expenses.

6. The Consulting Actuary reviewed the Claims Unpaid Liability and compared examination date claim liabilities to the subsequent runoff through March 31, 2005, July 31, 2005, or August 31, 2005. The following were noted:

a. The reported Claims Unpaid liability for the lag determined non-State of Idaho lines of business exceeded the subsequent runoff, including an estimate for remaining payments, by \$1,359,437.

b. The reported Claims Unpaid liability for the lag determined State of Idaho lines of business greatly exceeded the subsequent runoff, including an estimate for remaining payments. However, it was noted that any reduction in the Claims Unpaid liability would have a dollar-for-dollar increase in the reported liability for experience rating refunds.

- c. The Company's margins for conservatism and rounding of \$4,600,266 and \$28,630 were redundant.
- d. The reported Claims Unpaid liability for the Stop-Loss line of business was understated by approximately \$220,000.
- e. The reported Claims Unpaid liability for the vision lines of business exceeded the subsequent runoff by approximately \$95,000.

The following table summarizes the offsets or reserving redundancies noted above:

<u>Item</u> <u>(above)</u>	<u>Redundancy or Deficiency for Claims Unpaid Liability</u> <u>Reserving Issue</u>	<u>Redundancy or</u> <u>(Deficiency)</u>
a	Unpaid lag liability deficiency (Non-State of ID)	\$(1,359,437)
b	Unpaid lag liability deficiency (State of ID)	*0
c	Conservatism redundancy	4,600,266
c	Rounding redundancy	\$28,630
d	Claims Unpaid Liability – Stop Loss	(220,000)
e	Claims Unpaid Liability – Vision	<u>(95,000)</u>
	Net Redundancy	<u>\$ 2,954,459</u>

\* Deficiency is offset dollar for dollar by experience rating refund liability reduction

The balance sheet of the examination report was not adjusted to reflect the above differences due to a net redundancy of \$2,954,459.

Additional actuarial examination findings are discussed under *ACCOUNTS AND RECORDS, Data Completeness and Accuracy Validation and Actuarial Opinion*.

Note (6) – Mortgage Interest Rate Swap \$1,434,199

The note payable agreements discussed in Note 2 contained provisions for an interest rate swap program for the purposes of minimizing cash flow exposures to fluctuations in interest rates for the notes payable. The agreements effectively fixed the interest rates on the notes at a rate of 7.7 percent. The notional amount of interest rate swaps outstanding at December 31, 2004 was \$10,898,000.

The liability reported in the balance sheet was the estimated amount that the Company would receive or pay to terminate the swap agreement at December 31, 2004, taking into account current interest rates. Based on the rates available to the Company, settlement of the interest rate swap agreement would have required a net payment of \$1,434,199.

### Note (7) – Reconciliation of Capital and Surplus Account

The Company changed its reporting format from the NAIC Life, Accident and Health blank to the NAIC Health blank effective January 1, 2004. Under the Health blank, the Company was no longer required to maintain the Interest Maintenance Reserve or the Asset Valuation Reserve liabilities. The following reconciles capital and surplus reported in the 2003 Life, Accident and Health blank to the beginning balance reported in the 2004 Health blank Annual Statement:

Ending surplus per 2003 Life, Accident and Health blank:	\$ 98,121,526
Plus: Interest Maintenance Reserve	2,902,564
Plus: Asset Valuation Reserve	<u>3,170,488</u>
Beginning surplus per 2004 Health blank:	<u>\$104,194,578</u>

### COMMITMENTS AND CONTINGENT LIABILITIES

The Company was named in certain litigation matters during the examination period. In this connection, there were several lawsuits pending against the Company and another matter had been referred for arbitration as of December 31, 2004. Subsequent to the examination date, two of the cases were resolved, while the others remained pending. In 2005, a charge against the Company was filed with the Idaho Human Rights Commission and the Equal Employment Opportunity Commission.

During the examination period, two class action lawsuits were filed by physicians and other providers against the Blue Plans alleging improper practices related to payment of providers. The Company was participating in a joint defense with the Blue Cross Blue Shield Association and other Blue Plans. Although the Company continued to assert that it was not liable, it was anticipated that a settlement may be involved in the litigation. Therefore, a reserve of approximately \$3,900,000 was recorded as of December 31, 2004, on such matters, and included in *General expenses due or accrued* on the balance sheet. An additional \$400,000 and \$100,000 for claims and legal costs, respectively will be included in the 2005 financial statements.

The Company was also involved in litigation and regulatory investigations arising in the ordinary course of business. After consultation with legal counsel, management estimated that these matters would be resolved without material adverse effect on the Company's financial position, results from operations, or cash flows.

## SUBSEQUENT EVENTS

The Board of Directors approved a resolution on April 29, 2005 to move forward with the planning of an additional building for the Company to be located at its corporate headquarters in Meridian, Idaho.

At their meeting of November 8, 2005, the Board authorized the Executive Committee to review and approve the remaining stages of the building so long as anticipated costs for the overall project did not exceed 105 percent of the approved \$11,500,000 budget. If at any time anticipated costs were projected to exceed 105 percent of the budget, or \$12,075,000, a meeting of the full Board would be convened.

On January 12, 2006, the Executive Committee approved the following costs to date:

1. The guaranteed maximum price submitted by the construction manager, PETRA, Inc. in the amount of \$9,378,065 for the construction of the new parking lot and building.
2. The fixed contractual amount of \$587,738.74 for architectural and construction administration fees to be performed by the architect, CSQA.
3. All other estimated service fees for items including, but not limited to, surveying, inspections, and data communications, in the amount of \$293,895.16.
4. The estimated fixtures, fittings and equipment budget projected to be \$1,740,300.00 to accommodate 265 employees.
5. A total project budget not to exceed 5 percent of the \$11,500,000 budget or \$12,075,000 as approved at the November 8, 2005 Board of Directors meeting.

The building costs as of January 27, 2006 are summarized below:

Total Building and Site Budget (from PETRA)	\$ 9,378,065.00
Estimated Fees and Services	881,633.90
Estimated Fixtures, Fittings and Equipment	<u>1,740,300.00</u>
Total Project Budget	<u>\$11,999,998.90</u>

The total project budget was just under the Board-approved budget of \$12,075,000. A tentative move-in date of January 2007 is anticipated.

According to management, the cost of the additional building will be paid from existing cash and investments.

On July 30, 2005, the Board of Directors approved a resolution for the Company to participate in the Bank created by the Blue Cross Blue Shield Association for the Blues Plans. The main purpose of the Bank will be to assist in the administration of Consumer Driven Health Plans, such as Health Savings Accounts. The Board also approved an initial payment of \$50,000. An additional contribution of \$193,410 was made to the Bank. In exchange, the Company received 241 shares of the Bank's common stock and 241 shares of preferred stock at a cost of \$2,410 and \$241,000, respectively.

## SUMMARY, COMMENTS AND RECOMMENDATIONS

### Summary

The results of this examination disclosed that as of December 31, 2004, the Company had net admitted assets of \$287,456,463, liabilities of \$144,382,497, and unassigned funds (surplus) of \$143,073,966. Therefore, the Company's total capital and surplus exceeded the \$2,000,000 minimum prescribed by Section 41-313, Idaho Code.

### Comments and Recommendations

#### Page

- 22 It is again recommended that the Company file all amendments to affiliated agreements in accordance with the provisions of the Idaho Code.

Subsequent to the examination date, the amendments to the Development and Management Agreement and the Administrative Services Agreement effective January 1, 2003 were filed with the Idaho Department of Insurance.

- 31 It is recommended that the Company obtain the minimum financial institution bond coverage limits recommended by the NAIC.

- 34 In the current examination, numerous discrepancies were once more noted between the Department and Company listings of agents. Therefore, it is again recommended that the Company conduct a thorough review of its active and terminated agents and update the Department on any inaccuracies.

- 36 It is recommended that the Company file Forms IND-APP-2003 and BCI Form No. 3-397(07-04) with the Department. The Company also needs to file BCI Form 3-397(07-05) if it has not yet been filed.

The Company advised that it was filing the forms immediately.

Comments and Recommendations, (continued)

Page

- 38 It is recommended that the Company establish a control procedure to ensure that applications with and without premium refund payments are accurately tracked and monitored.

The Company subsequently advised that it had changed the application procedure since 2004.

- 38 It is recommended that in order to strengthen internal controls that the Company implement procedures to track an applicant's premium payment by check number, amount and date returned, either by including this information within the denial letter or by another tracking method.

The Company subsequently changed the application procedure since 2004.

- 39 The Company's underwriting files were maintained in hard copy and not available through the Company's imaging system. A review of the original files would have eliminated the need for the Company to copy file documents, or in some cases the entire file, and thereby incurring additional unnecessary expense.

Another difficulty arose because needed documents were not initially copied from the original underwriting files. The failure to provide complete information resulted in numerous additional examination requests and follow-up.

It is recommended that the Company provide access to the original underwriting files for future examinations. In addition, the Company should insure that signed waivers of coverage are included in the file for all those employees that are waiving the right to coverage according to the original census.

- 42 It is recommended that the Company provide the Department with an amended 2004 Grievance Report that complies with Section 41-3918, Idaho Code. It is also recommended that the Company file the delinquent Grievance Reports with the Department for calendar years 2002 and 2003. Furthermore, it is recommended that the Company develop a reporting system that accurately captures bona-fide managed care grievance items for annual filing with the Department of Insurance.

Comments and Recommendations, (continued)

Page

- 43 Although there were no grievances of this nature noted during this examination, it is again recommended that the Company implement procedures for submitting quality of care grievances to the Director in compliance with Section 41-3918(2), Idaho Code.
- 43 It is recommended that when changes are made to the managed care grievance procedures that conflict with the Idaho Code, such changes shall be reviewed with the Idaho Department of Insurance. It is further recommended that the Company establish an alternative mechanism to fulfill the requirements of Section 41-3916, Idaho Code if Advisory Panel meetings are not held.
- 46 It is recommended that requested documents and records be provided in a more  
64 timely manner for future examinations in compliance with Sections 41-223(3) and 41-247, Idaho Code.
- 47 The Information Systems Specialist agreed that whereas staffing in the IS Department was difficult and the goal was not to take on staff that will later have to be let go. It was the responsibility of the IS Division to provide adequate service to the users to enable business units to adequately and accurately perform the work of the Company. This should be the primary consideration.
- 48 The control deficiencies could be mitigated by the development of a protected testing environment. The addition of a Quality Assurance staff would greatly enhance the adequacy of the testing and the controls needed to ensure that all changes and new development processes were adequately tested, including regression testing and that no program was promoted that has been changed after testing had occurred.
- 48 It is recommended that the Company take steps to upgrade the Disaster Recovery Plan to adequately cover and mitigate the risk(s) of service interruptions. It is also recommended that the Company investigate how it might more effectively reduce the risk of sending claims to an incorrect payer and thereby violating HIPAA rules.
- 49 It is highly recommended that issues related to check processing be given top priority by the IS Department as they are an integral part of the reconciliation of checks to be printed.

Comments and Recommendations, (continued)

Page

- 50 It is recommended that the group that maintains the access to the applications attend to doing the processing in a timely manner.
- 50 It is recommended that the current access for all users should be reviewed for appropriateness on a quarterly basis.
- 50 It is highly recommended that the development of a workable Disaster Recovery Plan be made the highest priority in 2006.
- 52 It is strongly recommended that the Company include validation of the data in  
64 the data warehouse in its task list for 2006. It is also recommended that the Company adopt coding procedures to insure that the line of business assignment is consistent for all claims payments and to maintain a history of migrations to/from Small, Medium and Large groups.
- 54 It is recommended that future actuarial opinions be prepared in accordance with  
64 statutory accounting principles, Actuarial Standards Board, and the NAIC *Annual Statement Instructions*.
- 60 It is again recommended that the Company make certain that all custodial agreements with banks holding its securities include the NAIC recommended safeguards.
- 61 It is recommended that custodial agreements be executed between the Company and the various broker/dealers. It is further recommended that the custodial agreements contain the most recent safeguards set forth by the NAIC.
- 61 It is recommended that the Company record the trade date as the date acquired for all of its investments. It is further recommended that the Company be more diligent in recording the investment transactions in its investment records and general ledger.
- 63 It is recommended that the Company properly classify any specifically identified past due balances in the *nonadmitted* column of future Annual Statements.

Comments and Recommendations, (continued)

Page

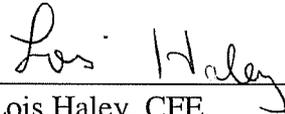
- 63 It is recommended that the Company disclose departures from the NAIC *Accounting Practices and Procedures* manual that affect net income, statutory surplus or risk-based capital in future financial statements.
- 64 It is recommended that the Company use a ratio of paid claims adjustment expenses to paid hospital and medical expenses that is consistent with Company experience.
- 64 It is recommended that the Company's calculation of Unpaid Claims Adjustment Expenses liability take into account all relevant CAE expenses.

CONCLUSION

The undersigned acknowledges the assistance and cooperation of the Company's officers and employees in conducting the examination.

In addition to the undersigned, Claudia Schwartz, CIE and Dean Cassens, CFE of the Idaho Department of Insurance, participated in the examination. Taylor-Walker & Associates, Inc. conducted the actuarial portion of the examination and Regulatory Associates, Inc. conducted the review of the Company's information systems.

Respectfully submitted,



Lois Haley, CFE  
Senior Insurance Examiner  
State of Idaho  
Department of Insurance

AFFIDAVIT OF EXAMINER

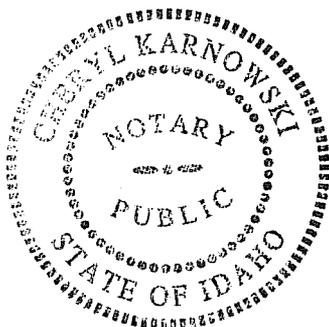
State of Idaho  
County of Ada

Lois Haley, being duly sworn, deposes and says that she is a duly appointed Examiner for the Department of Insurance of the State of Idaho, that she has made an examination of the affairs and financial condition of *Blue Cross of Idaho Health Service, Inc.* for the period from January 1, 2000 through December 31, 2004, including subsequent events, that the information contained in the report consisting of the foregoing pages is true and correct to the best of her knowledge and belief, and that any conclusions and recommendations contained in the report are based on the facts disclosed in the examination.

*Lois Haley*

Lois Haley, CFE  
Senior Insurance Examiner  
Department of Insurance  
State of Idaho

Subscribed and sworn to before me the 31<sup>st</sup> day of May, 2005, at Boise, Idaho



*Cheryl Karnowski*  
Notary Public

My commission Expires: 9/12/2009

# EXHIBIT B

# FAX TRANSMITTAL



3000 E. Pine Ave., Meridian, ID 83642 ♦ (208) 345-4550 ♦ www.bcidaho.com

**To:** Bill Michels  
Idaho Dept. of Insurance  
Fax: (208) 334-4398

**FROM:** Sharon Heindel for Jack Myers  
Fax: (208) 331-7321  
Voice: (208) 331-7613

**Subject:** Letter of Examination

**Date:** June 29, 2006

**Number of Pages Including Cover:** 8

**Comments:**

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**This FAX transmittal is intended only for the use of the individual(s) or entity to which it is addressed and may contain information that is confidential and protected by law. Any use or disclosure of this information except by the addressee is prohibited.**

**If you have received this facsimile in error, please notify us by telephone by calling (208) 345-4550 immediately to arrange for the return of the documents to us.**

**Thank you.**

**Blue Cross  
of Idaho**



June 28, 2006

Bill Michels, Examination Supervisor  
Idaho Department of Insurance  
P O Box 83720  
Boise, Idaho 83720

Re: Blue Cross of Idaho Health Service, Inc (BCI)  
Report of Examination by Department of Insurance (DOI)  
Dated May 31, 2006

Dear Mr. Michels,

In accordance with Idaho Code 41-227(4), upon completion of the Idaho Department of Insurance Examination of the Blue Cross of Idaho financial records, BCI has the opportunity to respond to the comments and recommendations made by the examiners at the conclusion of the Exam. We welcome the opportunity to address those recommendations and respectfully request that our responses be made a part of the official public document.

The following are the management responses to the applicable sections of the report:

**(p. 22) It is again recommended that the Company file all amendments to affiliated agreements in accordance with the provisions of the Idaho Code. Subsequent to the examination date, the amendments to the Development and Management Agreement and the Administrative Services Agreement effective January 1, 2003 were filed with the Idaho Department of Insurance.**

RESPONSE: As noted in the Exam report, BCI has complied with this recommendation.

**(p. 31) It is recommended that the Company obtain the minimum financial institution bond coverage limits recommended by the NAIC.**

RESPONSE: The Company's financial institution bond coverage amount of \$1 million no longer met the minimum limit since our asset growth placed us in a higher "tier" that requires at least \$1.25 million in coverage. The Company has increased their coverage and now meets or exceeds the limits recommended by the NAIC.

**(p. 34) In the current examination, numerous discrepancies were once more noted between the Department and Company listings of agents. Therefore, it is again recommended that the Company conduct a thorough review of its active and terminated agents and update the Department on any inaccuracies.**

RESPONSE: In May 2004, BCI began utilizing an online resource called Cratchit-NET to track all appointed brokers. An audit of the system is in process to verify all broker appointments between BCI and the DOI; we anticipate this process to be complete by June 30, 2006.

(208) 345-4550 • [www.bcidaho.com](http://www.bcidaho.com)  
3000 E. Pine Avenue, Meridian, ID 83642-5995  
P.O. Box 7408, Boise, ID 83707-1408

Blue Cross of Idaho  
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(p. 36) It is recommended that the Company file Forms IND-APP-2003 and BCI Form No. 3-397(07-04) with the Department. The Company also needs to file BCI Form 3-397(07-05) if it has not yet been filed. The Company advised that it was filing the forms immediately.

RESPONSE: As noted in the Exam report, BCI has complied with this recommendation.

(p. 38) It is recommended that the Company establish a control procedure to ensure that applications with and without premium refund payments are accurately tracked and monitored. The Company subsequently advised that it had changed the application procedure since 2004.

RESPONSE: As noted in the Exam report, BCI has complied with this recommendation

(p. 38) It is recommended that in order to strengthen internal controls that the Company implement procedures to track an applicant's premium payment by check number, amount and date returned, either by including this information within the denial letter or by another tracking method. The Company subsequently changed the application procedure since 2004.

RESPONSE: As noted in the Exam report, BCI has complied with this recommendation.

(p. 39) The Company's underwriting files were maintained in hard copy and not available through the Company's imaging system. A review of the original files would have eliminated the need for the Company to copy file documents, or in some cases the entire file, and thereby incurring additional unnecessary expense. Another difficulty arose because needed documents were not initially copied from the original underwriting files. The failure to provide complete information resulted in numerous additional examination requests and follow-up. It is recommended that the Company provide access to the original underwriting files for future examinations. In addition, the Company should insure that signed waivers of coverage are included in the file for all those employees that are waiving the right to coverage according to the original census.

RESPONSE: We will provide access to the original underwriting files for future examinations. Signed waivers of coverage are included in the original group files that were reviewed by the DOI and are maintained in the Enrollment and Billing department. All applications are now being converted to imaged documents and group files will begin to be converted to imaged documents in July 2006. These imaged documents will be easily accessible to appropriate personnel.

(p. 42) It is recommended that the Company provide the Department with an amended 2004 Grievance Report that complies with Section 41-3918, Idaho Code. It is also recommended that the Company file the delinquent Grievance Reports with the Department for calendar years 2002 and 2003. Furthermore, it is recommended that the Company develop a reporting system that accurately captures bona-fide managed care grievance items for annual filing with the Department of Insurance.

RESPONSE: We have sent to the Department under separate cover, the 2002, 2003, and amended 2004 Grievance Reports. BCI has a reporting system in place to capture the required data and will file timely reports in the future.

Blue Cross of Idaho  
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(p. 43) Although there were no grievances of this nature noted during this examination, it is again recommended that the Company implement procedures for submitting quality of care grievances to the Director in compliance with Section 41-3918(2), Idaho Code.

RESPONSE: BCI has implemented a procedure for submitting quality of care grievances to the Director.

(p. 43) It is recommended that when changes are made to the managed care grievance procedures that conflict with the Idaho Code, such changes shall be reviewed with the Idaho Department of Insurance. It is further recommended that the Company establish an alternative mechanism to fulfill the requirements of Section 41-3916, Idaho Code if Advisory Panel meetings are not held.

RESPONSE: BCI will comply with this recommendation and convene an Advisory Panel when changes are proposed to the managed care grievance procedures.

(p. 46 and p. 64) It is recommended that requested documents and records be provided in a more timely manner for future examinations in compliance with Sections 41-223(3) and 41-247, Idaho Code.

RESPONSE: BCI will comply with this recommendation and provide documents in a timely manner in future examinations.

(p. 47) The Information Systems Specialist agreed that whereas staffing in the IS Department was difficult and the goal was not to take on staff that will later have to be let go. It was the responsibility of the IS Division to provide adequate service to the users to enable business units to adequately and accurately perform the work of the Company. This should be the primary consideration.

RESPONSE: Information Services did acquire seven new positions in the 2006 budget to address needs in critical needs areas of IS. Outside technical resources are acquired typically on a short-term basis to assist with high priority or mandated projects to meet critical business needs. Project priorities, staffing assignments, and project backlog are periodically reviewed by the IS Steering Committee and Executive Staff to ensure critical business requirements are being met.

(p. 48) The control deficiencies could be mitigated by the development of a protected testing environment. The addition of a Quality Assurance staff would greatly enhance the adequacy of the testing and the controls needed to ensure that all changes and new development processes were adequately tested, including regression testing and that no program was promoted that has been changed after testing had occurred.

RESPONSE: BCI is moving toward (with an anticipated completion date of December 2006) the deployment of additional environments for critical applications that will provide for controlled QA and system test activities to occur. When implemented we will have a much higher confidence that objects moved to production will be the same objects that were tested and approved. No plans are being made to add dedicated staff to perform QA/test functions.

(p. 48) It is recommended that the Company take steps to upgrade the Disaster Recovery Plan to adequately cover and mitigate the risk(s) of service interruptions. It is also recommended

Blue Cross of Idaho  
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**that the Company investigate how it might more effectively reduce the risk of sending claims to an incorrect payer and thereby violating HIPAA rules.**

RESPONSE: BCI has contracted with a service provider to provide full disaster recovery services for the BCI datacenter and the mission critical applications that our housed on BCI equipment in our existing data center. Further, BCI will investigate opportunities to tighten processes and procedures to ensure claims are not inadvertently delivered to an incorrect payer.

**(p. 49) It is highly recommended that issues related to check processing be given top priority by the IS Department as they are an integral part of the reconciliation of checks to be printed.**

RESPONSE: The check stock is blank and does not contain check numbers or "MICR" (magnetic ink character reader) ink characters at the bottom with our account number on the checks. The MICR ink cartridges for the printer are kept in a locked storage. Access to the printers with the MICR cartridges is limited to the Accounting department personnel who can generate the checks. BCI is also implementing positive pay on all checking accounts. Before we release any checks, a file is sent to our bank with the check number, payee and amount of each check. The bank matches the information from our file to this information on any check presented for payment before they will allow a check to clear through our accounts. Positive pay will be effective on all BCI checks by July 1, 2006.

The next four bullet points on check processing have been corrected with the conversion from the JD Edwards accounting system to Lawson on January 1, 2006. For example, the second bullet point on check processing regarding the printing of the check type on the bottom part of a check is no longer an issue with Lawson. This was part of the check run when BCI was using JD Edwards as the accounting system for printing checks. The opening page for Lawson check runs is printed on plain paper instead of check stock and is shredded after printing.

The third bullet point on check processing regarding incorrect provider numbers was also solved by the Lawson system. The provider information for Lawson now comes directly from Facets (the claims payment system) which is updated daily. Employees are no longer required to change data in check files.

The bullet point regarding the overwriting of automatic deposits was overcome since the Lawson system's process for automatic deposits does not overwrite the previous file.

The bullet point regarding the balancing process done by Accounting staff is also no longer an issue with Lawson. Accounting staff no longer cut and paste information to balance since they now receive reports from Facets (the claims payment system) and Lawson that they can use for balancing.

**(p. 50) It is recommended that the group that maintains the access to the applications attend to doing the processing in a timely manner.**

RESPONSE: Network access termination is consistently done upon termination of the user, as indicated by the Information Systems Specialist that there were no exceptions. This activity prevents the terminated user from accessing the BCI computer system. It is often necessary however, for the terminated user's management to access the applications to continue unfinished

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work, reassign work to other personnel, or for other business purposes. This temporary access is specifically granted by the Security Administrator, and is terminated along with the terminated user's user profile after 30 days.

**(p. 50) It is recommended that the current access for all users should be reviewed for appropriateness on a quarterly basis.**

RESPONSE: Application access is validated through management approved security requests when an employee is hired, changes positions, or is terminated. As long as personnel remain in existing positions, we do not feel it is justified to validate application access on a quarterly basis, particularly due to the resources required for that task. We believe the procedure in place to validate application access is adequate.

**(p. 50) It is highly recommended that the development of a workable Disaster Recovery Plan be made the highest priority in 2006.**

RESPONSE: BCI has signed an agreement with Sungard Availability Services to provide Business Continuity Planning (BCP) and Disaster Recovery Services (DRP) effective August 1, 2006. The agreement includes Professional Services to conduct a business risk and assessment, develop a company wide business continuity plan, develop and maintain a plan to provide onsite or remote disaster recovery capabilities, and a software system to maintain both the BCP and DRP.

**(p. 52 and p. 64) It is strongly recommended that the Company include validation of the data in the data warehouse in its task list for 2006. It is also recommended that the Company adopt coding procedures to insure that the line of business assignment is consistent for all claims payments and to maintain a history of migrations to/from Small, Medium and Large groups.**

RESPONSE: BCI has developed the file specifications that will allow a detailed reconciliation between the IBNR data file and the data warehouse that is replacing the one used during the State's examination. Once programming for this is complete, regular reconciliations will be performed in preparation for year-end statement preparation.

BCI's Underwriting department maintains a history of migrations to and from Small, Medium, and Large group lines of business, and has done so since 2004. Assignment of Line of Business for the IBNR reports based on incurred date may take significant programming time for a modest increase in accuracy and will be prioritized accordingly.

**(p. 54 and p. 64) It is recommended that future actuarial opinions be prepared in accordance with statutory accounting principles, Actuarial Standards Board, and the NAIC *Annual Statement Instructions*.**

RESPONSE: BCI will comply with this recommendation for future filings.

**(p. 60) It is again recommended that the Company make certain that all custodial agreements with banks holding its securities include the NAIC recommended safeguards.**

RESPONSE: Standard custodial agreements do exist with the custodians. In the departmental personnel transitions since the last examination, no changes were made to these agreements. The

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Company has contacted appropriate custodians to update completed agreements to the NAIC recommended wording.

**(p. 61) It is recommended that custodial agreements be executed between the Company and the various broker/dealers. It is further recommended that the custodial agreements contain the most recent safeguards set forth by the NAIC.**

RESPONSE: See above comment on same recommendation.

**(p. 61) It is recommended that the Company record the trade date as the date acquired for all of its investments. It is further recommended that the Company be more diligent in recording the investment transactions in its investment records and general ledger.**

RESPONSE: The Company will ensure that the trade date is used to record all transactions in the future. Management agrees that all investment transactions should be recorded properly and practices the same. There were no financial statement or tax effects that occurred from any transactions that may have been recorded based on the settlement date. Any discrepancies noted were very small amounts related to broker fees that were recorded to another general ledger account by the investment accounting system. The software that is used by the Company for recording investment transactions expensed these miscellaneous fees instead of carrying them in the purchase cost of the investment. We have researched this issue with the software vendor and have determined that we can change the setup for the software to include these fees in the carrying costs of the investment and implemented this change immediately. Again, the total costs of the transactions were captured in a more conservative manner since the miscellaneous fees were expensed at acquisition, but there is no financial statement effect over time since the carrying costs offset the proceeds at the time of the sale. Most of these fees were small transaction fees and total amounts were very immaterial to the investment transactions and gains/losses.

**(p. 63) It is recommended that the Company properly classify any specifically identified past due balances in the *non-admitted* column of future Annual Statements.**

RESPONSE: BCI will comply with this recommendation with future statutory filings and will report all past due balances as non-admitted assets.

**(p. 63) It is recommended that the Company disclose departures from the NAIC *Accounting Practices and Procedures* manual that affect net income, statutory surplus or risk-based capital in future financial statements.**

RESPONSE: BCI will comply with this recommendation for future filings and will disclose the reporting differences between Idaho Code and the NAIC.

**(p. 64) It is recommended that the Company use a ratio of paid claims adjustment expenses to paid hospital and medical expenses that is consistent with Company experience.**

RESPONSE: The Company looks at this ratio when determining its unpaid claims adjustment expense liability. The Company's paid claims adjustment expenses includes many fixed and allocated expenses that are not included in the unpaid claims adjustment expenses (UCAE) liability estimate. The UCAE estimate falls into a normal range for industry standards of about 2% of unpaid claims which the Company believes is an appropriate level. The Company performs an

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analysis of all variable claims adjustment expenses (CAEs). The total of these variable CAEs for 2005 was less than 2.1% and supports the Company's experience and practice.

**(p. 64) It is recommended that the Company's calculation of Unpaid Claims Adjustment Expenses liability take into account all relevant CAE expenses.**

RESPONSE: The Company's calculation of Unpaid Claims Adjustment Expenses (UCAE) liability does take into account all relevant CAE expenses within materiality guidelines for the computations. The Company's unpaid claims adjustment expense falls into a normal range for industry standards in this area of about 2% of unpaid claims which the Company believes is an appropriate level. The Company does not include all fixed and allocated expenses in their computation of CAE expenses since many of these would not continue to occur to pay runout of claims if operations were to cease. The Company follows the guidelines for which departments and expenses to include in the UCAE computations. This computation includes most direct expenses such as claims payments but excludes other areas such as customer service expenses.

If you have any questions or concerns regarding our responses, please contact David Slonaker at 331-7456 or Carol Mulder at 331-7464.

Sincerely,



Jack Myers  
Sr Vice President & CFO