

**STATE OF WASHINGTON  
OFFICE OF THE INSURANCE COMMISSIONER**

*In the Matter of*

**REGENCE BLUESHIELD,**

Registered Health Care  
Service Contractor.

Order No. 25-0069

WAOIC No. 710

NAIC 53902

CONSENT ORDER LEVYING A FINE

This Consent Order Levying a Fine (“Order”) is entered into by the Insurance Commissioner of the state of Washington (“Insurance Commissioner” or “OIC”), acting pursuant to the authority set forth in RCW 48.02.060, RCW 48.44.160 and RCW 48.44.166, and Regence Blueshield. This Order is a public record and will be disseminated pursuant to Title 48 RCW and the Insurance Commissioner’s policies and procedures.

**BASIS:**

1. Regence Blueshield (the “Company”) is a Health Care Service Contractor registered in Washington since September 5, 1947. The Company is domiciled in Washington.

2. In 2018, the Center for Medicare and Medicaid Services awarded the OIC a grant to determine whether Washington State’s fully-insured health insurance markets offered comprehensive and affordable access to mental health (“MH”) and substance use disorder (“SUD”) services and treatment. This included comparative analyses of Non-Quantitative Treatment Limitations (“NQLTs”) as applied to MH/SUD benefits and medical/surgical (“M/S”) benefits. The grant-funded project resulted in the OIC sending two Market Scans to the Company, dated March 1, 2019, and January 10, 2020.

3. The second Market Scan required the Company to analyze three (3) health products: the individual market health product located in Washington state with the highest enrollment, the fully-insured small group market health product located in Washington state with the highest enrollment, and the fully-insured large group market health product that is a PPO located in Washington state with the highest enrollment. For these three (3) products, the second

Market Scan required the Company to use defined templates provided by the OIC's vendor, INS, to analyze its utilization management and provider admission standards NQTLs. The second Market Scan also required the Company to provide data measuring Out of Network ("OON") utilization for inpatient services, denial rates for inpatient services, denial rates for continued inpatient stays, denial rates for outpatient services, reimbursement rates for MH/SUD providers relative to its M/S providers, and number of claims submitted by in-network providers. If any of these data sets showed disparities between MH/SUD and M/S benefits, the OIC requested the Company to state if it would conduct a closer audit or take any actions to address the disparities. The Company responded to the Market Scan.

4. The OIC initiated a Continuum action with the Company on October 5, 2022, requesting comparative analyses and for the Company to provide additional information regarding the Company's reimbursement rates with supporting documentation pursuant to 42 U.S.C. § 300gg-26(a)(8); provider directory information; Network adequacy standards for appointment wait times and additional information to supplement the Company's response to the second Market Scan.

5. After receiving the Company's response to the information request, the OIC submitted initial findings to the Company on April 26, 2023. The OIC determined that the Company's comparative analysis submissions were insufficient to demonstrate compliance with 42 USC § 300gg-26(a)(8)(A) in the design and application of provider reimbursement rates and network adequacy.

6. On May 19, 2023, and June 14, 2023, the Company provided additional information in response to the OIC's initial findings. Thereafter, the OIC issued its final findings on September 11, 2023.

7. The OIC has determined that the Company's comparative analysis submissions were insufficient to demonstrate compliance with 42 USC § 300gg-26(a)(8)(A) for the following reasons:

- a. The OIC determined that the Company's documentation pursuant to 42 USC § 300gg-26(a)(8)(A) of its comparative analysis for its 2021 provider admissions standards NQTL was insufficient. The Company described some factors and definitions regarding 'what' the Company considers when setting standardized rates, which providers the Company negotiates with, and how the Company settles

on rates during negotiation. However, the OIC determined that the Company failed to provide sufficient information about strategies, processes, and evidentiary standards to explain ‘why’ it utilizes those considerations and ‘how’ those considerations impact provider reimbursement decisions.

- b. Where outcomes data demonstrated disparate results in measuring provider reimbursements against Medicare standards and in the number of providers on standard fee schedules, the OIC concluded that the explanations and additional information provided by the Company was insufficient.
- c. The OIC determined the Company’s documentation pursuant to 42 USC § 300gg-26(a)(8)(A) of its comparative analysis for its network adequacy NQTL was insufficient.
- d. Where outcomes data demonstrated disparate results in measuring wait times, out-of-network utilization, and provider participation, the OIC found that the Company failed to provide further review of the network adequacy NQTL sufficient to determine whether the Company was in parity compliance. The OIC determined that the Company’s explanations were insufficient to determine whether the Company was in compliance with 42 USC § 300gg-26(a)(8)(A).

8. The OIC has determined that, where the Company has provided data and documentation, the Company has applied factors, strategies, processes or evidentiary standards it utilizes to determine NQTLs in a more stringent manner for MH/SUD benefits. Specifically, the Company’s factor for network adequacy of wait times measures and considers high-impact and high-volume M/S practitioners separately from other M/S practitioners but does not measure high-impact and high-volume MH/SUD practitioners separately. In addition, the Company measures wait times goals for MH/SUD urgent care referrals on a 48-hour basis and M/S urgent care appointments on a 24-hour basis, a facial disparity that would result in a more easily met metric for urgent MH/SUD referrals.

9. On September 19, 2025, in regard to the Company’s comparative analysis, the Company provided the OIC with additional documentation. This documentation included a formalized and updated Network Composition Standards analysis. The Company’s Network Composition Standards analysis provided additional details regarding the factors that apply to the Network Adequacy NQTL. Among other details, the Company’s additional documents detailed

internal metrics and criteria for geographic access data. The documentation also explained how the Company collects its Network Availability data, provided additional detail for definitions related to high-impact, high-volume, and behavioral health specialists, and provided policies and procedures related to how network gaps are filled.

10. 42 U.S.C. § 300gg-26(a)(8)(A) states, “in the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits and that imposes nonquantitative treatment limitations (referred to in this section as "NQTLs") on mental health or substance use disorder benefits, such plan or issuer shall perform and document comparative analyses of the design and application of NQTLs and, beginning 45 days after December 27, 2020, make available to the applicable State authority (or, as applicable, to the Secretary of Labor or the Secretary of Health and Human Services), upon request, the comparative analyses and the following information:

- (i) The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification.
- (ii) The factors used to determine that the NQTLs will apply to mental health or substance use disorder benefits and medical or surgical benefits.
- (iii) The evidentiary standards used for the factors identified in clause (ii), when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to mental health or substance use disorder benefits and medical or surgical benefits.
- (iv) The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.
- (v) The specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results

of the analyses described in this subparagraph that indicate that the plan or coverage is or is not in compliance with this section.”

11. 45 C.F.R. § 146.136(4)(i), as it was in effect on November 24, 2020, states that a group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

12. WAC 284-43-0140 states health carriers shall comply with all Washington state and federal laws relating to the acts and practices of carriers and laws relating to health plan benefits.

13. RCW 48.44.160(1) allows the Insurance Commissioner to revoke, suspend, or refuse to accept or renew registration from any health care service contractor, or may issue a cease and desist order, or bring an action in any court of competent jurisdiction to enjoin a health care service contractor from doing further business in this state, if such health care service contractor fails to comply with any provision of chapter 48.44 RCW or any proper order or regulation of the Insurance Commissioner.

14. RCW 48.44.166 states that after hearing or upon stipulation by the registrant and in addition to or in lieu of the suspension, revocation, or refusal to renew any registration of a health care service contractor, the Insurance Commissioner may levy a fine against the party involved for each offense in an amount not less than fifty dollars and not more than ten thousand dollars.

15. By providing insufficient comparative analyses demonstrating the design and application of its provider admission and network adequacy standards and applying factors, strategies, processes or evidentiary standards it utilizes to determine NQTLs in a more stringent manner for MH/SUD benefits, the Company has not demonstrated its compliance with state and federal mental health parity laws, and therefore, the Insurance Commissioner finds that the Company violated 42 U.S.C. § 300gg-26(a)(8)(A), 45 C.F.R. § 146.136(4)(i) (as of November 24, 2020), and WAC 284-43-0140, justifying the imposition of a fine under RCW 48.44.166.

**CONSENT TO ORDER:**

The Insurance Commissioner of the state of Washington and the Company agree the best interest of the public will be served by entering into this Order. NOW, THEREFORE, the Company consents to the following in consideration of its desire to resolve this matter without further administrative or judicial proceedings. The Insurance Commissioner consents to settle this matter in consideration of the Company's payment of a fine, and upon such terms and conditions as are set forth below:

1. The Company acknowledges its duty to comply fully with the applicable laws of the state of Washington.

2. The Company consents to the entry of this Order, waives any and all hearing or other procedural rights, and further administrative or judicial challenges to this Order.

3. In order to consent to the entry of this Order, the Company must sign and return this Order in a manner acceptable to the Insurance Commissioner by **November 28, 2025**, unless the Insurance Commissioner grants a new deadline in writing. If the Company does not consent to the entry of this Order, the Insurance Commissioner is not bound by the penalty amount in this Order and may impose any penalty within the Insurance Commissioner's statutory authority, which may include a higher fine and/or different penalties.

4. By agreement of the parties, the Insurance Commissioner will impose a fine of Five-Hundred and Fifty Thousand Dollars (\$550,000), to be paid within thirty (30) days of the execution of this Order.

5. The Company's failure to timely pay the fine within 30 days of the execution of this Order may result in revocation of the Company's registration and may also result in recovery of the fine through a civil action brought on behalf of the Insurance Commissioner by the Attorney General of the state of Washington.


6. The Company understands and agrees that any further failure to comply with the statutes and/or regulations that are the subject of this Order constitutes grounds for further penalties, which may be imposed in direct response to further violations.

7. This Order and the violations set forth herein constitute admissible evidence that may be considered in any future action by the Insurance Commissioner involving the Company. However, the facts of this Order, and any provision, finding, or conclusion contained herein does

not, and is not intended to, determine any factual or legal issue, or have any preclusive or collateral estoppel effects in any lawsuit by any party other than the Insurance Commissioner.

EXECUTED this \_\_\_\_\_ day of 11/21/2025 \_\_\_\_\_ 2025.

REGENCE BLUESHIELD

By:  Signed by: Michael Cole  
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Printed Name: Michael Cole

Printed Corporate Title: President

**AGREED ORDER:**

Pursuant to the foregoing factual Basis and Consent to Order, the Insurance Commissioner of the state of Washington hereby Orders as follows:

1. The Company shall pay a fine in the amount of Five-Hundred and Fifty Thousand Dollars (\$550,000), to be paid within thirty (30) days of the execution of this Order.

2. The Company's failure to timely pay the fine within 30 days of the execution of this Order may result in revocation of the Company's registration and may also result in recovery of the fine through a civil action brought on behalf of the Insurance Commissioner by the Attorney General of the state of Washington.

3. This Order and the violations set forth herein constitute admissible evidence that may be considered in any future action by the Insurance Commissioner involving the Company. However, the facts of this Order, and any provision, finding, or conclusion contained herein does not, and is not intended to, determine any factual or legal issue, or have any preclusive or collateral estoppel effects in any lawsuit by any party other than the Insurance Commissioner.

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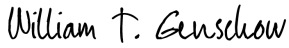
ENTERED at Tumwater, Washington, this \_\_\_\_\_ day of 11/21/2025 2025.



PATTY KUDERER  
Insurance Commissioner

By and through their designee

Signed by:



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WILL GENSCHOW  
Behavioral Health Insurance Attorney  
Legal Affairs Division