STATE OF OREGON
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
DIVISION OF FINANCIAL REGULATION

In the Matter of:	Case No. INS-16-0355
LIFEWISE HEALTH PLAN OF OREGON, Respondent.	ORDER TO CEASE AND DESIST, FINAL ORDER IMPOSING CIVIL PENALTY AND CONSENT TO ENTRY OF ORDER

The Director of the Department of Consumer and Business Services for the State of Oregon ("Director"), acting in accordance with Oregon Revised Statutes ("ORS") chapters 731, 732, 733, 734, 735, 737, 742, 743, 743A, 743B, 744, 746, 748 and 750 ("Insurance Code"), has conducted an investigation into the insurance related activities of LifeWise Health Plan of Oregon ("Respondent").

Respondent wishes to resolve and settle this matter with the Director.

Now, therefore, as evidenced by the signature(s) subscribed on this Order, Respondent hereby CONSENTS to entry of this Order.

FINDINGS OF FACT

The Director FINDS that:

1. Respondent is licensed in the State of Oregon as a domestic insurer, has been so licensed since December 24, 1986, and provided health insurance coverage in Oregon. Respondent's NAIC entity number is 84930. Respondent's principal place of business was 2020 SW 4th Street, Suite 1000, Portland, OR 97201.

2. On April 21, 2016, Respondent voluntarily agreed to withdraw from the Oregon healthcare insurer market effective December 31, 2016. As of the date of this Order, Respondent's Certificate of Authority remains effective.

3. Between August 2015 and June 2016, the Oregon Division of Financial

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Regulation, formerly the Oregon Insurance Division, ("Division") received 26 consumer complaints concerning Respondent. For illustrative purposes, the Division sets forth the details for 10 of the 26 consumer complaints to demonstrate Respondent's failure to timely process Change in Circumstance ("CIC") documentation that were received from the Federal Healthcare Exchange (the "Exchange").

A. Division case number 57228 involving Oregon consumer hereinafter referred to as "EG."

i. On February 10, 2015, Respondent received an enrollment file from the Exchange for EG. Respondent enrolled EG in LifeWise Standard Silver Exclusive Provider 2500 CSR3 policy effective March 1, 2015. The policy had a $100 deductible and a monthly premium of $222.00 with an Advanced Premium Tax Credit ("APTC") of $166.00. EG's total premium responsibility was $56.00 per month.

ii. On June 5, 2015, Respondent received CIC notification from the Exchange that EG no longer qualified for the monthly APTC.

iii. EG incurred a $13,279.00 claim after being hospitalized in October 2015.

iv. On November 11, 2015, Respondent processed the change to EG's policy (159 days after receiving the CIC documentation), resulting in a $2,500.00 deductible and monthly premium of $222.00 with no APTC. EG's total premium responsibility was $222.00 per month.

v. EG continued to receive monthly statements for $56.00 and was not made aware of the changes to her policy until Respondent sent EG a bill for approximately $1,300.00 in December 2015 in order to bring EG current on her deductible and monthly premiums. EG told Respondent she would appeal the Exchange's reduction of her tax credit. EG was not able to pay the outstanding balance owed, so her health insurance policy was cancelled retroactive to July 31, 2015. Respondent called EG twice to inquire about the status of her appeal, but was unable to reach her on the phone.

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vi. Because Respondent had cancelled EG's policy retroactive to July 31, 2015, the $13,279.00 hospital claim became EG's financial responsibility.

vii. On January 11, 2016, EG submitted a consumer complaint to the Division.

B. Division case number 56074 involving Oregon consumer hereinafter referred to as "DH."

i. On or before January 1, 2015, Respondent received an enrollment file from the Exchange for DH. Respondent enrolled DH in LifeWise Standard Silver Exclusive Provider 2500 CSR3 policy effective January 1, 2015. The policy had a monthly premium of $638.00 with an APTC of $581.00. DH's total premium responsibility was $57.00 per month.

ii. On March 24, 2015, Respondent received CIC notification from the Exchange that DH no longer qualified for the monthly APTC.

iii. DH incurred a medical claim of $596.90 on or after June 1, 2015.

iv. On November 6, 2015, Respondent processed the change to DH's policy (227 days after receiving the CIC documentation), resulting in a monthly premium of $638.00 with no APTC. DH's total premium responsibility was $638.00 per month.

v. DH continued to receive monthly statements for $57.00 and was not made aware of the changes to her policy until Respondent sent DH a bill for approximately $5,172.00 in December 2015 to bring DH current on her monthly premiums. DH chose to cancel her policy, and Respondent received a cancellation notice from the Exchange on December 3, 2015, which it processed on December 9, 2015. DH contested the amount due on the December bill, and Respondent provided DH with a form to appeal the CIC processed by the Exchange. Respondent offered DH a payment plan on January 1, 2016, but DH was not able to pay the outstanding balance owed, so her health insurance policy was cancelled retroactive to May 31, 2015.

vi. Because Respondent had cancelled DH's policy retroactive to May 31, 2015,

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the $569.00 medical claim became DH's financial responsibility.

vii. On February 26, 2016, DH submitted a consumer complaint to the Division.

C. Division case number 56224 involving Oregon consumer hereinafter referred to as "PS."

i. On or before January 1, 2015, Respondent received an enrollment file from the Exchange for PS. Respondent enrolled PS in LifeWise Exclusive Provider Bronze 6350 policy effective January 1, 2015. The policy had a monthly premium of $396.00 with an APTC of $317.00. PS's total premium responsibility was $79.00 per month.

ii. On March 14, 2015, Respondent received CIC notification from the Exchange that PS no longer qualified for the monthly APTC.

iii. PS incurred a medical claim of $142.33 on or after May 1, 2015.

iv. On November 5, 2015, Respondent processed the change to PS's policy (236 days after receiving the CIC documentation), resulting in a monthly premium of $396.00 with no APTC. PS's total premium responsibility was $396.00 per month.

v. PS continued to receive monthly statements for $79.00 and was not made aware of the changes to her policy until Respondent sent PS a bill for approximately $3,090.00 in December 2015 to bring her premium payments current. PS told Respondent that she had documentation showing her entitlement to the APTC. Respondent encouraged PS to communicate with the Exchange, provided PS with contact information for the Exchange, and provided PS with a direct phone number to Respondent's Customer Service Representative in case PS needed further help. PS contacted Respondent to advise that the Exchange required her to file an appeal. Respondent attempted to contact the Exchange multiple times on PS's behalf. Respondent also offered PS a payment plan on January 27, 2016, but PS was not able to pay the outstanding balance owed, so her health insurance policy was cancelled retroactive to April 30, 2015.

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vi. Because Respondent had cancelled PS's policy retroactive to April 30, 2015, the $142.33 hospital claim became PS's financial responsibility.

vii. On January 6, 2016, PS submitted a consumer complaint to the Division.

D. Division case number 56151 involving Oregon consumer hereinafter referred to as "MM."

i. On December 1, 2014, Respondent received an enrollment file from the Exchange for MM. Respondent enrolled MM in LifeWise Standard Silver Exclusive Provider 2500 policy effective January 1, 2015. The policy had a monthly premium of $1,081.00 with an APTC of $991.00. MM's total premium responsibility was $90.00 per month.

ii. On March 17, 2015, Respondent received a term notification from the Exchange that, effective April 1, 2015, the policy covering MM and her spouse would terminate. On March 25, 2017, Respondent received an enrollment notification for MM from the Exchange with a monthly premium that would be $525.00 with an APTC of $204.00 and total premium responsibility of $321.00 per month.

iii. On November 13, 2015, Respondent processed the termination and enrollment notifications (233 days after receiving the CIC documentation), reflecting the monthly premium of $525.00 with an APTC of $204.00 and total premium responsibility of $321.00 per month.

iv. MM continued to receive monthly statements for $90.00 until December 2015. In that month, Respondent processed the notification from the Exchange, and provided MM with a retroactive effective date of April 1, 2015 under her new policy. Respondent also sent a bill for approximately $1,848.00 in or around December 2015 to bring her premium payments current. MM was not able to pay the outstanding balance owed, so her health insurance policy was cancelled retroactive to July 1, 2015.

v. The amount of claims that became MM's financial responsibility due to the

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retroactive cancelation was not provided to the Division.

vi. On December 30, 2015, MM submitted a consumer complaint to the Division.

E. Division case number 57539 involving Oregon consumer hereinafter referred to as "VS."

i. On or before January 1, 2015, Respondent received an enrollment file from the Exchange for VS. Respondent enrolled VS in LifeWise Essential Gold 1000 policy effective January 1, 2015. The policy had a monthly premium of $620.00 with an APTC of $223.00. VS's total premium responsibility was $397.00 per month.

ii. In or around April 2015, Respondent received CIC notification from the Exchange that VS no longer qualified for the APTC.

iii. VS incurred $8,524.86 in medical claims between September 2, 2015 and December 15, 2015.

iv. In or around October 2015, Respondent processed the change to VS's policy (between 154 and 213 days after receiving the CIC documentation), resulting in a total premium responsibility of $620.00 per month.

v. VS continued to receive monthly statements for $397.00 and was not made aware of the changes to her policy until Respondent notified VS that she owed an outstanding balance of $1,561.00 to bring her premium payments current. Respondent advised VS to call the Exchange to appeal the reduction in her tax credit. VS was not able to pay the outstanding balance owed, so her health insurance policy was cancelled retroactive to September 1, 2015. On April 19, 2016, Respondent and VS called the Exchange to inquire about VS's subsidy. A representative of the Exchange indicated that VS has failed to create a username and password with the Exchange and so did not receive a notice of her lost subsidy. Respondent emailed VS a form on which to appeal the Exchange's removal of her subsidy. Respondent also offered VS a payment plan, and instructed that her policy would remain terminated unless she accepted the payment plan

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or made payment in full. VS declined to do so.

vi. Because Respondent had cancelled VS's policy retroactive to September 30, 2015, the $8,524.86 medical claims became VS's financial responsibility. Respondent offered to contact VS's medical providers in order to explain that she was appealing her eligibility for a subsidy with the Exchange and to ask the providers to refrain from immediate efforts to collect amounts due.

vii. On January 28, 2016, VS submitted a consumer complaint to the Division.

F. Division case number 57756 involving Oregon consumer hereinafter referred to as "CJ."

i. In December 2014, Respondent received an enrollment file from the Exchange for CJ. Respondent enrolled CJ in LifeWise Exclusive Provider Bronze 6350 policy effective January 1, 2015. The policy had a monthly premium of $370.00 with an APTC of $207.00. CJ's total premium responsibility was $163.00 per month.

ii. On April 7, 2015, Respondent received CIC notification from the Exchange that CJ no longer qualified for the APTC.

iii. On November 10, 2015, Respondent processed the change to CJ's policy (217 days after receiving the CIC documentation), resulting in a total premium responsibility of $370.00 per month.

iv. CJ continued to receive monthly statements for $163.00 and was not made aware of the changes to her policy until Respondent notified CJ in or around December 2015 that she owed an additional $1,656.00 to bring her premium payments current. CJ was not able to pay the outstanding balance owed, so her health insurance policy was cancelled retroactive to July 31, 2015.

v. The amount of claims that became CJ's financial responsibility due to the retroactive cancelation was not provided to the Division because CJ's policy was reinstated.

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vi. On April 6, 2016, CJ submitted a consumer complaint to the Division. On April 26, 2016, Respondent offered CJ a payment for $276 per month for six months, and CJ accepted the payment plan. On November 18, 2016, Respondent reinstated CJ's policy for the 2015 plan year.

G. Division case number 58085 involving Oregon consumer hereinafter referred to as "GE."

i. On February 15, 2015, Respondent received an enrollment file from the Exchange for GE. Respondent enrolled GE in LifeWise Exclusive Provider Bronze 5250 policy effective March 1, 2015. The policy had a monthly premium of $558.00 with an APTC of $374.00. GE's total premium responsibility was $184.00 per month.

ii. On May 5, 2015, Respondent received CIC notification from the Exchange that, effective June 1, 2015, GE's monthly premium would be $645.00 with an APTC of $152.00 and total premium responsibility of $493.00 per month.

iii. GE incurred $915.93 in medical claims in October 2015.

iv. On November 10, 2015, Respondent processed the change to GE's policy (189 days after receiving the CIC documentation), reflecting the total premium responsibility of $493.00 per month.

v. GE continued to receive monthly statements for $184.00 and was not made aware of the changes to her policy until Respondent notified GE in or around December 2015 that she owed an additional $2,163.00 to bring her premium payments current. GE was not able to pay the outstanding balance owed, so her health insurance policy was cancelled retroactive to September 1, 2015.

vi. Because Respondent had cancelled GE's policy retroactive to September 1, 2015, the $915.93 in medical claims became GE's financial responsibility. However, the policy was later reinstated for the 2015 plan year so that the medical claims were no longer GE's financial responsibility.

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vii. On April 6, 2016, GE submitted a consumer complaint to the Division. On May 20, 2016, Respondent reinstated GE's policy through the 2015 plan year.

H. Division case number 58072 involving Oregon consumer hereinafter referred to as "WD."

i. On February 3, 2015, Respondent received an enrollment file from the Exchange for WD. Respondent enrolled WD in LifeWise Standard Silver Exclusive Provider 2500 CSR2 policy effective March 1, 2015. The policy had a monthly premium of $483.00 with an APTC of $370.00. WD's total premium responsibility was $113.00 per month.

ii. On April 15, 2015 Respondent received CIC notification from the Exchange that WD no longer qualified for the APTC.

iii. On October 16, 2015, Respondent processed the change to WD's policy (184 days after receiving the CIC documentation), resulting in a total premium responsibility of $483.00 per month.

iv. WD continued to receive monthly statements for $113.00 and was not made aware of the changes to his policy until Respondent notified WD in or around November 2015 that he owed an additional $3,073.00 to bring his premium payments current. WD was not able to pay the outstanding balance owed, so his health insurance policy was cancelled retroactive to May 31, 2015.

v. The amount of claims that became WD's financial responsibility due to the retroactive cancelation was not provided to the Division.

vi. On April 20, 2016, WD submitted a consumer complaint to the Division.

I. Division case number 58514 involving Oregon consumer hereinafter referred to as "JL."

i. On December 16, 2014, Respondent received an enrollment file from the Exchange for JL. Respondent enrolled JL in LifeWise Exclusive Provider Silver 3000

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policy effective January 1, 2015. The policy had a monthly premium of $1,004.00 with an APTC of $645.00. JL's total premium responsibility was $359.00 per month.

ii. On April 15, 2015 Respondent received CIC notification from the Exchange that, effective May 1, 2015, JL's monthly premium would be $1,004.00 with no APTC and total premium responsibility of $1,004.00 per month.

iii. On July 29, 2015 Respondent received CIC notification from the Exchange that, effective September 1, 2015, JL's monthly premium would be $1,004.00 with an APTC of $725 and total premium responsibility of $279.00 per month.

iv. On September 29, 2015, Respondent processed the change to JL's policy (167 and 105 days respectively after receiving the CIC documentation), reflecting the above changes.

v. JL continued to receive monthly statements for $359 and was not made aware of the changes to his policy until Respondent notified JL in or around December 2015 that he owed an additional $2,260.00 to bring his premium payments current. JL was not able to pay the outstanding balance owed, so his health insurance policy was cancelled retroactive to June 30, 2015.

vi. The amount of claims that became JL's financial responsibility due to the retroactive cancelation was not provided to the Division.

vii. On April 4, 2016, JL submitted a consumer complaint to the Division.

viii. On July 19, 2016, Respondent reinstated JL's 2015 policy for the 2015 plan year following JL's payment of the outstanding balance owed.

J. Division case number 58513 involving Oregon consumer hereinafter referred to as "FA."

i. In or around February 2015, Respondent received an enrollment file from the Exchange for FA. Respondent enrolled FA in LifeWise Oregon Standard Silver Plan 2500 policy effective March 1, 2015. The policy had a monthly premium of $239.00

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with an APTC of $179.00. FA's total premium responsibility was $60.00 per month.

ii. On June 11, 2015 Respondent received CIC notification from the Exchange that, effective July 1, 2015, FA no longer qualified for the APTC.

iii. FA incurred $1,163.66 in medical claims between August 1, 2015 and December 31, 2015.

iv. On November 12, 2015, Respondent processed the change to FA's policy (154 days after receiving the CIC documentation), resulting in a total premium responsibility of $239.00 per month.

v. FA continued to receive monthly statements for $60.00 and was not made aware of the changes to her policy until Respondent notified FA in or around December 2015 that she owed an additional $1,074.00 to bring her premium payments current. Respondent encouraged FA to appeal the loss of her credit with the Exchange. Respondent offered FA a payment plan. FA was not able to pay the outstanding balance owed, so her health insurance policy was cancelled retroactive to August 1, 2015.

vi. Because Respondent had cancelled FA's policy retroactive to August 1, 2015, the $1,163.66 medical claims became FA's financial responsibility.

vii. On February 16, 2016, FA submitted a consumer complaint to the Division.

4. On February 23, 2016, the Division sent a letter to Respondent requesting an Excel spreadsheet containing all instances where Respondent took longer than 30 days to process a CIC.

5. On or around March 22, 2016, in a timely response to the Division's February 23, 2016 letter, Respondent provided a spreadsheet that included all instances where Respondent took longer than 30 days to process a CIC. The spreadsheet included the following:

A. A total of 1,565 members whose CIC were processed longer than 30 days after the receipt of the CIC documentation.

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B. A total of 769 members whose coverage was terminated because of nonpayment of premium.

C. A total of $2,050,169.48 in claims that were incurred by the 769 members whose coverage was terminated because of nonpayment of premium.

6. On June 3, 2016, Respondent explained in an email, "Given the several inconsistencies we have discovered on the spreadsheet, I have asked my team to start from scratch. I spoke with the manager of our Membership and Billing Department this morning, and she is targeting 6/15 for the updated spreadsheet."

7. On or around June 15, 2016, Respondent provided a revised spreadsheet that included all instances where Respondent took longer than 30 days to process a CIC.

A. A total of 3,625 members whose CIC were processed longer than 30 days after the receipt of the CIC documentation.

B. No details about the number of members whose coverage was terminated because of nonpayment of premium.

C. No information about the amount of claims that were incurred by the members whose coverage was terminated because of nonpayment of premium.

8. After reviewing and comparing the data Respondent provided on March 22, 2016 and June 15, 2016, the Division sent a letter on July 8, 2016 to Respondent requesting the following:

A. Provide an aggregate number of CIC documentation that Respondent received from the Exchange that were not processed within 30 days from the date of receipt.

B. Provide an aggregate number of members that were not able to continue their insurance coverage with Respondent after Respondent processed the CIC documentation.

C. For the members that were unable to continue their insurance coverage, provide the aggregate dollar amount of the claims that were incurred by members

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without insurance coverage.

9. On August 5, 2016, Respondent responded to the Division's July 8, 2016 letter and provided the following:

A. Respondent received CIC documentation for 7,280 members from the Exchange that were not processed within 30 days from the date of receipt.

B. Of the 7,280 members that Respondent received CIC documentation that were not processed within 30 days, 2,899 members did not continue their insurance coverage with Respondent following submission of a CIC.

C. For the 2,899 members that did not continue coverage with Respondent following submission of a CIC, the aggregate amount of claims incurred with no coverage in effect was $4,332,906.20.

10. Eleven months later, on July 12, 2017, the Division sent an email to Respondent requesting additional information and further clarification regarding the data described in Paragraph 9A through Paragraph 9C.

11. On September 5, 2017, Respondent sent a letter to the Division that provided the following:

A. The 2,899 member total from Paragraph 9B included members who terminated coverage for reasons other than the delayed CIC processing. Further, in calculating the $4,332,906.20 aggregate claims from Paragraph 9C, Respondent did not deduct member cost shares and claim payments that were not recovered by Respondent.

B. Of the 2,899 members who did not continue their insurance coverage with Respondent, the number of members who discontinued their coverage as a result of Respondent processing the CIC greater than 30 days was not more than 1,629.

C. Of the not more than 1,629 members who discontinued their coverage as a result of Respondent processing the CIC greater than 30 days, the aggregate amount of claims incurred with no coverage in effect was $2,102,412.

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D. Of the not more than 1,629 members who discontinued their coverage as a result of Respondent processing the CIC greater than 30 days, 1,025 of the members did not incur any member liability for claims, leaving 604 members that suffered the aggregate $2,102,412 claims liability.

E. Of the 26 members who filed complaints with the Division, Respondent proposed to reimburse the members or their providers, as appropriate, for the amounts of any post-termination claims recovered from the members.

12. On September 28, 2017, Respondent met with the Division to discuss the failure to process CIC documentation and the resultant consumer harm. At the end of the meeting, the Division requested that Respondent provide a final, correct and accurate list of members whose coverage was retroactively terminated as a result of the delay in processing CIC.

13. On October 27, 2017, Respondent sent a letter and spreadsheet to the Division that provided further refined analysis, as follows:

A. The number of members terminated as a result of having their subsidy decrease (which results in higher premium) processed greater than 30 days after the CIC was not more than 1,071.

B. Of the 1,071 members terminated because of the delay in CIC processing, 443 of the members were retroactively terminated and had outstanding claims.

C. The aggregate amount of the claims recovered by Respondent was not more than $1,399,760.

14. On November 6, 2017, the Division compared the three spreadsheets provided by Respondent on March 22, 2016, June 15, 2016 and October 27, 2017. The comparison revealed the following:

A. Fifty-nine members were on the October 27, 2017 spreadsheet that were not on the two previous spreadsheets.

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B. Of the 384 members that were on all three spreadsheets, none of the claim amounts from the October 27, 2017 spreadsheet match any of claim amounts from the prior spreadsheets. In aggregate for the 384 members that were included on all three spreadsheets, the incurred claim amount is 51% lower on the October 27, 2017 spreadsheet than the previous two spreadsheets.

C. The amount of premiums owed at termination by the 384 members is 70% higher on the October 27, 2017 spreadsheet than the amount of premiums owed by the same terminated members on the previous two spreadsheets. Only seven of the 384 premium amounts from the October 27, 2017 spreadsheet match the premium amounts from the previous two spreadsheets.

15. While over the course of the nearly two-year dialogue with the Division, Respondent provided specific member and aggregate claim information that was inconsistent and at times inaccurate, the Division does not find that any of the misinformation presented to the Division was an intentional effort to mislead the Division.

CONCLUSIONS OF LAW

The Director CONCLUDES that:

16. Pursuant to ORS 731.252(1), whenever the Director has reason to believe that any person has been engaged or is engaging or is about to engage in any violation of the Insurance Code, the Director may issue an order to discontinue or desist from such violation or threatened violation.

17. Pursuant to ORS 731.296, the Director may address any proper inquiries to any insurer in relation to its activities or condition or any other matter connected with its transactions. Any such person so addressed shall promptly and truthfully reply to such inquiries using the form of communication requested by the Director.

18. Respondent provided untruthful replies to the Director as follows:

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A. Members were omitted from the March 22, 2016 and June 15, 2016 spreadsheets as described in Paragraph 14A for two violations of ORS 731.296.

B. Incorrect claim amounts were included in the March 22, 2016 and June 15, 2016 spreadsheets as described in Paragraph 14B for two violations of ORS 731.296.

C. Incorrect amounts of premium owed were included in the March 22, 2016 and June 15, 2016 spreadsheets as described in Paragraph 14C for two violations of ORS 731.296.

19. Pursuant to ORS 746.240, no person shall engage in this state in any trade practice that, although not expressly defined and prohibited in the Insurance Code, is found by the Director to be an unfair or deceptive act or practice in the transaction of insurance that is injurious to the insurance-buying public.

20. Respondent violated ORS 746.240 on 7,280 occasions by failing to timely process CIC documentation received from the Federal Marketplace.

21. Pursuant to ORS 731.988(1), the Director may assess CIVIL PENALTIES in an amount not to exceed $10,000 per violation against a person who violates any provision of the Insurance Code or any lawful rule of the Director.

ORDERS

The Director issues the following ORDERS:

22. As authorized by ORS 731.252(1), the Director ORDERS Respondents to CEASE AND DESIST from violating any provision of the Insurance Code or the administrative rules promulgated thereunder.

23. Based upon the foregoing and as authorized by ORS 731.988(1), the Director ORDERS that Respondent pay a CIVIL PENALTY of $10,000 per occurrence for six violations of ORS 731.296 identified in Paragraph 18A through Paragraph 18C for a total CIVIL PENALTY of $60,000.

24. Based upon the foregoing and as authorized by ORS 731.988(1), the Director

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ORDERS that Respondent pay a CIVIL PENALTY of $100 per occurrence for 7,280 violations of ORS 746.240 identified in Paragraph 20 for a total CIVIL PENALTY of $728,000.

25. The $788,000 CIVIL PENALTY assessed above is due and payable at the time this Consent Order is returned to the Division.

SO ORDERED this 5th day of February, 2018.

CAMERON C. SMITH, Acting Director
Department of Consumer and Business Services

/s/ David Tatman
David C. Tatman, Chief of Enforcement
Division of Financial Regulation

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CONSENT TO ENTRY OF ORDER

I, James Havens, state that I am an officer of LifeWise Health Plan of ~~Oregon~~ Washington and I am authorized to act on its behalf. I have read the foregoing Consent Order, and I know and fully understand the contents hereof. I have been advised of the right to a hearing and of the right to be represented by counsel in this matter. LifeWise Health Plan of Oregon voluntarily and without any force or duress consents to the entry of this Consent Order expressly waiving any right to a hearing in this matter. It does so without an admission of liability under Oregon law and in the interest of resolving these allegations. LifeWise Health Plan of Oregon understands that the Director reserves the right to take further actions to enforce this Consent Order or to take appropriate action upon discovery of other violations of the Insurance Code. LifeWise Health Plan of Oregon will fully comply with the terms and conditions stated herein.

LifeWise Health Plan of Oregon understands that this Consent Order is a public document.

/s/ James Havens
Signature

James Havens
Printed name

President and CEO, LifeWise Health Plan of Washington
Office held

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ACKNOWLEDGMENT

There appeared before me this 24th day of January, 2018, James Havens, who was first duly sworn on oath, and stated that she/he was and is an officer of LifeWise Health Plan of ~~Oregon~~ Washington and that she/he is authorized and empowered to sign this Consent to Entry of Order on behalf of LifeWise Health Plan of ~~Oregon~~ Washington and to bind LifeWise Health Plan of ~~Oregon~~ Washington to the terms hereof.

/s/ Joanne Vlastelica
Signature of Notary Public

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