REPORT ON

TARGET MARKET CONDUCT EXAMINATION

OF

CAREFIRST BLUECHOICE, INC.

AS OF DECEMBER 31, 2016

Conducted from July 10, 2017

Through

March 18, 2019

By

Market Conduct Section

Life and Health Market Regulation Division

BUREAU OF INSURANCE

STATE CORPORATION COMMISSION

COMMONWEALTH OF VIRGINIA

FEIN: 52-1358219
NAIC: 96202

COMMONWEALTH OF VIRGINIA

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I, Mel Gerachis, Principal Insurance Market Examiner of the Bureau of Insurance (Bureau), do hereby certify that the attached copy of the Target Market Conduct Examination Report of CareFirst BlueChoice, Inc. as of December 31, 2016, completed at the State Corporation Commission in Richmond, VA is a true copy of the original Report on file with the Bureau and also includes a true copy of the Company's response to the findings set forth therein, and of the Bureau's review letters and the State Corporation Commission's Order in Case No. INS-2019-00200 finalizing the Report.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the official seal of the Bureau at the City of Richmond, Virginia, this 6th day of July, 2020.

Mel Gerachis

Examiner in Charge

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I. SCOPE OF EXAMINATION

The Target Market Conduct Examination of CareFirst BlueChoice, Inc. (hereinafter referred to as BlueChoice), a Health Maintenance Organization (HMO), was conducted under the authority of §§ 38.2-1317 and 38.2-4315 of the Code of Virginia (hereinafter referred to as "the Code"). The examination included a detailed review of BlueChoice's fully-insured individual, small group and large group comprehensive major medical, dental, and vision insurance coverage for the period beginning July 1, 2016 through December 31, 2016. The on-site examination was conducted from July 10, 2017, through October 20, 2017, at BlueChoice's offices in Baltimore, Maryland and Columbia, Maryland, and completed at the office of the Commission's Bureau of Insurance in Richmond, Virginia on March 18, 2019.

The purpose of the examination was to determine whether BlueChoice was in compliance with various provisions of the Code and regulations found in the Virginia Administrative Code (hereinafter referred to as "VAC" or "regulations"). BlueChoice's practices were also reviewed for compliance with the Corrective Action Plans required as a result of the examiners' findings during the prior examination.

A previous Target Market Conduct Examination covering the period of January 1, 2009, through March 31, 2009, was concluded on April 21, 2010. As a result of that examination, BlueChoice made a monetary settlement offer, which was accepted by the State Corporation Commission (Commission) on April 13, 2011, in Case No. INS-2011-00046, in which BlueChoice agreed to the entry by the Commission of an order to cease and desist from any conduct that constitutes a violation of certain sections of the Code and agreed to comply with the Corrective Action Plan contained in the Report.

Although BlueChoice had agreed after the prior examination to change its practices to comply with the Code and regulations, the current examination revealed a number of instances where BlueChoice had not done so. In the examiners' opinion, therefore, BlueChoice, in some instances, knowingly violated certain sections of the Code and regulations. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.

The examiners may not have discovered every non-compliant activity in which the company was engaged. Failure to identify or comment on specific company practices in the Commonwealth of Virginia or other jurisdictions does not constitute acceptance of such practices. Examples referred to in this Report are keyed to the numbers of the examiners' Review Sheets furnished to BlueChoice during the course of the examination.

II. EXECUTIVE SUMMARY

During the course of the examination, the examiners reviewed complaints, provider contracts, internal appeals and external reviews, advertisements, policy forms, agents, underwriting, premium and renewal notices, collections, reinstatements, cancellations, non-renewals, rescissions, and claim practices to determine compliance with the Code, the applicable regulations, the terms of BlueChoice's insurance contracts and their policies and procedures.

There are 210 violations and instances of non-compliance noted in this Report. The review of provider contracts revealed that 20 of the 23 sample contracts failed to contain 1 or more of the 11 required provisions required by § 38.2-3407.15 B of the Code and 4 of the 23 sample contracts failed to contain the provisions regarding prior authorizations required by § 38.2-3407.15:2 B of the Code. The violations of § 38.2-3407.15 B of the Code could be construed as knowing as BlueChoice was also cited for violations of this section during the previous exam.

The policy form review revealed 4 instances where group contracts had been altered or changed from forms previously filed with and approved by the Commission, in violation of §§ 38.2-316 A and 38.2-316 C 1 of the Code, and 6 instances where BlueChoice failed to file EOB forms used during the examination time frame, in violation of § 38.2-3407.4 A of the Code. BlueChoice failed in 2 instances to appoint an agent within 30 days of the date of execution of the first application, in violation of § 38.2-1833 A 1 of the Code and failed in 6 instances to provide notification to the agent of the termination of the appointment, in violation of § 38.2-1834 D of the Code. While, BlueChoice's agent appointment and termination review revealed a smaller percentage

of noncompliance than during the previous examination, the violations of both of these sections could be construed as knowing.

The review of Adverse Underwriting Decisions (AUD) revealed BlueChoice failed, in 14 instances, to provide an AUD notice when it closed the application after the applicant failed to respond to BlueChoice's request for additional information that was missing from the application, in violation of §§ 38.2-610 A 1 and A 2 of the Code.

Of the 210 violations and instances of non-compliance noted in the Report, 55 were identified during the Claims review. The claims violations of §§ 38.2-510 A 1, 38.2-510 A 5 and 38.2-510 A 6 of the Code were due to BlueChoice's intermediary's, Davis Vision, assessment of copays in excess of the copay required in the EOC and failure to provide EOBs.

A corrective action plan that must be implemented by BlueChoice was established as a result of these issues and others discussed in the Report.

III. COMPANY HISTORY

CareFirst BlueChoice, Inc. (BlueChoice), a Health Maintenance Organization, was incorporated under the name of CapitalCare, Inc. in the District of Columbia on June 22, 1984. Effective July 1, 1985, BlueChoice was licensed by the State Corporation Commission to conduct business in the Commonwealth of Virginia as a Health Maintenance Organization. On June 29, 2001, CapitalCare, Inc. (CapitalCare) changed its name to BlueChoice and, until October 9, 2002, when GHMSI transferred its shares in BlueChoice to The GHMSI Companies, Inc. (The GHMSI Co.), CapitalCare was a wholly-owned subsidiary of Group Hospitalization and Medical Services, Inc. (GHMSI), which operates under the trade name of CareFirst BlueCross BlueShield (CFBCBS).

As of January 16, 1998, GHMSI and CareFirst of Maryland, Inc. (CFMI) became affiliated under a newly incorporated, not for profit holding company, CareFirst Inc. On October 10, 2002, CFS Health Group, Inc. (CFS), a subsidiary of CFMI, transferred the net assets of its HMO subsidiaries to BlueChoice. These HMO subsidiaries were FreeState Health Plan, Inc. (FSHP), Delmarva Health Plan, Inc. (DHP), and Preferred Health Network of Maryland, Inc. (PHN). The net assets of FSHP were merged into BlueChoice while DHP and PHN became wholly owned subsidiaries of BlueChoice. PHN merged into BlueChoice on January 1, 2004, and DHP merged into BlueChoice on December 29, 2005. CFS has a 60% equity interest in BlueChoice with the remaining 40% retained by The GHMSI Co.

On April 8, 1986, a court order was issued outlining the territorial boundary of exclusivity between BlueCross BlueShield of Virginia and CFBCBS. The boundaries approximated Virginia State Route 123. BlueChoice's initial service area included the

counties of Prince William, Loudoun, Fairfax, Arlington and the cities of Alexandria, Falls Church and Fairfax City. Subsequent service area expansions approved by the Commission in April 1991, included the cities of Leesburg, Manassas, and Manassas Park. As of February 16, 1996, BlueChoice was approved to expand its service areas to the Virginia counties of Fauquier, Spotsylvania, and Stafford, as well as the city of Fredericksburg. BlueChoice also operates in the District of Columbia and the State of Maryland.

Individual and small group HMO contracts are available on the Federal exchange through navigators. Marketing efforts for off-exchange individual, small group and large group HMO contracts are carried out by account representatives, agents, and brokers. As of December 31, 2016, BlueChoice's annual statement reported Virginia direct premiums written totaled $410,616,358. Enrollment for health products at the end of 2016 totaled 86,893 members.

IV. OPERATIONS/ORGANIZATION DOCUMENTS

The purpose of this review was to determine if BlueChoice was operating within the scope of its basic organizational documents, its health care plan, or in a manner contrary to that described in and reasonably inferred from any other information submitted under § 38.2-4301 B of the Code and 14 VAC-5-211-10 et seq.

ENROLLEE PARTICIPATION

Section 38.2-4304 B of the Code requires that the governing body shall establish a mechanism to provide the enrollees with an opportunity to participate in matters of policy and operation through (i) the establishment of advisory panels, (ii) the use of advisory referenda on major policy decisions, or (iii) the use of other mechanisms.

The review revealed that BlueChoice was in substantial compliance with this section.

V. MANAGED CARE HEALTH INSURANCE PLANS (MCHIPs)

Section 38.2-5801 A of the Code prohibits the operation of an MCHIP unless the health carrier is licensed as provided in this title. Section 38.2-5802 of the Code sets forth the requirements for the establishment of an MCHIP, including the necessary filings with the Commission and the State Health Commissioner.

GENERAL PROVISIONS

Section 38.2-5801 C 2 of the Code requires the filing of a certificate of quality assurance by an HMO. The review revealed that BlueChoice was in substantial compliance with this secton.

Section 38.2-5802 D of the Code states that no MCHIP shall be operated in a manner that is materially at variance with the information submitted pursuant to this section. The Commission may determine that other changes are material and may require disclosure to secure full and accurate knowledge of the affairs and condition of the health carrier. The review revealed that BlueChoice was in substantial compliance with this section.

DISCLOSURES AND REPRESENTATIONS TO ENROLLEES

Section 38.2-5803 A of the Code requires that the following be provided to covered persons at the time of enrollment or at the time the contract or evidence of coverage is issued and made available upon request or at least annually:

1. A list of the names and locations of all affiliated providers.
2. A description of the service area or areas within which the MCHIP shall provide health care services.
3. A description of the method of resolving complaints of covered persons, including a description of any arbitration procedure if complaints may be resolved through a specific arbitration agreement.

4. Notice that the MCHIP is subject to regulation in Virginia by both the State Corporation Commission's Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.

5. A prominent notice stating, "If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided, which have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance."

The review revealed that BlueChoice was in substantial compliance with this section.

COMPLAINT SYSTEM

Section 38.2-5804 A of the Code requires that a health carrier establish and maintain a complaint system approved by the Commission and the State Health Commissioner. 14 VAC 5-211-150 A requires an HMO to establish and maintain a complaint system to provide reasonable procedures for the prompt and effective resolution of written complaints.

The examiners reviewed a sample of 100 from a population of 1,641 complaints and appeals received during the examination time frame.

TIMELINESS

14 VAC 5-216-40 E 2 states that if an internal appeal involves a post-service claim review request, the health carrier shall notify the covered person of its decision within 60 days after receipt of the appeal. BlueChoice's approved complaint system requires a written response to a post-service appeal within 60 calendar days. The review revealed 3 violations of this section. An example is discussed in Review Sheet CP04J-CF, where BlueChoice failed to respond to the covered person within 60 days from the date the appeal was received. BlueChoice agreed with the examiners' observations.

HANDLING

Section 38.2-5804 A 1 of the Code requires that the record of a complaint be maintained for no less than five years. The review revealed that BlueChoice was in substantial compliance with this section.

PROVIDER AND INTERMEDIARY CONTRACTS

The examiners reviewed a sample of 23 provider contracts from a population of 4,177 provider contracts in force during the examination time frame. The examiners also reviewed BlueChoice's contracts negotiated with intermediary organizations for providing health care services pursuant to an MCHIP.

Section 38.2-5805 C 10 of the Code and 14 VAC 5-211-30 C state that if there is an intermediary organization between the HMO and the health care providers, the "hold harmless" clause shall be amended to include nonpayment by the plan, the HMO, and the intermediary organization and shall be included in any contract between the HMO on behalf of the MCHIP and the intermediary organization. As discussed in Review Sheet MC01B-CF, the agreement between BlueChoice and its intermediary for the provision of mental health services failed to contain the required provision, in violation of these sections. BlueChoice disagreed with the examiners' observations stating, in part:

> The contract requires Magellan, as an intermediary, to comply with all federal and state statutes, regulations and rules in all relevant jurisdictions, which includes Virginia, applicable to its operations and performance under the contract. This would include holding the member harmless. *See section 10.8 of the Agreement.* Additionally, section 5.5-1 (attached) incorporates all provisions of Attachment E "Required Contractual Provisions In Network Provider and Facility Contracts" into the Agreement. Section 10 of Attachment E states, "Sufficient provisions to include all required provider contract language for Maryland, the District of Columbia and Virginia, as applicable, related to provider contracts." Therefore, section 10 of the contract, incorporates section

> 38.2-5805 of the Virginia Code into the Agreement as this section of Virginia's code is titled "Provider Contracts" and is expressly contemplated in Attachment E as incorporated into the contract by reference. Additionally, as 14 VAC 5-211-30 (C) imposes the hold harmless clause requirements of section 38.2-5805 (C)(9) upon HMOs and providers as well as HMOs and intermediary organizations, Attachment E would also incorporate by reference such hold harmless clause, pursuant to Attachment E's incorporation into the contract.

BlueChoice further disagreed based on the position that the contract complies by including a hold harmless clause addressing the relationship between BlueChoice and its providers. The examiners acknowledge that Section 10.8 and Attachment E of the contract refer to regulatory requirements and that Section 5.5-1 incorporates the provisions of Attachment E; however, the general references in Section 10.8 requiring each party to "…comply fully with all federal and state statutes, regulations and/or rules in all relevant jurisdictions…" and in Attachment E requiring "Sufficient provisions to include all required provider contract language for Maryland, the District of Columbia and Virginia, as applicable, related to provider contracts" do not satisfy the requirement that a hold harmless clause be included in any contract between a carrier and an intermediary organization. As there is no hold harmless clause addressing the relationship between BlueChoice and its intermediary, the examiners maintain that BlueChoice has failed to comply with § 38.2-5805 C 10 of the Code and 14 VAC 5-211-30 C.

VI. INTERNAL APPEAL AND EXTERNAL REVIEW

Chapter 35.1 of Title 38.2 of the Code and 14 VAC 5-216-10 et seq. set forth the requirements for the establishment of a health carrier's internal appeal process and a process for appeals to be made to the Bureau of Insurance to obtain an external review of final adverse determinations.

On July 14, 2011, the Bureau of Insurance issued Administrative Letter 2011-05, the purpose of which was to provide a summary of the new internal appeals and external review process under Virginia law, and to provide guidance for the submission of complaint system filings revised to comply with these new requirements.

The examiners reviewed the entire population of 7 appeals that obtained an external review of a final adverse determination during the examination time frame. In addition, the sample of 100 complaints and appeals were reviewed for compliance with the notice requirements for external review.

Section 38.2-3559 A of the Code requires that a health carrier shall notify the covered person in writing of an adverse determination or final adverse determination and the covered person's right to request an external review. The notice of the right to request an external review shall include the following, or substantially similar, language: "We have denied your request for the provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment you requested by submitting a request for external review to the Commission." The review revealed 6 violations of this

section. Section 38.2-3559 D of the Code states the health carrier shall include the standard and expedited external review procedures and any forms with the notice of the right to an external review. The review revealed 4 violations of this section. Section 38.2-5804 A of the Code of Virginia states that a health carrier subject to subsection B of § 38.2-5801 shall establish and maintain for each of its MCHIPs a complaint system approved by the Commission and the State Health Commissioner to provide reasonable procedures for the resolution of written complaints in accordance with requirements in or established pursuant to provisions in this title and Title 32.1. The review revealed 4 violations of this section. 14 VAC 5-211-150 A requires a health maintenance organization to establish and maintain a complaint system to provide reasonable procedures for the prompt and effective resolution of written complaints. The review revealed 4 violations of this section.

An example of non-compliance with these sections is discussed in Review Sheet CP25J-CF. BlueChoice's filed and approved complaint system states, in part, "…forms will be included with the written communication of an adverse determination. An electronic internet web link to the Virginia Bureau of Insurance can be accessed via www.Carefirst.com where the forms can be downloaded free of charge..." However, the aforementioned link was provided on an EOB for an adverse benefit determination. The filed and approved complaint system does not make mention of an electronic internet web link being provided for adverse benefit determinations. BlueChoice disagreed with the examiners' observations explaining that it was in the process of implementing changes as the result of a Bureau of Insurance (Bureau) External Review Inquiry. The Bureau acknowledges that the system changes to address these issues were in process during

the examination time frame. As a result, no monetary penalty will be assessed at this time.

VII. PROVIDER CONTRACTS

A review of BlueChoice's provider contracts was conducted to determine compliance with §§ 38.2-3407.15 B, 38.2-3407.15:1 B and 38.2-3407.15:1 C, 38.2-3407.15:2 B, 38.2-3407.15:3 B and 38.2-3407.15:3 C of the Code. Each section sets forth specific provisions that contracts between carriers and providers shall contain.

ETHICS AND FAIRNESS IN CARRIER BUSINESS PRACTICES

Section 38.2-3407.15 of the Code requires that every provider contract entered into by a carrier shall contain specific provisions, which shall require the carrier to adhere to and comply with minimum fair business standards in the processing and payment of claims for health care services. Section 38.2-510 A 15 of the Code prohibits, as a general business practice, the failure to comply with § 38.2-3407.15 of the Code or to perform any provider contract provision required by that section.

Provider Contracts

The examiners reviewed a sample of 23 from a population of 4,177 provider contracts in force during the examination time frame. The contracts were reviewed to determine whether they contained the 11 provisions required by § 38.2-3407.15 B of the Code. The review revealed 58 instances in which BlueChoice's contracts failed to contain 1 of the 11 required provisions. The particular provision, number of violations and Review Sheet examples are referred to in the following table:

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15 B 1	5	EF02B-CF
§ 38.2-3407.15 B 2	5	EF02B-CF
§ 38.2-3407.15 B 3	5	EF02B-CF
§ 38.2-3407.15 B 4	5	EF02B-CF
§ 38.2-3407.15 B 5	5	EF02B-CF
§ 38.2-3407.15 B 6	5	EF02B-CF

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15 B 8	1	EF06M-CF
§ 38.2-3407.15 B 9	21	EF03B-CF
§ 38.2-3407.15 B 10	5	EF02B-CF
§ 38.2-3407.15 B 11	1	EF06M-CF

Section 38.2-510 A 15 prohibits, as a general business practice, failing to comply with § 38.2-3407.15 of the Code. BlueChoice's failure to amend its provider contracts to comply with § 38.2-3407.15 B of the Code occurred with such frequency as to indicate a general business practice, placing BlueChoice in violation of § 38.2-510 A 15 of the Code.

Due to the fact that the violations of §§ 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10, and 38.2-3407.15 B 11 of the Code were discussed in the prior Report, the current violations could be construed as knowing. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.

Provider Claims

Section 38.2-510 A 15 of the Code prohibits, as a general business practice, the failure to comply with § 38.2-3407.15 of the Code or to perform any provider contract provision required by that section. Section 38.2-3407.15 B of the Code states that every provider contract must contain specific provisions, requiring the carrier to adhere to and comply with minimum fair business standards in the processing and payment of claims. Section 38.2-3407.15 C of the Code states that in the processing of any payment for claims for health care services, every carrier subject to this title shall adhere to and comply with the standards required under subsection B.

The examiners reviewed a sample of 280 claims from a population of 8,470 claims processed under the 23 provider contracts selected for review.

Section 38.2-3407.15 B 6 of the Code states that no HMO may impose any retroactive denial of a previously paid claim unless the HMO has provided the reason for the retroactive denial and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services identified on the claim were not delivered by the provider, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed the lesser of (a) 12 months or (b) the number of days within which the carrier requires under its provider contract that a claim be submitted by the provider following the date on which a health care service is provided. The review revealed 1 violation of this section. As discussed in review sheet EFCL01B-CF, BlueChoice issued a retroactive denial of payment over 12 months after the date of the payment of the original claim. BlueChoice disagreed with the examiners' observations explaining that the retroactive denial notification was forwarded within 12 months of the initial paid date. While the examiners acknowledge that the retraction notification was forwarded within 12 months of the initial paid date of the original claim, the actual retroactive denial occurred more than 12 months after the date of the original payment.

Section 38.2-3407.15 B 8 of the Code states that no provider contract may fail to include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid which is applicable to the provider or to the range of health care

services reasonably expected to be delivered by that type of provider on a routine basis. The review revealed 1 violation of this section. As discussed in review sheet EFCL04B-CF, BlueChoice underpaid the fee schedule specified for the health care service provided. BlueChoice disagreed with the examiners' observations explaining that procedure code A9575 was paid at 100% of the allowed amount of $0.21 per unit, with 10 units at $2.10 for the claim with a December 8, 2016, service date. The examiners responded that the September 27, 2016, Fee Schedule Update for allowed amounts effective December 1, 2016, mailed to the provider lists procedure code A9575 under "Codes Changing from ASP + 12% to ASP + 10%," indicating that the allowed amount for this procedure code should be the ASP, as published by the Centers for Medicare & Medicaid Services (CMS), increased by 10 percent. As the list made available by CMS lists the fourth quarter 2016 ASP for procedure code A9575 as .200, the examiners maintain that the per unit cost (.200 + 10 percent of .200) would be $.22 and that $2.20 should have been allowed on this claim.

Section 38.2-510 A 15 prohibits, as a general business practice, failing to comply with § 38.2-3407.15 of the Code. BlueChoice's failure to perform the provider contract provisions required by § 38.2-3407.15 B of the Code did not occur with such frequency as to indicate a general business practice.

CARRIER CONTRACTS WITH PHARMACY PROVIDERS; REQUIRED PROVISIONS; LIMIT ON TERMINATION OR NONRENEWAL

Section 38.2-3407.15:1 B of the Code requires that any contract between a carrier and its intermediary, pursuant to which the intermediary has the right or obligation to conduct audits of participating pharmacy providers, and any provider contract between a carrier and a participating pharmacy provider or its contracting agent, pursuant to which

the carrier has the right or obligation to conduct audits of participating pharmacy providers, shall contain specific provisions.

The examiners reviewed 2 sample provider contracts that were subject to this section of the Code. The review revealed that BlueChoice was in substantial compliance.

CARRIER CONTRACTS; REQUIRED PROVISIONS REGARDING PRIOR AUTHORIZATION

Section 38.2-3407.15:2 B of the Code requires that any provider contract between a carrier and a participating health care provider, or its contracting agent, shall contain specific provisions regarding prior authorizations. The examiners reviewed 23 sample provider contracts that were subject to this section of the Code. The review revealed 32 instances in which BlueChoice's contracts failed to contain 1 of the 8 required provisions. The particular provision, number of violations and Review Sheet examples are referred to in the following table:

Code Section	Number of Violations	Review Sheet Example
§ 38.2-3407.15:2 B 1	4	EF05B-CF
§ 38.2-3407.15:2 B 2	4	EF05B-CF
§ 38.2-3407.15:2 B 3	4	EF05B-CF
§ 38.2-3407.15:2 B 4	4	EF05B-CF
§ 38.2-3407.15:2 B 5	4	EF05B-CF
§ 38.2-3407.15:2 B 6	4	EF05B-CF
§ 38.2-3407.15:2 B 7	4	EF05B-CF
§ 38.2-3407.15:2 B 8	4	EF05B-CF

CARRIER AND INTERMEDIARY CONTRACTS WITH PHARMACY PROVIDERS; DISCLOSURE AND UPDATING OF MAXIMUM ALLOWABLE COST OF DRUGS; LIMIT ON TERMINATION OR NONRENEWAL

Section 38.2-3407.15:3 B of the Code requires that any contract between a carrier and its intermediary, pursuant to which the intermediary has the right or obligation to establish a maximum allowable cost, and any provider contract between a carrier and a

participating pharmacy provider or its contracting agent, pursuant to which the carrier has the right or obligation to establish a maximum allowable cost, shall contain specific provisions.

The examiners reviewed 2 sample provider contracts that were subject to this section of the Code. The review revealed that BlueChoice was in substantial compliance.

VIII. ADVERTISING

A review was conducted of BlueChoice's advertising materials to determine compliance with § 38.2-4312 A of the Code and the Unfair Trade Practices Act, to include §§ 38.2-502, 38.2-503, and 38.2-504 as well as 14 VAC 5-90-10 et seq., Rules Governing Advertisement of Accident and Sickness Insurance.

Where this Report cites a violation of this regulation it does not necessarily mean that the advertisement has actually misled or deceived any individual to whom the advertisement was presented. An advertisement may be cited for violations of certain sections of this regulation if it is determined by the Bureau of Insurance that the advertisement has the tendency or capacity to mislead from the overall impression that the advertisement may be reasonably expected to create within the segment of the public to which it is directed. (14 VAC 5-90-50)

14 VAC 5-90-170 A requires each insurer to maintain at its home or principal office a complete file containing every printed, published, or prepared advertisement with a notation attached indicating the manner and extent of distribution and the form number of any policy advertised. The review revealed that BlueChoice was in substantial compliance.

A sample of 20 from a population of 150 advertisements disseminated during the examination time frame was selected for review. The review revealed that 1 of the 20 advertisements contained violations. In the aggregate, there were 3 violations, which are discussed in the following paragraph.

14 VAC 5-90-55 A states that an invitation to inquire shall contain a provision in the following or substantially similar form: "This policy has exclusions, limitations,

reduction of benefits, terms under which the policy may be continued in force or discontinued. For cost and complete details of the coverage, call or write your insurance agent." 14 VAC 5-90-60 A 1 states that an advertisement shall not omit information or use words, phrases, statements, references or illustrations if the omission of the information or use of the words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements. 14 VAC 5-90-90 C states that the source of any statistics used in an advertisement shall be identified in the advertisement. As discussed in Review Sheet AD02H-CF, the review revealed 1 violation of each of these sections, where the invitation to inquire failed to contain the required disclosure and failed to provide the source for the statistics used in the advertisement. BlueChoice disagreed with the examiners' observations and stated that:

> 14 VAC 5-90-30 defines an "Invitation to inquire" as "*an advertisement having as its objective the creation of a desire to inquire further about accident and sickness insurance and that is limited to a brief description of the loss for which benefits are payable and does not contain an application for coverage but may contain (i) the dollar amount of benefits payable, and (ii) the period of time during which benefits are payable. An invitation to inquire may not refer to cost, except as otherwise permitted by this chapter.*" (EMPHASIS ADDED THROUGH UNDERLINING)
>
> CareFirst contends that the piece at issue does not meet the definition of an Invitation to Inquire. The piece does not include the items underlined above under the definitional statute. The piece does not describe the loss for which benefits are payable or the dollar amount of benefits payable. It discusses some cost sharing and Deductibles but does not address allowed benefits. Additionally, it does not address the period during which benefits

> are payable. In the absence of these items CareFirst respectfully submits that the requirements of 14 VAC 5-90-55(A) relating to an Invitation to Inquire would not apply and there is no violation of that Statute.
> Additionally, CareFirst contends that it did not violate 14 VAC 5-90-90 C regarding the citation of statistics. Under 14 VAC 5-90-90 (Use of Statistics) That statute provides that an advertisement relating to the dollar amounts of claims paid, the number of person [sic] insured, or similar statistical information shall not be used unless it accurately reflects all current and relevant facts. In the present case, the piece in question does not reference "statistics" within the meaning of the statute which discusses statistics similar to dollar amounts of claims paid or number of persons insured. Instead the piece compared cost sharing. CareFirst as a rule provides source information but this piece did not include such sourcing due to an unintentional oversight.

The examiners responded that this advertisement meets the 14 VAC 5-90-30 definition of an "invitation to inquire" as it does have as its objective the creation of a desire to inquire further about accident and sickness insurance and that is limited to a brief description of the loss for which benefits are payable and does not contain an application for coverage. This advertisement provides brief descriptions of various losses for which benefits are payable such as seeing a PCP or needing an x-ray. Additionally, the comparison chart listing the out of pocket costs for the Competitor Platinum Plan (in-network) was not identified and the source of the statistics was not provided.

SUMMARY

BlueChoice violated 14 VAC 5-90-55 A, 14 VAC 5-90-60 A 1 and 14 VAC 5-90-90 C which placed it in violation of subsection 1 of § 38.2-502 and § 38.2-503 of the Code

IX. POLICY AND OTHER FORMS

A review of policy forms in use during the examination time frame was performed to determine if BlueChoice complied with various statutory, regulatory, and administrative requirements governing the filing and approval of policy forms.

Sections 38.2-4306 A 2, 38.2-316 A and 38.2-316 C 1 of the Code prohibit the use of group and individual contracts, Evidences of Coverage (EOCs), and any applicable amendments to these forms prior to filing the forms with and receiving approval from the Commission. Other forms, such as the group application, individual applications and group enrollment forms, must also be filed with the Commission for approval under §§ 38.2-316 B and 38.2-316 C 1 of the Code.

GROUP CONTRACTS

The examiners reviewed the entire population of 12 group contracts issued during the examination time frame.

The review revealed that, in 3 instances, BlueChoice issued a group contract that had been altered or changed from forms previously filed with and approved by the Commission, in violation of §§ 38.2-316 A and 38.2-316 C 1 of the Code. An example is discussed in Review Sheet PF05M-CF, where BlueChoice issued a group contract with the policy form number VA/CFBC/2014 MANDATE (1/14) that had been altered or changed without being filed with and approved by the Commission. BlueChoice disagreed with the examiners' observations and stated that:

> Although there are discrepancies between form VA/CFBC/2014 MANDATE (1/14) and the EOV, the form was filed and approved by the VBOI on 11/22/13. Nonetheless, a subsequent version control issue resulted in a version of the form not supported by the filed EOV being unintentionally used in the production contract. Please also note that the production version of this form is being revised to align with the EOV and we have and continue

to implement process improvements to advance version control and QA reviews for accurate contract creation following form approvals.

The examiners maintained their findings and referred BlueChoice to 14 VAC 5-100-50 3, which requires that a form must be submitted in the final form in which it is to be issued.

INDIVIDUAL CONTRACTS

The examiners reviewed a sample of 50 from a population of 1,009 individual contracts issued during the examination time frame.

The review revealed that the individual contracts were filed and approved as required.

EVIDENCE OF COVERAGE

Section 38.2-4306 A 2 of the Code states that no evidence of coverage (EOC), or amendment to it, shall be delivered or issued for delivery in this Commonwealth until a copy of the form has been filed with and approved by the Commission. The review revealed that BlueChoice was in substantial compliance.

APPLICATIONS/ENROLLMENT FORMS

Sections 38.2-316 B and 38.2-316 C 1 of the Code require that application and enrollment forms be filed with and approved by the Commission.

As discussed in Review Sheet PF01M-CF, the review revealed that, in 1 instance, BlueChoice used an application/enrollment form that had not been filed with and approved by the Commission, in violation of §§ 38.2-316 B and 38.2-316 C 1 of the Code. BlueChoice agreed with the examiners' observations.

EXPLANATION OF BENEFITS (EOB)

Section 38.2-3407.4 A of the Code requires that each HMO shall file its EOBs with the Commission for approval. These forms are subject to the requirements of §§ 38.2-316 and 38.2-4306 of the Code, as applicable.

The review revealed that BlueChoice failed to file 6 EOB forms that it used during the examination time frame. An example is discussed in Review Sheet PF01B-CF, where form CUT0287-1E (10-13) was sent to enrollees in the processing of claims prior to being filed with and approved by the Commission, in violation of § 38.2-3407.4 A of the Code. BlueChoice agreed with the examiners' observations.

SCHEDULE OF CHARGES

Section 38.2-4306 B 1 of the Code prohibits the use of schedules of charges or amendments to the schedules of charges until a copy of the schedule or amendment has been filed with the Commission. The review revealed that BlueChoice was in substantial compliance.

COPAYMENTS

14 VAC 5-211-90 B states that if the HMO has an established out-of-pocket maximum for cost sharing, it shall keep accurate records of each enrollee's cost sharing and notify the enrollee when his out-of-pocket maximum is reached. The notification shall be given no later than 30 days after the HMO has processed sufficient claims to determine that the out-of-pocket maximum is reached. The HMO shall not charge additional cost sharing for the remainder of the contract or calendar year, as appropriate. The HMO shall also promptly refund to the enrollee all cost sharing payments charged after the out-of-pocket maximum is reached.

The examiners reviewed a sample of 30 from a population of 444 enrollees who had met their out-of-pocket maximum during the examination time frame. In addition, the cost shares of the 330 paid claim files were reviewed.

The review revealed 5 violations of this section. An example is discussed in Review Sheet PF04M-CF, where BlueChoice failed to notify 5 of its enrollees when his or her out-of-pocket maximum was reached. BlueChoice disagreed with the examiners' observations and stated that:

> Out of Pocket accumulations are not printed on explanation of benefits however they are available on CareFirst.com via portals 'My Account' (for members) and 'CareFirst Direct' (for providers) with full access to deductible, coinsurance, and out of pocket accumulations.

The examiners maintained their findings and responded that 14 VAC 5-211-90 B states that an HMO shall notify the enrollee when his out of pocket maximum is reached and notification shall be given no later than 30 days after the HMO has processed sufficient claims to determine that the out-of-pocket maximum is reached. Although the out-of-pocket accumulations were available on the member's portal on CareFirst.com, BlueChoice failed to provide notification to the above members when his or her out-of-pocket maximum was reached.

X. AGENTS

The purpose of this review was to determine compliance with various sections of Title 38.2, Chapter 18 and § 38.2-4313 of the Code. A sample of 25 from a population of 542 agents and agencies appointed during the time frame was selected for review. In addition, the writing agents or agencies designated in the 62 new business files were reviewed.

LICENSED AGENT REVIEW

Sections 38.2-1822 A and 38.2-4313 of the Code require that a person be licensed prior to soliciting contracts or acting as an agent in the Commonwealth. The review revealed that BlueChoice was in substantial compliance.

APPOINTED AGENT REVIEW

Section 38.2-1833 A 1 of the Code requires an HMO to, within 30 days of the date of execution of the first application submitted by a licensed but not yet appointed agent, either reject such application or appoint the agent.

The review revealed 2 violations of § 38.2-1833 A 1 of the Code. An example is discussed in Review Sheet AG08M-CF, where BlueChoice failed to appoint the agent within 30 days of the date of execution of the application, in violation of this section. BlueChoice agreed with the examiners' observations.

COMMISSIONS

Section 38.2-1812 A of the Code prohibits the payment of commissions or other valuable consideration to an agent or agency that was not appointed or that was not licensed at the time of the transaction. The review revealed that BlueChoice was in substantial compliance with this section.

TERMINATED AGENT APPOINTMENT REVIEW

Section 38.2-1834 D of the Code requires that an HMO notify the agent within 5 calendar days and the Commission within 30 calendar days upon termination of the agent's appointment. A sample of 25 was selected from a population of 134 agents whose appointments terminated during the examination time frame.

The review revealed 6 violations of § 38.2-1834 D of the Code. An example is discussed in Review Sheet AG06M-CF, where BlueChoice failed to provide notification to the agent of the termination of the appointment. BlueChoice agreed with the examiners' observations.

SUMMARY

Due to the fact that violations of §§ 38.2-1833 A 1 and 38.2-1834 D of the Code were discussed in the prior Report; the current violations could be construed as knowing. Section 38.2-218 of the Code sets forth the penalties that may be imposed for knowing violations.

XI. UNDERWRITING/UNFAIR DISCRIMINATION/INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

The examination included a review of BlueChoice's underwriting practices to determine compliance with the Unfair Trade Practices Act, §§ 38.2-500 through 38.2-514 of the Code, the Insurance Information and Privacy Protection Act, §§ 38.2-600 through 38.2-620 of the Code, as well as 14 VAC 5-180-10 et seq., Rules Governing Underwriting Practices and Coverage Limitations and Exclusions For Acquired Immunodeficiency Syndrome (AIDS).

UNDERWRITING/UNFAIR DISCRIMINATION

The review was conducted to determine if BlueChoice's underwriting guidelines were unfairly discriminatory and whether applications were underwritten in accordance with BlueChoice's guidelines and that correct premiums were charged.

UNDERWRITING REVIEW

The examiners reviewed a sample of 50 from a population of 1,009 individual HMO contracts issued during the examination time frame. The examiners also reviewed the entire population of 12 group HMO contracts issued during the examination time frame.

The examiners reviewed a sample of 50 from a total population of 568 individual applications declined during the examination time frame. The examiners were informed by BlueChoice that no group applications were declined during the examination time frame.

The review revealed no evidence of unfair discrimination and that coverage was underwritten or declined in accordance with established guidelines.

UNDERWRITING PRACTICES – AIDS

14 VAC 5-180-10 et seq. sets forth rules and procedural requirements that the Commission deems necessary to regulate underwriting practices and policy limitations and exclusions regarding HIV infection and AIDS. The review revealed that BlueChoice was in substantial compliance.

MECHANICAL RATING REVIEW

The review revealed that premiums were calculated correctly.

INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

Title 38.2, Chapter 6 of the Code requires an HMO to establish standards for the collection, use, and disclosure of information gathered in connection with insurance transactions.

DISCLOSURE AUTHORIZATION FORMS

Section 38.2-606 of the Code sets forth standards for the content and use of disclosure authorization forms to be used when collecting personal or privileged information about individuals. The review revealed that the disclosure authorizations used by BlueChoice in the underwriting of its group and individual contracts were in substantial compliance.

ADVERSE UNDERWRITING DECISIONS (AUD)

Section 38.2-610 of the Code requires that, in the event of an adverse underwriting decision on an applicant that is individually underwritten, the insurance institution or agent responsible for the decision shall give a written notice in a form approved by the Commission.

Administrative Letter 2015-07 provides life and health insurers with a prototype AUD notice. An AUD notice containing wording substantially similar to the wording in the prototype notice is deemed to be approved for use in Virginia.

A sample of 50 from a population of 568 individual applications declined was selected by the examiners for review

Section 38.2-610 A 1 of the Code states that, in the event of an adverse underwriting decision, the insurer shall give a written notice that either provides the applicant with the specific reason or reasons for the adverse underwriting decision in writing or advises such person that upon written request he may receive the specific reason or reasons in writing. Section 38.2-610 A 2 of the Code states that, in the event of an adverse underwriting decision, the insurer responsible for the decision shall give a written notice in a form approved by the Commission that provides the applicant with a summary of the rights established under subsection B of this section and §§ 38.2-608 and 38.2-609 of the Code.

The review revealed 14 violations of each of these sections. An example is discussed in Review Sheet UN04M-CF, where BlueChoice failed to provide a written notice of the AUD decision when it closed the application after the applicant failed to respond to BlueChoice's request for additional information that was missing from the application. BlueChoice agreed with the examiners' observations.

XII. PREMIUM & RENEWAL NOTICES/ COLLECTIONS/REINSTATMENTS

BlueChoice's practices for processing premium and renewal notices, collections and reinstatements were reviewed for compliance with its established procedures and certain requirements of the Patient Protection and Affordability Care Act (PPACA). BlueChoice' practices for notifying contract holders of the intent to increase premium by more than 35% were reviewed for compliance with the notification requirements of § 38.2-3407.14 of the Code.

PREMIUM & RENEWAL NOTICES

Section 38.2-3407.14 A of the Code states that an insurer issuing individual or group accident and sickness policies providing hospital, medical and surgical or major medical coverage shall provide in conjunction with the proposed renewal of coverage under any such policies prior written notice of intent to increase by more than 35 percent the annual premium charged for coverage thereunder. Section 38.2-3407.14 B of the Code states that an HMO providing individual coverage shall provide in conjunction with the proposed renewal of coverage prior written notice of intent to increase the annual premium charge for coverage or any deductible required thereunder. Section 38.2-3407.14 C states that the notice required by this section shall be provided in writing at least 60 days prior to the proposed renewal of coverage under a plan described in subsection A and at least 75 days prior to the proposed renewal of individual health insurance coverage described in subsection B.

Individual

A sample of 25 was selected from a population of 1,018 individual policies whose premium increased by more than 35%, and a sample of 25 was selected from a population of 4,658 individual policies renewed during the examination time frame. The review revealed that BlueChoice was in substantial compliance with the notification requirements.

Group

A review of the total population of 14 groups whose premium increased by more than 35% indicated that BlueChoice was in substantial compliance with the notification requirements of § 38.2-3407.14 of the Code.

REINSTATEMENTS

Individual

A sample of 20 was selected from a population of 104 individual HMO contracts reinstated during the examination time frame. The review revealed that BlueChoice was in substantial compliance with its established procedures for reinstatement.

Group

A sample of 13 was selected from a population of 26 group HMO contracts reinstated during the examination time frame. The review revealed that BlueChoice was in substantial compliance with its established procedures for reinstatement.

XIII.CANCELLATIONS/NON-RENEWALS/RESCISSIONS

The examination included a review of BlueChoice's cancellation/non-renewal practices and procedures to determine compliance with its contract provisions; the requirements of § 38.2-508 of the Code covering unfair discrimination; and the notification requirements of 14 VAC 5-211-230 B, 14 VAC 5-211-230 C and § 38.2-3542 of the Code. The examiners were informed by BlueChoice that no rescissions of coverage occurred during the examination time frame.

Individual

A sample of 60 from a population of 4,620 individual contracts terminated during the examination time frame was selected for review.

14 VAC 5-211-230 B 1 states that an HMO shall not terminate coverage for services provided under a contract without giving the subscriber written notice of termination, effective at least 31 days from the date of mailing or, if not mailed, from the date of delivery, except that, for termination due to nonpayment of premium, the grace period as required in 14 VAC 5-211-210 B 16 shall apply. The review revealed that BlueChoice was in substantial compliance.

Group

A sample of 16 from a population of 67 groups terminated during the examination time frame was selected for review.

Section 38.2-3542 C of the Code states that in the event the coverage is terminated due to nonpayment of premium by the employer, no such coverages shall be terminated by an HMO until the employer has been provided with a written or printed notice of termination, including a specific date, not less than fifteen days from the date of

such notice, by which coverage will terminate if overdue premium is not paid. Coverage shall not be permitted to terminate for at least fifteen days after such notice has been mailed. The review revealed that BlueChoice was in substantial compliance.

XIV. COMPLAINTS

BlueChoice's complaint records were reviewed for compliance with § 38.2-511 of the Code. This section sets forth the requirements for maintaining complete records of complaints to include the number of complaints, the classification by line of insurance, the nature of each complaint, the disposition of each complaint and the time it took to process each complaint. A "complaint" is defined by this section as "any written communication from a policyholder, subscriber or claimant primarily expressing a grievance."

The examiners reviewed a sample of 100 from a population of 1,641 written complaints received during the examination time frame. The review revealed that BlueChoice was in substantial compliance with this section.

XV. CLAIM PRACTICES

The purpose of the examination was to review the claim practices for compliance with §§ 38.2-510 and 38.2-4306.1 of the Code, as well as 14 VAC 5-211-10 et seq., Rules Governing Health Maintenance Organizations.

GENERAL HANDLING STUDY

The review consisted of a sampling of closed claims and encounters. Claims are defined as submissions for negotiated fee-for-service, per diem and per case payments for health care services provided by inpatient and outpatient physicians and facilities. The encounters reviewed were periodic capitated payments made to providers of laboratory services.

BlueChoice has contracted with intermediaries for the processing of its claims for vision and pharmacy services. Davis Vision, Inc. (Davis Vision) processes vision claims and CaremarkPCS Health, LLC (Caremark) processes pharmacy claims.

PAID CLAIM REVIEW

Group & Individual Medical

A sample of 150 was selected from a population of 383,369 claims paid during the examination time frame.

The review revealed 1 instance where BlueChoice failed to comply with the provisions of the EOC. An example is discussed in Review Sheet CL03B, where BlueChoice failed to assess a $50 copay as required in the EOC. BlueChoice agreed with the examiners' observations.

Section 38.2-510 A 14 of the Code prohibits, as a general business practice, failing to promptly provide a reasonable explanation of the basis in the insurance policy for a denial of a claim or for the offer of a compromise settlement. The review revealed that BlueChoice was in non-compliance with this section in 2 instances. Section 38.2-3407.4 B of the Code states that an EOB shall accurately and clearly set forth the benefits payable under the contract. The review revealed that BlueChoice was in violation of this section in 1 instance. Section 38.2-4306.1 B of the Code sets forth the requirement for payment of interest on claim proceeds from 30 days from the date the proof of loss is received to the date of claim payment. The review revealed 1 violation of this section. An example of BlueChoice's non-compliance with these 3 sections is discussed in Review Sheet CL39B. The subscriber's coverage was terminated on December 31, 2015, and reinstated on February 16, 2016, with an effective date of January 1, 2016. BlueChoice initially denied a claim on February 17, 2016, with a February 4, 2016, date of service for having no coverage in effect. The claim was reprocessed on March 9, 2016, with the first line for urinalysis applied to a $2.52 copay, the second line denied with the explanation "This service has been denied because the obstetrical ultrasound maximum was met on a previous line of this claim," and the third line denied with the explanation "This service has been denied because the obstetrical ultrasound maximum was met on a previous claim." The claim was later reprocessed with benefits approved for all 3 lines on August 31, 2016.

BlueChoice disagreed with the examiners' observations and explained that an appeal was received on July 26, 2016, resulting in the denial being overturned on August 29, 2016, which prompted the August 31, 2016, reprocessing. BlueChoice further explained that the March 9, 2016, denial was actually due to another ultrasound being performed on the same day by a different provider; however, both claims were ultimately eligible for payment as the claim in question involved an initial routine ultrasound performed by an OB and this prompted an additional diagnostic ultrasound.

The examiners responded that the appealed claim from the OB was for preventive services and should not have been denied. In addition, the denial explanation stating that the obstetrical ultrasound maximum for one line was met "on a previous line of this claim" and the other line was met "on a previous claim" provided unclear information to the member and was potentially misleading, resulting in the EOB failing to accurately and clearly set forth the benefits payable under the contract. As the claim from the OB should have been processed with benefits approved for all 3 lines based upon the February 16, 2016, date of reinstatement of coverage, interest is due and unpaid beginning 30 days from this date until the August 31, 2016, payment date.

Section 38.2-514 B of the Code states that no person shall provide to an insured, claimant, subscriber or enrollee under an accident and sickness insurance policy, subscription contract, or health maintenance organization contract, an EOB which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services. The review revealed that BlueChoice was in violation of this section in 1 instance. As discussed in Review Sheet CL31B, BlueChoice sent an EOB where Medicare was the primary plan

listing Provider Charges of $15.00 with Allowed Charges of $12.41; however, $11.43 was listed as being paid by another insurance plan and $2.92 was listed as being paid by BlueChoice, which does not add up to either the Allowed Charges or Provider Charges. In addition, the EOB indicated that the member was responsible for the $15.00 Provider Charges due to the provider being non-participating, but it appears that this amount should have been reduced by the $11.43 paid to the provider by Medicare. BlueChoice disagreed with the examiners' observations and stated, in part, that:

> The claim was…adjusted (see raw data) as follows:
> Medicare allowed $14.35
> Medicare disallowed .42 and the sequestration amount is .23 which adds us [sic] to .65 which is the amount applied in the sanction field.
> Medicare paid: $11.43 and CF paid the coinsurance $2.92.

The examiners maintained their findings and responded in part that:

> …the EOB displayed an allowed amount of $12.41 despite the fact that the $11.43 paid by Medicare and the $2.92 paid by CareFirst are actually based on an allowed amount of $14.35. The examiners acknowledge the explanation of the calculations in CareFirst's review sheet response, but all of this information was not actually included in the EOB sent to the member. In addition, it does not appear that the member would be responsible for the full $15.00 provider charge as indicated in the "What You Owe" column of the EOB. As the information displayed on this EOB would not allow the member to verify that the calculation of benefits is correct, the EOB fails to clearly and accurately disclose the method of benefit calculation.

14 VAC 5-211-80 B states that an HMO shall not be relieved of its duty to provide a covered health care service to an enrollee because the enrollee is entitled to coverage under other health care plans. In the event that benefits are provided by another health care plan, the determination of the order of benefits shall in no way restrict or impede the rendering of services required to be provided by the health care plan. The HMO shall be required to provide or arrange for the service first and then, at its option, seek coordination of benefits with any other health insurance or health care benefits or services that are

provided by other policies, contracts, or plans. Until a coordination of benefits determination is made, the enrollee shall not be held liable for the cost of covered services provided.

The review revealed 1 violation of this section. As discussed in Review Sheet CL16B, BlueChoice denied a claim for coordination of benefits information and held the enrollee liable for the cost of the covered services provided. BlueChoice agreed with the examiners' observations.

Mental Health & Substance Use Disorder

A sample of 65 was selected from a population of 20,694 mental health and substance use disorder claims paid during the examination time frame.

Section 38.2-510 A 3 of the Code states that no person shall, with such frequency as to indicate a general business practice, fail to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies. The review revealed that BlueChoice was in non-compliance with this section in 1 instance. Section 38.2-3407.4 B of the Code states that an EOB shall accurately and clearly set forth the benefits payable under the contract. The review revealed that BlueChoice was in violation of this section in 3 instances. An example of BlueChoice's non-compliance with these 2 sections is discussed in Review Sheet CL35B, where BlueChoice processed a claim on September 26, 2014, with an incorrect member liability and reprocessed the claim on September 20, 2016, with no documentation in the file of an EOB issued to the member to inform them of the correct liability. BlueChoice disagreed with the examiners' observations stating, in part:

> Carefirst agrees that the initial processing of the claim was incorrect. However, a provider file error was self identified by CareFirst which

> prompted the processing of the corrected claim 4265P0273300 to indicate the correct patient liability of $0.00. Please see the attached EOB to the member for the correct processing of the claim…. CareFirst does not agree with the conclusion that its actions in this case are indicative of a "business practice" much less a "general business practice" as required under the statutory provisions cited. With regard to the examiner's finding under section 38.2-3407.4 B of the Code of Virginia, CareFirst does not agree with the examiner's interpretation of the statute. Under this interpretation, this provision of the statute would be automatically violated each and every time that an error is made in the processing of a claim. Rather, we believe that Section 38.2-3407.4 B of the Code of Virginia is intended to address discrepancies between the information on the EOB and the conclusions reached when the claim was processed. Applied to the facts of this claim, while the claim was originally processed incorrectly, the information on the EOB was reflective of, and entirely consistent with, the manner in which the claim was processed, i.e., there is no discrepancy between the information presented in the EOB and the information in CareFirst's system resulting from the processing of the claim.

While the examiners acknowledge that BlueChoice self-identified the provider file error, the claim was not correctly reprocessed until nearly 2 years after the original receipt date and initial incorrect processing. BlueChoice failed to adopt and implement reasonable standards for prompt investigation in the case of this claim. The examiners also disagree with BlueChoice's response regarding § 38.2-3407.4 B of the Code. As the initial EOB includes information that is inconsistent with the benefits described in the EOC and is potentially misleading to the member, the EOB fails to accurately and clearly set forth the benefits payable under the contract.

Section 38.2-510 A 14 of the Code prohibits, as a general business practice, failing to promptly provide a reasonable explanation of the basis in the insurance policy for a denial of a claim or for the offer of a compromise settlement. The review revealed that BlueChoice was in non-compliance with this section in 1 instance. As discussed in Review Sheet CL38B, BlueChoice originally denied the claim with the explanation "This service is not covered because the provider is not part of the CareFirst BlueChoice

network." The claim was later reprocessed with no member responsibility. As the claim involves a contracted provider in the BlueChoice service area, the denial explanation provided on the original EOB was inaccurate and potentially misleading to the member. BlueChoice disagreed with the examiners' observations stating:

> The Plan disagrees with the auditor's position as the provider submitted under their contracted provider number with the Hosting Plan which is not contracted or affiliated under the BlueChoice Carefirst contract which makes the denial accurate. The provider submitted the claim properly under the BlueChoice contracted provider number on claim ID#634871121800 and was processed to the provider in network on 12/21/2016. The denial advised the provider through the notice of payment that they have misfiled their claim and directs them to file appropriately if applicable as they are dually contracted with multiple BCBS plans and networks.

The examiners acknowledge that the claim was initially incorrectly submitted by the provider to the host plan and that BlueChoice was correct to deny this submission and advise the provider to file appropriately; however, the explanation provided to the member on the EOB does not accurately reflect this reason for denial. The only denial explanation provided to the member indicated that "…the provider is not part of the CareFirst BlueChoice network…" and that the member is responsible for the billed amount of the claim, with no indication that the denial is based on a submission error by the provider or that the provider has been or will be advised to resubmit the claim to BlueChoice with a correct provider number.

Section 38.2-514 B of the Code states that no person shall provide to an insured, claimant, subscriber or enrollee under an accident and sickness insurance policy, subscription contract, or health maintenance organization contract, an EOB which does not clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services. The review revealed

1 violation of this section. As discussed in Review Sheet CL25B, BlueChoice processed the claim on October 28, 2016, with no member liability. The claim was resubmitted and processed on November 4, 2016, as a duplicate submission and was denied as such; however, during this processing, the full $221.00 billed amount was displayed in the "YOUR RESPONSIBILITY" section of the EOB. As the member was not actually responsible for this amount, BlueChoice issued an EOB that failed to clearly and accurately disclose the method of benefit calculation. BlueChoice agreed with the examiners' observations.

Dental

A sample of 25 was selected from a population of 529 dental claims paid during the examination time frame.

Section 38.2-510 A 3 of the Code states that no person shall, with such frequency as to indicate a general business practice, fail to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies. The review revealed that BlueChoice was in non-compliance with this section in 1 instance. Section 38.2-510 A 6 of the Code states that no person shall, with such frequency as to indicate a general business practice, not attempt in good faith to make prompt, fair and equitable settlements of claims in which liability has become reasonably clear. The review revealed that BlueChoice was in non-compliance with this section in 1 instance. Section 38.2-4306.1 B of the Code sets forth the requirement for payment of interest on claim proceeds from 30 days from the date the proof of loss is received to the date of claim payment. The review revealed that BlueChoice was in violation of this section in 1 instance. As discussed in Review Sheet CL03M-CF, BlueChoice received a dental claim

form reflecting 12 lines of service and paid 2 lines of service on the claim on May 19, 2016. On July 19, 2016, BlueChoice corrected the claim and paid all 12 lines of service. BlueChoice failed to adopt and implement reasonable standards for the prompt investigation of this claim; failed to make a prompt, fair and equitable settlement of the claim; and failed to pay the statutory interest owed. BlueChoice disagreed with the examiners' observations stating:

> 2 lines of service were initially paid in the appropriate time frame. Due to an honest mistake, the remaining claim lines were initially omitted. As this omission was completely unintentional, CareFirst strongly disagrees with the tentative finding under Section 38.2-510 A 6 that CareFirst did not "in good faith attempt" to settle this claim. In fact, after receiving a phone call from the provider pointing out the error, CareFirst processed and paid the remaining claim lines. Additionally, CareFirst believes that a violation of Sections 38.2-510 A 3 and/or 38.2-510 A 6 of the Code of Virginia requires a finding that the actions in question occurred "with such frequency as to indicate a general business practice." CareFirst does not agree with the conclusion that its actions in this case are indicative of a "general business practice" with respect to the statutory provisions cited.

The examiners responded that BlueChoice received the dental claim form with 12 lines of service but only paid 2 lines of service for the claim and it wasn't until the provider pointed out BlueChoice's error that the claim was paid in full.

Section 38.2-510 A 5 of the Code of Virginia states that no person shall, with such frequency as to indicate a general business practice, fail to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed. The review revealed that BlueChoice was in non-compliance with this section in 1 instance. As discussed in Review Sheet CL04M-CF, BlueChoice took 55 calendar days to affirm the claim. BlueChoice disagreed with the examiners' observations stating:

> It is not a general business practice to pay a processes [sic] claims 55 days after receipt of the claim. However, CareFirst believes that a violation of Section 38.2-510 A 5 of the Code of Virginia requires a finding that

unreasonably long delays occurred "with such frequency as to indicate a general business practice." CareFirst does not agree with the conclusion reached that the delay in this instance supports a factual finding of a "general business practice". It should be noted that the member was not harmed as the claim paid on 07/18/2016.

The examiners responded that:

CareFirst informed the examiners that its established time frame from receipt of complete proof of loss until a claim is affirmed or denied is 30 days. The EOB date and mail date for this claim was 7/18/16, which was 55 days after the receipt of proof of loss. Therefore, CareFirst failed to pay the claim within a reasonable time after proof of loss was received. Please note, that a general business practice is determined by observing the entire sample and is not based on an isolated case.

Vision

A sample of 40 claims was selected from a population of 2,054 vision claims paid during the examination time frame.

Section 38.2-510 A 1 of the Code prohibits, as a general business practice, misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue. The review revealed that BlueChoice was in non-compliance with this section in 5 instances. Section 38.2-510 A 6 of the Code prohibits, as a general business practice, not attempting in good faith to make prompt, fair and equitable settlement of claims in which liability has become reasonably clear. The review revealed that BlueChoice was in non-compliance with this section in 5 instances. In addition, the review revealed that BlueChoice was in non-compliance with its EOC in 5 instances. An example is discussed in Review Sheet CL05M-CF, where BlueChoice assessed a $40 copay instead of the $0 copay required in the EOC. BlueChoice disagreed with the examiners' observations stating:

Member was enrolled under a benefit plan design with Davis Vision at the time of service that the member was responsible for a $40.00 copayment

> for an eye exam. CareFirst's partner, Davis Vision, acted in good faith, without misrepresentations, and processed the members' claims, which complied with their benefit contracts.

The examiners maintained their findings and responded that the EOC provided by BlueChoice states that there is no copayment or coinsurance for an eye examination. Since BlueChoice did not provide documentation to support the $40 copayment for the eye exam, BlueChoice misrepresented policy provisions relating to coverages at issue, has failed to make a fair and equitable settlement, and is in non-compliance with the EOC.

Section 38.2-510 A 5 of the Code of Virginia states that no person shall, with such frequency as to indicate a general business practice, fail to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed. The review revealed that BlueChoice was in non-compliance with this section in 23 instances. As discussed in Review Sheet CL12M-CF, BlueChoice did not provide an EOB form to the members for the claims and, therefore, failed to affirm the claim within a reasonable time after proof of loss was received. BlueChoice agreed with the examiners' observations.

Pharmacy

A sample of 50 was selected from a population of 266,645 pharmacy claims paid during the examination time frame. The review revealed the claims were processed in accordance with the contract provisions.

DENIED CLAIM REVIEW

Group & Individual Medical

A sample of 95 was selected from a population of 80,511 claims denied during the examination time frame.

Section 38.2-510 A 5 of the Code prohibits, as a general business practice, failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed. The review revealed that BlueChoice was in non-compliance with this section in 1 instance. Section 38.2-510 A 14 of the Code prohibits as a general business practice, failing to provide a reasonable explanation of the basis in the insurance policy for denial of a claim. The review revealed that BlueChoice was in non-compliance with this section in 1 instance. As discussed in Review Sheet CL06F-CF, BlueChoice took 517 calendar days to deny the claim and failed to provide a reasonable explanation of the basis for the denial. BlueChoice agreed with the examiners' observations.

Mental Health & Substance Use Disorder

A sample of 40 was selected from a population of 3,174 mental health and substance use disorder claims denied during the examination time frame. The review revealed that the claims were processed in accordance with the contract provisions.

Dental

A sample of 10 was selected from a population of 219 dental claims denied during the examination time frame.

Section 38.2-510 A 5 of the Code of Virginia states that no person shall, with such frequency as to indicate a general business practice, fail to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed. The review revealed that BlueChoice was in non-compliance with this section in 1 instance. As discussed in Review Sheet CL01M-CF, BlueChoice took 33 calendar days to deny the claim. BlueChoice disagreed with the examiners' observations stating:

> Please note that the EOB was mailed on 7/19/16 – not 7/16/16 as noted in the observations. While this specific claim required 33 days from receipt to mailing of an EOB, CareFirst does not agree that the "additional" three days required to complete this claim should lead to an automatic determination of unreasonableness. In this particular instance, the processing was negatively affected by an [sic] isolated claims back log. Additionally, CareFirst believes that a violation of Section 38.2-510 A 5 of the Code of Virginia requires a finding that unreasonably long delays occurred "with such frequency as to indicate a general business practice." CareFirst does not agree with the conclusion reached that a minor delay in this instance is, by definition, unreasonable or that this alone supports a factual finding of a "general business practice."

The examiners maintained their findings and responded that BlueChoice informed the examiners that its established time frame from receipt of complete proof of loss until a claim is affirmed or denied is 30 days. The EOB date and mail date for this claim was 7/19/16, which was 33 days after the receipt of proof of loss.

Vision

A sample of 35 was selected from a population of 85 vision claims denied during the examination time frame.

Section 38.2-510 A 4 of the Code prohibits as a general business practice, refusing arbitrarily and unreasonably to pay claims. The review revealed that BlueChoice was in non-compliance with this section in 1 instance. Section 38.2-510 A 6 of the Code prohibits, as a general business practice, not attempting in good faith to make prompt, fair and equitable settlement of claims in which liability has become reasonably clear. The review revealed that BlueChoice was in non-compliance with this section in 1 instance. Section 38.2-510 A 14 of the Code prohibits, as a general business practice, failing to promptly provide a reasonable explanation of the basis in the insurance policy for a denial of a claim or for the offer of a compromise settlement. The review revealed that BlueChoice was in non-compliance with this section in 1 instance. In addition, the

review revealed that BlueChoice was in non-compliance with its EOC in 1 instance. As discussed in Review Sheet CL13M-CF, the claim file indicated that the date of service for the claim was February 23, 2016; the claim was submitted to BlueChoice by the provider on September 16, 2016; and BlueChoice denied this claim for the following reason on September 27, 2016, "Charges are not payable when submitted more than 90 days after the date of service in which the charges were incurred." However, the EOC stated that the timely filing submission limit was 12 months after the date the covered service was received. BlueChoice disagreed with the examiners' observations stating:

> Providers have 180 days to submit a claim for payment. This claim was received after the 180 days. The claims examiner did use the denial code indicating that it was greater than 90 days which was the incorrect denial code reason. The examiner should have selected the denial code that states 180 days. The claim was still received outside the timely filing limits and therefore was denied correctly.

The examiners responded that the EOC provided by BlueChoice states that claims for vision care must be submitted within 12 months following the date services were rendered. Since BlueChoice did not provide documentation to support the timely filing limit of 180 days; BlueChoice refused arbitrarily and unreasonably to pay the claim; failed to make a fair and equitable settlement; failed to provide a reasonable explanation of the basis in the insurance policy in relation to the facts for the denial of the claim; and is in non-compliance with the EOC.

Pharmacy

A sample of 30 was selected from a population of 63,120 pharmacy claims denied during the examination time frame. The review revealed the claims were processed in accordance with the contract provisions.

SUMMARY

BlueChoice's failure to comply with §§ 38.2-510 A 1, 38.2-510 A 5, and 38.2-510 A 6 of the Code occurred with such frequency as to indicate a general business practice, placing BlueChoice in violation of these sections.

THREATENED LITIGATION

BlueChoice informed the examiners that there were no claims that involved threatened litigation during the examination time frame.

XVI. CORRECTIVE ACTION PLAN

Based on the findings stated in this Report, BlueChoice will be required to implement the following corrective actions. BlueChoice shall:

1. Review and strengthen its procedures to ensure that it maintains its established complaint system approved by the Commission, as required by 14 VAC 5-211-150 A and § 38.2-5804 A of the Code;
2. Review and strengthen its procedures to ensure timely response to post-service appeals, as required by 14 VAC 5-216-40 E 2;
3. Establish and maintain procedures to ensure that if there is an intermediary organization between the HMO and health care providers, the hold harmless clause shall be amended to include nonpayment by the plan, the HMO and the intermediary organization and shall be included in any contract between the intermediary organization and health care providers and in any contract between the HMO on behalf of the MCHIP and the intermediary organization, as required by § 38.2-5805 C 10 of the Code;
4. As recommended in the prior Report, establish and maintain procedures to ensure that all provider contracts contain the provisions required by § 38.2-3407.15 B of the Code;
5. Review and strengthen procedures to ensure adherence and compliance with the minimum fair business standards in the processing and payment of claims, as required by §§ 38.2-510 A 15, 38.2-3407.15 B and 38.2-3407.15 C of the Code;
6. Establish and maintain business practices to ensure that all contracts between a carrier and a participating health care provider, or its contracting agent, shall

contain specific provisions regarding prior authorization, as required by §§ 38.2-3407.15:2 B and 38.2-3407.15:2 D of the Code;

7. Strengthen and maintain procedures to ensure that each invitation to inquire contains the disclosure required by 14 VAC 5-90-55 A;

8. Strengthen and maintain procedures to ensure that each advertisement complies with the requirements regarding the words and phrases identified in 14 VAC 5-90-60 A 1;

9. Strengthen and maintain procedures to ensure that statistical information shall not be used in advertisements unless it accurately reflects all current and relevant facts, as required by 14 VAC 5-90-90 A;

10. As recommended in the prior Report, establish and maintain procedures to ensure that all policy and application forms are filed with and approved by the Commission, as required by §§ 38.2-316 A, 38.2-316 B and 38.2-316 C 1 of the Code;

11. Establish and maintain procedures to ensure that all EOBs are filed for approval prior to use, as required by § 38.2-3407.4 A of the Code;

12. Establish and maintain procedures to ensure that each enrollee is notified when his or her out-of-pocket maximum is met, and that notification is given no later than 30 days after the HMO has processed sufficient claims to determine that the out-of-pocket maximum is met, as required by 14 VAC 5-211-90 B;

13. As recommended in the prior Report, establish and maintain procedures for compliance with §§ 38.2-1833 A 1, and 38.2-1834 D of the Code concerning the appointment and appointment termination of its agents and agencies;

14. Establish and maintain procedures to ensure that the AUD notice required by §§ 38.2-610 A 1 and 38.2-610 A 2 of the Code is provided to applicants in accordance with the guidelines established by Administrative Letter 2015-07;

15. Establish and maintain procedures to ensure compliance with §§ 38.2-510 A 1, 38.2-510 A 3, 38.2-510 A 4, 38.2-510 A 5, 38.2-510 A 6 and 38.2-510 A 14 of the Code;

16. Review and strengthen its procedures for ensuring that its EOBs accurately and clearly set forth the benefits payable under the contract, and clearly and accurately disclose the method of benefit calculation and the actual amount which has been or will be paid to the provider of services, as required by §§ 38.2-3407.4 B and 38.2-514 B of the Code. This shall include clearly and accurately indicating member liability, allowable amounts, deductibles, coinsurance, and copayments on its EOBs;

17. Review and strengthen its procedures to ensure that all claims are adjudicated in accordance with the EOC;

18. Review and strengthen its procedures for the payment of interest due on claim proceeds, as required by § 38.2-4306.1 B of the Code;

19. Review and strengthen its coordination of benefits claim handling practices and EOB forms for compliance with the requirements of 14 VAC 5-211-80 B;

20. Review and reopen the claims discussed in review sheets CL39B and CL03M-CF and re-adjudicate them to pay with statutory interest owed. Include with each check, an explanation stating that, “As a result of a Target Market Conduct

Examination by the Virginia State Corporation Commission's Bureau of Insurance, it was determined that this claim was processed incorrectly."; and

21. Within 90 days of this Report being finalized, furnish the examiners with documentation that each of the above actions has been completed.

XVII. ACKNOWLEDGMENT

The courteous cooperation extended to the examiners by Anthem's officers and employees during the course of this examination is gratefully acknowledged.

Mel Gerachis, FLMI, AIRC, AMCM, Brant Lyons, MCM, Janay Brown, MCM, Julie Atkins, Heather Webb, MCM, and Freddie Oliver, MCM, of the Bureau of Insurance participated in the work of the examination and writing of the Report.

Respectfully submitted,

Julie Fairbanks, AIE, FLMI, AIRC, MCM
BOI Manager, Market Conduct Section
Life and Health Market Regulation Division
Bureau of Insurance

XVIII. AREA VIOLATIONS SUMMARY BY REVIEW SHEET

MANAGED CARE HEALTH INSURANCE PLANS (MCHIPs)
Complaint System
14 VAC 5-216-40 E 2, 3 violations, CP03J-CF, CP04J-CF, CP17J
Provider Contracts
§ 38.2-5805 C 10, **1 violation**, MC01B-CF
14 VAC 5-211-30 C, 1 violation, MC01B-CF
ETHICS & FAIRNESS IN CARRIER BUSINESS PRACTICES
Ethics and Fairness – Provider Contracts
§ 38.2-3407.15 B 1, 5 violations, EF02B-CF (4), EF06M-CF
§ 38.2-3407.15 B 2, 5 violations, EF02B-CF (4), EF06M-CF
§ 38.2-3407.15 B 3, 5 violations, EF02B-CF (4), EF06M-CF
§ 38.2-3407.15 B 4, 5 violations, EF02B-CF (4), EF06M-CF
§ 38.2-3407.15 B 5, 5 violations, EF02B-CF (4), EF06M-CF
§ 38.2-3407.15 B 6, 5 violations, EF02B-CF (4), EF06M-CF
§ 38.2-3407.15 B 8, 1 violation, EF06M-CF
§ 38.2-3407.15 B 9, 21 violations, EF03B-CF (16), EF04B-CF (4), EF06M-CF
§ 38.2-3407.15 B 10, 5 violations, EF02B-CF (4), EF06M-CF
§ 38.2-3407.15 B 11, 1 violation, EF06M-CF
Ethics and Fairness – Provider Claims
§ 38.2-3407.15 B 6, 1 violation, EFCL01B-CF
§ 38.2-3407.15 B 8, 1 violation, EFCL04B-CF
Carrier contracts; required provisions regarding prior authorization
§ 38.2-3407.15:2 B 1, 4 violations, EF05B-CF (4)
§ 38.2-3407.15:2 B 2, 4 violations, EF05B-CF (4)
§ 38.2-3407.15:2 B 3, 4 violations, EF05B-CF (4)

§ 38.2-3407.15:2 B 4, 4 violations, EF05B-CF (4)
§ 38.2-3407.15:2 B 5, 4 violations, EF05B-CF (4)
§ 38.2-3407.15:2 B 6, 4 violations, EF05B-CF (4)
§ 38.2-3407.15:2 B 7, 4 violations, EF05B-CF (4)
§ 38.2-3407.15:2 B 8, 4 violations, EF05B-CF (4)
ADVERTISING
14 VAC 5-90-55 A, 1 violation, AD02H-CF
14 VAC 5-90-60 A 1, 1 violation, AD02H-CF
14 VAC 5-90-90 C, 1 violation, AD02H-CF
POLICY AND OTHER FORMS
§ 38.2-316 A, 3 violations, PF05M-CF, PF06M-CF, PF07M-CF
§ 38.2-316 B, 1 violation, PF01M-CF
§ 38.2-316 C 1, 4 violations, PF01M-CF, PF05M-CF, PF06M-CF, PF07M-CF
§ 38.2-3407.4 A, 6 violations, PF01B-CF, PF02B-CF (2), PF03B-CF, PF04B-CF, PF03M-CF
14 VAC 5-211-90 B, 5 violations, PF04M-CF (5)
AGENTS
§ 38.2-1833 A 1, 2 violations, AG08M-CF, AG09M-CF
§ 38.2-1834 D, 6 violations, AG06M-CF (3), AG07M-CF (3)
UNDERWRITING/UNFAIR DISCRIMINATION/INSURANCE INFORMATION AND PRIVACY PROTECTION ACT
§ 38.2-610 A 1, 14 violations, UN04M-CF, UN06M-CF, UN07M-CF, UN08M-CF, UN09M-CF, UN10M-CF, UN11M-CF, UN12M-CF, UN13M-CF, UN14M-CF, UN15M-CF, UN16M-CF, UN17M-CF, UN18M-CF

§ 38.2-610 A 2, 14 violations, UN04M-CF, UN06M-CF, UN07M-CF, UN08M-CF, UN09M-CF, UN10M-CF, UN11M-CF, UN12M-CF, UN13M-CF, UN14M-CF, UN15M-CF, UN16M-CF, UN17M-CF, UN18M-CF
CLAIM PRACTICES
§ 38.2-510 A 1, 5 violations, CL05M-CF, CL06M-CF, CL07M-CF, CL08M-CF, CL09M-CF
§ 38.2-510 A 3, 2 instances of non-compliance, CL35B, CL03M-CF
§ 38.2-510 A 4, 1 instance of non-compliance, CL13M-CF
§ 38.2-510 A 5, 26 violations, CL06F-CF, CL01M-CF, CL04M-CF, CL12M-CF (23)
§ 38.2-510 A 6, 7 violations, CL03M-CF, CL05M-CF, CL06M-CF, CL07M-CF, CL08M-CF, CL09M-CF, CL13M-CF
§ 38.2-510 A 14, 5 instances of non-compliance, CL06F-CF, CL13M-CF, CL37B, CL38B, CL39B
§ 38.2-514 B, 2 violations, CL25B, CL31B
§ 38.2-3407.4 B, 4 violations, CL29B, CL31B, CL35B, CL39B
§ 38.2-4306.1 B, 2 violations, CL39B, CL03M-CF
14 VAC 5-211-80 B, 1 violation, CL16B

COMMONWEALTH OF VIRGINIA

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July 25, 2019

SENT VIA EMAIL

Ms. Jenene Lyn Williams
Director, External Audit Coordination
CareFirst BlueChoice, Inc.
1501 South Clinton Street
Room 10147
Baltimore, MD 21224

RE: Market Conduct Examination Report
Exposure Draft – CareFirst BlueChoice, Inc.

Dear Ms. Williams:

Recently, the Bureau of Insurance conducted a Market Conduct Examination of CareFirst BlueChoice, Inc. (BlueChoice) for the period of July 1, 2016, through December 31, 2016. A preliminary draft of the Report is enclosed for your review.

Since it appears from a reading of the Report that there have been violations of Virginia Insurance Laws and Regulations on the part of BlueChoice, I would urge you to read the enclosed draft and furnish me with your written response within 30 days of the date of this letter. Please specify in your response those items with which you agree, giving me your intended method of compliance, and those items with which you disagree, giving your specific reasons for disagreement. BlueChoice's response(s) to the draft Report will be attached to and become part of the final Report.

Once we have received and reviewed your response, we will make any justified revisions to the Report and will then be in a position to determine the appropriate disposition of this matter.

Thank you for your prompt attention to this matter.

Yours truly,

Julie R Fairbanks

Julie R. Fairbanks, AIE, FLMI, AIRC, MCM
BOI Manager, Market Conduct Section
Life and Health Market Regulation Division
Bureau of Insurance
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Jenene L. Williams, Sr. Director, External Audit Coordination
CareFirst BlueChoice, Inc.
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Baltimore, MD 21224
Tel. 410.528.5796
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October 4, 2019

Ms. Julie R. Fairbanks, AIE, FLMI, AIRC, MCM
BOI Manager, Market Conduct Section
Life and Health Market Regulation Division
Bureau of Insurance
1300 E. Main Street
Richmond, Virginia 23219

RE: Market Conduct Examination Report
Exposure Draft – CareFirst BlueChoice, Inc.

Dear Ms. Fairbanks:

Thank you for the exposure draft of the market conduct examination of CareFirst BlueChoice, Inc. ("BlueChoice") for the period of July 1, 2016 through December 31, 2016. BlueChoice has received the exposure draft and this letter will serve as its response. Unless noted, BlueChoice has not commented on those sections of the examination in which the Virginia Bureau of Insurance found substantial compliance.

Kindly note that BlueChoice placed its corrective action measure within the body of its response.

Section I. Scope of Examination and Section II EXECUTIVE SUMMARY

In the development and implementation of its business policies and day-to-day practices, BlueChoice exercises its best intent and good faith efforts to comply with all applicable state and federal law, including Virginia law. BlueChoice objects to the assertions that the company knowingly violates Virginia law or engages in general business practices that fail to comply with it.

Section V. MANAGED CARE HEALTH INSURANCE PLANS (MCHIPS)

Complaint System – Timeliness

BlueChoice is committed to maintaining a compliant Complaint system where responses are timely and consistent with policies and procedures agreed and approved by the Commission.

Provider and Intermediary Contracts

MC01-CF: BlueChoice has reviewed the examiner's review sheet and continues to disagree with the VBOI's position. To the extent that the contract was deficient for not including a particular provision, BlueChoice has since terminated its contract with Magellan Health effective January 1, 2018. As such, no further corrective action plan is necessary.

Section VII. PROVIDER CONTRACTS

Ethics and Fairness in Carrier Business Practices – Provider Contracts

EF02B-CF: BlueChoice acknowledges the examiner's findings. Effective 1/1/18, BlueChoice no longer contracts with Magellan Health for use of its provider network and as such no further corrective action plan is necessary.

EF06M-CF: BlueChoice conducted a root cause analysis regarding this finding. To address the gap, BlueChoice will revise all dental provider contracts to include provisions required by § 38.2-3407.15:2 B 1 through B 11 of the Code of Virginia. This will be done by April 2020. BlueChoice conducts monthly meetings to review, revise and monitor through implementation.

EF10B-CF: BlueChoice disagrees with the observation regarding, "CareFirst has failed to comply with the notification requirements of Section 38.2-3407.15 B 9 of the Code of Virginia". The observation supposes the "letter would not have been delivered to the provider 60 days before the effective date," but the letters were mailed more than 60 days before the effective date and BlueChoice has seen no evidence for the supposition that the letters were not delivered within the statutory timeframe. However, to avoid any potential confusion in the future, BlueChoice implemented a procedural change to ensure all contractual provider notifications will be mailed at least 65 days prior to the effective date.

Attached to this response are the two reports (Attachments EF10B-CF1 and EF10B-CF2) showing the specific Outcome Incentive Award (OIA) results earned in performance year 2015, and effective on August 1, 2016. The providers voluntarily joined the PCMH program via an Addendum to their participation agreement. This Addendum, and the related PCMH Program Description and Guidelines, outlines the terms of the PCMH incentives, the annual OIA changes and how it impacts provider reimbursement arrangements.

EF03B-CF: BlueChoice respectfully disagrees with the examiners regarding the statement that any change to the provider manual must be considered an amendment to the agreement. BlueChoice provides material changes to providers at least 60 calendar days before the effective date of the change. BlueChoice does not consider aesthetic changes to the manual such as layout, misspellings and/or clarifications material changes and does not consider them an amendment to the contract. However, when the provider manual is updated or other non-material changes are made, providers are notified that such changes have been made to the manual.

BlueChoice agrees with the examiner's findings that only 59 calendar days' notice was provided for the changes to the drug prior authorization list. BlueChoice implemented improvements to process and procedures to ensure that all prior notices are mailed approximately 5 business days prior to the 60-day advance notice period.

EF04B-CF: BlueChoice acknowledges the examiner's finding. Effective 1/1/18, BlueChoice no longer contracts with Magellan Health for use of its provider network and as such no further corrective action plan is necessary.

Ethics and Fairness in Carrier Business Practices – Provider Claims

EFCL01B-CF: The retraction notification was initiated based on notification from the member that the member returned equipment to the provider and should not have been billed. Please see Attachments

EFCL01B-CF – 1 through 5, which were previously provided, including the retraction notification which was forwarded within the 12 months of the initial paid date of 11/25/15. BlueChoice also attaches the required notice of the retraction on 10/25/16, the EOB and the Notice of Payment (NOP) associated with these timestamps dated 12/2/16. BlueChoice acted in good faith based on the information and complaint received from the member of not receiving the equipment.

EFCL04B-CF: BlueChoice respectfully disagrees with the finding. Sample claim 635518877500 was received on 12/20/2016 and was processed to pay at the in-network level on 12/28/2016 systemically. The provider billed procedure code A9575 at $34.00 for 10 units. The procedure code paid 100% of the allowed amount of $.21 per unit at $2.10 on the P-027HMO-STD agreement ID. The provider billed procedure code 73222 at $2,580.00 for 1 unit. The procedure code had an allowed amount of $482.14 which was processed at 100% of the allowed amount as follows: applied $250.00 to the member's copay per the members CAT Scan benefit and paid $232.14. Please see the printout from the pricing tool for procedure A9575 and 73222 (Attachment EFCL04B-CF-1) and the copy of the provider's contract (Attachment EFCL04B-CF-2) with CareFirst that were previously provided.

Carrier Contracts: Required Provisions Regarding Prior Authorization

EF05B-CF: BlueChoice acknowledges the examiner's finding. Effective 1/1/18, BlueChoice no longer contracts with Magellan Health for use of its provider network and as such no further corrective action plan is necessary.

Section VIII. ADVERTISING

AD02H-CF: Regarding VAC 5-90-55 A, beginning June 2018 (the date BlueChoice's violation disagreement response was rejected by the VBOI), BlueChoice added the following statement to all invitations to inquire:

> *The policies may have exclusions, limitations or terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, call your insurance agent or CareFirst.*

To ensure that all BlueChoice advertisements and marketing materials are accurate, error-free and compliant, BlueChoice's product managers, product specialists and marketing project managers review all materials before they are shared publicly. During this review process, product managers and product specialists compare all plan and benefit information to the contract and plan design guide, which is formally reviewed each year during roundtable quality assurance sessions. Additionally, all marketing materials are reviewed by BlueChoice's legal team to ensure compliance and accuracy. This was the review process in 2016 and it continues to date.

Regarding VAC 5-90-60 A and VAC 5-90-90 C, beginning June 2018 (the date BlueChoice's violation disagreement response was rejected by the VBOI), BlueChoice provides the source of any statistics used to compare BlueChoice benefits to the benefits of other carriers. Additionally, BlueChoice will use caution when citing the benefits of other carriers to ensure the data is accurate.

To ensure that all BlueChoice advertisements and marketing materials are accurate, error-free and compliant, BlueChoice's product managers, product specialists and marketing project managers review all materials before they are shared publicly. During this review process, product managers and product specialists compare all plan and benefit information to the contract and plan design guide, which is formally reviewed each year during roundtable quality assurance sessions. Additionally, all marketing

materials are reviewed by BlueChoice's legal team to ensure compliance and accuracy. This was the review process in 2016 and it continues to date.

Section IX. POLICY AND OTHER FORMS

PF05M-CF: Regarding violations - § 38.2 316 A and § 38.2 316 C, although there are discrepancies between form VA/CFBC/2014 MANDATE (1/14) and the explanation of variations (EOV), the form was filed and approved by the VBOI on 11/22/13. Nonetheless, a subsequent version control issue resulted in a version of the form not supported by the filed EOV being unintentionally used in the production contract. Please also note that the production version of this form is being revised to align with the EOV and BlueChoice has and will continue to implement process improvements to advance version control and quality assurance reviews for accurate contract creation following form approvals.

Regarding corrective action measures, BlueChoice updated its standard operating procedures effective 1/1/19 to address version control protocols. All production forms must be compared to approved form from SERFF prior to implementation. The company also implemented mandatory internal benefit contract management pre and post filing quality assurance reviews. Regarding form correction, BlueChoice is in the process of updating its contract systems to have the correct form placed in production.

PF06M-CF: Regarding violations - § 38.2 316 A and § 38.2 316 C, although there are discrepancies between form VA/CFBC/CHIPRA (4/09) and the EOV, the form was filed and approved by the VBOI on 3/2/09. Nonetheless, a subsequent version control issue resulted in a version of the form not supported by the filed EOV being unintentionally used in the production contract. Please also note that the production version of this form is being revised to align with the EOV and BlueChoice has and will continue to implement process improvements to advance version control and quality assurance reviews for accurate contract creation following form approvals.

Regarding corrective action measures, BlueChoice updated its standard operating procedures effective 1/1/19 to address version control protocols. All production forms must be compared to approved form from SERFF prior to implementation. The company also implemented mandatory internal benefit contract management pre and post filing quality assurance reviews. Regarding form correction, BlueChoice is in the process of updating its contract systems to have the correct form placed in production.

PF07M-CF: Regarding violations - § 38.2 316 A and § 38.2 316 C, although there are discrepancies between form VA/CFBC/HBADV EOC (7/12) and the EOV, the form was filed and approved by the VBOI on 7/19/12. Nonetheless, a subsequent version control issue resulted in a version of the form not supported by the filed EOV being unintentionally used in the production contract. Please also note that the production version of this form is being revised to align with the EOV and BlueChoice has and will continue to implement process improvements to advance version control and quality assurance reviews for accurate contract creation following form approvals.

Regarding corrective action measures, BlueChoice updated its standard operating procedures effective 1/1/19 to address version control protocols. All production forms must be compared to approved form from SERFF prior to implementation. The company also implemented mandatory internal benefit contract management pre and post filing quality assurance reviews. Regarding form correction,

BlueChoice is in the process of updating its contract systems to have the correct form placed in production.

PF08M-CF: Regarding violations - § 38.2 316 A and § 38.2 316 C, BlueChoice inadvertently attached the wrong form in SERFF when this form was filed. Form number VA/CFBC/ALLBEN (1/13) was accidently attached in SERFF under two submission numbers CFBC-128698539 and CFBC-128698559. This was unintentional as noted by the correct form number (VA/CFBC/HBADV/ALLBEN (1/13)) being indicated in SERFF under the form schedule tab. Please note that form number VA/CFBC/HBADV/ALLBEN (1/13) was pulled from production on 12/31/16 and has been terminated.

PF01M-CF: Regarding violations of § 38.2 316 B and § 38.2 316 C, BlueChoice agrees that this application was manually processed in error by a BlueChoice associate. The broker in this case gave the incorrect form to the applicant. After receipt, the BlueChoice associate who manually processed the enrollment did not follow established procedures that require the rejection of applications submitted on forms not approved by the VBOI.

BlueChoice has revised its procedures regarding manually processing applications. The company implemented a quality check to validate that the applicant submitted an application on forms approved by the VBOI. In addition, BlueChoice has implemented a periodic second-level review of processed applications to ensure accuracy. This corrective action was deployed in 2018 and is ongoing.

PF01B-CF: Form number CUT0287-1E (10-13) was not filed for use by BlueChoice as the in-network explanation of benefits. EOB form number CUT0287 (10-13) was filed and approved for use with the company's in-network and out-of-network indemnity medical and dental products. Form number CUT0287-1E (10-13) was also filed and approved to use by GHMSI as the out-of-network explanation of benefits in conjunction with the company's dual offering product. Therefore, BlueChoice agrees with the VBOI's determination that CUT0287-1E (10-13) was not filed nor approved for use by BlueChoice in the processing of in-network claims.

However, BlueChoice respectfully disagrees that form number CUT0287-1E (10-13) was only filed for use by GHMSI in the processing of out-of-network claims. The attached submission letter from SERFF Tracking Number CFBC-129233106 indicates CareFirst's intent to use the form with its indemnity medical and dental products (Attachment PF01B-CF). The letter also indicates that the company will use the form for GHMSI as the out-of-network explanation of benefits in conjunction with the company's dual offering product.

PF02B-CF through PF04B-CF: BlueChoice acknowledges the examiner's findings. The company is finalizing its corrective action plan which will include a comprehensive standard operating procedure and the quality review measures of a team that is independent from the business unit.

PF03M-CF: BlueChoice acknowledges the examiner's findings. As of March 2019, BlueChoice has established a workgroup to implement explanation of benefits that will be filed with the VBOI for approval. Requirements were established for Davis Vision to implement in July, 2019. Discussions are taking place between Davis Vision and BlueChoice to finalize expectations and requirements. BlueChoice expects to file the EOBs for approval with the VBOI by Q1, 2020.

PF04M-CF: With respect to § 14 VAC 5-211-90 B, BlueChoice acknowledges that while the member does have full access to their deductible, coinsurance, and out of pocket accumulations through the Carefirst.com portal, "My Account," the company is updating member explanation of benefits to show year to date accumulations for deductible and out-of-pocket and to show when they have met their out-of-pocket maximum.

Section X. AGENTS

Appointed Agent Review

AG08M-CF and AG09M-CF: BlueChoice conducted a root cause analysis regarding this finding. To address the gap, on 4/2/18 BlueChoice updated procedures and conducted training that included: a) timeline of reviewing and approving agent agreements; b) procedures for processing appointments for VA licenses; c) log all appointments with the correct appointment date in a shared database; d) appointment log is checked daily; and e) monthly 100% audit of appointment log by validating against the appointment/termination website to ensure compliance

Terminated Agent Appointment Review

AG06M-CF and AG07M-CF: BlueChoice conducted a root cause analysis regarding this finding. To address the gap, on 4/2/18 BlueChoice updated procedures and conducted training that included: a) timeline and requirements for processing termination requests; b) timeline and requirements for sending the appointment termination notification letter directly to the agent and/or agency; c) timeline and requirements for sending termination notification to Commission and agent; and d) updated audit procedures to include source of termination request, timeline requirements and document retention to ensure compliance.

Section XI. UNDERWRITING/UNFAIR DISCRIMINATION/INSURANCE INFORMATION AND PRIVACY PROTECTION ACT

Adverse Underwriting Decision (AUD)

UN04M-CF, UN06M-CF through UN18M-CF: BlueChoice agrees with the findings and has developed Adverse Underwriting Decision letters to comply with §§38.2-610 A1 and 38.2-610 A2 of the Code of Virginia and Administrative Letter 2015-07. BlueChoice will deploy these letters no later than December 31, 2019.

Section XV. CLAIM PRACTICES

CL14B: With respect to §§ 38.2-510 Al and 38.2-510 A 6, BlueChoice respectfully continues to disagree to these violations. As the company has previously stated, the member was not charged the copay because the member had already met the out-of-pocket maximum. Thus, there was no copay. BlueChoice adjudicated the claim in full compliance with the member's evidence of coverage. Please see Page C-3 of the EOC, which confirms the out-of-pocket accumulations are calculated using both in-network and out-of-network claims. BlueChoice previously provided a spreadsheet showing that the member had reached the out-of-pocket maximum.

CL05M-CF through CL09M-CF: BlueChoice acknowledges the examiner's findings that the members were incorrectly charged copayment for routine vison exams. BlueChoice identified this error in 2018. In February 2018, BlueChoice and Davis Vision refunded payment and applicable interest to members who were incorrectly charged copayment due to this error. BlueChoice will provide documentation that the members listed in the review sheets received refunded payment plus applicable interest.

CL35B: Regarding § 38.2-3407.4 B, BlueChoice disagrees with this finding. BlueChoice self-identified the error on the pricing file and corrected the claim prior to the audit.

Regarding § 38.2-510 A3 , BlueChoice implemented a process improvement. A systemic drag date report was implemented in October 2018 to identify claims that would potentially need manual processing to ensure the claims are vouchered correctly to the participating provider group, thus, holding the member harmless. The company also implemented a system enhancement to proactively identify providers that completed credentialing. Potential claims are pended on a daily basis to ensure accurate processing. The audit sample claim was processed prior to the enhancement and was a manual processing error.

CL03M-CF: While there is no way to eliminate 100% of all human error potentially occurring within the claim adjudication process, BlueChoice has taken the necessary steps and required actions to ensure claims are adjudicated in accordance with the evidence of coverage and in compliance with regulatory requirements going forward. Proof of interest payment is enclosed under as Attachments CL03M-CF-1 and CL03M-CF-2.

CL13M-CF: BlueChoice acknowledges the examiner's findings. By January 1, 2020 BlueChoice and Davis Vision will review and update its current standard practice for notification of EOCs containing non-standard requirements. By January 1, 2020 BlueChoice and Davis Vision will amend their current vendor agreement to require that Davis Vision's provider agreements allow 365 days for all claim filings.

CL06F-CF: BlueChoice acknowledges the examiner's findings. Steps have been taken to ensure ongoing compliance.

CL01M-CF and CL04M-CF: BlueChoice will continue to review and strengthen its front end and back end procedures to ensure that claims are adjudicated in accordance with the evidence of coverage and in compliance with regulatory requirements going forward.

CL12M-CF: BlueChoice acknowledges the examiner's findings. As of March 2019, BlueChoice established a workgroup to implement explanation of benefits that will be filed with the VBOI for approval. Requirements were established for Davis Vision to implement on July, 2019. Discussions are taking place between Davis Vision and BlueChoice to finalize expectations and requirements. BlueChoice expects to file the EOBs for approval with the VBOI by Q1, 2020.

Once the VBOI approves the explanation of benefits, Davis Vision will implement notification of explanation of benefits. BlueChoice will establish a monitoring process to confirm ongoing compliance. The timeframe will be dependent upon the approval date from the VBOI.

CL37B and CL38B: BlueChoice respectfully disagrees with the examiner's finding. Initially, the provider submitted the claim under their contracted provider number with their local Blue Plan (Host Plan), which is not contracted or affiliated under the BlueChoice contract. As the provider number listed on the claim from the Host Plan was not listed as a BlueChoice provider, BlueChoice properly denied

the claim. Through the Notice of Payment of the denial, BlueChoice advised the provider of the misfiling of the claim and directed the provider to file the claim directly with BlueChoice with the appropriate provider number, if appropriate. The provider at issue is contracted with multiple BlueCross BlueShield plans and networks.

CL39B: BlueChoice disagrees with the examiner's finding. The company respectfully asks for another review of the sample and response. Please see Attachments CL39B-1 and CL39B-2 that were previously provided related to the appeal for this sample's claim.

CL25B: BlueChoice acknowledges that the correct denial of "another provider has billed for the services described in this claim. Payment of this service, therefore, would result in a duplicate payment according to the administration provisions of the subscriber's contract." was applied, however, the liability was erroneously displayed as a member liability. This should have been a provider liability. BlueChoice corrected its system on 4/6/18 to show provider liability for the rejection code when the provider is participating. Ultimately, BlueChoice received medical records and reviewed them along with the sample claim. The company adjusted the claim on 2/3/17 to reflect payment as two separate providers/provider specialties that were billing on the same date.

CL31B: BlueChoice acknowledges that the initial processor did not follow the company's standard operating procedure when processing the Medicare claim. The company corrected the error and to ensure ongoing compliance, provided feedback and training to the associates in the claims unit.

CL29B: BlueChoice disagrees with the finding. The member referenced in this sample was enrolled under a subscriber and dependent only policy on 10/1/15. Effective 5/1/16, the member changed his coverage to a subscriber only plan. During the segment of the benefit period in which the member had subscriber and dependent coverage, there was a total of $3,000 accumulated towards the $3,000 family maximum accumulator. However, the portion of the family deductible that was met by this member did not exceed $1,500.

Consequently, when the member changed his coverage to a subscriber only plan there was still a balance remaining on his individual deductible that the member was now required to meet on his own. Therefore, the amount that was credited to the member's individual deductible on this claim is correct and the claim was paid properly. The information summarized in the message is explained by the fact that the member's change to subscriber only coverage occurred during the same benefit period in which he was initially enrolled under a subscriber and dependent policy.

Because this member's deductible applied on a benefit period basis and the benefit period in which he originally enrolled under subscriber and dependent coverage was still in progress on the date of service (it would not end until 9/30/16), it was necessary to retain the family accumulator in the claims system in order to process additional claims for the period prior to the change in coverage while at the same time tracking the member's individual deductible. Consequently, the EOB correctly reflects what was accumulated for coverage under this group plan during the entire, and then still ongoing benefit period.

BlueChoice respectfully request that the VBOI evaluate this sample again.

CL35B: Regarding § 38.2-3407.4 B, BlueChoice disagrees with this finding. BlueChoice had self-identified the error on the pricing file and corrected the claim prior to the audit.

Regarding § 38.2-510 A3, BlueChoice implemented a process improvement. A systemic drag date report was implemented in October 2018 to identify claims that would potentially need manual processing to ensure the claims are vouchered correctly to the participating provider group, holding the member harmless. This was a system enhancement to proactively identify providers that have completed credentialing. Potential claims are pended on a daily basis to ensure accurate processing. The sample claim was processed prior to the enhancement and represents a manual processing error.

CL36B: BlueChoice respectfully disagrees with the finding. BlueChoice self-identified, addressed and resolved the claim. See Attachment CL36B, the EOB of the reprocessed claim.

CL40B: BlueChoice disagrees with the examiner's findings. On the original response we advised that the member was paid in full though 04/30/2016. The member was terminated effective 06/01/2016 for non-payment. Please see our previous response in the attachment labeled Attachment CL40B - CLMEM12B.

Claim 620920288600 was not part of the original review sheet questioned. Due to concerns that the premium payments may have been made but were not correctly attributed to the member, BlueChoice reinstated the policy on 07/20/2016 for an effective date of 06/01/2016 (see Attachment CL40B-1). BlueChoice received claim 62920288600 on 07/27/2016 and it was processed to pay the provider on 07/29/2016.

BlueChoice subsequently determined that the full amount of premiums owed had not been paid and the member was then re-terminated on 10/12/2016 with a termination date of 06/01/2016.
BlueChoice respectfully asks the VBOI to evaluate this sample again.

CL16B: CareFirst acknowledges that the company did not properly process and pay the original claim. The claim was erroneously rejected by the examiner using the message code with the explanation "This claim cannot be processed because the documentation that is needed is the coordination of benefits (COB) form completed by the member to let us know if they have other insurance."

Upon receipt of corrected information based on the updated coordination of benefits indicating there was primary insurance, BlueChoice adjusted the claim to pay the inappropriately denied claim lines. On 5/4/2018, the company re-adjusted the claim and included interest of $8.36 from the original receipt date of 5/10/16.

Ms. Fairbanks, on behalf of CareFirst BlueChoice, Inc., I thank you for the opportunity to respond to the market conduct examination report.

Sincerely,

Jenene Lyn Williams

Jenene Lyn Williams

Attachments (17)

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December 17, 2019

VIA EMAIL

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CareFirst BlueCross BlueShield
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RE: Response to the Draft Examination Report
CareFirst BlueChoice, Inc. (BlueChoice)

Dear Ms. Williams:

The examiners have received and reviewed BlueChoice's response to the Draft Report dated October 4, 2019. This letter will address BlueChoice's concerns in the same order as presented in your response. Since BlueChoice's response will also be attached to the final Report, this response does not address those issues where BlueChoice indicated agreement and/or action taken as a result of the Report. BlueChoice should note that upon finalization of this exam, BlueChoice will be given approximately 90 days to document compliance with all of the corrective actions in the Report.

Section II. Executive Summary

BlueChoice's response raised concerns regarding assertions in the Report that BlueChoice engages in general business practices that do not comply with Virginia law. To clarify the findings, the examiners would like to provide an explanation of the general business practices that were revealed during the examination. Generally, all instances of non-compliance are described in the Report; however, the examiners specifically identify those instances of non-compliance that occur with such frequency as to indicate a general business practice, as per the guidelines set forth in the NAIC's Market Regulation Handbook.

- **§ 38.2-510 A 15 of the Code:** The Provider Contract review (beginning on p. 15 of the Report) revealed 21 instances, in 23 sample provider contracts, where BlueChoice's contracts failed to contain one or more of the provisions required by § 38.2-3407.15 of the Code; this occurred with such frequency as to indicate a general

business practice, placing BlueChoice in violation of § 38.2-510 A 15 of the Code. (Note: this general business practice is identified on p. 16 of the Report.)

- **§ 38.2-510 A 1 of the Code:** The Paid Claims review (beginning on p. 38 of the Report) revealed 5 violations of § 38.2-510 A 1 of the Code out of a sample of 40 Group and Individual Vision paid claims; this occurred with such frequency as to indicate a general business practice, placing BlueChoice in violation of § 38.2-510 A 1 of the Code. (Note: this general business practice is identified on p. 53 of the Report.)

- **§ 38.2-510 A 5 of the Code:** The Paid Claims review (beginning on p. 38 of the Report) revealed 23 violations of § 38.2-510 A 5 of the Code out of a sample of 40 Group and Individual Vision paid claims; this occurred with such frequency as to indicate a general business practice, placing BlueChoice in violation of § 38.2-510 A 5 of the Code. (Note: this general business practice is identified on p. 53 of the Report.)

- **§ 38.2-510 A 6 of the Code:** The Paid Claims review (beginning on p. 38 of the Report) revealed 6 violations of § 38.2-510 A 6 of the Code out of a sample of 40 Group and Individual Vision paid claims; this occurred with such frequency as to indicate a general business practice, placing BlueChoice in violation of § 38.2-510 A 6 of the Code. (Note: this general business practice is identified on p. 53 of the Report.)

BlueChoice's instances of non-compliance with §§ 38.2-510 A 3, 38.2-510 A 4 and 38.2-510 A 14 of the Code did not occur with such frequency as to indicate a general business practice. No changes to the Report are necessary.

BlueChoice's response also raised concerns regarding assertions in the Report that BlueChoice knowingly violated Virginia law. BlueChoice was cited for violating §§ 38.2-3407.15 B 1 through B 6 and B 8 through B 11, 38.2-1833 A 1 and 38.2-1834 D of the Code in both the current and prior Reports, therefore these violations could be considered knowing. No changes to the Report are necessary.

Section IV. Managed Care Health Insurance Plans (MCHIPS)

Provider and Intermediary Contracts:

MC01-CF:
BlueChoice advised the examiners that the contract with its intermediary, Magellan Health, has been terminated. While BlueChoice cannot revise a contract that has been terminated, BlueChoice is required to complete Corrective Action #3 to ensure that its other intermediary contracts are in compliance with § 38.2-5805 C 10 of the Code. No changes to the Report are necessary.

Section VI. Provider Contracts

Ethics and Fairness in Carrier Business Practices – Provider Contracts

EF02B-CF: BlueChoice advised the examiners that the contract with its

intermediary, Magellan Health, has been terminated. While BlueChoice cannot revise a contract that has been terminated, BlueChoice is required to complete Corrective Action #4 to ensure that all of its provider contracts are in compliance with § 38.2-3407.15 B of the Code. No changes to the Report are necessary.

EF10B-CF: The examiners acknowledge BlueChoice's procedural change to ensure all contractual provider notifications will be mailed at least 65 days prior to the effective date. Please note that the January 2, 2019 examiner response for EF10B-CF states that additional violations of Section 38.2-3407.15 B 9 of the Code were not cited for the mailing of the OIA notification letter 61 days prior to the effective date, as BlueChoice's October 25, 2018, response indicates that a copy of the letter was delivered via email "almost instantly."

The examiners have reviewed Attachments EF10B-CF1 and EF10B-CF2. According to BlueChoice's claims system, Provider BOI Item Number 9 received OIA increases to its fee schedule resulting in reimbursement amounts of 193 percent effective August 1, 2015, and 113 percent effective August 1, 2016, and Provider BOI Item Number 16 received an OIA increase to its fee schedule resulting in reimbursement amounts of 127 percent effective August 1, 2016. The examiners requested documentation that these increases were made part of the provider contract, and the only information initially provided was a letter referring the provider to the website/portal to view the OIA results. While Attachments EF10B-CF1 and EF10B-CF2 appear to document information from the SearchLight Report made available to the provider, this report fails to include any reference to the specific percentage increases. The examiners maintain that an updated fee schedule was not made part of the contract or provided 60 calendar days before the effective date. In addition, no documentation of the PCMH Addendum has been provided to date. Please be advised that BlueChoice was also cited in this review sheet for the failure to provide documentation of the annual fee reassessment applicable to the examination time frame for both of these providers. No changes to the Report are necessary.

EF03B-CF: As stated in the Examiner Response for EF03B-CF dated October 10, 2018, the examiners maintain that several of the changes made to the provider manual in question are material, such as the number of times each calendar year a provider must verify practice information and the date ranges to do so on page 8; the number of days a pre-authorization can be entered before the outpatient date of service on page 9; stating that BlueChoice "will not" instead of "will" manually split charges on page 10; stating that observation services "may be" instead of "are" necessary on page 11; changes to the process for refunding erroneous payments on page 13; and removing reference to the modifier reimbursement guidelines on page 14. As BlueChoice failed to notify the provider at least 60 calendar days before the effective date of these amendments, no changes to the Report are necessary.

The examiners acknowledge BlueChoice's agreement regarding the drug prior authorization list and the Company's improvements to process and procedures to ensure that all prior notices are mailed approximately 5 business days prior to the 60-day advance notice period.

EF04B-CF: BlueChoice advised the examiners that the contract with its intermediary, Magellan Health, has been terminated. While BlueChoice cannot revise a contract that has been terminated, BlueChoice is required to complete Corrective Action #4 to ensure that all of its provider contracts are in compliance with § 38.2-3407.15 B of the Code. No changes to the Report are necessary.

Ethics and Fairness in Carrier Business Practices – Provider Claims

EFCL01B-CF: While the examiners acknowledge that the October 25, 2016, retraction notification was forwarded within 12 months of the initial paid date of November 25, 2015, the actual retroactive denial/retraction did not occur until on or after December 2, 2016, which is more than 12 months after the date of the original payment. No changes to the Report are necessary.

EFCL04B-CF: Regarding procedure code A9575, the examiners maintain that the Fee Schedule Update mailed to the provider states the allowed amount should be "ASP + 10%." This indicates that the allowed amount should be the ASP, as published by the Centers for Medicare & Medicaid Services, increased by 10 percent. The list made available by CMS lists the fourth quarter 2016 ASP as .200. Using this information, the per unit cost (.200 + 10 percent of .200) would be $0.22, and $2.20 should have been allowed for 10 units. The examiners also requested that BlueChoice provide an explanation as to how the $.21 per unit amount noted in BlueChoice's pricing tool is calculated in the event the company disagreed with the logic applied by the examiners in utilizing the CMS ASP pricing file. As BlueChoice failed to do so, no changes to the Report are necessary.

Please note that no violations were cited for procedure code 73222.

Carrier Contracts: Required Provisions Regarding Prior Authorization:

EF05B-CF: BlueChoice advised the examiners that the contract with its intermediary, Magellan Health, has been terminated. While BlueChoice cannot revise a contract that has been terminated, BlueChoice is required to complete Corrective Action #6 to ensure that all of its provider contracts are in compliance with §§ 38.2-3407.15:2 B and 38.2-3407.15:2 D of the Code. No changes to the Report are necessary.

Section IX. Policy and Other Forms

PF08M-CF: Upon further consideration, the examiners have removed the violation of §§ 38.2-316 A and 38.2-316 C 1 of the Code. The Report has been revised to reflect this change.

PF01B-CF: BlueChoice's agreement is noted regarding the determination that CUTO287-1E (10-13) was not filed or approved for use by BlueChoice as the in-network EOB. As stated in the Examiner Response dated April 24, 2018, the examiners acknowledge that the EOB was also filed and approved for use with GHMSI's medical and dental products.

Section XV. Claim Practices

CL14B: Please be advised that the observation regarding the failure to charge a copay in the sample claim was removed in the March 21, 2019 Examiner Response. BlueChoice was cited for non-compliance with § 38.2-510 A 1 of the Code, § 38.2-510 A 6 of the Code, 14 VAC 5-211-90 B, and the EOC because the provided spreadsheet indicates that, for other claims processed during the plan year, the copayment and coinsurance amounts were not applied to the deductible as required by the EOC and the individual in-network deductible and out-of-pocket maximum were exceeded. No changes to the Report are necessary.

CL35B: While the examiners acknowledge that BlueChoice self-identified the error on the pricing file, the claim was not correctly reprocessed until nearly 2 years after the original receipt date and initial incorrect processing. As the initial EOB includes information that is inconsistent with the benefits described in the EOC and is potentially misleading to the member, the EOB fails to accurately and clearly set forth the benefits payable under the contract. No changes to the Report are necessary.

CL37B and CL38B: The examiners acknowledge that the claims in question were initially incorrectly submitted by the provider to the host plan and that BlueChoice was correct to deny the initial submission and advise the provider to file appropriately; however, the explanation provided to the member on the EOB does not accurately reflect this reason for denial. The only denial explanation provided to the member indicates that "...the provider is not part of the CareFirst BlueChoice network..." and that the member is responsible for the billed amount of the claim, with no indication that the denial is based on a submission error by the provider or that the provider has been or will be advised to refile the claim to BlueChoice with a correct provider number. No changes to the Report are necessary.

CL39B: The examiners have performed another review of the sample file. As BlueChoice has not provided any additional arguments or new documentation, the examiners maintain the findings from the July 18, 2018 Examiner Response. No changes to the Report are necessary.

CL29B: The examiners have performed another review of the sample file. As BlueChoice has not provided any additional arguments or new documentation, the examiners maintain the findings from the May 7, 2018 Examiner Response. No changes to the Report are necessary.

CL36B: The examiners acknowledge BlueChoice's efforts to self-identify, address, and resolve the claim; however, as BlueChoice initially issued an EOB reflecting incorrect benefit information, this EOB fails to accurately and clearly set forth the benefits payable under the contract. No changes to the Report are necessary.

CL40B: Upon further consideration, the examiners have removed the violation of § 38.2-3407.4 B of the Code. The Report has been revised to reflect this change.

A copy of the entire Report with the revised pages noted is attached for your review, and the revised pages contains the only substantive revisions we plan to make before the Report becomes final.

On the basis of our review of the entire file, it appears that BlueChoice violated the Unfair Trade Practices Act, specifically §§ 38.2-510 A 1, 38.2-510 A 5, 38.2-510 A 6, 38.2-510 A 15 and 38.2-514 B, in addition to 14 VAC 5-90-55 A, 14 VAC 5-90-60 A 1 and 14 VAC 5-90-90 C of Rules Governing the Advertisement of Accident and Sickness Insurance.

It also appears that BlueChoice violated §§ 38.2-316 A, 38.2-316 B, 38.2-316 C 1, 38.2-610 A 1, 38.2-610 A 2, 38.2-1833 A 1, 38.2-1834 D, 38.2-3407.4 A, 38.2-3407.4 B, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.1-3407.15 B 10, 38.2-3407.15 B 11, 38.2-3407.15:2 B 1, 38.2-3407.15:2 B 2, 38.2-3407.15:2 B 3, 38.2-3407.15:2 B 4, 38.2-3407.15:2 B 5, 38.2-3407.15:2 B 6, 38.2-3407.15:2 B 7, 38.2-3407.15:2 B 8, 38.2-4306.1 B, 38.2-5805 C 10 of the Code, in addition to 14 VAC 5-211-30 C, 14 VAC 5-211-80 B, and 14 VAC 5-211-90 B of Rules Governing Health Maintenance Organizations and 14 VAC 5-216-40 E 2 of Rules Governing Internal Appeal and External Review.

Violations of the above sections of the Code can subject BlueChoice to monetary penalties of up to $5,000 for each violation and suspension or revocation of its license to transact business in the Commonwealth of Virginia.

In light of the foregoing, this office will be in further communication with you shortly regarding the appropriate disposition of this matter

Very truly yours,

Julie R Fairbanks

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January 29, 2020

Ms. Julie R. Fairbanks, AIE, FLMI, AIRC, MCM
BOI Manager, Market Conduct Section
Life and Health Market Regulation Division
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RE: Market Conduct Examination Report
Response to the Draft Examination Report – CareFirst BlueChoice, Inc.
Examination Period July 1, 2016 through December 31, 2016

Dear Ms. Fairbanks:

I write this letter in response to your December 17, 2019 letter wherein the Virginia Bureau of Insurance (VBOI) responds to CareFirst BlueChoice, Inc. ("BlueChoice") letter dated October 4, 2019. Your December 17th letter addresses BlueChoice's concerns as stated in the company's October 4th letter. In the interest of brevity, BlueChoice will not address those issues where the company previously indicated agreement and/or action taken.

Section II. EXECUTIVE SUMMARY

In the development and implementation of its business policies and day-to-day practices, BlueChoice exercises its best intent and good faith efforts to comply with all applicable state and federal law, including Virginia law. BlueChoice objects to the assertions that the company knowingly violates Virginia law or engages in general business practices that fail to comply with it.

CareFirst has identified and corrected the errors identified by the VBOI, but disagrees that the frequency of the findings or findings from previous Market Conduct Audits indicate as a matter of practice that CareFirst operates in this manner as a general business practice. CareFirst processes over 100,000 claims on a daily basis, and when viewing the relatively limited errors that the VBOI has identified in comparison to the numerous of claims that are properly adjudicated, such proportion would indicate that CareFirst does not as a business practice operate in the manner proposed by the VBOI.

Section IV. MANAGED CARE HEALTH INSURANCE PLANS (MCHIPS)

Provider and Intermediary Contracts

MC01-CF: BlueChoice has reviewed the examiner's review sheet and continues to disagree with the VBOI's position. To the extent that the contract was deficient for not including a particular provision, BlueChoice has since terminated its contract with Magellan Health effective January 1, 2018. As such, no further corrective action plan is necessary. BlueChoice requests an opportunity to discuss this matter with the VBOI.

Section VII. PROVIDER CONTRACTS Ethics and Fairness in Carrier Business Practices – Provider Contracts

EF02B-CF and EF04B-CF: With respect to the allegation of a violation of 38.2-510.15 A15, while BlueChoice agrees that certain Magellan provider agreements did not meet certain requirements under 38.2-3407.15 B, the occurrence of violations under a single arrangement with an intermediary, which violations were subsequently corrected and which intermediary is no longer a business partner of BlueChoice, does not in this case rise to the level of a general business practice under 38.2-510 A. BlueChoice relied on internal policy 0044 which requires intermediaries to provide a written attestation that the intermediary has met all applicable jurisdictional requirements. The attestation given by Magellan pursuant to that policy represented that they were in compliance during the period in question. That attestation proved to be incorrect, but the violations of 38.2-3407.15 B in the Magellan contracts were an oversight on the part of Magellan and BlueChoice, not a business practice of BlueChoice. As stated previously, BlueChoice has terminated its agreement with Magellan and as such no further action is required.

EF10B-CF: VBOI and BlueChoice representatives discussed this matter on January 21, 2020. Based on that conversation and as agreed, BlueChoice now provides the following additional documentation under a separate cover: i) the Patient-Centered Medical Home (PCMH) addendum for the two providers at issue; ii) the PCMH Program Description and Guidelines (note bottom of page 4 and top of page 10); iii) the 2015 and 2016 fee schedule change notice for the two providers at issue; and iv) notice of outcome incentive award letters for each provider.

EF03B-CF: BlueChoice acknowledges the examiner's findings.

Ethics and Fairness in Carrier Business Practices – Provider Claims

EFCL01B-CF: CareFirst disagrees with the VBOI finding. In accordance with Section 38.2-3407.15 B6, CareFirst initiated a retraction within the 12 months set forth in the provision by sending the required notice to the provider.

EFCL04B-CF: CareFirst respectfully disagrees with the finding. Sample claim 635518877500 was received on 12/20/2016 and was processed to pay at the in-network level on 12/28/2016. The provider billed procedure code A9575 at $34.00 for 10 units. The procedure code paid at 100% of the allowed amount of $.21 per unit for a total of $2.10 in accordance with the P-027HMO-STD agreement ID. The provider billed procedure code 73222 at $2,580.00 for 1 unit. The procedure code had an allowed amount of $482.14, which was processed at 100% of the allowed amount as follows: applied $250.00 to the member's copay per the members CAT Scan benefit and the remaining allowed amount was of $232.14 was paid. Please see the attached pdf for additional documentation that shows the pricing is correct. CareFirst respectfully requests an additional review of this sample.

Carrier Contracts: Required Provisions Regarding Prior Authorization

EF05B-CF: With respect to the allegation of a violation of 38.2-510.15 A15, while BlueChoice agrees that certain Magellan provider agreements did not meet certain requirements under 38.2-3407.15 B, the occurrence of violations under a single arrangement with an intermediary, which violations were subsequently corrected and which intermediary is no longer a business partner of BlueChoice, does not in this case rise to the level of a general business practice under 38.2-510 A. BlueChoice relied on internal policy 0044 which requires intermediaries to provide a written attestation that the intermediary has met all applicable jurisdictional requirements. The attestation given by Magellan pursuant to that policy represented that they were in compliance during the period in question. That attestation proved to be incorrect, but the violations of 38.2-3407.15 B in the Magellan contracts were an oversight on the

part of Magellan and BlueChoice, not a business practice of BlueChoice. As stated previously, BlueChoice has terminated its agreement with Magellan and as such no further action is required.

Section XV. CLAIM PRACTICES

CL14B: BlueChoice provides additional explanation and an attachment. The group deductible and out of pocket accumulations are as follows: in network deductible: $2,000; out of network deductible: $4,000; in network out of pocket: $4,000 and out of network out of pocket: $5,940.

In instances in which the member utilizes both in-network and out-of-network benefits in a benefit period, the deductibles and out of pocket maximum are calculated based on covered services received by the member for both the in-network and out-of-network basis *combined.*

This means in and out of network accumulations will be used to satisfy deductible and out of pocket maximums. Thus, once the in-network deductible/out-of-pocket maximum is satisfied *and* the covered services is in-network, the claim processes as if the maximum deductible/out of pocket maximum is satisfied. If the covered service is out of network, and the maximum deductible/out of pocket maximum has not been reached, the claim will process and pay without taking into account that an out of pocket maximum being reached and the appropriate amounts will calculate toward the out of network, out of pocket maximums and deductibles. In this instance, the claim at issue was for in-network services and the member had already reached the in-network out of pocket maximum, thus BlueChoice believes the claim processed correctly.

The individual out of network deductible (column L of the attachment) was satisfied with ICN 20161440518100 applying a $300.00 copay and $727.09 remaining to meet the in network deductible. The claims totaling $28.79 are prescription claims as indicated by the provider number ending in CARE (CVS Caremark). Following page C-2, these claims *will not* be used to satisfy the benefit period deductible.

Any additional deductible amounts that were applied after the member's in network deductible was satisfied were considered out of network. The out of network deductible of $4,000 will continue to accumulate until satisfied.

The in-sample claim (ICN 26163000153000) is for in network services. The member's in network deductible was satisfied, therefore, processed with no additional deductible taken. If the services were out of network, the claims would have continued to calculate towards the out of network deductible.

Following page C-3 confirms the out of pocket accumulations are calculated using both in network and out of network claims. Please see the attached spreadsheet that supports the deductible and out of pocket accumulations.

With respect to 14 VAC 5-211-90B, as of December 13, 2019, paper explanation of benefits for Virginia risk claims include the member's out of pocket details.

CL35B: Regarding § 38.2-3407.4 B, while BlueChoice acknowledges this finding, the company self-identified the error on the pricing file and corrected the claim prior to the audit. The EOB reflected the error which was corrected when the claim was adjusted.

CL37B and CL38B: BlueChoice respectfully disagrees with the examiner's finding. The provider submitted the claim with the incorrect provider number for BlueChoice. Thus, BlueChoice properly denied the claim because based on the incorrect provider number CareFirst did not identify the provider as a BlueChoice participating provider. Once the provider resubmitted the claim with the correct provider number, BlueChoice was able to process and pay the claim.

CL39B: BlueChoice continues to disagree and respectfully ask that the VBOI review the sample and response again. The attached appeal documentation and clinical rationale explain why the appeal was necessary versus the coverage decision that was made upon receipt of the original claim submission.

CL29B: BlueChoice continues to disagree with the finding. The member referenced in audit CL29B was enrolled under a Subscriber & Dependent Only policy on October 1, 2015. Effective May 1, 2016, the member changed his coverage to a Subscriber Only plan. During the segment of the benefit period in which the member had Subscriber & Dependent coverage, there was a total of $3000 accumulated towards the $3000 Family Maximum accumulator. However, the portion of the family deductible that was met by this member did not exceed $1,500. Consequently, when the member changed his coverage to a Subscriber Only plan there was still a balance remaining on his individual deductible that the member was now required to meet on his own. Therefore, the amount that was credited to the member's individual deductible on this claim is correct and the claim was paid properly. The information summarized in the message is explained by the fact that the member's change to Subscriber Only coverage occurred during the same Benefit Period in which he was initially enrolled under a Subscriber and Dependent policy. Because this member's deductible applied on a benefit period basis and because the benefit period in which he originally enrolled under Subscriber and Dependent coverage was still in progress on the date of service (it would not end until September 30, 2016), it was necessary to retain the family accumulator in the system in order to process additional claims for the period prior to the change in coverage while at the same time keeping track of the member's individual deductible.

Consequently, the EOB correctly reflects what was accumulated for coverage under this group plan during the entire, and then still ongoing, "benefit period." There is no adjustment needed on the claim because it was processed correctly. The issue was the plan change during the benefit year. The EOB may not be clear, but it is not incorrect. BlueChoice respectfully requests another review of this sample.

CL36B: Regarding § 38.2-3407.4 B of the Code of Virginia, BlueChoice respectfully disagrees with the finding. While BlueChoice erroneously processed the claim, the EOB correctly reflected how the claim was processed, thus, the EOB was not in error. Once BlueChoice self-identified the claims processing error and adjusted the claim accordingly with interest, the subsequent EOB also correctly reflected how the claim was processed.

Ms. Fairbanks, on behalf of CareFirst BlueChoice, Inc., I thank you for the opportunity to respond to the market conduct examination report.

Sincerely,

Jonene Lyn Williams

Attachments (13)

COMMONWEALTH OF VIRGINIA

SCOTT A. WHITE
COMMISSIONER OF INSURANCE
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

P.O. BOX 1157
RICHMOND, VIRGINIA 23218

1300 E. MAIN STREET
RICHMOND, VIRGINIA 23219

TELEPHONE: (804) 371-9741
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March 27, 2020

VIA EMAIL

Jenene Williams
Sr. Director, External Audit Coordination
CareFirst BlueCross BlueShield
1501 South Clinton Street
Room 10147
Baltimore, MD 21224

RE: Response to the Draft Examination Report
CareFirst BlueChoice, Inc. (BlueChoice)

Dear Ms. Williams:

The examiners have received and reviewed BlueChoice's response to the Draft Report dated January 29, 2020. This letter will address BlueChoice's concerns in the same order as presented in your response. Since BlueChoice's response will also be attached to the final Report, this response does not address those issues where BlueChoice indicated agreement and/or action taken as a result of the Report. BlueChoice should note that upon finalization of this exam, BlueChoice will be given approximately 90 days to document compliance with all of the corrective actions in the Report.

Section II. Executive Summary

BlueChoice's response raised concerns regarding assertions in the Report that BlueChoice engages in general business practices that do not comply with Virginia law. The Market Conduct section of the Bureau of Insurance ("Bureau") conducts examinations, to the extent practicable, in accordance with the guidelines and procedures set forth in the Market Regulation Handbook ("Handbook") as set forth in §§ 38.2-1317.1 A and 38.2-1318 B of the Code of Virginia ("the Code").

The Handbook has established a benchmark error rate of 7 percent for auditing claim practices. The Vision Paid Claims review revealed the following:

Code Section	Sample Size	Number of Errors	Error Rate
§ 38.2-510 A 1	40	5	12.5%
§ 38.2-510 A 5	40	23	57.5%
§ 38.2-510 A 6	40	5	12.5%

Based on the standard set forth in the Market Regulation Handbook, BlueChoice's non-compliance with these 3 sections occurred with such frequency as to indicate a general business practice, placing BlueChoice in violation of §§ 38.2-510 A 1, 38.2-510 A 5, and 38.2-510 A 6 of the Code.

The Handbook has also established a benchmark error rate of 10 percent for other trade practices. The Ethics and Fairness in Carrier Business Practices review revealed 20 provider contracts, out of a sample of 23 provider contracts, that failed to contain one or more of the provisions required by § 38.2-3407.15 of the Code, resulting in an error rate of 87%. Based on the standard set forth in the Market Regulation Handbook, BlueChoice's non-compliance with this section occurred with such frequency as to indicate a general business practice, placing BlueChoice in violation of § 38.2-510 A 15 of the Code.

BlueChoice's response also noted objection to assertions that BlueChoice knowingly violates Virginia law. BlueChoice was cited for violations of §§ 38.2-3407.15, 38.2-1833 A 1 and 38.2-1834 D of the Code in the prior report and should be familiar with the requirements set forth in these sections. Under the prior corrective action plan, BlueChoice was required to implement processes and procedures to ensure compliance going forward. In that additional violations of these sections were found during the current exam, these violations could be construed as knowing.

Regarding general business practices and violations that could be consider knowing, no changes to the Report are necessary.

In addition, please note that the Executive Summary has been revised to reflect the total number of violations and instances of non-compliance noted in the Report. This correction accurately reflects the findings noted in the Report and the counts in the Area of Violations Summary by Review Sheet section.

Section IV. Managed Care Health Insurance Plans (MCHIPS)

Provider and Intermediary Contracts:

MC01-CF: The examiners acknowledge that BlueChoice has terminated its contract with its intermediary, Magellan Health. However, BlueChoice is required to complete Corrective Action #3 to ensure all current and future intermediary contracts comply with § 38.2-5805 C 10 of the Code. No changes to the Report are necessary.

Section VI. Provider Contracts

Ethics and Fairness in Carrier Business Practices – Provider Contracts

EF02B-CF and EF04B-CF: The examiners acknowledge BlueChoice's comments regarding its internal policy regarding Magellan and other intermediary contracts. However, please be advised that the violations related to contracts entered into through Magellan were not the sole determinant of the general business practice.

The examiners reviewed a sample of 23 provider contracts, and 59 violations of § 38.2-3407.15 B of the Code were cited, resulting in the determination of a general business practice and violation of § 38.2-510 A 15 of the Code. No changes to the Report are necessary.

The examiners also acknowledge that BlueChoice has terminated its contract with its intermediary, Magellan Health. However, BlueChoice is required to complete Corrective Action #4 to ensure that all of its provider contracts are in compliance with § 38.2-3407.15 B of the Code. No changes to the Report are necessary.

EF10B-CF: Upon review of the additional documentation, the violations of §§ 38.2-3407.15 B 8 and 38.2-3407.15 B 9 of the Code associated with Review Sheet EF10B-CF have been removed. The Report has been revised to reflect these changes.

Ethics and Fairness in Carrier Business Practices – Provider Claims

EFCL01B-CF: While the examiners acknowledge that the October 25, 2016, retraction notification was forwarded within 12 months of the initial paid date of November 25, 2015, the examiners maintain that the actual retroactive denial/retraction did not occur until on or after December 2, 2016, which is more than 12 months after the date of the original payment. No changes to the Report are necessary.

EFCL04B-CF: BlueChoice's additional response is acknowledged. However, the only explanation provided for the ASP is "Per pricing information received from Pharmacy Management department, ASP EFF 11/1/2016 was $.19…." As no documentation of the ASP or how it is derived was included, the violation of § 38.2-3407.15 B 8 of the Code regarding procedure code A9575 will remain. Please note that no violations were cited for procedure code 73222. No changes to the Report are necessary.

Carrier Contracts: Required Provisions Regarding Prior Authorization:

EF05B-CF: The examiners acknowledge that BlueChoice has terminated its contract with its intermediary, Magellan Health. However, BlueChoice is required to complete Corrective Action #6 to ensure that all of its provider contracts are in compliance with §§ 38.2-3407.15:2 B and 38.2-3407.15:2 D of the Code. No changes to the Report are necessary.

Section XV. Claim Practices

CL14B: Upon review of BlueChoice's additional explanation and documentation, all violations referenced in Review Sheet CL14B have been removed, and the Report has been revised to reflect these changes. Please be advised, however, that the documentation originally provided to the examiners failed to indicate that the claims with deductibles of $131.84 and $121.57 were out-of-network and BlueChoice failed to explain previously that provider numbers ending in CARE indicate prescription

drug claims. As BlueChoice failed to provide these explanations during the initial Review Sheet response, a supplemental Review Sheet response, and its initial response to the Draft Report, BlueChoice is cautioned for any future examinations that adequate documentation and explanation should be provided earlier in the examination process.

CL35B: While the examiners acknowledge that BlueChoice self-identified the error on the pricing file, the examiners maintain that the claim was not correctly reprocessed until nearly 2 years after the original receipt date and initial incorrect processing. As the initial EOB includes information that is inconsistent with the benefits described in the EOC and is potentially misleading to the member, the EOB fails to accurately and clearly set forth the benefits payable under the contract. No changes to the Report are necessary.

CL37B and CL38B: The examiners acknowledge that the claims in question were initially submitted with the incorrect provider number and that BlueChoice was correct to deny the initial submission and advise the provider to file appropriately. However, the explanation provided to the member on the EOB does not accurately reflect this reason for denial. The only denial explanation provided to the member indicates that "…the provider is not part of the CareFirst BlueChoice network…" and that the member is responsible for the billed amount of the claim, with no indication that the denial is based on a submission error by the provider or that the provider has been or will be advised to refile the claim to BlueChoice with a correct provider number. No changes to the Report are necessary.

CL39B: The examiners have reviewed the sample and responses again, along with the attached appeal documentation and clinical rationale. The examiners maintain that the appealed claim from the obstetrician was for preventive services and should not have been denied. In addition, the denial explanation stating that the obstetrical ultrasound maximum for one line was met "on a previous line of this claim" and the other line was met "on a previous claim" provides unclear information to the member and is potentially misleading, resulting in the EOB failing to accurately and clearly set forth the benefits payable under the contract. As the claim from the obstetrician should have been processed with benefits approved for all 3 lines based upon the February 16, 2016, date of reinstatement of coverage, interest is due and unpaid beginning 30 days from this date until the August 31, 2016, payment date. No changes to the Report are necessary.

CL29B: The examiners have reviewed BlueChoice's additional response and performed another review of the sample. While the examiners acknowledge that the individual deductible was not exceeded, the inclusion of the statement "…this patient has satisfied $3000.00 of the $1500.00 2015 in-network deductible" on the EOB incorrectly indicates to the member that they have satisfied/exceeded the deductible and that future claims will not be applied to the deductible. In addition, reference to the $3,000.00 deductible does not appear to be applicable to the September 7, 2016, EOB, as both of the claims shown are for dates of service after the May 1, 2016, coverage change. As this statement has the potential to be misleading to the member, the EOB fails to accurately and clearly set forth the benefits payable under the contract. Please note that there is no language in

the Report requiring BlueChoice to adjust this claim. No changes to the Report are necessary.

CL36B: Upon further review, the violation of § 38.2-3407.4 B of the Code cited in Review Sheet CL36B has been removed, and the Report has been revised to reflect this change.

A copy of the entire Report with the revised pages noted is attached for your review, and the revised pages contains the only substantive revisions we plan to make before the Report becomes final.

On the basis of our review of the entire file, it appears that BlueChoice violated the Unfair Trade Practices Act, specifically §§ 38.2-510 A 1, 38.2-510 A 5, 38.2-510 A 6, 38.2-510 A 15 and 38.2-514 B, in addition to 14 VAC 5-90-55 A, 14 VAC 5-90-60 A 1 and 14 VAC 5-90-90 C of Rules Governing the Advertisement of Accident and Sickness Insurance.

It also appears that BlueChoice violated §§ 38.2-316 A, 38.2-316 B, 38.2-316 C 1, 38.2-610 A 1, 38.2-610 A 2, 38.2-1833 A 1, 38.2-1834 D, 38.2-3407.4 A, 38.2-3407.4 B, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.1-3407.15 B 10, 38.2-3407.15 B 11, 38.2-3407.15:2 B 1, 38.2-3407.15:2 B 2, 38.2-3407.15:2 B 3, 38.2-3407.15:2 B 4, 38.2-3407.15:2 B 5, 38.2-3407.15:2 B 6, 38.2-3407.15:2 B 7, 38.2-3407.15:2 B 8, 38.2-4306.1 B, 38.2-5805 C 10 of the Code, in addition to 14 VAC 5-211-30 C, 14 VAC 5-211-80 B and 14 VAC 5-211-90 B of Rules Governing Health Maintenance Organizations and 14 VAC 5-216-40 E 2 of Rules Governing Internal Appeal and External Review.

Violations of the above sections of the Code can subject BlueChoice to monetary penalties of up to $5,000 for each violation and suspension or revocation of its license to transact business in the Commonwealth of Virginia.

Considering the foregoing, this office will be in further communication with you shortly regarding the appropriate disposition of this matter

Very truly yours,

Julie R. Fairbanks

Julie R. Fairbanks, AIE, AIRC, FLMI, MCM
BOI Manager
Market Conduct Section
Life and Health Market Regulation Division
Telephone (804) 371-9385

Meryl D. Burgin
Executive Vice President, General Counsel and
Corporate Secretary

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CONFIDENTIAL

July 22, 2010

Julie Blauvelt
Deputy Commissioner
Bureau of Insurance
1300 East Main Street
Richmond, VA 23219

RE: Alleged violations of §§ 38.2-316 A, 38.2-316 B, 38.2-316 C 1, 38.2-510 A 1, 38.2-510 A 5, 38.2-510 A 6, 38.2-510 A 15, 38.2-514 B, 38.2-610 A 1, 38.2-610 A 2, 38.2-1833 A 1, 38.2-1834 D, 38.2-3407.4 A, 38.2-3407.4 B, 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2 -3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2 3407.15 B 8, 38.2-3407.15 B 9, 38.-3407.15 B 10, 38.2 3407.15 B 11, 38.2 3407.15:2 B 1, 38.2-3407.15:2 B 2, 38.2-3407.15:2 B 3, 38.2-3407.15:2 B 4, 38.2-3407.15:2 B 5, 38.2-3407.15:2 B 6, 38.2-3407.15:2 B 7, 38.2-3407.15:2 B 8, 38.2-4306.1 B, 38.2-5805 C 10 of the Code, in addition to 14 VAC 5-90-55 A, 14 VAC 5-90-60 A 1 and 14 VAC 5-90-90 C of Rules Governing the Advertisement of Accident and Sickness Insurance, in addition to 14 VAC 5-211-30 C, 14 VAC 5-211-80 B, and 14 VAC 5-211-90 B of Rules Governing Health Maintenance Organizations and 14 VAC 5-216-40 E 2 of Rules Governing Internal Appeal and External Review.
Case No. INS-2019-00200

Dear Ms. Blauvelt:

This will acknowledge receipt of the Bureau of Insurance's letter dated March 30, 2020, concerning the above-referenced matter.

BlueChoice wishes to make a settlement offer for the alleged violations cited above. Further, we agree to:

1. Enclose with this letter a certified check, cashier's check or money order payable to the Treasurer of Virginia in the amount of $90,600. Payment was received from BlueChoice on June 2, 2020.

2. Comply with the Corrective Action Plan contained in the Target Market Conduct Examination Report of BlueChoice as of December 31, 2016.

3. Acknowledge BlueChoice's right to a hearing before the State Corporation Commission in this matter and waive that right if the State Corporation Commission accepts this offer of settlement.

This offer is being made solely for the purpose of a settlement and does not constitute, nor should it be construed as, an admission of any violation of law.

Sincerely,

CareFirst BlueChoice, Inc.

Meryl D. Burgin
Executive President, General Counsel and Corporate Secretary

July 22, 2020
(Date)

COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

AT RICHMOND, JULY 28, 2020

COMMONWEALTH OF VIRGINIA, *ex rel.*

STATE CORPORATION COMMISSION

v. CASE NO. INS-2019-00200

CAREFIRST BLUECHOICE, INC.,
Defendant

SETTLEMENT ORDER

Based on a target market conduct examination conducted by the Bureau of Insurance ("Bureau"), it is alleged that CareFirst BlueChoice, Inc. ("Defendant"), duly licensed by the State Corporation Commission ("Commission") to transact the business of insurance in the Commonwealth of Virginia ("Virginia"), in certain instances violated §§ 38.2-316 A, 38.2-316 B, and 38.2-316 C 1 of the Code of Virginia ("Code") by failing to use insurance policies or forms on file and approved by the Commission; § 38.2-510 A 1 of the Code by misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue with such frequency as to indicate a general business practice; § 38.2-510 A 5 of the Code by failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed with such frequency as to indicate a general business practice; § 38.2-510 A 6 of the Code by not attempting in good faith to make prompt, fair and equitable settlements of claims in which liability has become reasonably clear with such frequency as to indicate a general business practice; § 38.2-510 A 15 of the Code by failing to comply with or perform any provider contract provision required by § 38.2-3407.15 with such frequency as to indicate a general business practice; § 38.2-514 B of the Code by failing to make proper disclosures on explanation of benefits; § 38.2-610 A 1 of the Code by failing to provide written notice of an adverse

underwriting decision; § 38.2-610 A 2 of the Code by failing to provide applicants with a summary of the rights established under subsection B of this section and §§ 38.2-608 and 38.2-609 on an adverse underwriting decision; § 38.2-1833 A 1 of the Code by failing to comply with agent appointment requirements; § 38.2-1834 D of the Code by failing to comply with the Commission's notification requirements of the termination of agent appointments; § 38.2-3407.4 A of the Code by failing to file explanation of benefit forms for approval by the Commission; § 38.2-3407.4 B of the Code by failing to accurately and clearly set forth in the explanation of benefits the benefits payable under the contract; §§ 38.2-3407.15 B 1, 38.2-3407.15 B 2, 38.2-3407.15 B 3, 38.2-3407.15 B 4, 38.2-3407.15 B 5, 38.2-3407.15 B 6, 38.2-3407.15 B 8, 38.2-3407.15 B 9, 38.2-3407.15 B 10 and 38.2-3407.15 B 11 of the Code by failing to demonstrate ethics and fairness in carrier business practices and by failing to include required provisions in provider contracts; §§ 38.2-3407.15:2 B 1, 38.2-3407.15:2 B 2, 38.2-3407.15:2 B 3, 38.2-3407.15:2 B 4, 38.2-3407.15:2 B 5, 38.2-3407.15:2 B 6, 38.2-3407.15:2 B 7, and 38.2-3407.15:2 B 8 of the Code by failing to demonstrate ethics and fairness in carrier business practices and by failing to include required provisions in carrier contracts; § 38.2-4306.1 B of the Code by failing to pay interest on claim proceeds; § 38.2-5805 C 10 of the Code by failing to include required provisions in provider contracts; as well as 14 VAC 5-90-55 A of the Commission's Rules Governing Advertisement of Accident and Sickness Insurance, 14 VAC 5-90-10 *et seq.* ("Rules"), by failing to include the required disclosure regarding the exclusions and limitations of the policy; 14 VAC 5-90-60 A 1 of the Commission's Rules by making misleading statements in the advertisements of covered benefits; 14 VAC 5-90-90 C of the Commission's Rules by failing to disclose the source of any statistics used in an advertisement; 14 VAC 5-211-30 C of the Commission's Rules Governing Health Maintenance

Organizations, 14 VAC 5-211-10 *et seq.*, by failing to include the required hold harmless clause in provider contracts; 14 VAC 5-211-80 B of the Commission's Rules by failing to provide or arrange for service prior to seeking coordination of benefits; 14 VAC 5-211-90 B of the Commission's Rules by failing to properly provide notice to an enrollee when his out-of-pocket maximum has been reached; and 14 VAC 5-216-40 E 2 of the Commission's Rules Governing Internal Appeal and External Review, 14 VAC 5-216-10 *et seq.*, by failing to notify the insured of the final benefit determination within the required period of time.

The Commission is authorized by §§ 38.2-218, 38.2-219, 38.2-4316 of the Code to impose certain monetary penalties, issue cease and desist orders, and suspend or revoke a defendant's license upon a finding by the Commission, after notice and opportunity to be heard, that a defendant has committed the aforesaid alleged violations.

The Defendant has been advised of the right to a hearing in this matter whereupon the Defendant, without admitting nor denying any violation of Virginia law, has made an offer of settlement to the Commission wherein the Defendant has agreed to comply with the corrective action plan contained in the target market conduct examination report of CareFirst BlueChoice as of December 31, 2016; has tendered to the Treasurer of Virginia the sum of Ninety Thousand Six Hundred Dollars ($90,600); and has waived the right to a hearing.

The Bureau has recommended that the Commission accept the offer of settlement of the Defendant pursuant to the authority granted the Commission in § 12.1-15 of the Code.

NOW THE COMMISSION, having considered the record herein, the offer of settlement of the Defendant, and the recommendation of the Bureau, is of the opinion that the Defendant's offer should be accepted.

Accordingly, IT IS ORDERED THAT:

(1) The offer of the Defendant in settlement of the matter set forth herein is hereby accepted.

(2) This case is dismissed, and the papers herein shall be placed in the file for ended causes.

A COPY of this order shall be sent by the Clerk of the Commission by electronic mail to: Jenene Williams, Senior Director, External Audit Coordination, CareFirst BlueChoice, Inc. at jenene.williams@carefirst.com, 1501 South Clinton Street, Room 10147, Baltimore, Maryland 21224; and a copy shall be delivered to the Commission's Office of General Counsel and the Bureau of Insurance in care of Deputy Commissioner Julie Blauvelt.