No. 2020- 6281

Official Order
of the
Texas Commissioner of Insurance

Date: MAR 0 6 2020

Subject Considered:

Health Care Service Corporation,
a Mutual Legal Reserve Company
doing business as
Blue Cross and Blue Shield of Texas,
a division of Health Care Service Corporation

300 East Randolph Street
Chicago, IL 60601

Consent Order
TDI Enforcement File Nos. 17946, 22697, 23810

General remarks and official action taken:

This is a consent order with Health Care Service Corporation, a Mutual Legal Reserve Company doing business as Blue Cross and Blue Shield of Texas, a division of Health Care Service Corporation (BCBSTX). BCBSTX issued explanation of benefits with incorrect notices to consumers, failed to timely process some out-of-network emergency claims, provided inaccurate summaries of policy information to consumers in its marketing materials, and had findings from a triennial quality of care examination. BCBSTX has agreed to pay restitution and a $10,000,000 administrative penalty.

Waiver

BCBSTX acknowledges that the Texas Insurance Code and other applicable law provide certain rights. BCBSTX waives all of these rights, and any other applicable procedural rights, relating to the entry of this consent order.

Pursuant to Texas Insurance Code Section 82.055(b), BCBSTX agrees to this consent order with the express reservation that it does not admit to a violation of any provision of the Texas Insurance Code, rule, or regulation of the department and maintains that the existence of any violation is in dispute.

Findings of Fact

1. BCBSTX holds a certificate of authority to act as a life, accident, and health insurer and a health maintenance organization (HMO) in Texas.

2. TDI conducted a market conduct examination for the period beginning January 1, 2016 and ending September 30, 2018. The examination was focused on BCBSTX's out-of-network emergency claim processing and Explanations of Benefits (EOBs). Based on its preliminary findings in the market conduct examination, TDI conducted additional reviews of BCBSTX relating to its out-of-network emergency claim processing, EOBs, and marketing materials.

3. BCBSTX has cooperated with TDI in its examinations and resolution of the matters covered by this order.

HMO Explanations of Benefits

Mediation notice to HMO members

4. HMO claims for services rendered before January 1, 2020 were not eligible for mediation under Texas Insurance Code Chapter 1467. Preferred provider organization (PPO) claims with balance bills greater than $500 were eligible for mediation.

5. From 2015 to December 2019, BCBSTX automatically generated EOBs for both PPO and HMO claims that included a notice stating the claim may be eligible for mediation.

6. The notice stated: "You may have received services from a facility, physician or other healthcare professional that is out-of-network. If you get a bill from the out-of-network provider for $500 or more (not including your copayment, coinsurance, and deductible), you may have the right to dispute and ask for a mediation of the claim amount. You can get more information and you may be able to reduce some of your out-of-pocket costs for an out-of-network medical or health care claim that

is eligible for mediation by contacting the Texas Department of Insurance.... If you get a bill from the out-of-network provider for under $500, you can call customer care at the number on your ID card for a claim review."

7. BCBSTX states that this language appeared on all HMO and PPO EOBs instead of only on PPO EOBs due to a system programming error.

8. From 2017 to 2019, BCBSTX received more than 500 HMO member mediation requests from TDI. For those HMO members that requested mediation, BCBSTX states that it has held those members harmless from the balance bill or determined the member did not receive a balance bill that was subject to the hold harmless process.

9. The inapplicable mediation notice remained on HMO EOBs until BCBSTX stated that it removed the notice from all HMO EOBs by December 16, 2019.

10. About 272,000 HMO EOBs, which equates to approximately 1.5% of all BCBSTX HMO EOBs sent between January 2015 and December 2019, related to an out-of-network emergency claim with a potential for a balance bill over $500.

HMO members' EOBs did not contain balance bill notice language

11. HMOs must hold their members harmless from balance bills for out-of-network emergency services under 28 TEX. ADMIN. CODE § 11.1611(d).

12. From at least August 2017 to January 2020, some BCBSTX members of one specific HMO plan, Blue Advantage Plus, who received out-of-network emergency services got EOBs stating that the out-of-network emergency service provided was covered up to the allowable amount and that BCBSTX would make no additional payment. Members were directed to TDI for complaints regarding the payment amount.

13. These Blue Advantage Plus EOBs should have contained a notice that the member was to contact BCBSTX if the member received a balance bill for an out-of-network emergency service.

14. BCBSTX represents that a programming error caused some Blue Advantage Plus EOBs for out-of-network emergency service claims to contain the incorrect notice. Since 2018, BCBSTX has used a filter to capture Blue Advantage Plus out-of-network freestanding emergency room claims so that claims processors could

apply the correct EOB message. BCBSTX represents that it corrected this notice error prior to the date of this order.

15. BCBSTX represents that during this period it sent approximately 29,000 EOBs with this incorrect notice to more than 15,000 Blue Advantage Plus members who received out-of-network emergency services.

Out-of-Network Emergency Claims Handling

16. Some provisions of the Texas prompt payment laws for health insurers apply to out-of-network emergency care under Texas Insurance Code Sections 843.351 and 1301.069. Generally, these statutes impose timelines for insurers like BCBSTX to adjudicate and pay out-of-network emergency claims for its HMO and PPO plans. However, these statutes do not require insurers to pay prompt pay penalties to out-of-network providers.

17. In August 2018, BCBSTX began routing out-of-network HMO emergency facility claims through a process it created, known as the Emergency Benefit Management (EBM) review process. The EBM process reviewed out-of-network HMO emergency facility claims and associated medical records.

18. Approximately 8,000 original and resubmitted claims went through this process between August 2018 and October 2019, when BCBSTX ended its EBM review process.

19. Based on data that BCBSTX provided to TDI, BCBSTX processed almost all of its total out-of-network emergency care claims within 30 days. However, BCBSTX did not adjudicate more than 80% of the approximately 8,000 EBM review claims within 30 days. A claim-by-claim analysis of whether each claim met all clean claim elements as defined under prompt pay laws and regulations was not performed, but BCBSTX acknowledges that some of these claims were clean and not timely processed.

Marketing and Sales Material

20. TDI received a complaint about an inaccuracy in summary of benefits and coverage (SBC) materials for certain BCBSTX HMO plans offered through the federal exchange in Texas for calendar year 2018.

21. Investigation revealed that, due to clerical error, the benefit described in the SBC was more beneficial to the consumer than the benefit described in the plan that had been filed with and approved by TDI. SBCs contain language referring consumers to their plan for more information about their coverage.

22. More than 70,000 people signed up for a 2018 HMO plan on the federal exchange and received a SBC with this discrepancy. BCBSTX sent a corrective notice to members who received the SBC with the discrepancy and advised members to call BCBSTX for assistance. BCBSTX received 89 member inquiries in response to this notice and offered a special enrollment period to any members who were dissatisfied with their plan because of the SBC discrepancy so that those members could choose another plan. Only one of those 89 members chose to take advantage of the special enrollment period to move to a different plan.

23. For plan years 2018-2019, BCBSTX identified more than 125 statements in documents summarizing benefits ("Summary Materials") that are described in detail in a member's plan that did not match the plan provisions filed with and approved by TDI.

24. About half of the discrepancies identified in the Summary Materials describe a greater benefit than was provided for in the plan that was filed with and approved by TDI. The other half described a lesser benefit than the benefits that were provided for in the plan that was filed with and approved by TDI. For example, one summary document stated that the plan would have an approximate eight percent decrease in maximum out-of-pocket charges, but the plan filed with TDI had not changed this term at all. Conversely, one summary document described a higher copay than the filed plan.

25. BCBSTX provided Summary Materials containing discrepancies to more than 450,000 of its HMO and PPO members.

26. BCBSTX's corrective actions during this period were to send corrected information to consumers when it discovered an error or to offer a special enrollment period if a consumer contacted BCBSTX.

Triennial Quality of Care Examination

27. TDI conducted a triennial quality of care examination of BCBSTX for the period beginning October 14, 2014 and ending December 31, 2017. The exam reviewed BCBSTX commercial HMO and some Texas government program claims.

28. TDI held an exit conference on July 11, 2019 to discuss its findings and issued a letter on December 19, 2019 stating the examination had been closed.

29. Among other findings, one exam finding was that BCBSTX did not timely acknowledge or resolve complaints in some reviewed files. Additionally, the exam found that BCBSTX issued adverse determinations in some reviewed files without affording the provider of record appropriate time to discuss the plan of treatment.

30. BCBSTX filed and implemented a corrective action plan to address findings from the exam.

Conclusions of Law

1. The commissioner of insurance has jurisdiction over this matter pursuant to TEX. INS. CODE chs. 541, 841, 843, and 1301; TEX. INS. CODE §§ 82.051-82.055 and 84.021-84.051; and TEX. GOV'T CODE §§ 2001.051-2001.178.

2. The commissioner of insurance has authority to informally dispose of this matter under TEX. GOV'T CODE § 2001.056; TEX. INS. CODE §§ 36.104 and 82.055; and 28 TEX. ADMIN. CODE § 1.47.

3. BCBSTX has knowingly and voluntarily waived all procedural rights to which it may have been entitled regarding the entry of this order, including, but not limited to, issuance and service of notice of intention to institute disciplinary action, notice of hearing, a public hearing, a proposal for decision, rehearing by the commissioner, and judicial review.

4. BCBSTX engaged in unfair or deceptive acts or practices in the business of insurance by making a statement misrepresenting the policy terms and benefits, pursuant to TEX. INS. CODE § 541.051(1) by including incorrect messages on some HMO EOBs for out-of-network emergency services and by distributing some Summary Materials with discrepancies.

5. BCBSTX failed to notify some Blue Advantage Plus members of the procedures for contacting BCBSTX if the member received a balance bill for out-of-network emergency care in violation of 28 TEX. ADMIN. CODE § 11.1611(e).

6. For many clean claims subject to EBM review, BCBSTX failed to comply with the applicable prompt payment timelines set forth in TEX. INS. CODE §§ 843.3385(a) and (c) and 1301.1054(a),(b).

7. As found in the triennial examination, BCBSTX violated TEX. INS. CODE § 843.252 because it did not maintain records that it acknowledged, investigated, and resolved complaints not later than the 30th calendar day from receipt.

8. As found in the triennial examination, BCBSTX violated TEX. INS. CODE § 4201.206 and 28 TEX. ADMIN. CODE §§ 19.1703(b)(26) and 19.1710 because it failed to afford the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee prior to issuing the adverse determination.

Order

It is ordered that BCBSTX pay an administrative penalty of $10,000,000 within 30 days of the date of this order. The administrative penalty must be paid by cashier's check or money order made payable to the "State of Texas." Mail the administrative penalty to the Texas Department of Insurance, Attn: Enforcement Division, Division 60851, MC 9999, P.O. Box 149104, Austin, Texas 78714-9104.

It is ordered that BCBSTX pay restitution sought by any of the following members according to the criteria and process described in Exhibit A attached to this order:

a) current or former BCBSTX HMO members with a claim for an out-of-network emergency service with dates of service from August 1, 2017 to December 31, 2019, who received an EOB with a mediation notice and/or without required balance bill language, and who received a balance bill for which BCBSTX has not already reimbursed the member or held the member harmless; and

b) current and former BCBSTX members who were enrolled in a 2018 or 2019 plan who received Summary Materials that described benefits greater than the benefit in the plan filed with and approved by TDI and who would have had a lower financial responsibility had the benefits described in the Summary Material been applied to their claims. This restitution plan does not apply to: (1) members who were enrolled in "grandfathered" plans, which are plans in place before the Affordable Care Act, or "grandmothered" plans, which are plans in place before November 2014, neither of which need to meet all Affordable Care Act requirements; or (2) members who previously received a corrective notice with respect to a 2018 plan.

BCBSTX must pay all restitution prior to December 31, 2020. BCBSTX must send to TDI by the tenth of each month (or next business day) an electronic spreadsheet detailing all restitution paid to its current and former members during the prior month. The information must be sent to TDI at EnforcementReports@tdi.texas.gov.

This consent order fully and finally resolves the issues addressed in this consent order and all findings in the market conduct and triennial quality of care examinations referenced above. This consent order does not resolve any allegations or violations with respect to any other TDI complaints, proceedings, or other investigations.

Kent C. Sullivan
Commissioner of Insurance

Recommended and reviewed by:

Leah Gillum, Deputy Commissioner
Enforcement Division

Affidavit

THE STATE OF TEXAS §
§
COUNTY OF COLLIN §

Before me, the undersigned authority, personally appeared the affiant, who being by me duly sworn, deposed as follows:

"My name is Dan K. McCoy, MD. I am of sound mind, capable of making this statement, and have personal knowledge of these facts which are true and correct.

I hold the office of President, Texas Division, and am the authorized representative of Blue Cross Blue Shield of Texas, a Division of Health Care Service Corporation (BCBSTX). I am duly authorized by BCBSTX to execute this statement.

BCBSTX has knowingly and voluntarily entered into the foregoing consent order and agree with and consent to the issuance and service of the same by the commissioner of insurance of the state of Texas."

Dan K. McCoy, MD

SWORN TO AND SUBSCRIBED before me on February 28, 2020.

YVONNE FRANCIS
Notary Public, State of Texas
Comm. Expires 05-04-2023
Notary ID 130213151

Signature of Notary Public

2020- 6281

Exhibit A

BCBSTX Restitution Plan

HMO Explanations of Benefits (EOBs)

Notification Process:

- Identify all Texas insured HMO members who had a claim for out-of-network emergency services with a date of service from August 1, 2017 through and including December 31, 2019, who received an EOB with a mediation notice and/or without required balance bill notice language, where the billed amount is greater than the allowed amount, and for which BCBSTX has not already held the member harmless.

- Begin sending notice letters to identified members no later than May 1, 2020, to be completed no later June 30, 2020. TDI will review the notices prior to BCBSTX sending the letters.

- For notice letters returned as undeliverable, BCBSTX will use reasonable efforts to contact the member, including phone contact and posting information online (all as may be allowed under HIPAA, the member's confidential communication request, potential do not call list restrictions, or other legal or regulatory requirements).

- Notification to inform member and provide instructions on how to seek restitution within sixty (60) days of receipt of the notice through submission of evidence of payment of a balance bill (credit card receipt, canceled check or receipt of payment from the provider), or if they have received a valid balance bill but have not yet paid, to submit the bill for disposition by BCBSTX. Notice to include specific submission instructions along with a dedicated customer service number to address any questions.

Administration:

- For submissions received within prescribed sixty (60) day period, process member refund as soon as possible but no longer than sixty (60) days of receipt of supporting documentation of balance bill payment by the member, or with respect to valid balance bills not yet paid by the member, hold the member harmless through BCBSTX standard disposition.

- If an identified member contacts a standard BCBSTX customer service number with a balance bill inquiry, BCBSTX will continue its existing process of adjusting claims on member emergency balance bills.

Marketing and Sales Material

Notification Process:

- Identify all current and former BCBSTX members who were enrolled in a 2018 or 2019 fully-insured plan who received Summary Materials that described benefits greater than the benefit in the plan filed with and approved by TDI and who would have had a lower financial responsibility had the benefits described in the Summary Material been applied. This restitution plan does not apply to: (1) members who were enrolled in "grandfathered" plans, which are plans in place before the Affordable Care Act, or "grandmothered" plans, which are plans in place before November 2014, neither of which need to meet all Affordable Care Act requirements; or (2) members who previously received a corrective notice with respect to a 2018 plan.

- Begin sending notice letters to identified members no later than May 1, 2020, to be completed no later June 30, 2020. TDI will review the notices prior to BCBSTX sending the letters.

- For notice letters returned as undeliverable, BCBSTX will use reasonable efforts to contact the member, including phone contact and posting information online (all as may be allowed under HIPAA, the member's confidential communication request, potential do not call list restrictions, or other legal or regulatory requirements).

- Notification to inform member as to their right to request potential restitution (based on the nature of the applicable discrepancy and their claims history under that plan) by submitting a request within sixty (60) days of receipt of the notice. Notice to include specific submission instructions along with a dedicated customer service number to address any questions.

Administration:

- For submissions received within prescribed sixty (60) day period, determine whether application of the benefits described in the Summary Material provided to the member would have resulted in lower financial responsibility for the member based on that member's claims history during that plan year.

- If so, promptly (targeting sixty (60) to ninety (90) days from receipt of the restitution request, but no later than December 31, 2020) remit payment to the member for the difference.