Final Report: Federal Targeted Market Conduct Examination of
Blue Cross Blue Shield of Tennessee
As of August 27, 2024

2023 - NONFED - NSA MCE- 5

Table of Contents

I. Scope of Examination

The Center for Consumer Information and Insurance Oversight (CCIIO) conducted a targeted Market Conduct Examination (Examination) of Blue Cross Blue Shield of Tennessee (Issuer) pursuant to 45 C.F.R. § 150.313, based on complaints submitted to CCIIO.

The Examination period was January 1, 2022 through December 31, 2022 (Examination Period). The purpose of the Examination was to assess the Issuer's compliance with certain Federal requirements under section 2799A-1(a) and (b) of the Public Health Service Act (PHS Act) and the following implementing regulations:

- 45 C.F.R. § 149.110(b)(3)(iv)(A) – Preventing Surprise Medical Bills for Emergency Services; and
- 45 C.F.R. § 149.120(c)(3) – Preventing Surprise Medical Bills for Non-Emergency Services Performed by Nonparticipating Providers at Certain Participating Facilities.

CCIIO contracted with Examination Resources, LLC to assist CCIIO with conducting this Review.

The Examination was based on a complaint file received by CCIIO. In addition to claims for fully insured health insurance coverage offered by the Issuer, the complaint file identified claims associated with 35 self-funded, non-federal governmental plans that contract with the Issuer for Third-Party Administrative (TPA) services. On April 21, 2023, the Issuer confirmed during the Examination entrance call that a single claims system is used for both the Issuer's fully insured plans and for the self-funded non-federal governmental plans administered by the Issuer acting as a TPA. Only claims associated with fully-insured health insurance coverage were reviewed for purposes of this Examination. However, CCIIO obtained authorization from each of the non-federal governmental plans to work directly with the Issuer in its capacity as a service provider to the plan so that CCIIO could conduct one consolidated examination. CCIIO will share a copy of this Final Report with the non-federal governmental plans for their awareness.

During this Examination, CCIIO requested information, records, and data related to claims submitted to the Issuer for both emergency services furnished by a nonparticipating provider or nonparticipating emergency facility and non-emergency services furnished by a nonparticipating provider with respect to a visit at a participating health care facility. CCIIO requests included:

- Complaints and electronic claim records. There was a total of 1,058 complaints submitted to CCIIO, which consisted of 791 unique claim numbers related to the fully-insured group and individual market plans. CCIIO selected 105 claim samples from the unique claim numbers;

- For each complaint sample, the Explanation of Payment (EOP) (also known as provider remittances) issued to the provider or facility for the claim, including the date of mailing;

- Proof that payment was issued to the provider or facility (e.g., check copies or remittance advice). If payment was submitted to the provider or facility via Electronic Funds Transfer (EFT), CCIIO requested an electronic file that included the Electronic Remittance Advice (ERA), or 835 file transaction records submitted to initiate an EFT payment to the provider or facility; and

- All provider correspondence related to the payment, including requests for additional information from the provider or facility.

This report is by exception; therefore, the only areas indicated in the report are areas where findings were noted. Any additional practices, procedures, and files subject to review during the Examination are omitted from this report if no findings are indicated. Some non-compliant practices may not have been discovered or noted in this report. Failure to identify or address business practices that do not comply with Federal statutes and regulations or those of other applicable jurisdictions does not constitute acceptance of such practices.

The examination and testing methodologies followed standards established by the National Association of Insurance Commissioners (NAIC) and procedures developed by CCIIO.[1] The Examination's claim sample was comprised of 105 Issuer claim complaints submitted to CCIIO from the fully-insured group and individual market plans associated with 791 claims submitted to CCIIO which alleged non-compliance with the stated regulations. The claims are summarized in the following table:

Area Reviewed	Total Complaints	Population /Unique Claims	Sample Size
Claims identified by complaints submitted to CCIIO.	1,058	791	105

[1] Market Regulation Handbook Examination Standards Summary 2022. https://content.naic.org/sites/default/files/publication-mes-hb-market-handbook-examination.pdf

We acknowledge that since the completion of CCIIO's Examination of the Issuer, the United States District Court for the Eastern District of Texas issued a ruling in TMA III. The ruling vacated certain provisions of the regulations and guidance implementing the No Surprises Act. This Examination takes into consideration the Issuer's compliance with applicable regulations and guidance as modified by the court's ruling in TMA III. However, the court's decision did not impact the findings nor scope of this Examination.

II. Issuer Profile

Blue Cross Blue Shield of Tennessee (Issuer) was formed in 1945 and originally named the Tennessee Hospital Service Association. The Issuer is a local not-for-profit company that has made health care coverage available to the Tennessee public since 1950 through its community enrollment plan.

Listed below are the 35 non-federal governmental plans that contract with the Issuer for TPA services and that are included within the scope of the Examination:

III. Examination Results

A. Failing to Send Initial Payment or Notice of Denial of Payment Not Later Than 30 Calendar Days After the Bill for Emergency Services or Non-Emergency Services was Transmitted by the Provider or Facility.

Violation of section 2799A-1(a)(1)(C)(iv)(I) and (b)(1)(C) of the PHS Act, as implemented at 45 C.F.R. §§ 149.110(b)(3)(iv)(A) and 149.120(c)(3).

In general, plans and issuers must send an initial payment or a notice of denial of payment, not later than 30 calendar days after the bill is transmitted for emergency services that were provided by a nonparticipating provider or a nonparticipating emergency facility and for non-emergency services furnished by a nonparticipating provider with respect to a visit at a participating health care facility that are subject to the surprise billing provisions of the No Surprises Act. The 30-calendar day period begins on the date the plan or issuer receives the information necessary to decide a claim for payment for the services.

CCIIO identified a violation of these provisions in the following instances:

Finding 1 – The Issuer failed to send an initial payment or notice of denial of payment not later than 30 calendar days after the bill was transmitted for emergency or non-emergency services subject to the No Surprises Act.

CCIIO identified 14 occurrences within the claims reviewed for which an initial payment or notice of denial of payment for emergency or non-emergency services provided by a nonparticipating provider with respect to a visit at a participating health care facility subject to the No Surprises Act was sent to the provider or facility later than 30 calendar days after the bill was transmitted by the provider or facility and the Issuer had received the information necessary to decide a claim for payment for the services.

Corrective Action:

The Issuer is directed to update and verify its claim processing procedures and claims system, if applicable. These improvements should ensure that an initial payment or notice of denial of payment for emergency and non-emergency services provided by a nonparticipating provider with respect to a visit at a participating health care facility subject to the No Surprises Act, is sent to the provider or facility not later than 30 calendar days after the bill for services is transmitted by the provider or facility. This 30-calendar-day period begins on the day the plan or issuer receives the information necessary to decide a claim for payment for the items or services. This review should

also encompass any potential organizational inefficiencies and consider updated trainings and workflow improvements. Within 45 calendar days of receipt of the final report, the Issuer will provide a copy of the updated procedure(s) and explanation of claim system update(s) needed to address the violations to CCIIO.

Issuer Response:

I. The Draft Report Should Consider Claims Instead of Line Items

First, BCBST [Issuer] disputes the Draft Report's calculation of "occurrences." The NSA makes clear that the 30-day payment requirement relates to entire claims by providers instead of line items within claims. See 45 C.F.R. §§ 149.110(b)(3)(iv), 149.120(c)(3) (providing that 30-day period to send initial payment or notice of denial of payment "begins on the date the plan or issuer receives the information necessary to decide a claim for payment for the services." (emphasis added)). Accordingly, any alleged violations of the NSA's 30-day payment requirement should be calculated on the claim level.

Here, several line items within the same claims were counted as separate "occurrences." Three sample claims, Sample #35, Sample #75, and Sample #80, each have multiple line items that are identified as unique "occurrences," causing the total number of occurrences to be inflated. When calculating occurrences at the claim level as directed by the NSA, the Draft Report refers to only 16 alleged occurrences.

II. Sample #38 Is Not Subject to the NSA

The claim at issue in Sample #38 was denied for lack of coverage. This is reflected on the claim's remittance advice BCBST provided to CCIIO. More specifically, the remittance indicates that the entire amount billed by the provider is "non-covered" with the following explanation code: "Benefits cannot be provided until we receive previously requested information concerning this member's other insurance." BCBST-000351, 353. Because BCBST was unable to assess benefits under the member's plan, BCBST denied the benefits as not covered. This claim therefore is not subject to the NSA and should not be at issue in the Examination.[2]

As part of our annual COB requirements, the COB update was requested from the member initially on January 3, 2022. A second request was sent to the member on February 7, 2022. Due to no response from the member, the claim in question was denied on June 30, 2022. These letters were not included in our response because they

[2]We note that the member had the right to appeal this benefit denial, which would have been treated as an appeal of an adverse benefit determination. This right of appeal does not, however, change the fact that the provider's claim is not eligible for evaluation under the NSA and should be excluded from the Examination and Draft Report.

were between the member (not the provider as requested in the exam notice) and BCBST, and because the updates are required annually, not specific to a particular claim. This claim was marked as not subject to the NSA on the data file and in our response letter [from May 15, 2023] it fell into Section a. *Claims Not Subject to the NSA*

III. Information Relating to Sample #51 Is Misrepresented

The information contained in Exhibit 1 of the Draft Report relating to Sample #51 is not accurate. Specifically, the table lists the "Date of Receipt" as February 15, 2022, and the "Date of Initial Payment or Notice of Denial" as September 15, 2022. However, that claim had been adjusted after it was originally received and paid.[3] The original claim[4] was received on February 15, 2022, and paid on March 17, 2022. BCBST-000455. An adjustment was initiated on August 10, 2022, due to a configuration update for the provider, and paid on September 15, 2022. BCBST-000462. Accordingly, it is not accurate to state that this sample is 183 days out of compliance.

IV. Corrective Action Is Not Appropriate

The Draft Report suggests that BCBST "update and verify its claim processing procedures and claims system" to ensure that NSA-eligible claims are paid within 30 days. Draft Report at 8. BCBST disputes that corrective action is appropriate.

Specifically, BCBST's claim processing procedures and claims system are already designed to meet deadlines even more stringent than the NSA. Specifically, under Tennessee law, insurers are required to pay claims received by electronic submission within 21 days and claims submitted on paper within 30 days.[5] Tenn. Code Ann. § 56-7-109. These state-law requirements predate the NSA by two decades and form much of the basis for BCBST's internal claims-processing policies and procedures.

In 2022, after the NSA's implementation, there were several system changes BCBST was required to make to ensure NSA compliance. These changes led to short-lived claim-processing delays while BCBST worked through the inevitable technical issues that arose. As explained in BCBST's May 12, 2023 response (the "Response") to the Notice of Targeted Market Conduct Examination dated April 13, 2023 (the "Notice"), a copy of which is attached hereto, the reasons behind the delays at issue have been fully addressed and resolved by BCBST. Specifically:

a. BCBST instituted a hold period in January 2022 to ensure its claims-processing system was correctly processing NSA-eligible claims. Response at 3. The backlog

[3] Claims ending in "-01," "-02," and so on reflect that a claim has been adjusted since its initial processing.
[4] The original claim ended in "00." The Examination concerns the adjusted claim ending in "-01."
[5] Where appropriate, BCBST paid interest on untimely payments pursuant to Tennessee law.

created by this temporary hold was resolved by April 2022. *Id*.

b. In 2022, BCBST experienced some technical issues related to an automated process it proactively initiated to ensure the efficient handling of out-of-network claims and claims subject to the NSA. Id. at 3–4. This process has been in place for over two years, and technical issues related to the process are now exceedingly rare. *Id*.

c. When the NSA was first implemented, a high volume of claims subject to the NSA required manual review due to unanticipated claim scenarios for which BCBST had not yet developed automated processing. Id. at 4. Now, over two years after the NSA's implementation, the vast majority of NSA-specific claim scenarios are fully automated, and manual review of eligibility is rarely required. *Id*.

BCBST developed and implemented corrective solutions to remedy these issues as they arose in 2022. Now, over two years later, BCBST's systems are fully NSA compliant. In fact, in 2023, BCBST's average processing time (from received date to paid date) for all out-of-network claims was a mere 15.81 days. With a fully operational and compliant system, any updates to BCBST's claim-processing procedures and claims system may, in fact, create more delays related to implementation and testing of updates without any corresponding benefit.

Moreover, since the Notice and Response, BCBST has endeavored to bring many out-of-network providers back in its network. Despite the [provider's] abuse of the independent dispute resolution process established under the NSA, see Response at 2, BCBST in September 2023 reached an agreement with [the provider] to come back in-network. Thus, not only have system-wide technical issues been resolved but also any prompt-payment issues specific to this provider.

Accordingly, because the reasons behind any NSA claim delays have been fully addressed, BCBST disputes that corrective action is appropriate.

CCIIO Response:

CCIIO disagrees with the Issuer's response in Section I because the No Surprises Act requirements apply at the item or service-level (see section 2799A-1(a) and (b) of the PHS Act; 45 C.F.R. §§ 149.110(a), 149.120(a) and (b)). Therefore, for violations of the requirements outlined at 45 C.F.R. §§ 149.110(b)(3)(iv)(A) and 149.120(c)(3), CMS identifies occurrences with respect to each individual line item or service within a bill for services received from a provider or facility.

CCIIO disagrees with the Issuer's response in Section II. Nothing in the No Surprises Act or its implementing regulations exempts a plan or issuer from disclosing information about the QPA or complying with other applicable requirements based on the presence of other coverage. As specified in 45 C.F.R. § 149.20, the requirements of 45 CFR part 149, subpart B, D and H apply to group health plans and health insurance issuers offering group or individual health insurance coverage (including grandfathered health plans as defined in § 147.140 of this subchapter), except as specified in 45 C.F.R. § 149.20(b) (which are not relevant here). This is true regardless of whether the plan or issuer pays primary or secondary to another payor. The fact that the Issuer may have been a secondary payor does not mean services were not subject to the No Surprises Act. The Issuer should have issued a notice of denial of payment (with the required QPA disclosures) if it determined the service was a covered benefit under the plan or coverage, but no payment would be made by the Issuer due to coordination of benefits.

CCIIO accepts the Issuer's responses in Section III and has removed one of the original nineteen occurrences. CCIIO also acknowledges that the Issuer implemented changes between January and April 2022 consistent with CCIIO's corrective action plan and that no additional corrective action is necessary.

IV. Closing

CCIIO conducted an Examination of the Issuer based on 1,058 complaints submitted to CCIIO. These complaints consisted of 791 unique claim numbers from the fully-insured group and individual market plans offered by the Issuer. CCIIO used these complaints to identify the claims sampled for the Examination. Of the claims reviewed, there were 2 findings that totaled 18 occurrences.

- Failing to send to the provider or facility an initial payment or a notice of denial of payment not later than 30 calendar days after the bill for emergency services was transmitted by the provider or facility and the Issuer had received the information necessary to decide a claim for payment for the services: 15 occurrences.

- Failing to send to the provider an initial payment or a notice of denial of payment not later than 30 calendar days after the bill for non-emergency services furnished by the nonparticipating provider with respect to a visit at a participating health care facility was transmitted by the provider and the Issuer had received the information necessary to decide a claim for payment for the services: 3 occurrences.

V. Examination Report Submission

The courtesy and cooperation extended by the officers and employees of the Issuer during the course of the Examination are hereby acknowledged.

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