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

In the Matter of: REGENCE BLUECROSS BLUESHIELD OF OREGON, Respondent.	Case No. INS-17-0082 FINAL ORDER TO CEASE AND DESIST AND ASSESSING CIVIL PENALTIES, ENTERED BY CONSENT

WHEREAS, the Director of the Department of Consumer and Business Services for the State of Oregon ("***Director***"), acting in accordance with Oregon Revised Statutes ("***ORS***") chapters 731, 732, 733, 734, 735, 737, 742, 743, 743A, 743B, 744, 746, 748 and 750 ("***Insurance Code***"), has conducted an investigation of Regence BlueCross BlueShield of Oregon ("***Respondent***") regarding violations of the Insurance Code; and

WHEREAS Respondent wishes to resolve this matter with the Director;

NOW THEREFORE, as evidenced by the signatures subscribed in this Order, Respondent hereby CONSENTS to entry of this Order upon the Director's Findings of Fact and Conclusions of Law.

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Labor and Industries Building
350 Winter Street NE, Suite 410
Salem, OR 97301-3881
Telephone: (503) 378-4387

FINDINGS OF FACT

The Director FINDS that:

1. Respondent is licensed by the Director, by and through the Division of Financial Regulation, previously known as the Insurance Division (collectively the "***Division***"), as a health care service contractor. Respondent's National Association of Insurance Commissioners ("***NAIC***") company number is 54933.

2. In 2016 and 2017, the Division requested certain information from Respondent as related to a number of consumer complaints against Respondent and as part of a targeted

data call. As the result of such inquiries, the Division discovered violations involving claims processing requirements of the Insurance Code by Respondent, among other violations, thereby prompting this action.

I. Failure to Identify Basis for Denial of Claim

3. On November 1, 2007, Respondent began using the following remark code, noted in the Explanation of Benefits ("***EOB***") provided to enrollees, when denying or partially denying certain health benefits claims: "PS0 This is not a covered service. Please refer to the Exclusions section in the member's benefit plan." (the "***PS0 Denial Code***").

4. The Exclusions section set forth in the applicable health benefit plans identified approximately 38 separate and distinct exclusions.

5. Respondent reported that it used the PS0 Denial Code when denying 81,616 individual health benefit claims between January 1, 2013 and February 27, 2017.

6. Upon denying the 81,616 health benefit claims, Respondent did not provide any explanation to the enrollees regarding the basis for denial on the EOB, other than the PSO Denial Code set forth in the EOB, which merely provided reference to a list of 38 exclusions and did not specifically identify which of those exclusion(s) formed the basis for the denial.

7. Without having information regarding the specific exclusion relied upon for denial, enrollees were unable to determine from the information provided in the EOB whether they were entitled to external review of the denied claims.

II. Failure to Promptly Pay or Communicate Regarding Claims

8. Upon receipt of a claim under a health benefit plan, Respondent routinely sends certain communications to enrollees and health care providers relating to the claim processing, including, but not limited to, the following:

A. **Acknowledgement Letter:** A form letter acknowledging receipt of the claim to the enrollee, stating that Respondent is processing the claim, and representing

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that Respondent will contact the enrollee if for some reason there is a delay in processing the claim. Respondent reported that it started using the Acknowledgment Letter in March 2008, and that between January 1, 2014 through January 24, 2017 it sent the letter to approximately 134,436 Oregon consumers enrolled in Respondent's health benefit plans;

B. **Information Request:** A letter to the health care provider and/or the enrollee, requesting additional medical records and other information needed to process the claim; and

C. **Explanation of Benefits ("*EOB*"):** A statement provided to the enrollee describing the status of the claim and assessing any initial or final payment obligations on the claim.

9. The Oregon consumer identified herein as "***CR***" was enrolled in Respondent's 2015 health benefit plan as a qualified dependent.

10. Respondent received and processed no less than three separate claims under the 2015 health benefit plan for payment of medical services provided to CR, as follows.

11. ***Claim 1 & 2***:

A. 6/24/15 - Claims 1 & 2 submitted for services rendered in January 2015 and February 2015, respectively;

B. 7/23/15 – Respondent sent CR an Acknowledgement Letter. The letter did not advise CR that there would in fact be a delay in processing Claims 1 & 2, and did not identify any additional information that Respondent needed in order to process Claims 1 & 2;

C. 7/28/15 – Respondent sent an Information Request to CR's provider, seeking additional information to process Claims 1 & 2. Respondent did not send a copy of the letter to CR;

D. 7/29/15 - Respondent sent a letter to CR informing him that Claims 1 & 2 were pending while awaiting additional information from the provider. The letter did not identify the specific information that Respondent needed to process Claims 1 & 2;

E. 9/21/15 – Respondent sent EOBs for Claims 1 & 2 to CR, which included the code "G0T Pending receipt of records, initial evaluation, RX for service,

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ABA assessment, initial functional analysis, progress notes." This was the first time that Respondent notified CR of the additional information needed to process Claims 1 & 2;

F. 8/4/15 – (Claim 2 only) Respondent received the additional information requested from the provider concerning Claim 2;

G. 10/2/15 – (Claim 1 only) Respondent received the additional information requested from the provider concerning Claim 1;

H. 11/10/15 – (Claim 1 only) Respondent issued an adjusted EOB to CR;

I. 11/11/15 – (Claim 1 only) Respondent finalized the processing of Claim 1, paying a portion of the amounts claimed as the provider was "out-of-network" with Respondent at the time the services were rendered;

J. 12/23/15 – (Claim 2 only) Respondent finalized the processing of Claim 2, paying the claim as an out-of-network benefit; and

K. 12/28/15 – (Claim 2 only) Respondent issued an adjusted EOB to CR.

12. ***Claim 3***

A. 7/1/15 – Claim submitted for services rendered in March 2015;

B. 7/30/15 – Respondent sent CR an Acknowledgement Letter. The letter did not advise CR that there would in fact be a delay in processing Claim 3, and did not identify any additional information that Respondent needed to process Claim 3;

C. 9/21/15 – Respondent sent an EOB for Claim 3 to CR, which included the code "G0T Pending receipt of records, initial evaluation, RX for service, ABA assessment, initial functional analysis, progress notes." This was the first time that Respondent notified CR of the additional information needed to process Claim 3; and

D. 12/28/15 –Respondent issued an adjusted EOB to CR, informing CR that it was paying a portion of the amounts claimed under Claim 3 as an out-of-network benefit.

13. With respect to Claims 1 & 2, Respondent did not notify CR until 35 days after Claims 1 & 2 were filed that processing of the claims would be delayed and that additional information was needed to process the claims. Respondent further did not notify CR until 89 days after Claims 1 & 2 were filed what specific additional information Respondent

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needed to process the claims.

14. With respect to Claim 1, Respondent did not process the claim until 40 days after it received the information requested from the provider.

15. With respect to Claim 2, Respondent did not process the claim until 141 days after it received the information requested from the provider. During this timeframe, Respondent did not notify CR that the investigation remained incomplete and/or the reason additional time was needed for an investigation of the claim, other than the EOB issued to CR on September 21, 2015.

16. With respect to Claim 3, Respondent did not notify CR until 83 days after Claim 3 was filed that processing of the claim would be delayed and that additional information was needed to process the claim. Respondent further did not process the claim until 51 days after the delay notice was provided, and 133 days after the claim was filed.

17. As part of the Division's inquiry with Respondent relating to CR's claims, other similar claims, and Respondent's use of the Acknowledgment Letter, Respondent provided the following inaccurate information to the Division:

A. On March 7, 2017, Respondent represented that the Acknowledgement Letter had been issued by Respondent in 1,887 instances between January 1, 2014 and January 24, 2017, when after further inquiry by the Division, Respondent reported that it had in fact been issued in 134,436 instances during this timeframe;

B. On March 7, 2017, Respondent represented that, following issuance of the Acknowledgement Letter, once Respondent confirms that there will be a delay in processing a claim "we immediately send a letter with that reason." After further inquiry by the Division, Respondent admitted on July 11, 2017, that prior to November 2015 a second letter was not in fact sent, and rather enrollees were not notified of the reason for delay until the issuance of an EOB.

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C. Despite request by the Division for all communications relating to CR's claims, Respondent failed to provide copies of the EOBs relating to the claims in two separate instances, and failed to provide copies of four other letters between Respondent and the provider and/or CR relating to the claims; and

D. In a data call inquiry that encompassed CR's claims, Respondent failed to include CR's claims in a spreadsheet of claims information, and later acknowledged that it had pulled the data incorrectly and CR's claims should have been included.

III. Prompt Payment Data Reporting Errors

18. On February 22, 2017, Respondent filed with the Director a Report of Prompt Payment of Data for the 2016 calendar year (the "***2016 Prompt Payment Report***"), as required by ORS 743B.450(6) and Oregon Administrative Rule ("***OAR***") 836-080-0085.

19. In the 2016 Prompt Payment Report, Respondent identified the total number of claims that were finalized during the 2016 calendar year, and out of those total claims the number that resulted in a final disposition later than 30 days from the date on which the claim was received. The 2016 Prompt Payment Report filed by Respondent inaccurately included final claims information for 2014 rather than 2016.

20. On February 27, 2017, Respondent filed an amended 2016 Report of Prompt Payment of Data with the Director, in an attempt to fix the errors identified by the Division in the initial report. The amended report once again included inaccurate information regarding the 2016 claims that resulted in a final disposition later than 30 days from the date on which the claim was received.

21. On February 28, 2017, as part of the 2016 Prompt Payment Report requirements, the Division sent Respondent a sample data file, requesting additional information relating to specific claims that were processed in 2016 outside of the 30 day window. Respondent was required to complete and return the sample data file to the Division. On April 3, 2017, Respondent submitted the completed sample data file, but the

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file contained a number of errors that made an accurate review of the file impossible.

22. The repeated inaccurate reporting errors included in the 2016 Prompt Payment Report and related filings were all discovered by the Division, and were promptly corrected by Respondent after request by the Division.

CONCLUSIONS OF LAW

The Director CONCLUDES that:

23. Respondent is an "insurer" under ORS 743B.005(9), and is subject to regulation by the Director.

Claims Denial Violations

24. Under ORS 746.230(1)(m), no insurer shall commit the unfair claim settlement practice of failing to promptly provide the proper explanation of the basis relied on in a subject insurance policy, in relation to the facts or applicable law, for the denial of a claim.

25. Under OAR 836-080-0235(1), an insurer shall not deny a claim on the grounds of a specific policy provision, condition, or exclusion, unless the denial includes reference to the provision, condition, or exclusion.

26. Respondent violated ORS 746.230(1)(m) and OAR 836-080-0235(1) when it denied no less than 81,616 health benefit claims between January 1, 2013 and February 27, 2017 using the PSO Denial Code and did not provide the claimants with any additional information regarding the specific exclusion(s) that formed the basis of the denials on the EOB.

Prompt Payment and Communications Violations – CR's Claims

27. ORS 743B.450(1) requires an insurer to pay a clean claim or deny the claim no later than 30 days after the date on which the insurer receives the claim. If an insurer requires additional information before payment of a claim, no later than 30 days after the date on which the insurer receives the claim, the insurer shall notify the enrollee and the provider in writing and give the enrollee and the provider an explanation of the additional

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information needed to process the claim. The insurer shall pay a clean claim or deny the claim no later than 30 days after the date on which the insurer receives the additional information.

28. OAR 836-080-0235(4) requires that, if an insurer needs more time to determine whether a claim should be accepted or denied, the insurer must notify the enrollee no later than 30 days after the date on which the insurer receives the claim, giving the reason more time is needed. The insurer further must notify the enrollee every 45 days thereafter, so long as the investigation remains incomplete, of the reason additional time is needed for investigation.

29. Respondent violated ORS 743B.450(1) and OAR 836-080-0235(4) in three instances when it failed to notify CR within 30 days from the date on which Respondent received Claims 1, 2, and 3 that processing of the claims would be delayed, that additional information was needed to process the claims, and what specific additional information was needed.

30. Respondent violated ORS 743B.450(1) when it failed to process Claim 1 until 40 days after it received the necessary additional information requested from the provider.

31. Respondent violated ORS 743B.450(1) and OAR 836-080-0235(4), respectively, when failed to process Claim 2 until 141 days after it received the necessary additional information requested from the provider, and failed to notify CR every 45 days that the investigation remained incomplete and of the reasons that additional time was needed for the investigation.

32. Respondent violated ORS 743B.450(1) and OAR 836-080-0235(4), respectively, when it failed to process Claim 3 until 51 days after the delay notice was provided and 133 days after the claim was filed, and when it failed to notify CR every 45 days that the investigation remained incomplete and of the reasons that additional time was needed for the investigation.

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Prompt Payment Data Reporting Violations

33. ORS 743B.450(6) requires an insurer to report to the Director regarding its compliance with ORS 743B.450(1), the prompt payment of claims statutes, according to requirements established by the Director.

34. OAR 836-080-0085(1) and (2) require an insurer to file an annual report relating to its compliance under ORS 743B.450(1), to be filed no later than March 1 of each year for the preceding year claim information. The report is required to include: (a) a count of all claims for which final disposition was made during the preceding year; (b) a count of all claims during the preceding year that were finally disposed of later than the 30th day after the insurer received the claim; and (3) a data file that includes a population list of all claims finally disposed of later than the 30th day (the "***Data File***").

35. Under OAR 836-080-0085(3), the Director shall select a number of sample claim files from the insurer's Data File, and the insurer is required to submit additional information regarding the sample claim files within 60 days. OAR 836-080-0085(4),(5).

36. Under ORS 731.296, insurers shall promptly and truthfully reply to all inquiries from the Director, and such reply is subject to the provisions of ORS 731.260.

Other Data Reporting Violations

37. Respondent violated ORS 731.296 when it submitted the reports and information more fully described in Paragraphs 17 above, which contained inaccurate information.

ORDERS

Now therefore, the Director issues the following Orders:

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

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39. As authorized by ORS 731.988(1), the Director hereby assesses CIVIL PENALTIES against Respondent in the total amount of Ninety Five Thousand Dollars ($95,000), as follows:

A. A CIVIL PENALTY of Thirty Five Thousand ($35,000) for violations of ORS 746.230(1)(m) and OAR 836-080-0235(1), as more fully described in Paragraphs 32 through 34 above;

B. A CIVIL PENALTY of Fifty Thousand Dollars ($50,000) for violations of ORS 743B.450(1) and OAR 836-080-0235(4), as more fully described in Paragraphs 35 through 40 above;

C. A CIVIL PENALTY of Five Thousand Dollars ($5,000) for violations of ORS 743B.450(6), OAR 836-080-0085, and ORS 731.296, as more fully described in Paragraphs 33 through 37 above; and

D. A CIVIL PENALTY of Five Thousand Dollars ($5,000) for violations of ORS 731.296, as more fully described in Paragraphs 17 and 52 above.

40. The $95,000 CIVIL PENALTY assessed above is due and payable at the time this signed Order is returned to the Division.

Remedial Measures

41. Respondent made the following changes to its claims processing procedures in furtherance of addressing the violations more fully described in Paragraphs 8-17 and 27-32 of this Order:

A. On or before July 6, 2018, Respondent activated certain claims processing system changes which will ensure that written notifications will be sent to consumers and providers within the time required by law, in accordance with ORS 743B.450(1) and OAR 836-080-0235(4). These changes include, but are not limited to, notifying the consumer and provider whether there will be a delay in processing the claim within the time required by Oregon law from the date the claim

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is received by Respondent, and providing an explanation of any additional information needed to process the claim (the "***Delay Letter***"); and

B. On or around July 6, 2018, Respondent activated certain claims processing system changes which will ensure that, for claims involving the Delay Letter described above, Respondent will send further written notification within the time period required by Oregon law (currently 45 days) after sending the initial Delay Letter, informing the consumer of the reason additional time is needed for investigation of the claims, and Respondent will continue to send such written notification as required by Oregon law thereafter until the claim is either paid or denied, in accordance with OAR 836-080-0235(4).

42. Respondent is in the process of making the following changes to its claims processing procedures in furtherance of addressing the violations more fully described in Paragraphs 3-7 and 24-26 of this Order:

A. Within 60 days from the date of execution of this Order, Respondent will activate certain claims processing system changes which will ensure that, for claims that are denied on the grounds of a specific policy exclusion, the consumer will receive timely written notification of the specific policy exclusion relied upon by Respondent (the "***Exclusion Notice***"), in accordance with ORS 743B.450(1), 746.230(1)(m) and OAR 836-080-0235(1).

B. The Exclusion Notice will be sent to the consumer in a written notification that is separate from the EOB that is sent to the consumer. Accordingly, the consumer will receive notice of the denial of the claim in two separate notifications. The Exclusion Notice will identify the specific exclusion relied upon by Respondent to deny the subject claim, and the EOB will identify the total amount the consumer will be responsible to pay as a result of the denial. The Exclusion Notice will be sent to the consumer either on the same day or no more than two

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days prior to the EOB. The date of the EOB will govern for purposes of determining the deadline for exercising any appeal rights.

C. In addition to the Exclusion Letter, Respondent will be evaluating its claims settlement processes to determine if there are any other situations that would necessitate the use of a secondary written notification, in addition to the EOBs, to meet the requirements of the Insurance Code. Regence will complete its evaluation and communicate its findings to the Division in writing no later than 90 days from the date of execution of this Order.

D. While the Division has determined that the use of the above-described Exclusion Notice in combination with the EOB does not violate the claims settlement communication requirements of ORS 743B.450, 746.230(1)(e) and OAR836-080-0235(1), the Division is concerned that the use of two separate letters to communicate on a single claim denial will lead to consumer confusion and/or an increased risk of error in Respondent's claims settlement processes.

E. The Division reserves the right to further investigate the claims settlement notifications sent from Respondent to consumers, including, but not limited to, the EOB, Exclusion Notice, and any other similar supplemental notices, to ensure compliance with the Insurance Code.

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43. This Order is a "Final Order" under ORS 183.310(6)(b). Subject to that provision, entry of this Order in no way limits or prevents further remedies, sanctions, or actions which may be available to the Director under Oregon law to enforce this Order, for violations of this Order, for conduct or actions of Respondent that are not covered by this Order, for conduct or actions that are specifically reserved in this Order for further investigation, or against any party not covered by this Order.

SO ORDERED this 29th day of November, 2018.

CAMERON SMITH, Director
Department of Consumer and Business Services

/s/ Dorothy Bean
Dorothy Bean, Chief of Enforcement
Division of Financial Regulation

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CONSENT TO ENTRY OF ORDER

I, _a. Dowling__, state that I am an officer of Regence BlueCross BlueShield of Oregon ("***Respondent***"), and that I am authorized to act on its behalf; that I have read the foregoing Order and that I know and fully understand the contents hereof; that I have been advised of Respondent's right to a hearing in this matter; that Respondent has been represented by counsel in this matter; that Respondent voluntarily and without any force or duress, consents to the entry of this Order, expressly waiving any right to a hearing in this matter; that Respondent executes this Order as a settlement of the matters referred to in the foregoing Order; that Respondent understands that the Director reserves the right to take further actions to enforce this Order or to take appropriate action upon discovery of other violations of the Insurance Code by Respondent, and; that Respondent will fully comply with the terms and conditions stated herein.

Respondent understands that this Order is a public document.

By: _/s/ a. Dowling_____
Signature
By: _Angela Dowling_____
Printed Name

Office Held: _President_____

State of OREGON
County of _Multnomah_

There appeared before me this 15 day of November__, 2018, Angela Dowling____, and stated that he/she was and is an officer of Respondent, and that he/she is authorized and empowered to sign this Order on behalf of Respondent, and to bind it to the terms hereof.

_/s/ Donna Lynn Toner____
Notary Public - State of Oregon

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Approved as to form:

_____ _____
Date

Attorney for Respondent