Report on

Market Conduct Examination

of

Blue Cross and Blue Shield of North Carolina

Durham, North Carolina

by Representatives of the

North Carolina Department of Insurance

as of

January 11, 2018

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Honorable Mike Causey
Commissioner of Insurance
Department of Insurance
State of North Carolina
Albemarle Building
325 N. Salisbury Street
Raleigh, North Carolina 27603

Honorable Commissioner:

Pursuant to your instructions and in accordance with the provisions of North Carolina General Statute (NCGS) 58-2-131 through 58-2-134, a target examination has been made of the market conduct activities of

Blue Cross and Blue Shield of North Carolina
(NAIC #54631)
NAIC Exam Tracking System Exam Number: NC-NC131-21
Durham, North Carolina

hereinafter generally referred to as the Company, at the Company's office located at 4615 University Drive, Durham, North Carolina, and at the North Carolina Department of Insurance (Department) office located at 325 N. Salisbury Street, Raleigh, North Carolina. A report thereon is respectfully submitted.

SCOPE OF EXAMINATION

The Department conducted a target examination of the Company. This examination commenced on August 21, 2017, and covered the period of January 1, 2017, through July 31, 2017, with analyses of certain operations of the Company being conducted through December 19, 2017. All comments made in this report reflect conditions observed during the period of the examination.

This examination was performed in accordance with auditing standards established by the Department and procedures established by the National Association of Insurance Commissioners (NAIC). The scope of this examination was not comprehensive, and consisted of an examination of the Company's practices and procedures specific to individual and small group membership in the areas of claims administration, and member appeals, grievances, and complaints. The findings and conclusions contained within the report are based on the work performed and are referenced within the appropriate sections of the examination report.

It is the Department's practice to cite companies in violation of a statute or rule when the results of a sample show errors/noncompliance that fall outside certain tolerance levels. The Department applied a 3 percent tolerance level for claims processing timeliness and accuracy, as well as for notification letter content of member appeals and grievances. A 0 percent tolerance level was applied for timeliness of member appeal and grievance acknowledgement and determination letters. Sample sizes were generated using Audit Command Language (ACL) software. The Department utilized a 95% Confidence Level to determine the error tolerance level.

EXECUTIVE SUMMARY

This market conduct target examination revealed concerns with Company procedures and practices in the following areas:

Claims Administration – Failure to send compliant and/or timely claim status notifications to claimants for claims processed beyond 30 days from receipt; and failure to process accurate claim payments due to system configuration or prior authorization linkage errors.

Utilization Management – Failure to conduct timely reviews for noncertification appeal requests; failure to provide timely acknowledgement letters to covered persons for noncertification appeals; and failure to provide compliant written decision notification letters to covered persons and/or providers for noncertification appeals.

Member Grievances – Failure to provide timely written acknowledgement letters to covered persons; and failure to provide compliant written decision notification letters to covered persons for member grievances.

Complaints – Revealed failure to prevent policy termination errors; and failure to apply in-network benefits to a covered person's claim.

Specific violations are noted in the appropriate sections of this report. All North Carolina General Statutes and rules of the North Carolina Administrative Code cited in this report may be viewed on the North Carolina Department of Insurance Web site www.ncdoi.com by clicking "Insurance Industry" then "Legislative Services" under "Other Divisions".

This examination identified various statutory violations, some of which may extend to other jurisdictions. The Company is directed to take immediate corrective action to demonstrate its ability and intention to conduct business in North Carolina according to its insurance laws and regulations. When applicable, corrective action for other jurisdictions must be addressed.

All statutory violations may not have been discovered or noted in this report. Failure to identify statutory violations in North Carolina or in other jurisdictions does not constitute acceptance of such violations.

CLAIMS ADMINISTRATION

The Company's claims administration practices were reviewed to determine compliance with applicable North Carolina Statutes and rules, as well as adherence to the Company's policies and procedures relative to claims processing. The examination of paid claims targeted individual and small group claims processed beyond 30 days from receipt of the claim, in order to more broadly assess the Company's adherence to interest payment requirements within NCGS 58-3-225 (Prompt Pay Law). Interest payment penalty adherence is not applicable to the examination

of denied claims, therefore, the denied claim sample reviews detailed within this section include charts illustrating service days to process sampled denied claims.

Policies and Procedures

The Company's policies and procedures for claims administration were examined to determine compliance with appropriate North Carolina statutes. The policies were found to adhere to the provisions of NCGS 58-3-225.

Paid Claims – Small Group Membership

The Company processed a total of 1,611,212 paid claim lines for its small group line of business during the examination period. A total of 18,608 of these claim lines were processed with delay beyond 30 days from receipt of the claim. A random sample of 131 paid claims was produced from this population of delayed claim lines. These paid claim files were reviewed to assess the Company's compliance with the provisions of NCGS 58-3-225 as well as its internal policies and procedures. The review revealed that late payment interest was applicable within 66 of the sampled files and was paid to the claimant. All interest payments processed were verified as correct and were determined to adhere to the provisions of NCGS 58-3-225(e). Further review of the paid claim files sample revealed that the Company did not adhere to the provisions of NCGS 58-3-225(b) within 47 files based on the following:

- The delayed claim status notification within 27 paid claim files did not specify the reason for delayed processing, specifically that the small group premium was delinquent.
- A delayed claim status notification was not sent to the claimant within 12 paid claim files.
- The delayed claim status notification was sent beyond 30 days from receipt of the claim within eight paid claim files.

Also noted during the sample review were two additional paid claim files which did not initially contain notification letters providing status of delayed claim processing to the claimant. The Company provided a copy of the letters for these two files during the examination in response to the sample review findings.

Paid Claims – Individual Plan Membership

The Company processed a total of 8,088,038 paid claim lines for its individual plan membership during the examination period. A total of 126,635 of these claim lines were processed with delay beyond 30 days from receipt of the claim. A random sample of 131 paid claims was produced from this population of delayed claim lines. These paid claim files were reviewed to assess the Company's compliance with the provisions of NCGS 58-3-225 as well as its internal policies and procedures. The review revealed that late payment interest was applicable within 93 of the sampled files and was paid to the claimant. All interest payments processed were verified as correct and were determined to adhere to the provisions of NCGS 58-3-225(e). Further review of the paid claim files sample revealed that the Company did not adhere to the provisions of NCGS 58-3-225 within 20 files based on the following:

- The delayed claim status notification within 15 paid claim files did not specify the reason for delayed processing, specifically that the member's premium was delinquent.
- A delayed claim status notification was not sent to the claimant within two paid claim files.
- The delayed claim status notification was sent beyond 30 days from receipt of the claim within one paid claim file.
- Review of one file revealed a payment error due to a prior authorization linkage issue. The Company reprocessed the claim, issuing an additional payment of $9,868.32, plus late payment interest in the amount of $141.13.

In addition, it was noted within one claim file that the Explanation of Benefits (EOB) reflected a potentially confusing remark code narrative regarding the member's financial responsibility for an emergency room visit to a non-contracted facility. However, the itemized portion of the EOB indicated the proper amount of member liability, which was $0.00.

Denied Claims – Small Group Membership

A review was conducted of 131 denied claim files for the Company's small group line of business. These claim files were selected based on a random sample produced from a total population of 185,599 denied claim lines processed during the examination period for small

groups. The files were reviewed to assess the Company's compliance with the provisions of NCGS 58-3-225 as well as its internal policies and procedures. The review revealed that the Company did not adhere to the provisions of NCGS 58-3-225 within five files based on the following:

- The claim was denied beyond 30 days from receipt without status notification to the claimant within two files.
- The claim was denied beyond 60 days from receipt without status notification to the claimant within one file.
- A system configuration error resulted in an erroneous claim denial within one file. Review of the file determined that the claim had not been reprocessed subsequent to correction of the system error. As a result of the review, the Company reprocessed this claim, and conducted a remedial investigation to identify any additional outstanding claims affected by this system error. This review identified eight additional claims affected. The Company reprocessed all nine claims, resulting in a net payment amount of $694.16, plus an additional total of $21.66 in late payment interest.
- A system configuration error resulted in the Explanation of Benefits and the Explanation of Payment reflecting no remark code or narrative for the denied claim within one file. This system error was subsequently corrected in July 2017.

Also noted during the sample review were two additional denied claim files which did not initially contain notification letters providing status of delayed claim processing to the claimant. The Company provided a copy of the letters for these two files during the examination in response to the sample review findings.

The average service time to process a denied claim within the sample reviewed for small group membership was 15 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	31	23.7
8 - 14	51	38.9
15 - 21	7	5.3
22 - 30	37	28.2
31 - 60	4	3.1
Over 60	1	0.8
Total	**131**	**100.0**

Denied Claims – Individual Plan Membership

A review was conducted of 131 denied claim files for the Company's individual plan membership. These claim files were selected based on a random sample produced from a total population of 791,097 denied claim lines processed during the examination period for individual plans. The files were reviewed to assess the Company's compliance with the provisions of NCGS 58-3-225 as well as its internal policies and procedures. The review revealed that the Company adhered to the provisions of NCGS 58-3-225, as the number of files noted with issues was below the established error tolerance level for claims administration. Review of the files revealed the following:

- The claim was denied beyond 30 days from receipt without status notification to the claimant within one file.
- The claim was denied beyond 60 days from receipt without status notification to the claimant within one file.
- A system configuration error resulted in the Explanation of Benefits and the Explanation of Payment reflecting no remark code or narrative for the denied claim within one file. This system error was subsequently corrected in July 2017.

Also noted during the sample review were nine additional denied claim files which did not initially contain notification letters providing status of delayed claim processing to the claimant. The Company provided a copy of the letters for these nine files during the examination in response to the sample review findings. Review of these notification letters determined adherence to the provisions of NCGS 58-3-225.

The average service time to process a denied claim within the sample reviewed for individual plan membership was 26 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	4	3.1
8 - 14	2	1.5
15 - 21	1	0.8
22 - 30	107	81.6
31 - 60	16	12.2
Over 60	1	0.8
Total	**131**	**100.0**

UTILIZATION MANAGEMENT – NONCERTIFICATION APPEALS

Members who are not satisfied with utilization review determinations have the right to appeal the Company's decision. A member is entitled to an expedited review of his or her appeal if a delay in the rendering of health care would be detrimental to the member's health.

Policies and Procedures

The Company's policies and procedures for utilization management noncertification appeals were examined to determine compliance with appropriate North Carolina statutes. The policies were found to adhere to the provisions of NCGS 58-50-61 and 58-50-62.

Standard Noncertification Appeal Files Review

The Company received a total of 708 standard utilization review appeal requests during the examination period for small group and individual lines of business. A random sample of 131 appeal files was selected from this total. These files were reviewed to assess the Company's compliance with the provisions of NCGS 58-50-61 and 58-50-62, as well as its internal policies and procedures. The review revealed that the Company did not adhere to the provisions of NCGS 58-50-61(k) within 12 files based on the following:

- The acknowledgement letter within four files was not sent to the covered person within three business days after receiving the appeal request.
- An acknowledgement letter was not sent to the covered person within one file.
- The written notification of the decision within two files was not sent to the member nor provider within 30 days from receipt of the appeal request.
- The written notification of the decision within one file erroneously advised a member with an individual policy of second-level appeal availability.

- Five files contained insufficient documentation to ascertain that the written notification of the decision was sent to both the member and/or provider.

Two additional files did not adhere to the provisions of NCGS 58-50-62(h)(8), as the decision letter, which was based on second-level grievance review protocol, did not include notice of the availability of the Commissioner's office for assistance, including the phone number and address of the Commissioner's office.

The average service time to process a member appeal within the sample reviewed was 25 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	8	6.1
8 - 14	8	6.1
15 - 21	10	7.7
22 - 30	103	78.6
31 - 60	2	1.5
Total	**131**	**100.0**

Expedited Noncertification Appeal Files Review

The Company received a total of 44 Expedited Appeal requests during the examination period for small group and individual lines of business. A review was conducted of each of these files to assess the Company's compliance with the provisions of NCGS 58-50-61 and 58-50-62, as well as the Company's internal policies and procedures. The review revealed that the Company did not adhere to the provisions of NCGS 58-50-61(l) within two files, as the decision letter was not sent to the covered person and their provider within four days after receiving the expedited appeal request.

In addition, the Company did not adhere to the provisions of NCGS 58-50-62(h)(8) within one file, as the decision letter, which was based on second-level grievance review protocol, did not include notice of the availability of the Commissioner's office for assistance, including the phone number and address of the Commissioner's office.

GRIEVANCES AND COMPLAINTS

Policies and Procedures

The Company's policies and procedures for handling member grievances, as well as member and provider complaints were examined to determine compliance with appropriate North Carolina statutes. The policies were found to adhere to the provisions of NCGS 58-50-62 and 11 NCAC 1.0602.

Member Grievance File Review

The Company received a total of 404 member grievance review requests during the examination period for small group and individual lines of business. A random sample of 131 grievance files was selected from this total. These files were reviewed to assess the Company's compliance with the provisions of NCGS 58-50-62, as well as its internal policies and procedures. The review revealed that the Company did not adhere to the provisions of NCGS 58-50-62 within seven files based on the following:

- The acknowledgement letter within three files was not sent to the covered person within three business days after receiving the appeal request.
- Four files contained a decision letter based on second-level grievance review protocol. However, the letter did not include notice of the availability of the Commissioner's office for assistance, including the phone number and address of the Commissioner's office.

Also noted during the sample review were three additional grievance files which did not initially contain an acknowledgement letter to the covered person. The Company provided a copy of the letters for these three files during the examination in response to the sample review findings.

The average service time to process a member grievance within the sample reviewed was 22 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	5	3.8
8 - 14	16	12.3
15 - 21	29	22.1
22 - 30	81	61.8
Total	**131**	**100.0**

Complaints Received by the Department's Consumer Services Division – File Review

The Department's Consumer Services Division (CSD) received a total of 895 complaints submitted against the Company during the examination period for a range of service issues. CSD forwarded these complaints to the Company requesting review and response to the Department. A random sample of 50 CSD complaint files was selected from this total. These files were reviewed to assess the Company's handling of complaints, and adherence to statutory and regulatory guidelines, as well as to the Company's internal policies and procedures. The review revealed that within four complaint files, the Company did not adhere to statutory guidelines indicated as follows:

- NCGS 58-68-65: Three complaint files revealed that the member's policy was terminated in error. One termination was due to a manual keying mistake. The other two terminations were caused by errors in premium notice issuance. Resolution for each member resulted in subsequent reinstatement of their policy retroactively, preventing a lapse in coverage.

- NCGS 58-3-200(d): One complaint file revealed that a member's claim was processed incorrectly, subjecting the member to out-of-network benefit levels in error. The claim was subsequently reprocessed and corrected approximately nine months after the date of service.

Complaints Received by the Company – File Review

The Company received a total of 482 complaints submitted directly during the examination period for a range of service issues. These complaints were received by various methods including telephone, standard mail, email and facsimile. A random sample of 50 complaint files was selected from this total. These files were reviewed to assess the Company's handling of complaints, and adherence to statutory and regulatory guidelines, as well as to the Company's internal policies and procedures. The review revealed that within one file, the Company did not

meet its internal standard of issuing a response within seven calendar days of receiving the complaint. In addition, the Company was unable to retrieve a record of one member's complaint which was received by telephone, however receipt of the call was logged within the system.

COMMENTS, RECOMMENDATIONS, AND DIRECTIVES

The Company must complete and implement corrective actions as a result of this target examination. These corrective actions must include but are not limited to: compliance with statutory requirements regarding claims processing timeliness, accuracy, and delayed status notification protocol; and member appeal, grievance, and complaint written notification decisions and acknowledgement letters (including timeliness and content of notifications).

CONCLUSION

A target examination has been conducted on the market conduct affairs of Blue Cross and Blue Shield of North Carolina for the period January 1, 2017, through July 31, 2017, with analyses of certain operations of the Company being conducted through December 19, 2017.

This examination was conducted in accordance with the North Carolina Department of Insurance and the National Association of Insurance Commissioners Market Regulation Handbook procedures, including analyses of Company operations specific to individual and small group membership. The examination focused on the Company's practices and procedures in the areas of claims administration, and member appeals, grievances, and complaints.

In addition to the undersigned, Darla Wright, MCM, North Carolina Market Conduct Senior Examiner, participated in this examination.

Respectfully submitted,

Scott D. Grindstaff, HIA, MHP, MCM
Examiner-In-Charge
Market Regulation Division
State of North Carolina

I have reviewed this examination report and it meets the provisions for such reports prescribed by this Division and the North Carolina Department of Insurance.

Bill George, CPCU, AIS, MCM
Assistant Chief Examiner
Market Regulation Division
State of North Carolina