STATE OF NORTH DAKOTA

BEFORE THE INSURANCE COMMISSIONER

In the Matter of	)	
	)	
Blue Cross Blue Shield of North Dakota, a North Dakota Nonprofit Mutual Insurance Company,	)	**CONSENT ORDER**
	)	**FILE NO. CO-19-785**
FEIN 45-0173185,	)	
	)	
Respondent.	)	

TO: Tim Huckle, President and CEO, Blue Cross Blue Shield of North Dakota, 4510 13th Avenue South, Fargo, ND 58121

Insurance Commissioner Jon Godfread (hereinafter "Commissioner") has determined as follows:

1. The Commissioner has authority in this matter pursuant to North Dakota Century Code Title 26.1.

2. Blue Cross Blue Shield of North Dakota, FEIN 45-0173185 (hereinafter "Respondent" or the "Company"), is a North Dakota nonprofit mutual insurance company that provides health insurance, is organized and governed by the laws of North Dakota, and has been duly authorized to do business in North Dakota since December 31, 1943.

3. The Commissioner has jurisdiction over the Respondent and the subject matter of this Consent Order, and this Consent Order is made in the public interest.

4. The North Dakota Insurance Department (hereinafter "Department") recently concluded a targeted market conduct examination (hereinafter "examination") of Respondent. The examination covered the period of June 1, 2013 through February 28, 2018.

COUNT I – Inappropriate Denials of Claims for Mental Health and Substance Use Disorders

5. During the course of the examination, the Department randomly tested 108 denied mental health and substance abuse claims files to determine accuracy of claims payments, specifically to determine if claims were handled in compliance with medical necessity, utilization review guidelines, the member's certificate, and North Dakota law.

6. N.D. Cent. Code § 26.1-04-03 provides:

> The following are unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:
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> . . .
>
> 7. Unfair discrimination.
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> . . .
>
> b. Making or permitting any unfair discrimination, including consideration of an individual's history or status as a subject of domestic abuse, between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatsoever.
>
> . . .

9. Unfair claims settlement practices. Committing any of the following acts, if done without just cause and if performed with a frequency indicating a general business practice:

. . .

a. Knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages at issue.

7. N.D. Cent. Code § 26.1-04-07 states:

An insurance or surety company, reciprocal, benevolent society, or any other insurance organization or association, however constituted or entitled, doing business in this state, and an officer, director, agent, or solicitor of the company, society, or organization, and an insurance producer, may not issue, circulate, or use, or cause or permit to be issued, circulated, or used, any written or oral statement or circular misrepresenting the terms of any policy issued or to be issued by the company, society, or organization, or the benefits or advantages, promised thereby, or make an estimate, with intent to deceive, of the future dividends or shares of surplus payable under the policy, or use any name or title of any policy or class of policies misrepresenting the true nature thereof.

8. Testing of these 108 files identified that ten (10) of the files failed to allow medically necessary services in compliance with the Company's medical necessity guidelines which were based on the American Society of Addiction Medicine ("ASAM") guidelines, and/or the Company's Medical Policy Behavioral Health Medical Necessity Criteria, the member's certificate, and North Dakota law. For one (1) of the ten (10) claim files, the Company provided preauthorization for the allowed date of service, but then denied the claim. The Respondent's practices and procedures concerning

payments and denials of mental health and substance abuse claims violated N.D.C.C. §§ 26.1-04-03(7)(b), 26.1-04-03(9)(a) and 26.1-04-07.

9. Pursuant to N.D.C.C. § 26.1-01-03.3, Respondent may be subjected to administrative penalties for violations of N.D.C.C. §§ 26.1-04-03(7)(b), 26.1-04-03(9)(a) and 26.1-04-07.

COUNT II – Inappropriate Preauthorization Denials for Mental Health and Substance Use Disorders

10. During the course of the examination, the Department randomly tested 107 preauthorizations concerning mental health and substance abuse claims to determine accuracy of claims payments, specifically to determine if preauthorizations were handled in compliance with medical necessity, the member's certificate, and North Dakota law.

11. Of the 107 preauthorization files tested, ten (10) files failed because the Company failed to allow medically necessary services that should have been approved based on ASAM standards/criteria and/or the BCBSND Medical Policy Behavioral Health Medical Necessity Criteria. These actions violated N.D.C.C. §§ 26.1-04-03(7)(b) & 9(a) and 26.1-04-07.

COUNT III – Mental Health and Substance Use Disorder Claims under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

12. During the course of the examination, the Department learned that the Company required pre-authorization for all mental health/substance abuse disorder

("MH/SUD") inpatient services, which was not required for all medical/surgical ("M/S") services. The Company's non-quantitative treatment limitation ("NQTL") preauthorization requirement for all in-network inpatient services was not comparable to the inpatient in-network preauthorization requirements for M/S services. Therefore, the requirement was applied more stringently to MH/SUD services than to M/S services, and not in compliance with N.D.C.C. §26.1-02-29, as noted under federal law 45 CFR §146.136(d)(3) and 45 CFR §147.160. Furthermore, the Company failed to supply substantiating documentation to support the preauthorization requirement, and therefore, the Company failed to comply with the requirements of N.D.C.C. §26.1-02-29, as noted under federal law 45 CFR §146.136(c)(4).

13. Pursuant to N.D.C.C. § 26.1-01-03.3, Respondent may be subjected to administrative penalties for violations of N.D.C.C. § 26.1-02-29.

COUNT IV – Failure to Properly Report Suspected Acts of Insurance Fraud

14. Section 45-15-01-01 of the North Dakota Administrative Code states:

> A person engaged in the business of insurance having knowledge or a reasonable belief that a fraudulent insurance act has been, is being, or will be committed shall provide information concerning the known or suspected fraudulent insurance act to the commissioner in writing within sixty days of having that knowledge or reasonable belief. The information may be reported on the national association of insurance commissioners uniform suspected insurance fraud reporting form, a copy of which is attached as appendix A. Thereafter, the person engaged in the business of insurance shall promptly provide to the commissioner any additional information that the commissioner may request concerning the known or suspected fraudulent insurance act. For the purposes of this rule, a reasonable belief means that the person engaged in the business of insurance has a given fact or combination of facts which in their totality result in a determination that more likely than not, a fraudulent insurance act has been, is being, or will be committed.

15. During the course of the examination, 518 cases were tested by the Department to determine if the Company appropriately reported suspected fraudulent insurance acts to the Commissioner. There were thirteen (13) cases the Company failed to report, which should have been reported in writing within sixty (60) days of having knowledge or reasonable belief that a suspected fraudulent insurance act had been committed. Therefore, the Company was not in compliance with N.D.A.C. §45-15-01-01.

16. During the course of the examination, the Department identified many cases where an applicant was attempting to gain coverage from both the on-Exchange and off-Exchange markets. An Exchange is a government-run marketplace of health insurance plans. From the listing of 124 files, there were seventy-four (74) cases that note an applicant had attempted to commit fraud to gain coverage or did gain coverage fraudulently. None of these seventy-four (74) cases were reported to the Commissioner. The Company agreed that thirty-one (31) of those cases were required to be reported to the Commissioner. The Company's failure to report these cases are violations of N.D.A.C. §45-15-01-01.

17. During an interview with the Company's Legal Department, it was identified that there were potential litigation cases wherein the Company requested, but had not received, refunds from members and providers. The Company provided thirty (30) member cases and two (2) provider cases, which were applicable for testing. For the thirty (30) cases involving member refunds, one (1) failed because the Company had knowledge or a reasonable belief that a fraudulent insurance act had been committed. Of the two (2) provider cases, one (1) failed because the Company had knowledge or a reasonable belief

that a fraudulent insurance act had been committed. Therefore, the Company's failure to report suspected fraudulent insurance acts to the Commissioner in writing within sixty (60) days was not in compliance with N.D.A.C. §45-15-01-01.

18. Pursuant to N.D.C.C. § 26.1-01-03.3, Respondent may be subjected to administrative penalties for violations of N.D.A.C. § 45-15-01-01.

COUNT V – Tier Rating

19. During the course of the examination, the Company provided a listing of large and small group plans issued with four (4) tiers. From the listing, it was determined that sixty-three (63) non-grandfathered and grandfathered large group plans were issued prior to August 1, 2015, and twelve (12) non-grandfathered and grandfathered small group plans were issued.

20. N.D. Cent. Code § 26.1-30-19 (1) states:

> 1. No insurance policy, contract, agreement, or rate schedule may be issued or delivered in this state until the form of that policy, contract, agreement, or rate schedule has been filed with and approved by the commissioner.

21. From review of the Company's filings with the Department, it was determined that the Company was not permitted to issue four (4) tier rates for small group plans during the Period, nor was it permitted to issue large group plans with four (4) tier rates prior to August 1, 2015, to be in compliance with N.D.C.C. §26.1-30-19. Ultimately, the testing determined that the Company failed to follow the Department's filing and approved rating procedures for seventy-five (75) groups. Therefore, in each instance, the Company failed to comply with N.D.C.C. §26.1-30-19.

22. Pursuant to N.D.C.C. § 26.1-01-03.3, Respondent may be subjected to administrative penalties for violations of N.D.C.C. § 26.1-30-19.

COUNT VI – Medicare Supplement Marketing/Sales

23. The Company's response to a data request acknowledged the Company provided an online application for Medicare Supplement plans. The Company stated that the online application was mistakenly placed on its website for four (4) months and indicated no applications were received through the web application. However, the Company direct-marketed and advertised the sale of Medicare Supplement plans by placement of the online application, wherein it offered those plans under an application and rating methodology that was not filed with and approved by the Commissioner.

24. N.D.C.C. § 26.1-04-03(2) states:

> The following are unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:
>
> > 2. False information and advertising generally. Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance or with respect to any person in the conduct of that person's insurance business, which is untrue, deceptive, or misleading.

25. N.D.C.C. § 26.1-36.1-07 states:

> Every insurer, health care service plan, or other entity providing Medicare supplement insurance or benefits in this state shall provide a copy of any Medicare supplement advertisement within ten days after its first use in this state

> whether through written, radio, or television medium for review or approval by the commissioner to the extent required or authorized by state law.

26. N.D.A.C. § 45-06-01.1-12(4)(b)(2) states:

> An issuer may offer, with the approval of the commissioner, up to four additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:
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> . . .
>
> (2) The addition of either direct response or agent marketing methods.

27. The Company's actions outlined in paragraph 23 violated N.D.C.C. §§ 26.1-04-03(2) & 26.1-36.1-07 and N.D.A.C. § 45-06-01.1-12(4)(b)(2).

28. During the course of the examination, Medicare Supplement applications were tested for compliance with North Dakota law. The Company provided a listing of 16,615 Medicare Supplement policies issued during the Period. It was determined that under the column "Agent," the listing included some blank fields, and other fields were noted as "APPS UN," "NAME NOT FOUND," and "UNCLAIMED APPS." The Company agreed that 113 Medicare Supplement applications did not identify the producer.

29. All of the 529 policies with fields noted above were selected for testing. An additional seventy-five (75) internal producer-related Medicare Supplement applications were judgmentally selected from the period of December 1, 2014 through May 1, 2015. Four (4) of the 75 files failed to identify the producer. Testing determined one (1) additional file failed to identify the producer.

30. N.D.C.C. § 26.1-26-13.1 (1) states in part:

> 1. An insurance producer may not act as an agent of an insurer unless the insurance producer becomes an appointed agent of that insurer.

31. N.D.A.C. § 45-06-01.1-15 requires an insurance producer to sign the Medicare Supplement application and also requires a Medicare Supplement replacement form to be used when a Medicare Supplement policy is being replaced with another Medicare Supplement policy.

32. Of the 626 total files tested, 118 failed to identify the insurance producer, which in each case was a violation of N.D.C.C. § 26.1-26-13.1 because the Company could not determine whether the insurance producers involved were properly appointed and also violations of N.D.A.C. § 45-06-01.1-15, as none of these files contained an insurance producer signature.

33. Pursuant to N.D.C.C. § 26.1-01-03.3, Respondent may be subjected to administrative penalties for violations of N.D.C.C. §§ 26.1-04-03(2), 26.1-36.1-07, 26.1-26-13.1, and N.D.A.C. §§45-06-01.1-12(4)(b)(2) & 45-06-01.1-15.

COUNT VII – Telehealth Services Coverage and Claims

34. During the course of the examination, the Company's Telehealth Corporate Medical policy was reviewed. This policy excludes "home and other non-listed potential originating sites" from covered telehealth services.

35. N.D.C.C. § 26.1-36-09.15 (2) states:

> 2. An insurer may not deliver, issue, execute, or renew a policy that provides health benefits coverage unless that policy provides coverage for health services delivered by means of telehealth which is the same as the coverage for health services delivered by in-person means.

36. As the policy excludes "home and other non-listed potential originating sites" from telehealth services, the policy limits the payment of health benefits delivered via telehealth means, which is not in compliance with N.D.C.C. §26.1-36-09.15.

37. The Company stated its medical policy intent concerning telehealth services was non-coverage for all inpatient telehealth services from the beginning of the Examination period through July 2017. The intent of its policy would have validated the telehealth claim denials. However, the Corporate Medical Policy language was not clear or concise concerning its intentions, and therefore misrepresented the terms and benefits of an issued policy because the language could have been construed by a provider to support the validity of inpatient telehealth services. There were eleven (11) telehealth multiple-line claims for sixty (60) dates of service that were denied inappropriately.

38. N.D.C.C. §26.1-04-03(1) states:

> The following are unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:
>
> 1. Misrepresentations and false advertising of policy contracts. Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or making any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policies, or making any misleading representation or any misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any life insurance company operates, or using any name or title of any policy or class of policies misrepresenting the true nature thereof, or making any misrepresentation tending to induce the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy

> or for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance.

39. The Company was instructed by the Department to pay the telehealth claims because the claim denials were not in compliance with N.D.C.C. §26.1-04-03(1) and N.D.A.C. §§45-06-04-04(1) & (2).

40. Pursuant to N.D.C.C. § 26.1-01-03.3, Respondent may be subjected to administrative penalties for violations of N.D.C.C. §§ 26.1-36-09.15, 26.1-04-03(1) and N.D.A.C. §§45-06-04-04(1) & (2).

COUNT VIII – Independent External Reviews

41. During the course of the examination, the Company's compliance with state law requirements for Independent External Reviews for grandfathered health plans was tested.

42. N.D.C.C. § 26.1-36-44 applies to grandfathered plans and states in relevant part as follows:

> Every insurance company, nonprofit health service corporation, and health maintenance organization that offers an accident and health line of insurance shall establish and implement an independent external review mechanism to review and determine whether medical care rendered under the line of insurance was medically necessary and appropriate to the claim as submitted by the provider. . . . The insurance commissioner shall take steps necessary to ensure compliance with this section.

43. The Company's position during the examination was that the Independent External Review process did not apply to grandfathered plans. In addition, none of the Company's grandfathered plan handbooks, certificates,

policies, denial letters, etc. provided Independent External Review allowances and information.

44. The Company's position that the Independent External Review process did not apply to grandfathered plans is contrary to N.D.C.C. § 26.1-36-44. The Company's failure to establish and implement an Independent External Review mechanism, including reasonable notice to its members of the opportunity for an Independent External Review, is in violation of N.D.C.C. §26.1-36-44.

45. Pursuant to N.D.C.C. § 26.1-01-03.3, Respondent may be subjected to administrative penalties for violations of N.D.C.C. § 26.1-36-44.

COUNT IX – Coordination of Benefits

46. During the course of the examination, the examiner tested files involving coordination of health benefit claims with no fault automobile insurance coverage for compliance with state law and regulations.

47. N.D. Cent. Code § 26.1-41-13 states:

> 1. A basic no-fault insurer has the primary obligation to make payment for economic loss because of accidental bodily injury arising out of the operation of a motor vehicle; provided, that the amount of all benefits a claimant recovered or is entitled to recover for the same elements of loss under any workforce safety and insurance law must be subtracted from the basic no-fault benefits otherwise payable for the injury.
>
> . . .
>
> 3. An insurer, health maintenance organization, or nonprofit health service corporation, other than a

> basic no-fault insurer, authorized to do business in this state may coordinate any benefits it is obligated to pay for economic loss incurred as a result of accidental bodily injury, with the first ten thousand dollars of basic no-fault benefits. A basic no-fault insurer authorized to do business in this state may coordinate any benefits it is obligated to pay for medical expenses incurred as a result of accidental bodily injury in excess of ten thousand dollars. An insurer, health maintenance organization, or nonprofit health service corporation, other than a basic no-fault insurer, may not coordinate benefits unless it provides those persons who purchase benefits from it with an equitable reduction or savings in the direct or indirect cost of purchased benefits. The commissioner shall approve any coordination of benefits plan.

48. N.D. Admin. Code § 45-08-01.2-05 states:

> In determining the amount to be paid by the secondary plan on a claim, should the plan wish to coordinate benefits, the secondary plan shall calculate the benefits it would have paid on the claim in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed one hundred percent of the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

49. Seventy-nine (79) files were tested. For fifteen (15) of the seventy-nine (79) claim files tested, the Company failed to properly credit deductibles and coinsurance while coordinating benefits with automobile insurance, which was not in compliance with N.D.C.C. § 26.1-41-13(3), N.D.A.C. § 45-08-01.2-05, and Bulletin 2015-1. For one (1) coordination of benefits claim file, the amount credited was greater

than the coinsurance allowance, and for the other ten (10) files, the Company failed to credit the applicable deductible or coinsurance amounts for the member.

50. Pursuant to N.D.C.C. § 26.1-01-03.3, Respondent may be subjected to an administrative penalty for a violation of N.D.C.C. § 26.1-41-13 and N.D.A.C § 45-08-01.2-05.

Informal Disposition

51. Respondent has agreed to an informal disposition of this matter, without a hearing, as provided under N.D.C.C. § 28-32-22.

52. For purposes of resolving this matter, without further administrative proceedings, Respondent and the Commissioner have agreed to enter into the following Order.

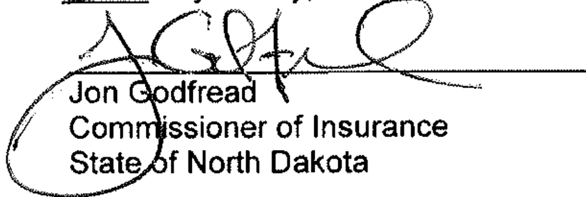
NOW, THEREFORE, IT IS HEREBY ORDERED THAT:

1. Respondent is assessed and shall pay an administrative penalty in the amount of $125,000, which shall be paid within 30 days of the execution of this Order. Payment must be mailed to: North Dakota Insurance Department, 600 East Boulevard Avenue, Dept. 401, Bismarck, ND 58505.

2. The Company agrees it will process mental health, behavioral health, and substance abuse claims solely in the interest of members, with the exclusive purpose of providing benefits to members, and in accordance with the member's policy. The Company will also proactively work with providers to specifically identify and timely notify providers when information delivered by providers is insufficient for the Company to make a determination on coverage under the member's policy.

3. The use of this Consent Order for competitive purposes by an insurance producer or agency holding a license in the State of North Dakota, or by any company holding a Certificate of Authority, or by anyone on their behalf, may be deemed unfair competition and be grounds for suspension or revocation of said license or authority.

DATED at Bismarck, North Dakota, this 5th day of July, 2019.



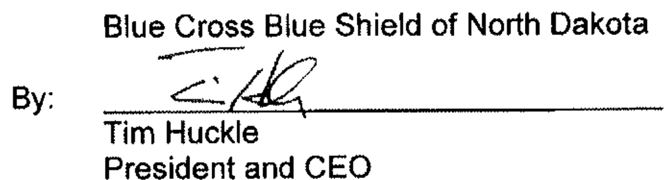
Jon Godfread
Commissioner of Insurance
State of North Dakota

CONSENT TO ENTRY OF ORDER

The undersigned, **Tim Huckle, on behalf of Blue Cross Blue Shield of North Dakota**, states that he has read the foregoing Consent Order, that he knows and fully understands its contents and effect; that he has been advised of his right to be represented by legal counsel, his right to a hearing in this matter, his right to present evidence and arguments to the Commissioner, and his right to appeal from an adverse determination after hearing; and that by the signing of this Consent to Entry of Order he knowingly and voluntarily waives those rights in their entirety, and consents to entry of this Order by the Commissioner of Insurance. It is further expressly understood that this Order constitutes the entire settlement agreement between the parties hereto, there being no other promises or agreements, either expressed or implied.

DATED this 3rd day of July, 2019.

Blue Cross Blue Shield of North Dakota

By: 

Tim Huckle
President and CEO

State of North Dakota

County of Cass

Subscribed and sworn to before me this 3rd day of July, 2019.

Stacy Brekke

Notary Public

My commission expires: 7-21-2022