STATE OF NORTH DAKOTA

TARGETED MARKET CONDUCT EXAMINATION REPORT

BLUE CROSS BLUE SHIELD OF NORTH DAKOTA

FARGO, NORTH DAKOTA

As of February 28, 2018

By Representatives of the

North Dakota Insurance Department

Table of Contents

SALUTATION

June 25, 2019

Honorable Jon Godfread
North Dakota Insurance Commissioner
600 E. Boulevard Ave.
Bismarck, ND 58505

Commissioner Godfread:

Pursuant to your instructions and in compliance with the provisions of North Dakota Century Code (N.D.C.C), Chapter 26.1-03 and procedures of the North Dakota Insurance Department, and the procedures established by the National Association of Insurance Commissioners, a targeted examination of the market conduct activities has been conducted of:

Blue Cross Blue Shield of North Dakota
4510 13th Avenue South
Fargo, ND 58121

I hereby respectfully submit, under oath and penalties of perjury, the report thereon, as of February 28, 2018 and certify that the contents of this report are true and accurate.

Sincerely,

Thomas D. McIntyre
Examiner-In-Charge

North Dakota Insurance Department
Market Conduct Examination
Blue Cross Blue Shield of North Dakota

AFFIDAVIT

STATE OF NORTH DAKOTA

COUNTY OF BURLEIGH

Thomas D. McIntyre, of lawful age, being first duly sworn, upon oath state that I have been charged with examining Blue Cross Blue Shield of North Dakota, as of February 28, 2018. I have prepared and read the foregoing Report of Market Conduct Examination, that I am knowledgeable of the matters set forth therein, and I certify the Report is true and complete to the best of my knowledge and belief.

Thomas D. McIntyre

Subscribed and sworn before me by Thomas D. McIntyre

On this 25 day of June, 2019.

[SEAL]

ROBERTA S. DODD
MY COMMISSION # FF 246392
EXPIRES: October 31, 2019
Bonded Thru Budget Notary Services

Notary Public

My commission Expires: 10-31-2019

SCOPE OF EXAMINATION

Representatives of the North Dakota Insurance Department ("NDID") conducted a targeted market conduct examination (the "Examination") of Blue Cross Blue Shield of North Dakota (the "Company" or "BCBSND") under the authority delegated by the Commissioner pursuant to N.D.C.C. ch. 26.1-03. The Examination covered the period of June 1, 2013 through February 28, 2018 (the "Period").

The scope of the Examination included, but was not limited to the following areas:

- Company Operations
- Insurance Fraud Reporting
- Corporate Governance and Governance of Subsidiaries
- Complaints
- Mental and Behavioral Health and Substance Use Parity
- Tier Rating
- Medicare Supplement Marketing/Sales
- Mental and Behavioral Health and Substance Use Denied Claims
- Mental and Behavioral Health and Substance Use Denied Preauthorizations
- Telehealth Services and Claims
- Independent External Review
- Coordination of Benefits with Automobile Insurance
- Formulary Review

This report of Examination (the "Report") reflects the North Dakota ("ND") insurance activities of the Company. The NDID Examination procedures were conducted at the direction and overall management and control of representatives of the NDID.

The Report is a report by exception. Files or materials reviewed containing no improprieties by the Company have been omitted from the Report. All unacceptable or non-complying practices may not have been identified. The failure to identify specific Company practices does not constitute acceptance of these practices.

Procedures were performed in accordance with the Market Regulation Handbook (the "Handbook") as adopted by the National Association of Insurance Commissioners ("NAIC") and consistent with the predetermined market conduct program presented to and approved by the NDID.

The purpose of the Examination was to make factual determinations of business practices in which the Company was engaged during the Period. The focus of the Examination was to determine if the Company fulfilled its obligations, based on the nature of its operations, to afford proper treatment to members, and its compliance with all applicable North Dakota statutes ("N.D.C.C."), administrative rules ("N.D.A.C."), bulletins, insurer policies, contractual obligations, and federal law.

COMPANY HISTORY

The North Dakota Hospital Services Association was incorporated on March 20, 1940, under the laws of the state of North Dakota relating to benevolent and charitable corporations. On February 28, 1964, the Articles of Incorporation were amended, changing the name to Blue Cross of North Dakota.

The North Dakota Physicians Service was incorporated on December 7, 1945, under the laws of the state of North Dakota relating to benevolent and charitable corporations. On March 27, 1971, the Articles of Incorporation were amended, changing the name to Blue Shield of North Dakota.

On July 1, 1986, the merger of the two companies was approved, with the name of the surviving company being Blue Cross Blue Shield of North Dakota.

Effective January 30, 1998, the Company converted from a not-for-profit health services corporation to a nonprofit mutual insurance company, and the Company's name was changed from Blue Cross Blue Shield of North Dakota ("BCBSND") to Noridian Mutual Insurance Company ("NMIC"). The conversion also passed ownership to policyholders and gave the Company the ability to market products in states other than North Dakota.

The Company implemented a change in its corporate structure effective January 1, 2019. A new parent company was created named Healthy Dakota Mutual Holdings ("HDMH"). The new structure transfers certain investments and subsidiaries from under NMIC/BCBSND to HDMH. As of January 1, 2019, NMIC changed its name to "Blue Cross Blue Shield of North Dakota".

BCBSND provides individual, group and association health insurance and pharmacy benefits under traditional and preferred provider organization contracts. It contracts with hospitals, physicians and other providers of health care in order to obtain discounts for subscriber members. In addition, BCBSND has a variety of arrangements with other Blue Cross and Blue Shield plans for out-of-state claims processing, and performs administrative services such as billing, collection and claim processing for various governmental agencies and various fully and self-insured groups within the state of North Dakota. The administrative services business represents a significant portion of their business.

The Company's direct written comprehensive hospital and medical health premium amounts for individual and group plans during 2014, 2015, 2016 and 2017 are provided in the table below:

2014	2015	2016	2017
$1,003,580,459	$884,045,683	$723,271,959	$744,125,585

The Company's membership enrollments during 2014, 2015, 2016 and 2017 are provided in the table below:

2014	2015	2016	2017
431,765	340,500	308,273	318,734

COMPANY OPERATIONS

I. ***The regulated entity is licensed for the lines of business that are being written?***

Chapter 16, Operations/Management - Standard 8 – The regulated entity is licensed for the lines of business that are being written.

The Company is an authorized accident and health insurer in the state of North Dakota.

II. ***The regulated entity cooperates on a timely basis with examiners performing the examination.***

Chapter 16, Operations/Management - Standard 9 – The regulated entity cooperates on a timely basis with examiners performing the examination.

The Examination fieldwork commenced on April 9, 2018 and concluded February 14, 2019. Company personnel were cooperative throughout the Examination. The Company generally responded timely to data requests and findings ("Criticisms") in accordance with the original deadlines, and in general, requests for extensions were tendered to the examiner-in-charge when the Company could not meet the deadlines. However, issues regarding the Company providing accurate and complete data occurred during testing performed in the following areas: Corporate Governance, Fraud, Coordination of Benefits and Independent External Reviews. As the Examination progressed, the request process was adjusted to ensure the Company's responses were aligned with the examiner's expectations.

INSURANCE FRAUD REPORTING

I. ***Determine if the Company took the appropriate action to report suspected fraudulent insurance acts to the Insurance Department.***

The Company provided a listing of 1,266 cases investigated by its Special Investigative Unit ("SIU") during the Period. After an initial review of sixty-three (63) cases, 748 cases were eliminated that were assessed as not being associated with fraud. The remaining 518 cases were tested to determine if the Company reported suspected fraudulent insurance acts to the NDID 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. Four (4) of the cases were associated with the amended language as of April 1, 2017, and nine (9) cases were applicable under the law effective March 1, 2004. The Company agreed it should have reported eleven (11) of those cases to the NDID Commissioner. Of the 518 cases tested, thirteen (13) cases should have been reported, and therefore three percent (3%) of the cases failed.

During interviews with the Company's SIU and Membership division managers, it was determined that the original population of cases provided to the examiners by the Company failed to include the applicant's files which the Company also investigated for suspected fraudulent insurance acts. The Company provided a joint SIU and Membership applicant listing of 124 cases, which were investigated for potential fraudulent activities. Many cases involved the applicant 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. The Company failed to report these cases in compliance with N.D.A.C. §45-15-01-01 under the current Administrative Rule, amended April 1, 2017. Therefore, sixty percent (60%) of the case files failed. The Company agreed thirty-one (31) of those cases were required to be reported to the NDID Commissioner. The NDID communicated with the Company on November 7, 2017 and indicated all suspected fraudulent applications should be reported.

During an interview with the Company's Legal Department, it was identified there were potential litigation cases wherein the Company requested, but 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. Thus, three percent (3%) of the member cases failed. 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. Thus, fifty percent (50%) of the provider cases failed. Therefore, the Company should have reported information concerning the suspected fraudulent insurance acts to the Commissioner in writing within sixty (60) days for compliance with N.D.A.C. §45-15-01-01, as amended April 1, 2017. The Company agreed with the finding.

The Company had a fraud, waste and abuse program in place during the Period, but the Company agreed that its suspected fraud reporting processes were not in compliance with the NDID's regulatory expectations and ND law. The Company has committed to the NDID to bring its suspected fraud reporting processes into full compliance. The Company has developed three (3) Corrective Action Plans ("CAPs") to address the findings.

The Company lacked sufficient oversight of its suspected fraudulent insurance acts reporting processes during the Period, which indicates a lack of effective process governance.

CORPORATE GOVERNANCE AND GOVERNANCE OF SUBSIDIARIES

I. ***Determine if there was an appropriate level of oversight of vendors associated with the insurance operations of the Company and its affiliates.***

The Company was requested to provide all of its vendor agreements entered into during thePeriod, in place during the Period or terminated during the Period, as well as those for its affiliates. During a meeting, the Company indicated it did not have a complete listing of the

agreements because each internal department and affiliate has ownership responsibility for its vendor agreements and relationships from inception through termination and there was not a centralized location for its vendor agreements, or its affiliates' vendor agreements. The Company stated it would be a substantial undertaking to assemble and provide all of the agreements. Therefore, the Company was allowed to provide a listing of the vendor agreements which were insurance related. The Company provided 103 vendor agreements related to its operations and forty-eight (48) vendor agreements relating to its affiliates. However, there was one agreement the NDID had brought to the attention of the Examination team, which was not included in the listing of agreements. The Company stated it had provided the agreement, along with its entire internal file, in June 2017 to the NDID as part of an NDID investigation and that was why it was omitted. The agreement was between the Company's brokerage affiliate, Noridian Insurance Services, Inc. ("NISI") and two (2) insurance producers who were selling a product that was created and marketed as a medical reimbursement program under Internal Revenue Code §105.

The insurance producers marketed the program to employers as a supplemental benefits plan for their employees for the reimbursement of medical expenses, such as co-pays and deductibles. The legitimacy of the product was brought to NISI's and the Company's attention when the insurance producers discontinued sales of the plan. NISI and the Company referred four (4) customers to the insurance producers who proceeded to make the sale of the program, and the NDID's investigation concluded that NISI and the Company had not violated any ND laws.

Following an initial review of the vendor agreements, it was noted that there was a contract with a doctor who had conducted clinical training in the past that was not provided. The Examination team questioned why it was not provided. The Company stated it did not provide any of the "medical services consultation agreements," which are for subject matter experts serving in an advisory capacity because they were not considered to be insurance related. The agreements with physicians were deemed to be insurance related by the Examination team and the NDID, and the Company later provided a listing of sixty-three (63) medical services consultation agreements.

The Company provided its policies and procedures regarding vendor agreement management. It was noted from review of the policies and procedures that agreements were to be submitted through the Company's Enterprise Contract Review Process. Included in those procedures were two mandated forms, "Contract Review Form" and the "Contract Summary Form." The Company later stated in part, "The Contract Summary Form mentioned in the outdated Enterprise Contract Review Policy inadvertently provided to the examination team . . . is no longer used in the Enterprise Contract Review Process. The information previously collected on the Contract Summary Form was consolidated into and requested on the Contract Review Form so that the Contract Review Form is the primary data collection form."

One NISI vendor agreement was judgmentally selected for the Company to provide the associated enterprise contract review and applicable forms. The Company stated it did not have any forms for the selected agreement. Therefore, the Company was requested to provide all of the NISI vendor agreements submitted through the Enterprise Contract Review Process,

and to provide the mandated forms for all the agreements. The Company provided three (3) agreements submitted through the Enterprise Contract Review Process with the required forms and all three (3) were in the required agreements repository. Of the forty-nine (49) NISI vendor agreements, three (3) were in the required agreement repository with the mandated forms. Therefore, NISI failed to follow the Enterprise Contract Review Process for ninety-four percent (94%) of the agreements.

The Company's response stated in part, "The passage of time since contracting (often significant lengths), fading memories and employee turnover creates challenges for NISI in responding to the examiner's question. For example: approximately seventeen (17) of the contracts were entered into in 2000 or prior years; approximately six (6) contracts were entered into in 2001 to 2010; and the majority of the remaining contracts were executed during former NISI employee . . . While NISI does not have any specific documented research for the identified vendor agreements, NISI can provide the general business process followed in making a determination to add carriers or services to the product portfolio. The process considerations are oftentimes fact-specific . . ." Another response stated in part, "For the same reasons as described . . ., NISI does not have documented research or specific recollection of research of financial status or stability that may have occurred for any of the identified vendor agreements. The Enterprise Contract Review Process includes verification of the state of incorporation of the contracting entity. That verification process is undertaken by staff during the contract review process and not formally documented in Contract Review files beyond revising draft agreements to ensure the contracting entity's legal name and address are correct. Negotiation of vendor agreements also attempts to ensure that vendors have insurance to cover any losses for which they may be responsible, as well as indemnification provisions for NISI. However, these provisions are not always agreed to by the contracting party. Beyond the items described above, the Enterprise Contract Review Process does not contain formal steps for additional research of financial status or stability."

During an interview with the Company's Legal Department, the interviewee stated the Company followed its vendor agreement guidelines. Subsequently, upon disclosing that examiner testing indicated that ninety-four percent (94%) of the NISI agreements were not in the required repository, the interviewee stated he could not explain why there were only three (3) agreements in the repository. The Company later clarified that agreements missing from the repository were the result of some employees not adhering to the Company's vendor agreement guidelines. The Company also stated twenty-one (21) of the agreements were no longer active agreements.

The Company has developed a CAP to review best practices in enterprise contract management systems and processes.

NISI failed to follow the Enterprise Contract Review Process and its review processes were insufficient with respect to the contracted entities, as noted above. The Company lacked appropriate oversight of the Enterprise Contract Review Process with respect to NISI, its vendor agreement processes and procedures and failed to follow the policies and procedures that were in place. This finding indicates a lack of operational reliability and effective process governance.

COMPLAINTS

I. ***Review one (1) Consumer Complaint to determine if the Company's actions for the member were in compliance with the Company's policies and procedures and in compliance with ND law.***

For a member that made three (3) complaints to the NDID associated with claims for a dependent, in some instances the Company failed to follow its own guidelines concerning holds on claims, wherein it allowed claims to be paid, which were later denied upon further review. As a result of the Examination, the Company agreed to write-off any amounts that appeared to be owed by the member, and agreed to discontinue investigation of other possible claims of this nature to resolve the issue. Further, there was a process governance issue associated with a lack of training for its claims personnel, and the Company agreed to prepare a Corrective Action Plan, which will be submitted to the NDID for additional training of its claims personnel associated with claims of this nature.

For months' the same member noted above was continually attempting to gain another avenue to appeal, or request reconsideration for medical necessity associated with a dependent's claims. As noted in a Company response and in the Independent External Review area of this report, the Company stated, "The External Review process did not apply to Grandfathered Plans." Therefore, the Company failed to 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 in compliance with N.D.C.C. §26.1-36-44. From review of all the communications with the member, and because the Company failed to implement an independent External Review process after appeals rights were exhausted, the grandfathered plan member was not allowed, or notified of an External Review for compliance with N.D.C.C. §26.1-36-44. The Company agreed an External Review option for this member was not made available and has developed a CAP to address the finding.

In connection with the examiner's review of the same member's complaint file, the following comment was noted in the Company's internal notes, dated December 1, 2015: "First, find out if the facility is licensed to perform psych IOP. If not, we will not be able to make any reimbursement and will likely submit a case through SIU for reporting." IOP is referencing intensive outpatient services. The Company's notes, communications and letters stated the member's dependent was a patient at a facility that was billing psychiatric services for which it was not licensed or credentialed. The Company should have reported this suspected fraudulent insurance act in writing to the NDID for compliance with N.D.A.C. §45-15-01-01. The Company agreed with the finding and has developed a CAP to address the finding. Please reference the Insurance Fraud area above.

The Company's actions related to the claims and complaints by the member indicated a lack of operational reliability and process governance concerning its claims processes and procedures, fraud reporting, and failure to establish and implement an External Review mechanism.

MENTAL HEALTH AND SUBSTANCE USE DISORDER CLAIMS, INCLUDING PARITY

I. Determine if the health plan complies with the requirements of the federal Mental Health Parity Act of 1996 (MHPA) and the revisions made in the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA").

The Company required pre-authorization for "all" mental health/substance abuse disorder ("MH/SUD") inpatient services, which was not required for "all" medical/surgical services. The Company's 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).

The Company's restrictions concerning preauthorizations for MH/SUD services indicated a lack of effective process governance concerning its practices and procedures related to regulatory oversight and compliance practices and procedures.

TIER RATING

I. Determine what Underwriting Tiers (Coverage Classes: Single, Single Plus Dependents, Family, etc.) were written by the Company and how that correlated to the NDID filings for those group plans.

Initially, the scope of the Examination focused on Tiering of a specific plan. However, the results of the initial review warranted expanding testing to all large and small group plans. 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. From review of the Company's filings with the NDID, it was determined that the Company was not permitted to issue four (4) Tier small group plans during the Period, nor was it permitted to issue large group plans with four (4) Tiers prior to August 1, 2015, to be in compliance with N.D.C.C. §26.1-30-19. Testing determined that the Company failed to follow its NDID filed 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. The Company accepted the NDID's position on this matter and developed a CAP to address the finding.

The Company's lack of compliance with its rate filings in connection with the inappropriate use of Tiering allowances indicates a lack of effective process governance and controls over such filings.

MEDICARE SUPPLEMENT MARKETING/SALES

I. Determine if the Company is marketing Medicare Supplement plans in compliance with its filings with the NDID.

The Company's response to a data request acknowledged the Company provided an online application for Medicare Supplement plans. The Company stated it 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 NDID Commissioner. This was in violation of N.D.A.C. §§45-06-01.1-12(4)(b), 45-06-04-01 & 45-06-04-04, and N.D.C.C. §§26.1-36.1-07 & 26.1-04-03(2). The Company agreed with this finding and has developed a CAP to address the findings.

The Company lacked regulatory oversight and controls of its website operations concerning the advertisement and posting of a Medicare Supplement application, which demonstrates a lack of effective process governance and regulatory compliance concerning controls associated with information published on its website.

II. Determine if the company issued Medicare Supplement plans in compliance with ND law.

The Company provided a listing of 16,615 Medicare Supplement policies issued during the Period. However, 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.

All 529 of the 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. Of the 626 total files tested, 118 failed to identify the producer, which in each case was a violation of N.D.C.C. §§26.1-26-03 and 26.1-26-13.1 because it could not determine whether producers involved, were licensed and appointed under ND law. Therefore, nineteen percent (19%) were failed. The Company was unable to verify whether the producer was either appointed or licensed. In addition, none of the applications contained a producer signature, which was in violation of N.D.A.C. §45-06-01.1-15. The Company agreed with the findings and has initiated a CAP.

In addition, of the population of 16,615 Medicare Supplement policies issued during the Period, the Company allowed two (2) unappointed producers to submit three (3) applications wherein the Company issued policies. Each instance was a violation of N.D.C.C. §26.1-26-13.1. Therefore, less than one percent (1%) of the files failed. The Company agreed with the findings and has initiated a CAP.

The Company lacked regulatory oversight and internal controls relative to acceptable producer application submissions and internal processing of applications in connection with Medicare Supplement policies. The findings noted above demonstrate a lack of effective process governance and regulatory compliance concerning controls associated with policy acceptance and issuance and producer management and accountability.

After completion of the initial testing noted above, the NDID determined testing of the Medicare Supplement Replacement forms was necessary. The initial plan was to review fifty (50) applications. A response from the Company indicated that if an applicant was a BCBSND member whose Medicare Supplement policy was being replaced with another BCBSND policy, the ND Medicare Supplement Replacement form law was not applicable (i.e., internal replacement). Testing continued during which a review of N.D.C.C. §45-06-01.1-15 was undertaken by the NDID and two (2) Company internal replacement files were set aside after an initial review. It was later determined by the NDID that the law was applicable in the internal replacement cases. However, fifty (50) files had been tested at the time of the determination, and therefore the two (2) set aside files were included, resulting in fifty-two (52) applications being tested. Of the applications tested, twelve (12) failed as follows: seven (7) failed to have a replacement form when required, and five (5) failed to have a producer's signature and/or date when required. Therefore, twenty-three percent (23%) of the files failed. The Company agreed in most instances, but challenged the reasonableness of the NDID's interpretation of ND law when replacing a BCBSND Medicare Supplement policy with another BCBSND policy. The Company has developed a CAP to address the findings.

The Company lacked appropriate process oversight and tracking of replacements of Medicare Supplement policies including replacement forms and related documentation. The findings noted above demonstrate a lack of effective process governance and controls concerning the handling of Medicare Supplement replacements.

DENIED CLAIMS FOR MENTAL HEALTH AND SUBSTANCE USE DISORDERS

I. ***Determine if denied claims and closed without payment claims are handled in accordance with policy provisions and procedures and state law.***

The Company provided a population of 9,865 denied claims for the four (4) applicable reason not allowed codes. From that population, the Audit Command Language ("ACL") was utilized to provide a random sample of 108 denied claims for testing.

Of the 108 denied claims files tested, ten (10) files failed because the Company failed to allow medically necessary services based on the requirements of the American Society of Addiction Medicine ("ASAM") guidelines and/or the BCBSND Medical Policy Behavioral Health Medical Necessity Criteria, which was not in compliance with N.D.C.C. §§26.1-04-03(7)(b) & 9(a) and 26.1-04-07. 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 Company has reprocessed this denied claim. Therefore, nine percent (9%) of the files failed. The Company

agreed with the findings and has initiated a CAP. In addition, the Company moved from the use of ASAM to InterQual criteria in July 2018, so ASAM reviews will no longer be undertaken by the Company.

Numerous claim files tested involved an appeal. The NDID determined some files did not allow medically necessary services at appeal, and should have been allowed based on ASAM standards/criteria and/or the BCBSND Medical Policy Behavioral Health Medical Necessity Criteria. The NDID believes denial of these claims was not in compliance with N.D.C.C. §§26.1-04-03(7)(b) & 9(a) and 26.1-04-07. The Company disagreed in each case and maintains that all standards and criteria were applied appropriately.

Furthermore, during testing, it was determined that a denied claim file contained a letter which stated in part, "Your request to have her case sent for Independent External Review has been evaluated and the following noted: . . . The insurance certificate for the CompChoice plan in effect at the time of the service did not include the option for the member to have an Independent External Review . . ." The Member's CompChoice plan was a grandfathered plan. Therefore, the Company denial of an Independent External Review was a violation of N.D.C.C. §26.1-36-44. See the Independent External Review area, where the Company stated during the Examination, "The External Review process did not apply to Grandfathered Plans." Therefore, for the Period, the Company's practices and procedures related to grandfathered plans were not in compliance with N.D.C.C. §26.1-36-44. The Company accepted the NDID's position on this matter.

During the testing concerning MHPAEA, the Company stated it removed the "waiting periods for pre-existing conditions" from the benefit plans on product anniversary month beginning January 1, 2014. However, the examination team identified three (3) grandfathered plan claims, which were denied for "waiting periods for pre-existing conditions" subsequent to January 1, 2014. The services were rendered after the plans' renewal and the removal of the pre-existing condition waiting period. The Patient Protection and Affordable Care Act ("ACA") prohibited grandfathered plans from denying claims based upon a pre-existing condition as of January 1, 2014. Claim denials for pre-existing conditions after that date were not allowed under the ACA. As a result of the Examination, the Company was directed to re-adjudicate and pay the claims in accordance with the member's coverage in effect at that time. The Company's denial of the three (3) claims was not in compliance with N.D.C.C. §26.1-02-29 (by reference of Section 2704 of the PHS Act), and N.D.C.C. §26.1-36-37.1, and N.D.C.C. §§26.1-04-03(7) & (9). The Company disagreed with the law references, but agreed to re-adjudicate the incorrectly denied claims. The Company provided verification to the Examination team for the re-adjudication of the three (3) claims.

The Company lacked appropriate regulatory oversight and controls relative to the handling of MH/SUD claims. The findings noted above demonstrate a lack of effective process governance and controls concerning the processing of MH/SUD and ACA claims.

DENIED PREAUTHORIZATION FOR MENTAL HEALTH AND SUBSTANCE USE DISORDERS

I. Determine if denied preauthorizations for mental health and substance use disorders are handled in accordance with policy provisions, the Company's medical policies and procedures, and state law.

The Company provided a population of 2,143 MH/SUD preauthorization files, after exclusion of administrative and related denial codes. From that population, ACL was utilized to provide a random sample of 107 preauthorization files for testing. Three (3) files were eliminated and replaced because a medical necessity determination was not associated with those files.

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, and was not in compliance with N.D.C.C. §§26.1-04-03(7)(b) & 9(a) and 26.1-04-07. Therefore, nine percent (9%) of the files failed. The Company agreed with the findings and has initiated a CAP. In addition, the Company moved from the use of ASAM to InterQual criteria in July 2018, so ASAM reviews will no longer be undertaken by the Company.

Some of the preauthorization files tested involved an appeal. The NDID believes one (1) file failed because the Company failed to allow for medical necessity that should have been approved based on ASAM standards/criteria, and was not in compliance with N.D.C.C. §§26.1-04-03(7)(b) & 9(a) and 26.1-04-07. The Company disagreed with this finding and maintains all standards and criteria were applied correctly.

The Company lacked appropriate regulatory oversight and controls relative to the handling of MH/SUD preauthorizations. The findings noted above demonstrate a lack of effective process governance and controls concerning the processing of MH/SUD preauthorizations.

TELEHEALTH SERVICES COVERAGE AND CLAIMS

I. Determine if the Company's policies and procedures for acceptance and denial of telehealth services are compliant with state law.

The Company's current Telehealth Corporate Medical policy was reviewed. The examiner noted the policy excludes "home and other non-listed potential originating sites" from telehealth services. Thus, the policy limited the payment of health benefits delivered via telehealth means, which was not in compliance with N.D.C.C. §26.1-36-09.15. The Company has developed a CAP consistent with the finding.

The Company lacked appropriate regulatory oversight and controls relative to the handling of telehealth claims. The finding noted above demonstrates a lack of effective process governance and controls concerning the processing of telehealth claims and the development of compliant telehealth policies.

II. Determine if telehealth denials were in compliance with ND laws (NDCC 26.1-36-09.15) and rules, and allowed for compliance with the contract/policy language.

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. The Company was instructed by the NDID 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). The Company agreed to re-adjudicate and pay the telehealth claims.

N.D.C.C. §26.1-36-09.15 was enacted August 1, 2017 and a legislative printing error was corrected after January 1, 2018. Due to the correction, the Company determined the best result for its members and its provider community would be to review and re-process denied telehealth claims between August 1, 2017 and May 9, 2018. The Company stated it started implementing corrective measures on July 24, 2018. The Examination identified two (2) out of fifty-seven (57) telehealth files tested between August 1, 2017 and May 9, 2018 where the Company had not re-processed the denied telehealth claims consistent with its corrective measures. The Company failed to pay the claims in compliance with N.D.C.C. §26.1-36-09.15. The Company agreed, and as a result of the Examination, the two (2) telehealth claim files were re-adjudicated and paid. Therefore, four percent (4%) of these telehealth claims failed. The Company has developed a CAP to address the findings.

The Company lacked appropriate regulatory oversight and controls relative to the handling of telehealth claims. The findings noted above demonstrate a lack of effective process governance and controls concerning the processing of telehealth claims and the management and updating of Company policy language.

INDEPENDENT EXTERNAL REVIEWS

Determine if the Company's policies and procedures for External Reviews are compliant with N.D.C.C. §26.1-36-44.

Relative to grandfathered plans and Independent External Reviews under N.D.C.C. §26.1-36-44, the Company's response stated, "The External Review process did not apply to Grandfathered Plans." In addition, none of the grandfathered plan handbooks, certificates, policies, denial letters, etc. provided Independent External Review allowances and information. The NDID undertook review of the External Review statute and determined it is

applicable to grandfathered plans. Therefore, the Company failed to establish and implement an independent External Review mechanism, including reasonable notice to its members of the opportunity for an External Review, which was not in compliance with N.D.C.C. §26.1-36-44. N.D.C.C. §26.1-36-44 requires " . . . 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 Company has developed a CAP to address the finding.

During testing of denied claims (See area: Denied Claims for Mental Health and Substance Use Disorders), it was determined that one (1) denied claim file contained a letter, which stated in part, "Your request to have her case sent for Independent External Review has been evaluated and the following noted: . . . The insurance certificate for the CompChoice plan in effect at the time of the service did not include the option for the member to have an Independent External Review . . ." The member's CompChoice plan was a grandfathered plan. As noted above, and concerning all grandfathered plans issued during the Period, the Company failed to allow External Reviews for grandfathered plans, which was a violation of N.D.C.C. §26.1-36-44. The Company stated it understood the NDID's position.

The Company's failure to provide Independent External Review data when requested and its failure to establish and implement an Independent External Review mechanism demonstrated a lack of adequate oversight and controls relative to Independent External Review processes and procedures for grandfathered plans.

COORDINATION OF BENEFITS

I. Determine if the Company's policies and procedures and its actions for COB of automobile accidents were in compliance with ND statutes, rules and Bulletin 2015-1.

Due to Company errors noted in the previous market conduct examination as of May 31, 2013, associated with coordination of benefits (COB) with an automobile carrier, a review of COB was completed during this Examination. During testing, it was determined that manual entries for cost sharing amounts were required for claims associated with COB claims. Five (5) COB claim files from January 1, 2016 through February 28, 2018 were judgmentally selected for testing. Testing determined one (1) of the five (5) files failed to have the manual entry cost sharing amount transferred appropriately and as a result testing was expanded.

The Company provided a population of 6,744 COB claim files from January 1, 2016 through February 28, 2018. The claims were segregated into files with cost share amounts under $10,000 and over $10,000, which provided 6,714 and thirty (30) files, respectively. All thirty (30) of the over $10,000 amounts were tested. Additionally, using ACL, thirty (30) files were selected from the under $10,000 population. Therefore, a total of sixty-five (65) files were selected for testing. Three (3) files were determined not to be applicable, thus the remaining sixty-two (62) files were tested. For eleven (11) of the sixty-two (62) COB 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) COB 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. Therefore, eighteen percent (18%) of the files failed. The Company agreed with these findings and has developed a CAP.

The Company initially stated its corrected procedures for COB were not completed until January 1, 2016. However, it was later determined to be approximately January 1, 2015. Therefore, further testing was warranted, and all of the COB claims during January 1, 2015 through September 30, 2015 were judgmentally selected for testing. There was a total of seventy-nine (79) applicable COB claim files during this period. For fifteen (15) of the seventy-nine (79) COB claim files tested, the Company failed to properly credit the applicable deductible and coinsurance amounts for its members, and therefore its actions were not in compliance with N.D.C.C. §26.1-41-13(3) and N.D.A.C. §45-08-01.2-05. Therefore, nineteen percent (19%) of these files failed. The Company agreed with the findings and has developed a CAP.

The Company lacked adequate process oversight and controls relative to its COB claims handling procedures. While the Company had prepared a CAP in connection with the prior market conduct examination, it did not implement all the corrective actions. The findings noted above demonstrate a lack of effective process governance concerning the handling and payment of COB claims.

RECOMMENDATIONS

I. As issues were raised during the examination, the Company proactively created draft Corrective Acton Plans ("CAPs") to address certain findings. The Company has committed to working collaboratively with the NDID to review draft CAPs implemented during the examination, as well as any additional CAPs needed to address examination findings. Each CAP should be provided to the NDID for review to determine compliance with ND law, and the Company should provide periodic updates or updates as requested by the Department during the stage(s) of development until each CAP has been implemented.

II. The Company has begun three (3) CAPs associated with Fraud. One (1) has been developed and is in process, and two (2) are in the development stage. The three (3) CAPs should be reviewed prior to implementation to ensure they provide for reporting of fraud or potential fraudulent activity in compliance with N.D.A.C. §45-15-01-01.

III. A robust CAP should be developed and implemented for the Company's operational decision-making, compliance and governance functions associated with all insurance operations. In addition, the Company's board and senior management should be more directly engaged in the oversight of CAP implementation and ongoing policies, practices, processes and procedures concerning all insurance operations to eliminate or mitigate the issues/errors noted during the Examination.

IV. The Company should work with the NDID to develop a more streamlined response process for complaints forwarded by the NDID to ensure that desired, responsive information is being provided by the Company to the NDID.

V. The Company has developed a CAP associated with claims "holds," which was noted during testing of Consumer Complaints. The CAP should be reviewed by the NDID prior to implementation to ensure claims are processed in compliance with N.D.C.C. §§26.1-04-03(7)(b) & 9(a) and 26.1-04-07.

VI. A CAP should be developed and implemented for regulatory compliance and sound operational decision-making with respect to claims processing.

VII. The Company has developed a CAP associated with the allowance for Tiers in group plans. The CAP should be reviewed by the NDID prior to implementation to ensure future NDID filings, and the procedures and processes concerning those filings, comply with N.D.C.C. §26.1-30-19.

VIII. The Company has completed four (4) CAPs associated with the Medicare Supplement testing: 1) Producer appointments and licensing, and signatures on applications, 2) Medicare Replacement forms, 3) Direct sales on website, and 4) Advertising on website. The four (4) CAPs should be provided to the NDID for review to ensure compliance with ND law, as noted below:

CAP 1: Provides for compliance with N.D.C.C. §§26.1-26-03 & 26.1-26-13.1, and N.D.C.C. §45-06-01.1-15.

CAP 2: Provides for compliance with N.D.C.C. §45-06-01.1-15

CAP 3: Provides for compliance with N.D.A.C. §45-06-01.1-12(4)(b).

CAP 4: Provides for compliance with N.D.A.C. §§45-06-04-01 & 45-06-04-04, and N.D.C.C. §§26.1-36.1-07 & 26.1-04-03(2).

IX. The Company has developed a CAP for MH/SUD claims adjudication concerning medically necessary services associated with the new utilization management InterQual criteria, and the Company's medical policy associated with MH/SUD criteria. The Company should develop procedures to ensure the medically necessary criteria is updated in compliance with the American Psychiatric Association guidelines/practices and ND law. The CAP should be reviewed by the NDID prior to implementation to ensure compliance with N.D.C.C. §§26.1-04-03(7)(b) & 9(a) and 26.1-04-07 N.D.C.C. §§26.1-04-03(7)(b) & 9(a) and 26.1-04-07.

X. The Company has developed a CAP for MH/SUD preauthorizations concerning medically necessary services associated with the new utilization management InterQual criteria, and the Company's medical policy associated with MH/SUD criteria. The Company should develop procedures to ensure the medically necessary criteria is updated in compliance with the American Psychiatric Association guidelines/practices and ND law. The CAP should be reviewed by the NDID prior to implementation to ensure compliance with N.D.C.C. §§26.1-04-03(7)(b) & 9(a) and 26.1-04-07 N.D.C.C. §§26.1-04-03(7)(b) & 9(a) and 26.1-04-07.

XI. The Company has begun two (2) CAPs for Telehealth services. Both CAPs have been developed and are in process. One (1) CAP concerns denial of claims associated with Telehealth services and the other concerns its Corporate Medical policy associated with Telehealth services. Both CAPs should be reviewed by the NDID prior to implementation to ensure they provide for compliance with N.D.C.C. §26.1-36-09.15, and N.D.C.C. §§26.1-04-03(7)(b) & 9(a) and 26.1-04-07 N.D.C.C. §§26.1-04-03(7)(b) & 9(a) and 26.1-04-07.

XII. The Company has developed a CAP associated with the establishment and implementation of an Independent External Review process for grandfathered plans. The CAP should be reviewed by the NDID prior to implementation to ensure compliance with N.D.C.C. §26.1-36-44.

XIII. The Company has developed a CAP associated with COB with automobile insurers. The CAP should be reviewed by the NDID prior to implementation to ensure claims are processed 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.