

Final Report Federal Targeted Market Conduct Examination Report of  
**Blue Cross and Blue Shield of Alabama HIOS ID #46944**  
State of Alabama as of June 30, 2015

Examination Report: 46944 - 2016 – FED – 1

June 2, 2017

In accordance with Title 45 of the Code of Federal Regulations (CFR), section 150.313, the Center for Consumer Information and Insurance Oversight (CCIIO) has completed a targeted Market Conduct Examination (Examination) of Blue Cross and Blue Shield of Alabama HIOS ID #46944 (Issuer) in the State of Alabama. The Examination review period was January 1, 2014, through June 30, 2015, and focused on:

- Summary of Benefits and Coverage (SBC): 42 U.S.C. §300gg-15 and 45 C.F.R. §147.200;
- The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) 42 U.S.C. §300gg-26 and 45 C.F.R. §§146.136 and 147.160;
- Discrimination Based on Health Status: 42 U.S.C. § 300gg-4 and 45 C.F.R. §§146.121 and 147.110;
- The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA): 42 U.S.C. §§300gg-25 and 300gg-51 and 45 C.F.R. §§146.130 and 148.170;
- The Women's Health and Cancer Rights Act of 1998 (WHCRA): 42 U.S.C. §300gg-27; and
- Patient Protections (Choice of Primary Care Physician (PCP)): 42 U.S.C. §300gg-19a(a) and 45 C.F.R. §147.138(a)(1).

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## I. Executive Summary

The Center for Consumer Information and Insurance Oversight (CCIIO) has conducted a targeted Market Conduct Examination (Examination) of Blue Cross and Blue Shield of Alabama (Issuer) to assess the Issuer's compliance with the requirements of the Summary of Benefits and Coverage (SBC): 42 U.S.C. §300gg-15 and 45 C.F.R. §147.200; The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) 42 U.S.C. §300gg-26 and 45 C.F.R. §§146.136 and 147.160; Discrimination Based on Health Status: 42 U.S.C. § 300gg-4 and 45 C.F.R. §§146.121 and 147.110; The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA): 42 U.S.C. §§300gg-25 and 300gg-51 and 45 C.F.R. §§146.130 and 148.170; The Women's Health and Cancer Rights Act of 1998 (WHCRA): 42 U.S.C. §300gg-27; and Patient Protections (Choice of Primary Care Physician (PCP)): 42 U.S.C. §300gg-19a(a) and 45 C.F.R. §147.138(a)(1). The period covered by the Examination was January 1, 2014 through June 30, 2015 (Examination Period).

A total of 2,551 randomly selected Issuer generated documents (samples) were reviewed. Of the selected samples, CCIIO found a total of 24 violations that occurred during the Examination Period. Through this examination report, the Issuer is directed to modify certain policies and procedures to ensure future compliance.

This report is by exception; therefore, the Examination Results section only indicates areas where findings were noted and includes Criticism responses from the Issuer (when provided). In summary, findings were identified for the following Federal requirements:

- a. 42 U.S.C. §300gg-15 and 45 C.F.R. §147.200(a)(3): Accuracy of SBC cost sharing;
- b. 42 U.S.C. §300gg-15 and 45 C.F.R. §147.200(a)(3): Accuracy of SBC limitations and exceptions;
- c. 42 U.S.C. §300gg-26 and 45 C.F.R. §§146.136 and 147.160: MHPAEA Non-quantitative treatment limitations;
- d. 42 U.S.C. §300gg-19a(b); 42 U.S.C. §1395dd; and 45 C.F.R. §147.138(b): Definition of Emergency Services.

Additional details regarding these findings are in the Examination Results section of this report.

The Examination identified practices that do not comply with applicable Federal requirements, some of which may also violate State insurance laws and regulations. The Issuer is directed to take immediate corrective action to demonstrate its ability and intention to conduct business in accordance with Federal requirements. When applicable, corrective actions for other jurisdictions should be addressed.

## II. Scope of Examination

CCIO conducted this Examination pursuant to 45 C.F.R. §150.313. The Examination Period was January 1, 2014 through June 30, 2015. The purpose of the Examination was to assess the Issuer's compliance with select applicable Federal requirements.

Some non-compliant practices may not have been discovered or noted in this report. Failure to identify or criticize non-compliant business practices of Federal requirements does not constitute acceptance of such practices. Examination findings and recommendations, if any, that do not reference specific Federal requirements are presented to improve the Issuer's business practices and ensure consumer protection.

The Examination and testing methodologies followed standards established by the National Association of Insurance Commissioners and procedures developed by CCIO. All samples were selected by using a computer-generated, random sample program unless otherwise stated herein.

AREA	POPULATION	SAMPLE SIZE
Applications	401,881	218
Cancellations/Declinations	75,787	191
NMHPA paid claims	72,497	282
NMHPA denied claims	21,674	203
WHCRA paid claims	110,261	295
WHCRA denied claims	14,808	229
MHPAEA paid claims	417,037	435
MHPAEA denied claims	132,076	396
MHPAEA paid methadone RX claims	5,154	109
MHPAEA denied methadone RX claims	3,671	109
Provider Contracts	222	84

The Issuer's response appears after each finding in the Examination Results section of this report. The Issuer's corrective action was not reviewed for proof of implementation or subjected to any procedures applied during the examination. CCIO's response is based solely on a review of the Issuer's response. CCIO reserves the right to review the actual implementation of the Issuer's corrective action for each finding and proposed action plan in future examinations or as otherwise may be appropriate.

### III. Summary of Findings

Finding #	Summary	Citation	Recommendation
1	Failure to provide an accurate SBC to a large group plan	42 U.S.C. §300gg-15, 45 C.F.R. § 147.200(a)(3) and the SBC Group Market Instruction Guide	Change the Specialist copay listed in the identified SBC to the amount noted in the policy.
2	Failure to note a significant cost share difference for test performed in outpatient facilities (individual and small group markets)	42 U.S.C. 300gg-15, 45 C.F.R. § 147.200(a)(3) and the SBC Individual Market and Group Market Instruction Guides	Add language in the identified SBCs under the "Limitations & Exceptions" column.
3	Failure to demonstrate that the processes, strategies, evidentiary standards and other factors used to develop the methadone treatment exclusion for opioid addiction are comparable to and applied no more stringently than those used for medical/surgical conditions	42 U.S.C. § 300gg-26, 45 C.F.R. §§ 146.136(c), 147.160, and 156.125	Provide parity for coverage of methadone treatment for opioid addiction, and implement a process to ensure compliance with Federal requirements.
4	Failure to comply with the definition of emergency services by adding additional requirements to be an emergency service	42 U.S.C. §§300gg-19a(b) and 1395dd and 45 C.F.R. § 147.138(b)	Change language in the identified provider agreement to comply with the Federal definition of "emergency services".

### IV. Issuer Profile

The Issuer was organized in 1936, as the Hospital Service Company of Alabama. In 1973, the name of the company was changed to Blue Cross and Blue Shield of Alabama (BCBS of AL). The Issuer is incorporated as a not-for-profit organization in the State of Alabama and is subject to the regulations of the State of Alabama Department of Insurance and of the Federal government. The Issuer is

headquartered in Birmingham, Alabama and operates in the State of Alabama to provide insurance coverage and health benefits to companies, organizations and individuals for the payment of hospital, physician and other medical services through subscriber or provider reimbursement contractual agreements. The Issuer also offers a broad range of health benefit services for self-funded plans, including claims processing, actuarial and reporting services, network access, medical cost management and other administrative services. In addition, the Issuer offers a range of other products, including coverage for dental, vision, prescription drugs (including Medicare Part D) and mental health. At the end of 2015, the Issuer was providing benefits for approximately 2.9 million members. The Issuer is an independent licensee of the Blue Cross and Blue Shield Association (Association), and accordingly, is subject to the Association's licensure standards. The Association establishes national policies and sets certain operating and financial guidelines for the independent licensees but is not an affiliate or guarantor of the Issuer.

## **V. Examination Results**

### **A. Summary of Benefits and Coverage (SBC): Cost-sharing information**

Issue 1 – Violation of 45 C.F.R. §147.200(a)(3) and the Instruction Guide for Group Coverage (SBC Group Market Instruction Guide)<sup>1</sup>, Accuracy SBC – cost sharing

The Issuer failed to provide an accurate SBC to a Large Group plan included in the sample tested.

Page nine of the SBC Instruction Guide for the “Your Cost columns” states in the pertinent part:

Plans and issuers must complete the responses under these sub-headings based on how the plan or issuer covers the specific services listed in the chart.

#### **Finding 1**

The Issuer failed to provide an accurate SBC to a Large Group plan included in the sample tested. During the review of the Issuer's Large Group Non-Qualified Health Plans (NQHP) for compliance with WHCRA in the paid claims sample, it was noted that for one claim, the SBC showed a \$30 copay for In-Network

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<sup>1</sup> What This Plan Covers and What It Costs, Instruction Guide for Group Coverage (February 2012), available at: <https://www.cms.gov/CCIIO/Resources/Files/Downloads/instructions-group-final.pdf>

Primary and Specialist office visits while the policy shows a \$50 copay for a Specialist visit. The Issuer is in violation of 45 C.F.R. §147.200(a)(3).

Area Reviewed	Population	Sample Size	Violations	% of Error	Exhibit
WHCRA LG NQHP Paid Claims	3,279	25	1	4%	Criticism 1

The Issuer should change the Specialist copay listed in the identified SBC to the amount noted in the policy.

**Company Response:**

The Company noted SBC that required verbiage updates as described in the recommendation above were no longer needed for the 2017 plan year. The Large Group in question joined a larger, self-funded group effective December 1, 2016, and the recommended verbiage changes were no longer applicable.

**CCIIO Response:**

CCIIO accepts the Issuer’s response.

**B. Summary of Benefits and Coverage: Limitations and Exceptions**

Issue 2 – Violation of 45 C.F.R. §147.200(a)(3), the SBC Group Market Instruction Guide and the SBC Instruction Guide for Individual Coverage, Accuracy of SBC – limitations and exceptions

The Issuer failed to note a significant cost sharing difference if tests are performed in outpatient facilities for Individual and Small Group plans included in the sample tested.

Page nine of the SBC Instruction Guide (Group coverage) and page eight of the SBC Instruction Guide (Individual coverage)<sup>2</sup> for the “Your Cost columns” states in pertinent part:

Limitations & Exceptions column:

In this column, list the significant limitations and exceptions for each row. Significance of limitations and exceptions is determined by the plan or issuer

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<sup>2</sup> What This Plan Covers and What It Costs, Instruction Guide for Individual Health Insurance Coverage (February 2012), available at: <https://www.cms.gov/CCIIO/Resources/Files/Downloads/instructions-individual-final.pdf>.



based on two factors: probability of use and financial impact on an individual. Examples include, but are not limited to, limits on the number of visits, limits on specific dollar amount paid by the plan, prior authorization requirements, or unusual exceptions to cost sharing, lack of applicability of a deductible, or a separate deductible.

Each limitation or exception should specify dollar amounts, service limitations, and annual maximums if applicable.

**Finding 2**

In the review of the WHCRA Small Group Professional paid claims sample, it was noted that the SBCs for one plan showed the physician’s office copay for diagnostic x-rays and labs in the “Your Cost” columns. Upon further review, the Examiners sampled Individual and Small Group SBCs, and it was found that for all twenty-one Individual and Small Group Plans SBCs in the sample, the Issuer failed to note a significant cost sharing difference.

The “Limitations and Exceptions” column in the SBCs that were part of the sample states, “Benefits listed are for physician services;” however, the “Limitations and Exceptions” column does not state that the copay for diagnostic x-rays and/or lab tests performed in an outpatient facility or hospital is subject to a facility copay, which can be \$200 to \$600, based on the plan. Physician services could also be performed in an outpatient facility.

While the Issuer is to determine the significant limitations and exceptions, the probability of use and financial impact on the individual would indicate that this is a significant limitation that should be addressed.

Area Reviewed	Population	Sample Size	Violations	% of Error	Exhibit
WHCRA Small Group Paid Claims	110,261	295	2	<1%	Criticisms 2
SBCs	21	21	21	100%	Criticism 9

The Issuer should add language such as, “\$300 copay if x-ray performed in an outpatient facility,” under the “Limitations & Exceptions” column in the SBCs that were included in the sample tested.

**Company Response:**

The Company has added facility verbiage to the “Limitations & Exceptions”

column for Imaging/Diagnostics section of the 2017 SBCs, where applicable.

**CCIIO Response:**

CCIIO accepts the Issuer's response.

**C. Mental Health Parity and Addiction Equity Act – Non-quantitative Treatment Limits**

Issue 3 – Violation of 42 U.S.C. §300gg-26, 45 C.F.R. §§146.136(c)(4), 147.160 and 156.125.

The Issuer imposed a non-quantitative treatment limitation on a mental health/substance use disorder (MH/SUD) benefit included in its Individual, Small Group and Large Group products that is more stringent than that imposed on medical/surgical services.

45 C.F.R. §146.136(c) states in pertinent part:

4) Non-quantitative treatment limitations—(i) General rule. A group health plan (or health insurance coverage) may not impose a non-quantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

45 C.F.R. §147.160(a) states in pertinent part:

(a) *In general.* The provisions of §146.136 of this subchapter apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner and to the same extent as such provisions apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the large group market.

45 C.F.R. §156.125 states:

Prohibition on discrimination.

(a) An issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected

length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.

- (b) An issuer providing EHB must comply with the requirements of §156.200(e) of this subchapter; and
- (c) Nothing in this section shall be construed to prevent an issuer from appropriately utilizing reasonable medical management techniques.

### Finding 3

During the review for compliance with MHPAEA requirements, a claim policy provided by the Issuer states that the Issuer does not cover methadone treatment for opioid addiction under plans; however, the policy provides for the Issuer to cover methadone treatment for the medical/surgical treatment of pain.

The use of Medication Assisted Treatment has been shown to be clinically effective in the treatment of opioid addiction. This includes the use of opioid dependence medications such as methadone. 45 C.F.R. §146.136(c)(4)(i) prohibits health plans and health insurance issuers from imposing a non-quantitative treatment limitation on MH/SUD benefits unless the processes, strategies, evidentiary standards and other factors used to apply the limitation are comparable to and applied no more stringently than those imposed on medical/surgical benefits in the same classification. The Issuer did not demonstrate that the processes, strategies, evidentiary standards and other factors used to develop the exclusion for methadone for treatment of opioid addiction are comparable to and applied no more stringently than those used for the medical/surgical pain relief applications in the same classification.

In addition, this is a discriminatory benefit design under 45 C.F.R. §156.125 as the plan fails to comply with essential health benefit (EHB) requirements as it discriminates based upon an individual's health condition—opioid addiction. The Issuer is in violation of 42 U.S.C. §300gg-26, and 45 C.F.R. §§146.136(c)(4) and 156.125.

The Issuer responded to a request for claims procedures as part of the Mental Health Parity Review data collection. The Issuer's claim policy states there was a blanket exclusion of coverage of methadone maintenance treatment for opioid addiction but not of coverage of methadone for treatment of pain.

The Issuer should provide parity in its coverage of methadone treatment for opioid addiction and implement a process to ensure compliance with Federal requirements.

### **Company Response:**

The Company has re-evaluated the medical necessity of methadone maintenance treatment programs. Therefore, the Company developed a 2017 medical necessity policy to replace the methadone maintenance treatment exclusion in the Company's 2017 plans which mirrors Federal Guidelines for Opioid Treatment Programs. The updated medical necessity criteria is included in the plan year 2017 benefit booklet and was posted to the BCBS of AL website with an effective date of 01/01/17.

### **CCIIO Response:**

CCIIO accepts the Issuer's response.

## **D. Emergency Services: Provider Contract Definition**

Issue 4 – Violation of 42 U.S.C. §300gg-19a(b); 42 U.S.C. §1395dd; and 45 C.F.R. §147.138(b)

The Issuer failed to comply with the Federal definition of “emergency services” at 42 U.S.C. §1395dd by adding additional requirements to be an “emergency service” and not including language from the Federal statutory definition in one of its provider agreements that was included in the sample tested.

45 C.F.R. §147.138(b) states in pertinent part:

(4) Definitions. The definitions in this paragraph (b)(4) govern in applying the provisions of this paragraph (b).

(i) Emergency medical condition. The term emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.)

### **Finding 4**

During the review of the sample of the Issuer's provider contracts for compliance with the Federal definition of “emergency services”, one provider agreement

included a definition of “Emergency” that did not comply with the Federal definition at 42 U.S.C. §1395dd. Specifically, the Issuer’s contractual definition of “Emergency”:

- does not include the following language from the Federal definition: “placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy”;
- includes a time element (“sudden onset”) that is not included in the Federal definition;

*The agreement indicates: “Emergency means a sudden onset of a medical condition manifesting itself by acute symptoms...”, whereas the definition within the law states, “a medical condition manifesting itself by acute symptoms...”*

- adds the following phrase “(2) causing other serious medical consequences”, which does not appear in the Federal definition; and
- includes the phrase “and permanent” in clause (4) of the contractual definition, which does not appear in the Federal definition.

*The agreement says: “(4) serious and permanent dysfunction of any bodily organ or part.”*

Area Reviewed	Population	Sample Size	Violations	% of Error	Exhibit
Emergency Services Provider Contracts	1	1	1	100%	Criticism 6

The language in the provider agreement that was part of the sample tested should be changed to comply with the Federal definition of “emergency services.”

**Company’s Response:**

The Company has begun the process of updating the sections of the Preferred Medical Doctor agreement that were part of the sample tested to mirror the definition of “emergency services” in accordance with the Emergency Medical Treatment & Active Labor Act (EMTALA) and the regulations thereunder. The updates should be completed and accepted by our provider network within 2017.

**CCIO Response:**

CCIO accepts the Issuer's response. Please provide CMS with the updated Preferred Medical Doctor's agreement once the "Emergency" definition has been updated by December 31, 2017.

**VI. Closing**

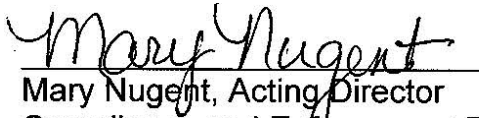
A total of 2,551 randomly selected samples were reviewed as part of this Examination. Of the selected samples, a total of 24 violations were observed during the Examination.

Violations include:

- Failure to provide accurate information in SBCs;
- Failure to comply with the MHPAEA non-quantitative treatment limitation requirements; and
- Failure to follow the Federal definition of "Emergency Services" in a provider contract.

## VII. Examination Report Submission

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

A handwritten signature in black ink that reads "Mary Nugent". The signature is written in a cursive style and is positioned above a horizontal line.

Mary Nugent, Acting Director  
Compliance and Enforcement Division  
Oversight Group  
Center for Consumer Information and Insurance Oversight  
Centers for Medicare and Medicaid Services  
US Department of Health and Human Services