

**STATE OF VERMONT  
DEPARTMENT OF BANKING, INSURANCE, SECURITIES  
& HEALTH CARE ADMINISTRATION**

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In re: Blue Cross Blue Shield	)	DOCKET NO. 03-031-I
Of Vermont	)	
	)	

**ORDER ADOPTING REPORT OF EXAMINATION**

**NOW COMES** John P. Crowley, Commissioner of the Vermont Department of Banking, Insurance, Securities and Health Care Administration, and hereby issues the following Order adopting the Market Conduct Examination Report in the above referenced docket number, subject to the exceptions and qualifications discussed below.

**FINDINGS OF FACT**

1. Pursuant to the authority granted by Vermont law, including that contained in 8 V.S.A. §§ 10-13, 18, chapter 101, subchapter 2, 4726, and 18 V.S.A. §§ 9412 and 9414, the Commissioner of the Department of Banking, Insurance, Securities and Health Care Administration (the “Department”) is charged with administering and enforcing the insurance laws and regulations of the State of Vermont and is authorized to conduct periodic examinations of insurers and licensees to determine whether they are in compliance with said laws and regulations.

2. Blue Cross Blue Shield of Vermont (“the Company” or “BCBSVT”) is a non-profit hospital service corporation authorized to transact business in Vermont pursuant to a Permit to Engage in Business issued by the Department dated January 8, 1998.

3. In 2002, the Department conducted a market examination of the Company that primarily focused on calendar years 2000 to 2001. The examination sought to address three specific issues: 1) whether the Company was processing claims in a timely fashion as required by 18 V.S.A. § 9418; 2) whether the Company paid interest on claims not processed in a timely fashion as required by 18 V.S.A. § 9418(e); and 3) whether the Company was responsive to the Department regarding consumer complaints. A draft report was issued dated January 6, 2003, and the Company had fifteen days to respond to the factual assertions contained in the draft report. On January 23, 2003, the Department met with representatives of the Company.

4. On February 12, 2003 the examiners issued a final report entitled BLUE CROSS BLUE SHIELD OF VERMONT MARKET CONDUCT EXAMINATION (the "Report"). In accordance with the requirements of 8 V.S.A. § 3574(b), the Report was transmitted to the Company and the Company was afforded a reasonable time to submit a formal written response or rebuttal to the findings of the Report.

5. On March 13, 2003 the Company submitted its formal written response to the Report (the "Response").

6. Pursuant to 8 V.S.A. § 3574(c), the undersigned Commissioner has fully considered the Report and the Company's Response.

#### **CONCLUSIONS OF LAW**

7. On page 3 of the Report, the examiners refer to a separate report that discusses the Company's Systems Unification Project. The examiners note the report

addressing the issues of the Systems Unification Project is confidential and will be presented to the Company separately.<sup>1</sup>

The Company requests the reference to the Systems Unification Project and the report examining it be removed from the Report. The Company does not clearly articulate a reason for the removal of this reference, although the Company may be implying the reference should be removed from the Report because of concerns about the proprietary nature of the Systems Unification Project.

The undersigned finds the mere reference to the existence of the Systems Unification Project does not constitute the release of any proprietary information. The undersigned declines to remove this portion of the Report, although the report addressing specifics of the Systems Unification Project is confidential and not subject to public inspection.

8. On page 3 of the Report, the examiners note the market conduct examination was prompted by concerns expressed by physicians, hospitals and other health care providers that the Company was failing to pay claims on time. The Report notes that these concerns were corroborated by declines in consumer satisfaction data related to customer service and claims handling for the Company's managed care product (Vermont Health Partnership). The Report then goes on to note that the 2000 and 2001 consumer satisfaction data is attached to the Report as Exhibit H.

The Company asserts that Appendix H fails to support the examiners' reference to a decline in consumer satisfaction and therefore requests that both Appendix H and the assertion of a decline in consumer satisfaction be removed from the Report.

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<sup>1</sup> The confidential report was given to the Company in February 2002.

The undersigned agrees that Appendix H does not directly relate to the examiners' assertion regarding declining customer satisfaction. However, the examiners do not purport to support their assertion with data contained in Appendix H. Apparently, Appendix H has been provided for context. The undersigned notes that consumer satisfaction did in fact decline from 1999 to 2000 and therefore declines the Company's invitation to remove the portion of the Report referring to declining customer satisfaction being one of the catalysts for the examination.

Nonetheless, the data contained in Appendix H, already a matter of public record elsewhere, does appear to be incidental to the primary findings of the report and as such Appendix H is not adopted. The sentence referencing Appendix H (page 3) is also not adopted and considered deleted from the Report.

9. On page 5, the Report notes the number of claims processed by the Company and the percentage of those claims paid and denied by the Company. The Company objects to these statements as not relevant and asks they be removed from the Report. There is no requirement that every piece of information contained in a market conduct report be directly relevant to the findings contained in the examination report. The first sentence of the first paragraph on page 5 is helpful background information that puts the findings contained in the report in a meaningful context. However, the second sentence of the first paragraph of page 5 appears to be sufficiently outside the scope of the market conduct exam. As such, the undersigned does not adopt the second sentence of the first paragraph of page 5 of the Report and it is considered deleted.

10. On page 6 of the Report, the examiners conclude that the Company did not consistently comply with the requirements of 18 V.S.A. § 9418 regarding timely

processing of health care claims from January 2001 through May 2002. The examiners support this conclusion with data from a chart on page 5 of the Report.

The Company objects, “the examiners constructed their findings in the light least favorable to” the Company. (Response at page 2.) Specifically, the Company notes the examiners cite to the percentage of managed care claims that were not processed within 45 days (16% on average for the data collection periods), rather than noting that on average only 2% of the indemnity claims were processed in violation of the statute. Further, the Company notes that when looking at all of the claims as a whole (rather than analyzing indemnity and managed care separately), the Company processed 92% of the claims within the statutory timeframe.

The undersigned notes that all of the data is available on the previous page and the examiners’ characterization of that data is not inaccurate. The undersigned declines to adopt the amendments to this portion of the Report suggested by the Company.

11. On page 9 of the Report, the examiners note that the Company’s responses to complaints “generally met a minimum acceptable threshold in terms of clarity and completeness.” However, the examiners go on to note that such responses were “not always as expansive as [Department] staff ideally desired”. The examiners note that the Company’s response to complaints provided opportunities for improvement, but that Company staff changes may have contributed to the Department’s dissatisfaction.

The Company requests this part of the report be amended to state simply that the Company’s responses to complaints were “compliant and adequate.” (Response at page 2.) The Company asserts the the examiners’ conclusions are “gratuitous and irrelevant” and should be removed from the Report.

The undersigned declines to remove this portion of the Report. The examiners did not conclude that the Company's responses were "compliant and adequate" but that the Company's responses "generally met a minimal acceptable threshold in terms of clarity and completeness." However, as noted by the examiners, this was not an opinion shared by Department staff. As such, the Company's proposed amendment to the Report fails to include all of the examiners' pertinent information.

However, the undersigned specifically notes the Company has shown dramatic improvement in responding to complaints from the Department and therefore adds the following sentence to the last paragraph of the Conclusion section which begins on page 9 and ends on page 10: "It now appears that BISCHA and BCBSVT personnel have developed a complaint response process which is generally satisfactory to both parties."

12. The Report includes Appendices A-H. Appendix A is entitled "*Review of Claim Processing Policy and Procedure Manuals Regarding Timely Processing*". This Appendix details the examiners review of certain Company contracts and policy and procedure manuals, specifically focusing on whether these documents contained any reference to the timely payment requirements included in 18 V.S.A. § 9418.

Appendix B is entitled "*Provider Survey and Interviews Regarding BCBSVT Timely Claim Processing*". This Appendix discusses the results of a mail survey and a telephone survey with medical providers. The survey attempted to measure provider experience with the Company's "claims processing and related provider support functions." (Report at page 15.) The Appendix concludes with the examiners' analysis of the findings as well as a table summarizing the Company's strengths and weaknesses.

Appendix C is entitled “*Current BCBSVT Staff Interviews Regarding BCBSVT Claim Processing*”. This Appendix discusses the examiners interviews with Company staff members in four areas of the Company organization. The Appendix describes the results of these interviews in a narrative fashion and does not quantify the data received as a result of these interviews.

Appendix D is entitled “*Review of Denied Claims and of Problem Claims Identified by Surveyed Providers*”. This Appendix describes the examiners review of a “a subset of claims that were paid after 45 days.” The examiners conclude there is no discernable pattern regarding the claims that did not get paid within 45 days. The examiners then discuss, in some detail, the investigation of “a small sample of cases gathered from specific provider complaints.” (Report at page 20.) The examiners conclude that “[h]aving reviewed only a few samples, [the examiners] cannot draw any major conclusions about the frequency with which BCBSVT erroneously denies legitimate claims.” (Report at page 21.)

Appendix E is entitled “*Provider Survey Results Regarding BCBSVT Interest Payment Practice*”. In this Appendix, the examiners describe follow up inquiries made with some of the providers concerning the providers’ knowledge of 18 V.S.A. § 9418 and the late payment penalty contained therein. The examiners note that many providers were unaware of the statute and further note two instances where providers did know about the statute, but had difficulties collecting the penalty from the Company.

Appendix F is entitled “*Review of Claim Adjudication Policy and Procedure Manuals Regarding Interest Payment*”. This Appendix essentially reiterates, with less detail, the discussion contained in Appendix A. However, Appendix F addresses whether

the documents referenced made mention of the interest payment obligations contained in 18 V.S.A. § 9418 and concludes that they do not.

Appendix G is entitled “*Interviews Regarding BCBSVT Responsiveness to Consumer Complaints*”. This Appendix discusses the procedures the Company has or has had in place to address both formal and informal complaints received from the Department. The examiners note the Company now handles Department complaint processing in the Company’s Legal Services department.

Appendix H is entitled “*2000 and 2001 Consumer Satisfaction Data Regarding Customer Service and Claims Handling*.” This Appendix provides Consumer Assessment of Health Plans Survey (CAHPS) data for 2000 and 2001, comparing the Company to the national and regional averages. CAHPS is a nationally validated and standardized survey.

The Company objects to the inclusion of these Appendices for three reasons. First, the Company asserts the Appendices contain “a significant amount of proprietary and confidential information”. (Response at page 2.) The Company requests these documents be removed from the Report and be treated as examination work papers, which are confidential. The Company also objects to the Appendices as containing information that was gathered without regard for obtaining statistically significant results. The Company asserts the National Association of Insurance Commissioners Handbook (the “NAIC Handbook”) contains requirements for conducting statistically significant studies. Finally, the Company asserts the Appendices “contain numerous subjective (and in our view, somewhat slanted) comments which are not based on objective fact.” (Response at page 2.)

The undersigned has reviewed the Appendices and the Company's concerns. As a preliminary matter, none of the information in the Appendices is confidential under 1 V.S.A. § 317(c)(9) (pertaining to trade secrets). *See Springfield Terminal Railway Company v. Agency of Transportation*, --- Vt. ---, 816 A.2d 448, (2002). In fact, some of the information, like that contained in Appendix H, is already public record.

The undersigned also rejects the Company's argument that the Appendices violate the guidelines of the NAIC Handbook and are, as such, not proper for inclusion in the Report. The examiners are not strictly limited to the NAIC guidelines and other examination methods shall be used as appropriate. 8 V.S.A. § 3573. Furthermore, the NAIC Handbook is intended only as a general guide. *See NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, MARKET CONDUCT EXAMINERS HANDBOOK 7 (2002)*. Many of the Appendices do contain anecdotal information. However, the examiners clearly describe their methodology in each Appendix so that a reader of the Report can assess the methodology employed when analyzing the data.

Nonetheless, the undersigned declines to adopt the Appendices in their entirety. In addition to Appendix H (see paragraph 8 above), the undersigned declines to adopt Appendices C, D, and E. As such, references to those Appendices in the main body of the Report are likewise not adopted.<sup>2</sup> The undersigned finds these Appendices include data that is not necessary to support the ultimate conclusions and recommendations of the Report. Further, the data is not useful background information that provides context for the examiners' conclusions and recommendations.

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<sup>2</sup> The following references are not adopted: 1) Page 3, fifth paragraph, sentence which references Appendix H; 2) Page 6, first full paragraph, the two sentences which refer to Appendix C and Appendix D; and 3) Page 8, first paragraph, sentence referring to Appendix E.

It must be noted, however, the law does not require removal of information that is not directly relevant to the ultimate conclusions and recommendations of an examiner. However, in this particular instance, it is the opinion of the undersigned that the inclusion of these Appendices in the Report is not warranted.

13. On page 10 of the Report, the examiners ultimately conclude the Company failed to comply with three regulatory requirements: timely payment of claims, payment of interest when claims were not processed in a timely manner and failing to respond to complaints transmitted by the Department in a timely fashion.

The examiners make six recommendations intended to address the problems identified in the Report. The examiners' Recommendation #1 states: "The company should provide BISHCA with documentation showing it has identified and remedied the problems that caused it to fail to comply with the 45-day timely processing requirement." (Report at page 10.)

The Company does not dispute that some violations occurred, but it disputes the gravity of the problem and further emphasizes the Company has made great improvements since the conclusion of the exam period. As a preliminary matter, the Company states "[w]hile the market conduct report indicated that there was no documentation of the timely processing requirement there was in fact a document that pertains to [18 V.S.A. § 9418] in the procedures used by the staff at BCBSVT."

(Response at page 3.) The Company notes information pertaining to the requirements of 18 V.S.A. § 9418 "was contained in the Lotus Notes system" and "available to staff for review" in 1999. (Response at page 3.) The undersigned finds the steps described by the Company were insufficient to reasonably implement the requirements of the statute

and the Company's failure to meet the statutory requirements supports this conclusion. Information "made available" may never be reviewed by busy staff. Further, the information provided was a copy of the statute itself – hardly user-friendly information for claims processing staff members. In the future, as new statutes are enacted, it will not be sufficient for the Company to make available a copy of the statute for staff review.

The Company asserts, "Many steps have been taken to raise employee awareness of the requirements for timely filing." (Response at page 3.)<sup>3</sup> The Company further asserts that the primary cause for difficulty in timely processing was "the actual monitoring by management staff" (Response at page 3) and notes that significant changes have been made in the reporting, monitoring and handling of claims as they age. Further, the Company describes several steps that have been taken by the Company at various levels of the organization to improve the processing of claims as they age.

The Company claims it monitors the age of inventories by generating daily reports of suspended claims that are provided to management for review. Exhibits 4a – 4g are samples of these reports. In addition, the Company notes these reports are available on the "Executive Information System (EIS), the internal system that allows all management within the company to review this material." (Response at page 3.) The exhibits indicate that very few suspended claims existed which were over 45 days old during the time periods in question (generally the first quarters of 2002 and 2003).

The Company has attached Exhibits 5a and 5b to its Response in support of its assertion that the failure to process claims timely has been remedied or is being remedied. The data contained in Exhibits 5a and 5b supports the assertion that the number of claims placed in suspense has been generally on the decline from 2002 to 2003, with the

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<sup>3</sup> Upon Department inquiry, the Company has indicated "filing" refers to timely claims processing.

exception of indemnity claims which appear to be increasingly placed in suspense in 2003 after a reduction in late 2002.

As further evidence of its contention that claims processing has improved the Company attached to the Response Exhibits 6a – 6e, which it describes as follows: “Exhibit 6a contains a summary of interest payments for the third and fourth quarter of 2002 and Exhibits 6b, 6c, 6d, and 6e are the detail reports that support Exhibit 6a.” (Response at page 3.) The Company’s description of Exhibits 6a – 6e is not entirely accurate. As a preliminary matter, it appears these exhibits have been improperly numbered.<sup>4</sup> Additionally, several of the exhibits appear duplicative (for example, two exhibits are called “*Third Qtr Sub Int Pmt*”).

Upon review of the exhibits, it appears that the duplicative exhibits are generally the same. The total amount of interest due reported on the duplicative exhibits is exactly the same,<sup>5</sup> however, the exhibits purporting to be a detailed summary of fourth quarter provider interest (Exhibits 6d and 6e), are not exactly the same, although substantially similar.

The numbers contained in the exhibits referring to interest paid for the third and fourth quarter of 2002 to providers do not match the numbers contained in the chart on page 4 of the Company’s Response, although the amounts are substantially similar. For example, the chart on page 4 states \$16,111 was paid for the third quarter to providers. However, Exhibits 6d and 6e reflect \$16,168.51. The difference in these numbers may be

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<sup>4</sup> There are two Exhibits 6a (“*Summary Claims Greater than 45 days*” and “*Third Qtr 2002 Sub Int Pmt*”); two Exhibits 6b (“*Third Qtr 2002 Sub Int Pmt*” and “*Fourth Qtr 2002 Sub Int Pmt*”); two Exhibits 6c (“*Third Qtr 2002 Prov Int Pmt*” and “*Fourth Qtr 2002 Sub Int Pmt*”); and two Exhibits 6d (“*Third Qtr 2002 Prov Int Pmt*” and “*Fourth Qtr 2002 Prov Int Pmt*”).

<sup>5</sup> According to the various exhibits provided by the Company, in 2002, third quarter subscriber interest due totaled \$532.49, third quarter provider interest totaled \$16,168.51, fourth quarter subscriber interest totaled \$545.80, and fourth quarter provider interest totaled \$3,325.77.

the result of the Company's proposed practice of setting a minimum penalty "threshold" amount, but the Company has not so stated. The issue of allowing the Company to withhold penalties due until total penalties owing to a consumer reach a "threshold" is discussed below in Paragraph 16.

Finally, the Exhibits 6a – 6e are of questionable relevance insofar as they are intended to support the Company's assertion that the payment of claims has become more timely. For example, the Summary (one of the Exhibits 6a) shows that in the third quarter of 2002 there were 396,351 claims. The Summary also shows of those, 58 (or less than .01%) were "subscriber claims over 45 days." Upon inquiry, the Company has explained the 396,351 total claims number refers to total claims *paid* in that quarter. The exhibits detailing 2002 third quarter interest payments to providers (one of the Exhibits 6a and 6b) reveal the vast majority of the claims paid were received in other than the third quarter of 2002.<sup>6</sup> Therefore, the percentage of the total claims paid which were over 45 days is insignificant – it is possible that other claims exist which were not paid, but which are still over the 45 days.

However, Exhibits 4a – 4g indicate minimal suspended claims over 45 days for certain specific days in the first quarter of 2002. The Company has represented to the Department that Exhibits 4a – 4g include all suspended claims for the time period in question.<sup>7</sup> Further, the Company has represented to the Department that as of March 31,

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<sup>6</sup> Of the 58 claims listed on these exhibits, only one was received in the third quarter of 2002. The remainder was received prior to that date. The undersigned also notes that five of these claims were paid *before* the third quarter, but were included on this chart nonetheless. Upon inquiry, the Company has indicated these payments were not made previously because the provider had not hit the \$50 threshold and thus the penalty was carried over.

<sup>7</sup> Although the Company has indicated it tracks the timeliness of payments on *all* claims (suspended and not suspended), the Company has not provided the Department with information regarding the timeliness of payment of claims that have not been suspended. However, the Company has indicated that it would be virtually impossible for a claim to not be paid within 45 days if it was not in suspension.

2002 it had no outstanding claims over 45 days unless a claim had been resubmitted after initial resolution for additional consideration.

Ultimately, the Company's mere ability to produce the information provided in Exhibits 4a-4g, 5a-5b, and 6a – 6e is encouraging. Now that the Company has the technical ability and procedures in place to routinely monitor the time taken to process and pay claims, the Department can reasonably anticipate continued improvement in this area. Additionally, the Company's payment of all claims over 45 days as of March 31, 2002 indicates a serious commitment to improvement.

Upon consideration, the undersigned adopts Recommendation #1. However, in light of the information provided in the Company's Response, the Company appears to have essentially satisfied the Recommendation. Although some information going forward will be required to ensure continued improvement, that information will be provided in the report described below in Paragraph 17. Thus, no further action is required by the Company on this recommendation.

14. In Recommendation #2 (page 10 of Report), the examiners state: "The company should provide evidence to BISHCA that its claims processing systems have been modified to accurately identify those circumstances regarding timely claim processing where interest penalties accrue and make corresponding interest payments."

In response, Company notes that it "generated one large and cumulative interest calculation and interest payment run." (Response at page 3.) The Company calculated penalties due on all claim payments over 45 days from mid-1997<sup>8</sup> to March 31, 2002. According to the Company, the total interest payment for that period was \$109,550 and

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<sup>8</sup> The Company calculated and paid penalties due to providers for claims received on or after July 1, 1997 and penalties due to subscribers for claims received on or after September 1, 1997.

checks were issued on June 6, 2002. The Company then asserts “This comprehensive interest payment brought BCBSVT current regarding compliance with Act 159.”

(Response at page 3.) The Company claims since June 6, 2002, the Company has performed interest penalty calculations quarterly and issued checks on the dates noted in the chart on page 4 of the Response. The chart indicates the Company made a \$13,517 interest payment on July 31, 2002 for the period of April 1, 2002 to June 30, 2002; a \$16,643 interest payment on October 31, 2002 for claims paid from July 1, 2002 to September 30, 2002; and, on February 11, 2003, the Company paid \$2,667 in interest for claims paid from October 1, 2002 to December 31, 2002. Further, the Company notes that it now generates penalty calculations each quarter.

As noted, the Company made a lump sum payment of penalties owing in June 2002 and has been paying penalties on a quarterly basis.<sup>9</sup> However, the Company did not calculate or pay interest on the penalties owed, but not paid until 2002. The Company withheld and had use of the penalty and the consumers did not. As such, consumers are entitled to 12% interest on the penalties from the date the claim was paid (and the penalty was due), until the penalty was actually paid.<sup>10</sup>

However, the Department has reviewed a detailed description of the lump sum penalty payment made in June 2002. This data reveals that paying interest on most of these claims would be excessively inefficient. The vast majority of the penalties owed

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<sup>9</sup> The quarterly payments have been subject to a threshold set by the Company. The use of this threshold is discussed in Paragraph 16 below.

<sup>10</sup> During discussions with the Department, the Company intimated that the Department was requiring the Company to compound the interest. However, this issue does not involve compound interest. The interest due on a penalty is 12% simple interest. The fact that the amount of the penalty happens to be a function of interest on the claim amount does not mean that calculating interest on the penalty amount compounds the interest.

were less than one dollar.<sup>11</sup> To force the Company, a non-profit health insurer that plays a critical role in the Vermont health care system, to pay interest owing on all penalties, would simply not benefit the consumer.

However, some of the penalties owed were substantial and the interest earned by the consumer justifies the payment. The Company is ordered to make interest payments on all the penalties it has paid (from June 2002 to the second quarter of 2003) which were over \$25.00 for providers and over \$10.00 for subscribers.<sup>12</sup> The Department's analysis of the data indicates this is a very small number of the total penalties paid. However, from June 1, 2003 going forward, the Company must pay interest on any penalty due, but not paid. A penalty is due the date the claim is paid and the penalty can be calculated.

Additionally, if a consumer requests interest on the penalty previously paid, the Company must pay that interest, regardless of the size of the original penalty payment. Interest on those claims will be calculated from the date the penalty was due until the date the Company paid the penalty.

The undersigned adopts Recommendation #2 and, with the exception of making interest payments on paid penalties (as discussed above) and the threshold issue discussed below, the undersigned finds the Company has satisfied the recommendation and no further action is required.

15. In Recommendation #3 (page 11 of the Report), the examiners state: "The company should provide to BISHCA a report detailing its payment of interest on all claims that did not meet the 45-day timely processing requirement."

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<sup>11</sup> Of the 62,332 total claims resulting in penalties, 56,936 involved claims where the penalty owed was less than one dollar.

<sup>12</sup> This threshold shall be calculated on a per claim basis – thus if one particular provider received more than one penalty payment, those penalties shall not be combined to determine whether the threshold has been met.

In response, the Company simply refers to the chart contained on page 4 of the Response. The chart, however, lacks sufficient detail allowing the Department to assess the Company's compliance with the statute. However, upon further Department inquiry, the Company provided a detailed list of all the penalties paid through March 31, 2002, including the date of original service, the date the claim was paid and the amount of the penalty paid.

The undersigned adopts the examiners' Recommendation #3. The Company has complied with the recommendation and no further action is necessary.

16. In Recommendation #4 (page 11 of the Report), the examiners state: "For any interest due on claims but not paid to date, the company should calculate interest, make payment accordingly and confirm to BISHCA."

In response, the Company confirms "that it is current regarding quarterly payment of interest to all providers with interest penalties in excess of \$50 and subscribers in excess of \$10." (Response at page 4.) The Company asserts it has adopted a process whereby penalties are paid to providers and subscribers upon the penalty due reaching a threshold amount set by the Company, in this case \$50 and \$10 respectively. The Company claims that such a procedure was necessary because "providers have indicated they do not want to receive small denomination checks (in most instances cents) and because of costly administrative and cost efficiencies." (Response at page 4.) In addition, the Company notes it will schedule an annual "interest penalty payment run" for providers and subscribers below the threshold levels. The Company requests that the Department approve the plan of using such thresholds.

Upon consideration, the undersigned adopts the examiners' recommendation. According to the Company, it is current on all interest due for providers and subscribers that are owed amounts in excess of the threshold levels. However, the undersigned is unconvinced that setting a threshold before making payment is necessary or, in any event, authorized by the statute. As discussed above, interest continues to accrue until the penalty has been paid. Thus, even if threshold levels were used, the Company would be required to calculate interest on those funds it chose to hold, which may operate to decrease the claimed efficiency of using the thresholds. The most logical and efficient way to handle this issue is for the Company to pay the penalty when it pays the claim. Thus, there would no need for an extra check or additional administrative measures associated with processing the payment, beyond simply calculating penalty owing.

The Company has indicated that it should have the ability to calculate and pay the penalty contemporaneously with the payment of the claim in the near future. As such, the Company is ordered to make penalty payments contemporaneously with the claim payment no later than October 1, 2003. In the meantime, the Company may continue to use its proposed threshold methodology, but only with the express understanding such method is a temporary measure that shall be employed only while the Company attempts to put the required technical capability in place. Further, as noted, the Company must calculate interest on the penalty for those penalties it withholds because of the threshold.

In the event compliance with this portion of the Order is not technically feasible, the Company shall meet with the Department before October 1, 2003 to negotiate an acceptable solution. Absent such a meeting and subsequent agreement, if the Company continues to apply a threshold before paying penalties beyond October 1, 2003, such

actions will be considered a violation of this Order and may result in the imposition of administrative penalties as allowed by statute.

17. In Recommendation #5 (page 11 of the Report), the examiners state: “Beginning in 2003, the company should provide to BISHCA a quarterly report, not later than 20 days from the end of the [sic] each quarter, showing all claim payments that exceed the 45-day timely processing parameters. In addition, the report should show the payment of interest for each claim specified above that has exceeded the 45-day timely processing requirement.”

In response, the Company “objects to any ongoing regulatory requirement which is not part of any statute or regulation.” (Response at page 4.) Further, the Company notes the regulation lacks any time limitation and is essentially “an evergreen requirement.” (Response at page 4.) The Company also implies that by virtue of applying this limitless report requirement on the Company and not other insurers, the Department would be placing the Company at a competitive disadvantage because the reports are expensive to produce.

The undersigned rejects the Company’s vague assertion that the Department lacks the regulatory authority to require the reports contemplated in the examiners’ recommendation. *See, e.g.,* 8 V.S.A. § 3574(c). Nonetheless, the undersigned does not adopt the examiners’ recommendation because it lacks a time limitation.

Instead the Company shall provide a report to the Department for the next year on a quarterly basis. The first report shall be due October 1, 2003. The purpose of this report will be to allow the Department to verify that the Company has maintained its improved timely payment of claims and, when unable to do so, is tracking claims and

paying penalties when due. Company representatives shall meet with the Department's Market Conduct Chief to formulate what specific information will be necessary for the Department's purposes. This meeting shall take place no later than ten days after the expiration of the appeal deadline of this Order.

18. In Recommendation #6 (page 11 of the Report), the examiners state: "BCBSVT should provide BISHCA with a written description of how it intends to maintain compliance with the 15-day response requirement for complaints."

In response, the Company notes that on July 1, 2002 the Company "transferred staffing and all accountability for complaints and grievances to the Legal Department." (Response at page 4.) The Company has two staff members dedicated to handling complaints and has devised new protocol for handling complaints referred from the Department. The Company has developed a database which allows it to track complaint response timeliness. Company management meets weekly with Department staff to discuss outstanding issues. Additionally, the Company provided provider satisfaction data for 1999 to 2002. Upon review, this data indicates improvement from 2001 to 2002 in almost every area surveyed.

Upon consideration, the undersigned adopts the examiners' recommendation. The Company has satisfied the recommendation and no additional action is necessary on this issue.

19. Pursuant to 18 V.S.A. § 9418(i), an administrative penalty of up to \$500.00 per violation may be levied if "the commissioner finds that a health plan has engaged in a pattern and practice of violating" the statute. In this situation, the Company has made tremendous improvement in its claims processing and has taken logical and

aggressive steps to implement changes in order to comply with the statute. Nonetheless, the Company failed to timely pay, on average, 8% of its claims during the examination period. Further, prior to the examination the Company did not pay the penalty contemplated by the statute when claims were not paid within 45 days. The undersigned finds this is sufficient to establish a pattern and practice of violation warranting an administrative penalty.

When assessing a penalty, the statute directs the consideration of (1) the appropriateness of the penalty with respect to the financial resources and good faith of the health plan; (2) the gravity of the violation or practice; (3) the history of previous violations or practices of a similar nature; (4) the economic benefit derived by the health plan and the economic impact on the health care facility or health care provider resulting from the violation; and (5) any other relevant factors. 18 V.S.A. § 9418(i).

In this case, the Company failed to comply with the statute for approximately five years. Further, by virtue of being a non-profit corporation, any savings realized were presumably passed along to the consumers. Additionally, once the examination uncovered the problems, the Company was aggressive in remedying the problem and presently appears to be in substantial compliance with 18 V.S.A. § 9418. Considering these factors and the others enumerated in the statute, a penalty of \$10,000 is warranted. In light of all the circumstances, including the Company's promising improvement and the unique role it plays in the Vermont health insurance market place, a minimal fine is warranted.

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## ORDER

Based upon the Findings of Fact and Conclusions of Law set forth above, **IT IS THEREFORE ORDERED** by the Commissioner of Insurance that the BLUE CROSS BLUE SHIELD OF VERMONT MARKET CONDUCT EXAMINATION dated February 12, 2003 (incorporated herein by reference) shall be and hereby is adopted with the following modifications and clarifications:

20. For the reasons discussed in Paragraph 8 above, the undersigned declines to adopt Appendix H and the reference to Appendix H contained in the Report at page 3.

21. For the reasons discussed in Paragraph 9 above, the undersigned does not adopt the second sentence of the first paragraph of page 5 of the Report.

22. For the reasons discussed in Paragraph 11 above, the undersigned adds the following sentence to the last paragraph of the Conclusion section of the Report (beginning on page 9 and ending on page 10): "It now appears that BISCHA and BCBSVT personnel have developed a complaint response process which is satisfactory to both parties."

23. For the reasons discussed above in Paragraph 12, the undersigned does not adopt Appendices C, D, and E. Likewise, the undersigned does not adopt references in the Report to those Appendices.

24. For the reasons discussed above in Paragraph 13, the undersigned adopts the examiners' Recommendation # 1 (Report at page 10). The Company has satisfied the recommendation and no further action is required on this recommendation.

25. For the reasons discussed above in Paragraph 14, the undersigned adopts the examiners' Recommendation #2 (Report at page 10). As more fully described above,

the Company shall pay interest on past due penalties paid when those penalty payments (per claim) exceeded \$25.00 for providers or \$10.00 for subscribers. Such payments shall occur no later than October 1, 2003. Further, if consumers, if not otherwise reimbursed, request interest on previously paid penalties, the Company shall pay that interest. Such interest shall be calculated as described in Paragraph 14. Beyond the payment of this interest, the Company has complied with the recommendation and no further action is warranted on to satisfy the recommendation.

26. For the reasons discussed above in Paragraph 15, the undersigned adopts the examiners' Recommendation #3 (Report at page 11). The Company has complied with this recommendation and no further action is necessary.

27. For the reasons discussed above in Paragraph 16, the undersigned adopts the examiners' Recommendation #4 (Report at page 11). The Company is ordered to start making interest penalty payments contemporaneously with the payment of claims no later than October 1, 2003. If the Company cannot meet this requirement for technical reasons, the Company must meet with the Department at least ten days prior October 1, 2003, and reach an agreement with the Department as to when it will begin to comply with this portion of the Order.

28. For the reasons discussed above in Paragraph 17, the undersigned does not adopt the examiners' Recommendation #5. However, instead the Company shall provide a quarterly report to the Department for the next year, with the first report due on October 1, 2003. The purpose of the report will be to ensure claims continue to be processed and paid in a timely fashion and that the Company is paying penalties consistent with the law.

The exact format of this report shall be finalized with the Department after the entry of this Order.

29. For the reasons discussed above in Paragraph 18, the undersigned adopts the examiners' Recommendation #6. The Company has satisfied this recommendation and no further action is necessary.

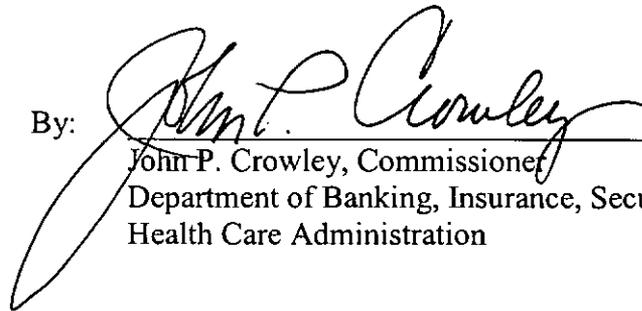
30. The Company shall pay a \$10,000 administrative penalty within ten days of the expiration of the appeal deadline of this Order.

**PURSUANT TO 8 V.S.A. § 3574(c), THIS ORDER AND REMEDIAL ACTION SET FORTH HEREIN MAY BE APPEALED TO THE COMMISSIONER BY FILING AN ADMINISTRATIVE APPEAL WITHIN THIRTY (30) DAYS OF THE DATE SET FORTH BELOW.**

Dated at Montpelier, Vermont this 20<sup>th</sup> day of May, 2003.

Department of Banking, Insurance,  
Securities and Health Care Administration

By:

  
\_\_\_\_\_  
John P. Crowley, Commissioner  
Department of Banking, Insurance, Securities and  
Health Care Administration