Illinois Department of Insurance

JB Pritzker
Governor

Dana Popish Severinghaus
Director

March 9, 2023

Mr. Maurice Smith, President & CEO
c/o Steven Mores
Health Care Service Corporation, A Mutual Legal Reserve Company
300 E. Randolph Street
Chicago, IL 60601-5099

Re: Health Care Service Corporation, A Mutual Legal Reserve Company, NAIC 70670
Market Conduct Examination Report Closing Letter

Dear Mr. Smith,

The Department has received your Company's proof of compliance. Therefore, the Department is closing its file on this exam.

I intend to ask the Director to make the Examination Report and Stipulation and Consent Order available for public inspection as authorized by 215 ILCS 5/132. At the Department's discretion, specific content of the report may be subject to redaction for private, personal, or trade secret information prior to making the report public. However, any redacted information will be made available to other regulators upon request.

Please contact me if you have any questions.

Sincerely,

Erica Weyhenmeyer

Erica Weyhenmeyer
Chief Market Conduct Examiner
Illinois Department of Insurance
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ILLINOIS DEPARTMENT OF INSURANCE
MARKET CONDUCT EXAMINATION

OF

HEALTH CARE SERVICE CORPORATION,
A MUTUAL LEGAL RESERVE COMPANY

NETWORK ADEQUACY MARKET CONDUCT EXAMINATION REPORT

DATE OF EXAMINATION:	November 2, 2020 through September 28, 2022
EXAMINATION OF:	Health Care Service Corporation, A Mutual Legal Reserve Company NAIC #70670
LOCATION:	300 East Randolph Street Chicago, IL 60601-5099
PERIOD COVERED:	Plan Years 2019-2022
EXAMINERS:	Elizabeth Harvey Michele Amstutz Tony Taylor Tanya Sherman June Coleman, Examiner-in-Charge Shelly Schuman, Supervisory Insurance Examiner

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I. FOREWORD

This is a market conduct examination report of Health Care Service Corporation, A Mutual Legal Reserve Company (the "Company"), NAIC Code 70670. This examination was conducted at other authorized offsite locations.

This examination report is generally a report by exception. However, failure to criticize specific practices, procedures or files does not constitute approval thereof by the Illinois Department of Insurance ("IDOI" or "Department").

During this examination, the examiners cited errors made by the Company. Statutory citations were as of the examination period unless otherwise noted.

II. SCOPE OF NETWORK ADEQUACY EXAMINATION

The Department has the authority to conduct this examination pursuant to, but not limited to, 215 ILCS 5/132.

The purpose of the examination was to determine if the Company complied with the Illinois Insurance Code (215 ILCS 5/1 et seq.), the Illinois Administrative Code (50 Ill. Admin. Code 101 et seq.), and to consider whether the Company's operations are consistent with the public interest. The primary period covered by this review was Plan Years 2019 through 2022, unless otherwise noted. Errors outside of this time discovered during the course of the examination, however, may also be included in the report.

The examination involved the lines of business of private and commercial group and individual health insurance were reviewed in this examination.

The scope of this examination focused on a review including the following areas:

A. Company Operations and Management
B. Complaints
C. Provider Relations
D. Network Adequacy

In performing this examination, the examiners reviewed a sample of the Company's practices, procedures, products, and files. Therefore, some noncompliant events may not have been discovered. As such, this report may not fully reflect all the practices and procedures of the Company. As indicated previously, failure to identify or criticize improper or noncompliant business practices in this state or other jurisdictions does not constitute acceptance of such practices.

III. SUMMARY OF FINDINGS

A network adequacy market conduct examination was performed to determine compliance with Illinois statutes, the Illinois Administrative Code, as well as federal statutes and rules related to the network adequacy. The following table represents general findings with specific details in each section of the report.

TABLE OF TOTAL VIOLATIONS					
Criticism #	**Statute/Rule**	**Description of Violation**	**Samples**	**Number of Violations**	**Error %**
187	215 ILCS 124/25	Failed to maintain the provider information on its website to keep it up to data with the status of providers.	10	2	20%
149	215 ILCS 5/143d(b)	Failed to provide a written response to written inquiries and complaints within 21 days of receipt.	4	2	50%
8	215 ILCS 124/10(d)	Failed to use maximum travel time and distance standards for plan beneficiaries.	N/A	N/A	100%
7	215 ILCS 124/25(a)(3)	Failed to contact providers without claims as part of its network adequacy monitoring process.	N/A	N/A	100%
5	215 ILCS 124/25(a)(1) 215 ILCS 124/25(a)(5)(D) 45 CFR § 156.230(b)(2)(i)	Failed to list all available specialty providers for HMO plans on the online directory or notate that authorization may be required to access some providers.	N/A	N/A	100%
9	215 ILCS 124/25(a)(4) 45 CFR §156.230	Failed to make available the PPO provider directory in hardcopy printed format for members or prospective members.	N/A	N/A	100%
117	215 ILCS 124/25(a)(3)	Failed to audit for each network plan at least 25% of its provider directories and failed to meet the statutory requirements in verifying the accuracy of the provider directories information via its audit process.	N/A	N/A	100%
139	215 ILCS 124/25(a)(6) 45 CFR §156.230(b)(2)(ii)	Failed to make it clear which of its electronic provider directory applies to which network plan available for Illinois and which of the three-digit codes are the pertinent ones for conducting a search.	N/A	N/A	100%
150	215 ILCS 124/10	Failed to provide accurate and most up-to-date network adequacy information in its SERFF filings to the state.	N/A	N/A	100%

IV. COMPANY BACKGROUND

Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), was created by the merger of Hospital Service Corporation (licensed in Illinois on October 1, 1936) and Illinois Medical Service, and it commenced operations as HCSC under the provisions of The Non-Profit Health Care Service Plan Act on October 1, 1975.

Effective December 20, 1982, the Illinois Director of Insurance approved HCSC's election to become subject to Article III of the Illinois Insurance Code, which governs mutual insurance companies. At that time, HCSC adopted the name "Health Care Service Corporation, a Mutual Legal Reserve Company."

HCSC does business in the State of Illinois as Blue Cross and Blue Shield of Illinois (BCBSIL). It also does business as Blue Cross and Blue Shield of Montana, Blue Cross and Blue Shield of New Mexico, Blue Cross and Blue Shield of Oklahoma, and Blue Cross and Blue Shield of Texas in those respective states. HCSC is an independent licensee of the Blue Cross and Blue Shield Association, licensed to use the Blue Cross and Blue Shield brands in these five states.

V. METHODOLOGY

The network adequacy market conduct examination process places emphasis on an insurer's systems and procedures used in dealing with insureds and beneficiaries. The private and commercial group and individual health insurance were reviewed in this examination. Self-funded, Medicare Supplement or Medicare/Medicaid plans were not reviewed.

The scope of this examination focused on a review including the following areas:

A. Company Operations and Management
B. Complaints
C. Provider Relations
D. Network Adequacy

The review of these categories was accomplished through examination of material related to the Company's operations and management, consumer and provider complaint files, and network adequacy filings, as well as interviews with various Company personnel and Company responses to the coordinator's handbook, information requests and criticisms. Each of the categories listed above was examined for compliance with Illinois statutes and the Illinois Administrative Code.

The following method was used to obtain the required samples and to ensure a statistically sound selection. Surveys were developed from Company-generated Excel spreadsheets. Random statistical file selections were generated by the examiners from these spreadsheets. In the event the number of files was too low for a random sample, the sample consisted of the universe of files.

Company Operations and Management

A review was conducted of the Company's underwriting and claims guidelines and procedures, policy forms, third party vendors, internal audits, record retention policy and procedures, certificate of authority, previous market conduct examinations and annual statements. These documents were reviewed for compliance with Illinois statutes and the Illinois Administrative Code. No exceptions were noted in the report.

Complaints

The Company was requested to identify all consumer, Illinois Department of Insurance complaints and consumer complaints related to network adequacy received during the period of January 1, 2021 to January 31, 2022. All complaint files were received. The files were reviewed for compliance with Illinois statutes and the Illinois Administrative Code. Exceptions are noted in the report.

Provider Relations

The Company was requested to provide policies and procedures handling provider concerns, inquiries, and complaints. In addition, the Company was requested to provide examples of provider relations analyses, reports and summaries prepared on a regularly recurring basis. The Company reported it had no provider complaints during the period of January 1, 2021 to January 31, 2022. No exceptions were noted in the report.

Network Adequacy

The Company was requested to provide policies and procedures that it maintains a network that is sufficient in number, files an access plan, and provides all required contracts and forms, as well as provide policies and procedures or other documentation demonstrating that the health carrier provides at enrollment a provider directory that lists all providers who participate in its network. The Company identified a universe for all providers during the examination time period of Plan Years 2019-2022. Random samples were selected from all the providers for the nine plans. The random samples

included at least one provider from each of the nine plans for the following categories: Primary Care, Pediatrician, OB-GYN, Hospital, Behavioral Health, Mental Health, Substance Abuse Disorder Facility, and a selection from all the other required categories for Illinois. Examples of other required specialty categories selected for further review were Cardiology, Gastroenterology, Neurology, Oncology/Radiation, Ophthalmology, Urology, Dermatology, Endocrinology, and Infectious Disease. The network adequacy files and responses to information requests were received and reviewed for compliance with Illinois statutes and the Illinois Administrative Code. Exceptions are noted in the report.

VI. SELECTION OF SAMPLES

Survey	Number Reviewed	Percentage Reviewed
Complaints		
Department of Insurance Complaints	10	100%
Consumer Complaints	4	100%
Network Adequacy		
Provider Data	116	<1%

VII. NETWORK ADEQUACY FINDINGS

A. Company Operations and Management

a. There were no criticisms in the review of operations and management for network adequacy.

B. Complaints

1. Department of Insurance Consumer Complaints
   a. Criticism #187- In two (2) instances of the ten (10) IDOI complaint files reviewed, the Company failed to maintain the provider information on its website to keep it up to date with the status of providers. This is in violation of 215 ILCS 124/25.

2. Consumer Complaints Received Directly by the Company
   a. Criticism #149 - One (1) file of the five (5) network adequacy direct consumer complaints samples was identified as being handled with another file. The sample size was adjusted to four (4) files. In two (2) instances of the four (4) network adequacy direct consumer complaints reviewed, for an error percentage of 50%, the Company failed to provide a written response to written inquiries and complaints within 21 days of receipt. In the one (1) file, the Company failed to provide a written response. In the other file, the Company failed to provide the written response within 21 days. This is a violation of 215 ILCS 5/143d(b).

C. Provider Relations

a. There were no criticisms in the review of provider relations for network adequacy.

D. Network Adequacy

1. Time and Distance Standards
   a. Criticism #8 - The Company failed to use maximum travel time and distance standards for plan beneficiaries. The maximum travel time and distance standards must include standards for each physician and other provider categories listed for which ratios have been established. It was confirmed that the Company used distance-only search results for several options. The distance-only searches utilize a straight-line distance calculation which does not properly factor in maximum travel time calculations. Utilizing distance-only criteria and estimates does not result in true maximum travel time and distance calculations. This is a violation of 215 ILCS 124/10(d).

      The Company response to Information Request 85.3 provided a chart entitled BCBSIL Standards of Availability which contained columns for "Time & Distance," however, the details for each provider listed time **or** distance and not both as required by 215 ILCS 124/10(d).

      The Company response to Information Request 85.5 explained whether the Company uses distance only or time and distance for ensuring providers are available within reasonable time frames. Specifically, the Company stated, "Time or Distance is the regulatory requirement for commercial and retail. The distance only setting also accounts for individuals traveling by car, public transportation, and/or walking. BCBSIL uses the option in Quest for Time or Distance settings when running our network adequacy assessments. Time and Distance standards are used for our MA (Medicare Advantage) lines of business."

Time and distance standards were also reviewed for the online provider directory for the Company. The calculations used by the Company for distance only, do not consider travel time by car, which can be significant for individuals in rural areas.

2. Providers without Claims
   a. Criticism #7 - The Company responded to Information Request 85.6 that it does not contact providers without claims as part of their network adequacy monitoring process. This is a violation of 215 ILCS 124/25(a)(3).

      The Company is amending the audit processes for the annual Provider Finder Audit to include an inquiry of Providers who have not submitted a claim within the last 12-18 months to determine their intent to stay in the network.

3. Provider Directory
   a. Criticism #5 - The Company failed to list all available specialty providers for any of the Health Maintenance Organization (HMO) plans on the online directory or notate that authorization or referral may be required to access some providers. This is a violation of 215 ILCS 124/25(a)(1), 215 ILCS 124/25(a)(5)(D), 45 CFR § 156.230(b)(2)(i)

      The Company responded to Information Request 85.6 that the online provider directory for any of the HMO plans does not display specialty providers. The Company explained that the IL HMO plans require that a member get a referral from their primary care physician (PCP) to see any specialists; specialists are therefore suppressed from search results for IL HMO plans. Specialists include behavioral health, mental health, infectious disease, and other specialties.

      The examiners confirmed the provider directory does not allow for viewing or searching for any providers the Company deems to be specialists and requires a PCP referral. Also, there were no notations on the online directory that authorization or referral is required to access specialty providers.

   b. Criticism #9 - The Preferred Provider Organization (PPO) plan provider directory was not available in hardcopy printed format for members or prospective members. When calling to request the directory, a prospective member was advised that the Company no longer has print copies of the PPO plan provider directory. The member would need to use the website, bcbsil.com, to access the provider finder to determine if a provider were in network. This is a violation of 215 ILCS 124/25(a)(4) and 45 CFR §156.230. This violation is effective through the plan year of 2021 and prior to a scheduled fix of February 24, 2022.

      The Company responded to this criticism stating that "had the caller selected the correct prompts and therefore spoken to a provider directory customer service agent, the prospective member would have been appropriately assisted with their request for printed directory information." To reply to the Company, an additional phone call was placed to verify if a printed directory could be obtained. The caller was initially told to go online for these items, but the caller informed the agent she wanted a printed copy of the provider directory. She was again advised they do not have a printed copy of the provider directory. The caller was insistent and asked if there was anyone that could send a printed copy of the provider directory for both HMO and PPO plans. The caller was then transferred to another customer service representative who asked for the caller's email address to email her a copy. The caller advised she had no printer and wanted a printed

copy for the Chicago area for both HMO and PPO providers. She provided her mailing address and was advised both a printed directory for the HMO and PPO plans would be sent. The directories had yet to be delivered at the time of this Criticism.

In addition, there was a chat with the website's virtual assistant, Ivy. When asking for a printed provider directory, Ivy responded several times that "I understand you need a member card…."

In summary, the examiner tried three times to request a printed provider directory by calling a customer service phone number two times and by chatting online with Ivy. It took several attempts to reach a representative who would respond to the request and resulted with no printed provider directory being provided to date.

c. Criticism #117 - The Company failed to audit for each network plan at least 25% of each of its provider directories. The Company is not meeting the statutory requirements in verifying the accuracy of the provider directories information via its audit process. This is a violation of 215 ILCS 124/25(a)(3).

The Company provided its 2021 network adequacy provider audit that was conducted for at least 25% of its provider files based on all network plans in the state of Illinois and not 25% of each of its network plans. It is required that the Company audit at least 25% of each of its provider directories for accuracy, make any corrections necessary, and retain documentation of the audit.

The Company based its audit on 25% of their total Provider File Identification Number (PFIN). An audit of 25% of the total number of PFINs is not 25% of each plan's directory. Additionally, a provider could have multiple PFIN records via one location, multiple locations or among multiple plans. If all of a single providers PFINs were not include in an audit, some but not all PFINs would be updated. The Company notes it had an estimated 145,000 PFIN records in 2021.

In addition, it could not be determined that the Company met the requirement to make "any corrections necessary" in the audit of 25% of its provider directories due to the information the Company provided. The Company stated it audited 40,351 PFIN records with confirmed updates made to 3,239 PFIN records or eight percent (8%) of the total PFIN records being reviewed. The remaining 37,112 PFIN records were grouped together as either "all data elements correct", "unable to audit" or "PFIN we could not update". Current audit practices included two attempted phone contacts to each provider being audited, if in both cases the provider did not answer or the Company was able to reach a live person, the Company closed the audit on that provider, it is recommended that this audit process be amended.

d. Criticism #139 - The Company failed to make clear which of its electronic provider directory applies to which network plan available for Illinois and which of the three-digit codes are the pertinent ones for conducting a search. The consumer or beneficiary must know the correct acronym and name as it is categorized in the system for each network plan to choose the applicable network plan. This is a violation of 215 ILCS 124/25(a)(6) and 45 CFR §156.230(b).

When accessing the Provider Finder, the Company's electronic provider directory, a drop-down of network plans available in Illinois is provided as the search option. The

drop-down choices are listed in full words, many containing acronyms for each network plan. It was noted that the Company has made improvements to the website as the original search option featured only the acronyms without full explanation of the plan; however, the available searching remains confusing for consumers.

The www.BCBSIL.com/find-a-doctor-or-hospital website currently list 57 different networks available to select from on this site. Of those 57 options, five (5) contain the acronym HMO, ten (10) contain the acronym PPO, eight (8) contain the word "Advantage", six (6) contain the word "Preferred" and there are also plans for CO, NY, OK and WI displaying as selections. Some plans have multiple acronyms, for example:

> Blue Choice OPT is a PPO plan but has acronyms in the system of BCO and a three-digit character prefix of XOX or CTY.
>
> Blue Choice PPO is a PPO plan and has the acronym in the system as BCS and a three-digit character prefix of XOU.

If a consumer was looking for the Illinois PPO plan, there are 10 within the drop-down for searching including Participating Provider Organization (PPO), Select PPO, Blue Choice Preferred PPO, Blue Choice Preferred PPO (Bronze, Silver, Gold, Security), Blue Choice Select PPO, etc.

It is noted that the Company does have a search feature that assists consumers in filtering the 57 plans display only the plans that are written in their county and that matches the type of plan a prospective consumer might be considering.

4. Accrediting Entity Certification by Health and Human Services (HHS)
   a. There were no criticisms in the certification survey for network adequacy.

5. Availability of Telehealth Telemedicine
   a. There were no criticisms in the telehealth telemedicine survey for network adequacy.

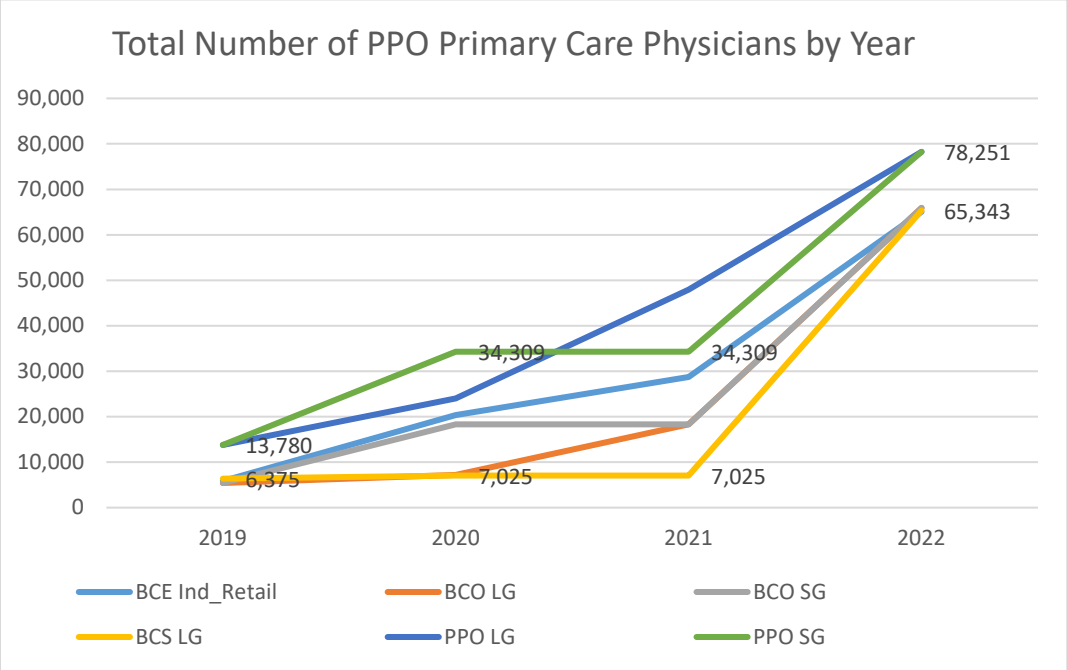
6. Data Integrity for State Filings
   a. Criticism #150 - The Company failed to provide accurate and most up-to-date network adequacy information in its SERFF filings to the state. It was determined that there were significant variances in the number of providers reported in the annual filings from 2019 to 2022. Also, in one provider category, there was a significant variance between the number of unique providers identified by name and location versus the number that the Company provided to calculate its Ratio of Anticipated Beneficiaries to Providers. This is in violation of 215 ILCS 124/10.

      The annual filings submitted by the Company for the plan years of 2019, 2020, 2021 and 2022 were reviewed. Part of the filings include the printed provider directories, provider data and the Ratio of Anticipated Beneficiaries to Providers reports. The Ratio of Anticipated Beneficiaries to Providers reports help to demonstrate to State and Federal regulators the sufficiency of each provider type in the state for a particular plan. The findings of the review of these three areas are explained below.

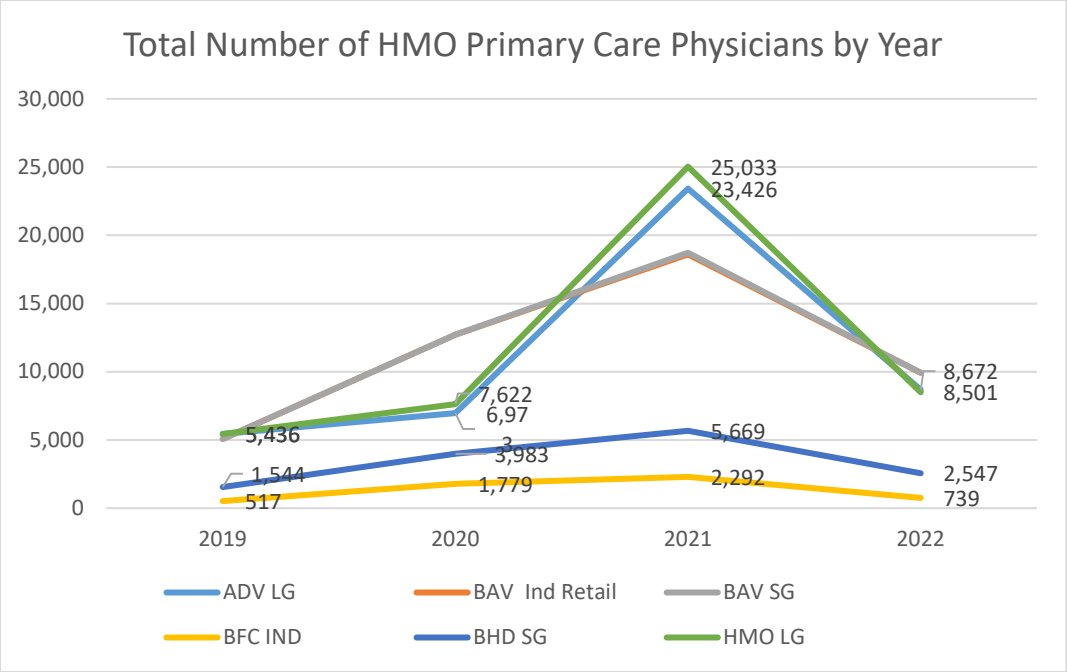
      Ratio of Anticipated Beneficiaries to Providers Reports

1. When reviewing Ratio of Anticipated Beneficiaries to Providers reports, it was identified that there was a significant variance in the number of providers reported from 2019 to 2022. In particular, the overall number of providers peaked in 2021 and 2022. The Health Maintenance Organization (HMO) plans noted substantial increases in the overall number of providers reported in 2021, but then those numbers decreased again in 2022. The Preferred Provider Organization (PPO) plans noted a substantial increase in 2021 and in 2022. An explanation for the significant changes was not provided by the Company in the Ratio of Anticipated Beneficiaries to Providers report.

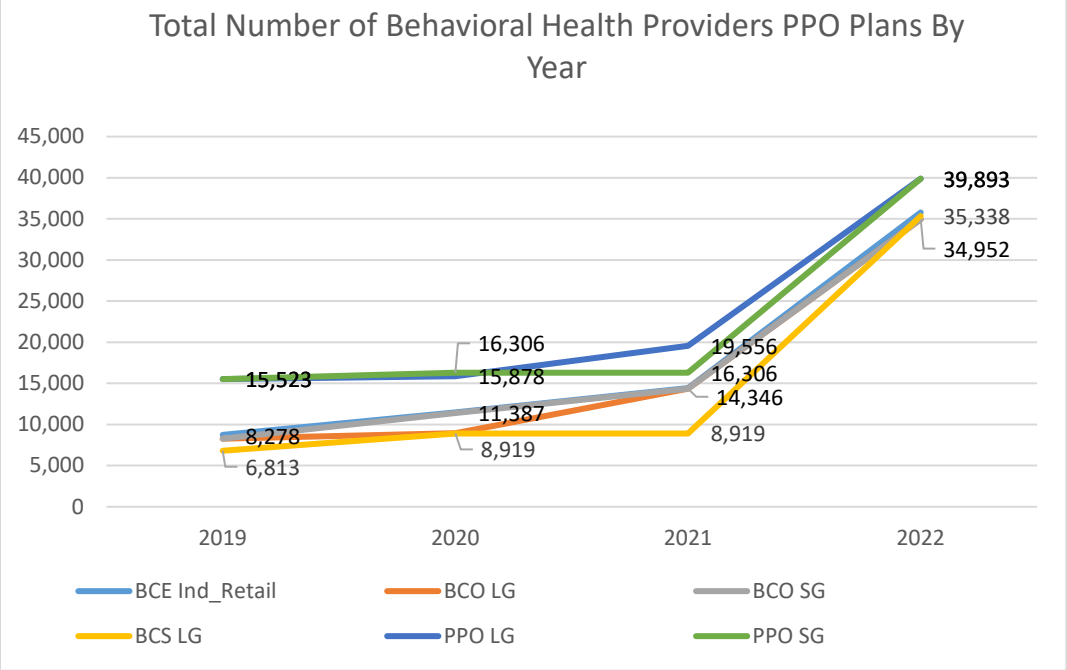
   The charts listed below demonstrate the variance in numbers of providers reported by plan for the Company during the examination period.



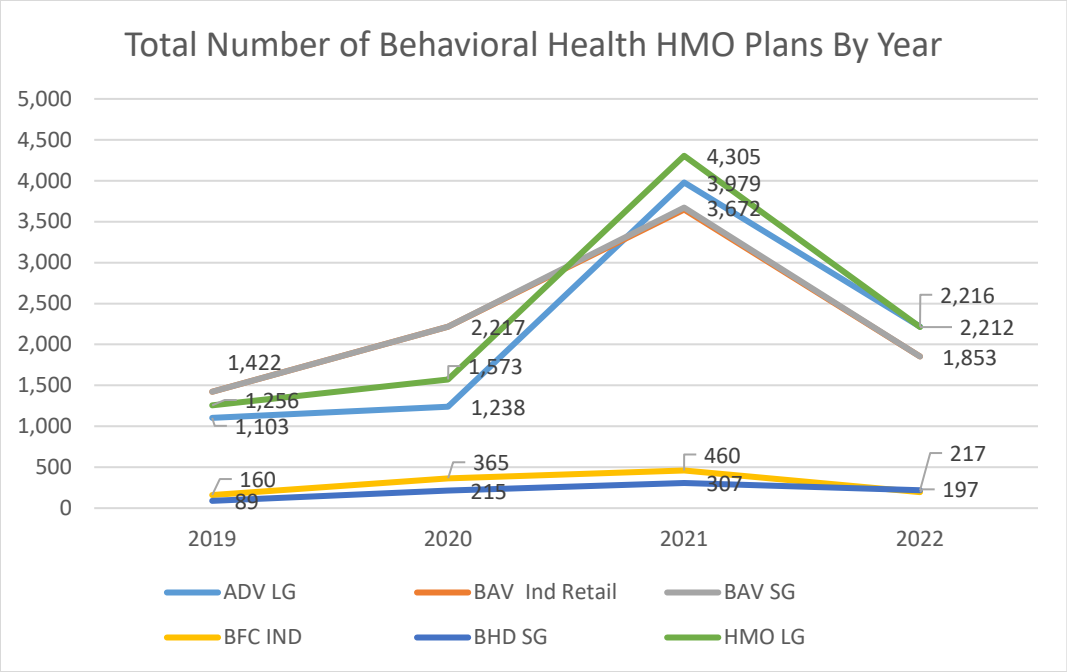
   The chart above indicates that the number of Primary Care Physicians reported for the BCS large group filing increased from 6,375 in 2019 to 65,343 in 2022, a percentage difference of 925% in four years.



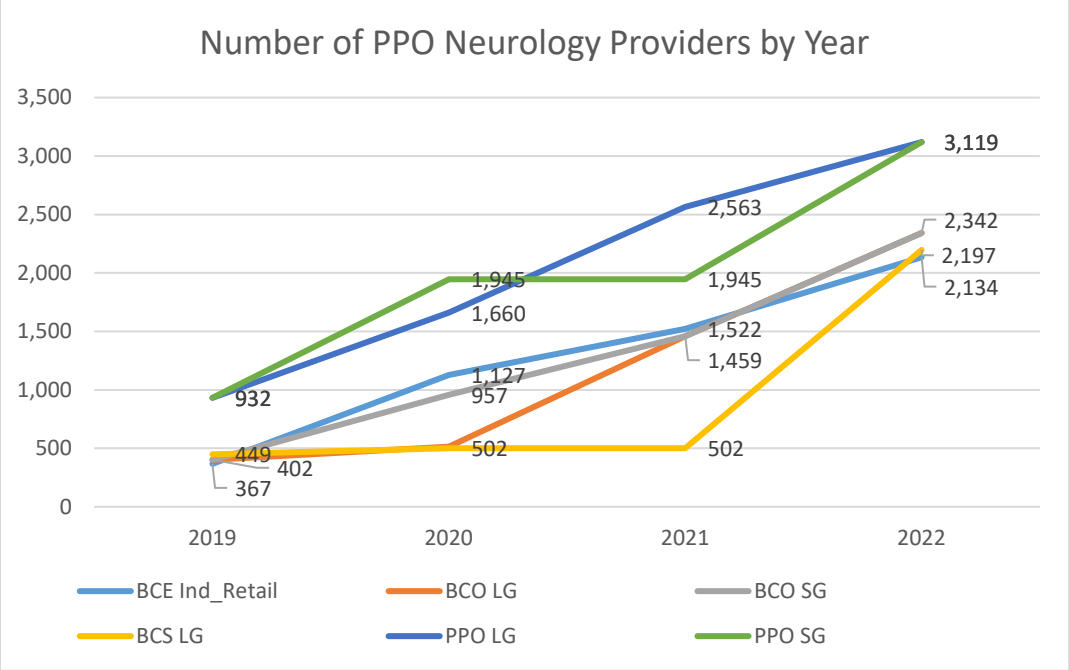
The chart above is also a report on the HMO plans reporting of Primary Care Providers for the HMO large group plan increased from 5,436 providers in 2019 to 25,033 in 2021, an increase of 361%, but then decreased back to 8,501 in 2022.



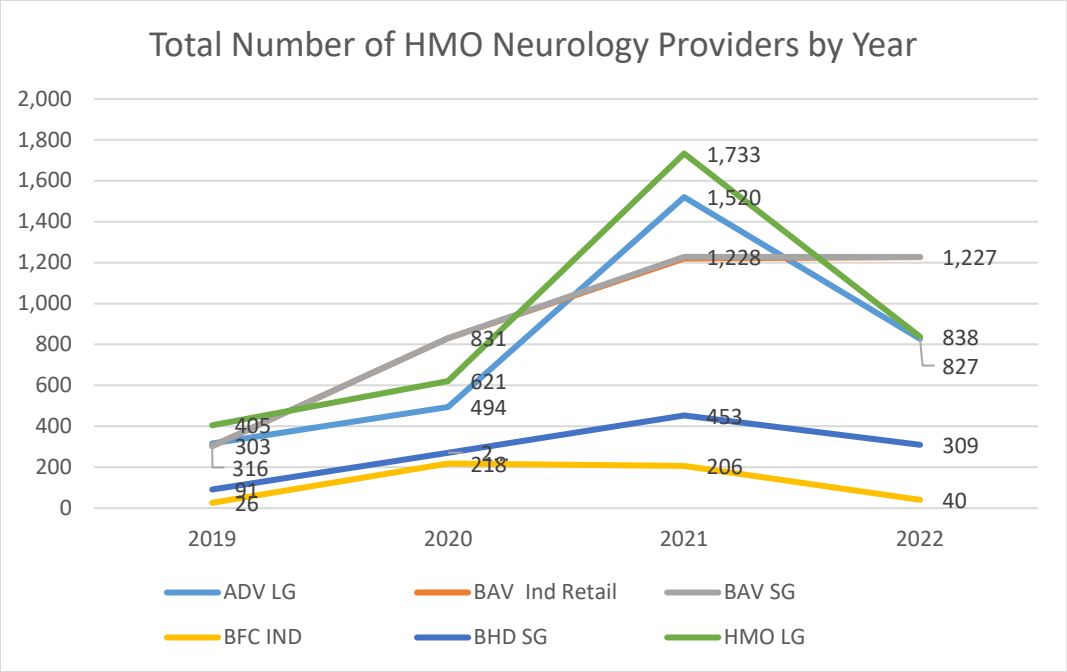
The chart above indicates that the number of Behavioral Health providers reported for the BCS large group filing increased from 6,813 in 2019 to 34,952 in 2022, a 413% increase in four years.



The chart above is also a report on the HMO plans reporting of Behavioral Health providers for the HMO large group plan increased from 1,256 providers in 2019 to 4,305 in 2021 an increase of 243%, but then decreased back to 2,216 in 2022.



The chart above indicates that the number of Neurology providers reported for the PPO large group filing increased from 932 in 2019 to 3,119 in 2022, a 235% increase in four years.



The chart above is also a report on the HMO plans reporting of Neurology providers for the HMO large group plan increased from 405 providers in 2019 to 1,733 in 2021 a 328% increase, but then decreased back to 838 in 2022.

Provider Data Compared to the Ratio of Anticipated Beneficiaries to Providers Reports

1. Another example of variances in the data provided by the Company relates to the number of Neurology providers in the provider data and the Ratio of Anticipated Beneficiaries to Providers report. The specialty provider type of Neurology was randomly selected for review.

   The screenshot of the Ratio of Anticipated Beneficiaries to Providers report was submitted for the 2022 filing year via SERFF to the state in March of 2022. As noted within the red ink, the number of Neurology providers is 3,119.

BCBSIL PPO Ratio of Anticipated Beneficiaries to Providers					
	Anticipated Beneficiaries	**Number of Providers**	**Actual Network**	**DOI Standard**	**Meet or Exceed Standard?**
PCP	124,650	78251	1:1.59	1:1,000	**Yes**
Cardiology	124,650	7240	1:17.22	1:10,000	**Yes**
Gastroenterology	124,650	2936	1:42.46	1:10,000	**Yes**
General Surgery	124,650	4061	1:30.69	1:5,000	**Yes**
Neurology	124,650	3119	1:39.96	1:20,000	**Yes**
OB/GYN	124,650	7904	1:15.77	1:2,500	**Yes**
Oncology/Radiation	124,650	3808	1:32.73	1:15,000	**Yes**
Ophthalmology	124,650	3503	1:35.58	1:10,000	**Yes**
Urology	124,650	2417	1:51.57	1:10,000	**Yes**
Behavioral Health	124,650	39893	1:3.12	1:5,000	**Yes**
Allergy/Immunology	124,650	806	1:154.65	1:15,000	**Yes**
Chiropractor	124,650	8188	1:15.22	1:10,000	**Yes**
Dermatology	124,650	3310	1:37.66	1:10,000	**Yes**
Endocrinology	124,650	1394	1:89.42	1:10,000	**Yes**
ENT/Otolaryngology	124,650	1692	1:73.67	1:15,000	**Yes**
Infectious Disease	124,650	1102	1:113.11	1:15,000	**Yes**
Nephrology	124,650	1842	1:67.67	1:10,000	**Yes**
Neurosurgery	124,650	941	1:132.47	1:20,000	**Yes**
Orthopedic Surgery	124,650	5024	1:24.81	1:10,000	**Yes**
Physiatry/Rehabilitative	124,650	1761	1:70.78	1:15,000	**Yes**
Plastic Surgery	124,650	866	1:143.94	1:20,000	**Yes**
Pulmonary	124,650	2256	1:55.25	1:10,000	**Yes**
Rheumatology	124,650	766	1:162.73	1:10,000	**Yes**
Pediatrics	124,650	7722	1:16.14	1:1,000	**Yes**

Facility					
Hospital	N/A	N/A	102/102*	1 per county	Yes
Mental Health Facility	N/A	N/A	102/102*	1 per county	Yes

When comparing the Neurology data for the PPO plan in the provider data submitted by the Company on March 2, 2022 in response to the Network Adequacy Handbook B.26 to the number of Neurology providers in the Ratio of Anticipated Beneficiaries to Providers report, there was a significant difference. The number of Neurologists listed in the provider data was 2,365, a variance of 754 Neurologist/clinics from the ratio report of 3,119 Neurologist.

Further review of the Neurology providers Information from the provider data was conducted. All duplicates in the PPO plan for Neurology at the same location were removed. Anything with the same address, but with a different suite number was considered unique and were not removed. Multiple doctors at the same location were included. The filtering to remove duplicates did include the removal of the same provider at the same location with the exact address, or if there were minor edits, such as "Suite" spelled out or "Ste" abbreviated. This data did not have PFIN records included in it. The results after the removal of duplicates at the same location for the same entity, was 1,801 unique Neurology clinics/providers. This was a variance of 1,318, or 42%, from the ratio report of 3,119 Neurology providers in the 2022 March re-filing for PPO plans.

Provider Type	Ratio of Anticipated Beneficiaries to Providers Report	Provider Data (no duplicates removed)	Provider Data (removal of duplicates)
Neurology Providers for 2022 PPO Plan Year	3,119	2,365	1,801

2. It was noted that the name of clinics is listed in the provider data. As an example, the clinic entitled Edward Health Ventures, was listed 59 times at the same address: 1200 S York Rd, Ste 1240, Elmhurst, IL. This location is a Bariatric clinic with two providers associated with the Elmhurst Hospital. However, this could be a recent change to a Suite location. This same address is also the location of the Edward-Elmhurst Medical Group. Further research on the individual NPIs for Edward Health Ventures listed other addresses and included taxonomies other than the clinic or Neurology.

VIII. OBSERVATIONS

A. Observation #1 - As concerns were expressed during the examination regarding the use of abbreviations for the plan names, the Company changed the names to include the full name and the abbreviation next to the full name in the parathesis. However, it was noted that in reviewing complaints, the members commented that their health insurance identification (ID) cards listed only the three-letter abbreviations and not the full name of the plan. Only displaying the three-letter abbreviations could hinder an enrollee's ability to utilize in-network providers, especially if enrollees are using the public website and not logging in. It is recommended that the Company include the full name of a member's plan on the ID card.

   The Company has been updating provider information by requiring providers to verify data in compliance with the new Consolidated Appropriations Act (CAA). The CAA requires issuers to verify and update provider directory information every 90 days, and these requirements took effect on January 1, 2022. The Company has an application called Availity for updating current provider records, a Demographic Change Form if users cannot utilize the Availity application, and a Provider Onboarding Form for new users.

   A remaining concern is the providers that are members of a group are being reported to the Company as active at every group location. As the Company continues to update the provider information, it is recommended that the Company review provider group information and crosscheck the data with providers that have no claims at specific locations. The Federal Essential Community Providers/Network Adequacy (ECP/NA) standards for 2023 limit a single provider from being listed at more than 10 unique locations on the ECP/NA Template.

B. Observation #2 - A review was conducted on the available providers for Sangamon County as a result of the removal of the major health system of Springfield Clinics. As part of this review, there was a reduction in the total number of providers available for certain provider categories, including the category for Obstetrics and Gynecology (OB/GYN). There were 99 available providers that remained in-network for the PPO plan for OB/GYN. It was verified that of the 99 available providers, 29 providers were Planned Parenthood providers, which provide only Gynecology services and do not provide any Obstetrics services.

   As the Company continues to update the provider information, it is recommended that the Company review provider group information and crosscheck the data with providers that have no claims at these Planned Parenthood locations.

   In addition, it was verified the amount of time it would take to make an appointment and whether these OB/GYN providers were accepting new patients. The PPO plan did have sufficient OB/GYN providers to meet the state ratio of anticipated enrollees to providers. However, the Company should be prepared for upcoming changes to the 2024 requirements Centers for Medicare & Medicaid Services (CMS) will be implementing by assessing appointment wait time standards.

C. Observation #3- A search of the provider directories was conducted to confirm that all providers were removed due to the contract termination of the major health system of Springfield Clinic. In our review, 56 providers remain on the directory with Springfield Clinic contractual affiliation. While it may be appropriate to list all in-network affiliated relationships and hospital locations, the directory in accordance with 215 ILCS 124/25 should clearly define and indicate to the consumer if that provider is accessible for appointment.

D. Observation #4- An audit of the provider directory accuracy was performed resulting in clear need for HCSC to improve their validation and audit procedures for provider information accuracy and for the directory to be a useful tool for consumers.

EXAMINATION DRAFT REPORT SUBMISSION

The courtesy and cooperation of the officers and employees of the Company during the examination are acknowledged and appreciated.

Elizabeth Harvey
Michele Amstutz
Tony Taylor
Tanya Sherman
June Coleman, Examiner-in-Charge
Shelly Schuman, Supervisory Insurance Examiner

Respectfully submitted,

June Coleman

JUNE COLEMAN
EXAMINER-IN-CHARGE

Shelly Schuman

SHELLY SCHUMAN
SUPERVISING EXAMINER

STATE OF ILLINOIS
DEPARTMENT OF INSURANCE

IN THE MATTER OF:

HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY
300 E. RANDOLPH STREET
CHICAGO, IL 60601-5099

STIPULATION AND CONSENT ORDER

WHEREAS, the Director of the Illinois Department of Insurance ("Department") is a duly authorized and appointed official of the State of Illinois, having authority and responsibility for the enforcement of the insurance laws of this State; and

WHEREAS, Health Care Service Corporation, A Mutual Legal Reserve Company, ("the Company"), NAIC 70670, is authorized under the insurance laws of this State and by the Director to engage in the business of soliciting, selling and issuing insurance policies; and

WHEREAS, a Market Conduct Examination of the Company was conducted by a duly qualified examiner of the Department pursuant to Sections 132, 401, 402, 403, and 425 of the Illinois Insurance Code (215 ILCS 5/132, 5/401, 5/402, 5/403, and 5/425); and

WHEREAS, as a result of the Market Conduct Examination, the Department examiner filed a Market Conduct Examination Report covering the examination period of March 1, 2019, to August 31, 2020, and Network Adequacy reviews of November-December 2021, and Plan Year 2022, which is an official document of the Department; and

WHEREAS, the Market Conduct Examination Report cited various areas in which the Company was not in compliance with the Illinois Insurance Code (215 ILCS 5/1 *et seq.*), the Network Adequacy and Transparency Act (215 ILCS 124/1 *et seq.),* and Department Regulations (50 Ill. Adm. Code 101 *et seq.*); and

WHEREAS, nothing herein contained, nor any action taken by the Company in connection with this Stipulation and Consent Order, shall constitute, or be construed as, an admission of fault, liability or wrongdoing of any kind whatsoever by the Company; and

WHEREAS, the Company is aware of and understands their various rights in connection with the examination and report, including the right to counsel, notice, hearing and appeal under Sections 132, 401, 402, 407, and 407.2 of the Illinois Insurance Code and 50 Ill. Adm. Code 2402; and

WHEREAS, the Company understands and agrees that by entering into this Stipulation and Consent Order, they waive any and all rights to notice and hearing; and

WHEREAS, the Company and the Director, for the purpose of resolving all matters raised by the report and in order to avoid any further administrative action, hereby enter into this Stipulation and Consent Order ("Order").

NOW, THEREFORE, IT IS AGREED by and between the Company and the Director as follows:

1. The Market Conduct Examination indicated various areas in which the Company was not in compliance with provisions of the Illinois Insurance Code and Department Regulations; and

2. The Director and the Company consent to this Order requiring the Company to take certain actions to come into compliance with provisions of the Illinois Insurance Code, the Network Adequacy and Transparency Act and Department Regulations.

THEREFORE, IT IS HEREBY ORDERED by the undersigned Director that the Company shall:

1. Institute and maintain policies and procedures whereby the Company shall provide a written response to written policyholder inquiries and complaints within 21 days of receipt. 215 ILCS 5/143d(b)

2. Institute and maintain policies and procedures whereby the Company shall use maximum travel time and distance standards for plan beneficiaries. 215 ILCS 124/10(d)

3. Institute and maintain policies and procedures whereby the Company shall contact in-network providers that have not submitted claims to the Company as part of its network adequacy monitoring process. 215 ILCS 124/25(a)(3)

4. Institute and maintain policies and procedures whereby the Company shall list all available specialty providers for HMO plans on the Company's online directory and notate that authorization or referral may be required to access some providers. 215 ILCS 124/25(a)(1), 215 ILCS 124/25(a)(5)(D), and 45 CFR § 156.230(b)(2)(i)

5. Institute and maintain policies and procedures whereby the Company shall make available the Company's PPO provider directory in print for members or prospective members upon request. 215 ILCS 124/25(a)(4) and 45 CFR §156.230

6. Institute and maintain policies and procedures whereby the Company shall audit for each network plan at least 25% of its provider directories and verify the accuracy of the provider directories information via its audit process. For purposes of this Order, the Company's network plans include Blue Choice Preferred PPO, Blue Choice Options PPO, PPO, Blue Choice Select, Blue Precision HMO, Blue Advantage HMO, HMO Illinois, BlueCare Direct and Blue FocusCare. 215 ILCS 124/25(a)(3)

7. Institute and maintain policies and procedures whereby the Company shall make clear which parts of its electronic provider directory apply to each network plan, with the use of plan identifiers and definitions. 215 ILCS 124/25(a)(6) and 45 CFR §156.230(b)(2)(ii)

8. Institute and maintain policies and procedures whereby the Company shall provide accurate and up-to-date network adequacy information in its SERFF filings to the State. 215 ILCS 124/10

9. Within 45 days of the execution of this Order: (i) complete the institution of policy and procedure updates for order 3, and (ii) institute corrections to the provider directory consistent with the terms of order 4.

10. Within 90 days of the execution of this Order, institute corrections to the provider directory consistent with the terms of order 7, with monthly updates to be provided by the Company to the Chief Examiner to show and confirm compliance progress.

11. Provide proof of updated policies and procedures for order 6 within 45 days of the execution of this Order, with monthly updates from the Company to the Chief Examiner demonstrating compliance progress with implementation of the policies and procedures for order 6 for a period of 1 year from the date of execution of this Order.

12. Submit to the Director of Insurance, State of Illinois, proof of compliance with orders one (1) through eight (8) within thirty (30) days of execution of this Order.

13. Pay to the Director of Insurance, State of Illinois, a civil forfeiture in the amount of $605,000 to be paid within ten (10) days of execution of this Order. However, if during the twelve-month period following the date of execution of this Order, HCSC fails to materially comply with any part of orders 9, 10, and 11 within the Order as determined by the Chief Examiner an additional fine up to a total of $605,000, proportionate to such material noncompliance may be assessed.

NOTHING contained herein shall prohibit the Director from taking any and all appropriate regulatory action as set forth in the Illinois Insurance Code or the Network Adequacy and Transparency Act including, but not limited to, levying additional forfeitures, should the Company violate any of the provisions of this Stipulation and Consent Order or any provisions of the Illinois Insurance Code, the Network Adequacy and Transparency Act, or Department Regulations.

On behalf of HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY

Signature

Stephen Harris
Name

President, Illinois Plan
Title

36-1236610
Tax Identification Number (TIN)

Subscribed and sworn to before me this
30TH day of JANUARY 2023.

Notary Public

TIMITRI TAYLOR
OFFICIAL SEAL
Notary Public, State of Illinois
My Commission Expires
June 29, 2026

DATE January 30, 2023

DEPARTMENT OF INSURANCE of the
State of Illinois:

Dana Popish-Severinghaus
Director