BEFORE THE DEPARTMENT OF INSURANCE
STATE OF NEBRASKA

STATE OF NEBRASKA DEPARTMENT OF INSURANCE,	)	
PETITIONER,	)	CONSENT ORDER
VS.	)	
BRIGHT HEALTH INSURANCE COMPANY, (NAIC CODE #15963)	)	CAUSE NO. C-2905
RESPONDENT.	)	

In order to resolve this matter, the Nebraska Department of Insurance ("Department"), by and through its representative, Michael W. Anderson and Bright Health Insurance Company, a Colorado domiciled life insurance company ("Respondent"), mutually stipulate and agree as follows:

JURISDICTION

1. The Department has jurisdiction over the subject matter and Respondent pursuant to Neb. Rev. Stat. §44-101.01, §44-303 and §44-4047, et seq.

2. Respondent was licensed as an insurance company under the laws of Nebraska at all times material hereto.

STIPULATIONS OF FACT

1. This Consent Order was arrived at following the conclusion of a market conduct examination into Bright Health Insurance Company. A copy of the final findings of that examination was served upon the Respondent, at the Respondent's address registered with the Department by certified mail, return receipt requested.

2. Respondent violated, on multiple occasions, Neb. Rev. Stat. §§44-361, 44-710.04(9), 44-785, 44-1524, 44-1525(1), 44-1525(11), 44-1540(4), 44-1540(3), 44-5807(2), 44-5807(3), 44-5905(2)(B)(ii), 44-8004(1), 44-8008, 44-8005(1), 44-710.19 and 210 Neb. Admin. Code, Chapter 61 §008.02 & §008.04, as a result of the conduct as outlined in the Market Conduct Examination report, attached hereto as "Exhibit 1" and incorporated by reference.

3. Respondent was informed of the right to a public hearing. Respondent waives that right and enters into this Consent Order freely and voluntarily. Respondent understands and acknowledges that by waiving its right to a public hearing, Respondent also waives its right to confrontation of witnesses, production of evidence, and judicial review.

4. Respondent admits that conduct as alleged in Exhibit 1 constitutes numerous violations of the Revised Statutes of Nebraska and the Nebraska Administrative Code.

5. Respondent has been cooperative with the Department and offered to enter into this Consent Order voluntarily.

CONCLUSIONS OF LAW

The conduct of Bright Health Insurance Company, as alleged above, constitutes numerous violations of Neb. Rev. Stat. §§44-361, 44-710.04(9), 44-785, 44-1524, 44-1525(1), 44-1525(11), 44-1540(4), 44-1540(3), 44-5807(2), 44-5807(3), 44-5905(2)(B)(ii), 44-8004(1), 44-8008, 44-8005(1), 44-710.19 and 210 Neb. Admin. Code, Chapter 61 §008.02 & §008.04.

CONSENT ORDER

It is therefore Ordered by the Director of Insurance and agreed by Respondent that:

1. To settle and resolve the issues relating to the allegations, Respondent agrees to pay an administrative penalty in the amount of one million dollars and zero cents ($1,000,000), payment of which shall be deferred until after such time as Respondent completes its obligation to runoff the business, including without limitation, completing payments due to Nebraska policyholders, and providers as well as risk adjustment related obligations.

2. Respondent agrees that Bright Health Insurance Company's certificate of authority to operate as an insurer in the State of Nebraska shall be revoked. Respondent shall still be allowed to process past claims and conduct any necessary business to administer those claims, progress of which shall be reported to the Petitioner's Office as outlined below in section 3.

3. In order to monitor the ongoing payment of claims, Respondent shall report to Petitioner's office monthly a status report of outstanding claims and provider payment disputes.

In witness of their intention to be bound by this Consent Order, each party has executed this document by subscribing their signatures below.

Michael W. Anderson, #25671
Department of Insurance
1526 "K" Street, Suite 200
Lincoln, Nebraska 68508
(402) 471-2201

11/3/2023
Date

Bright Health Insurance Company

11/3/2023
Date

State of Minnesota)
) ss.
County of Hennepin)

On this 3rd day of November, 2023, Jeff Craig, Secretary of Bright Health Insurance Company personally appeared before me and read this Consent Order, executed the same and acknowledged the same to be his voluntary act and deed.

SHELLEY RAE SANDERS
Notary Public
Minnesota
My Commission Expires
Jan 31, 2027

Shelley Sanders
Notary Public

I hereby certify that the foregoing Consent Order is adopted as the Final Order of the Nebraska Department of Insurance in the matter of State of Nebraska Department of Insurance vs. Bright Health Insurance Company, Cause No. C-2905.

STATE OF NEBRASKA
DEPARTMENT OF INSURANCE

Eric Dunning
Director of Insurance

11/3/23
Date

CERTIFICATE OF SERVICE

I hereby certify that a copy of the executed Consent Order was sent to the Respondent at 8000 Norman Center Drive, Suite 900, Minneapolis, MN 55437, by certified mail, return receipt requested on this 3rd day of November, 2023.

Shelly Stone

NEBRASKA

Good Life. Great Opportunity.

DEPARTMENT OF INSURANCE

Market Conduct Final Examination Report

for

Bright Health Insurance Company
8000 Norman Center Drive, Suite 900
Minneapolis, MN 55437

NAIC CODE: # 15963

NEBRASKA EXAM CODE: NE033-49

as of **February 28, 2022**

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I. OVERVIEW/PREFACE

This is a market conduct examination report of the practices and procedures of the Bright Health Insurance Company (hereinafter referred to as the "Company") (NAIC Company Code #15963).

The examination was conducted at the Nebraska Department of Insurance office located at 1526 K Street, Suite 200, Lincoln, NE 68508. An on-site visit was conducted on July 11, 2022, through July 14, 2022, at the Company's corporate offices located in Minneapolis, Minnesota.

This examination report is, in general, a report by exception. All unacceptable or noncompliant practices may not have been discovered or noted in this report. Failure to identify or criticize improper or noncompliant business practices in Nebraska or in other jurisdictions does not constitute acceptance of such practices.

This is due, in part, to the Company being uncooperative and dismissive of regulators questions in certain instances, hiding behind a veil of confidentiality that doesn't exist for a regulated entity. The examiners only reviewed a sample of the Company's procedures and files. The findings in this report are based on the data and responses received from the Company, both through direct questions from the examiners, as well as from a total of 91 complaints handled by the Nebraska Department of Insurance during the exam period.

The Company was required to provide a statistically significant sample of claims, as calculated by the Examiners. Review of these files led to the discovery of additional violations, among which were the following notable findings:

- The Company was found to have denied coverage for newborn dependents in no less than 163 cases during the Examination period.
    - In one notable case, the Company not only failed to cover a claim for a newborn for which care was billed in excess of $200,000, but subsequently failed to include the large claim in documentation to the Department, despite other claims for the same newborn being included.
- The Company was found to have sent 2,245 claims for immunizations to cost sharing, despite being required by law for such care to be covered at 100% with no cost sharing.

Errors in the files from the Company resulted in the following notable findings:

- Numerous claims were denied simply due to transpositional errors (e.g., in claim documents, capitalization of a provider's name and/or facility caused claims to be rejected due to not being recognized by the Company's systems)
- The Company failed to provide claim delay letters and stated they did not historically send such delay letters, even though required by law to do so.

- The Company was required to reprocess thousands of claims, which were originally denied for various reasons, despite such claims being unambiguously covered by the policies held by the policyholders.

Examiners did not have access to the system and solely relied on the files and spreadsheets provided by the Company. Some noncompliant practices may not have been discovered during this examination. As such, this report may not fully reflect all the procedures and files of the Company.

In the following portions of this report, the examiners cited potential violations made by the Company. Statutory citations are as of the period under examination unless otherwise noted.

Throughout the pendency of this exam, the total amount of money recovered within the scope of this report was $13,268,834.92; further, no evidence of a compliance program which would have discovered the errors on which this recovery is based was discovered in the Company's files.

II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted pursuant to the authority granted by, but not limited to, Neb. Rev. Stat. § 44-1527 and §§ 44-5901 through 44-5910. The purpose of this examination was to ensure the Company complied with applicable Nebraska statutes, Nebraska Department of Insurance regulations, and guidance documents issued by the Nebraska Director of Insurance. In addition, examiners documented practices and procedures that did not appear to be in the best interest of Nebraska insurance consumers.

The examination focused on the Company's policies, procedures, and processes in the following areas: Operations and Management, Policyholder Services, and Claims Handling. The period covered by this examination is generally January 1, 2020, to February 28, 2022. The examiners requested files within the above date range; however, due to findings within the initial claim files examiners expanded the scope of the examination and reviewed additional files with errors outside of the date range.

This examination was conducted and performed in accordance with Market Regulation standards established by the Department and examination procedures outlined by the National Association of Insurance Commissioners (NAIC). Error rates calculated in the claims review are compared with the NAIC historic benchmark error rate of seven percent (7%), with those exceeding the benchmark presuming to indicate a general business practice contrary to law. The starting point of the examination focused on two areas which included the accuracy of the Company's online directory and denied claims. From there, issues were identified, and further areas were investigated.

When conducting the in-network provider listing accuracy portion of the exam, examiners requested the Company provide a listing of all in-network providers as of the day of request. Using Galvanize software (formerly ACL), examiners then generated a random list of 366 providers to contact in to verify the accuracy of their listing in the Bright Health online provider directory. The error rate in this accuracy verification project was approximately 6.8%. It was also noted, the Company failed to update errors with the online directory that were reported to the Company by users of the online directory.

To begin the claim-handling analysis, examiners requested the Company provide a listing of all Nebraska claims denied during the review period. Using Galvanize software (formerly ACL) to select a random sample from the universe of files provided by the Company, a valid sample size was determined as 184.

Of the 184 claims in the sample, a total of 102 were reviewed. Of these 102 reviewed, a total of 46 errors were identified which resulted in an overall error ratio of 45% (significantly higher than the 7% error threshold which would seem to indicate a conscious and flagrant disregard of the law). Due to specific negative trends identified during the examination, the focus of the claims review shifted to specific denial codes for claims denied as out-of-network and

reprocessed claims. Throughout the examination, the Company was sent a total of 274 critique forms, otherwise identified as CFs.

Unless otherwise stated in the report, all the findings were brought to the attention of the Company by the examiners.

III. COMPANY PROFILE

Bright Health Insurance Company is a wholly owned subsidiary of Bright Health Management, Inc., which is a health insurer management corporation. Bright Health is a for-profit publicly held company incorporated January 12, 2016. The Company is licensed to sell health insurance policies in 11 states and began offering individual and family health insurance plans in Nebraska starting in 2020 through the Affordable Care Act (ACA). As of December 31, 2022, Bright Health Insurance Company has exited the Nebraska market.

As noted in the Company's Annual and Quarterly reports submitted to the NAIC, the Company leadership is as follows:

2022 (End of Year)

OFFICERS	DIRECTORS
Jeff Cook, President	Jeff Cook
Jay Matushak, Chief Financial Officer	A. Bartley Bryt
Jeff Craig, Secretary	Jeff Craig

Note: Michael Carson served as President & CEO from March-December 2022 (prior to Jeff Cook)

2021 (End of Year)

OFFICERS	DIRECTORS
Simeon Schindelman, President & Chief Executive Officer	Simeon Schindelman
Kara Rios, Chief Financial Officer	Nicolas Alvin Christianson
George Lyford, Secretary	Keith Nelsen
Tomas David Valdivia M.D., Chief Medical Officer	

2020 (End of Year)

OFFICERS	DIRECTORS
Simeon Schindelman, President & Chief Executive Officer	Simeon Schindelman
Kara Rios, Chief Financial Officer	Nicolas Alvin Christianson
George Lyford, Secretary	Keith Nelsen
Tomas David Valdivia M.D., Chief Medical Officer	

BRIGHT HEALTH GROUP EXECUTIVE TEAM	
G. Mike Mikan	Vice Chairman, President, and CEO
Cathy Smith	Chief Financial & Administrative Officer
Jeff Cook	Chief Operating Officer
Jay Matushak	Sr. Vice President
Jeff Craig	General Counsel
Brett Erhardt	Chief Strategy & Growth Officer
Jon Porter	Chief Product Officer

BRIGHT HEALTH GROUP'S BOARD OF DIRECTORS		
Bob Sheehy	Mike Mikan	Mohamad Mahkzoumi
Steve Kraus	Adair Newhall	Kendrick Adkins
Naomi Allen	Jeff Immelt	Manny Kadre
Matt Manders	Andy Slavitt	Linda Gooden

IV. EXECUTIVE SUMMARY

The Nebraska Department of Insurance conducted a targeted examination of the claim-handling practices and the online directory of Bright Health Insurance Company (NAIC Company Code 15963). The following is a summary of the examination findings:

Examination Findings

As a result of this examination, the total amount of money recovered within the scope of this report was $13,268,834.92; further, no evidence of a compliance program which would have discovered the errors on which this recovery was based was discovered.

The examination findings also incorporate issues that were discovered by the Department of Insurance Complaint Division which are described in the supplemental findings section of the report. This is a summary of the findings and violations discovered during the examination:

Category	Violation	Description of Violation	Number of Violations
Examination Coordination	Neb. Rev. Stat. § 44-1524 & Neb. Rev. Stat. § 44 -1525 (11)	The Company failed to respond in a timely manner to examiner inquiries.	126*
	Neb. Rev. Stat. § 44-5905(2)(B)(ii)	The Company failed to provide complete claim files for the examiners to review causing unnecessary delays in the progression of the exam.	16
Third Party Administrator	Neb. Rev. Stat. § 44-5807(2) and (3)	The Company failed to provide adequate oversight of the claim-handling operations of third-party administrators (TPAs) and did not audit the operations of the TPAs as required.	55
Policyholder Service/Online Directory	Neb. Rev. Stat. § 44-1525(1)	The Company failed to publish up-to-date, accurate, and complete provider directory information in 25 out of 366 online directory entries surveyed.	25
		The Company failed to complete corrections collected through the company's online reporting link. The Company did not remove inaccurate information according to their	7

		procedures within 10 business days of receiving the information.	
Policyholder Service	Neb. Rev. Stat. § 44 -710.04(9)	The Company failed to provide written notice of termination to the insured.	3
Policyholder Service	Neb. Rev. Stat. § 44-361	The Rewards Program offered by the Company was not specified in the policy documents, nor did the Company offer a valid exception for said program; therefore, it is considered a violation of the rebate law.	1
Claims Handling Practices	Neb. Rev. Stat. § 44-1540(4)	The Company did not attempt in good faith to effectuate prompt, fair, and equitable settlement of claims submitted in which liability became reasonably clear.	11,068*
Claims Handling Practices/ Prompt Pay Act	Neb. Rev. Stat. § 44 -8004(1)	The Company failed to pay, deny, or settle a clean claim within thirty calendar days after receipt if submitted electronically and within forty-five calendar days after receipt if submitted in a form other than electronically.	9,292*
Claims Handling Practices/ Delay Letters	Neb. Rev. Stat. § 44-1540(3) & Neb. Rev. Stat. § 44-8008 & 210 Neb. Admin. Code, Ch 61 § 008.02	The Company failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies. This includes providing the claimant a reasonable written explanation for the delay.	25
Claims Handling Practices/ Prompt Pay Act	Neb. Rev. Stat. § 44–8005(1) & Neb. Rev. Stat. § 44-8008	The Company failed to pay, deny, or settle a clean claim in accordance with the time periods set forth in subsection (1) of section 44-8004 or take other required action within the time periods set forth in subsection (2) of section 44-8004 which states the Company shall pay interest at the rate of twelve percent per annum on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to section 44-8004.	721*

Claims Handling Practices	Neb. Rev. Stat. § 44-710.19	The Company failed to pay for newborn services that occurred within the first 31 days of birth.	163
Explanation of Benefits	Neb. Rev. Stat. § 44-1540(13) & 210 Neb. Admin. Code, Ch 61 § 008.04	The Company failed to promptly provide the claimant an accurate explanation of benefits including the name of the provider or services covered and a clear explanation of the computation of benefits.	89
Total Number of Violations			**21,591**

**Violations for supplemental findings are included*

V. EXAMINATION BACKGROUND

The Company's Online Provider Directory

The Nebraska Department of Insurance (NDOI) conducted a review of the Company's online provider directory in response to complaints surrounding the accuracy of whether a provider is in-network or out-of-network. The accuracy of the directory was important since the Company had "closed network" plans in Nebraska. In a closed network plan, the Company only pays "in network" rates for providers within the "closed network". Out-of-network provider services are generally not covered.

The review consisted of a survey of 366 providers, chosen at random from the comprehensive in-network listing of 48,111 providers for Nebraska. Providers listed in the Company's online directory were compared with the Healthcare.gov website. Providers were called to verify in-network status, location, phone number and practice name. The exam team found the Company failed to publish up-to-date, accurate, and complete provider directory information in 25 out of 366 online directory entries surveyed. These are 25 violations of Neb. Rev. Stat. § 44-1525 (1).[A]

To increase accuracy, the Company's online website contained a reporting link on each page of the directory which allowed the public to suggest changes. The link was not activated until 2022 and 36 suggested edits were submitted by consumers and providers between February 10, 2022, and March 22, 2022. It was found that seven suggested edits were not investigated or updated as of June 2022. The Company should have removed the inaccurate information according to their IFP Provider Directory Standards Reporting Policy within 10 business days of receiving the information. These findings accounted for seven additional violations of Neb. Rev. Stat. § 44-1525 (1).[A]

Review of Denied Claims

While the examination began with a focus on the accuracy of the Company's provider online directory, due to inaccuracies found within the online directory, it segued into a review of denied claims to determine the potential impact on claims.

This portion of the examination was conducted and performed in accordance with Market Regulation standards established by the Department and examination procedures outlined by the National Association of Insurance Commissioners (NAIC). Error rates calculated in the claims review are compared with the historical NAIC benchmark error rate of seven percent (7%), with those exceeding the benchmark presuming to indicate a general business practice contrary to law.

[A] These may also constitute violations of Federal Statute 45 CFR §§ 156.230(b)(2).

Initially, as part of claims handling analysis, examiners requested the Company provide a spreadsheet listing all Nebraska claims denied during the review period. The Company responded with an excel spreadsheet consisting of 41,887 individual, specific claims. Using Galvanize software (formerly ACL) to select a random sample from the universe of files provided by the Company, a valid sample size was determined as 184.

Random Sample

The exam team started with a random sample of 55 denied claims from the sample list of 184. Twenty-three errors were found for a 42% error ratio (significantly higher than the 7% error threshold which would seem to indicate a conscious and flagrant disregard of the law). One trend identified was that clean claims were being denied when they should have been paid. Next, the exam team reviewed an additional 31 denied claims from the sample list that were denied specifically for "out-of-network". Out of the 31 denied claims, 21 errors were found for a 68% error ratio (significantly higher than the historic 7% error threshold put forth by the NAIC, which would seem to indicate a conscious and flagrant disregard of the law). Due to errors and inconsistencies within the Company's systems and the apparent lack of communication between said systems, the practice of incorrectly denying a clean claim for "out-of-network" (for various reasons) became identified as a systemic issue.

It was also noted in claim files when a member initiated a change to their plan through healthcare.gov, the change did not always translate correctly or timely to the Company's claim-handling Third-Party Administrator (TPA). This resulted in a member's claim incorrectly being denied for "No Coverage in Effect". This prompted the exam team to review an additional 16 denied claim files that were denied due to the member appearing to not have coverage in effect. Out of the 16 files, two errors were found which resulted in a 13% error ratio.

The cumulative review of the 102 claim files, resulted in a total of 46 errors and an overall error ratio of 45% (significantly higher than the 7% error threshold which would seem to indicate a conscious and flagrant disregard of the law). The errors accounted for 46 violations of Neb. Rev. Stat. § 44-1540(4), 66 violations of Neb. Rev. Stat. § 44 -8004(1), 26 violations of Neb. Rev. Stat. § 44–8005(1), 25 violations of 210 Neb. Admin. Code, Ch 61 § 008.02, and one violation of Neb. Rev. Stat. § 44-710.19.

Additional Claims

During the review of the 102 denied claims, when a claim was determined to have been denied incorrectly, the Company was prompted by the examiner to not only reprocess the incorrectly denied claim, but also to review additional claims denied for the same reason and the same provider. These additional claims were retrieved from the initial universe of denied claims (41,887). There were 1,408 additional claims reviewed and reprocessed for a total payment amount of $355,286.44. This accounted for 1,408 additional violations of Neb. Rev. Stat. § 44-1540(4), 1,408 additional violations of Neb. Rev. Stat. § 44 -8004(1), and 39 additional violations of Neb. Rev. Stat. § 44–8005(1). *Referenced in Table 1 - Summary of Additional Reprocessed Claims.*

Reprocessing Projects
During the examination, reprocessing projects were established. The Company provided the examiners reports listing claims that were overturned and reprocessed. Throughout this exam, these reports were referred to by the Company as "impact reports". The initial impact reports included five projects: Newborn, Chiropractic, Behavioral Health, Network, and In-Office Labs. These impact reports resulted in 3,387 additional claims reprocessed for a total payment amount of $1,081,007.06. The claims were overturned and reprocessed resulting in 3,387 additional violations of Neb. Rev. Stat. § 44-1540(4), 3,387 additional violations of Neb. Rev. Stat. § 44 -8004(1), 567 additional violations of Neb. Rev. Stat. § 44–8005(1), and 116 additional violations of Neb. Rev. Stat. § 44-710.19. *Referenced in Table 2 - Summary of Reprocessed Projects.*

Review of Reprocessed Claim files
Examiners used the impact reports to pull an additional 50 claims to ensure the claims were reprocessed correctly. Out of the 50 reprocessed claim files reviewed, 11 of the files had errors which resulted in a 22% error ratio (significantly higher than the 7% error threshold which would seem to indicate a conscious and flagrant disregard of the law) for claims that were expected to be corrected.

Impact Reports
It was clear due to the inaccuracies and inconsistencies in the impact reports the Company did not review the spreadsheets prior to sending them to the exam team. Therefore, the exam team cannot confirm the accuracy of the information within each of the impact reports. Nevertheless, issues were evident such as:

- Interest not being applied to claims when required
- Denied claims being reprocessed multiple times with the same incorrect result
- Multiple iterations of the same impact reports were being produced due to inconsistencies and omissions within the impact report

Supplemental Findings
Examiners continued to pursue additional projects to recover payments due. The *Supplemental Findings* section of this report provides information on additional findings and violations were discovered by the Insurance Department Complaints Division.

For a comprehensive list of violations see the Executive Summary.

VI. EXAMINATION FINDINGS

NOTE: Unless noted otherwise, this section is presented in a chronological order, discussing violations in approximate order in which they were discovered; the order is not intended to represent the severity of any individual finding.

A. OPERATIONS AND MANAGEMENT

This section is an overview of the findings within the operations and management of the Company during the exam period.

1. Examination Coordination

In order to ensure the Company's compliance with Neb. Rev. Stat. § 44-1524 and Neb. Rev. Stat. § 44-1525(11), examiners maintained logs to analyze the Company's timeliness of responses for items requested during the examination.

Findings:

a. A total of 274 critique forms were submitted. Out of 274, the company failed to respond timely on 58 critique forms. On average, critique forms were 24 days late causing unnecessary delays in the exam.

b. Consistent delays necessitated the implementation of weekly status calls with the Company to obtain needed information and updates on requests.

This accounts for 58 violations of Neb. Rev. Stat. § 44-1524 and Neb. Rev. Stat. § 44-1525(11).

2. File Organization

In order to ensure the Company's compliance with Neb. Rev. Stat. § 44-5905(2)(B)(ii), examiners evaluated the file organization, legibility, and structure to ensure records, both paper and electronic, are adequate, accessible, and orderly.

Findings:

The vast majority of claim files were incomplete and did not contain all the information to assess a claim. A total of 16 critique forms were required to obtain a complete response file causing unnecessary delays in the progression of the exam. This accounts for 16 violations of Neb. Rev. Stat. § 44-5905(2)(B)(ii).

3. Documents Reviewed

The Company provided the following documents outlining their policies and procedures:

- Auditing and Monitoring Policies and Procedures – CMP-008
- IFP Clean Claims Prompt Payment of Claims Policy - Policy Number OPS-003
- IFP Provider Directory Standards and Reporting Policy – Policy Number NET-006

Findings:

Based on the multiple findings within the report, the Company did not follow their written policies and procedures within the above noted documents.

4. Third-Party Administrators

The Third-Party Administration Act, Neb. Rev. Stat. § 44-5807(2), establishes the Company is responsible for the competent administration of services provided by third-party administrators (TPAs) on its behalf.

Examiners requested a listing of all third-party administrators (TPAs) contracted to perform claim processing functions.

The Company identified 14 TPAs that were hired for different aspects of claim processing and/or types of claims: Eye Med, HQSI, First Health, Liberty Dental, Med Impact, The Loomis Company ("Loomis"), MRIOA, AIM, HGS, Dr on Demand, Change Healthcare, Multiplan, Optum, and Midlands Choice.

The Company's primary TPA for claims processing is The Loomis Company.

Findings:

Systemic problems between the Company and the TPAs became evident during the examination when numerous claims were discovered to be incorrectly denied. Although exact root causes of all issues could not be determined, key factors became evident to the examiners such as:

- The lack of capacity and deficient technical capability of the primary claim-processing TPA (The Loomis Company)
- Errors and inefficient timing with deliverables to Loomis, from the Company and other TPAs. These deliverables were necessary to process claims correctly and included:
    - Enrollment changes from the Federally Facilitated Marketplace
    - Utilization Management approvals
    - Provider Roster information
    - Required repricing by Midlands Choice for providers in the statewide network

Under Neb. Rev. Stat. § 44-5807(2), the Company is responsible for these systemic errors.

5. Internal Audit of Third-Party Administrator

Neb. Rev. Stat. § 44-5807(3) requires the Company to conduct a review of the operations of the TPA at least semi-annually with at least one such review being an onsite audit of the operations of the TPA.

In order to evaluate the Company's compliance with Neb. Rev. Stat. § 44-5807(3), examiners requested the Company to provide all internal audit reports of third-party administrators.

Finding:

The Company provided one Executive Summary page of an audit for one out of fourteen TPAs (The Loomis Company) for 2021. The Executive Summary simply stated, "No audit findings found".

Over the course of the exam period, the Company was required to perform 56 separate audits of their TPA's; despite providing documentation of only one such audit being performed in that period. The lack of oversight and minimal execution of TPA audits demonstrated the Company's lack of compliance with Neb. Rev. Stat. § 44-5807(2) and (3). This accounts for 55 violations of Neb. Rev. Stat. § 44-5807(2) and (3).

B. POLICYHOLDER SERVICE

1. Online Directory Accuracy

The Nebraska Department of Insurance conducted a review of the Company's online provider directory in response to complaints surrounding the accuracy of whether a provider is in-network or out-of-network. The accuracy of the directory is of utmost importance especially since the Company has "closed network" plans in Nebraska.

The Company began selling ACA individual market coverage in Nebraska in 2020. As required in Nebraska, the Company offered statewide coverage. For the "Statewide" product, the Company used a provider network contracted through Midlands Choice. The Company also offered a "narrow network" product, referred to as "NHN," in the five counties that make up the Omaha and Lincoln metropolitan areas. For the "NHN" product the Company directly contracted with providers. Some providers were in both the Statewide network through Midlands Choice and the NHN network using direct contracts with the Company.

The Company provides provider data to healthcare.gov for shoppers to evaluate whether their preferred providers are in-network. There is also a URL

link to the same provider directory that displays on their website. This information is relied upon by potential policyholders to evaluate whether or not the policies offered by the Company would suit their individual needs; such reliance on an inaccurate list could, and has, led policyholders to believe that they had coverage for various services at various providers when, in fact, they did not. In these instances, policyholders throughout the exam period were shown to be facing large bills for services for which they believed they had coverage.

To evaluate whether a shopper would think a provider is in the Company's network, examiners used provider directory. In the process of the examination, it was discovered the provider search tool displays a smaller population of providers compared to the posted network data on healthcare.gov for shoppers to use. According to the Company, the company online directory is intended to display providers at the location where a member could schedule an appointment. The https://www.healthcare.gov/ website displays providers at all locations (facilities, medical groups) where they would be in-network if they provide a service at that location.

The Company gives providers the option to list themselves as not accepting new patients and separately, gives providers the option to not appear in the provider directory. "Hidden list" providers predominantly include types of providers an insured would not search for, such as phlebotomists and anesthesiologists, but also include primary care physicians and mental health counselors. References to the "hidden list" in this report describe physicians that are listed in the network used to determine network adequacy that people see when shopping for insurance, where those physicians have opted not to appear when an insured searches for a provider using the Company provider search tool.

In plan year 2022, the Company had 31,000 total enrollees in Nebraska, representing almost one third of Nebraska's ACA individual market.[B] This examination focused on the accuracy of the Company's provider online directory and in the following sections of this report, turned to claim denials and member complaints.

a. Online Directory Survey

During the online directory survey, examiners selected 366 providers at random from the comprehensive in-network provider listing of 48,111 for Nebraska. Twenty-five errors were found. The review consisted of:

1. Comparing the Company's online provider directory with the Healthcare.gov website.

[B] Enrollment data at: https://www.cms.gov/research-statistics-data-systems/marketplace-products/2022-marketplace-open-enrollment-period-public-use-files shows Nebraska enrollment of 99,011 for open enrollment in plan year 2022.

2. Calling providers to verify in-network status, location, phone number and practice name.

Ten of these discrepancies were pointed out to the Company through critique forms. All other findings were written up as observations after doing steps 1 and 2. Calls were attempted with all 366 providers. Not all providers could be reached and not all providers were forthcoming; at times, they were hesitant to respond or said to call the insurance company for verification.

Findings:

The Company failed to publish up-to-date, accurate, and complete provider directory information in 25 out of 366 online directory entries surveyed, resulting in an error rate of 6.8%. While this number is not above the 7% figured discussed previously, it is worth noting that being below the error threshold does not absolve the Company of error. These findings account for 25 violations of Neb. Rev. Stat. §44-1525 (1). [C]

b. Reporting Link on Provider Directory

The Company's website contained a reporting link that allows the public to suggest an edit to the provider directory. The Company created this as a way to be notified of inaccurate provider directory information. The link is displayed on every provider listing page.

The examiners requested the information that was collected by the Company through this link for Nebraska consumers as of January 1, 2020. The Company advised the link was not activated until 2022 and 36 suggested edits were submitted by consumers and providers between February 10, 2022, and March 22, 2022. The examiners reviewed the 36 suggested edits to determine if corrections were investigated and whether the directory was updated. It was found that seven suggested edits were not investigated or updated as of June 2022 when examiners inquired about the status of these requested changes.

Findings:

The Company failed to maintain and publish up-to-date, accurate, and complete provider directory information because the Company did not complete a thorough review into reports being made and collected through the company's online reporting link as required by Federal Statute 45 CFR §§ 156.230(b)(2). The Company should have removed inaccurate information within 10 business days of receiving the information

[C] These may also constitute violations of Federal Statute 45 CFR §§ 156.230(b)(2).

according to their IFP Provider Directory Standards Reporting Policy. These findings account for 7 violations of Neb. Rev. Stat. §44-1525(1). [D]

2. **Failure to send Termination Notices**

In three denied claims, the Company failed to provide written notice of cancellation to the insured as required by Neb. Rev. Stat. § 710.04(9).

Findings:

The Company terminated the policies and failed to provide written notice of cancellation to the insured. This accounts for three violations of Neb. Rev. Stat. § 710.04(9).

a. Claim # 213409905 - The members policy was terminated on June 30, 2021, for non-payment. Company documentation in the file notes, *"We are not reflecting a termination notice on file."*

b. Claim # 200112089 – The Company acknowledged, *"Based on the total notification history sent to the subscriber, we are only showing one termination notice sent, dated November 19, 2021, which was for termination of 2022 coverage. We are not reflecting any termination notice sent to subscriber indicating spouse terminated as of January 7, 2020."*

c. Claim # 200632503 - The members policy was terminated on January 7, 2020. Company documentation in the file's notes state, *"We are not reflecting a termination notice prior to that, indicating that a termination notification was not sent regarding spouse terminating as of January 7, 2020."*

3. **Rewards Program**

The Company offered a rewards program to all members to earn up to $500.00. The rewards program was discovered through a consumer complaint. Members could earn $225.00 by signing up for the program, selecting a primary care provider, taking a health survey, opting in to receive communications, and a bonus reward by completing the four actions in the first sixty days of the plan. An additional $275.00 could be earned by checking the member hub throughout the year. Members were to receive reward amounts on a reloadable Visa card sent to them in the mail.

The NDOI received a complaint when the Company advised a consumer the rebate program ended in May 2022 and rebates were no longer offered.

[D] These findings may also constitute violation of Federal Statute 45 CFR §§ 156.230(b)(2)

In response to the complaint, the Company stated in part: *"The rewards program was not discontinued; the first part of the rewards was completed at the beginning of the year and the second part was opened starting in November."*

The Department requested the Company provide rationale as to why this program would not be classified as a rebate, and to identify which exception under Neb. Rev. Stat. §44-361 it believed the program falls under to not be considered a rebate.

In response, the Company stated in part:

"Additionally, this is not a rebate program, it was a rewards program and there are no exceptions under Nebraska Statute § 44-361. All members had the same opportunity to complete their rewards and they all had 60 days after their termination date to use the funds on the card. Bright Health discontinued the Reward Program in 2022 for all Bright Health members and no exceptions can be made to add a reward or funds."

Examiners requested the Company provide the exact number of Nebraska members who enrolled in the Rewards program per plan year. In response, the Company stated the program was available in 2020, 2021 and 2022, and provided the following number of enrollees:

- 2020 – 984
- 2021 – 19,311
- 2022 – 15,389

Findings:

The Company did not provide any support to justify their Rewards Program can be defined as an exception to Neb. Rev. Stat. § 44-361, therefore it is considered a violation of the rebate law. This accounts for one violation of Neb. Rev. Stat. § 44-361.

C. CLAIMS-HANDLING PRACTICES

In order to ensure the Company's compliance with Neb. Rev. Stat. § 44 -1540(4), examiners reviewed claims handling practices of the Company to determine efficiency of handling, accuracy of payment, adherence to contract provisions, and compliance with applicable Nebraska statutes and Nebraska Department of Insurance regulations.

Examiners reviewed the duration of time the Company used to investigate the claim and the amount of time to make payment or provide a written denial. Neb. Rev. Stat. § 44 -8004(1) defines a reasonable duration of time for claim-handling as follows: A clean claim must be paid, denied, or settled within thirty calendar days after receipt by the company if submitted electronically and within forty-five calendar days after receipt if submitted in a form other than electronically.

If the Company fails to pay or settle a clean claim within this time period, Neb. Rev. Stat. § 44–8005(1) requires the Company to pay interest at the rate of twelve percent per annum on the total amount allowed on the claim.

Additionally, Neb. Rev. Stat. § 44-1540(13) requires the Company in a denial of a claim to promptly provide a reasonable and accurate explanation for such action if a claim is denied on the grounds of specific policy provision or exclusion.

In addition, 210 Neb. Admin. Code, Ch 61 § 008.04 requires the Company to provide the insured an Explanation of Benefits (EOB) that shall include the name of the provider or services covered, amount charged, dates of service, and a reasonable explanation of the computation of benefits.

Number of denied claim files reviewed	Number of files found in error	Error ratio
102	46	45%

1. Incorrectly Denied Claims

A total of 102 denied claims were reviewed. Due to trends identified in the examination, the focus shifted to specific denial codes.

Attached are examples of the responses from the Company acknowledging the improper denial trends. Additional Company admissions of improper denials are available upon request.

- Claims incorrectly denied as being out-of-network due to systemic network issues
- Claims incorrectly denied for "re-submit for repricing" when the claim had already been submitted for repricing

- Claims incorrectly denied for no prior authorization when prior authorization was previously obtained
- Claims incorrectly denied for newborn services within the first 31 days
- Claims incorrectly denied for "no coverage in effect" for claimant
- Clean claims incorrectly denied due to the provider record not being uploaded timely with the TPA
- Claims incorrectly denied due to an adjustor error

Findings:

a. Out of the 102 claims reviewed, it was found in 46 instances, the Company did not attempt in good faith to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear. This represents an error rate of 45%, well above the 7% required to indicate a general business practice. This accounts for 46 violations of Neb. Rev. Stat. § 44-1540(4).

b. In one instance of the original sample of 102, the Company failed to pay newborn services that occurred within the first 31 days of the birth. While this accounts for one violation of Neb. Rev. Stat. § 44-710.19, this issue was subsequently explored in greater detail through a critique form, uncovering a total of 162 instances of the Company failing to pay newborn claims. These are discussed later in the additional findings section.

Claim files identified as being incorrectly denied:

1. Claim #216768719 - The claim was identified as a systemic error in the processing of chiropractic claims. The claim was reprocessed and payment with interest was sent to the provider.
2. Claim #211100364 – The Company failed to pay the newborn services that occurred within the first 31 days of the birth. This claim was resubmitted and paid. However, the Company failed to pay interest until the claim was reviewed a third time. This is in violation of Neb. Rev. Stat. § 44-710.19.[E]
3. Claim #216184769 – The claim was identified as a systemic error in the processing of chiropractic claims. The claim was reprocessed and payment with interest was sent to the provider.
4. Claim #200105619 – The Company uploaded the provider record on April 8, 2020 but did not transmit to the third-party administrator until June 24, 2020. The Company acknowledged the claim should not have been denied. The claim was paid under a new claim number after the provider re-submitted the claim. The

[E] Refer to Table 2 - Summary of the newborn reprocessing project

examiner requested all claims denied for the same reason be reviewed. *This resulted in additional denied claims being reprocessed and paid for this provider.* [F]

5. Claim #220661669 – On April 4, 2022, the provider requested the claim be reprocessed. In the call log, the service representative advised the provider to allow up to 60 business days to reprocess. On July 12, 2022, the Company acknowledged the claim should have been reprocessed. After a final request from the examiner, the claim was reprocessed and payment with interest was sent to the provider on August 8, 2022.
6. Claim #213463359 – The claim was identified as a systemic error in the processing of chiropractic claims. On March 3, 2022, the provider requested the claim be reprocessed. The claim was reprocessed on July 21, 2022. The payment went to cost sharing; therefore, no interest was due.
7. Claim #213462192 – The claim was incorrectly denied for no record of preauthorization. It was determined that the claim did not require pre-authorization. This claim was reprocessed with interest. *There were four additional claims discovered and reprocessed.* [F]
8. Claim #216799011 - The claim was identified as a systemic error in the processing of chiropractic claims. The claim was reprocessed, and payment with interest was sent to the provider.
9. Claim #214049892 - The provider submitted a dispute on December 15, 2021, and the company upheld the incorrect denial decision. The examiner identified the repricing had been received and was in the claim file. The claim was reprocessed and payment with interest was sent to the provider.
10. Claim #201682923- Prior authorization was approved on November 18, 2020, for a date of service on December 2, 2020. The explanation of benefits statements incorrectly stated, *"no record of pre-authorization for these services"*. The claim was reprocessed and payment with interest was sent to the provider.
11. Claim #200342184 - The claim was resubmitted and denied twice incorrectly. The claim was reprocessed and payment with interest was sent to the provider.
12. Claim #220445151 – The claim was resubmitted by the provider and processed under a different claim number. The Company acknowledged the original claim should have been paid. The claim was reprocessed to include an interest payment that was sent to the provider.

[F] Refer to Table 1 – Summary of additional reprocessed claims

13. Claim #220060672 – The claim was not processed under the correct plan year or network. As a result, the claim was incorrectly denied due to the incorrect information when the member had active coverage. The claim was reprocessed and payment with interest was sent to the provider. *There were additional claims identified for the same provider for the same reason. Interest was paid on all additional claims.*[G]
14. Claim #220567684 – The member had active coverage, but the claim was denied using an incorrect cancelled policy number. The Company did not identify the active coverage. The claim was reprocessed and payment with interest was sent to the provider.
15. Claim #216912349 - The claim was identified as a systemic error in the processing of chiropractic claims. The original claim was reprocessed under a different claim number. The claim was reprocessed and payment with interest was sent to the provider.
16. Claim #221477849 – The claim was denied after an error in determining eligibility between networks. This resulted in the reprocessing of denied claims for a member and dependents with active coverage. The claim was reprocessed and payment with interest was sent to the provider.
17. Claim #220930662 – The claim was incorrectly processed under a prior plan year. The Company acknowledged the error, and the claim was reprocessed under a new claim number. The payment went to cost sharing.
18. Claim #213332843 - The claim was identified as a systemic error in the processing of chiropractic claims. The claim was reprocessed, and payment went to cost sharing, therefore no interest was due.
19. Claim #216216257 - The claim was identified as a systemic error in the processing of chiropractic claims. The claim was reprocessed, and payment went to cost sharing, therefore no interest was due.
20. Claim #200111377 – The Company acknowledged the denial was in error. The third-party administrator did not have the provider records to correctly process the claim. The claim was reprocessed and payment with interest was sent to the provider. *Additional claims were identified to be reprocessed.* [G]
21. Claim #220641295 – The adjustor failed to manually enter the provider into the claim system which resulted in the claim being denied. The claim was reprocessed. The Company acknowledged when a provider submits a claim for the first time, the adjustor needs to manually enter the provider into the system.

[G] Refer to Table 1 – Summary of additional reprocessed claims

The examiner requested all denied claims for this same provider be reviewed. *This resulted in additional denied claims being reprocessed and paid.* [H]

22. Claim 213278786 – The claim was incorrectly denied because it was processed under the incorrect policy number due to error on behalf of the Company. The claim was reprocessed and payment with interest was sent to the provider.
23. Claim #216106034 - The claim was identified as a systemic error in the processing of chiropractic claims. The claim was reprocessed, and payment went to cost sharing, therefore no interest was due.
24. Claim #221206734 – The claim denial did not instruct the provider to resubmit to the correct network for repricing which resulted in the member incorrectly owing the billed amount. Eventually, the claim was resubmitted which resulted in a zero-amount due for the member.
25. Claim #220683818 - The claim was reprocessed, and payment was sent to the provider. Additional claims had to be reprocessed; however, the company failed to pay interest. *All claims were reprocessed a third time to pay interest.* [H]
26. Claim #2100234432 - This claim was reprocessed a third time and payment with interest was sent to the provider. *Additional claims were identified and reprocessed.* [H]
27. Claim #216501326 – The claim was incorrectly denied as out-of-network and was charging the member the full billed amount. It was reprocessed 8 months later and paid to the provider without interest which resulted in a $0 amount due for the member. After the second reprocessing, the provider received interest due.
28. Claim #200291005 - The claim denial did not instruct the provider to resubmit to the correct network for repricing which resulted in the member incorrectly owing the billed amount. The claim was paid with interest.
29. Claim #221055474 – The claim was reprocessed and a payment with interest was sent to the provider. *Additional claims were identified and paid with interest.* [H]
30. Claim #200112440 - The claim was initially denied after 20 days from receipt due to incorrect coding. The claim was reprocessed under a different claim number. Payment was sent to the provider. *Additional claims were identified and paid.* [H]
31. Claim # 211705118 - The claim was reprocessed and payment with interest was sent to the provider.

[H] Refer to Table 1 – Summary of additional reprocessed claims

32. Claim #211212240 - The claim denial did not instruct the provider to resubmit to the correct network for repricing which resulted in the member incorrectly owing the billed amount. The claim was resubmitted, and payment was sent to the provider. *Additional claims were identified and paid.*[1]
33. Claim #212675760– The Company did not update the online directory in a timely manner to show the provider was no longer in network. The claim was denied but the Company acknowledges it should have been paid based on the policyholder relying on the information. The claim was resubmitted and paid under a different claim number. *Additional claims were paid based on the same error for this provider.*[1]
34. Claim #200342266 - The claim denial did not instruct the provider to resubmit to the correct network for repricing which incorrectly reflected the member owing the billed amount. A*dditional claims were identified and reprocessed.*[1]
35. Claim #220894079 – The provider was showing "in-network" in the Company's online directory. The Company did not update the online directory in a timely manner to show the provider was no longer in network. The claim was denied but the Company acknowledges it should have been paid based on the policyholder relying on the information. The claim was reprocessed and payment with interest was sent to the provider.
36. Claim #216799067 – The claim was identified as a systemic error in the processing of chiropractic claims. On May 9, 2020, the provider submitted the claim. The claim was reprocessed on July 22, 2022. The payment went to cost sharing. *Additional claims were identified for the same provider and reprocessed.*[1]
37. Claim #211182585 – The Company acknowledged the claim was denied in error. The claim was reprocessed and a payment with interest was sent to the provider. *Additional claims were identified for the same provider and reprocessed.*[1]
38. Claim #220531990 - The member was showing in the wrong network in the Company system. The Company acknowledged the error and reprocessed the claim. Payment was sent to the provider. *Additional claims for this provider were identified and paid* [1]
39. Claim #216768665 - The claim was reprocessed and payment with interest was sent to the provider.
40. Claim #216238542 – The claim was identified as a systemic error in the processing of chiropractic claims. The claim was reprocessed and payment with interest was sent to the provider.

[1] Refer to Table 1 – Summary of additional reprocessed claims

41. Claim #211312237 –The claim was reprocessed and payment with interest was sent to the provider. *Additional denied claims for this provider were identified and reprocessed.* [J]
42. Claim #210395831 –The claim was reprocessed. The payment went to cost sharing.
43. Claim #216655438 – The claim was identified as a systemic error in the processing of chiropractic claims. The claim was reprocessed. Payment with interest was sent to the provider.
44. Claim #200382879 - The Company acknowledged the provider was an in-network provider. The claim was reprocessed and payment with interest was sent to the provider. *Additional denied claims for this provider were identified and reprocessed.* [J]
45. Claim #220759971 - The error stemmed from a plan change due to the member's Advanced Premium Tax Credit. The claim was reprocessed and a payment with interest was sent to the provider.
46. Claim #217089928 - The claim was reprocessed and a payment with interest was sent to the provider.

[J] Refer to Table 1 – Summary of additional reprocessed claims

2. Failure to process claims in timely manner

In order to ensure compliance with Neb. Rev. Stat. § 44-1540(3), Neb. Rev. Stat. § 44-8008, Neb. Rev. Stat. § 44-8004(1) and 210 Neb. Admin. Code, Ch. 61§ 008.02, examiners reviewed the claim files for timely-handling and delay notifications. The Company acknowledged they do not send out delay letters as required by 210 Neb. Admin. Code Ch. 61 § 008.02.

Findings:

a. In 25 instances, the Company failed to process an initial claim within 30 days for electronic claims and within 45 days if submitted in a form other than electronically. This accounts for 25 violations of Neb. Rev. Stat. § 44-8004(1). *(Column 3)*

b. In 25 instances, the Company failed to send a delay letter. When examiners inquired about delay letters, the written response from the Company stated, *"No, a delay letter was not sent to the claimant, as required pursuant to Section 008.02 of, Chapter 60, Title 210. Bright Health has not historically sent out delay letters."* This accounts for 25 violations of 210 Neb. Admin. Code, Ch. 61§ 008.02.

c. In 41 additional instances, the company failed to reprocess a clean claim within 30 days for electronic claims and within 45 days if submitted in a form other than electronically. This accounts for 41 violations of Neb. Rev. Stat. § 44-8004(1). *(Column 4)*

Claim File Number	Claim number	*(Column 3)* Number of days beyond 30 the company failed to process the initial clean claim	*(Column 4)* Number of days beyond 30 to correctly reprocess and pay the clean claim
1	216768719	N/A	222
3	216184769	N/A	224
9	220601938	N/A	15
14	220661669	44	145
19	213463359	96	328
23	210056650	69	N/A
24	211549841	201	N/A
26	210368528	25	N/A
29	213462192	N/A	545
30	216799011	N/A	45
32	214049892	N/A	425
33	201682923	N/A	270
34	200342184	N/A	812

Claim File Number	Claim number	*(Column 3)* Number of days beyond 30 the company failed to process the initial clean claim	*(Column 4)* Number of days beyond 30 to correctly reprocess and pay the clean claim
35	212658316	76	N/A
36	220445151	26	44
37	220060672	N/A	208
39	220567684	N/A	243
40	216912349	N/A	198
41	221477849	N/A	161
42	220930662	N/A	67
44	213332843	103	320
48	216216257	N/A	231
49	210929680	30	N/A
50	200111377	N/A	895
51	220641295	N/A	136
53	213278786	N/A	324
54	216106034	N/A	293
55	214199452	10	N/A
60	220683818	20	217
61	210023443	N/A	598
62	216501326	N/A	180
63	200291005	N/A	870
64	221055474	15	220
67	200112440	20	171
68	211705118	204	490
69	211212240	17	N/A
70	212675760	115*	N/A
72	220894079	N/A	206
73	216799067	N/A	203
74	211828585	N/A	181
75	220531990	20	236
76	216768665	N/A	208
77	213902255	54	N/A
78	216238542	N/A	269
79	211312237	205	520
81	210395831	N/A	316*
82	216655438	N/A	248
83	220609726	16	N/A
84	213711242	66	N/A
85	200382879	N/A	916
86	216044327	13	N/A
87	213941003	20	N/A

Claim File Number	Claim number	*(Column 3)* Number of days beyond 30 the company failed to process the initial clean claim	*(Column 4)* Number of days beyond 30 to correctly reprocess and pay the clean claim
90	220759971	N/A	210
92	220277173	8	N/A
95	217089928	N/A	368
97	200953543	1	N/A

**These claims have been identified as being submitted in a form other than electronic and granted 45 days.*

3. Failure to pay interest on reprocessed claims

In accordance with Neb. Rev. Stat. § 44-8008 and Neb. Rev. Stat. § 44–8006 health insurers shall be exempt from paying interest if the Prompt Payment Act Compliance Statement is signed and filed with the Director of Insurance. Since the Company failed to sign a certificate of compliance statement, they must comply with Neb. Rev. Stat. § 44-8005(1). This statute requires insurers that fail to pay, deny, or settle a clean claim in accordance with the time period in section Neb. Rev. Stat. § 44-8004 shall pay interest at the rate of twelve percent per annum on the total amount allowed on the claim, accruing from the date payment was due.

Findings:
In 26 out of 46 instances (representing an error rate of 57%), the Company failed to pay interest on the claims that were not correctly paid or reprocessed within the required time. This accounts for 26 violations of Neb. Rev. Stat. § 44-8005(1).

Claim File Number	Claim Number
30	216799011
32	214049892
33	201682923
34	200342184
36	220445151
37	220060672
39	220567684
50	200111377
53	213278786
61	210023443
62	216501326
64	221055474
67	200112440
68	211705118
70	212675760
72	220894079
73	216799067
74	211828585
76	216768665
78	216238542
79	211312237
82	216655438
83	221794279
85	200382879
90	220759971
95	217089928

4. **Failure to provide a reasonable description (EOBs)**

In order to ensure compliance with Neb. Rev. Stat. § 44-1540(13) and 210 Neb. Admin. Code, Ch 61 § 008.04, examiners reviewed the Explanation of Benefits (EOBs) for the 102 denied claims and 50 reprocessed claims.

Number of EOBs reviewed	Number of EOBs found in error	Error ratio
152	89	59%

Findings:

The Company failed to provide the claimant an Explanation of Benefits (EOB) that included a reasonable explanation of computation of benefits and additionally failed, in cases of the denial of a claim, to promptly provide a reasonable and accurate explanation of the basis for such action. This accounts for 89 violations of Neb. Rev. Stat. § 44-1540(13) and 210 Neb. Admin. Code, Ch 61 § 008.04.

Examples of EOB errors are listed:

- In 24 instances, the Company produced an EOB with a zero-balance due when the claim was denied for out-of-network or no active coverage. When the exam team inquired about the errors, the Company advised it identified 3,481 claims with the zero-balance due to an EOB processing error. The EOBs are being corrected by reprocessing them on a case-by-case basis as they are brought to the attention of the company via the contact center or as an appeal.

- In 5 instances, the Company failed to provide a reasonable explanation of the computation of benefits.

- In 4 instances, the Company failed to provide an accurate benefit description. For example, EOBs indicated HOS MISC FEE and SPECIAL SVCS as a benefit description.

- In 6 instances, the company failed to provide a clear and accurate denial explanation within the remarks of the EOB.

- In 11 instances, the EOB should have said, "resubmit to the correct network for repricing" with no balance due. However, it said, "services rendered by out-of-network provider" and the member incorrectly owed the entire amount. This was identified by examiners as a systemic issue and over 500 additional EOBs had to be reissued.

- In 39 instances, the EOB stated "No Coverage" or "Not Covered" in the benefit description. This is not an adequate benefit description or a denial reason.

- A source of inaccuracies on 135 out of 152 EOBs sampled was caused by the way the Company displayed the name of the provider. The 135 EOBs for professional services incorrectly displayed the name of the medical office as the provider instead of the name of the healthcare professional. This is not considered a violation; however, it is not considered in the policyholder's best interest. [K]

[K] Claims denied for this reason have been captured as violations in other areas of this report.

Table 1 - Summary of Additional Reprocessed Claims

During the review of 102 denied claims, when examiners discovered the claim was denied incorrectly and the Company reprocessed the claim, a list of additional claims denied for the same reason and the same provider were submitted to the Company for review. Despite being notified of these errors, the Company was not proactive in identifying when an error was systemic and instead only fixed one claim at a time when it was brought to their attention. In these instances, the Company had to be prompted to reprocess the additional claims. The table reflects the additional claims the Company reprocessed based on the review of denied claims.

Findings:

a. In 1,408 instances, the Company did not attempt in good faith to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear. This accounts for 1,408 violations of Neb. Rev. Stat. § 44-1540(4).

b. In 39 instances, the Company failed to pay interest on claims that were not reprocessed within the required time. This accounts for 39 violations of Neb. Rev. Stat. § 44-8005(1).

c. In 1,408 instances, the company failed to process a clean claim within 30 days for electronic claims and within 45 days after receipt if submitted in a form other than electronically. This accounts for 1,408 violations of Neb. Rev. Stat. § 44-8004(1).

Claim File Number	Number of claims paid in addition to the original claim	Total Amount Paid	Number of violations of Neb. Rev. Stat. § 44-1540(4)	Number of violations of Neb. Rev. Stat. § 44-8005(1)	Number of violations of Neb. Rev. Stat. § 44-8004(1)
11	18	$328.10	18	N/A	18
29	4	$2213.73	4	N/A	4
37	5	$809.85	5	5	5
50	11	$9,909.07	11	N/A	11
51	192	$24,305.85	192	N/A	192
60	11	$381.00	11	11	11
61	23	$5,263.68	23	17	23
64	154	$39,800.00	154	N/A	154
67	6	$67.64	6	6	6
69	104	$82,020.67	104	N/A	104
70	36	$3,106.31	36	N/A	36
71	79	$75,734.45	79	N/A	79
73	1	$41.08	1	N/A	1
74	24	$6,331.75	24	N/A	24
75	32	$3,103.82	32	N/A	32
79	655	$90,174.87	655	N/A	655
85	53	$11,694.57	53	N/A	53
Totals	**1,408**	**$355,286.44**	**1,408**	**39**	**1,408**

5. Survey of Reprocessed Claims

Examiners reviewed a total of 50 reprocessed claims sampled from the reprocessed projects listed below:

- Newborn – 20 reprocessed claims
- Chiropractic – 6 reprocessed claims
- Behavioral Health – 7 reprocessed claims
- Network – 14 reprocessed claims
- In-Office Lab – 3 reprocessed claims

Findings resulting from the review of the reprocessed claims are listed within each respective reprocessing project.

a. Newborn Reprocessed Claims

During the on-site visit, examiners discovered newborn claims were being improperly denied. The Company advised they became aware of the error in July of 2021 and changed the language in their procedures to comply with Neb. Rev. Stat. § 44-710.19. Neb. Rev. Stat. § 44-710.19 requires that any insurance policy in force shall provide benefits for the newly born child of the insured or subscriber from the moment of birth through the first 31 days. Although the Company became aware of the error in July 2021, the Company did not attempt to correct claims that occurred prior to July of 2021. The exam team requested the universe of all newborn claims denied under the "BN" code. The "BN" code states, *"no enrollment on file for newborn"*. In October 2022, the Company produced a claims impact report identifying 144 Nebraska claims. Only 88 of the 144 were reprocessed. The Nebraska DOI required a notification letter be sent to all the impacted claimants. The Company did not comply with the request until October 6, 2022 and provided a draft of the letter that was sent. The Company stated they did not send the letter to all affected policyholders.

Findings:

Based on the newborn impact report (see Table 2):

- The BN Impact Report consisted of 144 claims with remark code BN. These 144 BN claims were reviewed by the Company and 88 claims were reprocessed and paid with interest in the amount of $100,544.23. This accounted for 88 violations of Neb. Rev. Stat. § 44-1540(4), Neb. Rev. Stat. § 44-710.19 and Neb. Rev. Stat. § 44-8004(1)

- Out of the 88 reprocessed claims, 35 claims had to be reprocessed a second time to include interest. This accounts for 35 violations of Neb. Rev. Stat. § 44-8005(1).
- Next, the examiners' reviewed 20 claim files from the BN Impact Report. Seven files had findings that revealed 28 additional incorrectly denied claims. This accounts for 28 additional violations of Neb. Rev. Stat. § 44-1540(4), Neb. Rev. Stat. § 44-710.19 and Neb. Rev. Stat. § 44-8004(1).

  The seven claim files with findings are noted below:

  1. Claim #210021916 - On the newborn impact report, the Company stated this claim was denied because no delivery date was on file. There were six additional claims for this newborn that were denied for the same reason. Examiners determined the delivery date was in the file and requested the claims be reprocessed a second time. The newborn claim and six additional claims were paid.
  2. Claim #2001660802 –The claim was correctly reprocessed as part of the newborn reprocessing project. However, there were seven additional files that were reprocessed three times incorrectly because they reprocessed under the wrong plan due to an enrollment change. All seven claims were reprocessed a fourth time resulting in payment with interest.
  3. Claim #210182563 - This claim was correctly reprocessed, however there were four additional claims for this same member that were reprocessed incorrectly. Three of the reprocessed claims did not have interest. The fourth reprocessed claim incorrectly denied a second time. The fourth claim was reprocessed a third time and payment with interest was sent to the provider.
  4. Claim #210168327 - This claim was correctly denied for no active coverage for a date of service January 5, 2021. However, two additional reprocessed claims with dates of service in December 2020 were incorrectly denied and had to be reprocessed a second time because coverage was active in 2020. One claim went to the deductible and one preventative service was paid with interest.
  5. Claim #201348850 - The newborn impact report showed a denial reason *"Newborn was not enrolled, and the DOS was 30 days after their DOB"* for all 10 claims for this newborn. The claim file clearly showed the baby's date of birth was within the first 31 days of each claim. It took over two years to get the claims reprocessed and paid, with interest.

6. Claim # 200549959 – The claim was denied for the newborn not being enrolled under the subscriber's plan. The member at the time was in a grace period and made a payment which covered the date of service. The claim was reprocessed and paid after examiners notified the Company of the error. A payment was sent to the provider.
7. Claim #210509544 - Claim was reprocessed and denied incorrectly for no pre-authorization. The claim was reprocessed a second time to pay interest. The Company acknowledged "No pre-authorization on file or needed for a healthy baby." However, the Company advised *"No payment will issue because provider was overpaid on past claims, as such this payment is being withheld to recover those over payments."* The Company has not been able to provide proof of overpayment. Payment of this claim is currently being withheld by the Company.

b. Chiropractic Reprocessed Claims

Examiners were advised during an on-site visit that a specific chiropractor network was incorrectly denied as out-of-network. It was determined 3,610 impacted claims were repriced on January 10, 2022, but still needed to be reprocessed. The Company advised the majority of the claims had not been reprocessed as of July 13, 2022. The exam team learned the Company and third-party administrator (Loomis) were still working on how to prioritize the reprocessing of the remaining claims since it would involve a manual process. The Company provided a report of impacted claims (Referred to by the Company as "impact reports") on October 3, 2022.

Six reprocessed claim files were sampled from the report and there were no findings. However, the findings discovered elsewhere in the impact report are noted below.

Findings:

Based on the Chiropractic impact report (see Table 2):

- 3,610 claims were impacted which resulted in 1,710 claims being paid with interest in the amount of $153,338.51.
- Out of the 1,710 claims 453 claims had to be reprocessed a second time to include interest. This accounts for 453 violations of Neb. Rev. Stat. § 44-8005(1).
- Additionally, 168 were not reprocessed. The 168 had to be reprocessed and 96 claims were paid with interest. The 96

claims paid added to the 1,710 claims bring the total to a minimum of 1,806 claims being denied incorrectly. This accounts for 1,806 violations of Neb. Rev. Stat. § 44-1540(4) and Neb. Rev. Stat. § 44-8004(1).

c. Behavioral Health Reprocessed Claims

During an on-site visit, examiners were informed the Company worked with the rental network, Midlands Choice, to review a group of providers that were concerned due to delays in payment of their claims. The examiners were advised approximately 80 claims were impacted. However, the impact report contained multiple duplicates. When duplicates were removed, the number of claims impacted was reduced from 79 to 38.

The Company contracted with TPA Evolent Health, LLC (Evolent) to complete a review of the claims for this provider. It resulted in over 600 claims being reprocessed which was part of the Evolent report.

Findings:

- Examiners reviewed seven reprocessed claims and discovered the Company failed to pay interest on all seven claims. This accounts for seven violations of Neb. Rev. Stat. § 44-1540(4), Neb. Rev. Stat. § 44-8005(1) and Neb. Rev. Stat. § 44-8004(1).
- The impact report listed an additional 31 claims that did not include interest. This accounts for 31 violations of Neb. Rev. Stat. § 44-1540(4), Neb. Rev. Stat. § 44-8005(1) and Neb. Rev. Stat. § 44-8004(1).

d. Network Reprocessed Claims

Examiners discovered errors in denied claims based on various issues regarding the Company's two networks. The exam team requested the Company conduct an analysis of claims incorrectly denied for out-of-network. The Company provided the following impact report:

Fourteen reprocessed claim files were reviewed from the network impact report. No findings were discovered in the fourteen reprocessed files. However, the findings discovered in the impact report are noted below.

Findings:

Based on the network impact report (see Table 2):

- 515 claims out of the 1,130 were incorrectly denied for out-of-network. The 515 claims had to be reprocessed and paid. This accounts for 515 violations of Neb. Rev. Stat. § 44-1540(4).
- An additional, 500 claims out of the 1,130 should have advised the provider to resubmit for repricing. Instead, the 500 claims were incorrectly denied for out-of-network. This accounts for 500 violations of Neb. Rev. Stat. § 44-1540(4).
- 41 claims had to be reprocessed a second time to include interest. This accounts for 41 violations of Neb. Rev. Stat. § 44-8005(1).
- 1,015 claims were not processed timely as required by Neb. Rev. Stat. § 44-8004(1). This accounts for 1,015 violations of Neb. Rev. Stat. § 44-8004(1).

e. In-Office Lab Reprocessed Claims

The Company identified in-office lab claims were being incorrectly denied. The issue was identified at the end of July 2022 and posted on the Company website. The Company website advised the claims would be fixed and instructed providers to not file disputes. However, the date to fix the issue was continually extended by the Company. These actions by the Company attempted to circumvent the provider dispute process, which is in place to protect not only the providers, but also the policyholders affected by adverse determinations and denials. A report of claims impacted was requested and included a total of 740 Nebraska claims.

Three reprocessed in-office lab claim files were reviewed.

Findings:

Based on the review of the three reprocessed claim files:

- One additional claim was discovered and reprocessed. Payment with interest was sent to provider. This accounts for one violation of Neb. Rev. Stat. § 44-1540(4), and Neb. Rev. Stat. § 44-8004(1).

Based on the in-office lab impact report (see Table 2):

- 411 claims out of the 740 were incorrectly denied. The claims were reprocessed and paid with interest. This accounts for 411 violations of Neb. Rev. Stat. § 44-1540(4) and Neb. Rev. Stat. § 44-8004(1).

Table 2 - Summary of Reprocessing Projects

Reprocessed Projects	Number of reprocessed claims	Total Amount Paid	Number of violations of Neb. Rev. Stat. § 44-1540(4)	Number of violations of Neb. Rev. Stat. § 44-8005(1)	Number of violations of Neb. Rev. Stat. § 44-8004(1)	Number of violations of Neb. Rev. Stat. § 44-710.19
Behavioral Health	38	$267.51	38	38	38	N/A
Chiropractic	1,806	$153,338.51	1,806	453	1,806	N/A
Network	515	$145,925.25	1,015	41	1,015	N/A
In-Office Lab	412	$670,305.11	412	N/A	412	N/A
Newborn	116	$111,170.68	116	35	116	116
Totals	**2,887**	**$1,081,007.06**	**3,387**	**567**	**3,387**	**116**

Note: There were multiple times examiners identified inconsistencies and omissions within the impact reports. It was evident the information was not reviewed prior to being sent to the exam team. Therefore, the exam team cannot confirm the accuracy of the information within each of the impacted claim listings.

D. SUPPLEMENTAL FINDINGS

The Supplemental Findings section of this report provides information on additional findings that were discovered by the **Insurance Department's Complaint Division.**

1. Department of Insurance Complaints

A total of 91 complaints were handled during the exam. The 91 complaints included 429 claims that were overturned with a total payment of $1,241,723.11.

Findings:

Based on the review of complaints (see table 3):

- 417 claims had to be reprocessed and paid. This accounts for 417 violations of Neb. Rev. Stat. § 44-1540(4).
- The company failed to respond timely in 68 instances regarding complaints. This caused unnecessary delays in the resolution of these complaints which accounts for 68 violations of Neb. Rev. Stat. § 44-1525(11).
- 339 claims were not processed timely as required by Neb. Rev. Stat. § 44-8004(1). This accounts for 339 violations of Neb. Rev. Stat. § 44-8004(1).
- In 13 instances, the Company failed to pay newborn services that occurred within the first 31 days of the birth. This accounts for 13 violations of Neb. Rev. Stat. § 44-710.19.

Table 3 - Summary of Complaint Findings

Complaint Tracking ID	**Company admission of error	Number of claims overturned	Total Amount Recovered for Consumer	Number of violations of Neb. Rev. Stat. § 44-1540(4)	Number of violations of Neb. Rev. Stat. § 44-8004(1)	Number of violations of Neb. Rev. Stat. § 44-1525(11)	Number of violations of Neb. Rev. Stat. § 44-710.19
30920	Yes	10	$1,600.00	10	10	3	N/A
30986	Yes	4	$6,296.47	4	4	2	4
31047	Yes	1	$448.11	1	1	2	N/A
31106	Yes	2	$880.00	2	2	N/A	N/A
31199	Yes	2	$368.00	2	2	N/A	N/A
31218	Yes	2	$3,715.07	2	2	2	N/A

Complaint Tracking ID	**Company admission of error	Number of claims overturned	Total Amount Recovered for Consumer	Number of violations of Neb. Rev. Stat. § 44-1540(4)	Number of violations of Neb. Rev. Stat. § 44-8004(1)	Number of violations of Neb. Rev. Stat. § 44-1525(11)	Number of violations of Neb. Rev. Stat. § 44-710.19
31219	Yes	7	$8,975.44	7	7	N/A	N/A
31255	Yes	1	$1,019.00	1	1	1	N/A
31297	Yes	2	$350.00	2	2	1	N/A
31341	Yes	1	$376.30	1	1	1	N/A
31351	Yes	9	$1,954.43	9	9	N/A	N/A
31402	Yes	N/A	N/A	N/A	N/A	2	N/A
31436	Yes	3	$12,317.85	3	3	N/A	N/A
31437	Yes	1	$488.61	1	1	3	N/A
31475	Yes	15	$2,020.00	15	14	N/A	N/A
31479	Yes	9	$1245.10	9	5	1	N/A
31579	Yes	13	$3,171.52	13	7	1	N/A
31584	Yes	1	$100.00	1	1	N/A	N/A
31627	Yes	6	$2,850.65	6	3	1	N/A
31650	Yes	1	$140.00	1	1	1	N/A
31659	Yes	1	$488.61	1	1	N/A	N/A
31685	Yes	1	$1,266.16	1	1	N/A	N/A
31692	Yes	1	$48.69	1	1	N/A	N/A
31723	Yes	7	$3,274.35	7	6	1	N/A
31743	Yes	N/A	N/A	N/A	N/A	1	N/A
31781	Yes	2	$5,766.00	2	2	1	N/A
31848	Yes	2	$3,616.00	2	1	1	N/A
31853	Yes	2	$76.73	2	2	N/A	N/A
31902	Yes	1	$1,500.00	1	N/A	N/A	N/A
31973	Yes	N/A	N/A	N/A	N/A	1	N/A
31982	Yes	2	$303.59	2	2	N/A	N/A
31993	Yes	1	$304.00	1	1	1	N/A
32022	Yes	5	$2,506.00	5	5	1	N/A
32216	Yes	9	$3,225.00	9	9	N/A	N/A
32227	Yes	1	$83,512.50	1	1	5	N/A

Complaint Tracking ID	**Company admission of error	Number of claims overturned	Total Amount Recovered for Consumer	Number of violations of Neb. Rev. Stat. § 44-1540(4)	Number of violations of Neb. Rev. Stat. § 44-8004(1)	Number of violations of Neb. Rev. Stat. § 44-1525(11)	Number of violations of Neb. Rev. Stat. § 44-710.19
32228	Yes	15	$237,168.09	15	2	N/A	5
32296	Yes	4	$4,881.81	4	4	N/A	N/A
32309	Yes	1	$50.00	1	1	N/A	N/A
32314	Yes	1	$385.00	1	1	1	N/A
32416	Yes	1	$2,983.67	1	1	N/A	N/A
32496	Yes	14	$2,355.00	14	11	1	N/A
32524	Yes	1	$10,435.62	1	1	N/A	N/A
31816	Yes	2	$115,438.24	2	2	4	N/A
31874	Yes	24	$123,540.59	24	24	N/A	N/A
31912	Yes	2	$1,453.84	2	1	2	N/A
31954	Yes	8	$2,244.43	2	2	1	N/A
31976	Yes	6	$3,031.27	6	6	N/A	N/A
31990	Yes	2	$3,191.58	2	2	1	N/A
32019	Yes	11	$1,942.78	11	11	2	N/A
32132	Yes	2	$3,726	2	2	1	N/A
32207	Yes	2	$150.00	2	2	N/A	N/A
32254	Yes	5	$845.00	5	5	N/A	N/A
32312	Yes	27	$8,475.44	25	25	1	N/A
32339	Yes	N/A	N/A	N/A	N/A	2	N/A
32359	Yes	8	$42,727.90	8	8	3	N/A
32382	Yes	3	$317.71	3	3	N/A	N/A
32394	Yes	1	$217.81	1	1	N/A	N/A
32408	Yes	6	$572.06	6	6	N/A	N/A
32437	Yes	2	$14,766.00	2	2	N/A	N/A
32450	Yes	14	$1,554.14	14	10	N/A	N/A
32493	Yes	1	$385.00	1	1	N/A	N/A
32508	Yes	1	$122.95	1	1	N/A	N/A
32535	Yes	6	$24,485.97	2	1	1	N/A

Complaint Tracking ID	**Company admission of error	Number of claims overturned	Total Amount Recovered for Consumer	Number of violations of Neb. Rev. Stat. § 44-1540(4)	Number of violations of Neb. Rev. Stat. § 44-8004(1)	Number of violations of Neb. Rev. Stat. § 44-1525(11)	Number of violations of Neb. Rev. Stat. § 44-710.19
32537	Yes	6	$1,793.09	6	5	N/A	N/A
32590	Yes	2	$139.00	2	2	N/A	N/A
32663	Yes	1	$50.00	1	1	N/A	N/A
32960	Yes	1	$6,152.00	1	1	N/A	N/A
32848	Yes	1	$340.33	1	N/A	N/A	N/A
32533	Yes	1	$308.46	1	1	N/A	N/A
32791	Yes	4	$618.86	4	3	4	N/A
32962	Yes	1	$1,000.00	1	1	1	N/A
32999	Yes	1	$890.00	1	1	1	N/A
33109	Yes	3	$481.25	3	3	N/A	N/A
33064	Yes	3	$470.68	3	3	N/A	N/A
32721	Yes	1	$19,650.00	1	1	N/A	N/A
32815	Yes	2	$884.25	2	2	N/A	N/A
32624	Yes	13	$131,042.08	13	13	N/A	N/A
32751	Yes	1	$520.26	1	1	N/A	N/A
32585	Yes	1	N/A	1	N/A	1	N/A
32857	Yes	1	$247.00	1	1	N/A	N/A
32991	Yes	9	$274.89	9	9	N/A	N/A
32909	Yes	1	$24.81	1	1	N/A	N/A
31434	Yes	4	$3,419.90	4	4	N/A	N/A
33057	Yes	6	$235,918.43	6	6	1	N/A
32703	Yes	1	$475.00	1	N/A	N/A	N/A
32475	Yes	43	$21,083.10	43	10	2	N/A
33165	Yes	2	$600.00	2	2	N/A	N/A
32840	Yes	2	$1,468.00	2	2	1	N/A
32516	Yes	5	$35,828.64	5	4	4	4
33504	Yes	16	$4,601.00	16	16	N/A	N/A
33549	Yes	2	$11,790.00	2	2	N/A	N/A
TOTALS		**429**	**$1,241,723.11**	**417**	**339**	**68**	**13**

***Exhibits provided upon request*

2. Overpayments Withheld

During the exam, it was discovered the Company was withholding claim payments to providers due to overpayments. When examiners inquired about the overpayments, the Company's response was:

"... the process to be followed by Loomis included a regular review to track payments and release the hold as appropriate. However, in January 2023, Bright became aware that this process was not followed consistently. The withholding process was halted on 02/03/2023 and Bright initiated retroactive processing of claims that required payment."

Based on this discovery, examiners found during claim file reviews, the primary reason for overpayments was due to the Company not coordinating payment of benefits when members had primary and secondary coverage. The Company acknowledged they did not have a Coordination of Benefit (COB) provision except for Medicare prior to January 1, 2022. Examiners noted the following concerns:

- The Company could not produce the original letters which notified the provider of the overpayments.
- The large amount of money being withheld makes it difficult to determine how many future claims will be impacted.
- The Company provided a report outlining alleged overpayments from previous years with Medicare as primary coverage that had not been coordinated and are now being withheld from providers.
- One provider asked for proof of overpayment through the dispute process. The Company upheld its overpayment decision without providing proof of overpayment and provided a blank overpayment notification form implying the provider needs to complete due to overpayment. The provider had no overpayment in their system.

3. Additional Impact Reports

a. Enrollment Impact Report

Insurance Complaint Division (ICD) discovered claims were being incorrectly denied after members made changes to their enrollment.

When the Company received instructions from the Federally Facilitated Marketplace (FFM) regarding member enrollment changes, there were frequent errors and delays when instructions were sent to the claim-handling TPA, Loomis.

The exam team requested the Company provide the following impact report of claims that needed to be reprocessed because the Company failed to provide timely and accurate enrollment instructions to the claim-handling TPA.

Findings:

The enrollment impact report resulted in:

- 1,932 claims were reprocessed which resulted in 1,260 claims being paid with interest in the amount of $644,028.94.
- This accounts for 1,932 violations for Neb. Rev. Stat. § 44-1540(4).
- This accounts for 1,260 violations for Neb. Rev. Stat. § 44-8004(1).

b. Utilization Management (UM) Impact Report

Examiners discovered during claim file reviews and complaint investigations claims were being incorrectly denied for lack of pre-authorization, when pre-authorization was previously approved.

On November 18, 2022, examiners requested an impact report of all claims that were incorrectly denied for no record of pre-authorization.

On March 31, 2023, the Company provided a report titled, UM rework full universe claims impact report. The Company stated, *"The UM rework project is a comparison of the denied UM claims universe, and the authorization approval numbers. Any claim that was incorrectly denied when an authorization was on file, or an authorization was granted after the claim was processed, would be in the scope."*

Findings:

- 2,185 claims were impacted which resulted in 1,787 claims being paid in the amount of $7,888,003.34.
- Out of the 1,787 claims, interest was paid on 1,418 claims.
- This accounts for 2,185 violations of Neb. Rev. Stat. § 44-1540(4) and 1,418 violations of Neb. Rev. Stat. § 44-8004(1).

c. Ambulance – Systemic errors with air and mobile ambulance claims were identified through consumer complaints. The Company advised the root cause of the issue was due to a change in the Company reimbursement tables for Nebraska. This change impacted plan years 2021 and 2022. The ambulance claims should have triggered a $0

reimbursement for ground/air ambulance which would have directed the claims to a processor for manual adjustment. However, the manual review was bypassed and allowed the system to adjudicate payment incorrectly. Based on the Company's response, the claims for 2020 were not impacted and used the correct rate table with CMS guidelines for the reimbursement. A total of five reports were provided to examiners for this project. The reports included a universe report of claims which included 6,285 lines (it appeared there were many duplicate claims listed). Following the universe report, three different iterations of impact reports were provided. An additional separate report was included for the 2020 claims. The examiners cannot confirm the accuracy of the information within each of the claim impact reports. While the Company reprocessed multiple claims, it was difficult to determine the exact number of claims reprocessed due to the number and inconsistency of reports provided.

Findings:

- 618 claims during 2021 and 2022 were impacted and reprocessed during March 2023. 487 of the reprocessed claims resulted in payments, including interest, totaling $530,028.39.
- In a response to an examiner inquiry, two air ambulance claims were reprocessed and paid with interest totaling $118,831 in February 2023 but were not reflected on any of the ambulance reprocessing reports.
- The systemic ambulance claims error account for 620 violations of Neb. Rev. Stat. § 44-1540(4) and 482 violations of Neb. Rev. Stat. § 44-8004(1).

d. **Mammogram** – It was discovered through two consumer complaints that claims were either incorrectly denied or cost sharing was incorrectly applied. The Department requested a claims universe report for women ages 40-49. The universe of 8,210 claims for the mammogram benefit was received March 23, 2023. On April 28, 2023, an impact report of 47 claims revealed all 47 claims were reprocessed and paid with interest in the amount of $12,696.19. Due to inconsistencies throughout the examination, the exam team cannot confirm the accuracy of the information within each of the impacted claim listings.

Findings:

- This accounts for 47 violations of Neb. Rev. Stat. § 44-1540(4) and Neb. Rev. Stat. 44-8004(4).

e. **Immunizations** – The Company initially reported 2,245 claims required reprocessing as of 12/05/2022. The incorrect denial of the immunization line item in a paid claim became identified through a complaint investigation. Federal regulation 42 U.S. Code § 300gg-13 requires preventive services such as immunizations must be paid at 100% with no cost sharing. The Company was incorrectly processing these claims with cost sharing and exclusions. The Company acknowledged the error with immunization claims became a nationwide issue of approximately 20,000 claims. An impact report of the reprocessed claims for Nebraska was received from the Company. Due to inconsistencies throughout the examination, the exam team cannot confirm the accuracy of the information within each of the impacted claim listings.

Findings:

The Company provided an impact report of claims that required reprocessing. Although most of the claims had been partially paid, the impact report shows 824 claims were reprocessed resulting in a total additional payment amount of $98,791.37.

- This accounts for 824 violations of Neb. Rev. Stat. § 44-1540(4).
- This accounts for 690 violations of Neb. Rev. Stat. § 44-8004(4)

f. **Additional Newborn Claims Overturned** – Through analysis of the various impact reports mentioned above, and consumer complaints, examiners discovered that newborn claims continued to be denied incorrectly for a variety of reasons. Neb. Rev. Stat. § 44-710.19 requires that any insurance policy in force shall provide benefits for the newly born child of the insured or subscriber from the moment of birth through the first 31 days.

The Company made several attempts to identify all impacted Newborn claims. Although, the exam team cannot confirm the accuracy of the information, the following items provided by the Company are being counted for violations and payments recovered:

- May 5, 2023 - Newborn Impact Report – 23 reprocessed claims; $136,605.98
- Response to CF – 9 reprocessed claims; $1,250.63
- Response to CF – 1 reprocessed claim; $272,753.45

Findings:

- This accounts for 33 separate violations of Neb. Rev. Stat. §44-1540(4), Neb. Rev. Stat. §44-8004(4), and Neb. Rev. Stat. §44-710.19.

4. Evolent Oversight

Evolent (TPA) was hired by the Company to provide oversight of the primary third-party administrator (The Loomis Company). Evolent's work with Loomis was *"to conduct a priority claims analysis and aged/pended claims review, addressing root cause, and implementing appropriate resolution.")*

The Company provided the department with weekly progress reports from Evolent since February 8, 2023. Evolent has been working with providers to process or reprocess claims to resolution. The Company is working with providers on payment options.

5. Summary of Additional Findings – Provider Disputes

During the exam, several providers expressed concerns and frustrations to the Nebraska Department of Insurance (NDOI) regarding the Company's failure to communicate and properly handle provider claim disputes. Extensive delays and inaccuracies with claim payments were not resolved through the Company's provider dispute process. While provider disputes are not in the NDOI's jurisdiction, the NDOI forwarded these provider concerns to the Company. A total of 169 claims were paid for an amount of $883,503.42. *Reference Table 4 – Summary of Additional Findings – Provider Disputes.*

Findings:

- 169 claims were incorrectly denied, reprocessed, and paid. This accounts for 169 violations of Neb. Rev. Stat. § 44-1540(4).
- 89 out of the 169 claims had to be reprocessed to include interest. This accounts for 89 violations of Neb. Rev. Stat. § 44-8005(1).
- 162 claims were not processed timely as required by Neb. Rev. Stat. § 44-8004(1). This accounts for 162 violations of Neb. Rev. Stat. § 44-8004(1).

Table 4 - Summary of Additional Findings – Provider Disputes

CF Number or Tracking ID #	Number of claims paid	Total Amount Paid	Number of violations of Neb. Rev. Stat. § 44-1540(4)	Number of violations of Neb. Rev. Stat. § 44-8005(1)	Number of violations of Neb. Rev. Stat. § 44-8004(1)
CF	7	$570,286.09	7	1	7
CF	15	$2,512.63	15	N/A	15
CF	9	$1,103.37	9	N/A	9
32351	5	$1,295.83	5	N/A	N/A
32348	4	$460.26	4	N/A	4
32303	1	$73,667.77	1	N/A	1
32142	1	$56,294.98	1	N/A	1
32110	5	$35.43	5	5	5
32076	12	$95.99	12	12	12
CF	12	N/A	12	12	12
32168	5	$13,647.34	5	N/A	3
CF	9	$1,461.84	9	N/A	9
CF	3	$19,544.07	3	N/A	3
32854	7	$415.64	7	N/A	7
33054	1	$168.36	1	N/A	1
CF	72	$131,651.87	72	59	72
CF	1	$10,861.95	1	N/A	1
Totals	**169**	**$883,503.42**	**169**	**89**	**162**

a. Weekly Updates on Provider Disputes

Examiners were provided weekly progress reports from the Company on incoming and closed provider disputes. The chart below reflects the weekly updates. The Company's target date for completion of provider disputes is December 2023.

Weekly Updates of Provider Disputes

Week of	Number of disputes received	Number of disputes closed in week	Number of disputes still open	Number of disputes over 45 days
2/23/23	87	264	1873	53% over
3/2/23	74	187	1914	52% over
3/9/23	42	127	1882	60% over
3/16/23	83	180	1815	64% over
3/23/23	94	133	1829	70% over
3/30/23	84	105	1851	74% over
4/6/23	54	84	1854	77% over
4/20/23	69	111	1850	75% over
4/27/23	26	91	1847	75% over
5/4/23	90	91	1871	76% over
5/11/23	46	486	1458	80% over
5/18/23	86	147	1434	78% over
5/25/23	142	145	1380	83% over
5/31/23	30	48	1369	85% over
6/8/23	28	179	1229	85% over
6/15/23	45	71	1238	85% over
6/22/23	42	218	1084	82% over
6/29/23	80	129	1072	81% over
7/6/23	31	339	790	81% over
7/13/23	19	400	419	76% over
7/20/23	19	91	427	76% over
7/27/23	81	208	327	52% over
8/3/23	40	61	313	52% over
8/10/23	19	56	227	52% over
8/17/23	15	115	185	52% over
8/24/23	17	30	178	52% over
8/31/23	14	87	117	52% over
9/8/23	19	26	112	52% over

VII. EXAMINATION REPORT SUBMISSION

The courtesy and cooperation extended by the officers and employees of the Company during this examination are hereby acknowledged. In addition to the undersigned, Megan Keck, CIE, MCM, APIR, AU, and Angela Naber, MCM, Allison Powell, Renee Foster, and Rob McCullough, Nebraska Insurance Examiners, participated in this examination and in the preparation of this report.

Market Conduct Examiner in Charge

Department of Insurance
State of Nebraska
1526 K Street, Suite 200
PO Box 95087
Lincoln, NE 68509-5087
(402) 471-2201

Nebraska Relay System
TDD (800) 833-7352

VIII. VERIFICATION OF WRITTEN REPORT

STATE OF NEBRASKA

COUNTY OF LANCASTER

I, Eva Priebe, Market Conduct Examiner, being first duly sworn, upon oath state the following:

That I have been charged with examining the Bright Health Insurance Company, generally covering the period of January 1, 2020, through February 28, 2022; that I have overseen the preparation of, and read the Report of Examination; that I am familiar with the matters set forth therein, and certify that the Report is true and complete, subject to the Nebraska Insurers Examination Act.

Subscribed and sworn to before me on October 23, 2023, by Eva Priebe.

Eva Priebe

GENERAL NOTARY - State of Nebraska
PATRICIA K. HILL
My Comm. Exp. August 8, 2027

Patricia K Hill

Notary Public

NEBRASKA

Good Life. Great Opportunity.

DEPARTMENT OF INSURANCE

Governor Jim Pillen

CERTIFICATION

Friday, November 3, 2023

I, Eric Dunning, Director of Insurance of the State of Nebraska, do hereby certify that the attached is a full and correct copy of the Market Conduct Examination Report of

Bright Health Insurance Company
As of February 28, 2022

The report is now on file and forming a part of the records of this Department.

I hereto subscribe my name under the seal of my office at Lincoln, Nebraska.

Director, Eric Dunning

Eric Dunning, Director
Department of Insurance
1526 K Street, Suite 200
PO Box 95087
Lincoln, Nebraska 68509-5087
OFFICE 402-471-2201 FAX 402-471-4610
doi.nebraska.gov