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DEPARTMENT OF INSURANCE

Governor Jim Pillen

CERTIFICATION

March 13, 2025

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

Oscar Insurance Company
As of June 30, 2023

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

STATE OF NEBRASKA
DEPARTMENT OF INSURANCE

MAR 13 2025

FILED

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

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DEPARTMENT OF INSURANCE

Governor Jim Pillen

March 13, 2025

J. Ryan Tredway, Associate General Counsel
Oscar Insurance Company
75 Varick Street
New York, NY 10013

RE: Oscar Insurance Company
NAIC CODE: 1577
Market Conduct Insurance Examination Report

Dear Mr. Tredway :

The Oscar Insurance Company Report of Examination was placed on official file on March 13, 2025.

The Company must submit a copy of the report of examination to each of its directors. Within 30 days from the date the report is officially filed, the Company must file affidavits executed by each of its directors stating under oath that they have received a copy of the report.

Thank you for your attention to the final steps in closing this examination report.

Respectfully,

Michael W. Anderson
Legal Counsel
Nebraska Department of Insurance

Eric Dunning, Director
Department of Insurance
1526 K Street, Suite 200
PO Box 95087
Lincoln, Nebraska 68509-5087
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NEBRASKA

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DEPARTMENT OF INSURANCE

Governor Jim Pillen

February 25, 2025

J. Ryan Tredway, Associate General Counsel
Oscar Insurance Company
75 Varick Street
New York, NY 10013

RE: Oscar Insurance Company
NAIC CODE: 15777
Market Conduct Insurance Examination Report

Dear Mr. Tredway,

Attached is the adopted Market Conduct Examination report. This report was adopted on February 25, 2025.

As provided by the Nebraska Insurers Examination Act, you have a period of ten days from the adoption date on which to make a written request to the Director of Insurance for a formal hearing on this report.

Upon expiration of this period, if a hearing has not been requested, the report will be accepted as the final report and filed for public inspection on March 12, 2025. If you would like to waive your rights to a hearing, please advise us and the report will be placed on the official file upon receipt of your letter.

If you have any questions, please let me know.

Sincerely,

John J. Koenig

John J. Koenig, FLMI, CPCU, CIE
Chief of Market Conduct
Market Conduct Division

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NEBRASKA

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DEPARTMENT OF INSURANCE

Market Conduct Examination Report

for

Oscar Insurance Company
75 Varick St
New York, NY 10013

NAIC CODE: # 15777

NEBRASKA EXAM CODE: NE051-1

as of June 30, 2023

TABLE OF CONTENTS

I. OVERVIEW/PREFACE

This is a market conduct examination report of the practices and procedures of Oscar Insurance Company (hereinafter referred to as the "Company") (NAIC Company Code #15777). 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 December 4, 2023, through December 07, 2023, at the Company's corporate office located in New York, New York.

The Company provided a sample of claim files that reflected issues discovered through Market Analysis, Complaint Analysis, and poor responsiveness to the Nebraska Insurance Complaint Division (ICD). Review of these files led to the discovery of additional violations, among which were the following notable findings:

- The Company was found to have processed 264 preventive claims with cost-sharing to the member, despite being required by the Affordable Care Act for such services to be covered at 100% with no cost-sharing.
- Ground ambulance reimbursement did not account for rural mileage rates.
- Numerous claims were incorrectly denied as out-of-network and were subsequently made reprocessing projects.
- Company's system was incorrectly denying facility claims which caused claims to be incorrectly paid at $0.
- Numerous claims remained in a "pending status" and were not finalized after requested additional information was not received from the provider within 90 days, despite internal company policy dictating that such claims should be closed after 90 days.

The Company's Market Share in Nebraska in 2022 was 0.989% with written premiums at $26,668,796. In 2023, the Companies Market Share was .277% with $7,787,251 in written premiums. The majority of the revealed errors occurred in 2022. The total loss to policyholders which was recovered within the scope of this report was $5,713,446.22. No evidence of a compliance program was noted during the exam which potentially would have remediated the errors on which this recovery is based. The Company is tracking all issues from this exam and will complete an analysis to guide trainings and corrective action plans (CAPS) systematically at the conclusion of this exam.

This examination report is, in general, a report by exception. Examiners did not have access to the system and solely relied on the files and spreadsheets provided by the Company, which were routinely delayed and/or incomplete. Most of the identified errors were discovered and corrected by the Company through provider disputes. However, it was discovered during this exam, the Company failed to pay interest and remediate all impacted claims that could be validated from what the Company provided Examiners. In the following sections of this report, the Examiners identified violations of Nebraska Statutes and internal company policies.

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, and regulations. 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, Complaints, Appeals, and Claims Handling. The period covered by this examination is generally January 1, 2022, to June 30, 2023. The examiners requested files within the above date range; however, due to findings within the initial claim files and consumer complaints, examiners expanded the scope of the examination and reviewed additional files with errors outside of the date range.

To begin the claim-handling analysis, examiners requested a listing of all Nebraska claims processed during the review period. Examiners selected a sample of denied claims from the universe of files provided by the Company that targeted identified issues from Market Analysis, Complaint Analysis, and responses from the Company to ICD.

During the review of denied claims, complaints, and appeals, incorrect claim handling issues were revealed. The Company was advised by the Examiners to identify all impacted claims and create reprocessing projects to remediate all affected claims.

All unacceptable or noncompliant practices may not have been discovered via 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. Due to frequently missed deadlines, the Company was provided a final date for submission of documents of October 14, 2024. No further documents were accepted after this deadline.

III. COMPANY PROFILE

Oscar Insurance Company is a wholly owned subsidiary of Oscar Health, Inc., which is a health insurer management corporation. Oscar Insurance Company is a for-profit publicly held company incorporated January 01, 2016. The Company is licensed to sell health insurance policies in 10 states and began offering individual and family health insurance plans in Nebraska starting in 2022 through the Affordable Care Act (ACA).

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

2024 (Quarter 2)

OFFICERS	DIRECTORS
Alessandrea Quane (President)	Alessadrea Quane
Victoria Baltrus (Treasurer)	Aaron Davidson
Melissa Curtin (Corporate Secretary)	Sean Martin MD
	Fausto Palazzetti
	Dennis Hillen
	Steven Wollin

2023 (End of Year)

OFFICERS	DIRECTORS
Alessandrea Quane (President)	Alessandrea Quane
Victoria Baltrus (Treasurer)	Aaron Davidson
Melissa Curtin (Corporate Secretary)	Sean Martin MD
	Fausto Palazzetti
	Dennis Hillen
	Steven Wollin

2022 (End of Year)

OFFICERS	DIRECTORS
Alessandrea Quane (President)	Alessandrea Quane
Victoria Baltrus (treasurer)	Aaron Davidson
Melissa Curtin (Secretary)	Sean Martin MD
	Fausto Palazzetti
	Dennis Hillen
	Steven Wolin

IV. EXECUTIVE SUMMARY

The Department conducted a targeted examination of the claim-handling practices of the Company (NAIC Company Code 15777). The following is a summary of the examination findings:

Examination Findings

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.	23
	Neb. Rev. Stat. § 44-1524 & Neb. Rev. Stat. § 44 -1525 (11)	The Company failed to provide complete responses to Examiner inquiries causing unnecessary delays in the progression of the exam.	23
Complaints-Handling Practices	Neb. Rev. Stat. § 44-1525(11) Neb. Rev. Stat. § 44-5905(2)(B)(ii) 210 Neb. Admin. Code, Ch. 61 § 006.01 Neb. Rev. Stat. § 44-1525(9)	The Company failed to adequately document and timely respond to consumer complaints.	4
Claims-Handling Practices	45 CFR § 149.120 (c)(4)	Federal No Surprises Act - The Company did not allow non-contracted professional claims to pay a necessary qualifying payment amount when there was an in-network facility claim on file for the related service.	123
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.	2,978
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.	1,741

Claims-Handling Practices/ Prompt Pay Act	Neb. Rev. Stat. § 44–8004 & Neb. Rev. Stat. § 44-8005	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 44-8005.	1,740
Appeal and Grievance Handling Practices	Neb. Rev. Stat. § 44-7308(3)(f) Neb. Rev. Stat. § 44-7310(2) Neb. Rev. Stat. § 44-7310(3)	The Company failed to adequately ensure compliance with the Grievance Procedure Act	12
Explanation of Benefits	Neb. Rev. Stat. § 44-1540(13) & 210 Neb. Admin. Code, Ch 61 § 008.01	The Company failed to provide the claimant a clear explanation/reason for the denial and had misleading messaging on the Explanation of Benefits (EOB).	31
Total Number of Violations			**6,675**

V. EXAMINATION BACKGROUND

Review of Complaints and Complaint Handling

Initially, 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 processing claims were not resolved timely through the Company's dispute process. Due to an overwhelming amount of provider complaints as well as policyholder claim handling complaints, this examination was necessary.

Appeals & Grievances Handling

Examiners reviewed the handling of appeal requests and sampled adverse and approved determinations issued in 2022 and 2023, to include initial and final appeal outcomes. This review provided further insight into claim handling as well as compliance with Nebraska's Health Carrier Grievance Procedure Act as applicable to the sampled files.

Review of Denied Claims

Examiners requested the Company to provide a spreadsheet listing all Nebraska claims incurred during the review period. The Company responded with an Excel spreadsheet consisting of 108,366 individual, specific claim lines.

A review of the Company's spreadsheet revealed two of the more frequent types of denials as "out-of-network" and "medical necessity approval requirement not met". These types of denials were also revealed in complaints investigated by ICD. Examiners targeted stratified samples of these two denial types and reviewed the entire claim file of 59 claims.

Reprocessing Projects – Denied Claims

During the review of denied claim samples and claims within ICD complaints, examiners discovered many claims were denied incorrectly. Despite processing errors being corrected by the Company after being notified through provider disputes, the Company had not proactively identified all impacted claims. During the examination, the Company was prompted to identify and review all impacted claims. According to the Company, as of the conclusion of this examination, all affected claims are now reprocessed, and paid with interest where applicable.

Responses from the Company acknowledged the improper denial trends. The Company admissions of improper denial trends are available upon request.

Reprocessing Projects- Paid Claims

During the review of Appeals, Grievances, and ICD Complaints, examiners discovered errors that directly impacted "ground ambulance" and "preventive services" paid claims. As these claim errors were identified, all affected claims have been reprocessed, and paid with interest where applicable.

The Company admissions of improper calculation of ground ambulance and processing of preventative claims as non-preventative services are available upon request.

VI. EXAMINATION FINDINGS

A. OPERATIONS AND MANAGEMENT

1. Examination Coordination

To ensure the Company's compliance with Neb. Rev. Stat. § 44-1524 and Neb. Rev. Stat. § 44-1525(11) and Neb. Rev. Stat. § 44-5905(2)(B)(ii), examiners-maintained critique form logs to analyze the Company's timeliness and completeness of responses for items requested during the examination.

Findings:

a. A total of 159 critique forms were submitted. Out of 159, the company failed to respond timely on 23 critique forms. On average, critique forms took 22 days causing unnecessary delays in the exam. These did include Company requests for extensions.

This accounts for 23 violations of Neb. Rev. Stat. § 44-1524 and Neb. Rev. Stat. § 44-1525(11).

b. Persistent delays and incomplete responses on 23 critique forms necessitated the implementation of bi-weekly status calls. A weekly status tracker of incomplete critique forms and projects was provided by the Company to track needed information and updates on requests.

B. POLICYHOLDER SERVICES

In addition to looking for practices and procedures that violate Nebraska law, Examiners also look for practices and procedures that do not appear to be in the best interest of policyholders.

1. Prior-Authorization Requirements – outpatient facilities

Finding:

In one denied claim file, the Company denied payment to a radiologist because records justifying medical necessity for radiology services were not submitted for prior approval. Prior authorization for the primary service (that requires a radiologist to interpret) had already been submitted and approved for the outpatient facility. An Explanation of Payment (EOP) was sent to the radiologist requesting records for medical necessity. When records were not received within 90 days, the claim was denied.

Comment:

The Company's provider contract requires each tethered specialty service in an episode of care at an outpatient facility, to obtain separate medical necessity approval, even when approval has already been received by the outpatient facility. This business practice results in excessive requirements for prior-authorization approvals for related specialty services (radiology, pathology, anesthesiology, etc.) that are intrinsic to the episode of care.

While this is not a violation, the Company has agreed to review the issue as a process improvement item.

Of note, these specialty services are not required to obtain medical necessity approval when an **inpatient** facility has received approval for the service.

2. Failure to provide a reasonable description in the member's Explanation of Benefits (EOB)

To ensure compliance with Neb. Rev. Stat. § 44-1540(13) and 210 Neb. Admin. Code, Ch 61 § 008.01, examiners reviewed the EOBs for 60 denied claims.

Number of EOBs reviewed	Number of EOBs found in error	Error ratio
60	31	52%

Findings:

In a sample selection of 60 EOBs, the Company failed 31 times to issue an Explanation of Benefits (EOB) that provided the policyholders a reasonable and accurate explanation of the basis for denying their claims.

Although the Company states these EOB messages reflect the correct processing of the claim, the Company also agrees these EOBs do not explain why the Company denied the claim, why the provider is paid $0.00, nor why the member owes $0.00.

a. In 18 instances, the Company produced an EOB regarding an unpaid claim with the following statements:

- "You don't owe anything for this care."
- A "discount" for members shown as the entire billed amount,
- No messaging letting the member know the claim was denied nor the reason for the denial or the reason a claim was pended.

b. In 8 instances, the Company produced an EOB with a statement "You don't owe anything for this care", with messaging letting the member know the provider is out-of-network. This is contradictory because the member should owe the entire billed amount if the provider is out-of-network.

c. In 5 instances, not only did the EOB state "You don't owe anything for this care", but it also did not state the claim was denied nor did it have a description of the services provided.

Examples of these EOBs provided upon request.

Recommendation:

When a claim is denied, the Company must provide in writing, a reasonable and accurate explanation of the denial as required by Neb.Rev.Stat. § 44-1540(13) and 210 Neb. Admin. Code, Ch 61 § 008.01.

3. Confusing claim-numbering system

With each adjustment to a claim, the Company's system will generate a new claim number. This creates a unique identifier for each change that may occur during the adjudication of a claim. This can be challenging for providers and members to follow the sequence of adjustments. The Company acknowledges this issue and states, "Oscar continues to evaluate opportunities to improve our communications with providers regarding their claims."

Recommendation:

The Company should consider adopting a numbering system that identifies the sequence of adjustments that are made for each claim, i.e., Z31GVYC7-2, Z31GVYC7-3, Z31GVYC7-4. This would improve communication with providers and members to help them follow the sequence of changes that have been made during a claim lineage.

C. CLAIMS HANDLING

1. Claims incorrectly denied as Out-Of-Network (OON)

Findings:

Number of OON denied sample claim files reviewed	Number of files found in error	Error ratio
29	19	66%

Out of the 29 claim files reviewed, it was found in 19 instances that the Company failed to correctly process claims for providers that should not have been denied as out-of-network. In most instances, this caused the entire billed amount to be the policyholder's responsibility. This represents an error rate of 66% and accounts for 19 violations of Neb.Rev.Stat. § 44-1540(4). The delay in correctly reprocessing these claims caused further violations of the Prompt Pay Act - Neb.Rev.Stat. § 44-8004 and 44-8005.

This targeted review of individual claim files that were denied as out-of-network revealed systemic errors in claim processing. These sampled files and ICD complaints were included in the ensuing reprocessing projects. See Table 1 – Summary of Reprocessing Projects.

Recommendation:

The Company must attempt in good faith to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear as required by Neb.Rev.Stat. § 44-1540(4).

2. Pre-Authorizations

The examination shifted to a targeted review of individual claim files that were denied or pended for not obtaining medical necessity approval, also known as pre-authorization. Claims that required authorization approval were targeted for review when Examiners noticed the frequency of provider dispute metrics related to medical necessity approvals.

Upon review of the universe of claims list received from the Company, Examiners also noticed a significant number of claims in a pended status for more than 90 days that also appeared to be related to authorizations. This prompted Examiners to select a sample of pended files to review status and why they were pended.

Denial Reason	Number of denied claim files reviewed	Number of files found in error	Error ratio
Documentation required for approval not provided	15	2	13%
Pended for authorization approval	15	10	67%
Total	30	12	40%

Findings:

a. The Company incorrectly denied a claim (for lack of documentation required for approval) which resulted in the member being sent to collections for the billed amount of $57,184. The claim was submitted by the provider on April 13, 2022. It was then incorrectly denied on March 4, 2023, for not providing itemized billing (when itemized billing had been provided). This was a processing error and multiple attempts were made by the member and provider to overturn the denial. The covered portion of the claim was eventually paid and reprocessed on February 9, 2024, in the amount of $27,013. The Company did not pay interest until Examiners inquired. Interest in the amount of $5,302 was paid on May 4, 2024.

b. On August 23, 2022, the Company received a claim for a radiology service completed on June 5, 2022. The claim was denied and a request for clinical documentation to support medical necessity and an itemized bill was sent to the provider. The claim file shows that medical records, a pre-authorization, and an itemized bill were received. However, the claim continued to be denied multiple times after multiple provider disputes. The claim was eventually paid and reprocessed 318 days later, on December 05, 2023. The delay was acknowledged by the Company to be human error. Interest was not paid until Examiners inquired. Interest in the amount of $2,206.77 was paid on July 23, 2024.

c. Ten out of 15 files reviewed failed for being in a "pended" status and not finalized within the time frame required by Nebraska's Prompt Pay Act and Company's processing requirements. This finding resulted in a reprocessing project of 187 claims. See the reprocessing claims project for pended claims below. The project includes these 10 sample claim files.

Recommendation:

The Company must pay, deny, or settle a claim within the timeline required by its contract with the provider and the requirements of Nebraska's Prompt Pay Act, Neb. Rev. Stat. § 44-8001-8010.

D. SURVEY OF REPROCESSED CLAIMS

As a result of reviewing sampled claims, consumer complaints and provider disputes, systemic errors were identified during the exam and reprocessing projects were required. Many errors had been fixed when provider disputes brought processing issues to the Company's attention. However, Market Conduct Examiners noticed that not all impacted claims had been reprocessed. The Company subsequently identified and reprocessed all impacted claims. Interest payments were applied where applicable.

The Company reported that notification was sent on October 8, 2024, to 20,962 providers stating that recent EOPs of reprocessed claims were the result of a NDOI Market Conduct Review.

- TIN/NPI Combo – 4 reprocessed claims
- Out-of-Network Toggle Issue (03/22-03/24) – 34 reprocessed claims
- Behavioral Health "Blacklist" – 17 reprocessed claims
- Rental Network/Behavioral Health contract priority – 593 reprocessed claims
- OON Providers claims sequence - 53 reprocessed claims
- Pending Report – 187 reprocessed claims
- NPIOR - 33 reprocessed claims
- Rental Network Pricing – 1,708 reprocessed claims
- Location 24 – 37 reprocessed claims
- Ambulance- 38 reprocessed claims
- Miscellaneous Claims – 8 reprocessed claims
- Preventive Services – 264 reprocessed claims

Findings and resulting violations from the review of the reprocessed claims are listed within each respective reprocessing project. See Table 1 – Summary of Reprocessing Projects.

a. TIN/NPI Combo

Findings:

In one sample claim file that was denied as out-of-network (OON), it was revealed that a provider's contract had been incorrectly set up as "facility only" instead of "provider and facility". The Company was made aware the provider was in-network by three provider disputes.

This sample claim required reprocessing, payment, and interest, due to this error. Three other claims, that had been previously reprocessed, required interest.

Action Taken:

The Company reprocessed four claims. Payment and interest were applied. See Table 1 – Summary of Reprocessing Projects.

b. Out-of-Network/Toggle Issue (03/22/2022-03/24/2022)

Findings:

In a sample claim file that was denied as out-of-network, it was discovered that the facilities' data was loaded into the claims processing system as "professional" instead of "institutional" during a 3-day period March 22, 2022, to March 24, 2022. This caused facility claims billed on a UB-04 form, adjudicated during that period, to incorrectly deny as out-of-network.

Although the Company became aware of the error on March 22, 2022, the Company did not attempt to correct all claims that occurred during this 3-day period. The exam team requested the universe of all claims impacted from this error.

Action Taken:

The Company produced a claims impact report identifying 34 Nebraska claims. Seven were reprocessed prior to this exam. Payment and interest were applied where applicable. See Table 1 – Summary of Reprocessing Projects.

c. Behavioral Health "Blacklist" Reprocessed Claims

Findings:

During the review of out-of-network claims, examiners discovered behavioral health claims were incorrectly denied. The Company referred to this project as the Behavioral Health "Blacklist". Messaging on the Explanation of Payment (EOP) should have guided the provider to "resubmit to behavioral health vendor for payment consideration" instead of denying the claim for being out-of-network and causing the member to owe the entire billed amount.

Although the Company became aware of the error on March 22, 2022, the Company did not attempt to correct claims that occurred prior to March 22, 2022.

Action Taken:

The Company produced a claims impact report identifying 27 behavioral health claims affected by this error. Fifteen claims had been resubmitted by providers to the behavioral health claims processor and processed, despite the absence of the message to submit to behavioral health delegate on the EOP. Interest was reviewed and confirmed required on one claim. Twelve claims do not appear to have been submitted to behavioral health delegate and have been reprocessed with updated messaging on new EOPs directing providers to submit these claims to behavioral health delegate.

See Table 1 – Summary of Reprocessing Projects.

d. Behavioral Health Processor/Rental Network Contract Priority

Findings:

During the review of out-of-network claims, Examiners discovered providers' claims were being improperly denied as out-of-network from a systemic error that was causing the tax identification numbers (TINs) on the claims to match to both the rental network and behavioral health contract. At the time, the TIN matched to the higher priority contract in the Company system (in this case, behavioral health contract), and as such, was routed as out-of-network. Had the claim matched to the rental network contract, it would have processed as in-network. The Company became aware of the systemic error on January 26, 2023, and corrected the error on January 27, 2023.

Although the Company became aware of the error on January 26, 2023, the Company did not attempt to correct all claims that occurred prior to January 26, 2023. During the exam, this became a reprocessing project known as Contract Prioritization Issue 1/1/2022-1/27/2023.

Action Taken:
After subtracting 26 claims that were accounted for in four other projects (Pended, Sequence, Pricing and Behavioral Health Blacklist) 593 claims were reprocessed and 145 claims were paid with interest. See Table 1- Summary of Reprocessing Projects.

e. OON Providers Claim Sequence Error

Findings:

The Company's claims configuration, designed to reflect No Surprises Act (NSA) requirements for out-of-network providers performing services in in-network facilities, appropriately allows non-contracted professional claims to pay a necessary qualifying payment amount when there is an overlapping in-network facility claim on file. However, because fifty-three out-of-network professional claims were received before the in-network facility claims, the claim system did not allow the out-of-network professional claims to pay and were instead denied as out of network.

Action Taken:

The Company produced a claims impact report identifying 53 reprocessed Nebraska claims. All claims were incorrectly denied in 2022. 50 claims did not get reprocessed until this exam. Payment and interest were applied where applicable. See Table 1 – Summary of Reprocessing Projects.

f. Claims in pended status for more than 90 days

Findings:

During the review of the "universe of all claims" list, Examiners had questions about 190 claims that were in a pending status for more than 90 days and not finalized.

The Company advised claims are in "pended" status, meaning the Company needed additional information to make an adjudication decision. This status is communicated with providers via an explanation of payment (EOP) and to members via their explanation of benefits (EOB). The Provider has 90 days to respond with the required additional information for further processing. Otherwise, the claim should deny and close without payment according to the provider contract.

Action Taken:

All 190 claims have been reprocessed. Thirty were closed without payment for no documentation received. The others were denied for other reasons or, paid including interest, if applicable. See Table 1 – Summary of Reprocessing Projects.

g. Denial code - NPIOR (NPI-Provider Identification Number + OR- Organization)

Findings:

Examiners noticed during their review more information was needed regarding the out-of-network denials of claims with the denial code NPIOR.

After review, the Company identified an error and determined these NPIOR claims should not have been denied.

It was revealed that claims submitted by facilities using the 837P electronic form were being flagged as having a technical issue. Because the facility was billing the service, and not an individual health care professional, this technical issue prevented them from moving forward in the processing hierarchy. Thirty-three claims were impacted.

Action Taken:

The Company produced a claims impact report identifying 33 reprocessed Nebraska claims. Payment and interest were applied when applicable. below See Table 1 – Summary of Reprocessing Projects.

h. Rental Network Pricing Error

Findings:

The NDOI was notified on May 24, 2022, by two hospitals, that a multitude of claims were paying at $0. It was revealed that the Company became aware of this processing error on May 4, 2022.

After being priced by the rental network, the claim pricing was located on the header level of the feed. The Company's system was expecting the pricing to be on the line level. As a result, when the Company's system tried to read pricing at the line level, claims were paying at $0. The issue was resolved June 2, 2022.

Although 90% of these claims were reprocessed in 2022 through provider disputes, none of the untimely claim payments included interest and 49 remained incorrectly denied until this exam.

Action Taken:

The Company produced a claims impact report identifying 1,708 reprocessed Nebraska claims. Payment and interest were applied were applicable. below See Table 1 – Summary of Reprocessing Projects.

i. Location 24 Coding Error

Findings:

A coding error regarding (POS) Place of Service- 24 (Ambulatory Surgical Center) specifically impacted seven anesthesiologists causing out-of-network anesthesiology claim denials. All impacted claims were identified and the underlying system issue causing these denials was corrected in May of 2023 when brought forward by a DOI complaint.

When examiners reviewed this complaint, it was noted that interest had not been paid on the reprocessed claims.

Action Taken: The Company paid interest on the reprocessed claims. The impact report below shows the recovery and violations for this coding error. See Table 1 – Summary of Reprocessing Projects.

j. Ground Ambulance mileage calculation

Findings:

An NDOI consumer complaint revealed a ground ambulance claim payment did not account for the cost of mileage from Columbus to Lincoln, NE (76 miles). This caused the member cost-sharing to be higher than expected. For two years, the company delayed resolving this complaint due to the uncertainty of calculating the correct rates for 2022.

Action Taken: Due to the difficulty in achieving certainty of member protection when paying the CMS rate for mileage, the Company has taken the approach to resolution of allowing 38 ground ambulance claims to be paid at the billed amount. The Company produced a claims impact report identifying 39 reprocessed ground ambulance claims that occurred in 2022 and 2023. Payment and interest were applied where applicable. See Table 1 – Summary of Reprocessing Projects.

The Company has modified wording in the 2025 policy language regarding this benefit. In response to concerns raised by the NDOI, the Company offered the following framework for payment of ground ambulance claims:

"In the absence of a median network rate for a service, ambulance or otherwise, Oscar would look to an eligible third party database for a rate to be paid. The initial reference to a median rate is borrowing the federal No Surprises Act (NSA) approach to certain out-of-network services when

the member had no opportunity to choose a provider. The use of an eligible third-party database when no median rate exists is also how the NSA would direct a payer to evaluate the claim."

The Company also agreed to add the following language to their ground ambulance policies: "For Emergency Services provided by other Out-of-Network Providers, or Covered Services provided by an Out-of-Network Providers at an In-Network facility, at the median of Oscar's contracted rates for the same or similar service in the same geographic area. If Oscar cannot calculate a median rate due to the lack of a sufficient number of contracted providers, Oscar will use a third-party database to evaluate reasonable and customary rate for the ambulance services. Ambulance services providers may balance bill You for the difference between the provider's charges and Oscar's payment. If You are balance billed, please contact Us for assistance."

k. Miscellaneous Claims – Examiners noticed during the review that there were isolated denied claims that needed to be reprocessed and paid with applicable interest OR were already reprocessed without interest. A total of 8 claims were reprocessed and/or paid with interest where applicable. The individual claims are described in this section.

Findings:

- The Company incorrectly denied two claims by two different providers for cesarean delivery services. The Company denied both claims for lack of pre-authorization. Upon further review, the Company acknowledged that one of the two claims could have been paid without the pre-authorization requirement. The Company reprocessed the claim and paid $2,000.36 on May 03, 2024, and $192.69 in interest on May 09, 2024.

- A request for medical necessity had been submitted by the provider and approval received from the Company. However, the claim continued to be denied multiple times until the Company reversed the denial and paid the claim on December 06, 2023. The Company took 319 business days to correctly process the claim. The Company paid $18,907.73 on December 05, 2023, and paid $2,206.77 in interest on July 23, 2024,

- The Company incorrectly denied a claim for laboratory services by a provider that is the only laboratory in the world which conducts the necessary testing. Even though a post-authorization was on file, the claim was denied. The Company reviewed, reprocessed, and paid the claim on March 09, 2024, in the amount of $4,415.22. and subsequently paid $868.04 in interest on August 30, 2024.

- The Company incorrectly denied a claim (for lack of documentation required for approval) which resulted in the member being sent to collections for the billed amount of $57,184. The claim was submitted by the provider on April 13, 2022, and incorrectly denied on March 4, 2023, for not providing itemized billing (when itemized billing had been provided). This was a processing error and multiple attempts were made by the member and provider to overturn the denial. The covered portion of the claim was eventually paid and reprocessed on February 9, 2024, in the amount of $27,013. The Company did not pay interest until examiners inquired. Interest in the amount of $5,302 was paid on May 4, 2024.

- The original claim was denied for code NPIOR. Provider submitted a corrected claim to trigger an adjustment. This claim was for a colonoscopy. The Company acknowledged that the Company system was incorrectly denying claims as having invalid coding. The Company acknowledged this claim has not been identified for NPIOR reprocessing project since it had a dispute attached. The claim was reprocessed and paid with interest on May 10, 2024. The Company made two payments to the provider, $1,130.40 on February 11, 2023, and $401.89 on May 04, 2024. Interest was paid in the amount of $63.03 on May 09, 2024.

- The Mental Health claim was denied as out-of-network and was included in the Behavior Health/Rental Network project below as an incorrect denial. Because the claim was sent to the Company instead of the behavioral health delegate, the EOP should have directed the provider to resubmit to behavioral health delegate instead of denying as out-of-network. The incorrect denial was processed after 42 days. The Company failed to pay, deny, or settle a clean claim within thirty calendar days violating Neb.Rev.Stat. § 44 -8004(1).

- In one DOI complaint file, a facility claim processed with an allowed amount of $0 due to a technical issue between the Company and rental network that occurred January 1, 2022, through June 30, 2022. The reprocessing project became known as the "Rental Network Pricing Issue" See Table 1 – Summary of Reprocessing Projects). However, this claim was missed in the generation of that report. The claim ended up paying $1,920.72 and interest $348.57.

- Four of the member's medical claims were denied as out-of-network and were included in the Rental Network/Behavioral Health project below. However, the Examiner discovered one of the member's claims, Z30RXHBX, was not on the list. This claim was reprocessed and paid in October of 2022. Interest was paid in the amount of $37.93 in 2024.

I. Preventive Care Services

Part 1 – Mammograms and Immunizations

Findings:

Market Conduct Examiners reviewed a complaint submitted to Oscar from a member regarding claims for an annual physical exam, mammogram screening, and vaccination that incorrectly applied cost-sharing to these preventive benefits. The Company agreed claims should have been paid in full and reprocessed them accordingly.

Examiners inquired about the root cause for this error and the Company completed a review of what occurred at the time the complaint was submitted to the Company. Confirmed outcomes of the Company's review identified that between 11/07/2022 – 01/03/2023, 265 claims (179 immunizations and 86 preventative breast cancer screenings were incorrectly processed as non-preventive.

Action Taken:

Out of the 265, it was found 194 claims with preventive services originally incurred patient responsibility greater than $0 and after reprocessing, patient responsibility is now $0.

See Table 1 – Summary of Reprocessing Projects for recovery amount and violations incurred.

Part 2 – Preventive Consults, labs, procedures

Findings:

The Company's review of preventive services identified three additional services that had preventive benefit misalignments. These claims were not reprocessed and were incorrectly assigned to non-preventive services. The impact report identified originally incurred patient responsibility greater than $0.

Action Taken:

Seventy claims with preventive services originally incurred patient responsibility greater than $0 and after reprocessing, patient responsibility is now $0 or a decreased patient responsibility.

See Table 1 – Summary of Reprocessing Projects for recovery amount and violations incurred.

Table 1 - Summary of Reprocessing Projects

Claims Reprocessing Projects	Number of Reprocessed Claims*	Total Amount Paid Including Interest	Violations of Neb.Rev.Stat. § 44-1540(4)*	Violations of Neb.Rev.Stat § 44-8005(1)	Violations of Neb Rev.Stat. § 44-8004(1)*	NSA 44-CFR §149.120 (C) (4)*Provided informationally*
TIN/NPI Combo	4	$658.30	4	4	4	N/A
Toggle Issue (3/22-03/24)	34	$97,520.71	34	28	28	N/A
Behavioral Health "Blacklist"	17	$0.04	17	1	1	N/A
Rental Network/ Behavioral Health Contract Priority	593	$1,668,705.34**	593	145	145	N/A
OON Providers Claim Sequence	53	$165,220.95	53	37	37	53
Pending Report	187	$341,935.91	187	45	45	N/A
NPIOR	33	$36,031.30	33	22	22	33
Rental Network Pricing	1,708	$3,022,725.76	1,708	1,127	1,127	N/A
Invalid Coding Place of Service 24	37	$23,244.06	37	37	37	37
Ground Ambulance	41	$61,815.03	41	33	33	N/A
Miscellaneous Claims	8	$45,900.62	7	7	8	
Preventive Services Part 1 Immunizations & Mammograms	194	$24,455.72	194	189	189	
Preventive Care (Part 2) **1. Preventive Consults** **2. Preventative Labs/ Pathology** **3. Preventive Surgery/ Procedures**	70	$6,679.97	70	65	65	N/A
Totals	**2,979***	**$5,713,446.22**	**2,978***	**1,740**	**1,741***	**123***

Note: The Company completed an analysis/cross-reference of claims associated with the CFs identified by the Department and the Company that were believed to pertain to other related projects.

*Total violation number includes a subset of violations which were reported to Company by the Department of Insurance and/or providers prior to official commencement of the exam.

** Examiners were able to validate from NDOI complaint 32952 that ten claims totaling $218,552.51 were left out of this recovered amount.

The exam team cannot confirm the accuracy of the information within each of the impacted claim listings.

E. GRIEVANCES AND APPEALS HANDLING

1. Failure to ensure required elements of the Grievance Procedure Act

To review compliance with Neb. Rev. Stat. § 44-7308 (1) through (3), Examiners reviewed appeals, and grievances submitted by policyholders or, providers on behalf of policyholders.

Number of Appeals/Grievances files reviewed	Number of Appeals/Grievances files found in error	Error ratio
28	12	43%

Findings:

a. The Company did not have the correct address of the NDOI on the External Review request form being sent to members in the first-level grievance determination letter. This form must contain notice of the covered person's right to contact the NDOI and must contain the phone number and address as required by Neb. Rev. Stat. § 44-7308(3)(f).

Action Taken:

In a follow up inquiry, the Company provided evidence that the corrected address for the NDOI went into production in January 2024 for all pertinent member correspondence.

b. The first level grievance denial letter in Claim Z31VY6JZ does not have the following required elements: 1. A statement of the reviewer's understanding of the covered person's grievance; 2. The reviewer's decision in clear terms 3. The contract basis or medical rationale for *Service not covered under the plan* and 4. A reference to the evidence or documentation used as the basis for the decision.

Recommendation

The written decision of a First Level Grievance Review must contain the elements described in Neb. Rev. Stat. § 44-7308(1) through (3).

c. The provider made repeated attempts through appeals and phone calls to clear up confusion about which knee required medically necessary treatment. The Company finally did a re-review of the original case when it was submitted by the provider to External Review and the denial was immediately overturned. The Company agreed the Final Appeal Determination Reviewer did not have the appropriate expertise as required by Neb. Rev. Stat. § 44-7308(1) and caused unnecessary delay in the approval.

d. Sample files 3, 4, 5, 6, 7, 8, 14, and 20 were approved appeal decisions overturning an adverse determination. All eight approval letters did not have the name and credentials of the reviewer. The letters were signed, "Sincerely, Oscar".

Recommendation

The Company must ensure that a standard review of an adverse determination shall be evaluated by an appropriate clinical peer in the same or similar specialty as would typically manage the case being reviewed. Neb. Rev. Stat. § 44-7310(2).

e. In one Utilization Management (UM) Appeal file, the initial authorization request was received January 4, 2022. The Company's initial adverse determination letter was issued 20 working days later. A UM appeal was received February 3, 2022, and Company's approval was sent 21 working days later. In both instances, the Company failed to respond within 15 working days.

Recommendation:

Both the covered person and the ordering provider must receive a written decision for a standard review of an adverse determination within 15 days as required by Neb. Rev. Stat. § 44-7310(3).

F. COMPLAINTS HANDLING PRACTICES

Examiners requested the Company's complaint handling procedures and reviewed files to ensure the timeframe the Company responds to complaints is in accordance with applicable statutes and regulations; the Company is maintaining adequate documentation; and the Company is taking adequate steps to finalize and dispose of complaints in accordance with applicable Nebraska statutes, regulations, and policy language. The Company is required to maintain a registry of all written complaints received by the Company pursuant to Neb. Rev. Stat. § 44-1525(9).

The Company provided documentation that showed 26 complaints. Of those, 7 complaints were sent to the NDOI, 17 complaints were sent directly to the Company and 2 were sent to the Better Business Bureau. The Company did not provide information regarding social media complaints. The Examiners then requested 19 files listed on the complaint register for review. One NDOI file was not on the complaint register. It was added to the sample making 20 reviewed files.

As required by Neb. Rev. Stat. § 44-1525(9) the Examiners ensured the Company's complaint register indicated the total number of complaints, a classification by line of insurance, the nature of each complaint, the disposition of the complaint, and the time taken to process the complaint.

Complaints Sent Directly to the Company, Better Business Bureau, and NDOI

Number of Complaints in population	Number of files sampled by examiners	Number of files found in error	Found error rate
26	20	4	20%

Findings:

1. The NDOI made eight attempts to get a clear explanation of the cost-sharing computation of a member's claim which was the subject of a consumer complaint. The complaint was unnecessarily extended over six months.

Recommendation

The Company must respond to a written inquiry from the NDOI within fifteen working days as required by Neb. Rev. Stat. § 44-1525(11).

2. Consumer expressed a complaint about provider which was related to a claim. Actual complaint was not included in claim file. According to Company, there is no written complaint, as this was a provider survey sent to the consumer. However, the emailed response triggered a JIRA ticket. Because there is no record of the actual complaint, there is no record of why the JIRA ticket was generated.

Recommendation

The Company must retain records relating to the business of insurance that permits examination of those records for five years as required by Neb. Rev. Stat. § 44-5905(2)(B)(ii).

3. A Company complaint file was closed on August 30, 2022, but was not resolved until December 23, 2022. The member expressed dissatisfaction regarding the lack of in-network oxygen supply companies within her proximity. The member began contacting the Company as of June 23,2022 attempting to find an in-network provider. Four months later, the Company set up a single contract agreement on December 23, 2022, with a supplier to provide the oxygen tank. The complaint file was closed four months before it was resolved.

Recommendation

The Company agreed that a clinical decision should have been reached before the consumer complaint was closed by the Complaint/Grievance Team. Further, the Company must, within fifteen days of receipt, acknowledge and respond to any written communication relating to a claim as required by 210 Neb. Admin. Code, Ch. 61 § 006.01.

4. The NDOI attempted to get a clear explanation of the cost-sharing/balance billing of a member's claim for emergency medical transport services which was the subject of a consumer complaint. From May 2022 until July 2024, the claim and complaint were unresolved. In addition to failing to timely resolve this complaint, the Company failed to document this NDOI complaint on the Company Complaint Register.

Recommendation:

The Company must respond the Department of Insurance as required by Neb. Rev. Stat. § 44-1525(11) and maintain a complete record of all complaints as required by Neb. Rev. Stat. § 44-1525(9).

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, Eva Priebe, CPCU, APIR, MCM, AIE, Allison Powell, MCM, APIR, and Rob McCullough, Nebraska Insurance Examiners, participated in this examination and in the preparation of this report.

Angela Naber

Market Conduct Examiner in Charge

Department of Insurance

State of Nebraska

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VIII. VERIFICATION OF WRITTEN REPORT

STATE OF NEBRASKA

COUNTY OF LANCASTER

I, Angela Naber, Market Conduct Examiner, being first duly sworn, upon oath state the following:

That I have been charged with examining the Oscar Insurance Company, generally covering the period of January 1, 2022, through June 30, 2023; 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 February 25, 2025, by Angela Naber.

GENERAL NOTARY - State of Nebraska
SHELLY G. STORIE
My Comm. Exp. January 16, 2028

Notary Public

Nebraska
Market Conduct Examination

Oscar Insurance Company
Draft Report Response
Amended 2/24/2025

NAIC CODE: #15777
Nebraska Exam Code: NE051-1

Table of Contents

Summary of Oscar Insurance Company's Response

Oscar Insurance Company ("Oscar") takes the matters detailed in the Examination Report ("Report") seriously and is committed to addressing the matters through process improvement. However, there are also significant concerns with the presentation of material in the Report. Oscar is seeking to highlight some key areas demonstrating the potential for the Report to lead to inaccurate perceptions of the impact of the examination. One major issue is that **the report could lead a reader to incorrect conclusions in terms of overall claim dollars recovered by the examination for Oscar's members or providers in Nebraska.**

Oscar's response to each item in the Report that merited a response is detailed in the pages that follow. This summary is limited to provide necessary context to understand the Report's presentation of key issues.

1. The actual monetary recovery resulting from the examination process, as suggested by the Report, is less than reported. **The financial impact of the examination process in terms of claims recovery or reprocessing is roughly $970,800, which is significantly less than the $5.71M suggested in the Report.**

    a. Two projects constitute the majority of the Report's impact: Rental Network/Behavioral Health Contract Priority, and Rental Network Pricing. These two projects represent 70.6% of the total volume of claims reprocessing mentioned in the Report, and 81.6% of the total financial impact.
    b. It was not made clear in the report that 96.5% of claims associated with these two issues were reprocessed prior to the exam.

2. Oscar has included a more detailed table **(Oscar Table 1)** as part of this summary demonstrating two important issues:

    a. Overreporting total impacted claim volume (and financial impact), resulting in inflation of the total claims reprocessed by 697 claims (this represents $1.38M of total financial impact). Oscar provided reports to NDOI using expansive criteria to include any claim that was evaluated by Oscar for potential impact, including claims that did not ultimately require reprocessing. Failure to exclude these correct claims from the Report inflates the perceived impact of these issues.
    b. Pre-examination claims issues resolved by Oscar, issues the required resolution through the examination, and the dollar values for those separate categories. The Report combines these amounts in a way that has the opportunity to inflate a reader's perception of the actual impact of the examination process.

3. **The Report's presentation of Findings is not clear and leads to an overall concern that the Report could lead a reader to incorrect conclusions regarding Oscar's performance or positions.** For example -

a. The Report indicates that Oscar's explanation of benefits ("EOB") failed to meet statutory or regulatory standards. The Report also indicates that "the Company also agrees these EOBs" failed to meet those standards. Oscar agreed in only one instance that a single EOB failed to meet these standards. The Report unfortunately leads a reader to believe that Oscar agreed on multiple occasions that its EOBs did not meet these standards. This was pointed out in Oscar's response to the draft report, but was not changed.

b. The Report suggests that Oscar incorrectly delayed or denied payment by pending claims. The Report unfortunately fails to present that the services in question required preauthorization and no preauthorization was evident in the claim. Rather than deny the claims, Oscar requested information regarding the existence of preauthorization or simply gave the provider an opportunity to instead enable a post-service review by providing medical records to Oscar (this is the "pending" of claims referred to in the Report). This is important contextual information not provided in the Report. The Report could establish this issue in a single explanation and issue recommendations or findings the Examiner believes flow from this practice. The Report instead presents this issue as a violation and 187 claims that required reprocessing.

c. The Report's "Rental Network Pricing Error" issue was a system error in which claims from providers contracted with Oscar's leased network partner were being paid, but at $0. Rather than language observing the impact of the issue on a defined set of claims, the Report uses the term "multitude" to describe the impact of the error. Oscar does agree that through the exam an additional 39 claims were paid for a total amount of $129,294.28. **A reader of the Report could incorrectly conclude that the issue resulted in over 1700 reprocessed claims and recovery of over $3,000,000 through the examination process. 97% of claims were reprocessed prior to the exam, leaving 39 claims that were addressed as part of the examination (less than $210,000 was actually paid to providers in connection with the examination).**

Oscar is seeking to place the items presented in the Report into a more appropriate context that reflects the work done by Oscar prior to the examination. While Oscar did present this perspective prior to the adoption of the Final Report, the clear delineation between items addressed prior to and during the examination was not included in the Final Report. Instead, the delineation and perspective will be included only as an appendix to the Report. **This summary is an attempt to draw readers to a key issue not adequately covered in the Report - Oscar is committed to addressing claims processing errors, will continue to do so through its internal processes, and did so in the context of its Nebraska experience.**

Please review "Oscar Table 1" and its explanation at the next page.

Oscar Table 1

Table 1 of the Report does not accurately represent the outcome of the same and prior remediations completed by Oscar:

1) The Report is overreporting/inflating total impacted claim volume (and financial impact) as it does not appropriately filter reporting provided by Oscar, which included all claims evaluated for impact (some of which did not require reprocessing), resulting in inflation of the total claims reprocessed by 697 claims (which represents $1.38M of total financial impact).
2) The Report does not distinguish between claims (and financial impact) reprocessed by Oscar prior to the examination vs. reprocessed as a result of the examination.
    - Two projects constitute the majority of the Report's impact: Rental Network/Behavioral Health Contract Priority, and Rental Network Pricing. These two projects represent 70.6% of the total volume of claims reprocessing mentioned in the Report, and 81.6% of the total financial impact. It was not made clear in the Report that 96.5% of claims associated with these issues were reprocessed prior to the exam.

Overreporting due to inadequate filtering of provided reports

To demonstrate exhaustive remediation, certain Oscar reports to the NDOI were inclusive beyond claims that were reprocessed as part of the exam (i.e. including claims that were evaluated for impact even if ultimately not reprocessed, or claims that were outside of the exam period of January 1, 2022, to June 30, 2023). The Report does not remove any of these additional claims from the presentation of these issues, resulting in overreporting/inflation of the impacted claim (and financial impact) amounts by 697 total claims. This is the difference between a total financial impact of $5.71M reported by the Department vs. $4.33M for the same data set, according to Oscar.

Two projects (Rental Network/Behavioral Health Contract Priority, and Rental Network Pricing) represent 690 of the 697 extra claims that should not have been included in the Report. Oscar provided reports to the NDOI using broad criteria that included claims that were correctly denied/correctly priced. This was done in response to feedback from the NDOI to demonstrate that Oscar's remediations were exhaustive. Claims where there was no observed change to the claim outcome (when compared to the original claim adjudication) should be removed from the total claims reprocessed.

Also, to further demonstrate Oscar's commitment to remediation, claims reprocessing was not limited to claims within the exam scope (January 1, 2022, to June 30, 2023). As such, in 3 projects (Pending Report, NPIOR, and Ground Ambulance), claims reprocessing included claims that were beyond the exam period. Oscar has not suggested these claims be removed from the Report.

Overreporting due to inclusion of claims not processed as part of the exam

If the Report included only the claims that were reprocessed during the exam, the total claim volume would be 716 claims for a financial impact of $970.8K, rather than the 2978 claims for financial impact of $5.71M stated in the Report's Table 1.

Once controlling for the inaccurate filtering of reports mentioned in the section above, 31% of claims (716 claims) were reprocessed during the exam; 69% of claims were reprocessed prior to the exam (1566 claims).

Two projects reprocessed $3.3M (1555 claims) prior to the exam beginning, which represents substantial overreporting in the Report. The Rental Network Pricing item (1458 claims) makes up $3.02M of total reprocessing - 97% of these claims (1419 claims) were reprocessed prior to the exam beginning, which represents 93% ($2.82M) of the financial impact of this item. Similarly, the next largest item, Rental Network/BH contract priority (153 claims), makes up $509K of total reprocessing - 89% of these claims (136 claims) were reprocessed prior to the examination, which represents 94% of the dollars ($478.8K) of the financial impact of this item.

How to read Oscar Table 1

Oscar has provided a breakdown of claims (and amount paid) prior to the examination vs. during the examination, which highlights the overreporting due to inclusion of claims reprocessed by Oscar prior to the exam. Oscar has also included total claims reprocessed (i.e. prior to the exam + during exam) to highlight the impact of improper filtering of Oscar-provided reports when compared to the unfiltered Department Report totals.

Column headers highlighted in orange and blue indicate additional columns that were recommended by Oscar to include in the Report (as seen in Appendix 1). This would reflect claim volume and payments addressed or collected prior to the examination and also during or as a result of the examination process. Text in red indicates where Oscar believes totals should be decreased in alignment with the feedback included in the Company Responses to the Report. Text in blue indicates where Oscar believes totals may be increased in alignment with the feedback included in the Company Responses to the Report

Oscar Table 1:

	The Company Report						The Department Report	
	Total = PRIOR + DURING		PRIOR to exam		DURING exam		Department Report Total	
Claims Reprocessing Projects	Number of Reprocessed Claims	Total Amount Paid Including Interest	Number of Reprocessed Claims	Total Amount Paid Including Interest	Number of Reprocessed Claims	Total Amount Paid Including Interest	Number of Reprocessed Claims	Total Amount Paid Including Interest
TIN/NPI Combo	4	$869.27	3	$378.08	1	$491.19	4	$658.30
Toggle Issue (3/22-03/24)	34	$97,520.71	7	$14,170.40	27	$83,350.31	34	$97,520.71
Behavioral Health "Blacklist"	17	$0.04	0	$0.00	17	$0.04	17	$0.04
Rental Network/Behavioral Health Contract Priority	153	$509,231.91	136	$478,800.37	17	$30,431.54	593	$1,668,705.34
OON Providers Claim Sequence	53	$165,220.95	4	$2,378.45	49	$162,842.50	53	$165,220.95
Pending Report	187	$341,935.91	0	$0.00	187	$341,935.91	187	$341,935.91
NPIOR	33	$36,031.30	0	$0.00	33	$36,031.30	33	$36,031.30
Rental Network Pricing	1458	$3,022,725.76	1419	$2,816,637.03	39	$206,088.73	1708	$3,022,725.76
Invalid Coding Place of Service 24	37	$23,244.06	0	$0.00	37	$23,244.06	37	$23,244.06
Ground Ambulance	41	$61,815.03	0	$12,981.96	41	$48,833.07	41	$61,815.03
Miscellaneous Claims	5	$11,378.85	0	$1,130.40	5	$10,248.45	8	$45,900.62
Preventive Services Part 1 Immunizations & Mammograms	194	$46,513.43	0	$23,690.40	194	$22,823.03	194	$24,455.72
Preventive Care (Part 2) 1. Preventive Consults 2. Preventative Labs/ Pathology 3. Preventive Surgery/ Procedures	70	$11,831.26	0	$6,877.24	70	$4,954.02	70	$6,679.97
Total	2282	$4,327,449.21	1566	$3,356,666.25	716	$970,782.96	2975*	$5,494,235.41**

* Please note that the Department's report shows 2978 as the total claims; however, that does not appear to be the correct column total (2975)
** Please note that the Department's report shows $5,713,446.22 at the total amount paid including interest; however, that does not appear to be the correct column total ($5,494,235.41)

I. OVERVIEW

Oscar Insurance Company (hereinafter referred to as the "Company") (NAIC Company Code #15777) would like to begin by thanking the examination team ("Examiner") for their comprehensive review of our operations and processes. The findings and recommendations shared in the draft audit report have been and are being carefully considered by our leadership team and we appreciate the thoroughness of the review in highlighting areas for improvement.

We take these findings seriously. We recognize the importance of addressing any identified issues in Nebraska and are fully dedicated to taking corrective actions.

In response to these findings, we have taken immediate steps to address the identified concerns, including reviewing and reprocessing affected claims. Our goal is to ensure that claims are processed accurately and in full compliance with our policies and Nebraska's regulatory requirements.

We have also identified areas of disagreement with the draft report. While we are committed to working with the Department, we did indicate issues we noticed in the draft report that could be altered for greater clarity. Often this included additional context for the findings and not a removal of a finding. You will also notice a proposed change to Table 1 to provide additional context. We disagreed with the nature of the presentation of Table 1 as a companion to the findings in sections VI.C and VI.D. The nature of Table 1 could potentially be misleading and requires additional content or language in the headers to appropriately communicate that not all claims and payments reflected in the were addressed or collected as a result of the exam process. For example, a reader of the report could conclude that the "Rental Network Pricing" project resulted in over 1700 reprocessed claims and recovery of over $3,000,000 through the examination process. However, 39 claims were addressed as part of the examination and less than $210,000 was paid to providers in connection with the project during the examination.

The Company has provided an example for restructuring Table 1 to better clarify which claims and recovered amounts were the result of the examination and which amounts were completed prior to the examination (see Appendix 1).

We are confident that Oscar can and will affirmatively address and resolve the identified concerns. We are also committed to fostering an environment of continuous improvement, accountability, and transparency with our regulator in Nebraska.

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, and regulations. 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, Complaints, Appeals, and Claims Handling. The period covered by this examination is generally January 1, 2022, to June 30, 2023. The examiners requested files within the above date range; however, due to findings within the initial claim files and consumer complaints, examiners expanded the scope of the examination and reviewed additional files with errors outside of the date range.

To begin the claim-handling analysis, examiners requested a listing of all Nebraska claims processed during the review period. Examiners selected a sample of denied claims from the universe of files provided by the Company that targeted identified issues from Market Analysis, Complaint Analysis, and responses from the Company to ICD.

During the review of denied claims, complaints, and appeals, incorrect claim handling issues were revealed. The Company was advised by the Examiners to identify all impacted claims and create reprocessing projects to remediate all affected claims.

All unacceptable or noncompliant practices may not have been discovered via 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. Due to frequently missed deadlines, the Company was provided a final date for submission of documents of October 14, 2024. No further documents were accepted after this deadline.

Company Response: ***The Company has no comments or response for this section of the draft report.***

III. COMPANY RESPONSE

A. OPERATIONS AND MANAGEMENT

1. Examination Coordination

Finding: *To ensure the Company's compliance with Neb. Rev. Stat. § 44-1524 and Neb. Rev. Stat. § 44-1525(11) and Neb. Rev. Stat. § 44-5905(2)(B)(ii), examiners-maintained critique form logs to analyze the Company's timeliness and completeness of responses for items requested during the examination.*

Company Response: The indication of 23 instances is unclear in that 23 instances are referred to in 1a and 1b of Section VI. Is this intended as 46 separate incidents or 23? The repeat use of 23 instances or violations is also found in the table used within Section IV (two separate indications of 23 violations). Additionally, the Company cannot agree with 23 or 46 at this time due to the mixed nature of the category itself. The Company does see that 6 CFs were submitted after the stated deadline. Assuming this number is correct and agreed to (at least for the purpose of discussion herein), the remaining 17 (or 40) instances may be made up of: (1) responses the examiner considered incomplete; (2) responses that were subject to a requested and granted extension of a deadline; or (3) responses submitted after a requested deadline that appears to be inconsistent with standard turnaround times used by the Department (a call between the examiner and the Company was conducted during the examination to re-establish appropriate deadlines, though this was not included in the description of the finding so it is unclear if this is being addressed in the finding). The Company does not agree with including within the stated violations instances in which: (1) the Company is not provided an opportunity to respond to the Department and agree or disagree as to the characterization of a complete or incomplete response; (2) instances in which an extension of a deadline was reasonably necessary, requested, and granted; or (3) instances in which a deadline was inconsistent with and shorter than guidelines used by the Department for examinations.

b. Bi-weekly status calls

Finding: *Persistent delays and incomplete responses on 23 critique forms necessitated the implementation of bi-weekly status calls. A weekly status tracker of incomplete critique forms and projects was provided by the Company to track needed information and updates on requests.*

Company Response: While the Company agrees that the implementation of the bi-weekly meeting was valuable for all parties to gain alignment on the intention of CFs and clarity of responses, and the Company did voluntarily implement a weekly status tracker to support this

work with the Department, the Company does not believe it appropriate that 23 additional violations are issued for the same statute cited in the above finding regarding delays. The nature of the presentation of materials in Sections IV and VI could be understood to indicate 46 separate violations. The Company is requesting clarification or changes to the report to make the observations and findings clear. Additionally, the Company's response to 1a applies to 1b as well.

B. POLICYHOLDER SERVICES

In addition to looking for practices and procedures that violate Nebraska law, Examiners also look for practices and procedures that do not appear to be in the best interest of policyholders

1. Prior-Authorization Requirements - outpatient facilities

Finding: *In one denied claim file, the Company denied payment to a radiologist because records justifying medical necessity for radiology services were not submitted for prior approval. Prior authorization for the primary service (that requires a radiologist to interpret) had already been submitted and approved for the outpatient facility. An Explanation of Payment (EOP) was sent to the radiologist requesting records for medical necessity. When records were not received within 90 days, the claim was denied. CF-113 EP CF 113.docx*

Company Response: As this is not a violation of any statute, the Company requests that this item be removed from the report. The language in VI.B.1 ("An Explanation of Payment (EOP) was sent to the radiologist requesting records for medical necessity. When records were not received within 90 days, the claim was denied") is not provided with appropriate context. First, when the preauthorization requirement was not met by the provider, the Company did not deny the claim and instead provided a new opportunity for submission of information that would have been made available through the preauthorization process. This is not counter to the interests of policyholders and providers, which is the stated goal of section VI.B. Second, the denial of the claim after the passage of 90 days is consistent with what the Examiner has indicated is a statutory requirement in Section VI.C.2.c and was avoidable through a provider response to the information request. Although the Company reiterates that the exam finding is not a violation and therefore unnecessary, should the Examiner determine to retain this finding, the discussion should appropriately ground the Company's handling of the claim (additional opportunity to avoid a preauthorization denial and resulting claim denial after 90 days per the Department's guidance) in the overall context of the claim and examination.

Additionally, as described in the response to CF-125 during the examination:
"Prior to, and independent of, this market conduct exam, Oscar evaluates opportunities to improve claims processes on an ongoing basis. Over the past two years (2022-2024), which

includes Oscar's first two years operating in Nebraska (Oscar entered Nebraska 1/1/2022), Oscar has evaluated and implemented opportunities to modify claims authorization practices. Examples include:

- If an IP professional claim is submitted with the same NPI or TIN as an approved facility claim, Oscar will use the presence of the approved facility claim (with the same NPI or TIN) instead of an authorization for the IP professional claim.
    - This happens when the IP professional claim is outside of the date range on the auth, but within the date range on the facility claim.
    - IP professional claims do not require separate authorization when IP facility auth is present and do not accumulate against authorized units.
- Allow NPI or TIN match for IP professional authorizations to increase opportunities for avoiding denials or requests for information that were made when seeking a TIN match
- OP ancillary providers do not require a separate auth in specific places of service, and will not accumulate against authorized units
- No longer require the date of service (range) on the claim and the auth to overlap entirely when matching authorizations for certain outpatient services (e.g. PT/OT). We allow +/- 30 day grace period
- Authorizations matching logic includes both contract and TIN basis match opportunity to avoid unnecessary denials or requests for OP (facility and professional) claims
- No longer require authorization for E&M coded lines on IP professional claims unless we have a matching denied facility authorization on file

These alterations to the preauthorization requirements and processes are consistent with the Company's goals regarding interactions with network providers. While the company disagrees that a provider could assume inapplicability based on convenience to the provider, the Company is very interested in process improvement on an ongoing basis. Provider and regulator interaction aid in identifying these issues and Oscar has taken action to engage in procedural changes in this area."

2. Failure to provide a reasonable description in the member's EOB

To ensure compliance with Neb. Rev. Stat. § 44-1540(13) and 210 Neb. Admin. Code, Ch 61 § 008.01, examiners reviewed the EOBs for 60 denied claims.

Finding: *In a sample selection of 60 EOBs, the Company failed 31 times to issue an Explanation of Benefits (EOB) that provided the policyholders a reasonable and accurate explanation of the basis for denying their claims. Although the Company states these EOB messages reflect the correct processing of the claim, the Company also agrees these EOBs do not explain why the Company denied the claim, why the provider is paid $0.00, nor why the member owes $0.00. (CF-70)*

Company Response: The Company's statements in CF-70 were not made applicable to all EOB messaging. CF-70 referred to a single EOB, but is being referenced in the draft report as an

indication ("the Company also agrees these EOBs . . .") in a manner that suggests agreement for all, or at least more than one, instance of the EOB messaging finding. Further, the Company agreed in CF-70 that additional language in an EOB could be helpful, but did not agree to a violation or that the "EOBs do not explain why the Company denied the claim" as indicated in the draft report. The final report should be edited to remove any incorrect characterization of the Company's stance or position in CF-70 on the broader issue of the EOB messaging. Additionally, the report should provide context for the EOB messaging finding. Errors in claim processing will impact the accuracy of the issued EOB. For example, an incorrect denial for non-network status of a provider could also result in an incorrect indication that a member is responsible for amounts billed by what is actually a network provider. These findings therefore represent a second manner in which the Examiner includes a finding in the report for the same singular processing error.

The Examiner's comments in the draft report in subsection (b) and (c) focus on the EOB indications that a member does not owe. While the Company understands the overall point the Examiner is advancing, this EOB indication can also be understood to be grounded in the amounts owed by a member according to the insurance contract itself (i.e. cost-sharing responsibilities). Some denials will result in a member owing nothing for care provided (a preauthorization denial is one such scenario). Each claim denial does not, at a practical level, require an EOB indicating member responsibility. This would result in inaccuracies and/or additional member confusion.

The Company will assess the messaging and triggers for messaging on EOBs but does not agree with the draft report's characterization of the issue or the Company's broad agreement with the Examiner through reference to CF-70.

3. Confusing claim-numbering system

Finding: *With each adjustment to a claim, the Company's system will generate a new claim number. This creates a unique identifier for each change that may occur during the adjudication of a claim.*

Company Response: The Company appreciates the Examiner's comments and will continue to evaluate opportunities to ensure providers are aware of the full sequence of claims events as necessary.

C. CLAIMS HANDLING

1. Claims incorrectly denied as Out-Of-Network (OON)

Findings: *Out of the 29 claim files reviewed, it was found in 19 instances that the Company failed to correctly process claims for providers that should not have been denied as out-of-network. In most instances, this caused the entire billed amount to be the policyholder's responsibility. This represents an error rate of 66% and accounts for 19 violations of Neb.Rev.Stat. § 44-1540(4). The delay in correctly reprocessing these claims caused further violations of the Prompt Pay Act - Neb.Rev.Stat. § 44-8004 and 44-8005. This targeted review of individual claim files that were denied as out-of-network revealed systemic errors in claim processing. These sampled files and ICD complaints were included in the ensuing reprocessing projects. See Table 1 – Summary of Reprocessing Projects.*

Company Response: The Company understands the 19 claims described in this finding to be also more specifically represented in the presentation of claims issues and projects in Section D. Responses to any specific claim issue will be included within Section D responses. The company understands and acknowledges the need for focus on the out-of-network denial issues represented in the examination. The Company's efforts in addressing the issues more specifically called out in Section D are designed to and will improve present and future outcomes in this area.

2. Pre-Authorizations

The examination shifted to a targeted review of individual claim files that were denied or pended for not obtaining medical necessity approval, also known as pre-authorization. Claims that required authorization approval were targeted for review when Examiners noticed the frequency of provider dispute metrics related to medical necessity approvals.
Upon review of the universe of claims list received from the Company, Examiners also noticed a significant number of claims in a pended status for more than 90 days that also appeared to be related to authorizations. This prompted Examiners to select a sample of pended files to review status and why they were pended.

Findings:
a. The Company incorrectly denied a claim (for lack of documentation required for approval) which resulted in the member being sent to collections for the billed amount of $57,184. The claim was submitted by the provider on April 13, 2022. It was then incorrectly denied on March 4, 2023, for not providing itemized billing (when itemized billing had been provided). This was a processing error and multiple attempts were made by the member and provider to overturn the denial. The covered portion of the claim was eventually paid and reprocessed on February 9, 2024, in the amount of $27,013. The Company did not pay interest until Examiners inquired. Interest in the amount of $5,302 was paid on May 4, 2024. Sample 3, wave 3 EP CF-93,116

b. On August 23, 2022, the Company received a claim for a radiology service completed on June 5, 2022. The claim was denied and a request for clinical documentation to support medical necessity and an itemized bill was sent to the provider. The claim file shows that medical records, a pre-authorization, and an itemized bill were received. However, the claim continued to be denied multiple times after multiple provider disputes. The claim was eventually paid and reprocessed 318 days later, on December 05, 2023. The delay was acknowledged by the Company to be human error. Interest was not paid until Examiners inquired. Interest in the amount of $2,206.77 was paid on July 23, 2024. Sample 7 wave 3 AN CF-95, CF-149

c. Ten out of 15 files reviewed failed for being in a "pended" status and not finalized within the time frame required by Nebraska's Prompt Pay Act and Company's processing requirements. This finding resulted in a reprocessing project of 187 claims. See the reprocessing claims project for pended claims below. The project includes these 10 sample claim files.

Company Response: The Company partially agrees and disagrees with these findings.

VI.C.2.a - This scenario does represent errors by the Company, but the Company disagrees that the root cause of this error is appropriately categorized as a preauthorization failure. The underlying claim should not have been denied and processor error was found to be the root cause. The Company regrets the multiple attempts to address the error that did not result in appropriate resolution.

VI.C.2.b - This scenario does represent errors by the Company, but the Company disagrees that the root cause of this error is appropriately categorized as a preauthorization failure. The underlying claim should not have been denied and processor error was found to be the root cause. The Company regrets the multiple attempts to address the error that did not result in appropriate resolution.

VI.C.2.c - The Company disagrees with the characterization of the "pended" claims and the resulting violation finding. The Company did routinely seek to avoid denials to providers for failure to secure required preauthorization for certain services. Instead of issuing a denial based on the provider contract requirement and technical failure by the provider to secure a pre-service determination of medical necessity, the Company allowed the provider to establish medical necessity after receipt of the claim. The Company did this through the information request the Examiner referenced. This is important contextual information, as the enforcement of the contractual preauthorization requirement would remove the opportunity for payment to the provider and the need to "pend" a claim. In Section VI.D.f, the Examiner again addresses these same claims. The report could establish this issue in a single explanation and issue recommendations or findings the Examiner believes flow from this practice. This will enable the Company to make decisions regarding process improvement or cessation of some practices.

The Company disagrees with the presentation of the errors and error ratio in table at VI.C.2. The Examiner appears to rely upon Nebraska's Prompt Pay Act, Neb. Rev. Stat. § 44-8001-8010 for the error findings. Specific to the "pended" claims and lack of resolution, the language in Section VI.D.f is helpful to isolate the actual violation: "The Provider has 90 days to respond with the required additional information for further processing. Otherwise, the claim should deny and close without payment according to the provider contract." The Examiner appears to be indicating that the Company's non-enforcement of a contractual 90-day turnaround time results in a statutory prompt payment of claims violation. The Company disagrees. Neb. Rev. Stat. § 44-8004(2) includes a permissive rather than mandatory opportunity to deny such a claim: "The insurer ***may*** deny a claim if a health care provider receives a request for additional information and fails to submit additional information requested under this subsection." (emphasis added) The finding essentially transforms the "may" into a "shall" or "must" and then holds the Company responsible for failing to comply. The Company acknowledges that the decision to allow more time for a provider to provide requested information may create a lack of a measurable deadline for each and every claim. The Examiner discussed this issue with the Company during the examination process and the Company agreed to enforce the 90-day contractual requirement. However, the Company does not agree that this should result in a retroactive finding of a violation of section 44-8004(2) because the Company did not deny each claim that it "may" deny.

D. SURVEY OF REPROCESSED CLAIMS

a. TIN/NPI Combo

Finding: *In one sample claim file that was denied as out-of-network (OON), it was revealed that a provider's contract had been incorrectly set up as "facility only" instead of "provider and facility". The Company was made aware the provider was in-network by three provider disputes. This sample claim required reprocessing, payment, and interest, due to this error. Three other claims, that had been previously reprocessed, required interest. Sample 3 wave 2, CF-25, 45, 62, 81*

Company Response: The Company partially agrees with the language of section VI.D.a, but seeks to add necessary clarification. Of the four (4) claims cited in subsection (a), only one claim required reprocessing as part of the examination process. The other three (3) claims were reprocessed in 2022, prior to the examination. The draft report, and Table 1, lack the proper contextualization that the three (3) claims not in the sample were affirmatively processed outside of and prior to the examination. The Company does not dispute that interest payments were required for the four (4) claims. The inclusion of the 4 claims as violations for all categories in Table 1 is not consistent with the narrative in VI.D.a, which could more properly indicate the distinctions among the four (4) claims. Please note that The Company was unable

to replicate the calculated total payment amount in Table 1 for this finding. The Company believes that the amount paid during the exam was $491.19 (total amount paid prior to + during exam was $869.27).

Additionally, the Company has instituted a process change that includes a centralized team to manage/implement all contract setup for greater control over contract updates and related processes. This new process implementation was made in efforts to avoid recurrences of the issues raised in this section.

b. Out-of-Network/Toggle Issue (03/22/2022-03/24/2022)

Finding: *In a sample claim file that was denied as out-of-network, it was discovered that the facilities' data was loaded into the claims processing system as "professional" instead of "institutional" during a 3-day period March 22, 2022, to March 24, 2022. This caused facility claims billed on a UB-04 form, adjudicated during that period, to incorrectly deny as out-of-network. Although the Company became aware of the error on March 22, 2022, the Company did not attempt to correct all claims that occurred during this 3-day period. The exam team requested the universe of all claims impacted from this error. CF-3 & 60*

Company Response: The Company has made changes to limit the front-end functional ability to update the "provider type" for rosters. Changes to this field are required to go through change management protocol in efforts to reduce the opportunity for recurrence of an issue of this type. As indicated, the Company has completed reprocessing and interest payments where applicable.

c. Behavioral Health "Blacklist" Reprocessed Claims

Findings:
During the review of out-of-network claims, examiners discovered behavioral health claims were incorrectly denied. The Company referred to this project as the Behavioral Health "Blacklist". Messaging on the Explanation of Payment (EOP) should have guided the provider to "resubmit to behavioral health vendor for payment consideration" instead of denying the claim for being out-of-network and causing the member to owe the entire billed amount.
Although the Company became aware of the error on March 22, 2022, the Company did not attempt to correct claims that occurred prior to March 22, 2022. CF-15,61.

Company Response: The "Blacklist" reference in the finding should be contextualized such that the reader understands that the Company was routinely identifying behavioral health claims

and sending EOPs to remind the provider to send to the appropriate address. The "error" being called out in the finding is more specifically a subgroup of claims that did not trigger the EOP messaging. Nevertheless, the underlying contractual responsibility of the provider is to send claims to the delegated vendor with which the provider is contracted. The provider's decision to instead submit the claim to the Company is the underlying issue. At a simpler level, the network provider failed to submit a claim to the appropriate address for processing. The direction to submit behavioral health claims is also repeated on the member ID card and the provider manual.

The Company partially agrees with this finding, but disagrees based on what it views as necessary clarifications. Two separate issues are the core elements of this finding: (1) the contracted providers were required by contract to submit claims to the delegated processor with which the providers originally contracted and did not submit the claims to the proper address; and (2) the efforts in place by the Company to send EOP messaging to guide the providers (though this was not required by contract) were not triggered due to a failure to identify the claims as behavioral health claims. In the absence of identification of the claim as a behavioral health claim, the claim would most likely be identified as a medical claim from a non-network provider.

d. Behavioral Health Processor/Rental Network Contract Priority

Findings:
During the review of out-of-network claims, Examiners discovered providers' claims were being improperly denied as out-of-network from a systemic error that was causing the tax identification numbers (TINs) on the claims to match to both the rental network and behavioral health contract. At the time, the TIN matched to the higher priority contract in the Company system (in this case, behavioral health contract), and as such, was routed as out-of-network. Had the claim matched to the rental network contract, it would have processed as in-network. The Company became aware of the systemic error on January 26, 2023, and corrected the error on January 27, 2023.

Although the Company became aware of the error on January 26, 2023, the Company did not attempt to correct all claims that occurred prior to January 26, 2023. During the exam, this became a reprocessing project known as Contract Prioritization Issue 1/1/2022-1/27/2023.

Company Response: It appears the Examiner arrived at 593 violations by looking for any adjusted claim associated with TINs that overlap with Optum that denied as non-network, excluding only claims that were identified to be overlapping with other claims reprocessing projects. This will incorrectly capture the population, as this will include claims that were adjusted as part of the other critiques or projects, claims that were adjusted outside of the examination, and claims that were correctly denied as non-network. Using the report that the

Company provided, the claims that were reprocessed as a result of this project may be found by filtering on column AL of the impact report, wherein the Company indicates that the adjustment was completed as part of this project. 51 total claims fall into this category, of which 17 were adjusted to pay an amount that was different than on original claims adjudication (total $9972.65 paid including interest, account for the $1485.21 paid previously on original claims). The other 854 claims were included in the impact report for completeness in response to the Department's request, but were not impacted by the project undertaken during the examination. The Company has continued to improve the ability to proactively mitigate instances of TIN overlaps across contracts that could impact claims payment, through a TIN Management process. The Company's system automatically flags when a TIN is on multiple contracts in the same market, and assigns a team member to review the overlap and either approve it in cases where there is no overlap in covered services, or escalate to the contracting team to determine actions.

e. OON Providers Claim Sequence Error

Findings:
The Company's claims configuration, designed to reflect No Surprises Act (NSA) requirements for out-of-network providers performing services in in-network facilities, appropriately allows noncontracted professional claims to pay a necessary qualifying payment amount when there is an overlapping in-network facility claim on file. However, because fifty-three out-of-network professional claims were received before the in-network facility claims, the claim system did not allow the out-of-network professional claims to pay and were instead denied as out of network. CF-39 & 57

Company Response: The Company agrees subject to the following: The draft report indicates that 53 claims were reprocessed as part of the exam; 4 of these claims were reprocessed prior to the exam and the 49 impacted claims that were identified through this exam have been reprocessed and paid with interest where applicable (total amount paid including interest as a result of the exam $162,842.5). The Company has also continued to improve the ability to identify non-network professional claims associated with network facility claims to avoid denial of the professional claims when received prior to the facility claim.

f. Claims in pended status for more than 90 days

Findings:
During the review of the "universe of all claims" list, Examiners had questions about 190 claims that were in a pending status for more than 90 days and not finalized.
The Company advised claims are in "pended" status, meaning the Company needed additional information to make an adjudication decision. This status is communicated with providers via an explanation of payment (EOP) and to members via their explanation of benefits (EOB). The

Provider has 90 days to respond with the required additional information for further processing. Otherwise, the claim should deny and close without payment according to the provider contract.

Company Response: Please see the Company's response to VI.C.2.c.

g. Denial code - NPIOR (NPI-Provider Identification Number + OR- Organization)

Findings:
Examiners noticed during their review more information was needed regarding the out-of-network denials of claims with the denial code NPIOR.
After review, the Company identified an error and determined these NPIOR claims should not have been denied. It was revealed that claims submitted by facilities using the 837P electronic form were being flagged as having a technical issue. Because the facility was billing the service, and not an individual health care professional, this technical issue prevented them from moving forward in the processing hierarchy. Thirty-three claims were impacted.

Company Response: The Company agrees with the finding.

h. Rental Network Pricing Error

Findings:
The NDOI was notified on May 24, 2022, by two hospitals, that a multitude of claims were paying at $0. It was revealed that the Company became aware of this processing error on May 4, 2022. After being priced by the rental network, the claim pricing was located on the header level of the feed. The Company's system was expecting the pricing to be on the line level. As a result, when the Company's system tried to read pricing at the line level, claims were paying at $0. The issue was resolved June 2, 2022. Although 90% of these claims were reprocessed in 2022 through provider disputes, none of the untimely claim payments included interest and 49 remained incorrectly denied until this exam.

Company Response: The Company points out a characterization in the draft report finding - the use of the term "multitude" - rather than an available observation of fact. The finding applies a percentage (90%) observation regarding the claims addressed prior to the exam. This appears to indicate that the Examiner is aware of the number of claims that make up the base of claims included in the finding - the base when extrapolated based on a 90% assumption would be approximately 490 claims. However, Table 1 indicates 1708 claims were impacted. If 39 of 1708 claims remained unaddressed at the time of the exam, the percentage addressed prior to the exam is over 97%, not 90%. The Company agrees that the issue was mostly identified independent of and prior to the exam. The issue was resolved 6/2/2022 within 30 days of

identification and claims were reprocessed. The total population of reprocessed claims when excluding claims where the $0 allowed was a valid outcome on the original claim is 1458 rather than 1708. The Company's report flagged that claims that correctly allowed for $0 were included in the report in an effort to provide an exhaustive universe. Through the exam an additional 39 claims were paid (with interest where applicable) for a total amount of $129,294.28, which were not included in the original claims reprocessing in 2022 (i.e. 97.% of claims were resolved prior to this exam). The Company agrees with the Examiner's finding regarding the lack of interest payments in the resolution of the issue. This appears to be the core issue presented in this finding.

i. Location 24 Coding Error

Findings:
A coding error regarding (POS) Place of Service- 24 (Ambulatory Surgical Center) specifically impacted seven anesthesiologists causing out-of-network anesthesiology claim denials. All impacted claims were identified and the underlying system issue causing these denials was corrected in May of 2023 when brought forward by a DOI complaint.
When examiners reviewed this complaint, it was noted that interest had not been paid on the reprocessed claims.

Company Response: The Company does not dispute this finding.

j. Ground Ambulance mileage calculation

Findings:
An NDOI consumer complaint revealed a ground ambulance claim payment did not account for the cost of mileage from Columbus to Lincoln, NE (76 miles). This caused the member costsharing to be higher than expected. For two years, the company delayed resolving this complaint due to the uncertainty of calculating the correct rates for 2022.

Company Response: The Company does not dispute the indication that the Company made the decision to reprocess all such claims during the examination period. The Table 1 summary shows 41 claims and the Action Taken section indicates 39 claims. This should be made consistent or explained for clarity.

k. Miscellaneous Claims

Examiners noticed during the review that there were isolated denied claims that needed to be reprocessed and paid with applicable interest OR were already reprocessed without interest. A total of 8 claims were reprocessed and/or paid with interest where applicable. The individual claims are described in this section.

***Findings*:**

- The Company incorrectly denied two claims by two different providers for cesarean delivery services. The Company denied both claims for lack of pre-authorization. Upon further review, the Company acknowledged that one of the two claims could have been paid without the preauthorization requirement. The Company reprocessed the claim and paid $2,000.36 on May 03, 2024, and $192.69 in interest on May 09, 2024. (CF-107)
- A request for medical necessity had been submitted by the provider and approval received from the Company. However, the claim continued to be denied multiple times until the Company reversed the denial and paid the claim on December 06, 2023. The Company took 319 business days to correctly process the claim. The Company paid $18,907.73 on December 05, 2023, and paid $2,206.77 in interest on July 23, 2024, (Sample 7 wave 3 AN CF-95,149)
- The Company incorrectly denied a claim for laboratory services by a provider that is the only laboratory in the world which conducts the necessary testing. Even though a post-authorization was on file, the claim was denied. The Company reviewed, reprocessed, and paid the claim on March 09, 2024, in the amount of $4,415.22. and subsequently paid $868.04 in interest on August 30, 2024 (CF-30, CF-68, CF-154)
- The Company incorrectly denied a claim (for lack of documentation required for approval) which resulted in the member being sent to collections for the billed amount of $57,184. The claim was submitted by the provider on April 13, 2022, and incorrectly denied on March 4, 2023, for not providing itemized billing (when itemized billing had been provided). This was a processing error and multiple attempts were made by the member and provider to overturn the denial. The covered portion of the claim was eventually paid and reprocessed on February 9,2024, in the amount of $27,013. The Company did not pay interest until examiners inquired. Interest in the amount of $5,302 was paid on May 4, 2024. (Sample 3, wave 3 EP CF-93,116)
- The original claim was denied for code NPIOR. Provider submitted a corrected claim to trigger an adjustment. This claim was for a colonoscopy. The Company acknowledged that the Company system was incorrectly denying claims as having invalid coding. The Company acknowledged this claim has not been identified for NPIOR reprocessing project since it had a dispute attached. The claim was reprocessed and paid with interest on May 10, 2024. TheCompany made two payments to the provider, $1,130.40 on February 11, 2023, and $401.89 on May 04, 2024. Interest was paid in the amount of $63.03 on May 09, 2024. (CF-105 – AP)
- The Mental Health claim was denied as out-of-network and was included in the Behavior Health/Rental Network project below as an incorrect denial. Because the claim was sent to the Company instead of the behavioral health delegate, the EOP should have directed the provider to resubmit to behavioral health delegate instead of denying as out-of-network. The incorrect denial was processed after 42 days. The Company failed to pay, deny, or settle a clean claim within thirty calendar days violating Neb.Rev.Stat. § 44 -8004(1). (CF-28)
- In one DOI complaint file, a facility claim processed with an allowed amount of $0 due to a technical issue between the Company and rental network that occurred January 1, 2022, through June 30, 2022. The reprocessing project became known as the "Rental

Network Pricing Issue"See Table 1 – Summary of Reprocessing Projects). However, this claim was missed in the generation of that report. The claim ended up paying $1,920.72 and interest $348.57. (DOI complaint 34007 CF-128 MK) CF-128 Follow-Up 20240719

- Four of the member's medical claims were denied as out-of-network and were included in the Rental Network/Behavioral Health project below. However, the Examiner discovered one of the member's claims, Z30RXHBX, was not on the list. This claim was reprocessed and paid in October of 2022. Interest was paid in the amount of $37.93 in 2024. (CF-132)

Company Response: Partial agree. The Company has reprocessed claims and paid interest. However, 3 of 8 of the claims listed in this section were included in other findings or were included in claims reprocessing projects. The Company has referred to the CF documents to track each claim referenced:

- CF107 - Agree
- CF95 - This appears to be a duplicate of the finding in Section VI.2.b.
- CF30 - The Examiner appears to be omitting the fact that the provider was not contracted with the Company as a network provider in Nebraska until 5/15/2024.
- CF93 - This appears to be a duplicate of the finding in Section VI.2.b.
- CF105 - Agree
- CF28 - This claim is included in a project related to behavioral health claims. Including the same claim here appears to create a duplicative finding regarding a single claim.
- CF128 - Agree
- CF132 - Agree

I. Preventive Care Services

Part 1 – Mammograms and Immunizations

***Findings*:**
Market Conduct Examiners reviewed a complaint submitted to Oscar from a member regarding claims for an annual physical exam, mammogram screening, and vaccination that incorrectly applied cost-sharing to these preventive benefits. The Company agreed claims should have been paid in full and reprocessed them accordingly. Examiners inquired about the root cause for this error and the Company completed a review of what occurred at the time the complaint was submitted to the Company. Confirmed outcomes of the Company's review identified that between 11/07/2022 – 01/03/2023, 265 claims (179 immunizations and 86 preventative breast cancer screenings were incorrectly processed as nonpreventive.

Company Response: The Company generally does not dispute this Findings section. There is some limited disagreement with the amount paid as the Company was unable to replicate the Department's calculation of total amount paid (but not the number of claims reprocessed or

interest amounts). The amount paid as part of the exam including interest should be $22,823.03 (as some claims were previously paid). Total amount paid (prior to + during exam) associated with these claims was $46,513.43.

Part 2 – Preventive Consults, labs, procedures

Findings:
The Company's review of preventive services identified three additional services that had preventive benefit misalignments. These claims were not reprocessed and were incorrectly assigned to non-preventive services. The impact report identified originally incurred patient responsibility greater than $0.

Company Response: The Company generally does not dispute this Findings section. There is some limited disagreement with the amount paid as the Company was unable to replicate the Department's calculation of total amount paid (but not the number of claims reprocessed or interest amounts). The amount paid as part of the exam including interest should be $4954.02 (as some claims were previously paid). Total amount paid (prior to + during exam) associated with these claims was $11,831.26.

E. GRIEVANCES AND APPEALS HANDLING

1. Failure to ensure required elements of the Grievance Procedure Act
To review compliance with Neb. Rev. Stat. § 44-7308 (1) through (3), Examiners reviewed appeals, and grievances submitted by policyholders or, providers on behalf of policyholders

Number of Appeals/Grievances file reviewed	*Number of Appeals/Grievances files found in error*	Error Ratio
28	12	43%

Findings:
The Company did not have the correct address of the NDOI on the External Review request form being sent to members in the first-level grievance determination letter. This form must contain notice of the covered person's right to contact the NDOI and must contain the phone number and address as required by Neb. Rev. Stat. § 44-7308(3)(f). CF-2,16.

Company Response:
E.1.a - The Company does not dispute this finding.
E.1.b - The Company does not dispute this finding.
E.1.c - The Company does not dispute this finding.
E.1.d - The Company does not dispute this finding.
E.1.e - The Company does not dispute this finding.

F. COMPLAINTS HANDLING PRACTICES

Examiners requested the Company's complaint handling procedures and reviewed files to ensure
the timeframe the Company responds to complaints is in accordance with applicable statutes and regulations; the Company is maintaining adequate documentation; and the Company is taking adequate steps to finalize and dispose of complaints in accordance with applicable Nebraska statutes, regulations, and policy language. The Company is required to maintain a registry of all written complaints received by the Company pursuant to Neb. Rev. Stat. § 44-1525(9).

The Company provided documentation that showed 26 complaints. Of those, 7 complaints were sent to the NDOI, 17 complaints were sent directly to the Company and 2 were sent to the Better Business Bureau. The Company did not provide information regarding social media complaints. The Examiners then requested 19 files listed on the complaint register for review. One NDOI file was not on the complaint register. It was added to the sample making 20 reviewed files.

As required by Neb. Rev. Stat. § 44-1525(9) the Examiners ensured the Company's complaint register indicated the total number of complaints, a classification by line of insurance, the nature of each complaint, the disposition of the complaint, and the time taken to process the complaint.
Complaints Sent Directly to the Company, Better Business Bureau, and NDOI

Number of Complaints in population	*Number of of files sampled by examiners*	Number of files found in error	Found Error Ratio
26	20	4	20%

Findings:
1. The NDOI made eight attempts to get a clear explanation of the cost-sharing computation of a member's claim which was the subject of a consumer complaint. The complaint was unnecessarily extended over six months. CF-20

Company Response: As indicated during the examination process, the Company has revised its regulatory complaint handling processes since the restructuring of the pertinent team in February 2023. As a result, increased quality controls and standardized processes to assist staff in responding to regulatory complaints have been implemented, including the provision of a spreadsheet for consumer complaints regarding claim accumulators (which would address the lack of clarity experienced for the particular complaint reviewed).

2. Consumer expressed a complaint about provider which was related to a claim. Actual complaint was not included in claim file. According to Company, there is no written complaint, as this was a provider survey sent to the consumer. However, the emailed response triggered a JIRA ticket. Because there is no record of the actual complaint, there is no record of why the JIRA ticket was generated. CF-106 AP.

Company Response: The Company points out that the complaint/survey response at issue was handled consistent with other instances in which a provider survey is completed providing negative feedback about their provider. All information from the survey is transferred to a Jira ticket. As such, the complaint-ticket referenced in the examination finding contained the full text submitted by the complainant, which was brief and amounted to "Not a good fit for me" (which can be seen in the "description" section of the Complaint ticket). The Company disagrees that it did not maintain appropriate records, as the six word complaint was recorded and made available to the Examiner.

3. A Company complaint file was closed on August 30, 2022, but was not resolved until December 23, 2022. The member expressed dissatisfaction regarding the lack of in-network oxygen supply companies within her proximity. The member began contacting the Company as of June 23,2022 attempting to find an in-network provider. Four months later, the Company set up a single contract agreement on December 23, 2022, with a supplier to provide the oxygen tank. The complaint file was closed four months before it was resolved. CF- 121 EP

Company Response: Regarding the first issue, the Company has improved grievance and appeal policies and processes to ensure that all escalation tickets and external requests relating to a complaint or appeal are resolved prior to the closure of a complaint case. Additionally, internal training materials and job aids for grievance liaisons have been updated to include this expectation. Regarding the latter issue, the Company identified that service staff members failed to recognize and escalate the member's grievance to the Complaint/Grievance Team at its initial expression. To correct this, the Complaint/Grievance team issued supplemental training and coaching to those team members regarding grievance identification and handling.

4. The NDOI attempted to get a clear explanation of the cost-sharing/balance billing of a member's claim for emergency medical transport services which was the subject of a consumer complaint. From May 2022 until July 2024, the claim and complaint were unresolved. In addition to failing to timely resolve this complaint, the Company failed to document this NDOI complaint on the Company Complaint Register. (CF-9, 27, 42, 54, 111)

Company Response: The Company does not dispute this finding.

Appendix 1

Column headers highlighted in orange indicate additional columns for consideration to reflect claim volume and payments addressed or collected prior to the examination and during/as a result of the exam process. Text in red indicates where the Company believes totals should be decreased in alignment with the feedback included in the Company Responses below. Text in blue indicates where the Company believes totals may be increased in alignment with the feedback included in the Company Responses below.

In the case of 2 projects (Rental Network/Behavioral Health Contract Priority, and Rental Network Pricing), the Company provided reports to the Department using broad criteria that included claims that were correctly denied/correctly priced. This was done in response to feedback to demonstrate that the Company's remediations were exhaustive. Claims where there was no observed change to the claim outcome (when compared to the original claim adjudication) should be removed from the total claims reprocessed. Also, to further demonstrate the Company's commitment to exhaustive remediation, claims reprocessing was not limited to claims within the exam scope (January 1, 2022, to June 30, 2023). As such, in 3 projects (Pending Report, NPIOR, and Ground Ambulance), claims reprocessing included claims that were beyond the exam period.

Claims Reprocessing Projects	Related CF's, Sample Files and NDOI Complaints	Number of Reprocessed Claims [PRIOR TO EXAM]	Number of Reprocessed Claims [DURING EXAM]	Number of Reprocessed Claims [TOTAL = Prior to exam + During Exam]	Total Amount Paid Including Interest [PRIOR TO EXAM]	Total Amount Paid Including Interest [DURING EXAM]	Total Amount Paid Including Interest [TOTAL = Prior to exam + During Exam]	Violations of Neb.Rev.Stat. § 44-1540(4)	Violations of Neb.Rev.Stat § 44-8005(1)	Violations of Neb Rev.Stat. § 44-8004(1)	NSA 44-CFR §149.120 (C) (4) *Provided informationally
TIN/NPI Combo	CFs 25, 62, 45, 81	3	1	4	$378.08	$491.19	$869.27	4	4	4	N/A
Toggle Issue (3/22-03/24)	CFs 3 ,14, 60, 129, 138, 152	7	27	34	$14,170.40	$83,350.31	$97,520.71	34	28	28	N/A
Behavioral Health "Blacklist"	CF- 15,60	0	17	17	$0.00	$0.04	$0.04	17	1	1	N/A
Rental Network/Behavioral Health Contract Priority	Complaint 32952 Part 1 CFs 21, 31, 35, 64, 71, 99, 29, 120, 127 Part 2- CFs 19, 29, 46, 48, 63	136	17	153	$478,800.37	$30,431.54	$509,231.91	153	104	104	N/A

OON Providers Claim Sequence	CF 39/58, 56,57,128	4	49	53	$2,378.45	$162,842.50	**$165,220.95**	53	36	36	53
Pending Report	CF's 6, 41, 74, 87, 89	0	187	187	$0.00	$341,935.91	**$341,935.91**	187	45	45	N/A
NPIOR	CFs 43, 94, 117 Complaint 33913	0	33	33	$0.00	$36,031.30	**$36,031.30**	33	22	22	33
Rental Network Pricing	Complaint 31132, 34007 CFs 128, 58, 131	1419	39	1458	$2,816,637 .03	$206,088.73	**$3,022,725.76**	1458	1127	1127	N/A
Invalid Coding Place of Service 24	Complaint 33095 CFs 55, 77, 105, 126	0	37	37	$0.00	$23,244.06	**$23,244.06**	37	37	37	37
Ground Ambulance	CF-111	0	41	41	$12,981.96	$48,833.07	**$61,815.03**	41	33	33	N/A
Miscellaneous Claims	Sample: 3, 5, 7, 13, 23 1-BBB, DOI 34007	0	5	5	$1,130.40	$10,248.45	$11,378.85	5	5	5	
Preventive Services Part 1 Immunizations & Mammograms	CF-148	0	194	194	$23,690.40	$22,823.03	$46,513.43	194	189	189	
Preventive Care (Part 2) 1. Preventive Consults 2. Preventative Labs/ Pathology 3. Preventive Surgery/ Procedures	CFs 144, 145, 153, 156	0	70	70	$6,877.24	$4,954.02	$11,831.26	70	65	65	N/A
Total		**1566**	**716**	**2282**	**$3,356,66 6.25**	**$970,782.96**	**$4,327,449.21**	**2282**	**1692**	**1692**	**123**

NEBRASKA

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DEPARTMENT OF INSURANCE

Governor Jim Pillen

CERTIFICATE OF ADOPTION

Take notice that the proposed report of the market conduct examination of Oscar Insurance Company dated as of June 30, 2023, verified under oath by the examiner-in-charge on February 25, 2025, and received by the company on February 25, 2025, has been adopted without modification as the final report pursuant to Neb. Rev. Stat. § 44-5906(3)(a).

Dated this 25th day of February, 2025.

STATE OF NEBRASKA
DEPARTMENT OF INSURANCE

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