Final Report Federal Targeted Market Conduct Examination of
Tennessee State Group Insurance Program
As of July 08, 2024.

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I. Scope of Examination

The Center for Consumer Information and Insurance Oversight (CCIIO) conducted a targeted Market Conduct Examination (Examination) of Tennessee State Group Insurance Program (Plan), a self-funded non-Federal governmental plan, pursuant to 45 C.F.R. § 150.313, based on complaints submitted to CCIIO.

The Examination period was January 1, 2022, through December 31, 2022 (Examination Period). The purpose of the Examination was to assess the Plan's compliance with the following Federal requirements under section 2799A-1(a) of the Public Health Service Act (PHS Act) and implementing regulations:

- 45 C.F.R. § 149.110 – Preventing Surprise Medical Bills for Emergency Services; and
- 45 C.F.R. § 149.140 – Methodology for Calculating Qualifying Payment Amount (QPA).

CCIIO contracted with Examination Resources, LLC to assist CCIIO with conducting this Review.

During this Examination, CCIIO requested information, records, and data related to claims submitted to the Plan for emergency services furnished to Plan participants and beneficiaries. CCIIO requests included:

- Electronic claim records for the 108 claims associated with the complaints submitted to CCIIO; and
- For each complaint, the Explanation of Payment (EOP) (also known as provider remittances), and any other document the Plan used to convey required QPA disclosures to nonparticipating providers or emergency facilities with an initial payment or notice of denial of payment.

This report is by exception; therefore, the only areas indicated in the report are areas where findings were noted. Any additional practices, procedures, and files subject to review during the Examination are omitted from this report if no findings are indicated. Some non-compliant practices may not have been discovered or noted in this report. Failure to identify or address business practices that do not comply with Federal statutes and regulations or those of other applicable jurisdictions does not constitute acceptance of such practices.

Please note: this report describes the Plan's compliance during the Examination Period with applicable regulations and guidance as modified by *Texas Medical Association et al. v. U.S. Department of Health and Human Services et al.* Case No. 6:22-cv-450-JDK (TMA III), which was issued by the United States District Court for the Eastern District of Texas after completion of CCIIO's examination of the Plan. The ruling vacated certain provisions of the regulations and guidance regarding the calculation of the QPA. The court's decision did not impact the findings or scope of this Examination.

The examination and testing methodologies followed standards established by the National Association of Insurance Commissioners[1] and procedures developed by CCIIO. The Examination's claim sample comprised 108 complaints submitted to CCIIO and which alleged non-compliance with the requirements cited above. The claim sample is summarized in the table below:

Area Reviewed	Population	Sample Size
Complaints submitted to CCIIO	108	108

[1] Market Regulation Handbook Examination Standards Summary 2022. https://content.naic.org/sites/default/files/publication-mes-hb-market-handbook-examination.pdf.

II. Plan Profile

The Tennessee State Group Insurance Program offers self-funded health benefits to its employees and dependents.

The state employee health benefit plans are developed using the Tennessee essential health benefit benchmark plan. The State of Tennessee offers both Preferred Provider Organization (PPO) plans and Consumer Directed Health Plans (CDHPs).

The Tennessee State Group Insurance Program contracts with Cigna Health and Life Insurance Company (Cigna) as its third-party administrator to process claims.

III. Executive Summary

CCIIO conducted the Examination to assess the Plan's compliance with the following requirements under Title XXVII of the PHS Act:

- Section 2799A-1(a) of the PHS Act – Preventing Surprise Medical Bills;
- 45 C.F.R. § 149.110 – Preventing Surprise Medical Bills for Emergency Services; and
- 45 C.F.R. § 149.140 – Methodology for Calculating Qualifying Payment Amount.

The Examination Period was January 1, 2022, through December 31, 2022.

The Examination included the review and analysis of information, records and claims data. The claim sample totaled 108 claims. All items and services were for emergency services.

This report is by exception; therefore, the only areas indicated in the report are areas where findings were noted. Any additional practices, procedures, and files subject to review during the Examination are omitted from this report if no findings are indicated. Please note: all statutes and regulations cited in this report refer to those applicable during the Examination Period. In summary, findings were identified in violation of the following Federal requirements:

Finding 1	
Summary	Failing to send to the provider or facility an initial payment or a notice of denial of payment, not later than 30 calendar days after the bill for emergency services is transmitted by the provider or facility. This 30-calendar-day period begins on the date the Plan receives the information necessary to decide a claim for payment for the services.
Citation(s)	Section 2799A-1(a)(1)(C)(iv)(I) of the PHS Act; 45 C.F.R. § 149.110(b)(3)(iv)(A)
Corrective Action	The Plan is directed to update its claim processing procedures to ensure that all initial payments or notices of denial of payment

	for emergency services covered under the Plan are sent to the nonparticipating provider or a nonparticipating emergency facility no later than 30 calendar days after the bill for services is transmitted. This 30-calendar-day period begins on the date the Plan receives the information necessary to decide a claim for payment for the services. The Plan is also directed to review its policies and procedures to ensure it complies with the requirement to send all initial payments or notices of denial of payment for non-emergency services subject to the No Surprises Act furnished by a nonparticipating provider with respect to a visit at a participating health care facility to the provider or facility no later than 30 calendar days after the bill for services is transmitted. See 45 CFR 149.120(c)(3). This 30-calendar-day period begins on the date the Plan receives the information necessary to decide a claim for payment for the services. Within 45 calendar days of receipt of this final report, provide a copy of the updated procedure(s) to CCIIO.

Finding 2	
Summary	Failing to provide required QPA disclosures to the provider or facility in cases in which the recognized amount with respect to an item or service is the QPA.
Citation(s)	Section 2799A-1(a)(2)(B)(ii) of the PHS Act; 45 C.F.R. § 149.140(d)(1)(i), (iii)-(v)
Corrective Action	The Plan is directed to update its claim processing procedures to ensure all required disclosures are provided to the provider or facility, as applicable, with an initial payment or notice of denial of payment. Within 45 calendar days of receipt of this final report, provide a copy of the updated procedure(s) to CCIIO.

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

The Examination identified practices that do not comply with Federal requirements applicable during the Examination Period. The Plan is directed, within 45 calendar

days of receipt of this final report, to take corrective action to demonstrate its ability and intention to conduct business in accordance with Federal requirements. CCIIO strongly recommends that the Plan apply the corrective actions outlined in this Examination Report and share information about the corrective actions taken, as applicable, with any third-party administrator(s), regardless of situs or regulatory jurisdiction, for No Surprises Act-eligible claims.

IV. Examination Results

A. Failing to Timely Send Initial Payment or Notice of Denial of Payment No Later Than 30 Calendar Days After the Bill for Emergency Services is Submitted.

Violation of section 2799A-1(a)(1)(C)(iv)(I) of the PHS Act, as implemented by 45 C.F.R. § 149.110(b)(3)(iv)(A)

CCIIO identified a violation in the following instances:

Finding 1 – The Plan failed to send an initial payment or a notice of denial of payment no later than 30 calendar days after the bill was transmitted for emergency services.

CCIIO identified six occurrences within the claims reviewed for which the Plan sent an initial payment or the notice of denial of payment for covered emergency services to the provider or facility later than 30 calendar days after the bill was transmitted by the provider or facility and the plan had received the information necessary to decide a claim for payment for the services.

Corrective Action:

The Plan is directed to update its claim processing procedures and/or its claims handling process to ensure that an initial payment or notice of denial of payment is sent to the provider or facility not later than 30 calendar days after the bill for emergency services covered under the Plan is transmitted by the provider or facility. The 30-calendar-day period begins on the day the Plan receives the information necessary to decide a claim for payment for the services. The Plan is also directed to review its policies and procedures to ensure that they comply with the requirement to send all initial payments or notices of denial of payment for non-emergency services subject to the No Surprises Act furnished by a nonparticipating provider with respect to a visit at a participating health care facility are sent to the provider or facility no later than 30 calendar days after the bill for services is submitted. Within 45 calendar days of receipt of this final report, provide a copy of the updated procedure(s) to CCIIO.

Plan Response:

The Plan respectfully disagrees with the number of occurrences listed in the March 11, 2024, Draft Report of the Federal Targeted Market Conduct Examination of The State of Tennessee Employee Health Benefit Plan.

For all samples listed in Exhibit 1 of the Draft Report, the "Number of Days Out of Compliance" appears to be based on the date of bank settlement rather than the date the Plan processed the claim and issued initial payment. Payment transmission for each of the samples in Exhibit 1 of the Draft Report was transmitted to the bank on February 18, 2022. As there was a federal holiday on February 21, 2022, bank settlement did not occur until four (4) days later, February 22, 2022.

When accounting for the Plan's issuance of payment information to the bank and the federal holiday, the Number of Days Out of Compliance should be reduced by four (4) for each sample. As a result, Samples 20, 33 and 35 were processed for initial payment on the 30th calendar day and therefore not out of compliance. Screenprints showing the date electronic funds transfer (EFT) was initiated for each of these three claims is attached to this submission. Please refer to Attachment I (EFT Screenprints_State of TN Exam). "CHK ISSUE DATE" in each of the screenprints represents the date Cigna transmitted payment information to the bank.

Accordingly, the Plan respectfully requests the Number of Days Out of Compliance to be adjusted in the Final Report, and the number of occurrences listed in Finding #1 be reduced from nine (9) to six (6).

CCIIO Response:

CCIIO accepts the Plan's response and has removed three of the original nine occurrences. Additionally, we have adjusted the number of days out of compliance for the remaining violations.

B. Failing to Provide Required QPA Disclosures with Each Initial Payment or Notice of Denial of Payment.

Violation of section 2799A-1(a)(2)(B)(ii) of the PHS Act, as implemented by 45 C.F.R. § 149.140(d)(1)(i), (iii)-(v)

CCIIO identified a violation in the following instances:

Finding 2 – The Plan failed to provide certain required QPA disclosures with an initial payment or notice of denial of payment.

CCIIO identified 178 occurrences in which the Plan failed to provide required QPA disclosures. CCIIO determined the following violations occurred where required disclosures were not provided:

- The QPA for each item or service involved, in violation of 45 C.F.R. § 149.140(d)(1)(i): 100 occurrences;
- Certification that the QPA applies for purposes of the recognized amount, in violation of 45 C.F.R. § 149.140(d)(1)(iii)(A): 24 occurrences;
- Certification that each QPA shared with the provider or facility was determined in compliance with 45 C.F.R. § 149.140, in violation of 45 C.F.R. § 149.140(d)(1)(iii)(B): 24 occurrences;
- A statement advising how to initiate a 30-day open negotiation period and a statement that the provider or facility, generally, may initiate the Independent Dispute Resolution (IDR) process within four days after the end of open negotiation period, in violation of 45 C.F.R. § 149.140(d)(1)(iv): 24 occurrences; and
- A phone number and email address for the appropriate person or office to initiate open negotiations, in violation of 45 C.F.R. § 149.140(d)(1)(v): six occurrences.

CCIIO received and reviewed 108 complaints and electronic claim records submitted to the Plan. CCIIO determined that the violations occurred due to different factors, which included procedures that excluded QPAs from certain claim processing results and omissions of forms. In many cases, these violations

occurred in two key scenarios: (1) when the Plan did not issue an initial payment because the services were subject to a deductible greater than or equal to the QPA (in which case the Plan should have sent a notice of denial of payment); and (2) for when claims that had both paid and denied claim lines.

Corrective Action:

The Plan is directed to update its claim processing procedures to ensure that all required disclosures are included with each initial payment or notice of denial of payment for all applicable No Surprises Act eligible claims. Within 45 calendar days of the receipt of this final report, provide a copy of the updated procedure(s) to CCIIO.

Plan Response:

The Plan respectfully disagrees with the number of occurrences listed in Exhibit 2 of the Draft Report. As outlined below, the Plan provided the required information indicated to be missing for certain claims/Samples.

"Missing Notice of Option 30-Day Neg/4-Day IDR"

The documentation provided by the Plan for Samples #7, #9, #15, #16, #21, #23, #25, #26, #27, #30, #31, #33, #35, #36, #38, #39, #40, #41, #42, #50, #89 and #106 includes a statement informing providers of the applicability of the federal dispute resolution process. This disclosure can be found in the Remark Code language on the final page of the documentation for these Samples and states: “FEDERAL LAW PROHIBITS BALANCE BILLING. PROVIDER: FEDERAL DISPUTE RESOLUTION PROCESS APPLIES – CONTACT CIGNA.”

"Missing Contact Info"

For samples #24, #47, #68, #73, #89 and #106, the documentation provided includes contact information, including a telephone number and email address, for a provider to initiate open negotiations for purposes of determining an amount of payment (including cost sharing) for such item or service.

Please refer to the Remark Code language on the final page of the documentation submitted for Samples #24, #47, #68, #73, #89 and #106, which includes the statement: “FEDERAL LAW PROHIBITS BALANCE BILLING.

PROVIDERS SHOULD CONTACT ZELIS AT NSA@ZELIS.COM OR 888.346.8488 WITH QUESTIONS."

CCIIO Response:

CCIIO disagrees with the Plan's position on both the "Missing Notice of *Option* 30-day Neg/4-Day IDR" and "Missing Contact Info." The disclosures in the remark codes identified by the Plan do not comply with the requirements under the PHS Act and its implementing regulations because the language provided does not include the following: the required 30-day open negotiation period notice along with the information on initiating an IDR and contact information for requesting as 45 CFR 149.140 (d)(1)(iv) and (v) require. As part of the corrective action to update its claim processing procedures to ensure that all required disclosures are included with each initial payment or notice of denial of payment for all applicable No Surprises Act eligible claims the Plan is required to update the language that meets the requirements outlined in regulation. For example, revised language could state:

- "The Federal No Surprises Act (NSA) applies for this claim. The qualifying payment amount (QPA) applies for purposes of the recognized amount. Each QPA was determined in compliance with the NSA. Under the NSA, if you do not accept this initial payment amount, you have 30 business days from receipt of the initial payment or notice of denial of payment to initiate open negotiation. You may initiate open negotiation by contacting [email] or [phone number]. If no agreement is reached during the Open Negotiation, you have 4 business days following the conclusion of the Open Negotiation period to initiate the independent dispute resolution process."
- "The Federal No Surprises Act (NSA) applies for this claim. For services rendered that were not air ambulance services, the qualifying payment amount (QPA) applies for purposes of the recognized amount. For air ambulance services rendered, the QPA applies for calculating the member cost share. The QPA for each item or service included on this notice was determined in compliance with the NSA. If you wish to initiate a 30-day open negotiation period for purposes of determining the amount of total payment of the claims in this notice you have 30 business days from receipt of the initial payment or notice of denial of payment to initiate a 30-day open negotiation period. You may initiate open negotiation by contacting [email] or [phone number]. If no agreement is reached during the 30-day open negotiation period for purposes of determining the

amount of total payment of claims at issue, you may initiate the independent dispute resolution process within 4 business days beginning on the 1st business day following the conclusion of the open negotiation period."

V. Closing

CCIIO conducted an Examination of the Plan based on 108 complaints submitted to CCIIO. CCIIO used these complaints as the claim samples for the Examination. CCIIO reviewed claim samples and identified two findings that totaled 184 occurrences.

Findings included:

- Failing to send the provider or facility an initial payment or a notice of denial of payment not later than 30-calendar days after the bill for the emergency services is submitted: six occurrences; and

- Failing to provide required disclosures regarding the QPA with an initial payment or a notice of denial of payment: 178 occurrences.

VI. Examination Report Submission

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

Jeffrey C. Wu -S Digitally signed by Jeffrey C. Wu -S
Date: 2024.07.08 11:28:18 -04'00'

Jeff Wu,
Deputy Director, Policy
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services

In addition, the following individuals participated in this Examination and in the preparation of this report:

Center for Consumer Information and Insurance Oversight

- Nicole McClain, MCM

Examination Resources, LLC