Health Care Financing Administration
Kansas City Regional Office

Market Conduct Examination Report

TriSource HealthCare, Inc., d/b/a Blue Advantage

Background

Generally, the individual and group market requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) became effective on July 1, 1997.

As of the commencement of the market conduct examination of TriSource HealthCare, Inc., d/b/a Blue Advantage (TriSource), the state of Missouri had not incorporated into Missouri state law provisions and/or requirements that would bring Missouri state law into compliance with HIPAA. As a result, pursuant to Federal Regulations found at 45 CFR 146.184 (b)(2)(I) and 45 CFR 148.200 (b)(1) (since replaced by Federal Regulations found at 45 CFR 150.203(a)), the enforcement of the requirements of HIPAA in Missouri are the responsibility of the Health Care Financing Administration (HCFA), primarily the HCFA Kansas City Regional Office (KCRO).

Utilizing enforcement tools similar to those used by State insurance departments, the HCFA KCRO undertook the responsibility of the enforcement of HIPAA through form review, complaint investigation, and market conduct examinations.

HuffThomas, a regulatory consulting firm, was contracted by HCFA to perform the on-site portion of market conduct examinations of issuers identified by HCFA.

On July 29, 1999, a letter was sent to BCBSKC President, John P. Mascotte announcing the examination of BCBSKC and all affiliated companies which include TriSource.

On September 13, 1999 an entrance conference was held at BCBSKC headquarters in Kansas City, Missouri and the examination of TriSource began.

History

TriSource HealthCare, Inc d/b/a Blue Advantage (TriSource) was incorporated on November 25, 1991, as a for profit corporation and operates as a Health Maintenance Organization under the Health Services Corporation law (Chapter 354) of the State of Missouri. TriSource is 52% owned by a subsidiary of Blue Cross and Blue Shield of Kansas City and the remaining stock is owned equally by 5 other health care provider organizations.

The Missouri Department of Insurance issued a Certificate of Authority to operate as a Health Maintenance Organization (HMO) on February 26, 1992. The Company's licensing area includes 30 northwestern counties in Missouri and Johnson and Wyandotte counties in Kansas.

Management Structure

The Officers and Board of Directors of TriSource are as follows:

John Willard Kennedy	President
Richard Alan Stilley	Assistant Secretary
Marilyn Teague Tromans	Chief Financial Officer
Francis Vincent Creeden, Jr.	
Richard William Brown	
Francis Henry Devocelle	
Tom Ellis Bowser	
Nettie Lou Agnew	
Irene Margaret Cumming	
John Pierre Mascotte	
Frank Jerauld Ditirro	
John William Knack, Jr.	
Robert Roger Lundeen	

Insurance Products

TriSource is licensed in Missouri as an HMO subject to sections 354.010 through 354.380 of the Health Services Corporation law. TriSource offers an individual and group HMO product under the product name Blue Advantage. Blue Advantage is an HMO network consisting of 14 Kansas City metropolitan hospitals, nine non-metropolitan hospitals, 260 primary care physicians and another 1,188 specialists. The 57,000 members enrolled in Blue Advantage select a primary care physician to coordinate their health care and make referrals to specialists when necessary.

Use of Agents and Managing General Agents

TriSource does not use General Agents (GA) or Managing General Agents (MGA) as a distribution system for their products. Licensed agencies, agents and brokers are used for the external distribution system.

NOTE: Prior to the completion of this report HCFA was notified by TriSource that Blue Cross and Blue Shield of Kansas City had acquired 100% interest in TriSource effective April 1, 2001.

Exception # 1- - Violation of 45 CFR 148.126

General Subject Area(s) - - Determination of an Eligible Individual

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Background

TriSource HealthCare, Inc d/b/a Blue Advantage (TriSource) furnishes health insurance in the individual market in the State of Missouri. As such, pursuant to Federal Regulations found at 45 CFR 148.120, TriSource is required to offer products that do not impose any preexisting condition exclusions on those individuals meeting the definition of an "eligible individual" as defined in Federal Regulations found at 45 CFR 148.103. In addition, TriSource is required to determine the eligibility of all individual applicants pursuant to the requirements found at 45 CFR 148.126.

The information provided to the examiners does not confirm that TriSource correctly determines the eligibility of each applicant for individual coverage.

Specific Violation

- **TriSource does not determine if all individuals applying for individual coverage are "eligible individuals" entitled to guaranteed available individual coverage without any preexisting condition exclusions.**

Federal Regulations found at 45 CFR 148.126 place the responsibility of determining the eligibility of an applicant to guaranteed available coverage on the issuer. An issuer must exercise "reasonable diligence" in making the determination and is allowed to request additional information if the information provided by the applicant is "substantially insufficient." In addition, this subject was further clarified in the HCFA June 1999 *Program Memorandum 99-02*.

The TriSource underwriting procedures provided the on-site contract examiners state in part:

> "8. Each application is reviewed for HIPAA eligibility (or other pre-existing waivers) by reviewing question #30 on the application and any attached certificates of creditable coverage…"

The application provided the on-site contract examiners and represented as the only application used by TriSource in the determination of eligible individuals question #30 states:

"DO YOU OR ANY PERSON APPLYING FOR COVERAGE HAVE A MINIMUM OF 18 MONTHS OF CONTINUOUS PRIOR COVERAGE, MOST RECENT UNDER AN EMPLOYER GROUP PLAN, GOVERNMENT PLAN OR CHURCH PLAN?

___YES ___NO

IF 'YES,' PLEASE PROVIDE CERTIFICATE(S) OF CREDITABLE COVERAGE FROM PRIOR PLAN(S)."

Issue with Application Question #30

It is unclear if TriSource actually only uses question #30 and a certificate of creditable coverage to determine the eligibility of an applicant. While the applicable Federal Regulations would not prevent a less stringent standard than those outlined at 45 CFR 148.103 it would be unusual for an issuer to develop such a standard.

In this regard, HCFA notes that question #29 of the same application appears to be designed to also find out if applicants are eligible for a group health plan, Medicare, Medicaid, or have other health insurance coverage.

However, there is currently no evidence to indicate TriSource attempts to discover if applicants' last coverage was terminated due to nonpayment of premiums or fraud.

More importantly, there is no indication TriSource asks any questions to discover if applicants who have been offered COBRA or other State continuation coverage have elected and exhausted this option.

When responding to Exception #1 of this report HCFA requests TriSource include information and/or supporting documentation to clarify this issue.

Problems with Application Question #30

There appear to be at least two (2) problems with TriSource's apparent determination of eligible individual process.

1) **Question #30 does not correctly reflect the requirements of 45 CFR 148.103(1)** – Federal Regulations found at 45 CFR 148.103(1) state that in order for an applicant to meet the definition of an eligible individual, the individual must have "…at least 18 months of creditable coverage (as determined under 45 CFR 146.113)…"

At the risk of oversimplification, "creditable coverage" as defined at 45 CFR 146.113 can be made up of almost an uncountable number of various coverage and 18 month coverage scenarios. Such coverage scenarios could include, but would not be limited to, all the varying periods of time when an applicant was insured by a group health plan, Medicaid, Medicare, Indian Health Service coverage, State Risk pool coverage, coverage provided to members of uniformed services, etc. It is at least questionable, whether a question using the phrase "continuous coverage" would lead an applicant to consider all these various types of coverage scenarios when answering.

However, the most clear indication that question #30 will not properly identify all eligible individuals is **the question does not take into account breaks in coverage which do not meet the definition of a "significant break in coverage" as defined at 45 CFR 146.113(b)(iii)**. A period of "Creditable coverage" does not necessarily need to be "continuous coverage" as is asked by question #30. Federal Regulations found at 45 CFR 146.113(b)(ii) state in part "Days of creditable coverage that occur before a significant break in coverage are not required to be counted (emphasis added)." However, the definition of a "significant break in coverage" found at 45 CFR 146.113(b)(iii) generally defines a "significant break in coverage" as "…a period of 63 consecutive days during all of which the individual does not have any creditable coverage…" In summary, a TriSource applicant may in fact have 18 months of "creditable coverage" without necessarily having 18 months of "continuous coverage."

2) **TriSource appears to only accept certificates of creditable coverage as evidence –** Based on HCFA's current understanding of TriSource's determination of eligible individual process, it would at least appear TriSource does not make any provisions for accepting other evidence of prior creditable coverage as required by 45 CFR 148.126(c)(1). There is no language in question #30 (or elsewhere in the application) which would indicate an applicant may demonstrate creditable coverage through other means as allowed by following the requirements of 45 CFR 148.124(d)(1).

Adverse Impact to Missouri Consumers

- Based on the current information provided HCFA, not all applicants for individual coverage with TriSource are properly determined as either meeting, or not meeting, the definition of an "eligible individual."

Recommendation(s)

- TriSource should either:

1) Provide explanations and evidence addressing HCFA's conclusions regarding their determination of eligible individual process sufficient to prove compliance to HCFA or;

2) Develop procedures which would determine if all applicants for individual coverage meet the definition of an "eligible individual" as defined at 45 CFR 148.103.

Examination Note: Prior to the finalization of this examination report TriSource provided HCFA with information and documentation indicating it had taken affirmative steps attempting to correct the problems and/or issues outlined in this exception. While HCFA is not prepared at this time to confirm that all of these problems and/or issues have been corrected, TriSource's apparent commitment to addressing this exception and HCFA's concerns is hereby noted.

Exception # 2- - Violation of 45 CFR 148.120

General Subject Area(s) - - Offering all available coverage options

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Background

TriSource HealthCare, Inc. d/b/a Blue Advantage (TriSource) furnishes health insurance in the individual market in the State of Missouri. As such, pursuant to Federal Regulations found at 45 CFR 148.120 TriSource is required to offer products that do not impose any preexisting condition exclusions on those individuals meeting the definition of an "eligible individual" as defined in Federal Regulations found at 45 CFR 148.103. TriSource is also required to determine the eligibility of all individual applicants pursuant to the requirements found at 45 CFR 148.126.

Upon determination an applicant meets the definition of an "eligible individual," Federal Regulations found at 45 CFR 148.120(a)(1)(i) require an insurer to provide the applicant "…information about all available coverage options." Pursuant to 45 CFR 148.120(a)(1)(ii) the insurer must then "Enroll the individual in any coverage option the individual selects." Pursuant to Federal regulations found at 45 CFR 148.120(a)(2) eligible individuals also have access to policies which do not "…impose any preexisting condition exclusion on the individual."

Pursuant to 45 CFR 148.120 insurers have three (3) general options regarding which products they will offer eligible individuals. This can include:

1) an "all products guarantee"
2) the insurer's two most popular policies, or
3) two (2) representative policy forms [see 45 CFR 148.120(a)(3)].

TriSource offered the following two (2) products to "eligible individuals":

1) Blue Advantage HMO
2) Blue Advantage Select HMO

While the two (2) aforementioned products are marketed on an underwritten basis without any preexisting condition limitations, not all applicants are accepted. However, when an applicant meets the definition of an "eligible individual" they are to be accepted without regard to their evidence of insurability.

Specific Violation

- **TriSource does not provide information regarding all available coverage options to all eligible individuals.**

Federal Regulations found at 45 CFR 148.120 require that "…with respect to any eligible individual who requests coverage." issuers must provide information regarding all coverage options and enroll the individual in any coverage option the individual selects.

As outlined in exception #1 of this report, the information provided to the on-site contract examiners does not confirm that TriSource properly determined if all individuals applying for coverage are "eligible individuals" entitled to guaranteed available individual coverage. As such, TriSource is unable to confirm all applicants meeting the definition of "eligible individuals" were informed of all available coverage options, that is, the option to purchase either the Blue Advantage HMO or the Blue Advantage Select HMO policy on a guaranteed available basis without regard to their evidence of insurability.

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Adverse Impact to Missouri Consumers

- Based on the current information provided HCFA, those applicants for individual TriSource coverage who meet the definition of an eligible individual are not provided information regarding all the coverage options available to them. Such applicants are forced to make an uninformed purchase decision and perhaps purchase a policy with a preexisting condition limitation from another insurer or seek coverage with the State of Missouri Health Insurance Pool when guaranteed available coverage with TriSource was an option for them.

Recommendation(s)

- TriSource should either:

1) Provide explanations and evidence addressing HCFA's conclusions regarding it's providing information about all available coverage options to those applicants for individual coverage meeting the definition of an "eligible individual" as defined at 45 CFR 148.103.

2) Develop procedures which would provide information about all available coverage options to those applicants for individual coverage meeting the definition of an "eligible individual" as defined at 45 CFR 148.103.

Examination Note: Prior to the finalization of this examination report TriSource provided HCFA with information and documentation indicating it had taken affirmative steps attempting to correct the problems and/or issues outlined in this exception. While HCFA is not prepared at this time to confirm that all of these problems and/or issues have been corrected, TriSource's apparent commitment to addressing this exception and HCFA's concerns is hereby noted.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Federal Office Building
601 East 12th Street, Room 235
Kansas City, Missouri 64106

9/25/2001

John P. Mascotte, President and Chief Executive Officer
Blue Cross and Blue Shield of Kansas City
P.O. Box 419169
Kansas City, Missouri 64141-6169

RE: May 8, 2001 Market Conduct Examination Reports
Blue Cross and Blue Shield of Kansas City
TriSource HealthCare, Inc., d/b/a Blue Advantage
Your letter Dated June 4, 2001

Dear Mr. Mascotte:

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) market conduct examination requirements found at 45 CFR 150.313(e)(3), this letter will convey the results of the Centers for Medicare and Medicaid Services' (CMS) (formerly the Health Care Financing Administration) review of Blue Cross and Blue Shield of Kansas City's (BCBS of KC) June 4, 2001 response to the market conduct examination reports of BCBS of KC and TriSource HealthCare, Inc., d/b/a Blue Advantage dated May 8, 2001.

Specifically, the requirements of 45 CFR 150.313(e)(3) provide CMS with the following four (4) response options to each issue identified in a market conduct examination report:

1. Concurrence with the issuer's position.

2. Approval of the issuer's proposed plan of correction.

3. Conditional approval of the issuer's proposed plan of correction, which will include any modifications CMS requires.

4. Notice to the issuer that there exists a potential violation of HIPAA requirements.

With respect to any issues CMS chooses to "Approve" or "Conditionally Approve" in this letter, CMS may pursue a Civil Monetary Penalty (CMP) should BCBS of KC not fulfill the requirements and/or take the appropriate corrective actions within the appropriate time frames. In addition, CMS will consider such a failure by BCBS of KC to be an aggravating factor as provided for at 45 CFR 150.312 and calculate any CMPs to the maximum amount allowed under the law.

TriSource HealthCare, Inc., d/b/a Blue Advantage

Effective April 1, 2001, Blue Cross and Blue Shield of Kansas City (BCBS of KC) acquired 100% interest in TriSource HealthCare, Inc., d/b/a Blue Advantage (TriSource). At the conclusion of the transaction on April 1, 2001, TriSource had merged into BCBS of KC and the Blue-Advantage product line became a d/b/a of BCBS of KC. While TriSource ceased to exist as a legal entity, the products and networks remained as before, however BCBS of KC is now the only underwriting carrier for those products.

In their response to this market conduct examination, BCBS of KC provided actuarial information indicating that their two most popular plans as defined in Federal Regulations found at 45 CFR 148.120(c)(2) continues to be the following:

1) BCBSKC-Preferred Care Blue Premium Plan (PPO $500 Premium Deductible)

2) BCBSKC-Preferred Care Blue Rate Saver Plan (PPO $1,000 Rate Saver Deductible)

The market conduct examination findings for TriSource were essentially the same as those for BCBS of KC. Given TriSource no longer exists, BCBS of KC consolidated their comments to CMS. Therefore CMS will be responding in the same manner.

Blue Cross and Blue Shield of Kansas City

Exception #1 – Violation of 45 CFR 148.126 – Determination of Eligible Individuals

Background – The information provided to the on-site market conduct examiners did not confirm that BCBS of KC determined whether or not all applicants for individual coverage met the definition of an eligible individual as defined in Federal Regulations found at 45 CFR 148.103. BCBS of KC disputes CMS's findings in this regard, and indicated they are unaware of Missouri residents who have been denied their HIPAA rights.

However, BCBS of KC has revised its HIPAA training materials, revised its marketing brochure, and revised its Direct Enrollment application in order to ensure all applicants for individual coverage are properly identified.

CMS Response – Accept response based on the corrective actions described above provided:

1) BCBS of KC puts into use the revised direct enrollment application form number BCBSKC-DIRECT-0601 submitted to this agency via BCBS of KC letter dated June 15, 2001. A copy of this agency's acceptance of this form is enclosed.

2) BCBS of KC puts into use the revised training materials and incorporates the revised language submitted in BCBS of KS' response into its marketing brochure. **A final copy of the revised marketing brochure should be submitted to CMS when it is printed**.

Exception #2 – Violation of 45 CFR 148.120 – Offering All Available Coverage Options

Background – The information provided to the on-site market conduct examiners did not confirm that BCBS of KC provided information regarding all available coverage options to applicants identified as an "eligible individual." It appeared that some options were only discussed when the applicants made specific inquiries.

In its response, BCBS of KC disputed CMS's findings. However, BCBS of KC clarified and submitted evidence indicating that it makes available all of its individual products, and the opportunity to have the coverage issued either with or without any preexisting condition limitation, to eligible individuals meeting the company's underwriting guidelines.

Those applicants who are eligible individuals but do not meet the company's underwriting guidelines are offered one of the company's two most popular policies (i.e. PPO $500 Premium Deductible Plan or the PPO $1,000 Rate Saver Deductible Plan) without any preexisting condition limitations.

BCBS of KC further indicated they would be revising the language in their marketing brochure to better clarify which products are the PPO guarantee issue products as well as clarify when an eligible individual may request that a preexisting condition limitation apply.

In addition, BCBS of KC has revised the letters included with the delivery of the policies issued to eligible individuals who meet their underwriting guidelines to include the opportunity for the individual to change the preexisting condition limitation terms. Specifically, each letter, whether issued with or without a preexisting condition limitation, will include both the rate for the policy, and instructions on how to either add the preexisting condition limitation (for a reduced premium) or remove the preexisting condition limitation (for an increased premium). Examples of this language is outlined below:

Example Paragraph #1 - Used when an Applicant Initially **Waives** Preexisting Condition Limitation

"If you qualify as an eligible individual under the Health Insurance Portability and Accountability Act (HIPAA) as described in your application, you are not subject to the pre-existing exclusion period and the rate above includes a minimum 10% premium surcharge. If you would like to have the pre-existing exclusion period apply in consideration of a reduced rate, please call our Customer Service Department."

Example Paragraph #2 - Used when an Applicant Initially **Does Not Waive** Preexisting Condition Limitation

"If you qualify as an eligible individual under the Health Insurance Portability and Accountability Act (HIPAA) as described in your application, you are not subject to the pre-existing exclusion period. However, you have requested that the pre-existing exclusion period apply in consideration of a reduced rate. The rate above is the reduced rate. If you would like to have the pre-existing exclusion period waived, please call our Customer Service Department."

As outlined earlier, those eligible individuals who do not meet BCBS of KC's underwriting guidelines are only offered the options of BCBS of KC's two most popular policies without a preexisting condition limitation.

CMS Response – Accept response based on the corrective actions described above provided:

BCBS of KC appropriately revises its marketing brochure and puts the brochures into use. **A final copy of the revised marketing brochure should be submitted to CMS when it is printed**.

BCBS of KC puts into use the aforementioned revised policy issuance letters.

Please direct any materials, information, or confirmations referenced in this letter that are required to be submitted to CMS to Jorge Lozano of my Insurance Reform Staff. In addition, if you have any questions please contact Jorge directly at (816) 426-5472 ext. 3120.

Sincerely,

///original signed///

Richard P. Brummel
Deputy Regional Administrator

CC: Connie Fries, Counsel, BC/BS of MO
Gale Arden, CMS, Private Health Insurance Group
Ruth Bradford, CMS, Private Health Insurance Group