BEFORE THE COMMISSIONER OF
THE DEPARTMENT OF COMMERCE AND INSURANCE
FOR THE STATE OF TENNESSEE

TENNESSEE INSURANCE DIVISION,	)	
Petitioner,	)	
	)	
v.	)	**TID No.: 26-16**
	)	
OSCAR INSURANCE COMPANY	)	
Respondent.	)	
	)	

CONSENT ORDER

The Insurance Division of the Tennessee Department of Commerce and Insurance ("Division") and Oscar Insurance Company ("Oscar" or "Respondent"), hereby stipulate and agree to the entry and execution of this Consent Order ("Order") in accordance with Title 56 of the Tennessee Code Annotated ("Tenn. Code Ann."), subject to the approval of the Commissioner of the Tennessee Department of Commerce and Insurance ("Commissioner").

GENERAL STIPULATIONS

1. It is expressly understood that this Order is subject to the Commissioner's acceptance and it has no force and effect until entered and executed by the Commissioner.

2. It is expressly understood that this Order is in the public interest, necessary for the protection of consumers, and consistent with the purposes fairly intended by Title 56 of the Tennessee Code Annotated.

3. This Order is executed by the Commissioner, the Division, and the Respondent to avoid further administrative action with respect to this cause. Should this Order not be accepted

by the Commissioner, it is agreed that presentation to and consideration of this Order by the Commissioner shall not unfairly or illegally prejudice the Commissioner from further participation or resolution of these proceedings.

4. The Respondent fully understands that this Order will in no way preclude additional proceedings by the Commissioner against the Respondent for acts or omissions not specifically addressed in this Order.

5. The Respondent fully understands that this Order will in no way preclude proceedings by state government representatives, other than the Commissioner, for the facts, acts, or omissions addressed in or arise out of this Order.

6. The Respondent waives all further procedural steps and all rights to seek judicial review of, or otherwise challenge, the validity of this Order, including the stipulations, the imposition of discipline, and the consideration, entry, and execution of this Order by the Commissioner.

7. This Order is submitted on the condition that if accepted, the Commissioner will not bring any future actions against the Respondent alleging violations based on the same factual findings herein.

AUTHORITY AND JURISDICTION

8. The Commissioner has jurisdiction over the Respondent, this matter, and the Order, pursuant to Title 56 of the Tennessee Code Annotated ("Tenn. Code Ann."), including Tenn. Code Ann. §§ 56-1-101 et seq., 56-1-201 et seq., 56-6-101 et seq, 56-2-301 et seq., 56-8-101 et seq., 56-9-101 et seq., and 56-13-101 et seq. (hereinafter "Law").

9. The Division is the lawful agent through which the Commissioner discharges this responsibility.

PARTIES

10. The Commissioner administers the Law through the Division and brings this action in the public interest and for the protection of insureds and claimants.

11. Oscar ("Respondent") is a Tennessee-licensed foreign Accident and Health company (NAIC #15777). Respondent's primary address of record is 1999 Bryan Street, Suite 900, Dallas, Texas 75201.

FINDINGS OF FACT

12. At all times relevant hereto, the Respondent held a certificate of authority to operate as an Accident and Health Insurance company in the state of Tennessee and was responsible for complying with Tennessee insurance laws and rules.

13. The Respondent was first authorized to write Accident and Health insurance in the state of Tennessee on August 1, 2017.

14. Any entity that offers health insurance coverage to its enrollees that restricts reimbursement for covered services to a defined network of providers with no out-of-network benefits is considered a "managed health insurance issuer" ("MHII") as defined in Tenn. Code Ann. § 56-32-128(a) and must comply with all requirements applicable to MHIIs in Tenn. Code Ann. Title 56.

15. MHIIs are subject to numerous requirements in state law, including the requirement to file network adequacy standards with the Division and update the description annually as outlined in Tenn. Code Ann. § 56-7-2356(a)(2)(A)(i).

16. Based on the most recent policy forms filed with the Division, the Respondent offers health insurance coverage that restricts reimbursement for covered services to a defined network of providers with no out-of-network benefits. The Respondent is therefore subject to

state law requirements applicable to MHIIs, including the requirement to file network adequacy standards with the Division and to update the description annually, as outlined in Tenn. Code Ann. § 56-7-2356(a)(2)(A)(i), with regard to the Respondent's offer and administration of such coverage.

17. Tenn. Code Ann. § 56-7-2356 was amended by 2023 Pub. Ch. 352 to modify various aspects of the network adequacy standards and how they must be reported to the Division. The changes were effective January 1, 2024.

18. In light of these changes, the Commissioner issued Bulletin 24-02 on August 6, 2024 (the "Bulletin") to clarify to all Tennessee-authorized insurance companies of the MHII requirements.

19. The Bulletin explained that all companies falling within the definition of MHII set out in Tenn. Code Ann. § 56-32-128(a) must comply with all legal requirements applicable to MHIIs contained in Title 56.

20. The Bulletin concluded with a timeline for compliance and stated that "all health plans that meet the criteria in Tenn. Code Ann. § 56-32-128(a) [. . .] must begin complying with all sections of Tenn. Code Ann. Title 56 applicable to MHIIs (in addition to those applicable to health insurers generally, with which the insurer should currently be complying) for plans that are entered into or take effect on or after January 1, 2025. Filings submitted to the Department regarding policies that will be effective on or after January 1, 2025, must also comply."

21. The Division finds that the Respondent never filed its network adequacy standards description in the years 2024 or 2025 as required by Tenn. Code Ann. § 56-7-2356(a)(2)(A)(i).

CONCLUSIONS OF LAW

22. Beginning January 1, 2024, Tenn. Code Ann. § 56-7-2356(a) provides:

(1) Each managed health insurance issuer that offers a plan that limits its enrollees' choice of providers shall maintain a network that is sufficient in numbers and types of providers to assure that all covered benefits to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access to health care services twenty-four (24) hours per day, seven (7) days per week. Sufficiency shall be determined in accordance with the requirements of this section and may be established by reference to network adequacy standards established by the managed health insurance issuer, specifically:

(A) Primary care provider-covered person ratios; and

(B) Geographic accessibility;

(2) (A) Each managed health insurance issuer shall:

(i) File a network adequacy standards description with the commissioner, review the description for adequacy and compliance with this section, and update the description annually; and

(ii) Report to the commissioner each material change to an approved network plan at least fifteen (15) days before such change, including each change that would result in a failure to satisfy the requirements of this section. Upon receiving the report, the commissioner shall reevaluate the issuer's network plan for compliance with the network adequacy standards of this section.

(B) As used in this subdivision (a)(2), "material change" means a significant reduction in the number of providers available in a network plan, including, but not limited to, a reduction of ten percent (10%) or more of a specific type of provider in a geographic market, the removal of a major health system that causes a network to be significantly different from the network when the beneficiary enrolled in the network plan, or a change that would cause the network to no longer satisfy the requirements of this section or the commissioner's rules for network adequacy.

(3) In an effort to ensure that consumers within a geographic region have an adequate opportunity to select an in-network provider, including specialty providers and facilities, and to avoid unanticipated out-of-network costs, the network adequacy standards description must include a report for each network hospital that provides the percentage of providers in each of the specialties of emergency medicine, anesthesiology, radiology, radiation oncology, pathology, and hospitalists practicing in the hospital who are in the health benefit plan's network.

23. Beginning January 1, 2024, Tenn. Code Ann. § 56-7-2356(g) provides:

(g) If the commissioner determines that a managed health insurance issuer has not met

the sufficiency standards established by this section, then the commissioner shall require a modification to the network or may institute a corrective action plan to ensure access for enrollees. The commissioner may take other disciplinary action for violations of this section as permitted pursuant to [Tenn. Code Ann.] § 56-2-305, and in accordance with the Uniform Administrative Procedures Act, compiled in [Tenn. Code Ann.] title 4, chapter 5.

24. Tenn. Code Ann. § 56-32-128(a) provides:

(a) As used in this section, "managed health insurance issuer" means an entity that:

(1) Offers health insurance coverage or benefits under a contract that restricts reimbursement for covered services to a defined network of providers; and

(2) Is regulated under this title or is an entity that accepts the financial risks associated with the provision of health care services by persons who do not own or control, or who are not employed by, the entity.

25. Tenn. Code Ann. § 56-2-305 provides:

(a) If, after providing notice consistent with the process established by [Tenn. Code Ann.] § 4-5-320(c) and providing the opportunity for a contested case hearing held in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, part 3, the commissioner finds that any insurer, person, or entity required to be licensed, permitted, or authorized by the division of insurance has violated any statute, rule or order, the commissioner may, at the commissioner's discretion, order:

(1) The insurer, person, or entity to cease and desist from engaging in the act or practice giving rise to the violation;

(2) Payment of a monetary penalty of not more than one thousand dollars ($1,000) for each violation, but not to exceed an aggregate penalty of one hundred thousand dollars ($100,000), unless the insurer, person, or entity knowingly violates a statute, rule or order, in which case the penalty shall not be more than twenty-five thousand dollars ($25,000) for each violation, not to exceed an aggregate penalty of two hundred fifty thousand dollars ($250,000). […] For purposes of [Tenn. Code Ann. § 56-2-305(a)(2)], each day of continued violation shall constitute a separate violation[.]

26. Tenn. Code Ann. § 56-1-110(b) provides:

(1) The commissioner may, against any person, agency, or company licensed, registered, or permitted by or operating under a certificate of authority issued by the commissioner, or acting in an unlawful capacity that brings such person, agency, or company under the jurisdiction of the commissioner, assess the actual and reasonable costs of the investigation, prosecution, and hearing of any disciplinary action held in accordance with the contested case provisions of the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, part 3, in which sanctions of any kind are imposed on that person, agency, or company. These costs may

include, but are not limited to, those incurred and assessed for the time of the prosecuting attorneys, investigators, expert witnesses, administrative judges, and any other persons involved in the investigation, prosecution, and hearing of the action.

[. . .]

> (3) (A) All costs assessed pursuant to this section become final thirty (30) days after the date of a final order of assessment is served.
>
> (B) If the individual or entity disciplined fails to pay an assessment when it becomes final, the commissioner may apply to the chancery court of Davidson County, which shall have jurisdiction over recovery of the costs, for a judgment and seek execution of the judgment.

27. The Division Findings of Fact demonstrate that the Respondent did not file its network adequacy standards descriptions in the years 2024 or 2025, constituting violations of Tenn. Code Ann. § 56-7-2356(a)(2)(A)(i).

ORDER

NOW, THEREFORE, based on the foregoing, including the Respondent's waiver of the right to a hearing and appeal under the Tennessee Uniform Administrative Procedures Act, Tenn. Code Ann. §§ 4-5-101 *et seq*., and otherwise, and the Respondent's admission to the jurisdiction of the Commissioner, the Commissioner finds that the Respondent agrees to the entry and execution of this Order to settle this matter as evidenced by the Respondent's signature.

IT IS ORDERED, pursuant to Tenn. Code Ann. § 56-7-2356 that:

1. The Respondent **COMPLY** with the Law, the Act, and all applicable rules; and

2. The Respondent **PAY A CIVIL PENALTY** to the State of Tennessee of ten thousand dollars ($10,000) via check made payable to the Tennessee Department of Commerce and Insurance within (15) calendar days of the execution of this Order by the Commissioner.

Page one (1) of this Order must accompany the payment for reference. Payment shall be mailed to:

Tennessee Department of Commerce and Insurance
Attn: Virginia Smith
500 James Robertson Parkway
Davy Crockett Tower
Nashville, Tennessee 37243

3. **GRACE PERIOD** – Payment shall be timely made if postmarked within five (5) business days of the date payment is due.

4. **ACCELERATION** – The Respondent hereby agrees that failure to remit any civil penalty payment more than sixty (60) calendar days following the due date of the civil penalty as indicated in this Order shall constitute a default. Upon default, the civil penalty of ten thousand dollars ($10,000) is due and payable immediately.

5. **DELINQUENCY –** The Respondent hereby agrees that failure to make any payment according to this Order shall result in the immediate revocation of the Respondent's registrations with the Division.

6. **MODIFICATION** – The Division and the Respondent hereby agree that modifications to this Order regarding any term may only be made in writing and signed by an authorized representative of each party.

7. The Respondent's failure to comply with the terms of this Order, including the manner and method of payment of the civil penalty described above, shall result in further administrative disciplinary actions, including the potential for assessing additional civil penalties.

8. This Order represents the complete and final resolution and discharge of the Respondent and the Division's administrative and civil claims, demands, actions, and causes of action for violations of the law cited herein with respect to the failure to timely notify the Division

mentioned in the above-referenced facts and Conclusions of Law. However, excluded from and not covered by this paragraph, are any claims by the Division arising from or relating to the enforcement of this Order

9. This Order is in the public interest and the best interests of the Parties. It represents a settlement between the Parties and is for settlement purposes only. By the signatures affixed below, or in two (2) or more counterparts, the Respondent affirmatively states: it freely agrees to the entry and execution of the Order; the Respondent waives the right to a hearing on, or a review of, the matters, the Findings of Fact, and the Conclusions of Law underlying this Order or the enforcement of this Order; and it encountered no threats or promises of any kind by the Commissioner, the Division, or any agent or representative thereof.

10. By signing this Order, the Commissioner, the Division, and the Respondent affirmatively state their agreement to be bound by the terms of this Order and aver that no promises or offers relating to the circumstances described herein, other than the terms of settlement as set forth in this Order, are binding.

11. This Order may be executed in two (2) or more counterparts, each of which shall be deemed an original but all of which together shall constitute one and the same document. The facsimile, email, or other electronically delivered signatures of the parties shall be deemed to constitute original signatures, and facsimile or other electronic copies shall be deemed to constitute duplicate originals.

ENTERED AND EXECUTED ON April _____, 2026.

_____
Carter Lawrence, Commissioner
Department of Commerce and Insurance

ADDITIONAL SIGNATURES ON THE LAST AND FINAL PAGE

APPROVED FOR ENTRY AND EXECUTION:

_____
Signature

_____
Typed Name

_____
Title
On behalf of the Respondent

_____
Scott McAnally
Assistant Commissioner for Insurance
Department of Commerce and Insurance

/s/Virginia Smith_____
Virginia Smith, BPR #31248
Chief Counsel for Insurance and TennCare Oversight
Department of Commerce and Insurance