

STATE OF OREGON

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

INSURANCE DIVISION

REPORT OF TARGET MARKET CONDUCT EXAMINATION

OF

**CASCADE EAST HEALTH PLANS, INC.  
HERMISTON, OREGON**

**NAIC COMPANY CODE 47096**

AS OF

MARCH 31, 1999

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November 30, 1999

Honorable Michael Greenfield, Director  
Department of Consumer and Business Services  
State of Oregon  
350 Winter Street NE, Room 440  
Salem, Oregon 97301-3883

Dear Director:

In accordance with your instructions and pursuant to ORS 731.300, we have examined the business affairs of

**Cascade East Health Plans, Inc.  
645 West Orchard Avenue  
Hermiston, Oregon 97838**

**NAIC Company Code 47096**

hereinafter referred to as the "Company." The following report of examination is respectfully submitted.

## **SCOPE OF EXAMINATION**

The market conduct examination of the Company was conducted as of March 31, 1999 covering the period of January 1, 1998 through March 31, 1999.

A special target examination limited to practices and procedures in compliance with the Patient Protection Act of 1997 was performed. This examination of the Company was conducted pursuant to ORS 731.300 and in accordance with procedures and guidelines as established by the Oregon Insurance Division Market Conduct Program. The program generally follows the Market Conduct Examination Handbook as adopted by the National Association of Insurance Commissioners to the extent that it is consistent with Oregon law. The purpose was to determine the Company's ability to fulfill and manner of fulfillment of its obligations, the nature of its operations, whether it has given proper treatment to policyholders, and its compliance with the Oregon Insurance Code and Administrative Rules.

In order to evaluate the Company's operations, the examiner reviewed policies, procedures and manuals provided by the Company.

## **COMPANY HISTORY**

The Company was incorporated as non-profit charitable corporation under the laws of the State of Oregon on November 7, 1994. Its sole voting member is Good Shepherd Community Hospital, an Oregon non-profit charitable corporation, operating as an acute care hospital in Hermiston, Oregon.

The Company became licensed as a health care service contractor on April 27, 1998.

## **GRIEVANCE PROCEDURES (GP)**

GP1. Is the Company's definition of grievance as broad as the definition found in ORS 743.801(4)?

Findings: Passed

GP2. Does the Company have a written grievance policy in compliance with ORS 743.804(1)(a)? Does the Company have a timely and organized system for resolving grievances and appeals in compliance with ORS 743.804(3)(a)-(f)?

Findings: Failed

The second level of appeal provided by the Company is to the Center for Health Dispute Resolution and requires the member to pay a \$25 fee. The Company is required to have two levels of appeal. If the Company chooses to have the second required level of appeal be to the Center for Health Dispute Resolution, the Company must pay the fee. This fee can only be charged to the member if the Company provides for two appeals prior to the external review through the Center for Health Dispute Resolution.

Also, the Company's grievance and appeal process did not provide for the following; but, during the course of the examination, they did revise their procedures to do so:

- Written decisions in plain language justifying grievance determinations, including appropriate references to relevant policies, procedures and contract terms. (The procedures provided by the Company indicate that enrollees will be notified of decisions in writing, but they did not indicate that the written notification will be in plain language with appropriate references to relevant policies, procedures and contract terms.)
- Opportunity for enrollees and representatives of enrollees to appear before a review panel at either the first or second level of review.

**I recommend the Company revise their grievance and appeal procedures to include an appeal process that provides for two levels of review without charge to the member in compliance with ORS 743.804(3)(f).**

Subsequent to the examination, the Company advised they had eliminated the \$25 fee being charged to the member for appeals to the Center for Health Dispute Resolution. If the member is not charged for appeals to the Center for Health Dispute Resolution, making such appeals available satisfies the requirement for a second request.

GP3. Did the Company file an annual summary in accordance with ORS 743.804(9) and OAR 836-053-1000(3)(a)?

Findings: Not applicable. The Company was not in operation during the 1998 reporting period.

GP4. Was the summary in the format prescribed by OAR 836-053-1070(1) and Bulletin 98-6?

Findings: Not applicable. The Company was not in operation during the 1998 reporting period.

GP5. Does the Company provide to all enrollees a summary of information explaining the procedures regarding grievances in compliance with ORS 743.804(5)(f) and (h)?

Findings: Passed with comment.

The Company does provide enrollees with information on the grievance and appeal process. However, the process, itself, is not in compliance with ORS 743.804(3) for the reasons outlined under GP2.

GP6. Does the summary disclose the right to file a complaint or seek assistance from the Insurance Division in accordance with ORS 743-804(5)(q) and OAR 836-053-1030(6)?

Findings: Passed

GP7. Does the Company provide, upon request from an enrollee or prospective enrollee, a copy of the insurer's annual report on grievances and appeals in accordance with ORS 743.804(6)?

Findings: Passed

GP8. Does the Company provide an enrollee who has filed a grievance with detailed information about the Company's procedures and how to use them and include information on how to access the Insurance Division's complaint line in accordance with ORS 743.804(8)?

Findings: Passed

GP9. Does the Company provide notice in all written decisions of the right to file a complaint or seek assistance from the director of the Department of Consumer and Business Services in accordance with ORS 743.804(3)?

Findings: Passed

GP10. Does the Company record data relating to grievances and the actions taken in a sufficient manner in compliance with OAR 836-053-1080?

Findings: Passed with comment.

During the course of the examination, the Company revised their “appeals and complaint log” to categorize complaints according to the categories established by OAR 836-053-1080.

GP11. Does the Company respond within the timeliness standards required by OAR 836-053-1100?

Findings: Passed

**CLAIMS REGARDING EMERGENCIES (ER)**

ER1. Does the Company use the definitions of “emergency medical condition” “emergency services” and “emergency medical screening exam” in compliance with ORS 743.801(1)(2)&(3)?

Findings: Passed

ER2. Does the Company have a written procedure to offer emergency health benefits without prior authorization in compliance with ORS 743.699(1)(a)(b)&(c)?

Findings: Passed

ER3. Does the Company provide the required disclosures to all enrollees in compliance with ORS 743.699(2) and OAR 836-053-1030(4)?

Findings: Passed with comment.

The Company's disclosure regarding the use of 9-1-1 was in a section of their benefit book regarding emergency services provided outside of the service area. There was no discussion of the use of 9-1-1 for services inside the service area. However, during the course of the examination, the Company revised their member handbook to discuss the use of 9-1-1 without reference to where the emergency occurs.

ER4. Does the Company provide coverage without prior authorization for emergency medical screening exams, stabilization of emergency medical conditions and emergency services of a nonparticipating provider using the prudent layperson standard in compliance with ORS 743.699(1)(a)(b)&(c)?

Findings: Passed

ER5. Does the Company discourage the use of 9-1-1 or deny coverage for emergency services solely because 9-1-1 was used in compliance with ORS 743.699(3)?

Findings: Passed

The Company does not discourage the use of 9-1-1; but, as previously indicated, they only discussed the use of 9-1-1 in the section regarding emergency services provided outside the service area. However, during the course of the examination, the Company revised their member handbook to discuss use of 9-1-1 without reference to where the emergency occurs.

ER 6. Does the Company apply the same claims payment standards including the prudent layperson standard to all ancillary emergency services including ambulance in compliance with ORS 743.699(c)?

Findings: Passed

### **DRUG FORMULARY (DF)**

#### **Open Formulary**

DF1. Does the Company have a written procedure that includes the written criteria or explains the review process established by the insurer for determining when an item will be limited or excluded in compliance with OAR 836-053-1020(2)?

Findings: Not applicable. The Company uses a closed formulary.

#### **Closed Formulary**

DF2. Does the Company have a written procedure stating that FDA approved prescription drug products are covered only if they are listed in the formulary in compliance with OAR 836-053-1020(3)?

Findings: Passed

DF3. Do the Company's written procedures include how the insurer determines the content of the closed formulary and how the insurer determines the application of a medical exception in compliance with OAR 836-053-1020(3)?

Findings: Passed with comment.

During the course of the examination, the Company revised their drug formulary brochure to include the required information on how application of a medical exception is determined.

DF4. Do the Company's written procedures describe how a provider may request inclusion of a new item in the closed formulary and ensure a timely written response to a provider making such a request in compliance with OAR 836-053-1020(3)?

Findings: Passed with comment.

During the course of the examination, the Company revised their drug formulary brochure to provide for a response within 30 days to requests for inclusion of a new item.

**Mandatory Closed Formulary**

DF5 through DF7 do not apply as the Company does not use a mandatory closed formulary. They are presented here solely as a reference.

DF5. Does the Company have a written procedure stating that FDA approved prescription drug products are covered only if they are listed in the formulary in compliance with OAR 836-053-1020(4)?

DF6. Do the Company's written procedures describe how the insurer determines the content of the mandatory closed formulary in compliance with OAR 836-053-1020(4)?

DF7. Do the Company's written procedures describe how a provider may request inclusion of a new item in the closed formulary and ensure a timely written

response to a provider making such a request in compliance with OAR 836-053-1020(4)?

**All Formularies**

DF8. Does the Company furnish a summary of formulary provisions to a provider with the authority to prescribe drugs and medications, upon the request of the provider, in compliance with OAR 836-053-1020(5)?

Findings: Passed

DF9. Does the Company provide to all enrollees a summary including the required information concerning its drug formulary in compliance with ORS 743.804(5)(p)?

Findings: Passed

DF10. Does the Company provide to any enrollee or prospective enrollee, upon request, information on whether a particular drug is included or excluded from the formulary in compliance with ORS 743.804(6)(a)?

Findings: Passed

DF11. Does the Company exclude coverage of a drug for a particular indication solely on the grounds that the indication has not been approved by the FDA if

the Health Resources Commission recognizes the drug is effective for that indication in compliance with ORS 743.697?

Findings: Passed with comment.

The Company's brochure describing their RxAmerica plans indicated that "Cascade East Health Plans will not cover prescription drugs when prescribed for experimental, investigational or non-FDA approved indications."

During the course of the examination, however, the Company revised their brochure to provide for an exception to this exclusion when "the Health Resources Commission determines that the drug is effective for that indication."

#### **UTILIZATION REVIEW (UR)**

UR1. Did the Company submit an annual summary regarding utilization review activities in compliance with ORS 743.807(1) and OAR 836-053-1130(1)?

Findings: Not applicable. The Company was not in operation during the 1998 reporting period.

UR2. Does the Company provide all enrollees with summary information on how the insurer makes decisions regarding utilization review requirements that affect coverage or payment in compliance with ORS 743.804(5)(j)?

Findings: Passed with comment.

The Company provided a copy of the "limitations and exclusions" section of their plan booklet for this requirement. This section does not specifically address utilization review, but it does include an exclusion of services determined "not to be

medically necessary or accepted medical practice in the service area.” This exclusion along with the definition of “medically necessary” in the plan booklet does provide information on how the Company makes utilization review decisions.

UR3. Does the Company provide to enrollees, upon request, a written summary of information that the insurer may consider in its utilization review of a particular condition or disease to the extent the insurer maintains such criteria in compliance with ORS 743.804(7)?

Findings: Passed with comment.

The information provided by the Company for this requirement is from their provider handbook. The Company advises, however, that this information would be given to enrollees upon request.

UR4. Is a licensed doctor of medicine or osteopathy responsible for all final utilization review recommendations regarding the necessity or appropriateness of services or the site at which the services are provided in compliance with ORS 743.807(2)(b)?

Findings: Passed

UR5. Does the Company make available qualified health care personnel for same-day telephone responses to inquiries concerning certification of continued length of stay in compliance with ORS 743.807(2)(d)?

Findings: Passed

UR6. Does the Company provide for an appropriate appeal process before a medical consultant or peer review committee when a request for treatment or payment for services is denied as not medically necessary or experimental in compliance with ORS 743.807(2)(c)?

Findings: Failed

The Company's procedures allowed members to appeal utilization review decisions, but there was no specific indication that providers can appeal such decisions.

Also, the Company's procedures did not provide for expedited review in situations in which the time otherwise allowed for the Company to make a decision is too long to accommodate clinical urgency.

**I recommend the Company revise their procedures to allow providers as well as members to appeal utilization review decisions and to provide for expedited review in situations involving clinical urgency in compliance with ORS 743.807(2)(c) and OAR 836-053-1140(2)(a).**

The Company advised that they have always allowed providers as well as members to appeal utilization review decisions. Subsequent to the examination, they revised their benefits book to specifically indicate that providers may use the grievance and appeal process. The Company also advised that they allow for expedited review in situations involving clinical urgency. Subsequent to the examination, they revised their benefit book to indicate that a response to such appeals will be provided within 72 hours.

UR7. Does the Company respond to the first appeal of a decision to deny treatment or payment of services as not medically necessary or experimental in compliance with OAR 836-053-1140(1)(a) & (b)?

Findings: Passed

**PRIOR AUTHORIZATION (PA)**

PA1. Does the Company provide all enrollees with summary information on how the insurer makes decisions regarding requirements for prior authorization that affect coverage or payment in compliance with ORS 743.804(5)(j)?

Findings: Passed

PA2. Does the Company bind prior authorization determinations relating to benefit coverage and medical necessity for 30 days in compliance with ORS 743.837(1)?

Findings: Passed

PA3. Does the Company bind prior authorization determinations relating to eligibility for five business days unless the insurer knows coverage will terminate in less than five business days and specifies the termination date in compliance with ORS 743.837(2) & OAR 836-053-1200(6)?

Findings: Passed

PA4. Does the Company answer provider requests for prior authorization of nonemergency service within two days in accordance with ORS 743.807(2)(d)?

Findings: Passed

PA5. Does the Company respond to a request by a provider for prior authorization of nonemergency services with one of the required responses in compliance with OAR 836-053-1200(9)?

Findings: Passed with comment.

During the course of the examination, the Company instituted procedures to provide the required responses to requests for prior authorization.

### **QUALITY ASSURANCE (QA)**

QA1. Does the Company file an annual summary of quality assessment activities in compliance with ORS 743.814(2) and OAR 836-053-1170(1)?

Findings: Not applicable. The Company was not in operation during the 1998 reporting period.

QA2. Does the Company file annually the results of all publicly available federal HCFA reports and accreditation surveys in compliance with ORS 743.814(3) and OAR 836-053-1170(2)(a)?

Findings: Not applicable. The Company was not in operation during the 1998 reporting period.

QA3. Does the Company file annually a report of health promotion and disease prevention activities, if any, including a summary of screening and preventive health care activities in compliance with OAR 836-053-1000(3)(e) and including the benchmarks as outlined in compliance with ORS 743.814(3)(b), OAR 836-053-1170(2)(b) and OAR 836-053-1170(3)?

Findings: Not applicable. The Company was not in operation during the 1998 reporting period.

QA4. Does the Company provide, upon request, a description of the insurer's efforts, if any, to monitor and improve the quality of health services in compliance with ORS 743.804(6)(e)?

Findings: Passed

QA5. Does the Company have a written quality assurance program to evaluate, maintain and improve the quality of health services provided to enrollees in compliance with ORS 743.814(1)?

Findings: Passed

QA6. Does the program include the measurement of progress on specific quality improvement goals chosen by the insurer in compliance with ORS 743.814(1)?

Findings: Failed

The Company's quality management program provides for "task forces to ... establish measurement mechanisms and outcome goals." It does not identify specific quality improvement goals on which progress will be measured. However, the Company has only been in operation since January 1, 1999.

**I recommend the Company include the measurement of progress on specific quality improvement goals in their quality assurance program in compliance with ORS 743.814(1).**

Subsequent to the examination, the Company advised they are analyzing data from their first year of operations to determine what quality assurance goals would be most beneficial to members.

**SCOPE OF NETWORK (SN)**

SN1. Does the Company file an annual summary describing its ongoing monitoring to ensure that all covered services are reasonably accessible to enrollees in compliance with OAR 836-053-1190(1)?

Findings: Not applicable. The Company was not in operation during the 1998 reporting period.

SN2. Does the annual summary contain an attachment that lists all primary care, direct access and specialty care providers with whom the Company has directly contracted as of December 31 of the year to which the summary pertains in compliance with OAR 836-053-1190(3)?

Findings: Not applicable. The Company was not in operation during the 1998 reporting period.

**PROVIDER TREATMENT (PT)**

PT1. Does the Company provide participating providers, upon request, a summary of policies on enrollee's rights and responsibilities in compliance with ORS 743.804(2)?

Findings: Passed

PT2. Are the Company's utilization review process activities made available for review to contracting providers, upon request, in compliance with ORS 743.807(2)(a)?

Findings: Passed

PT3. Does the Company prohibit the termination or financial penalty of a provider for providing information to a patient that is not slanderous, defamatory or intentionally inaccurate in compliance with ORS 743.834(1)(a)(b) and (c)?

Findings: Passed

PT4. Does the Company prohibit the termination or financial penalty of a provider for referring a patient to another provider whether or not that provider is under contract with an insurer in compliance with ORS 743.834(2)(a)?

Findings: Passed

### **LATE ENROLLEE AND SPECIAL ENROLLMENT (EN)**

EN1. Does the Company use the correct definition of late enrollee in compliance with ORS 743.730(23)?

Findings: Failed

The Company's definition of "late enrollee" does not include an exception for those individuals who qualify for special enrollment in accordance with 42 U.S.C. 300gg due to acquisition of a new dependent as provided for in ORS 743.730(23).

**I recommend the Company revise their definition of late enrollee to comply with ORS 743.730(23).**

Subsequent to the examination, the Company revised their definition of late enrollee to include an exception for situations involving acquisition of a new dependent.

EN2. Do all policy forms and enrollee summaries for SEHI plans containing a preexisting condition provision clearly disclose how creditable coverage will be counted in compliance with OAR 836-053-0040(3)?

Findings: Not applicable. The Company does not have any SEHI plans. In addition, the Company's plans do not include a preexisting condition limitation or exclusion.

Note: The benefits book indicates that "except for late enrollees, there is no waiting period for benefits for a preexisting condition." In regard to the indicated exception for late enrollees, the waiting period that applies to them is actually a six-month waiting period for coverage to commence, not a waiting period that only applies to preexisting conditions.

EN3. Does the insurer include a question on all enrollment forms regarding potential creditable coverage in compliance with OAR 836-053-0040(4)(a) and OAR 836-053-0230(8)(a)?

Findings: Not applicable. The Company's plans do not include a preexisting condition limitation or exclusion.

Note: The benefits book indicates that "except for late enrollees, there is no waiting period for benefits for a preexisting condition." In regard to the indicated exception for late enrollees, the waiting period that applies to them is actually a six-month waiting period for coverage to commence, not a waiting period that only applies to preexisting conditions.

EN4. Does the Company's definition of an eligible enrollee comply with ORS 743.730(23)(a)(b) and (c)?

Findings: Failed

The Company's "special eligibility" provision allows for enrollment in situations involving loss of coverage under another employer health benefit plan. The plan also makes provision for an already covered employee to add new dependents. However, the plan does not include the required special enrollment provisions for the following:

- an employee not previously covered to enroll himself/herself with or without his/her new spouse following marriage;
- an already covered employee to enroll his/her spouse and/or family following the birth or adoption of a child;
- an employee not previously covered to enroll himself/herself with or without his/her spouse and/or family following birth or adoption of a child;
- employees and their dependents to enroll during open enrollments; and
- enrollment of a spouse or child for whom a court has ordered coverage.

**I recommend the Company revise their definition of an eligible enrollee to comply with ORS 743.730(23).**

Subsequent to the examination, the Company revised their special enrollment provisions to allow for enrollment in the above situations.

EN5. Does the Company limit preexisting conditions and waiting periods for a late enrollee to a 12-month period in compliance with ORS 743.737(4)?

Findings: Passed with comment.

The Company's plan includes a six-month waiting period for late enrollees. The plan also indicates that late enrollees must submit health statements. However, the Company advised that the information on the health statement does not affect the six-month exclusion period.

Also, the benefits book indicates that "except for late enrollees, there is no waiting period for benefits for a preexisting condition." In regard to the indicated exception for late enrollees, the Company advised that the only waiting period that applies to them is the six-month waiting period for coverage to commence and that there is no additional waiting period for preexisting conditions.

EN6. Does the insurer include a notice about potential creditable coverage whenever a claim has been denied for preexisting conditions in compliance OAR 836-053-0040(4)(b) and OAR 836-053-0230(8)(b)?

Findings: Not applicable. The Company's plans do not include a preexisting condition limitation or exclusion.

Note: The benefits book indicates that “except for late enrollees, there is no waiting period for benefits for a preexisting condition.” In regard to the indicated exception for late enrollees, the waiting period that applies to them is actually a six-month waiting period for coverage to commence, not a waiting period that only applies to preexisting conditions.

EN7. Does the insurer apply credit for prior creditable coverage if an enrollee is subject to a preexisting condition in compliance with OAR 836-053-0040(8) and OAR 836-053-0230(9)?

Findings: Not applicable. The Company’s plans do not include a preexisting condition limitation or exclusion.

Note: The benefits book indicates that “except for late enrollees, there is no waiting period for benefits for a preexisting condition.” In regard to the indicated exception for late enrollees, the waiting period that applies to them is actually a six-month waiting period for coverage to commence, not a waiting period that only applies to preexisting conditions.

EN8. Does the Company exempt maternity services from the category of preexisting conditions in compliance with OAR 836-053-0060(3)?

Findings: Passed

### **PORTABILITY (PO)**

PO1. For the purpose of administering portability plans does the Company define the term “eligible individual” in compliance with ORS 743.760(1)(b)(A)(i) and (ii)?

Findings: Passed with comment.

The Company's "eligibility" provisions for portability coverage indicate that a person must apply "for portability coverage not later than the 63<sup>rd</sup> day after termination of prior coverage." However, these provisions also indicate that a person must "be currently enrolled as a CEHP member." This appears to be contradictory. An eligible individual must be allowed to apply for portability coverage within 63 days following the date such person's group coverage with CEHP terminated. If such person's coverage with CEHP has terminated, he/she is not "currently enrolled" as a CEHP member.

The Company advised, however, that the reference to "currently enrolled" is intended to require that the most recent group coverage have been with CEHP rather than another carrier.

PO2. Does the Company include an explanation of portability coverage in all Oregon issued policies and summary plan descriptions in compliance with OAR 836-053-0750(3)?

Findings: Passed

PO3. Does the Company offer at least two portability plans, including a prevailing benefit plan and a low cost benefit plan, in compliance with ORS 743.760(2)(a)?

Findings: Passed

PO4. Does the Company send a portability notification to any individual losing group coverage (unless it is a total group replacement) within 10 days

following the date of any administrative action taken by a carrier to initiate or document the loss of coverage in compliance with OAR 836-053-0750(4)?

Findings: Passed with comment.

During the course of the examination, the Company formulated written procedures documenting that portability information is to be sent to terminated employees within the required time frame.

**MISCELLANEOUS OPERATIONAL REQUIREMENTS (OR)**

OR1. Does the Company have a policy which allows enrollees to change participating primary care physicians at will in compliance with ORS 743.808(a)?

Findings: Passed

OR2. Does the Company have a point of service benefit plan available to employers having more than 25 employees in compliance with ORS 743.808(b)?

Findings: Passed

OR3. Does the Company ensure patient confidentiality by adopting written confidentiality policies and procedures in compliance with ORS 743.804(10)?

Findings: Passed

OR4. If the Company offers managed health care, does the provider contract contain a provision prohibiting the provider from billing the enrollee or attempting to

collect from the enrollee amounts owed by the insurer in compliance with ORS 743.821?

Findings: Passed

OR5. Does the Company comply with the Federal Newborns' and Mothers' Health Protection Act of 1996 in compliance with ORS 743.823 and OAR 836-053-1000(11)?

Findings: Passed

OR6. Does the Company allow a female enrollee to designate a women's health care provider as her primary care provider in compliance with ORS 743.845(2)?

Findings: Passed

OR7. Does the Company allow female enrollees direct access to a women's health care provider for at least one annual preventative women's health examination and pregnancy care if the enrollee has not chosen a women's health care provider as her primary care physician in compliance with ORS 743.845(3)?

Findings: Passed

OR8. Did the Company establish a means to provide enrollees, purchasers and providers a meaningful opportunity to participate in the development of insurer policy and operations in compliance with ORS 743.817(2)?

Findings: Passed with comment.

The benefit book indicates that members are encouraged to “make suggestions and comments to us” and provides instructions for submitting such suggestions, but did not indicate how these suggestions are reviewed and their affect on the Company’s policy and operations. However, during the course of the examination, the Company formulated written procedures regarding how suggestions are reviewed and their effect on the Company’s policies and operations.

#### **MISCELLANEOUS REQUIRED DISCLOSURES (RD)**

RD1. Does the Company disclose the required information to all enrollees either directly, or in the case of a group policy, to the employer or other policyholder for distribution to enrollees, written general information informing enrollees about services provided, access to service, charges and scheduling applicable to each enrollees’ coverage in compliance with ORS 742.699(2), ORS 743.804(5)(all subparts), OAR 836-053-1020(5), OAR 836-053-1030(3), and OAR 836-053-1090?

Findings: Failed

The following disclosures were not indicated to have been provided:

- Description of procedures by which providers may participate in the development and implementation of the Company’s policy and procedures. (The disclosure provided by the Company discusses how enrollees can make suggestions, but it does not discuss how providers can do so.)

- Notice that an enrollee “may request an additional written summary of information that the insurer may consider in its utilization review of a particular condition.” (The original disclosure provided by the Company advises that enrollees may request “information used in a particular prior authorization decision.” This only provides for information on specific decisions that have already been made. It does not provide for obtaining information in advance in regard to criteria used in regard to a particular condition.)
- General disclosure regarding risk-sharing arrangements with a statement indicating that a plan includes risk-sharing and a brief description of risk-sharing in general. (The original disclosure provided by the Company discusses various provider payment arrangements, but does not clearly indicate that the provider is actually accepting a share of the risk under some arrangements.)
- Notice that additional information is available upon request. (The member handbook advises members to call if they would like additional information, but it does not indicate that specific additional information is available.)

During the course of the examination, the Company revised their member handbook to include the required disclosures regarding information considered in utilization review of a particular condition and risk-sharing arrangements. However, they did not advise how or when they planned to provide the revised disclosures to current enrollees.

Only those disclosures not reviewed in other sections of the examination were reviewed for this standard. For other disclosures to be provided to all enrollees, see GP5, GP6, GP7, GP8, ER3, DF8, DF9, UR2 and PA1.

**I recommend the Company provide the following disclosures to all enrollees:**

- **Description of procedures by which providers may participate in the development and implementation of the Company’s policy and procedures. (See OAR 836-053-1030(7).)**
- **Notice that an enrollee “may request an additional written summary of information that the insurer may consider in its utilization review of a particular condition.” (See OAR 836-053-1030(8).)**

- **General disclosure regarding risk-sharing arrangements with a statement indicating that a plan includes risk-sharing and a brief description of risk-sharing in general. (See 743.804(5)(m) and OAR 836-053-1030(10).)**
- **Notice that additional information is available upon request. (See ORS 743.804(5)(r).)**

Subsequent to the examination, the Company advised that they had revised the “suggestions” section of their benefits book to advise enrollees that providers may call the Company to make comments and suggestions. They also advised that they had distributed a revised benefits book to all of their enrollees.

### **INFORMATION UPON REQUEST (IR)**

IR1. Does the Company provide the required information upon request from an enrollee or a prospective enrollee in compliance with ORS 743.804 and ORS 743.807(2)?

Findings: Passed

Only those disclosures not reviewed in other sections of the examination were reviewed for this standard. For other disclosures to be provided upon request, see DF10, UR3, QA4, PT1 and PT2.

### **ANNUAL REPORTS (AR)**

AR1. Did the Company file all appropriate annual reports in compliance with ORS 743.804(9), ORS 743.807(1), ORS 743.814(2) and (3), OAR 836-053-1000(3)(a) and (e), OAR 836-053-1130(1), and OAR 836-053-1170(1), (2)(a) and (b) and (3)?

Findings: Not applicable. The Company was not in operation during the 1998 reporting period.

## **COMPLIANCE WITH PRIOR EXAMINATION RECOMMENDATIONS**

This was a special target examination limited to practices and procedures in compliance with the Patient Protection act of 1997. There were no prior examinations.

## **CONCLUSIONS**

<b><u>Recommendation</u></b>	<b><u>Page</u></b>
1 I recommend the Company revise their grievance and appeal procedures to include an appeal process that provides for two levels of review without charge to the member in compliance with ORS 743.804(3)(f).	6
2 I recommend the Company revise their procedures to allow providers as well as members to appeal utilization review decisions and to provide for expedited review in situations involving clinical urgency in compliance with ORS 743.807(2)(c) and OAR 836-053-1140(2)(a).	15
3 I recommend the Company include the measurement of progress on specific quality improvement goals in their quality assurance program in compliance with ORS 743.814(1).	18
4 I recommend the Company revise their definition of late enrollee to comply with ORS 743.730(23).	20
5 I recommend the Company revise their definition of an eligible enrollee to comply with ORS 743.730(23).	22

<b><u>Recommendation</u></b>	<b><u>Page</u></b>
6 I recommend the Company provide the following disclosures to all enrollees:	28
<ul style="list-style-type: none"><li>• Description of procedures by which providers may participate in the development and implementation of the Company’s policy and procedures. (See OAR 836-053-1030(7).)</li><li>• Notice that an enrollee “may request an additional written summary of information that the insurer may consider in its utilization review of a particular condition.”(See OAR 836-053-1030(8).)</li><li>• General disclosure regarding risk-sharing arrangements with a statement indicating that a plan includes risk-sharing and a brief description of risk-sharing in general. (See 743.804(5)(m) and OAR 836-053-1030(10).)</li><li>• Notice that additional information is available upon request. (See ORS 743.804(5)(r).)</li></ul>	

**MANAGEMENT AFFIRMATION**

## **ACKNOWLEDGMENT**

The cooperation and assistance rendered by the management of the Company during this examination is hereby acknowledged and appreciated.

A special thanks is extended to the examination coordinator for his courtesy, assistance, and promptness in providing, correlating, or coordinating all requested documents and statistics necessary to ensure a smooth transition during the overall examination process. The responsibilities that were undertaken during this examination were in addition to the scope of his regular assigned duties.

In addition to the undersigned, Kathleen Kalk, market conduct examiner, participated in this examination.

Respectfully submitted,

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Jann Goodpaster, CIE, CPCU  
Chief Market Conduct Examiner  
Market Conduct Section  
Department of Consumer and Business Services  
Insurance Division  
State of Oregon

**AFFIDAVIT**

STATE OF OREGON        }  
                                      }  
County of Marion        }  ss

Jann Goodpaster, being duly sworn, deposes and says that the foregoing market conduct report of examination as of March 31, 1999, of Cascade East Health Plans, Inc., Hermiston, Oregon, subscribed by her is true to the best of her knowledge and belief.

\_\_\_\_\_  
Jann Goodpaster, CIE, CPCU  
Chief Market Conduct Examiner  
Market Conduct Section  
Department of Consumer and Business Services  
Insurance Division  
State of Oregon

Subscribed and sworn to before me on the \_\_\_\_\_ day of \_\_\_\_\_, 2000.

\_\_\_\_\_  
Notary Public for the State of Oregon  
My commission expires: March 22, 2001