

STATE OF OREGON

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

INSURANCE DIVISION

REPORT OF MARKET CONDUCT EXAMINATION

OF

**OREGON MEDICAL INSURANCE POOL
SALEM, OREGON**

AS OF

DECEMBER 31, 1999

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March 6, 2001

Honorable Mary C. Neidig, 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

OREGON MEDICAL INSURANCE POOL (OMIP)
625 Marion Street NE
Salem, Oregon 97310

hereinafter referred to as the "Health Plan" or "OMIP." The following report of examination is respectfully submitted.

SCOPE OF EXAMINATION

The market conduct examination of the Health Plan was conducted as of December 31, 1999, covering the twelve month period then ended, and included a review of material transactions or events which occurred subsequent to the examination cut-off date and were noted during the examination.

The examination of the Health Plan 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 Health Plan'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 determine the practices and procedures of the Health Plan's operations, one or more of the following procedures was performed in each phase:

1. A sample of files was selected from listings provided by the Health Plan. The examiner then reviewed each file.
2. The procedure manuals and/or memorandum were evaluated.
3. The Health Plan responded to a series of questions regarding the phase being examined.

The Health Plan's underlying data was measured against an established standard. A list of all standards used can be found in Appendix A at the end of the report. The examination is a report by test. Additional findings and procedures which became evident during the examination but were outside the scope of the standards are reported at the end of the appropriate phase.

The examination was comprised of the following seven phases (each phase contained subparts):

Company operations/management	Claims
Grievance procedures	Reports
Enrollment procedures	Policyholder treatment
Rates and forms	

COMPANY/MANAGEMENT

Company Description

The Oregon Medical Insurance Pool was created by the 1987 Oregon Legislature through Senate Bill (SB) 583. The Health Plan was required to become operational by April 1, 1998, and it offers major medical expense coverage to every eligible person.

OMIP was originally an agency of its own until the 1993 Legislature made it a division of the Department of Consumer and Business Services (DCBS).

OMIP is a component of the Oregon health plan. The OMIP program is funded by insurance premiums paid by members and with assessments made to insurance carriers who write business in the state of Oregon.

A Third Party Administrator (TPA) handles eligibility, enrollment and claims processing for OMIP.

Management and Control

OMIP is a governmental body and not a standard corporate entity. The OMIP Board is granted authority to operate through statute, specifically ORS 735.600 to ORS 735.650. The Board consists of nine individuals, eight of whom are appointed by the director of DCBS. The director or designee is also a member of the Board. The members of the Board elect the chair.

The members of the Board serving as of December 31, 1999, were:

<u>Name</u>	<u>Principal Affiliation</u>
Denise Honzel, Kaiser Permanente	Board Chair, Health Maintenance Organization Representative
Robert Gootee, ODS Health Plans	Reinsurer Representative
Steve Lynch, PacifiCare of Oregon, Inc.	Domestic Carrier Representative
Randy Cline, Regence BlueCross BlueShield of Oregon	Domestic Not-for-Profit Representative

<u>Name</u>	<u>Principal Affiliation</u>
Beverly Bettis	General Public Representative
Cary Walker, Providence Health Plan	Health Care Contractor Representative
Dr. John Santa, Oregon Health Plan	Oregon Health Plan Policy and Research
Deborah Lincoln, Department of Consumer and Business Services	DCBS Designee
David Houck	General Public Representative

Management

Operating management of the Health Plan as of December 31, 1999, was under the direction of the following:

<u>Name</u>	<u>Title</u>
Howard “Rocky” King	Administrator
Karla Messer-Holt	Executive Assistant
Shawn Muma	Fiscal Coordinator
Barbara Ries	Deputy Administrator
Pamela Sloan	OMIP Coordinator

GRIEVANCE PROCEDURES

The period of review for this examination is January 1, 1999 to December 31, 1999. The Health Plan became subject to certain provisions of the Patient Protection Act effective October 23, 1999, which includes ORS 743.801(4) and ORS 743.804. These statutes set forth the current required procedures for handling grievances and appeals.

Since the majority of the examination period occurred prior to October 23, 1999, the Health Plan was tested for compliance with the standards referenced below that are based upon the requirements that were in effect prior to that date.

Information regarding the Health Plan’s compliance with current regulation can be found under the Additional Findings and Procedures section of this phase.

During the examination period, the TPA assigned two employees to handle the Health Plan's grievances and appeals. The Health Plan indicated these employees applied the TPA's written grievance and appeals procedures to the Health Plan's grievances and appeals according to the process outlined in the member handbook. The exceptions to the TPA's standard guidelines were not formally documented. The employees followed a standard operating procedure through historical knowledge of the employees responsible for those duties.

Findings

The Health Plan provided the appeal log maintained by the TPA as well as two appeal logs from the Health Plan which represented appeals that were not claim related and appeals that dealt with claim issues. The combined population was 52. Due to the small size of the population, all of the records were reviewed. One file was not actually an appeal and was eliminated from the population.

<u>Population List</u>	<u># of Appeals</u>
Appeals handled by TPA	26
Appeals related to claims handled by Health Plan	2
Appeals not related to claims handled by Health Plan	<u>23</u>
Total	<u>51</u>

Standard #3 was waived for this examination.

Summaries of the reasons for and dispositions of the grievances and appeals reviewed are shown below:

<u>Reason</u>	<u># Files</u>	<u>% to Total</u>
Claim denial	23	45%
Dissatisfied with claim payment	2	4
Preauthorization denial	2	4
Claim refund requested	1	2
Requested preexisting condition waiver	5	9
Requested reinstatement	13	26
Requested earlier effective date	3	6
Requested reenrollment within 12 months	1	2
Requested covered even though ineligible	<u>1</u>	<u>2</u>
Total	<u>51</u>	<u>100%</u>

<u>Disposition</u>	<u># Files</u>	<u>% to Total</u>
Corrective action taken	24	47%
Satisfactory explanation given	26	51
Appeal withdrawn by member	<u>1</u>	<u>2</u>
Total	<u>51</u>	<u>100%</u>

Grievances Standard #1 – Claims appeals are processed in the manner outlined in the benefit book.

Reference: OAR 443-010-0010(2)(a).

Findings: Failed. 61% compliance to applicable files. Nine files (39%) failed this standard.

The benefit book provides two levels of claims appeal. The TPA handles the initial written appeal. If the individual is still dissatisfied with the TPA’s decision, a second level written appeal may be made directly to the Health Plan within 30 days of the date of the TPA’s appeal decision.

Effective July 1, 1999, the TPA changed its procedures and insureds are now offered three levels of claims appeal. The first level (grievance) and second level (first appeal) are processed by the TPA and the Health Plan handles the third level (second appeal).

Acknowledgement letters mailed to seven appellants informed them that they were entitled to three levels of review with the TPA and did not explain the Health Plan level of appeal was available to them. All seven of these appeals were received after the TPA had changed its procedures. The Health Plan indicated there was period of time immediately following implementation of the new procedures when the language of the letters did not reflect the amended process. The letters referenced in this paragraph were sent between August 13, 1999 and November 1, 1999.

Another letter mailed to an appellant informed her that she had the right to a second appeal and erroneously stated that the appeal must be received within 60 days of that letter. That correspondence did not notify the member of her right to appeal to the Health Plan directly.

The TPA's response to an appeal informed a member that she could have her concerns addressed by the appeal committee. That letter did not explain that if the member wished to appeal the TPA's decision, an appeal must be sent to the Health Plan within 30 days of the TPA's decision.

Since the Health Plan is now subject to the Patient Protection Act regulation governing grievances and appeals, a recommendation regarding this standard is not warranted. **A recommendation regarding compliance with the current statute appears in the Additional Findings and Procedures section following Grievances Standard #6.**

The Health Plan indicates it will be revising its benefit books and contracts during the first quarter of 2001 and will revise its explanation of the grievance and appeals process.

Grievances Standard #2 – Other grievances are processed in the manner outlined in the benefit book. Reference: OAR 443-010-0010(1).

Findings: Failed. 88% compliance to applicable files. Two files (12%) failed this standard.

OAR 443-010-0010(1) requires the Health Plan to provide a written response regarding appeals unrelated to claim or benefit issues to the appellant and the TPA within 30 days of receiving the appeal.

A bank representative submitted a grievance on behalf of a member whose coverage had been cancelled. The Health Plan did not acknowledge this grievance or provide any written response because the Health Plan did not consider this a "formal appeal." Although the Health Plan took corrective action, it appears a response to this written grievance was required. This case was assigned an appeal number, entered in the Health Plan's appeal log and was referenced as an appeal in correspondence between the Health Plan and the TPA.

The other grievance was received after October 23, 1999. The Health Plan indicated it did not consider this an "appeal" even though it was entered in the Health Plan's appeal log, assigned an

appeal number, and an appeal summary was prepared regarding this case. The member was not allowed two levels of appeal following the initial grievance and was not furnished with detailed information regarding the grievance and appeal procedures and how to use them in accordance with ORS 743.804. This grievance was submitted by a caseworker on the appellant's behalf.

The Health Plan considers any grievance or appeal submitted to be related to claims or benefit issues. No procedures existed during the examination period for processing appeals in accordance with OAR 443-010-0010(1). The benefit book provided to members only describes how to submit a claims appeal.

A recommendation regarding compliance with this standard does not appear to be warranted since the Health Plan is now subject to the Patient Protection Act regulation governing grievances and appeals. A recommendation regarding compliance with the current statute appears in the Additional Findings and Procedures section following Grievances Standard #6.

Grievances Standard #4 – All grievances are acknowledged within seven days from receipt.
Reference: Benefit booklet.

Findings: Failed. 80% compliance. Ten files (20%) failed this standard because they were not acknowledged within the required time frame.

<u># Days to Acknowledge</u>	<u># Appeals</u>	<u>% to Total</u>
0 – 7	41	80%
8 – 14	3	6
15 – 30	4	8
Over 30	1	2
Unknown	<u>2</u>	4
Total	<u>51</u>	<u>100%</u>

I recommend the Health Plan acknowledge grievances within seven days from receipt of the grievance in accordance with ORS 743.804(3)(d) and OAR 836-053-1100(1)(a).

The Health Plan indicates that the TPA has implemented a process for acknowledging all grievances, including those received from the Health Plan, within 48 hours of receipt (two business days).

Grievances Standard #5 – All grievances and appeals are answered within 30 days from the receipt.

Reference: Benefit booklet.

Findings: Failed. 86% compliance. Seven files (14%) failed this standard because they were not answered within the required time frame.

I recommend the Health Plan make a decision regarding grievances within 30 days from receipt of the grievance in accordance with ORS 743.804(3)(d) and OAR 836-053-1100(1)(b).

The Health Plan indicated that the TPA has taken corrective action towards compliance and it will continue to monitor the TPA's progress.

Additional Findings and Procedures

Appeal Log

The Health Plan does not make a distinction between the type of correspondence received, but logs each item as a grievance, then investigates and responds to each one.

ORS 743.804(1)(a) requires the Health Plan to have a timely and organized system for resolving grievances and appeals. The system shall include a systematic method for recording all grievances and appeals, including the nature of the grievances, and significant actions taken. ORS 743.801(4) defines grievance as a written complaint submitted by or on behalf of an enrollee.

I recommend the Health Plan treat as a grievance any written complaint submitted by or on behalf of a covered person in compliance with ORS 743.801(4). Correspondence regarding issues other than complaints should not be logged in and treated as grievances or appeals.

TPA Identification

Correspondence from the TPA to appellants also identifies a health plan affiliated with the TPA which has no contractual agreement with the Health Plan.

The Health Plan will have the TPA take corrective action to remove the reference to the other health plan from correspondence to Health Plan members.

I recommend correspondence generated by the TPA on behalf of the Health Plan correctly identify the TPA as the third party administrator for the insurer and not refer to other companies that are not a party to the contractual agreement between the Health Plan and the TPA in accordance with ORS 746.110.

The Health Plan indicated that the TPA is revising the form and content of the letters used to Health Plan members and it will include a specific reference to the OMIP policy. Additionally, all references of the TPA's affiliate (which is not contracted by the Health Plan) will be eliminated from the body of the letter.

Other Processing Errors

March 23, 1999, an appellant was informed that her claim would be paid. The Health Plan received another letter from the appellant on August 13, 1999, asking about the payment. The Health Plan did not respond to this correspondence until the market conduct examiner asked about this situation in July of 2000. The Health Plan sent a letter of explanation to the appellant July 27, 2000.

The Health Plan was forced to make a decision regarding a case without complete information because the TPA refused to provide the Health Plan with a transcript of a telephone conversation the TPA employee had with the member. The Health Plan instructed the TPA to pay this claim on April 26, 1999, and the claim was not paid until September 17, 1999. This TPA indicates this delay was due to an administrative oversight.

The file evaluation revealed that the TPA mailed letters to eight different members (16% of sample) indicating the policy contract was issued by the TPA, not the Health Plan. Additionally, the appeal files maintained by the TPA contained copies of policies issued by the TPA, not the Health Plan, as reference material for three of the grievances processed by the TPA.

I recommend the Health Plan be correctly identified as the insuring health plan in all correspondence and forms in accordance with ORS 746.110, OAR 836-020-0260 and Oregon Insurance Division Bulletin 96-5.

Compliance with ORS 743.804

The Health Plan became subject to the Patient Protection Act legislation governing grievances and appeals effective October 23, 1999. Grievances that are first sent to the TPA do receive two levels of appeal following the initial grievance. Grievances that are initially submitted to the Health Plan do not receive any further level of appeal.

The procedures followed by the TPA during the examination period did not properly define grievances in accordance with ORS 743.801(4). The TPA has now revised its policies and procedures to reflect the correct definition of grievance.

The Health Plan does not keep a formal record of appeals that have been sent to the Health Plan because they have exhausted all of the levels of appeal through the TPA. OAR 836-053-1070(2) requires the Health Plan to report to the Insurance Division the number and percentage of all grievances that are closed at the second level of appeal. Since the Health Plan does not maintain this documentation, it will not be able to prepare an accurate annual summary for the Insurance Division in accordance with ORS 743.804(9).

The Health Plan received seven grievances after October 23, 1999, and did not offer two levels of appeal following the initial grievance. The enrollee was not furnished with detailed information regarding the grievance and appeal procedures and how to use them in accordance with ORS 743.804.

The Health Plan applied the provisions of OAR 443-010-0010 to this request and made decisions at the final level by the administrator.

From the information reviewed, it appears the Health Plan has not implemented procedures to ensure compliance with the provisions of ORS 743.804(3) and (8), OAR 836-053-1060 through OAR 836-053-1100, and OAR 836-053-1140.

I recommend the Health Plan maintain a timely and organized system for resolving grievances and appeals in accordance with ORS 743.804(3)(a)-(f).

I recommend the Health Plan file with the commissioner an annual report in the format prescribed by rule in accordance with ORS 743.804(6)(c) and (9), OAR 836-053-1000(3)(a), OAR 836-053-1070(1), (2), and (3), and Oregon Insurance Division Bulletin 98-6.

I recommend the Health Plan provide to any enrollee who has filed a grievance detailed information on its grievance and appeal procedures and how to use them and information on how to access the complaint line of the Department of Consumer and Business Services in accordance with ORS 743.804(3)(e), (5)(q), and (8).

I recommend the Health Plan's grievance and appeal process offer the appellant at least two levels of appeal following the initial grievance in accordance with ORS 743.804(3)(f).

The Health Plan indicated to the examiners that it is in the process of implementing changes in all affected areas to bring the program into compliance.

ENROLLMENT PROCEDURES

The Health Plan has contracted with a TPA to process applications.

Applications are received through the mail from applicants, licensed agents, or from the TPA's district offices. The applications are date stamped, sorted and distributed to appropriate personnel for processing.

All applications are entered into the TPA’s tracking system. An eligibility checklist is completed for each application that is reviewed.

The TPA reviews the application for completeness and obtains any outstanding requirements from the applicant. If the applicant does not respond to a written request for information within 21 days from the date of the letter, the TPA closes the file.

Once accepted for coverage, an approval letter is generated and mailed to the applicant, then the billing is established and the policy is mailed to the new subscriber.

Findings

The Health Plan provided listings of new business issued, policies cancelled, and applications rejected during the examination period. From these populations, random samples were selected for review.

<u>Population</u>	<u>Population Size</u>	<u>Sample Size</u>	<u>% to Total</u>
New business issued	3,935	50	1.27%
Policies cancelled	2,287	50	2.19%
Applications rejected	216	50	23.14%

The Health Plan passed the following standard without comment:

Standard

Regulatory Authority

Enrollment Procedures Standard #4 – Policies are terminated according to the reasons and procedures found in the policy contract. OAR 443-005-0000, OMIP Plan 7/99

<u>Reason for Termination</u>	<u>Number of Policies</u>	<u>% to Total</u>
Eligible for Medicare	6	12%
Insured’s request	18	36
Nonpayment of premium	<u>26</u>	<u>52</u>
Total	<u>50</u>	<u>100%</u>

The following exceptions were noted:

Enrollment Procedures Standard #1 – Key information on the application is verified prior to approval or denial of the application. Reference: OAR 443-005-0000.

Findings: Passed with comment. 97% compliance. Three files (3%) failed this standard.

The TPA staff lost an application and supporting documentation that was provided by the agent. The policy was issued from a faxed copy of the application. There was no evidence to indicate key information was verified.

Another file did not contain a completed form titled “Appendix B OMIP Application Eligibility Checklist” and no other documentation was available for the examiner’s review to confirm that key information on the application was verified prior to declining that case.

The other case was included with the list of applications declined during the examination period, but the Health Plan is unable to provide documentation that would verify that action. A policy was issued for this applicant in December of 1999, but the Health Plan cannot locate records regarding the November 1999 rejection. The population list indicated coverage was declined in November of 1999 because information requested was not received.

A failure rate of 3% does not represent a pattern; therefore, no recommendation is warranted.

Enrollment Procedures Standard #2 – All eligible applicants are accepted. Reference: OAR 443-005-0000, administrative agreement between Health Plan and TPA.

Findings: Failed. 94% compliance. Six files (6%) failed this standard.

One case was included with the list of applications declined during the examination period, but the Health Plan is unable to provide documentation that would verify that action. A policy was issued for this applicant in December of 1999, but the Health Plan cannot locate records regarding the November 1999 rejection.

The examiner was unable to verify that the other five applicants had been residents of Oregon for six months prior to the date of application. Applicants who may not have been eligible for coverage may have been issued coverage.

The TPA informed the examiner that the OMIP Board removed the six-month residency requirement in December of 1997. Administrative Rule OAR 443-005-0000 was amended effective March 1, 2000, to change the definition of Oregon resident from residency of six months or more to resident of Oregon only.

Although the Health Plan may have been out of compliance during the examination period, a recommendation does not appear to be warranted since the six-month residency requirement is no longer applicable. The other case failed this standard due to a recordkeeping deficiency.

Enrollment Procedures Standard #3 – Policies are issued 30 days from receipt of the application. Reference: ORS 735.560, ORS 742.046, and administrative agreement between Health Plan and TPA.

Findings: Failed. 90% compliance. Five files (10%) failed this standard which applied only to the sample of new business issued.

These policies were not issued within 30 days from receipt of the application.

<u>Number of Days to Issue Policy</u>	<u>Number of Reviewed Policies</u>	<u>% to Total</u>
0-30	45	90%
30-45	5	10
Over 45	<u>0</u>	<u>0</u>
Total	<u>50</u>	<u>100%</u>

The Health Plan informed the examiner that it experienced a heavy incoming volume of new business in 1999 and that the TPA was having staffing problems during this period of time.

I recommend the Health Plan issue policies within 30 days from receipt of applications in accordance with ORS 735.560, ORS 742.046, and the administrative agreement between the Health Plan and the TPA.

Corrective action taken to resolve this situation included a change in the procedure to consider an incomplete application a “return file.” Now when additional information is requested from an

applicant and no response is received after 21 days, the file is closed. The file is reopened if the required information is returned. The examiner did not take an additional sample of files to determine if the corrective actions taken by the health plan resulted in compliance.

Additional Findings and Procedures

Medical Eligibility

OAR 443-005-0000(1) sets forth the eligibility requirements individuals must meet when applying for Oregon Medical Insurance Pool coverage. One of the medical eligibility requirements is that individual health insurance coverage must have been declined within the last six months due to health reasons. The Health Plan has determined that persons age 65 or older who are ineligible for Medicare benefits do qualify for OMIP coverage. The denial of Medicare is identified as a denial of coverage under the medical eligibility of the program.

Family Health Insurance Assistance Program (FHIAP) and Reinstatement

The Health Plan provided the following information regarding the FHIAP program:

FHIAP is a program that subsidizes insurance premiums for eligible members who meet program requirements. OMIP is one of the certified carriers that accept FHIAP members and make special provisions for premium billing purposes. FHIAP is billed by carriers, and in this instance, OMIP for premiums due. FHIAP in turn bills the member for their portion of the total premium and bills the Insurance Pool Governing Board (IPGB) for their portion of the premium. The combined total is then forwarded to the carrier to pay the premium due.

During the examination period, a TPA was responsible for collecting premiums from the FHIAP member and the IPGB and then remitting the total premium to the Health Plan. That TPA experienced internal difficulties that resulted in premium payments not being forwarded to insurance carriers. In many cases, the member and the IPBG sent their portion of the premium to the TPA in a timely manner, but it was not forwarded to the Health Plan causing the coverage to lapse.

The Health Plan investigated appeals and complaints received regarding this issue and found that the majority of the terminations were not the fault of the subscriber, but were due to the actions of the TPA. The Health Plan made an administrative decision not to penalize subscribers for errors that were out of their control and to reinstate these subscribers even though the policy contracts do not contain a provision for reinstatement and the Oregon Administrative Rules indicate that a member may not reapply for coverage for twelve months after coverage terminates.

The Health Plan conducted a blanket reinstatement clean up in May of 1999 for specific FHIAP accounts. At that time, a procedure was established to allow a 45 day grace period for premium payment in order to reduce the number of policies that were being terminated because premium payments were not being sent to the Health Plan in a timely manner. The policy contracts state that premium is due in advance for all payment methods. A ten-day grace period is allowed after the premium due date if payments are made by monthly automatic transfer from a checking account. If payments are made every two months or every three months, the grace period is 31 days.

A reinstatement procedure was also implemented in May of 1999. Reinstatements are handled on a case by case basis and policies are reinstated on an exception basis.

Declinations

While requirements for timely issuance of policies exist, no performance standards have been established for notifying applicants of declination of coverage on a timely basis. One application was received September 21, 1998, and the outstanding information was not requested from the applicant until November 11, 1998. This policy was declined January 4, 1999, 105 days after the application was received. The sample of rejected applications reviewed produced the following results regarding timely notification of declination.

<u>Number of Days to Decline</u>	<u>Number of Applications</u>	<u>% to Total</u>
0-30	12	24%
31-45	4	8
46-60	8	16
61-90	14	28
91-120	4	8
Over 120	<u>8</u>	<u>16</u>
Total	<u>50</u>	<u>100%</u>

Applications, when received by the TPA, were reviewed for completeness. If information was missing, the insured was contacted in writing by the TPA to request the specific information needed to complete the application. The applicant was allowed 30 to 60 days to provide the requested information. The application was denied and the file closed if no information was received from the applicant.

The Health Plan indicated it attempts to maintain the same level of turnaround for all files, including those that are declined for enrollment. It appears this goal is not being met since 90% of the issued policies were issued within 30 days and only 24% of the declined applicants were notified of this action within 30 days.

In the absence of a law or stated performance standard, no recommendation is warranted.

RATES AND FORMS

The Oregon Medical Insurance Pool Board establishes appropriate rates in accordance with ORS 735.610(4)(d). The OMIP administrator submits rate recommendations to the Board for each of the plans offered and the new rates are charged only after the Board has approved them.

Findings

The Health Plan provided a list of policies issued during the examination period. From this total population of 3,935 policies, a random sample of 50 (1.27%) was selected for review. One of the policies in the sample was actually issued in 1998, so an alternate record was chosen to replace that policy that was issued prior to the examination period.

The Health Plan passed the following standards without comment:

Standard

Reference

Rates and Forms Standard #1 – All forms issued to OMIP policyholders have been filed and approved prior to issue.

ORS 735.650, ORS 742.003, ORS 742.005

Rates and Forms Standard #2 – Members are charged rates that have been approved by the OMIP Board for the examination period.

ORS 735.610(4)(d)

The following exception was noted:

Rates and Forms Standard #3 – All rates have been filed with the Insurance Division. Reference: ORS 735.650, ORS 743.018.

Findings: Passed with comment. This standard was tested globally rather than with specific reference to each file. The Health Plan has filed information rates filing with the division. To date, the division has accepted this method of filing.

CLAIMS

The Health Plan contracts with a TPA to handle claims administration. The TPA receives claims from insured members and providers by mail. The claims are scanned into an image system where a claim number is assigned. Claims are also received from providers electronically. For these claims, claim numbers are assigned by the electronic media claim system. Facsimiles of electronic claims are stored on image along with paper claims.

Claim processing units receive paper claims for adjudication after the claims have been sorted by type and product. A small percentage of electronic claims are automatically adjudicated. Most electronic claims are automatically pended to member history files. Facsimiles of these auto-pended electronic claims are distributed to claim processing analysts for handling.

The TPA uses two different claims processing systems.

After managed care claims are adjudicated, the claims are released to a batch process. Explanation of Benefit forms (EOB) and provider vouchers are generated biweekly.

For traditional product claims, after the final adjudication steps are completed, the claims are released to a batch process where EOB forms are produced. These EOBs are mailed within one to two days after they are produced. Provider vouchers are generated weekly for participating providers and biweekly for nonparticipating providers.

Findings

The Health Plan (through the TPA) provided population lists of claims paid, claims denied, and emergency claims denied during the examination period. The examiner selected random samples from each of these lists for review.

<u>Type of Claim</u>	<u>Total Population</u>	<u>Random Sample</u>	<u>% to Total</u>
Claims paid	43,000	100	0.23%
Claims denied	11,789	100	0.8%
Emergency claims denied	233	50	21%

The Health Plan passed the following standards without comment:

Standard

Reference

Claims Standard #6 – The Health plan promptly and in good faith equitably settles claims in which liability has become reasonably clear.

ORS 746.230(1)(f)(h) & (L)

Claims Standard #8 – The Health plan did not delay investigation or payment of claims by requiring a claimant to submit a preliminary claims report and then requiring subsequent submission of loss forms when both require essentially the same information.

ORS 746.230(1)(k)

Claims Standard #13- The contractual performance standards for claims are met.

Administrative Agreement between Health plan and TPA, Article XI, Section 1, Page 12

The following exceptions were noted:

Claims Standard #1 – The initial contact by the Health Plan with the claimant is within 14 days.
 Reference: ORS 746.230(1)(b), OAR 836-080-0225(1) and (4), administrative agreement between Health Plan and TPA.

Findings: Pass with comment. 58% compliance to applicable files.

One hundred three files failed this standard because the Health Plan did not acknowledge or process the claims within 14 days following receipt of claim as required by the administrative agreement between the Health Plan and the TPA. The Health Plan uses the same procedures the TPA follows for its own business and acknowledgement letters are usually sent on the 28th day after receipt of claim.

The Health Plan indicated that the 14 day provision of the agreement was intended to apply to claims after all information is received. The Health Plan did acknowledge 97% of all claims within 30 days indicating they are in substantial compliance with state laws.

<u># Days to Acknowledge</u>	<u># Files</u>	<u>% to Total</u>
0-14	147	59%
15-30	94	38
31-60	7	2
Over 60	<u>2</u>	<u>1</u>
Total	<u>250</u>	<u>100%</u>

<u>Population Reviewed</u>	<u># Units</u>	<u># Not Applicable (N/A)</u>	<u># Passed Standard</u>	<u># Failed Standard</u>
Claims paid	100	1	62	37
Claims denied	100	0	53	47
Emergency claims denied	<u>50</u>	<u>1</u>	<u>30</u>	<u>19</u>
Subtotal	250	2	145	103
Less N/A files	<u>2</u>			
Total	<u>248</u>	<u>2</u>	<u>145</u>	<u>103</u>

Claims Standard #2 – Investigations are conducted within 45 days. Reference: ORS 746.230(1)(c), OAR 836-080-0230.

Findings: 97% compliance to applicable files. Seven files (3%) failed this standard.

A denied claim was held while a related claim was investigated for a preexisting condition. Both claims were held in error because the preexisting condition investigation was not necessary. The processing delay was due to the Health Plan's failure to coordinate the response received with all claims pending receipt of that response.

Another denied claim was not investigated in a timely manner because of premium accounting issues. The Health Plan indicated the processing delay was due to several bank debits received. The coverage was cancelled in the eligibility system May 28, 1999. The claim was received April 9, 1999, and denied June 14, 1999, more than two weeks following termination.

A denied claim was placed in pending because another claim was being investigated for a preexisting condition. This claim was pended in error since the diagnosis was not related to the claim being investigated.

The Health Plan denied a claim on June 8, 1999, because no authorization was received from the provider for the services rendered. Due to a claims analyst error, an EOB was not mailed to the member regarding this denial. After the claims personnel were informed that no authorization was required for this claim, the Health Plan investigated the claim for a preexisting condition and on August 9, 1999, the claim was denied because the condition was preexisting. From the information reviewed, it appears the Health Plan should have investigated claim for the preexisting condition when the claim was first received in June.

The other denied claim that failed this standard was delayed when it was initially received. The claim was routed to an incorrect section of the claims department and this is the reason why the investigation could not be completed within 45 days.

An emergency services claim was delayed due to an eligibility problem. The claim was received February 8, 1999 and denied April 5, 1999, 56 days later. The Health Plan did not send a notice to the member explaining the reason for the processing delay.

The other emergency services claim was also delayed due to an eligibility problem. The member did not receive a notice explaining the reason for the delay. The claim was received July 7, 1999, and denied September 7, 1999, 62 days later.

<u>Population Reviewed</u>	<u># Units</u>	<u># Not Applicable (N/A)</u>	<u># Passed Standard</u>	<u># Failed Standard</u>
Claims paid	100	0	100	0
Claims denied	100	0	95	5
Emergency claims denied	<u>50</u>	<u>1</u>	<u>47</u>	<u>2</u>
Subtotal	250	1	242	7
Less N/A files	<u>1</u>			
Total	<u>249</u>	<u>1</u>	<u>242</u>	<u>7</u>

A failure rate of 3% does not represent a pattern. **Therefore, no recommendation is warranted.**

Claims Standard #3 – Claims are resolved in 30 days unless a delay letter (45 days) has been sent.

Reference: ORS 746.230(1)(e), OAR 836-080-0235(1) and (4).

Findings: Failed. 93% compliance to applicable files. Eighteen files (7%) failed this standard.

Delay letters were not mailed to nine claimants and the letters mailed to the other nine members did not explain the reason for the claim delay.

Two claim systems are used to process claims. An acknowledgement letter, which also serves as the delay letter, is generated on the 28th day following receipt of claim if the claim has not yet been processed. The form letter used by one of the claims systems did not contain language explaining the reason for the claim delay.

<u>Population Reviewed</u>	<u># Units</u>	<u># Not Applicable (N/A)</u>	<u># Passed Standard</u>	<u># Failed Standard</u>
Claims paid	100	0	100	0
Claims denied	100	0	85	15
Emergency claims denied	<u>50</u>	<u>1</u>	<u>46</u>	<u>3</u>
Subtotal	250	1	231	18
Less N/A files	<u>1</u>			
Total	<u>249</u>	<u>1</u>	<u>231</u>	<u>18</u>

I recommend the Health Plan resolve claims within 30 days unless a delay letter (45 days) has been sent in accordance with ORS 746.230(1)(e) and OAR 836-080-0235(1) and (4).

Subsequent to the examination, the Health Plan has reported that the TPA is revising the language of its denial letters to include a reason for the delays. However, the examiners did not test an additional sample to determine compliance.

Claims Standard #4 – The Health Plan responds to claim correspondence in 30 days. Reference: ORS 746.230(1)(b), OAR 836-080-0225(3).

Findings: Failed. 60% compliance to applicable files. Four files (40%) failed this standard.

Along with a claim, a member submitted a written request for prescription claim forms. The Health Plan received this request June 1, 1999. July 12, 1999, the member called the office and once again requested prescription claim forms. From the information reviewed, it appears the Health Plan did not respond to the written claim correspondence received from the member on June 1, 1999. The Health Plan indicated the procedure for responding to claim form requests received on a claim is to mail them from the processing unit and note on the claim the date the forms were mailed. No such date was noted on the original June 1, 1999, correspondence.

Another claimant submitted a written request for claim forms and the Health Plan's file documentation does not indicate the Health Plan ever responded to this request.

The Health Plan received correspondence from an attorney regarding a claim on November 16, 1999.

The Health Plan's file documentation does not indicate a response was ever sent.

January 7, 1999, the Health Plan received a letter from a member regarding seven denied claims. The Health Plan indicated the member's written inquiry was handled by reprocessing the claims and letting the EOB be the response. The EOB was not sent until May 10, 1999, four months after the member's correspondence was received and the EOB did not address all of the denials questioned in the member's letter.

October 11, 1999, a provider submitted a written request that a claim be reconsidered.

<u>Population Reviewed</u>	<u># Units</u>	<u># Not Applicable (N/A)</u>	<u># Passed Standard</u>	<u># Failed Standard</u>
Claims paid	100	95	3	2
Claims denied	100	96	2	2
Emergency claims denied	<u>50</u>	<u>49</u>	<u>1</u>	<u>0</u>
Subtotal	250	240	6	4
Less N/A files	<u>240</u>			
Total	<u>10</u>	<u>240</u>	<u>6</u>	<u>4</u>

I recommend the Health Plan respond to claim correspondence within 30 days in accordance with ORS 746.230(1)(b) and OAR 836-080-0225(3).

Subsequent to the examination, the Health Plan has reported that the TPA is implementing a new procedures to ensure compliance. However, the examiners did not test an additional sample to determine compliance.

Claims Standard #5 – Claims are not denied without first conducting a reasonable investigation.

Reference: ORS 746.230(1)(c) and (d).

Findings: Failed. 92% compliance to applicable files. Twelve files (8%) failed this standard.

Five claims were denied at the same time the information required for processing was requested. It appears these claims should have been pended for a response to the inquiry and not denied.

Three claims were denied because information requested had not yet been received from the providers when in fact the information needed to process the claims had already been received.

One claim was denied in error. The claims system contained information indicating the condition was authorized for payment. The claim was first denied as preexisting when it was not a preexisting condition and was denied a second time as a duplicate claim.

Another claim was denied because the member did not return an accident report. However, the claim documentation does not indicate an accident report was ever mailed to the member for completion.

A claim was denied in error. The EOB stated the member's primary care physician (PCP) did not authorize the service. There was no authorization from the PCP to pay this claim at the time benefits were denied.

A claim was denied because medical information had not been received from the provider. From the information provided, the examiner was unable to determine when, and from whom, medical information had been requested.

<u>Population Reviewed</u>	<u># Units</u>	<u># Not Applicable (N/A)</u>	<u># Passed Standard</u>	<u># Failed Standard</u>
Claims denied	100	0	91	9
Emergency claims denied	<u>50</u>	<u>0</u>	<u>47</u>	<u>3</u>
Subtotal	150	0	138	12
Less N/A files	<u>0</u>			
Total	<u>150</u>	<u>0</u>	<u>138</u>	<u>12</u>

I recommend the Health Plan not deny claims without first conducting a reasonable investigation in accordance with ORS 746.240(1)(c) and (d).

Subsequent to the event, the Health Plan reported that the TPA has worked with the claims analyst and other staff to reemphasize the importance of complete and accurate documentation and the importance of conducting a thorough review of the information available before requesting additional materials from the member or provider.

Claims Standard #7 – The Health Plan did not misrepresent the facts or policy provisions while settling a claim. Reference: ORS 746.230(1)(a).

Findings: Failed. 98% compliance. Four files (2%) failed this standard.

The Health Plan denied a claim informing the member that the bill had been submitted to the Health Plan in error. This was an incorrect denial. The place of treatment was in Oregon but the provider has a Washington billing address.

The Health Plan loaded incorrect benefit information regarding outpatient physical therapy into the computer system. One claim was denied because the 30 maximum visits had been used when in fact, the member had 60 (an additional 30) visits available under the policy contract. The examiner also noted incorrect benefit information was given to another provider when the provider called the customer service department to ask how many physical therapy visits were available for her patient. The Health Plan expects to have its system corrected sometime in October 2000. The Health Plan will review all physical therapy claims denied on the 30-visit maximum and will make the necessary corrections.

The Health Plan notified a member that a claim was denied because the provider had not responded to the Health Plan’s request for information. At the time the denial was sent, the Health Plan had already received the required report from the provider. This claim was paid as a result of the examiner’s inquiry during this examination.

<u>Population Reviewed</u>	<u># Units</u>	<u># Not Applicable (N/A)</u>	<u># Passed Standard</u>	<u># Failed Standard</u>
Claims paid	100	0	100	0
Claims denied	100	0	96	4
Emergency claims denied	<u>50</u>	<u>0</u>	<u>50</u>	<u>0</u>
Subtotal	250	0	246	4
Less N/A files	<u>0</u>			
Total	<u>250</u>	<u>0</u>	<u>246</u>	<u>4</u>

A failure rate of 2% would not ordinarily generate a recommendation. However, the examiner is unable to measure the full impact the incorrect computer information regarding physical therapy had on consumers. It is not possible to determine how many telephone calls were received from members or medical providers asking for benefit information and how many people were provided this incorrect information, or how the erroneous information altered the course of treatment for these patients.

I recommend the Health Plan not misrepresent the facts or policy provisions while settling claims in accordance with ORS 746.230(1)(a).

Subsequent to the examination, the TPA corrected the number of outpatient physical therapy visits on its system to reflect the contracted amount. The TPA will be reprocessing all claims denied in connection with this error and has implemented corrective action to ensure such an error does not occur in the future.

Claims Standard #9 – The Health Plan did not fail to promptly provide the proper explanation of the basis relied on in the insurance policy in relation to facts or applicable law for the denial of claim. Reference: ORS 746.230(1)(m).

Findings: Failed. 83% compliance to applicable files. Twenty-five files (17%) failed this standard because the denial language on the EOB mailed to the member did not include a reference to the policy provision upon which the denial was based.

<u>Population Reviewed</u>	<u># Units</u>	<u># Not Applicable (N/A)</u>	<u># Passed Standard</u>	<u># Failed Standard</u>
Claims denied	100	0	79	21
Emergency claims denied	<u>50</u>	<u>0</u>	<u>46</u>	<u>4</u>
Subtotal	150	0	125	25
Less N/A files	<u>0</u>			
Total	<u>150</u>	<u>0</u>	<u>125</u>	<u>25</u>

<u>Reason for Denial</u>	<u># Files</u>
Another provider was paid for this service	1
Applied to deductible	1
Assistant surgeon	1
Auto carrier is responsible	1
Claim processed in error	1
Coding problem	1
Coverage lapsed	38
Duplicate claim	31
Not a covered benefit	17
Not medical emergency	3
Information requested from member not received	3
Information requested from provider not received	14
Maximum benefits paid	5
Need Medicare EOB	1
No authorization	5
No surgeon's bill	1

<u>Reason for Denial</u>	<u># Files</u>
No reason shown on EOB	2
Not enough information	1
Patient is not enrolled	6
Provider write-off	3
Sent to local plan for pricing	3
Waiting period not met	9
Workers compensation claim	<u>2</u>
Total	<u>150</u>

I recommend the Health Plan promptly provide the proper explanation of the basis relied on in the insurance policy in relation to facts or applicable law for the denial of claim in accordance with ORS 746.230(1)(m).

The Health Plan reports that the TPA is in the process of reviewing EOB denial messages.

Claims Standard #10 – Denied and closed-without-payment claims are handled in accordance with policy provisions and state law. Reference: OAR 836-080-0235(1).

Findings: Passed with comment. 99% compliance to applicable files. One file (1%) failed this standard.

The Health Plan delayed this claim because it was routed to an incorrect section of the claims department upon receipt. It was not denied within 30 days of receipt, no investigation was conducted and the denial did not refer to the policy provision upon which it was based.

<u>Population Reviewed</u>	<u># Units</u>	<u># Not Applicable (N/A)</u>	<u># Passed Standard</u>	<u># Failed Standard</u>
Claims denied	100	1	98	1
Emergency claims denied	<u>50</u>	<u>0</u>	<u>50</u>	<u>0</u>
Subtotal	150	1	148	1
Less N/A files	<u>1</u>			
Total	<u>149</u>	<u>1</u>	<u>148</u>	<u>1</u>

A failure rate of 1% does not represent a pattern. **Therefore, no recommendation is warranted.**

Claims Standard #11 – Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy. Reference: ORS 746.230(1)(g).

Findings: Passed with comment. The Health Plan informed the examiner that no claim files were submitted for or closed through litigation during the examination period.

A recommendation is not warranted.

Claims Standard #12 – The Health Plan adjusts all claims for emergency services and auxiliary emergency services including ambulance services in compliance with applicable laws, rules and regulations. Reference: ORS 743.699(1)(2)(3), ORS 743.801(1)(2)(3), and OAR 836-053-1030(4).

The Health Plan became subject to the regulation supporting this standard on October 23, 1999. The applicable files represent claims submitted to the Health Plan on or after that date.

Findings: Passed with comment. 87% compliance to applicable files. One file (13%) failed this standard.

This claim was denied November 15, 1999, because the Health Plan did not have a valid approval on file from the patient's primary care physician. ORS 743.699 requires the Health Plan to provide coverage of emergency services without prior authorization. The Health Plan indicated this claim was denied in error. The claim was paid in May of 2000 after the hospital called to inquire about the claim.

<u>Population Reviewed</u>	<u># Units</u>	<u># Not Applicable (N/A)</u>	<u># Passed Standard</u>	<u># Failed Standard</u>
Emergency claims denied	<u>50</u>	<u>42</u>	<u>7</u>	<u>1</u>
Subtotal	250	42	7	1
Less N/A files	<u>42</u>			
Total	<u><u>8</u></u>	<u><u>42</u></u>	<u><u>7</u></u>	<u><u>1</u></u>

Due to the small sample size and the fact that the TPA responsible for processing claims appears to have adequate procedures in place to ensure correct processing of emergency services claims, a recommendation is not warranted.

Additional Findings and Procedures

Claim Processing Errors

The following claim processing errors were noted during the examination. Some of these errors may also have been described under the standards referenced above.

<u>Description of Error</u>	<u># Files</u>
Due to coding error, EOB indicated incorrect patient responsibility amount	2
When information requested from provider was received, the claim analyst did not process all claims previously closed for lack of information from the provider	6
Health Plan requested wrong information needed to process claim	1
Health Plan investigated for preexisting when this investigation was not necessary and failed to process claim when response was received	1
Coverage was reinstated and claims previously denied were not reprocessed in a timely manner	4
Claim denied in error	6
Health Plan denied claim for lack of provider response when information had already been received by the Health Plan	2
Member did not receive EOB due to coding error	1
Claim sent to wrong processing unit	1
Claim paid to wrong provider	1
Health Plan wrote for information regarding claim when it already had all information necessary to process the claim	1
Total	26

Health Plan Identification

The EOB form used to process the Health Plan's claims contains incorrect information. The Health Plan's claims are administered by a TPA and the EOB indicates the claims are administered by the TPA and another health plan affiliated with the TPA.

Additionally, the acknowledgement letter used by the TPA does not include the Health Plan's name, but instead identifies the carrier as the TPA and its affiliated health plan. The claim forms used by the TPA for processing the Health Plan's business also identify the TPA and its affiliated companies as the insurance carrier.

The incorrect information that appears on these documents is misleading since the claimant is not informed that the claim is being processed in accordance with insurance coverage issued by the Health Plan.

The Health Plan is subject to the provisions of ORS 746.110, which prohibits the use of false, deceptive or misleading statements.

A recommendation that correspondence generated by the TPA on behalf of the Health Plan correctly identify the TPA as the third party administrator for the insurer and not refer to other companies that are not a party to the contractual agreement between the Health Plan and the TPA appears in the Grievances section of the report.

Subsequent to the examination, the Health Plan reports all claims correspondence has been revised to clearly identify the Health Plan as opposed to the TPA.

REPORTS

The administrative agreement between the Health Plan and the TPA (Third Party Administrator) that was signed in February of 1999 requires the TPA to provide the Health Plan with specific reports at certain intervals. The agreement also sets forth minimum standards for retention of claims and correspondence records. The purpose of this phase is to determine whether the TPA is performing in

accordance with the terms of the administrative agreement and whether the Health Plan is adequately supervising the TPA.

Findings

The examiner requested the weekly, monthly and quarterly enrollment reports that should have been generated during the examination period pursuant to the terms of the administrative agreement. Financial reports were not requested since the Oregon Insurance Division is performing a financial examination of the Health Plan.

The Health Plan passed the following standards without comment:

Standard

Reference

Reports Standard #2 – Claims files are maintained and regularly updated and claims histories are established for record retention.

OMIP/RBCBSO Administrative Agreement, Article IV, Section 7, page 5.

Reports Standard #3 – Correspondence files are maintained documenting all inquiries and responses by name, subject, and date.

OMIP/RBCBSO Administrative Agreement, Article V, Section 1, page 6

The following exceptions were noted:

Reports Standard #1 – The Health Plan maintains membership and eligibility data according to the specifications found in the TPA agreement. Reference: OMIP/RBCBSO administrative agreement, Article XI, Section 1, pages 8 and 9.

Findings: Failed.

The quarterly enrollment reports are due within 45 days of the quarter end cut-off. The quarter end cut-off date is the last day of the month for each quarter. The TPA is unable to provide the examiner with documentation demonstrating the date these reports were submitted to the Health Plan. The TPA is taking corrective action to include a cover letter with each quarterly report that will convey the date the reports are submitted. Additionally, these reports should include “length of stay of

current enrollees” information. This data is not included in the information provided to the Health Plan even though it is specified in the administrative agreement.

The monthly enrollment reports are due within 21 days of the month end cut-off. The Health Plan informed the examiner that the month end cut-off date is the end of the month. However, the TPA does not use the end of the month as the cut-off date when preparing all monthly reports. The TPA stated that since the variety of data produced for the Health Plan is from different systems and different departments, the cut-off date for each piece of the reporting could vary. This does not appear to correspond with the cut-off dates defined by the Health Plan.

The monthly Board eligibility recap with running totals of approved applications report does not include running totals. The cut-off date used by the TPA for this report is between the 15th and the 19th of each month, not the end of the month.

The monthly enrollment reports for January 1999, June 1999, and September 1999 were not submitted to the Health Plan on time.

<u>Month</u>	<u>Date Report Submitted</u>	<u>Reason for Delay</u>
January 1999	February 8, 1999	Multiple adjustments made to reporting programs to accommodate charges requested by the Health Plan
June 1999	July 2, 1999	System problems at TPA
September 1999	October 6, 1999	System problems at TPA

The administrative agreement indicates a monthly enrollment report of Medicaid/Oregon Medical Insurance Pool client match for members with known social security numbers is to be generated. The TPA does not provide a report in this format. The TPA indicates this data can be obtained by reviewing the monthly termination reports. Each member whose coverage is suspended or cancelled due to Medicaid/Oregon Health Plan eligibility is identified on the monthly termination report with a specific termination code and the social security number is also found on that report.

The monthly agent referral fee listing prepared by the TPA does not include the agent's address and telephone number as required by the administrative agreement. The TPA informed the examiner that the Health Plan has direct access to this information from the Insurance Division's Licensing Section.

Although the administrative agreement that was signed February 5, 1999, states that weekly enrollment reports are to be generated, these reports were not prepared during the examination period. Since the first quarter of 1999, the OMIP program manager has visited the TPA office usually once a week to review enrollment, workload, appeals and other issues that affect the program instead of requiring a weekly report. One reason for this change was the unforeseen workload caused by the enrollment of FHIAP members. Additional information regarding the FHIAP program can be found under Enrollment Procedures.

The TPA informed the examiner that these weekly enrollment reports were eliminated in late 1998 because the Health Plan determined that the data being provided was not valid. The TPA did not retain documentation supporting this response to the examiner since the discussions between the Health Plan and the TPA were informal and were not documented.

The Health Plan indicated that during the examination it became clear the administrative agreement does not accurately reflect the current business practices regarding reports. The Health Plan will be revising its contract with the TPA and will correctly identify all reporting requirements. **The changes in reporting requirement were done by mutual understanding and although the contract should have been amended it does not appear that a recommendation is warranted.**

Reports Standard #4 – The required reports are submitted by the TPA to the Health Plan as indicated in the contract. Reference: OMIP/RBCBSO administrative agreement, Article VIII, Section 2, page 8.

Findings: Failed.

The TPA is required to submit quarterly case management reports to the Health Plan within 45 days of the quarter end cut-off. The quarter end cut-off date is the last day of the month for each quarter.

None of the quarterly case management reports due for the examination period were prepared on time and the examiner was unable to determine the date these reports were submitted to the Health Plan.

<u>Report for Quarter Ending</u>	<u>Report Due Date</u>	<u>Date Report Prepared</u>
3/31/99	5/15/99	7/19/99
6/30/99	8/15/99	10/16/99
9/30/99	11/15/99	3/31/00
12/31/99	2/15/00	5/1/00

The examiner also reviewed the weekly large claim voucher reports that were submitted to the Health Plan during the examination period. Eight of the 50 reports (16%) were not delivered to the Health Plan within the required time frame. Weekly large claim vouchers are to be submitted within seven days of the week end cut-off.

As indicated above, all changes in the report requirements appear to have been mutually agreed upon.

Therefore, no recommendation is warranted.

POLICYHOLDER TREATMENT

The policyholder service portion of the examination is designed to test the Health Plan's compliance with statutes regarding the Patient Protection Act. The Health Plan became subject to the Patient Protection Act regulation October 23, 1999. Disclosures are also included in this phase.

Testing for compliance in this phase may take several forms. Most items are tested by reviewing disclosure forms, reviewing policy procedures and reading instructions provided to customer service representatives, marketing personnel and agents. In some instances, samples are drawn to determine compliance.

Findings

Standards 3 through 16 were waived for this examination.

Policyholder Treatment Standard #1 – The Health Plan discloses 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. Reference: ORS 743.804(2)(5) and (8), OAR 836-053-1020(6), OAR 836-053-1030, OAR 836-053-1090.

Findings: Failed.

The Health Plan informed the examiner that the summary of policies on enrollee's rights and responsibilities appears in the policy contract and is clearly indicated in the policy's Table of Contents. The examiner was unable to locate an item titled "Enrollee's Rights and Responsibilities" in policy form #OMIP-1 7/99 and did not find within the policy contract the enrollee's right to be provided with information about the organization, its services and the providers providing care. The enrollee's right to participate in decision making regarding their health care and to be treated with respect and recognition of their dignity and need for privacy is not disclosed in the policy form reviewed. These enrollee's rights are required by the provisions of ORS 743.804(1).

The examiner asked the Health Plan how it discloses the procedures for notifying enrollees of a change or termination of any benefit, termination of a primary care delivery office or site, and assistance available to enrollees affected by termination of a primary care delivery office or site in selecting a new primary delivery office or site. The Health Plan indicated it follows the TPA's corporate procedures for notifying members of changes, but did not explain how it discloses these procedures to enrollees in accordance with ORS 743.804(5)(e).

The Health Plan did not provide the examiner with an explanation of how it discloses to members the procedures by which enrollees and their representatives may participate in the development of the Health Plan's corporate policies and practices pursuant to ORS 743.804(5)(i). The Health Plan informed the examiner that its Board meetings are open to the public and that public comment is welcome, but did not explain how it discloses this information to enrollees.

It appears the Health Plan does not provide written general information for the policy offered that provides managed health care which includes a description of the procedures by which enrollees,

purchasers and providers may participate in the development and implementation of the Health Plan's policies and procedures as required by OAR 836-053-1030(7).

It appears the Health Plan does not provide written general information describing how the Health Plan makes decisions regarding coverage and payment for treatment or services including a notice to enrollees that they may request an additional written summary of information that the Health Plan may consider in its utilization review of a particular condition. A written general notice to enrollees with the name and telephone number of the administrative section of the Health Plan that handles enrollee requests for information was not provided for the examiner's review. OAR 836-053-1030(8) requires the Health Plan to disclose this information to the enrollee in writing.

The Health Plan did not provide the examiner with summary of criteria used to determine if a service or drug is considered experimental or investigational that is included in the written general information furnished to enrollees in accordance with ORS 743.804(5)(k).

The examiner was not provided with the information about provider, clinic and hospital networks, if any, including a list of network providers and information about how the enrollee may obtain current information about the availability of individual providers, the hours the providers are available and a description of any limitation on the ability of enrollees to select primary and specialty care providers that is furnished to enrollees in accordance with ORS 743.804(5)(L).

The Health Plan did not provide the examiner with a copy of the general disclosure of any risk-sharing arrangements it has with physicians and other providers as required by ORS 743.804(5)(m) and OAR 836-053-1030(10), but did indicate the same disclosure the TPA uses for its commercial business is used for the Health Plan. From the information provided, it appears that disclosure would not identify the Health Plan as the insurer. A recommendation regarding health plan identification appears in the Grievances section of this report.

It appears the Health Plan does not furnish to enrollees a notice of the information that is available upon request pursuant to ORS 743.804(6) as required by ORS 743.804(5)(r).

ORS 743.804(5)(f) and (h) requires the Health Plan to disclose to enrollees the appeal process and the procedures for voicing grievances. The appeal rules set forth in OAR 443-010-0010 specify that appeals of determinations unrelated to benefit or claim issues are to follow one set of procedures, and appeals of benefit or claim issues have their own procedures. The information the Health Plan discloses to enrollees does not explain the process for submitting appeals that are unrelated to benefit or claim issues.

I recommend the Health Plan disclose the required information to all enrollees written general information informing enrollees about services provided, access to service, charges and scheduling in accordance with ORS 743.804(2) and (5) and OAR 836-053-1030.

The Health Plan indicated it will be making the necessary disclosures in the first quarter of 2001.

Policyholder Treatment Standard #2 – The Health Plan provides the required information upon request from an enrollee or a prospective enrollee. Reference: ORS 743.804(2)(6) and (7), ORS 743.807(2)(a), OAR 836-053-1020(5).

Findings: Failed.

The Health Plan relies on the TPA to provide the disclosures required by this standard. The TPA does have procedures in place, but the information disclosed identifies the TPA as the insurer, not the Health Plan.

The Health Plan does not have a procedure for providing a summary of policies on enrollee's rights and responsibilities to participating providers in accordance with ORS 743.804(2).

A recommendation regarding proper identification of the insuring health plan appears in the Grievances section of this report.

I recommend the Health Plan provide the required information upon request from an enrollee or a prospective enrollee in accordance with ORS 743.804(2)(6) and (7) and ORS 743.807(2)(a).

Additional Findings and Procedures

The administrative agreement between the Health Plan and the TPA specifies that 95% of all customer service inquiries made via telephone calls placed to the Health Plan’s dedicated telephone line will not be on “hold” for longer than the length defined as the TPA’s corporate standard.

The agreement also states that performance of this standard is to be monitored on a monthly basis and evaluated on a quarterly basis. The TPA is to provide the Health Plan with a report showing performance under this standard 30 days after the end of each calendar quarter.

This report was not furnished to the Health Plan during the examination period. The Health Plan informed the examiner that this data is available and the TPA will provide this report to the Health Plan in the future.

I recommend the Health Plan monitor the TPA’s performance standards defined in the administrative agreement between the Health Plan and the TPA.

COMPLIANCE WITH PRIOR EXAMINATION RECOMMENDATIONS

This was the first market conduct examination performed for the Health Plan. Therefore, no prior recommendations exist.

CONCLUSION/RECOMMENDATIONS

#	Recommendation	Page
1	I recommend the Health Plan acknowledge grievances within seven days from receipt of the grievance in accordance with ORS 743.804(3)(d) and OAR 836-053-1100(1)(a).	10
2	I recommend the Health Plan make a decision regarding grievances within 30 days from receipt of the grievance in accordance with ORS 743.804(3)(d) and OAR 836-053-1100(1)(b).	11
3	I recommend the Health Plan treat as a grievance any written complaint submitted by or on behalf of a covered person in compliance with ORS 743.801(4). Correspondence regarding issues other than complaints should not be logged in and treated as grievances or appeals.	11
4	I recommend correspondence generated by the TPA on behalf of the Health Plan correctly identify the TPA as the third party administrator for the insurer and not refer to other companies that are not a party to the contractual agreement between the Health Plan and the TPA in accordance with ORS 746.110.	12

#	Recommendation	Page
5	I recommend the Health Plan be correctly identified as the insuring health plan in all correspondence and forms in accordance with ORS 746.110, OAR 836-020-0260 and Oregon Insurance Division Bulletin 96-5.	13
6	I recommend the Health Plan maintain a timely and organized system for resolving grievances and appeals in accordance with ORS 743.804(3)(a)-(f).	14
7	I recommend the Health Plan file with the commissioner an annual report in the format prescribed by rule in accordance with ORS 743.804(6)(c) and (9), OAR 836-053-1000(3)(a), OAR 836-053-1070(1), (2), and (3), and Oregon Insurance Division Bulletin 98-6.	14
8	I recommend the Health Plan provide to any enrollee who has filed a grievance detailed information on its grievance and appeal procedures and how to use them and information on how to access the complaint line of the Department of Consumer and Business Services in accordance with ORS 743.804(3)(e), (5)(q), and (8).	14
9	I recommend the Health Plan's grievance and appeal process offer the appellant at least two levels of appeal following the initial grievance in accordance with ORS 743.804(3)(f).	14
10	I recommend the Health Plan issue policies within 30 days from receipt of applications in accordance with ORS 735.560, ORS 742.046, and the administrative agreement between the Health Plan and the TPA.	17
11	I recommend the Health Plan resolve claims within 30 days unless a delay letter (45 days) has been sent in accordance with ORS 746.230(1)(e) and OAR 836-080-0235(1) and (4).	26
12	I recommend the Health Plan respond to claim correspondence within 30 days in accordance with ORS 746.230(1)(b) and OAR 836-080-0225(3).	27
13	I recommend the Health Plan not deny claims without first conducting a reasonable investigation in accordance with ORS 746.240(1)(c) and (d).	28
14	I recommend the Health Plan not misrepresent the facts or policy provisions while settling claims in accordance with ORS 746.230(1)(a).	30
15	I recommend the Health Plan promptly provide the proper explanation of the basis relied on in the insurance policy in relation to facts or applicable law for the denial of claim in accordance with ORS 746.230(1)(m).	31
16	I recommend the Health Plan disclose the required information to all enrollees written general information informing enrollees about services provided, access to service, charges and scheduling in accordance with ORS 743.804(2) and (5) and OAR 836-053-1030.	41
17	I recommend the Health Plan provide the required information upon request from an enrollee or a prospective enrollee in accordance with ORS 743.804(2)(6) and (7), ORS 743.807(2)(a) and OAR 836-053-1090.	41
18	I recommend the Health Plan monitor the TPA's performance standards defined in the administrative agreement between the Health Plan and the TPA.	42

ACKNOWLEDGMENT

The cooperation and assistance rendered by the officers and employees of the Health Pan during this examination is hereby acknowledged and appreciated.

A special thanks is extended to the examination coordinators for their courtesy and assistance 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 their regular assigned duties.

In addition to the undersigned, Gayle L. Woods, AIE, participated in this examination.

Respectfully submitted,

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

APPENDIX A
STANDARDS
OREGON MEDICAL INSURANCE POOL (OMIP)
MARKET CONDUCT EXAMINATION

Grievances

1	Claims appeals are processed in the manner outlined in the benefit book.	OAR 443-010-0010(2)(a)
2	Other grievances are processed in the manner outlined in the benefit book.	OAR 443-010-0010(1)
3	Claims grievances are provided the same three-step process as the Health plan.	Benefit Booklet
4	All grievances are acknowledged within seven days from receipt.	Benefit Booklet
5	All grievances and appeals are answered within 30 days from the receipt.	Benefit Booklet
6	The TPA meets the contractual performance standards.	Administrative Agreement between Health Plan and TPA

Enrollment Procedures

1	Key information on the application is verified prior to approval or denial of the application.	OAR 443-005-0000
2	All eligible applicants are accepted.	OAR 443-005-0000, Administrative Agreement between Health Plan and TPA
3	Policies are issued 30 days from receipt of the application.	ORS 735.650, ORS 742.046, Administrative Agreement between Health Plan and TPA
4	Policies are terminated according to the reasons and procedures found in the policy contract.	OAR 443-005-0000, OMIP Plan 7/99

Rates and Forms

1	All forms issued to OMIP policyholders have been filed and approved prior to issue.	ORS 735.650, ORS 742.003, ORS 742.005
2	Members are charged rates that have been approved by the OMIP Board for the examination period.	ORS 735.610(4)(d)
3	All rates have been filed and approved by the Insurance Division prior to use.	ORS 735.650, ORS 743.018

Claims

1	The initial contact by the Health Plan with the claimant is within 14 days.	ORS 746.230(1)(b), OAR 836-080-0225(1)&(4)
2	Investigations are conducted within 45 days.	ORS 746.230(1)(c), OAR 836-080-0230
3	Claims are resolved in 30 days unless a delay letter (45 days) has been sent.	ORS 746.230(1)(e), OAR 836-080-0235(1)&(4)

4	The Health Plan responds to claim correspondence in 30 days.	ORS 746.230(1)(b), OAR 836-080-0225(3)
5	Claims are not denied without first conducting a reasonable investigation.	ORS 746.230(1)(c)&(d)
6	The Health Plan promptly and in good faith equitably settles claims in which liability has become reasonably clear.	ORS 746.230(1)(f)(h)&(L)
7	The Health Plan did not misrepresent the facts or policy provisions while settling a claim.	ORS 746.230(1)(a)
8	The Health Plan did not delay investigation or payment of claims by requiring a claimant to submit a preliminary claims report and then requiring subsequent submission of loss forms when both require essentially the same information.	ORS 746.230(1)(k)
9	The Health Plan did not fail to promptly provide the proper explanation of the basis relied on in the insurance policy in relation to facts or applicable law for the denial of claim.	ORS 746.230(1)(m)
10	Denied and closed-without-payment claims are handled in accordance with policy provisions and state law.	OAR 836-080-0235(1)
11	Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy.	ORS 746.230(1)(g)
12	The Health Plan adjusts all claims for emergency services and auxiliary emergency services including ambulance services in compliance with applicable laws, rules and regulations.	ORS 743.699(1)(2)(3), ORS 743.801(1)(2)(3), OAR 836-053-1030(4)
13	The contractual performance standards for claims are met.	Administrative Agreement between Health plan and TPA

Reports

1	Membership and eligibility data are maintained according to the specifications found in the TPA agreement.	Administrative Agreement between Health plan and TPA
2	Claims files are maintained and regularly updated and claims histories are established for record retention.	Administrative Agreement between Health plan and TPA
3	Correspondence files are maintained documenting all inquiries and responses by name, subject, and date.	Administrative Agreement between Health plan and TPA
4	The required reports are submitted by the TPA to OMIP as indicated in the contract.	Administrative Agreement between Health plan and TPA

Policyholder Treatment

1	The Health Plan discloses 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.	ORS 743.804(2)(5)&(8), OAR 836-053-1020(6), OAR 836-053-1030, OAR 836-053-1090
2	The Health Plan provides the required information upon a request from an enrollee or a prospective enrollee.	ORS 743.804(2)(6)&(7), ORS 743.807(2)(a), OAR 836-053-1020(5)