

STATE OF OREGON

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

INSURANCE DIVISION

REPORT OF MARKET CONDUCT EXAMINATION

OF

**PROVIDENCE HEALTH PLAN  
PORTLAND, OREGON**

**NAIC COMPANY CODE 95005**

AS OF

MARCH 31, 2000

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March 2, 2001

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

Dear Director:

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

**PROVIDENCE HEALTH PLAN  
3601 SW Murray Blvd., Suite 10  
Beaverton, Oregon 97005**

**NAIC Company Code 95005**

hereinafter referred to as the “Company” or “Plan.” The following report of  
examination is respectfully submitted.

## **SCOPE OF EXAMINATION**

The market conduct examination of the Company was conducted as of March 31, 2000, covering the period of April 1, 1999 through March 31, 2000, and included a review of material transactions or events which occurred subsequent to the examination cut-off date and were noted during the examination.

A target market conduct examination was performed. The examination of the Company was conducted pursuant to ORS 731.300 and in accordance with procedures and guidelines 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 determine the practices and procedures of the Company'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 Company. The examiner then reviewed each file.
2. The procedure manuals and/or memorandum were evaluated.
3. The Company responded to a series of questions regarding the phase being examined.

The 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. Standards with 100% compliance are identified as passed without comment. Exceptions include standards with less than 100% compliance that either

warranted a recommendation or where errors were noted but a recommendation was not made. 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 nine phases:

Company Operations/Management	Underwriting
Grievance Procedures	Claims
Network Adequacy	Utilization Review
Policyholder Service	Provider Administration
Quality Assessment and Improvement	

Administrative actions may result as a result of this examination. Examiners may not have discovered all unacceptable or noncomplying practices of the Plan. Failure to identify specific practices does not constitute acceptance of such practice.

## **COMPANY OPERATIONS/MANAGEMENT**

### **Company History**

The Plan was established on February 1, 1984. It was originally incorporated under the name Physician Interhospital Health Plan. The Plan is a non-profit, tax exempt, Federally qualified HMO. It is operated as a subsidiary of Providence Plan Partners whose majority stockholder is Sisters of Providence Health System.

The Plan recently finalized corporate restructuring and acquisition involving two statutory mergers and a name change of the surviving entity to Providence Health Plan. Good Health Plan of Washington and SelectCare Health Plans merged into Providence Health Plan, and Providence Health Plan, dba Good Health Plan of Oregon was renamed Providence Health Plan. As part of the restructuring, the composition of the Board of Directors was changed to reflect the regional scope of the Plan. To preserve

local influence on important issues, the Board of Directors established state health plan executive councils to serve in an advisory capacity to the Board.

Governance powers are reserved from Providence Plan Partners to the Providence Health Plan Board of Directors. These powers include the rights to appoint the executive director, issue or authorize debt, and effect dissolution of Providence Health Plan. The composition of the Board of Directors meets that required for a Federally qualified plan, *i.e.*, one-third consumer, one-third provider, and one-third management representative officers.

The sale of Providence Health Plan–Washington to Regence BlueCross in Seattle, Washington, was finalized January 1, 1999.

The Plan's main office is located in Portland, Oregon. Commercial, Medicare and Medicaid products are offered in the Portland service area.

The location of branch offices and the products offered in those areas are as follows:

- Bend – Commercial
- Eugene – Commercial, Medicare, Medicaid
- Medford – Commercial, Medicare, Medicaid
- Salem – Commercial, Medicare
- Longview, Washington – Commercial, Medicare

As of March 2000, the Plan's total membership was 335,231 – 240,143 (72%) commercial, 51,699 (15%) Medicare, and 43,389 (13%) Medicaid.

### **Board of Directors**

Members of the Board of Directors, duly elected and serving as of March 31, 2000, were as follows:

<b><u>Name</u></b>	<b><u>Location</u></b>	<b><u>Principal Affiliation</u></b>
Karin Dufault, S.P., Chairperson	Seattle, WA	Sisters of Providence
Donald D. Blem	Bothell, WA	ATL Ultrasound
Lynn Chappell, S.P.	Seattle, WA	Sisters of Providence
John Collins, Jr., M.D.	Irving, TX	VHA, Inc.
Barbara Donaho	St. Petersburg, FL	
Orcilia Zuniga Forbes	Corvallis, OR	Oregon State University
Susanne Hartung, S.P.	Seattle, WA	Sisters of Providence
John Hayward	Bellevue, WA	PeaceHealth
Fred Herskowitz, M.D.	Oakland, CA	
Celeste Koebel, S.C.	Cincinnati, OH	
Skip Kriz	Bellevue, WA	PeaceHealth
Carol Pacini, L.C.M.	Torrance, CA	
Al Parrish	Anchorage, AK	
Kay Stepp	Portland, OR	Executive Solutions

### **Officers**

The principal officers of the Company as of March 31, 2000 were as follows:

<b><u>Name</u></b>	<b><u>Office</u></b>
Karin Dufault, S.P.	Chairperson of the Board
Celestia Koebel, S.C.	Vice Chairperson
Henry G. Walker	President/CEO
Greg VanPelt	Chief Executive
Lowell W. Johnson	Vice President - Finance/Treasurer
Jeffrey W. Rogers	Secretary
Jennifer Clough	Assistant Secretary

### **Findings**

The Company operations/management portion of the examination is designed to provide a view of what the Company is and how it operates. It is not based on sampling techniques, but is more concerned with structure.

Company operations/management Standards 1, 2, 3, 4 and 8 were waived for this examination as they were reviewed in the recent financial examination. All standards can be found in the appendix following the report.

The following exceptions to the Company operations/management standards were noted:

Company Operations/Management Standard #5 – The Company is adequately monitoring the activities of the MGA, GA, TPA or any entity that contractually assumes a business function or is acting on behalf of the company. Reference: Managing General Agents – ORS 744.300 through ORS 744.316, OAR 836-071-0115, OAR 836-071-0150, OAR 836-071-0160, OAR 836-071-0297 and OAR 836-071-0315; Third Party Administrators – ORS 744.700 through 744.740.

Findings: Failed.

During the examination period, the Plan utilized the services of three third party administrators – TPA A, TPA B, and TPA C. These third party administrators handled at least some aspects of claims adjudication for the following types of claims.

- TPA A – Prescription Drug Claims
- TPA B – Chiropractic Claims
- TPA C – Elective Abortion and Sterilization Claims

During the examination period, the Plan did not conduct formal audits of any of the above third party administrators. The only audits performed were informal desk audits of TPA A, in regard to payment for drugs requiring prior authorization.

**I recommend the Plan conduct a review of the operations of third party administrators who administer benefits for more than 100 certificate holders on the Plan's behalf at least annually in compliance with ORS 744.740.**

Company Operations/Management Standard #6 – Company contracts with MGA, GA, TPA comply with applicable statutes, rules and regulations. Reference: Managing General Agents – ORS 744.300 through ORS 744.316, OAR 836-071-0115, OAR 836-

071-0150, OAR 836-071-0160, OAR 836-071-0297 and OAR 836-071-0315; Third Party Administrators – ORS 744.700 through 744.740.

Findings: Failed.

During the examination period, the Company had agreements in force with three third party administrators – TPA A, TPA B, and TPA C. None of these agreements included the following required provisions:

- A provision that the third party administrator retain the agreement between itself and the Company with its records “for the duration of the agreement and for five years following the date of its termination.” (See ORS 744.720(2).)
- A provision specifying the Company is responsible for providing competent administration of its programs. (See ORS 744.720(3)(b) and ORS 744.740(2).)
- A provision specifying the Company shall conduct a review of the operations of the third party administrator at least annually. (See ORS 744.720(3)(b) and ORS 744.740(3).) One of the agreements gave the Company the right to conduct audits “at reasonable times and upon reasonable advance notice,” but did not specify that such audits shall be conducted annually. The other two agreements did not provide for audits at all.
- A provision the third party administrator shall make available to the Department of Consumer and Business Services copies of all contracts and amendments. (See ORS 744.720(5).)

In addition to the above, the Company’s agreements with TPA B did not include the following required provisions:

- A provision specifying that the Plan is responsible for determining the benefits, premium rates, underwriting criteria and claims payment procedures applicable to the coverage and for securing reinsurance. (See ORS 744.720(3)(b) and ORS 744.740(1).)
- A provision specifying that the Plan is required to provide rules for the above matters in writing to the third party administrator. (See ORS 744.720(3)(b) and ORS 744.740(1).)

Also, the Plan's agreement with TPA C, did not include a provision establishing which disputes, if any, arising under the contract shall be decided by arbitration, mediation or other means of dispute resolution. (See ORS 744.720(3)(e).)

**I recommend the Plan's agreements with third party administrators comply with the requirements of ORS 744.700 through 744.740.**

Company Operations/Management Standard #7 – Records are adequate, accessible, consistent and orderly and comply with record retention requirements. Reference: ORS 733.170.

Findings: Failed.

Following is a list of record keeping and documentation problems encountered during the course of the examination:

- Inaccurate and incomplete grievance and appeal information. (See Grievance Procedures Standard #3.)
- Failure to document second level review of grievances. (See Grievance Procedures Standard #10.)

- Failure to document denial of claim notice sent to member. (See Claims Standard #5.)
- Failure to document what prompted a claim to be reviewed and reprocessed for payment. (See Claims Standard #5.)
- Failure to document when revised information was received. (See Claims Standard #5.)

**I recommend the Plan keep records that are adequate, accessible, consistent and orderly in compliance with ORS 733.170.**

### **Delegated Claims Adjudication Functions**

During the examination period, the Plan delegated certain claims adjudication functions to three third party administrators. One was not licensed as a third party administrator in the State of Oregon.

**I recommend the Plan delegate claims adjudication only to licensed third party administrators in accordance with ORS 746.110 and ORS 746.240.**

## **GRIEVANCE PROCEDURES**

### **Introduction**

The Plan's "member complaint policy" defines complaints to include any "expression of dissatisfaction regarding an incident or a concern involving a practitioner, staff, facility, or THE PLAN benefits or services." Their procedures indicate all member complaints submitted orally or in writing are registered, acknowledged, investigated, and resolved according to the Plan's procedures. If possible, oral complaints are resolved at the time the member or member's representative contacts customer service. Oral complaints not resolved at that time and all written complaints are to be acknowledged in three working days.

Complaints involving quality of care issues are routed to quality management for investigation and resolution. Those involving other issues, *i.e.*, Plan benefits, services or processes, are handled by the appeals/grievance specialist. Appeals requiring clinical review or involving medical necessity are routed to the medical management unit for investigation and resolution. Those involving only non-clinical issues are investigated and resolved by the appeals specialist. The appeals/grievance process includes three levels of review. The third level is a hearing before the Plan’s grievance committee.

**Grievances and Appeals**

The Plan was asked to provide lists of grievances and appeals received during the examination period identifying those grievances closed at the first level of review (initial grievances), those closed at the second level of review (first appeals), and those closed at the third level of review (second appeals). The examiners received the following three lists:

Complaint Data list	First level grievances that did not involve a decision made by the plan, such as those involving quality of care or plan services.
Appeals Data list	A list of grievance that did involve a decision made by the plan, such as a claim or prior authorization. The list included grievances closed at any level.
Grievance Data list	Third level grievance that did involve a decision made by the plan. Since the Plan did not limit the Appeals Data list the Grievance data appeared on both lists.

The Plan advised that second appeals were scheduled for grievance committee hearings, but were also reviewed prior to the scheduled hearing. If the pre-hearing review resulted in a decision in the member’s favor, the appeal was not sent to the grievance committee. If the pre-hearing review resulted in a decision to uphold the original denial, the appeal was sent to the grievance committee for hearing. The Plan considered the pre-hearing to be the second level of review.

The “complaint data” list included 116 entries and the “appeal data” list included 625 entries for a total of 741 entries involving review of the initial grievance. A random sample of 50 of these files (initial grievances) was reviewed and tested for compliance with the standards indicated under “Findings” based on Oregon Revised Statutes or Oregon Administrative Rules.

The “grievance data” list included 64 entries, 19 of which were indicated to have been reviewed at a grievance committee hearing. Interval samples of ten files not indicated to have had a hearing (1<sup>st</sup> appeals) and ten files indicated to have had a hearing (2<sup>nd</sup> appeals) were reviewed. These samples were tested for compliance with the standards indicated under “Findings” based on Oregon Revised Statutes or Oregon Administrative Rules.

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

<b><u>Reasons</u></b>	<b><u># Of Files</u></b>	<b><u>Percentage</u></b>
Denial based on experimental	3	4.3%
Denial based on medical necessity	18	25.7
Denial based on other Plan provisions	22	31.4
Eligibility	2	2.9
Emergency	3	4.3
Quality of clinical care	4	5.7
Quality of Plan services	3	4.3
Referral issues	15	21.4
Total	<u>70</u>	<u>100.0%</u>

<b><u>Dispositions</u></b>	<b><u># Of Files</u></b>	<b><u>Percentage</u></b>
Appeal withdrawn	1	1.4%
Corrective action taken	25	35.7
Outcome not indicated	5	7.2
Satisfactory explanation given	28	40.0
Unsatisfactory response	11	15.7
Total	<u>70</u>	<u>100.0%</u>

### **Insurance Commissioner Complaints**

The Plan's logs for Insurance Division inquiries received during the examination period were used to develop the population of Insurance Division complaints. From a total population of 133 inquiries indicated to have been received from the State of Oregon Insurance Division during the examination period, a random sample of 50 files was selected for review. Six were deleted from the sample – three because they were inquiries from the Washington Insurance Division, one because another company was the actual insurer, one because it involved a self-funded plan, and one because the person was not a member under any of the Plan's plans. Replacement files were requested, so the sample still included 50 files, which were tested for compliance with the standards indicated under "Findings" based on Oregon Revised Statutes or Oregon Administrative Rules.

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

<b><u>Reasons</u></b>	<b><u># Of Files</u></b>	<b><u>Percentage</u></b>
Denial based on experimental	1	2.0%
Denial based on medical necessity	14	28.0
Denial based on other Plan provisions	14	28.0
Eligibility	7	14.0
Premium increase	3	6.0
Quality of Plan services	6	12.0
Referral issues	5	10.0
Total	<u>50</u>	<u>100.0%</u>

<b><u>Dispositions</u></b>	<b><u># Of Files</u></b>	<b><u>Percentage</u></b>
Corrective action taken	19	38.0%
Satisfactory explanation given	22	44.0
Unsatisfactory response	9	18.0
Total	<u>50</u>	<u>100.0%</u>

**Findings**

Each item was tested for compliance with those of the following standards that applied based on Oregon Revised Statutes and Oregon Administrative Rules.

Grievance Procedures Standard #5 was waived because the information was included in Policyholder Service Standard #1. All standards can be found in the appendix following the report.

The Plan passed the following grievance procedures standard without comment:

#	Standard	Regulatory Authority
4	A health carrier files with the commissioner an annual report in the format prescribed by rule.	ORS 743.804(6)(c)&(9), OAR 836-053-1000(3)(a), OAR 836-053-1070(1),(2)&(3), and Bulletin 98-6

The following exceptions to the Grievance Procedure standards were noted:

Grievance Procedures Standard #1 – The health carrier treats as a grievance any written complaint submitted by or on behalf of a covered person. Reference: ORS 743.801(4).

Findings: Passed with Comment.

ORS 743.801(4) defines “grievance” as “a written complaint submitted by or on behalf of an enrollee regarding the: (a) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization; (b) Claims payment, handling or reimbursement for health care services; or (c) Matters pertaining to the contractual relationship between an enrollee and an insurer.”

The Plan’s definition of “grievance” is a “member or member representative request for a second level appeal.” Their definition of “appeal” is a “request made by a member representative to reconsider any previous decision or policy made by Providence Health

Plan.” Their definition of “complaint” is “any expression of dissatisfaction.” Their definition of “grievance” is not as broad as that found in ORS 743.801(4). However, when combined, their definitions of “grievance,” “appeal” and “complaint” are as broad.

One file reviewed as part of the Insurance Division complaint sample included correspondence indicating there are “no rights for Level 2 grievance when a policy has been cancelled due to premium delinquency.” Since the statutory definition of grievance includes “matters pertaining to the contractual relationship between an enrollee and an insurer,” a written complaint regarding termination for nonpayment of premium qualifies as a grievance and is, therefore, eligible for all levels of grievance and appeal review. The Plan indicated that the grievance specialist had made an erroneous determination regarding a terminated member who did not have the right to file a grievance. During the examination, they sent a memo to their staff advising that complaints regarding termination for nonpayment qualify as grievances.

Grievance Procedures Standard #2 – A health carrier has a timely and organized system for resolving grievances and appeals. Reference: ORS 743.804(3)(a)-(f).

Findings: Failed.

During the examination period, the Plan’s grievance and appeal procedures did not include the following:

- Written decisions on grievances involving quality of care. (See Standard #8 for additional information.)
- Standards for timeliness based on calendar days. The Plan’s appeal procedures included timeliness standards based on a number of “working” days that could be greater than the calendar days allowed by OAR 836-053-1100(1).

- An appeal process for grievances that included at least two levels of review. (See Standard #10 for additional information.)

The Plan’s procedures did provide for written decisions in plain language justifying grievance determinations, including appropriate references to relevant policies, procedures and contract terms. However, in the files reviewed, responses were found that did not comply with these requirements for the following reasons:

<b>Reason</b>	<b># Of Files</b>
Some issues were not addressed.	10
Information on the outcome of the review was not provided. (These concerned quality of care issues.)	4
Explanations of the decisions made were incomplete or unclear.	3
Appropriate references to relevant policies, procedures and contract terms were not included.	3

**I recommend the Plan have a timely and organized system for resolving grievances and appeals in compliance with ORS 743.804(3)(a)-(f) and OAR 836-053-1100.**

Grievance Procedures Standard #3 – The health carrier records data related to grievances and the action taken in a sufficient manner to reconstruct all pertinent events. Reference: OAR 836-053-1080.

Findings: Failed – 64% compliance.

This standard applied to all 70 files in the grievance and appeal samples. Twenty-five (36%) of the files reviewed failed this standard. Following is a summary of the reasons:

<b>Reason</b>	<b># Of Files</b>
Some issues in the grievance were not addressed in the response.	10
Log did not indicate the grievance went to a grievance committee hearing.	6
Information regarding the outcome of the review was not available.	4
Log indicated denial was upheld at first review with no indication it was overturned at a subsequent review.	3
Contract provisions were not correctly cited.	3
Explanations of decisions were incomplete or unclear.	3
Copies of correspondence were not found.	2

Note: Some files failed for more than one of the above reasons.

Additionally, the Plan tracked initial grievances and appeals of the initial grievance decision in separate logs under different log numbers. The Plan's "appeal data" log listed initial grievances and indicated the decision at the first level of review, but did not indicate if that decision was subsequently overturned on appeal. The Plan's "grievance data" log listed appeals of the initial grievance decisions, but under a different log number than the initial grievance. It was, therefore, difficult to use the logs to track grievances through all levels of review.

**I recommend the Plan record data related to grievances and the action taken in a sufficient manner to reconstruct all pertinent events in compliance with OAR 836-053-1080.**

Grievance Procedures Standard #6 – The health carrier provides 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. Reference: ORS 743.804(3)(e),(5)(q) and (8).

Findings: Failed – 30% compliance.

This standard applied to all 70 files in the grievance and appeal samples. Forty-nine (70%) of the files reviewed failed this standard.

ORS 743.804(3)(e) requires notice of the right to file a complaint with DCBS to be provided in all written decision letters. ORS 743.804(8) requires information on the grievance and appeal process and how to file a complaint with the Department of Consumer and Business Services (DCBS) to be provided when an enrollee files a grievance.

During the examination period, the Plan's standard procedure was to include this information in those written decision letters advising that a denial was being upheld. They did not have a procedure in place to provide the required information when the grievance was filed. The initial acknowledgement of the grievance included the required information only if the same letter served as both acknowledgement of and written decision on the grievance and the decision was to uphold the denial.

Following is a summary of the reasons files failed this standard:

<b>Reason</b>	<b># Of Files</b>
Required information was not provided in either the initial acknowledgement or written decision letter(s).	25
Required information was not provided in initial acknowledgement, but was provided in subsequent written decision letter(s).	21
Copy of initial acknowledgement was not found.	3

The Plan advised they are including the information on filing a complaint with DCBS in all their grievance and appeal letters as of June 1, 2000, and provided copies of sample acknowledgement letters confirming this; so a recommendation is not necessary.

In regard to providing detailed information on grievance and appeal procedures, the Plan advised they were not sending this information when an enrollee files a grievance. They advised they would correct this, but had not yet revised their procedures.

**I recommend the Plan provide to any enrollee who has filed a grievance detailed information on its grievance and appeal procedures and how to use them in compliance with ORS 743.804(8).**

Grievance Procedures Standard #7 – The health carrier acknowledges grievances within seven days from the receipt of the grievance. Reference: ORS 743.804(3)(d) and OAR 836-053-1100(1)(a).

Findings: Failed – 91% compliance.

This standard applied to all 70 files in the grievance and appeal standards. Six (9%) of the files reviewed failed this standard.

<u># Of Days to Acknowledge</u>	<u># Of Files</u>	<u>Percentage</u>
0 – 7	64	91%
8 – 30	5	8
31 – 45	0	0
45+	0	0
Copy of acknowledgement not found	1	1
Total	<u>70</u>	<u>100%</u>

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

Grievance Procedures Standard #8 – The health carrier makes a decision regarding grievances within 30 days from the receipt of the grievance. Reference: ORS 743.804(3)(d) and OAR 836-053-1100(1)(b) and (2).

Findings: Failed – 81% compliance.

This standard applied to all 70 files in the grievance and appeal samples. Thirteen (19%) of the files reviewed failed this standard.

<b># Of Days to Provide Written Decision</b>	<b># Of Files</b>	<b>Percentage</b>
0 – 30	55	79%
31 – 45	6	9
45+	3	4
Written decision not provided	5	7
Written decision sent to wrong member	1	1
Total	70	100%

Note: One of the files in the 31-45 category and one of the files in the 45+ category did not fail this standard because the hearing was delayed due to member request.

Of the five files on which no written decision was provided, four involved quality of clinical care issues. The Plan acknowledged quality of clinical care grievances and advised the issue would be reviewed. However, they did not send a resolution letter advising the type of review conducted or the results of such review. The Plan indicated that the findings of a peer review committee are confidential. However, the law that was cited appears to apply only to the evidence presented at such a hearing and not to the final outcome.

**I recommend the Plan provide a written decision regarding grievances within 30 days from the receipt of the grievance in compliance with ORS 743.804(3)(d) and OAR 836-053-1100(1)(b) and (2).**

Grievance Procedures Standard #9 – The Plan responds to Insurance Commissioner complaints adequately and conclusively within 21 calendar days. Reference: OAR 836-080-0225(2).

Findings: Failed – 70% compliance.

This standard applied to all 50 files in the Insurance Division Complaint sample.

Fifteen (30%) of the files failed this standard. Following is a summary of the reasons:

<b>Reason</b>	<b># Of Files</b>
Some issues in complaint were not addressed in response.	8
Requested copies of applicable contract provisions were not included.	3
Incorrect information was provided in response.	2
Final determination was not provided. (Plan advised final decision was pending review, but did not advise outcome of review.)	1
Requested criteria was not provided with response.	1
Response was not provided within 21 days. (Plan sent response 106 days after receipt of initial inquiry in response to a second request.)	1

Note: One file failed for two reasons.

**I recommend the Plan respond to Insurance Commissioner complaints adequately and conclusively within 21 calendar days in compliance with OAR 836-080-0225(2).**

Grievance Procedures Standard #10 – The health carrier has a grievance appeal process with at least two levels of appeal. Reference: ORS 743.804(3)(f).

Findings: Failed – 63% compliance.

This standard applied to 43 files in the grievance and appeal samples. (It was not applied to files in which the denial was overturned at the level being reviewed.) Sixteen (37%) of the files reviewed failed this standard. Following is a summary of the reasons:

<b>Reason</b>	<b># Of Files</b>
A second appeal was not offered.	9
No appeals were offered.	6
Copies of acknowledgement and written decision letters were not found.	1

During the examination period, the Plan offered what they called a first appeal and a second appeal on grievances involving a decision made by the Plan. However, what they called a “first appeal” was actually the initial review of the grievance.

If a “second appeal” was received, it was scheduled for a grievance committee hearing. As previously noted, such appeals were reviewed prior to the scheduled hearing. If the pre-hearing review resulted in a decision in the member’s favor, the member was notified of the decision and the appeal was not sent to the grievance committee. If the pre-hearing review resulted in a decision to uphold the original denial, the appeal was sent to the scheduled grievance committee for hearing without notice to the member or documentation of the outcome of the interim review. Because this interim review was not documented and no written decision was provided, it did not qualify as a second level of review, *i.e.*, first appeal of the initial grievance decision. The appeal before the grievance committee was the second documented review of the grievance and was, therefore, the first appeal of the initial grievance determination. However, the Plan advised members that the decision of the grievance committee was final and did not offer another appeal.

The nine files that failed this standard for not offering a second appeal involved situations in which the grievance committee decided to uphold the original denial. In those cases, only two documented levels of review were provided – review of the initial grievance and the grievance committee’s review of the first appeal of the initial grievance determination.

After the examination period, the Plan revised their procedures to document the pre-hearing review of an appeal and send notice of the outcome of such review to the member. This review is now the first appeal of the initial grievance decision, *i.e.*, second

level of review, and the grievance committee hearing is the second appeal, *i.e.*, third level of review.

Of the six grievances reviewed on which no appeals were offered, four involved quality of clinical care. As previously noted, the Plan acknowledged such complaints, but did not send a resolution letter. They also did not consider clinical care issues to be eligible for the appeal process.

**I recommend the Plan have a grievance appeal process with at least two levels of appeal for all grievances, including those concerning quality of clinical care, in accordance with ORS 743.804(3)(f).**

## **NETWORK ADEQUACY**

### **Introduction**

This phase of the examination addresses the annual summary on network adequacy required by ORS 743.817(1) and OAR 836-05301190(1) for companies that offer managed health insurance as defined by ORS 743.801(8). The purpose of this summary is to document the scope of a Plan's provider network and their ongoing efforts to monitor that network to ensure that all covered services are accessible to enrollees.

### **Findings**

Network Adequacy Standard #2 was waived because this examination also included Policyholder Service Standard #1. The following exception to the network adequacy standards was noted:

Network Adequacy Standard #1 – The Plan files an annual summary by June 30 of each year for the preceding calendar year. Reference: ORS 743.817(1), OAR 836-053-1190(1) and OAR 836-053-1190(3).

Findings: Failed.

The Plan did submit an annual scope of network filing during the examination period, but it did not include all of the required elements. The report filed on June 29, 1999, did not include information on continuity of care. The required attachment listing providers with whom the Plan had contracted as of December 31, 1998, was not indicated to have been sent.

However, the annual scope of network filing the Plan submitted on June 28, 2000, did include both the continuity of care information and the list of providers with whom the Plan had contracted as of December 31, 1999. Since they included the required information in the most recent report, a recommendation is not warranted.

## **POLICYHOLDER SERVICE**

### **Introduction**

This phase of the examination is a review of the Plan's compliance with statutes regarding required disclosures, portability and creditable coverage. Testing for compliance in these areas may take several forms. Most items are tested by reviewing disclosure forms and company policies and procedures. In some instances, samples were requested to determine compliance.

### **Findings**

Policyholder Service Standard #9 was waived because this examination also included Policyholder Service Standards #1 and #2. All standards can be found in the appendix following the report.

Policyholder Service Standards #14 and #16 were not applicable. During the examination period, the Plan had only one plan that included a preexisting condition provision and that plan was amended to delete the provision prior to the end of the examination period.

The Company passed the following policyholder service standards without comment:

#	Standard	Regulatory Authority
4	The Company established a means to provide enrollees, purchasers and providers with a meaningful opportunity to participate in the development of insurer policy an operations.	ORS 743.817(2)
5	The Company maintains policies to ensure adequate treatment for female enrollees.	ORS 743.823, ORS 743.845(2)&(3) and OAR 836-053-1000(11)
6	The Company ensures patient confidentiality by adopting written confidentiality policies and procedures.	ORS 743.804(10)
7	The Company has a policy that allows enrollees to change participating primary care providers at will.	ORS 743.808(1)(a)
8	The Company's written procedures pertaining to drug formularies contains all the required provisions.	OAR 836-053-1020
10	The Company does not 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.	ORS 743.697
13	The Company's rates are determined according to applicable laws, rules and regulations.	ORS 743.760(7)
15	The Company correctly identifies late enrollees and eligible enrollees as pertaining to late enrollment.	ORS 743.730(23)(a),(b),(c)&(d)

The following exceptions to the policyholder service standards were noted:

**Disclosures**

Policyholder Service Standard #1 – The Company discloses 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 services, charges and scheduling. Reference: ORS 743.699(2), ORS 743.804(2)(5) and (8), OAR 836-053-1020(6), OAR 836-053-1030 and OAR 836-053-1090.

Findings: Passed with comment.

The Plan provided all of the required disclosures. The following comments are in regard to the content of four of those disclosures.

It was noted in the complaint phase of the examination that the Plan does not approve referrals from a person's primary care physician to another physician with the same specialty. For example, if a person's primary care physician's specialty is internal medicine, referral to another internal medicine physician would not be approved even if the other physician had more expertise or was more familiar with the condition being treated. The restriction on this type of referral was not mentioned in the Plan's disclosure. It should be included in the disclosure regarding how to obtain a referral.

The Plan provided a disclosure entitled "Risk Sharing and Incentive Agreements," but it did not specifically indicate whether or not a plan involved risk sharing. The disclosure indicated primary care providers "are paid to coordinate the health care of their patients by providing preventative services and making appropriate referrals for specialty care and diagnostic testing." It also indicated many primary care physicians "are prepaid, based on the population they serve, for providing primary care services." It did not indicate the "primary care services" for which some physicians are "prepaid" included more than just "providing preventative services and making appropriate referrals." Prepayment also covered the primary care physician's treatment of acute illnesses and injuries and ongoing treatment of chronic conditions.

The Plan's disclosure regarding additional information available through the Oregon Insurance Division included a Website address that incorrectly included the word "internal" instead of "external." The Plan advised they would correct this when the member handbook was reprinted.

The Plan's disclosure regarding assistance available to members in filing a written grievance indicated members should request assistance if they were "unable to complete a written complaint." Assistance must be provided to any enrollee who states a

complaint and requests assistance in putting the complaint in writing whether or not the Plan considers the person to be “unable to complete a written complaint.” The Plan advised they provided assistance to enrollees who requested it and could change the language in the member handbook.

Policyholder Service Standard #2 – The Company provides the required information upon a request from an enrollee, a prospective enrollee or a provider. Reference: ORS 743.804(2)(6) and (7), ORS 743.807(2)(a) and OAR836-053-1020(5).

Findings: Failed.

This standard was tested by determining if the Plan has procedures to process requests when they occur.

Although the Plan did not have specific procedures, the Plan’s member handbook indicates the additional information to be provided to enrollees on request is available.

In regard to information on their drug formulary, including whether a particular drug is included or excluded, the Plan did not have written procedures regarding provision of the “detailed information” referenced in the “Prescription Drug Benefit Summary” provided to members. The Plan indicated that customer service had access to information on which drugs were excluded or required prior authorization and would provide such information on a particular drug if requested.

However, in regard to the following, the Plan did not document the information they would provide if requested nor did they have procedures in place detailing how requests for such information would be handled:

- A description of the Plan’s risk sharing arrangements with physicians and other providers consistent with risk sharing information required by HCFA.

- Information about the Plan's procedures for credentialing network providers.
- Information the Plan may consider in its utilization review of a particular condition or disease.

**I recommend the Plan, upon request from an enrollee or prospective enrollee, provide the information regarding risk sharing, credentialing of network providers, and utilization review of a particular condition required by ORS 743.804(6)(d) and (f) and (7).**

Policyholder Service Standard #3 – At policy issuance and termination, the proper notices are sent. Reference: ORS 743.560, OAR 836-052-0810, OAR 836-052-0820, OAR 836-052-0830, OAR 836-052-0840, OAR 836-052-0850 and OAR 836-052-0860.

Findings: Passed with comment.

This standard was evaluated by reviewing the Plan's written procedures, which indicated the proper notices were sent at termination. In regard to the notice to the prior carrier required at policy issuance, the written procedures for large groups specifically included an instruction to Sales to send this notice. Their written procedures for small groups indicated Sales was to review the application to determine if information on the prior carrier was included, but did not include an instruction to send any notice to the prior carrier. However, the Plan advised in writing that the notice was sent on small group as well as large group business.

### **Portability**

Policyholder Service Standard #11 – The Company correctly identifies the term “eligible individual” for the purpose of administering portability plans. Reference: ORS 743.760(1)(b)(A)(i).

Findings: Passed with comment.

The Plan's procedure manual indicated they allowed 60 days, rather than the required 63 days, for a person to apply for a portability plan. However, their portability notices advised the member had 63 days to apply, and the Plan advised they had been allowing 63 days.

Policyholder Service Standard #12 – The Company applies all provisions regarding portability including disclosure and application. Reference: ORS 743.760(4)-(6) and (8)-(11), OAR 836-053-0730(2) and OAR 836-053-0750(3) and (4).

Findings: Failed - 30% compliance.

The examiner reviewed 100 randomly selected files of terminated enrollees to determine if the Plan had properly administered portability. The standard did not apply to 34 of the files reviewed. In 22 cases, the group number, database or benefit plan changed, but coverage did not terminate. In seven cases, five involving plans covering Federal employees and two involving plans issued to Washington policyholders, the contract was not subject to Oregon law. In one case, the terminated coverage was a portability plan, not group coverage. In one case, the group advised they had replaced coverage. In one case, the member had died. In one case, termination was requested because the person was eligible for Medicare. In one case, the terminated person was a newborn who had never been added to coverage.

The remaining 66 files were reviewed to determine if the required portability information had been sent within 10 days of action to terminate. Of those files, 46 (70%) failed. The reasons for failure are summarized below.

<b>Reason</b>	<b># Of Files</b>
The Plan did not send portability information to members of certain groups because the groups processed their own creditable coverage information. The groups referred members to the Plan for portability information, but such information was not sent unless requested by the member.	14
The Plan did not send portability information because the address in the system was outside of Oregon. (No documentation of whether or not member was an Oregon resident.)	4
The Plan did not send portability information because coverage terminated more than 63 days prior to termination date being entered in system.	3
The Plan did not send portability information because termination due to Plan's withdrawal from county in which majority of group located. (No documentation of whether or not group obtained replacement coverage.)	2
The Plan did not send portability information because they were advised group replaced coverage, but they did not have documentation.	2
The Plan was unable to document if portability information was sent.	11
The Plan sent portability information, but not within 10 days.	4
The Plan sent portability information, but was unable to document the date sent.	6

Portability information is to be sent to all individuals who lose group coverage for any reason other than group replacement of coverage. Even if the Plan thinks a particular person is not eligible for portability coverage, the required information should be sent. If the person applies for portability coverage, determination of whether or not the individual is eligible for such coverage can be made at that time based on current information.

**I recommend the Plan provide information on portability coverage to all individuals losing group coverage, for any reason other than group replacement of coverage, within 10 days following the date of any administrative action taken to initiate or document the loss of coverage in accordance with OAR 836-053-0750 (3) and (4).**

## **QUALITY ASSESSMENT AND IMPROVEMENT**

A formal written program has been in effect since November 1993, under the direction of the Plan's chief medical officer and a corporate administrative quality council. The Plan's Board of Directors retains ultimate accountability, but has established a quality and performance improvement committee to assist with its oversight of this program and function. The program is evaluated and updated on an annual basis. The current program description and work plan was approved by the Plan's Board of Directors September 28, 1999. The written objectives of the Plan's current quality management program include the following:

- To improve the quality of care and services provided to members.
- To promote effective health management for members with acute and chronic illnesses.
- To promote member wellness through the provision of preventive health services.
- To meet or exceed the standards of federal and state regulatory bodies and accrediting organizations.

The administrative quality council is designated by the Board of Directors as the policy making body with regard to quality issues and initiatives. It has two principle committee arms, both with several subcommittees, and four additional working committees report directly to the council:

1. The quality improvement team focuses on the clinical aspects of the annual work plan;
2. The service improvement team focuses on the service aspects of the annual work plan;
3. A credentialing committee, to verify provider qualifications;
4. An ethics and accountability committee;
5. A quality of work life team; and
6. A grievance committee for panel review of second level appeals.

The Plan has established a written goal and objectives for its quality management program which are detailed in annual reports of activities to the director of the Department of Consumer and Business Services.

**Findings**

The Plan was tested for compliance with standards based on Oregon Revised Statutes or Oregon Administrative Rules.

Standard #2 was not assessed during this phase of the examination since an identical requirement is included in Policyholder Services Standard #2.

Standard #4 was judged to be inapplicable to this examination, because the Plan does not delegate quality assessment or quality improvement functions.

The Plan passed the following standards without comment:

<b><u>Standard</u></b>	<b><u>Regulatory Authority</u></b>
<u>Quality Assessment and Improvement Standard #1</u> – The Company maintains a written quality assessment program to evaluate, maintain, and improve the quality of health services provided to enrollees.	ORS 743.814(1).
<u>Quality Assessment and Improvement Standard #3</u> – The Company annually files the required quality assessment reports.	ORS 743.814(2)&(3) OAR 836-053-1000(3)(c)(d)&(e) OAR 836-053-1170(1)(2)& (3)

No exceptions were noted.

**UNDERWRITING PRACTICES**

The Plan provided its small employer underwriting guidelines and sales procedures for large and small groups. Legal definitions are applied to distinguish between two types of small groups:

- Oregon Small Employer Health Insurance (SEHI) groups of 2 to 25 eligible employees, and
- Federal Health Insurance Portability and Accountability Act (HIPAA) groups of 2 to 50 employees.

Groups that do not meet either of the small group definitions are classified as large groups. The underwriting guidelines applied to SEHI groups differ from those used with HIPAA and large groups. The Plan's underwriting staff cooperates with sales staff and agents to confirm appropriate group size classifications based on information received from the group.

Requests for new and renewal rate quotes are prepared by the sales department and include known demographic information about the group. This data is used to price the group's requested benefit plans. Completed rate quotes are returned to the source of the request for presentation to the prospective group. If they are accepted, the sales department assists the group, or its agent, in the enrollment process.

The Plan does not market "non-group" (individual and family) medical plans, although it offers portability plans for terminating group members and Medicaid plans. Compliance to portability laws was reviewed in the section titled, "Policyholder Services."

### **Findings**

Sample underwriting files were selected for review from the following classifications according to the populations provided by the Plan:

- Newly issued SEHI small groups (2 - 25 eligible employees) 50 of 1831
- Newly issued HIPAA small groups (26 - 50 eligible employees) 29 of 57

The Plan provided files related to each group selected in the sample. Underwriting and sales rating files were made available.

Plan records for each sample unit were reviewed, testing for compliance with standards based on Oregon Revised Statutes and Oregon Administrative Rules. Standards 1

through 3, 5 through 7, 9 through 27, and 29 were waived for purposes of this examination. Results for the remaining standards are presented below.

The Plan passed the following standards without comment:

<b><u>Standard</u></b>	<b><u>Regulatory Authority</u></b>
<u>Underwriting and Rating - Small Groups 26-50, Standard #4</u> - The Company correctly identifies all small employer groups 26-50 and verifies the number of employees in accordance with Oregon law.	ORS 743.733 ORS 743.746
<u>Underwriting and Rating - Small Employer Groups 2-25, Standard #8</u> - The Company correctly identifies all Oregon small employer groups and verifies the number of employees annually.	ORS 743.730(30) ORS 743.733

The following exceptions were noted:

Underwriting and Rating - Forms, Standard #28 - Each policy form that has not been filed with the Oregon Insurance Division because it qualifies as a negotiated form is only issued to one group, has a company-assigned form number, and contains the mandated benefits. Reference: ORS 742.003(1)(c), OAR 836-010-0011(1)(j), and Bulletin 98-3.

As requested in the resource list that accompanied the call letter for this examination, the Plan provided a listing of all unique or manuscript forms in use but not filed with the Insurance Division. This list included the names of 37 employer groups that were issued "custom language/custom contracts." The examiner used the interval method to select ten group negotiated policies to review for the presence of Oregon mandated provisions.

When the Plan presented the requested review sample documents, it became apparent that the original list of 37 groups did not accurately reflect the number of negotiated policy forms issued during the examination period. Two of the ten groups selected for

review were issued more than one custom contract in order to allow for a selection of benefits and to accommodate sub-groups, such as active and retired employees. One group was initially issued the Plan's standard contract and was added to the list of negotiated groups because it renewed (after the exam period) with custom provisions. A second group also received the Company's standard contract, but the custom contract issued to its local affiliate group was substituted for review. And one group was removed from the review sample because the underwriting department (incorrectly) classified it as a small group (ineligible to receive the requested custom benefit provisions). The final review sample used to measure compliance with this standard included fourteen negotiated group policies issued to eight large employer groups.

Findings: Failed. The examiner identified three issues of concern, as detailed below:

1. Unique form numbers. Eleven custom contracts (78.6% of 14), representing seven (87.5% of 8) employer groups did not show uniquely assigned form numbers on each page of policies issued to those groups. However, the Plan's approved, standard form number was replaced with the group name in the footer of those contract pages that included negotiated benefit provisions. Because this procedure identified the unique nature of both the policy and its negotiated provisions, the examiner determined that the requirement for a special (identifying) form number was satisfied. In addition, the Plan's director of regulatory affairs provided a written statement that the Plan began to include unique form numbers on all pages of negotiated contracts as they renewed for the 2000 contract year. This statement is supported by the one group (and its three custom contracts) with unique policy form numbers noted above, a policy that was issued effective January 1, 2000. Since the Plan has shown evidence that action has been taken to conform with the form number requirement, a recommendation is not warranted.

2. Creditable coverage. Seven custom contracts (50% of 14) issued to two employer groups (25% of 8) did not specifically allow creditable coverage from any prior plan toward the transplant qualification period. A response to this concern was received from the Plan's transplant coordinator stating that creditable coverage has "always" been administered according to the legal mandate, although transplant management unit personnel are aware that the wording of some existing contracts requires a twelve-month waiting period and does not specify that credit is granted for prior coverage under any health plan.

**I recommend the Plan any revise the transplant waiting or exclusion period provisions in any and all affected custom contracts (negotiated group policy forms) to apply creditable coverage from any prior health plan, in compliance with ORS 743.754(3) and ORS 836-053-0250.**

3. Right to select a women's health care provider as primary care physician. Two custom contracts (14.3% of 14), issued to one employer group (12.5% of 8), did not specifically say that women were allowed to select a women's health care provider as their PCP. However, the contracts did instruct members to select a PCP "from a list provided" and stated that no referral or preauthorization was required for annual examinations and maternity services from a women's health care provider who is also a network provider. Information provided in applicable member handbooks was reviewed and found to be consistent with the contract language. The examiner concluded that appropriate direct disclosures were given to satisfy this requirement and that a recommendation is not warranted.

Additional Note: All fourteen contracts reviewed contained conformity clauses, indicating that applicable laws will be met. Such statements would presume to correct

any legal deficiencies. Please see the table below which outlines two variations of contract language the Plan used in the contracts selected for review:

<b>Statement Type</b>	<b>Actual Wording of Conformity Clause</b>	<b>Times Used</b>
“Choice of Law”	“The laws of the State of Oregon govern the interpretation of this <i>Employer Contract</i> (or) <i>Master Group Contract</i> .”	11
“Conformity with Federal and State Statues (sic)”	“Any provisions of the Master Group Contract which are in conflict with Federal laws and/or laws of Oregon are amended to conform to the minimum requirements of those laws.”	3

## **CLAIMS**

### **Introduction**

Paper claims are first received in the Plan’s mailroom and then forwarded to the claims department. In the claims department, they are sorted and scanned in an imaging system. Imaged documents are retained until the Plan confirms they are in the imaging system and are later destroyed. The imaging system has a limited amount of space available for immediate access to records. When this space is full, the older records are archived. Upon request, the older records can be retrieved and restored to the system for access.

The Plan also receives electronic claims for which imaged data files are created. Once the claims are in the imaging system, they are converted to the Plan’s computerized claims processing system format.

The claims are processed in date received order. Claims may be paid, pended, or denied.

A computer check processing cycle is run three times a week. If the claim is paid, an EOP (Explanation of Payment) is generated and mailed with the payment to the provider payee. If certain conditions exist, an EOB (Explanation of Benefits) is also generated and mailed to the member.

The Plan does not send an EOB on every fee-for-service claim processed. If there is secondary coverage, the Plan advises it issues an EOB if requested. The Plan advises it also sends an EOB in the following situations:

- If a claim or portion of a claim is denied as member responsibility, an EOB is generated.
- If charges are applied to a deductible, an EOB is generated.
- If the member's benefit package has a 20% copay, an EOB is generated to specify an exact dollar amount.

Responses to the Plan's requests for information on pended claims are handled on a date received basis.

When claims are denied, a notation is included on the EOP to let the provider know why benefits are not payable. The member will received either an EOB or a letter explaining the reason for denial.

### **Findings**

Claims Standards 13 and 14 were waived because paid claims testing was targeted. The entire claims population was tested use ACL (audit command language) software to determine compliance with Claims Standards 1, 2 and 3. The Plan was provided with the results and ask to accept them or provide contrary information.

A random sample of 100 claims was selected for review from the total population of 103,321 denied claims identified by the Plan. Of the 103,321 denied claims, 67,944 were processed on the Plan's Amisys claims system and 35,377 were processed on the Plan's DisCorp claims system. Based on the percentage of the total denied claims on each system, 66 of the 100 files reviewed were selected from the Amisys population and 34 were selected from the DisCorp population. This sample was used to evaluate compliance for Claims Standards 4, 5, 6, 7, 8, 9, 10, 11 and 12.

A summary of denial reasons is shown below:

<b>Reason</b>	<b># of Files</b>
Member not covered at time of service.	34
PCP referral information not in system.	22
Services provided by nonplan providers.	5
Service was incidental.	5
No vision benefit.	5
Vision benefit does not cover type of expense.	3
Chiropractic services not covered.	3
Item not covered.	3
Vision benefit already used.	2
Duplicate bill.	2
Prior authorization not obtained.	2
Provider not member's PCP.	2
Condition not covered.	2
No diagnosis on claim.	2
Patient's sex not appropriate for diagnosis.	1
Patient's age not appropriate for diagnosis.	1
Preexisting waiting period not satisfied.	1
Clinical documentation not included.	1
Medicare EOB not included.	1
Should be covered by PIP.	1
Claim submitted after time limit.	1
Vision not paid through office to which claim submitted.	1

Each item was tested for compliance with those of the following standards that applied based on Oregon Revised Statutes and Oregon Administrative Rules.

The Plan passed the following claims standards without comment:

<b>#</b>	<b>Standard</b>	<b>Regulatory Authority</b>
4	A response to any claim correspondence was made within 30 days.	ORS 746.230(1)(b) OAR 836-080-0225(3)
7	The Company promptly and in good faith equitably settles claims in which liability has become reasonably clear.	ORS 746.230(1)(f)(h)&(L)
9	The Company 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).

The following exceptions to the claims standards were noted.

Claims Standard #1 – The initial contact by the Company is within 30 days. Reference: ORS 746.230(1)(b) and OAR 836-080-0225(1) and (4).

Findings: Failed – 86% compliance on claims processed by the Company; 37% compliance on claims processed for the Plan by a third party administrator.

This standard was tested electronically with an ACL program. Of the 1,688,135 claims on the population lists of claims paid or denied by the Plan during the examination period, 267,919 were not resolved within 30 days. Of those claims, 175,763 were not acknowledged prior to being paid or denied and 66,753 were acknowledged more than 30 days after receipt. A total of 242,516 claims (14%) were neither resolved nor acknowledged within 30 days.

In addition, 32,454 claims for chiropractic services were processed by a third party administrator. Of those claims, 20,428 (63%) were not resolved within 30 days. During the examination period, the third party administrator did not have a procedure for sending acknowledgement letters prior to paying or denying. They advised they plan to establish such a procedure.

**I recommend the Plan resolve or acknowledge claims within 30 days of receipt in accordance with ORS 746.230(1)(b) and OAR 836-080-0225(1) and (4).**

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

Findings: Failed – 92% compliance on claims processed by the Company; 79% compliance on claims processed for the Plan by a third party administrator.

This standard was tested electronically with an ACL program. Of the 1,688,135 claims on the population lists of claims paid or denied by the Plan during the examination period, 137,817 (8%) were not resolved within 45 days. In addition, of the 32,454 claims for chiropractic services processed by a third party administrator, 6,886 (21%) were not resolved within 45 days.

**I recommend the Plan conduct investigations within 45 days of receipt of the claim in accordance with ORS 746.230(1)(c) and OAR 836-080-0230.**

Claims Standard #3 – Claims are resolved in 30 days unless a delay letter (45 days) has been sent. Reference: ORS 746.230(1)(e) and OAR 836-080-0235(1) and (4).

Findings: Failed – 85% compliance on claims processed by the Plan; 37% compliance on claims processed for the Plan by a third party administrator.

This standard was tested electronically with an ACL program. Of the 1,688,135 claims on the population lists of claims paid or denied by the Plan during the examination period, 267,919 were not resolved within 30 days. Of those claims, 175,763 were not acknowledged prior to being paid or denied, 66,753 were acknowledged more than 30 days after receipt, and 6,561 were not paid within 45 days of the acknowledgement letter. A total of 249,077 claims (15%) were neither resolved nor acknowledged within 30 days or were not resolved within 45 days of sending the acknowledgement letter.

In addition, 32,454 claims for chiropractic services were processed by a third party administrator. Of those claims, 20,428 (63%) were not resolved within 30 days. The third party administrator did not have a procedure for sending acknowledgement letters prior to paying or denying a claim during the examination period, but advised they plan to establish such a procedure.

**I recommend the Plan resolve claims in 30 days or send a delay letter within 30 days and every 45 days thereafter until the claim is resolved in accordance with ORS 746.230(1)(e) and OAR 836-080-0235(1) and (4).**

Claims Standard #5 – Claim files are adequately documented. Reference: ORS 733.170 and OAR 836-080-0215.

Findings: Failed – 65% compliance.

This standard applied to all 100 of the denied claim files reviewed. Thirty-five (35%) of the files reviewed failed this standard. Following is a summary of the reasons for failure.

<b><u>Reason</u></b>	<b><u># Of Files</u></b>
No documentation of notice sent to member.	25
No documentation of what prompted claim to be reviewed and reprocessed for payment.	7
No documentation of when revised information received.	3

**I recommend the Plan adequately document claim files in accordance with ORS 733.170 and OAR 836-080-0215.**

Claims Standard #6 – Claims are not denied without first conducting a reasonable investigation. Reference: ORS 746.230(1)(c) and (d).

Findings: Failed – 89% compliance.

This standard applied to all 100 of the denied claim files reviewed. Eleven (11%) of the files reviewed failed this standard. Following is a summary of the reasons for failure.

<b>Reason</b>	<b># Of Files</b>
Claim denied because it was processed under another family member's ID number. Correct patient name shown on claim, but no investigation conducted to resolve discrepancy between name and number.	3
Claim denied because PCP referral not shown in system. Indication of PCP referral shown on claim, but no investigation conducted to verify.	3
Claim denied because services not provided by listed PCP. Information in phone log indicated provider was person's new PCP in one case and was on-call for PCP in the other case. Phone log information not checked before denial.	2
Claim denied as cosmetic based solely on diagnosis. No investigation conducted to determine if office call and lab work for cosmetic purposes.	1
Claim denied as preexisting based solely on diagnosis. No investigation to determine when or if services had been provided prior to effective date.	1
Claim denied because Medicare EOB not submitted.	1

**I recommend the Plan not deny claims without conducting a reasonable investigation to determine if the charges being denied are, in fact, ineligible for benefits in accordance with ORS 746.230(1)(c) and (d).**

Claims Standard #8 – The Company did not misrepresent the facts or policy provisions while settling a claim. Reference: ORS 746.230(1)(a) and OAR 836-080-0220.

Findings: Failed – 95% compliance.

This standard applied to all 100 of the denied claim files reviewed. Five (5%) of the files reviewed failed this standard. A failure rate of 5% does not generally warrant a recommendation. However, the Plan indicated the first of the following reasons for failure was their standard practice.

<b>Reason</b>	<b># Of Files</b>
Denial notice stated “services with this diagnosis are not covered.” However, the claims did not include a diagnosis. Plan advised it was their standard procedure to deny claims without a diagnosis with this statement.	2
Denial notice stated “services with this diagnosis are not covered.” However, the contract specifically covered non-surgical services for the condition. (Claim was for non-surgical services, so claim was denied in error.)	1
Denial notice stated “service not eligible for payment.” However, the service was a covered benefit. The actual basis for denial was failure to submit the claim within the required time frame.	1
Denial notice stated “Vision is not paid through THE PLAN. Please bill Eugene office.” However, THE PLAN did pay this group’s vision benefit. They just didn’t process the vision claims at their Portland office.	1

**I recommend the Plan not misrepresent facts or policy provisions while settling a claim in accordance with ORS 746.230(1)(a) and OAR 836-080-0220.**

Claims Standard #10 – The Company pays (or denies) claims in accordance with policy provisions and in compliance with the applicable laws, rules and regulations. Reference: ORS 743.693 through ORS 743.729 and ORS 746.240.

Findings: Failed – 79% compliance.

This standard applied to all 100 of the denied claim files reviewed. Twenty-one (21%) of the files reviewed failed this standard. Sixteen claims were denied in error and five claims were denied for an incorrect reason.

**I recommend the Plan deny claims in accordance with policy provisions in accordance with ORS 746.240.**

Claims Standard #11 – The Company 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 the claim. Reference: ORS 746.230(1)(m) and OAR 836-080-0235(1).

Findings: Failed – 49% compliance.

This standard applied to all 100 of the denied claim files reviewed. Fifty-one (51%) of the files reviewed failed this standard. Following is a summary of the reasons for failure. Some files failed for more than one reason.

<b>Reason</b>	<b># Of Files</b>
Plan unable to verify member sent a written explanation of denial.	25
Explanation of denial did not reference applicable contract provisions.	29
Explanation did not clearly indicate reason for denial.	7
Explanation incorrectly indicated contract did not cover service or condition.	5
Explanation provided wrong reason for denial.	4
Explanation did not identify type of expense being denied.	2

In addition, the third party administrator that processed the Plan's claims for chiropractic services did not have a procedure for sending written denial notices to members. According to information provided by the third party administrator, they denied 495 claims on behalf of the Plan during the examination period. Of those claims, 73.4% were denied for reasons that could result in member liability. The third party administrator did advise they were in the process of establishing a procedure for sending denial notices to members.

The 25 files that failed because the Plan was unable to verify whether or not the Member was sent a written denial were all processed on a claims system no longer being used by the Plan. Their current claim system does provide this information.

**I recommend claim denials include a proper explanation of the basis relied on in the insurance policy and be made in writing in accordance with ORS 746.230(1)(m) and OAR 836-080-0235(1).**

Claims Standard #12 – Denied and closed-without-payment claims are handled in accordance with policy provisions and state law. Reference: OAR 836-053-0040(4)(b) and OAR 836-053-0230(8)(b).

Findings: Passed with comment – 97% compliance.

This standard applied to all 100 of the denied claim files reviewed. One (3%) of the files reviewed failed this standard. The file failed because the claim was denied based on a preexisting condition limitation, but a reference to possible creditable coverage was not included in the denial notice. During the examination period, only one of the Plan's plans included a preexisting condition limitation; and that plan had been amended to delete the preexisting condition provision. At the time the examination was conducted, none of the Plan's plans included preexisting condition provisions. A recommendation regarding this issue is, therefore, not necessary.

Claims Standard #15 – All claims that are subject to the application of coordination of benefits provisions are processed in accordance with all applicable rules and regulations. Reference: OAR 836-020-0735(3) and OAR 836-020-0740(3).

Findings: Failed.

This standard was evaluated by reviewing the coordination of benefits procedures in the Plan's claims manual.

During the portion of the examination period prior to January 1, 2000, if the Plan determined they were the secondary carrier for a member and received a claim without indication of the primary carrier's benefits, they estimated those benefits. However, they estimated the primary carrier's benefits as payment in full. The Plan, therefore,

paid nothing on the claim unless they received an explanation of benefits or other documentation that the primary carrier did not pay charges in full.

Effective January 1, 2000, they revised their procedures. Under the revised procedures, if the Plan determined they were the secondary carrier for a member and received a claim without indication of the primary carrier's benefits, they requested information regarding the primary carrier's benefits. If they did not receive the information within 44 days of the date the claim was initially received, they paid the claim as primary carrier.

As of August 1, 2000, the investigation and payment of claims involving coordination of benefits (COB) are handled by a special unit. If they are unable to determine the primary carrier's exact benefit on a particular claim within 44 days, they estimate the benefit based on benefits paid on other claims or information obtained from the primary carrier regarding benefits.

The Plan failed this standard because, during a portion of the examination period, they routinely processed claims involving COB based on an estimate of payment in full by the other carrier. However, since the Plan has revised their procedures to no longer estimate the other carrier's benefits on this basis, a recommendation is not necessary.

Claims Standard #16 – The 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) and (3), ORS 743.801(1)(2) and (3) and OAR 836-053-1030(4).

Findings: Failed – 94% compliance.

For this standard, a random sample of 50 claims was selected for review from the total population of 3,154 denied emergency facility claims identified by the Plan. Of the 3,154 denied emergency facility claims, 2,160 were processed on the Plan's Amisys claims system and 994 were processed on the Plan's DisCorp claims system. Based on the percentage of the total denied claims on each system, 34 of the 50 files reviewed were selected from the Amisys population and 16 were selected from the DisCorp population.

The 50 emergency facility claims reviewed were denied for the following reasons:

<b><u>Reason</u></b>	<b><u># Of Claims</u></b>
Coverage not indicated to be in effect on date of service.	23
No response to inquiry regarding accident.	4
Third party liability, including PIP.	4
Extra charge for night services not covered.	4
Urgent/emergent criteria not met	4
Medicare EOB not submitted.	3
Duplicate bill or refund of duplicate payment.	3
Work-related conditions not covered.	2
Services rendered by a non-participating provider.	2
Diagnosis not a covered condition.	1

Only six of the above claims were denied for reasons related to required coverage for emergency services, the four denied as not meeting urgent/emergent criteria and the two denied as being for services of a nonparticipating provider. Three of these claims failed the standard. This represents 6% of the denied emergency facility claims reviewed and 50% of the claims reviewed that were denied for reasons related to required coverage for emergency services.

One of the claims denied as not meeting urgent/emergent criteria and one of the claims denied as being for services of a nonparticipating provider failed because they were denied in error. Both of these claims had been reprocessed for payment because the

Plan subsequently determined they were eligible. The other claim failed because it was denied for an invalid reason. The claim was for a dental condition, and the policy excluded services related to dental conditions unless provided within 48 hours of an accident. Instead of denying the claim as not qualifying under the exception to the dental exclusion, the Plan denied it as not meeting urgent/emergent criteria because services were not provided within 48 hours of an accident. However, services being provided within 48 hours of an accident is not a valid urgent/emergent criteria.

In addition, the Plan failed this standard because of the following provisions in their written procedures regarding emergency services:

- The Plan indicated “emergent care” to be for “sudden onset of an unforeseen illness or injury in which delay in receiving medical treatment would threaten life or cause permanent disability.” They indicated “urgent care” to be for a “non-life threatening condition which requires immediate attention.” Their procedures provided, in part “urgent care ... should be obtained at a participating provider or facility ... since these situations are not emergent.” The procedures also provided “urgent level of care services will not be covered when a primary care physician can provide the necessary care” and “urgent care is covered only when provided at participating Plan facilities.”

Since they included only those conditions that “threaten life or cause permanent disability” in their “emergent care” definition, limiting benefits for “urgent care” to participating facilities is not in compliance with ORS 743.699.

The Plan’s written procedures did include the definition of “emergency medical condition” required by ORS 743.801. However, when asked why their definition of conditions qualifying for “emergent care” was more restrictive than their definition

of “emergency medical condition,” they advised they considered an “emergency” to be a “life-threatening, sudden onset of unforeseen illness or injury.” These limitations are not in compliance with the required definition of and benefits for an emergency.

- For services on or prior to June 30, 2000, the written procedures included an instruction to deny claims from participating hospitals if an emergency room report was not included. The Plan advised all claims were pended for review. However, they did not provide any explanation for the contradictory instruction in their written procedures for services prior to June 30, 2000.
- The written procedures also included an instruction to deny claims from certain hospitals that did not include an emergency room report. The Plan advised they did request reports from these hospitals. However, again, they did not provide any explanation for the instruction to deny in their written procedures.
- The written procedures indicated emergency services at one hospital were covered only if the condition was life-threatening. The Company advised they paid such claims if they met “emergency criteria.” However, as indicated above such criteria cannot limit coverage to “life-threatening” conditions.

**I recommend the Plan adjust all claims for emergency services and auxiliary emergency services in accordance with ORS 743.699(1)(2) and (3), ORS 743.801(1),(2), and (3); and OAR 836-053-1030(4).**

Claims Standard #17 – The Company processes all requests for prior authorizations in compliance with applicable laws, rules and regulations. Reference: ORS 743.807(2)(d), ORS 743.837(1) and (2) and OAR 836-053-1200(6)-(9).

Findings: Failed.

This standard was evaluated by reviewing the Plan's written prior authorization procedures. The Plan failed for the following reasons:

- The written procedures in effect during the examination period did not provide for requests for prior authorization of nonemergency services to be answered within two business days. They allowed two business days from the time necessary information was received to make a decision on prior authorization requests for nonemergency services and one business day from the date of the decision to notify the provider by telephone. Even if all necessary information was included with the request, this allowed a total of three days to answer the request – two days to make the decision and one additional day to notify the provider. The Plan advised they generally notify the provider the same day a decision is made, but the written procedures in effect during the examination period did not confirm this. In addition, they advised if a decision was made late in the second day following receipt of the request, the provider might not be notified of the decision until the next day.

During the course of the examination, the Plan revised their procedures to provide for making a decision within two business days of receipt of the prior authorization request and notifying the provider by telephone or fax the same day the decision is made. A recommendation is, therefore, not necessary on this issue.

- In situations in which all necessary information was not provided with the request for prior authorization, the procedures in effect during the examination period allowed 10 days to resolve the prior authorization. The Plan advised it was their standard practice to contact the provider within one business day of receiving the prior authorization request to advise they need additional information. However, their written procedures did not confirm this.

During the course of the examination, the Plan revised their procedures to indicate additional information needed is to be obtained within two business days. A recommendation is, therefore, not necessary on this issue.

- During the examination period, the procedures did not provide for the response to a prior authorization request to be one of the four required answers.

During the course of the examination, the Plan revised their procedures to provide for the required responses. A recommendation is, therefore, not necessary on this issue.

- The Plan did not provide authorizations that were binding for 30 days on benefits and five days on eligibility. Their claims system automatically processed claims in accordance with the benefit and eligibility information in the system at the time the claim was processed whether or not prior authorization had been obtained. If that information indicated the member's coverage terminated prior to the date of service, the claim was denied even if prior authorization had been provided within five days of the date of service. The Plan advised they could handle such claims by exception, but only if the member or provider contacted them. They had not established a way of preventing claims for previously authorized services from being denied based on benefit and eligibility information in the system at the time the claim was processed.

**I recommend the Plan provide binding authorizations in accordance with ORS 743.837(1) and (2) and OAR 836-053-1200(6)-(8).**

Claims Standard #18 – The group health plan adjudicates all mental health and behavioral health claims in accordance with all applicable laws, rules and regulations. Reference: ORS 743.556, OAR 836-052-0220 through OAR 836-052-0245 and Bulletin 90-6.

Findings: Failed.

This standard was evaluated by reviewing the mental health and chemical dependency procedures in the Plan's claims manual. The Plan failed this standard for the following reasons:

- The Plan requires prior authorization of mental health and chemical dependency services, but did not provide the criteria used to determine the level of care authorized. Responsibility for handling such authorizations had recently been transferred to PBH, a third party administrator. The Plan advised they no longer had access to the criteria used prior to the transfer and did not yet have the criteria used by PBH.
- When the Plan provided coverage to a member under two separate contracts, the Plan provided only one set of mental health and chemical dependency benefit maximums. Their procedures indicated such members were not entitled to a benefit maximum under each plan. The secondary plan paid copayments on charges for which payment was made by the primary coverage. However, if the primary plan had paid maximum benefits, the secondary plan did not provide benefits on additional charges even if payments made by the secondary plan were less than their maximum benefits.

A group health insurance policy cannot limit payments to less than specified amounts. If the copayments paid by the secondary plan total less than those amounts, the secondary plan has paid less than the required benefits. If the primary plan has paid their maximum benefits, the secondary plan should provide benefits on additional charges until the total payments made by the secondary plan equal the required benefits. Even if two group plans happen to be through the same carrier,

each plan must provide the required benefits for mental health and chemical dependency.

**I recommend the Plan adjudicate all mental health and behavioral health claims in accordance with ORS 743.556, OAR 836-052-0220 through OAR 836-052-0245 and Bulletin 90-6.**

### **UTILIZATION REVIEW**

The Plan's utilization management program is part of its quality management program with the goal to promote optimal management of health care services through planning, stewardship of resources, and continual improvement of healthcare delivery. Oversight and direction for the program and its staff comes from the Plan's analysis and program committee, a subcommittee of the quality improvement team, which reports to the administrative quality council, a committee of the Board of Directors. The chief medical officer is a member of the analysis and program committee and chairs the quality improvement team. Program personnel include licensed doctors of medicine, and clinical staff members, such as registered pharmacists and nurses. The analysis and program committee and its utilization management delegation subcommittee perform the following functions:

- Oversight of clinical utilization programs.
- Approval of standards, criteria, and policies that govern utilization management practices.
- Approval of policy and criteria that govern medical management decisions, including medical practice, drug formulary, and new technology choices.
- Evaluation of utilization data, especially as it relates to concerns for under- and over- utilization of care or services.

- Oversight of all delegated utilization management activities, such as delegation policies, audit results and reports, corrective action plans for improvement, and approval or revocation of delegation authority.

The utilization management program description, policies and procedures provide the structure through which the Plan determines whether services are medically necessary, setting- and urgency-appropriate, effective and efficient. These utilization management tools are applied to various healthcare service areas to prevent unnecessary medical costs and provide for timely, coordinated medical services. Examples follow:

1. Prior authorization and preadmission review
2. Urgent and emergent admission review
3. Second opinions and physician advisors
4. Referral management
5. Concurrent review and discharge planning
6. Retrospective review
7. Care and case management
8. Maternity management
9. Organ transplants
10. Pharmacy and drug utilization management
11. Home health care and durable medical equipment
12. Mental health and chemical dependency services

Medical review, care and quality management staff members communicate with attending physicians, service providers, and facilities to coordinate the utilization review process.

Requests for referral and preauthorization of nonurgent services are decided within 48 hours of receiving all necessary information. Urgent care requests are handled within one calendar day. And concurrent review of inpatient (continued) stays are completed within one working day of the request. (See standard #5 for additional information.)

Members who are dissatisfied with the Company's decision to deny a course of treatment of service on the basis that it is experimental or investigational may submit a

written request to appeal. Such appeals are presented to an appropriate medical consultant or peer review committee. Member handbooks provide definitions of “emergency medical condition,” “experimental or investigational services,” and “medically necessary.” The handbooks also outline services that require preauthorization and how to obtain referrals for specialized care or treatment, and they include information about members’ rights to file grievances or appeal decisions.

**Findings**

The Company was tested for compliance with standards shown below. The standards are based on Oregon Revised Statutes or Oregon Administrative Rules.

Standards #2 and #3 were not assessed during this phase of the examination since similar requirements are included in Policyholder Services Standards #1 and #2, respectively.

The Company passed the standards listed below without comment:

<b><u>Standard</u></b>	<b><u>Regulatory Authority</u></b>
<u>Utilization Review Standard #1</u> – The health carrier files with the commissioner an annual summary report of its utilization review activities.	ORS 743.807(1) OAR 836-053-1000(3)(b) OAR 836-053-1130(1)
<u>Utilization Review Standard #4</u> – The health carrier makes 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.	ORS 743.807(2)(b)
<u>Utilization Review Standard #6</u> – The health carrier provides an appropriate appeal system when an adverse utilization review determination is made.	ORS 743.807(2)(c) OAR 836-053-1140
<u>Utilization Review Standard #7</u> – The health carrier monitors the activities of the utilization review organization or entity with which the carrier contracts and ensures that the contracting organization complies with applicable laws, rules, and regulations.	ORS 731.302(1) ORS 746.240

The following exception was noted:

Utilization Review Standard #5 – The health carrier makes available qualified health care personnel for same-day telephone responses to inquiries concerning certification of continued length of stay. Reference: ORS 743.807(2)(d).

Findings: Passed with comment.

The Plan's timeliness standards require concurrent review decisions within one "working day" of obtaining all necessary information and is based on 1999 National Committee on Quality Assurance (NCQA) requirements. According to member handbook information, and oral and written statements of Plan personnel, utilization management staff members do not review requests for additional inpatient days, but do provide input regarding discharge planning. Since attending physicians determine whether or not a patient requires continued hospitalization, the Plan provides benefits through the day that clinical staff sends notice to both the member and the practitioner that continued stay is no longer authorized.

### **PROVIDER ADMINISTRATION**

The Plan's provider network consists of more than 1,875 primary care practitioners (PCPs) and nearly 3,500 additional specialty care practitioners (SCPs). The network is a mixed model, predominantly an individual practice association (IPA) provider networks. Most PCPs (55%) are reimbursed by capitation, while the remaining PCPs (45%), and all plan specialists practice under fee-for-service contracts. The Plan also contracts with 43 hospitals, 55 skilled nursing facilities, and 28 home health agencies located throughout the state of Oregon and southwestern Washington.

The Oregon Practitioner Credentialing Application and National Committee on Quality Assurance (NCQA) guidelines are used to determine the qualifications of prospective healthcare providers. Any gaps in education or practice must be explained and all licenses verified. Personal sanction history, criminal background, professional liability and malpractice insurance coverage limits, and claims history must be verified and documented. Practitioners are required to complete recredentialing procedures every two years.

Physician and provider agreements are basically consistent in their provisions, but may vary in recognition of the practitioner's specialty and association relationships. The contracts allow the Plan to terminate practitioners immediately in cases where a member's health, safety or welfare is jeopardized, or if the practitioner's license or medical staff privileges are limited, revoked, terminated, or suspended. The Plan may also terminate providers with 10 days written notice for specified causes, and the agreement may be terminated by either party, without cause, giving 60 days written notice. Providers have the right to request a hearing or appeal disciplinary or termination actions. Provider contracts indicate that practitioners will not be subject to termination or penalty for acting as an advocate on behalf of patients with regard to decisions, policies or practices.

### **Findings**

The Plan was tested for compliance with standards based on Oregon Revised Statutes and Oregon Administrative Rules. The standards used in this phase of the examination are shown below.

Standard #1 was not assessed during this phase of the examination since an identical requirement is included in Policyholder Services Standard #2.

The Plan passed the remaining standards listed below without comment:

<b>Standard</b>	<b>Regulatory Authority</b>
Provider Treatment Standard #2 – The Company does not terminate or financially penalize providers for the reasons prohibited by the applicable laws, rules or regulations.	ORS 743.834(1)(a) (b) & (c) ORS 743.834(2)(a)
Provider Treatment Standard #3 – The provider contract holds enrollees harmless and prohibits balance billing.	ORS 743.821 ORS 750.095

**COMPLIANCE WITH PRIOR EXAMINATION RECOMMENDATIONS**

A total of 19 recommendations were made as part of the last market conduct examination of the Plan. One of the prior recommendations pertained to an Underwriting standard that is no longer applicable due to a change in the statutes regarding small group plans. Six of the prior recommendations pertained to underwriting standards that were waived for this examination. Three of the prior recommendations pertained to standards for which a file sample was not reviewed during this examination. Based on a review of their written procedures, the Plan appears to have complied with those recommendations. They were also in compliance with one of the remaining nine recommendations. Following is a list of the eight prior recommendations with which the Plan continued to be out of compliance.

I recommend the Plan furnish a response within 20 working days of any inquiry from an insured in accordance with OAR 836-080-0225(3). (Note: This standard is now evaluated under both Claims and Grievance Procedures. The Plan passed this standard in regard to claim correspondence other than grievances, but failed in regard to grievances.)
I recommend the Plan keep its books, records, accounts and transaction source data in such manner that the director may readily ascertain whether the Plan has given proper treatment to policyholders and has complied with the Insurance Code in accordance with ORS 733.170.
I recommend the Plan acknowledge or pay claims within 20 working days of notification of the claim in accordance with ORS 746.230(1)(b) and OAR 836-080-0225(1)&(4).
I recommend the Plan complete its claim investigations within 45 working days unless the investigation cannot reasonably be completed within that period of time in accordance with ORS 746.230(1)(c)&(k) and OAR 836-080-0230.

I recommend the Plan provide written notification to first party claimants of any delay in the investigation of a claim within 20 working days from receipt of the Proof of loss and every 45 days after the first notice in accordance with OAR 836-080-0235(3). All such notices must include a reason for the claim delay.
I recommend the Plan not refuse to pay claims without conducting a reasonable investigation in accordance with ORS 746.230(1)(d).
I recommend the Plan's claim denials include a proper explanation of the basis relied on in the insurance policy and are made in writing in accordance with ORS 746.230(1)(m) and OAR 836-080-0235(1).
I recommend the Plan pay claims in accordance with the contract and the claims handling procedures of the Plan in accordance with ORS 731.300 and ORS 733.170.

### **CONCLUSION**

	<b><u>Recommendation</u></b>	<b><u>Page</u></b>
1	I recommend the Plan conduct a review of the operations of third party administrators who administer benefits for more than 100 certificate holders on the Plan's behalf at least annually in compliance with ORS 744.740.	9
2	I recommend the Plan's agreements with third party administrators comply with the requirements of ORS 744.700 through 744.740.	11
3	I recommend the Plan keep records that are adequate, accessible, consistent and orderly in compliance with ORS 733.170.	12
4	I recommend the Plan delegate claims adjudication only to licensed third party administrators in accordance with ORS 746.110 and ORS 746.240.	12
5	I recommend the Plan have a timely and organized system for resolving grievances and appeals in compliance with ORS 743.804(3)(a)-(f) and OAR 836-053-1100.	18
6	I recommend the Plan record data related to grievances and the action taken in a sufficient manner to reconstruct all pertinent events in compliance with OAR 836-053-1080.	19
7	I recommend the Plan provide to any enrollee who has filed a grievance detailed information on its grievance and appeal procedures and how to use them in compliance with ORS 743.804(8).	21
8	I recommend the Plan acknowledge grievances within seven days from the receipt of the grievance in compliance with ORS 743.804(3)(d) and OAR 836-053-1100(1)(a).	21
9	I recommend the Plan provide a written decision regarding grievances within 30 days from the receipt of the grievance in compliance with ORS 743.804(3)(d) and OAR 836-053-1100(1)(b) and (2).	22
10	I recommend the Plan respond to Insurance Commissioner complaints adequately and conclusively within 21 calendar days in compliance with OAR 836-080-0225(2).	23
11	I recommend the Plan have a grievance appeal process with at least two levels of appeal for all grievances, including those concerning quality of clinical care, in accordance with ORS 743.804(3)(f).	25

	<b><u>Recommendation</u></b>	<b><u>Page</u></b>
12	I recommend the Plan, upon request from an enrollee or prospective enrollee, provide the information regarding risk sharing, credentialing of network providers, and utilization review of a particular condition required by ORS 743.804(6)(d) and (f) and (7).	30
13	I recommend the Plan provide information on portability coverage to all individuals losing group coverage, for any reason other than group replacement of coverage, within 10 days following the date of any administrative action taken to initiate or document the loss of coverage in accordance with OAR 836-053-0750 (3) and (4).	32
14	I recommend the Plan revise the transplant waiting or exclusion period provisions in any and all affected custom contracts (negotiated group policy forms) to apply creditable coverage from any prior health plan, in compliance with ORS 743.754(3) and ORS 836-053-0250.	38
15	I recommend the Plan resolve or acknowledge claims within 30 days of receipt in accordance with ORS 746.230(1)(b) and OAR 836-080-0225(1) and (4).	42
16	I recommend the Plan conduct investigations within 45 days of receipt of the claim in accordance with ORS 746.230(1)(c) and OAR 836-080-0230.	43
17	I recommend the Plan resolve claims in 30 days or send a delay letter within 30 days and every 45 days thereafter until the claim is resolved in accordance with ORS 746.230(1)(e) and OAR 836-080-0235(1) and (4).	44
18	I recommend the Plan adequately document claim files in accordance with ORS 733.170 and OAR 836-080-0215.	44
19	I recommend the Plan not deny claims without conducting a reasonable investigation to determine if the charges being denied are, in fact, ineligible for benefits in accordance with ORS 746.230(1)(c) and (d).	45
20	I recommend the Plan not misrepresent facts or policy provisions while settling a claim in accordance with ORS 746.230(1)(a) and OAR 836-080-0220.	46
21	I recommend the Plan deny claims in accordance with policy provisions in accordance with ORS 746.240.	46
22	I recommend claim denials include a proper explanation of the basis relied on in the insurance policy and be made in writing in accordance with ORS 746.230(1)(m) and OAR 836-080-0235(1).	47
23	I recommend the Plan adjust all claims for emergency services and auxiliary emergency services in accordance with ORS 743.699(1)(2) and (3), ORS 743.801(1)(2) and (3) and OAR 836-053-1030.	52
24	I recommend the Plan provide binding authorizations in accordance with ORS 743.837(1) and (2) and OAR 836-053-1200(6)-(8).	54
25	I recommend the Plan adjudicate all mental health and behavioral health claims in accordance with ORS 743.556, OAR 836-052-0220 through OAR 836-052-0245 and Bulletin 90-6.	56

**MANAGEMENT AFFIRMATION**

## **ACKNOWLEDGMENT**

The cooperation and assistance rendered by the officers and employees of the Plan 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 her regular assigned duties.

In addition to the undersigned, Kathleen Kalk, AIE, and Thomas G Moeller CLU, 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

**AFFIDAVIT**

STATE OF OREGON        }  
                                  }  ss  
County of Marion        }

Jann Goodpaster, being duly sworn, deposes and says that the foregoing market conduct report of examination as of March 31, 2000, of Providence Health Plan, Portland, 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 \_\_\_\_\_, 2001.

\_\_\_\_\_  
Linda J. Rothenberger  
Notary Public for the State of Oregon  
My Commission Expires: March 22, 2005

**APPENDIX A**  
**STANDARDS**  
**PROVIDENCE HEALTH PLAN**  
**MARKET CONDUCT EXAMINATION**

**Company Overview**

#	<b><u>Standard</u></b>	<b><u>Regulatory Authority</u></b>
1	The Company has an up-to-date, valid internal, or external, audit program.	ORS 731.302(1)
2	The Company has appropriate controls, safeguards and procedures for protecting the integrity of computer information.	ORS 731.302(1)
3	The Company has an antifraud plan in place.	ORS 731.302(1)
4	The Company has a valid disaster recovery plan.	ORS 731.302(1)
5	The Company is adequately monitoring the activities of the MGA, GA, TPA or any entity that contractually assumes a business function or is acting on behalf of the Company.	ORS 744.300 to ORS 744.316, OAR 836-071-0115, OAR 836-071-0150, OAR 836-071-0160, OAR 836-071-0297, OAR 836-071-0315, ORS 744.700 through ORS 744.740
6	Company contracts with MGA, GA, TPA comply with applicable statutes, rules and regulations.	ORS 744.300 to ORS 744.316, OAR 836-071-0115, OAR 836-071-0150, OAR 836-071-0160, OAR 836-071-0297, OAR 836-071-0315, ORS 744.700 through ORS 744.740
7	Records are adequate, accessible, consistent and orderly and comply with record retention requirements.	ORS 733.170
8	The company is licensed for the lines of business that are being written.	ORS 731.022, ORS 731.146, ORS 731.354

**Grievance Procedures**

#	<b>Standard</b>	<b>Regulatory Authority</b>
1	The health carrier treats as a grievance any written complaint submitted by or on behalf of a covered person.	ORS 743.801(4)
2	A health carrier has a timely and organized system for resolving grievances and appeals.	ORS 743.804(3)(a)-(f)
3	The health carrier records data related to grievances and the action taken in a sufficient manner to reconstruct all pertinent events.	OAR 836-053-1080
4	A health carrier files with the commissioner an annual report in the format prescribed by rule.	ORS 743.804(6)(c)&(9), OAR 836-053-1000(3)(a), OAR 836-053-1070(1)(2)&(3), Oregon Insurance Division Bulletin 98-6
5	The health carrier provides to all enrollees either directly or through the group policyholder a summary explaining the procedures for voicing grievances and for appealing decisions adversely affecting the enrollee's benefits or enrollment status.	ORS 743.804(5)(f)(h)&(q)
6	The health carrier provides 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.	ORS 743.804(3)(e),(5)(q)&(8)
7	The health carrier acknowledges grievances within seven days from the receipt of the grievance.	ORS 743.804(3)(d), OAR 836-053-1100(1)(a)
8	The health carrier makes a decision regarding grievances within 30 days from the receipt of the grievance.	ORS 743.804(3)(d), OAR 836-053-1100(1)(b)&(2)
9	The Company responds to Insurance Commissioner complaints adequately and conclusively within 21 calendar days.	OAR 836-080-0225(2)
10	The health carrier has a grievance appeal process with at least two levels of appeal.	ORS 743.804(3)(f)

## ***Advertising***

<b>#</b>	<b>Standard</b>	<b>Regulatory Authority</b>
1	The Company's advertising does not contain false, deceptive or misleading statements.	ORS 746.110, OAR 836-020-0220(1), OAR 836-020-0225(1)(a)
2	The Company's advertising does not contain words or phrases whose definition is clear only by implication or by familiarity with insurance terminology. The Company also does not use prohibited words or illustrations.	OAR 836-020-0220(2), OAR 836-020-0225(1)(b)
3	The Company's advertising contains the name of the actual insurer and the form number of the policy advertised.	ORS 731.430(1), OAR 836-020-0260(1)
4	Testimonials must be in accordance with all applicable laws.	OAR 836-020-0235(1), OAR 836-020-0235(2), OAR 836-020-0235(4)
5	The Company's advertising containing statistical information must be in compliance with all applicable laws.	OAR 836-020-0240(1)
6	The Company's advertising does not make unfair or incomplete product comparisons and does not make disparaging remarks about other insurers or other marketing methods.	OAR 836-020-0250
7	Company advertising contains only true and factual information regarding the Company's corporate structure or financial status. If a reference to a commercial rating system is used, it clearly indicates the purpose of the recommendation and limitations of the scope and extent of the recommendation.	OAR 836-020-0275
8	The Company's advertising is in compliance with all other laws and regulation pertaining to advertising.	OAR 836-020-0215, OAR 836-020-0225(2), OAR 836-020-0230, OAR 836-020-240(2), OAR 836-020-0245(1), OAR 836-020-0255(3), OAR 836-020-0265

<b>#</b>	<b><u>Standard</u></b>	<b><u>Regulatory Authority</u></b>
9	The Company complies with all policies and procedures regarding the administration of advertising compliance.	OAR 836-020-0205(2), OAR 836-020-0280(1)&(2)
10	Company internal producer training materials are in compliance with applicable statutes, rules and regulations.	OAR 836-020-0205 through OAR 836-020-0280
11	Outlines of coverage are in compliance with all applicable statutes, rules and regulations.	OAR 836-020-0305, OAR 836-052-0160(3) (Medicare Supplement), OAR 836-052-0600 (Long Term Care)

### **Network Adequacy**

<b>#</b>	<b><u>Standard</u></b>	<b><u>Regulatory Authority</u></b>
1	The Company files an annual summary by March 31 of each calendar year for the preceding year.	ORS 743.817(1), OAR 836-053-1190(1), OAR 836-053-1190(3)
2	The Company discloses to the enrollee (or to the group policyholder for distribution to the enrollee) information regarding the provider, clinic and hospital networks.	ORS 743.804(5)(L)

### **Producer Licensing**

<b>#</b>	<b><u>Standard</u></b>	<b><u>Regulatory Authority</u></b>
1	Company records of licensed and appointed producers agree with department of insurance records.	ORS 744.051
2	Producers are properly licensed and appointed in the jurisdiction where the application was taken.	ORS 744.051, ORS 744.054, ORS 744.155(1)&(2), OAR 836-071-0287
3	Termination of producers complies with applicable standards, rules and regulations regarding notification to the producer and notification to the state, if applicable.	ORS 744.175

<b>#</b>	<b><u>Standard</u></b>	<b><u>Regulatory Authority</u></b>
4	The Company's policy of producer appointments and terminations does not result in unfair discrimination against policyholders.	ORS 746.015, ORS 746.018, OAR 836-081-0030
5	Records of terminated producers adequately document reasons for terminations.	ORS 733.170, ORS 744.175

**Policyholder Services**

<b>#</b>	<b><u>Standard</u></b>	<b><u>Regulatory Authority</u></b>
1	The Company 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 743.699(2), ORS 743.804(2)(5)&(8), OAR 836-053-1020(6), OAR 836-053-1030, OAR 836-053-1090
2	The Company 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)
3	At policy issuance and termination, the proper notices are sent.	ORS 743.560, OAR 836-052-0810, OAR 836-052-0820, OAR 836-052-0830, OAR 836-052-0840, OAR 836-052-0850, OAR 836-052-0860
4	The Company established a means to provide enrollees, purchasers and providers a meaningful opportunity to participate in the development of insurer policy and operations.	ORS 743.817(2)
5	The Company maintains policies to ensure adequate treatment for female enrollees.	ORS 743.823, ORS 743.845(2)&(3), OAR 836-053-1000(11)
6	The Company ensures patient confidentiality by adopting written confidentiality policies and procedures.	ORS 743.804(10)

#	<b>Standard</b>	<b>Regulatory Authority</b>
7	The Company has a policy that allows enrollees to change participating primary care providers at will.	ORS 743.808(1)(a)
8	The Company's written procedures pertaining to drug formularies contain all the required provisions.	OAR 836-053-1020
9	The Company provides the required summaries and disclosures regarding drug formularies.	ORS 743.804(5)(p)&(6)(a), OAR 836-053-1020(5)&(6)
10	The Company does not 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.	ORS 743.697
11	The Company correctly identifies the term "eligible individual" for the purpose of administering portability plans.	ORS 743.760(1)(b)(A)(i)
12	The Company correctly applies all provisions regarding portability including disclosure and application.	ORS 743.760(4)-(6)&(8)-(11), OAR 836-053-0730(2), OAR 836-053-0750(3)&(4)
13	The Company's rates are determined according to applicable laws, rules and regulations.	ORS 743.760(7)
14	The Company correctly applies pre-existing condition provisions and waiting periods.	ORS 743.737(1)(2)&(4), ORS 743.754(1)(2)&(4), OAR 836-053-0060(1)(3)&(4), OAR 836-053-0250(1)&(2)
15	The Company correctly identifies late enrollees and eligible enrollees as pertaining to late enrollment.	ORS 743.730(23)(a)(b)(c)(d)
16	The Company correctly applies all provisions regarding creditable coverage including disclosure and application.	ORS 743.737(3), ORS 743.754(3), OAR 836-053-0040(2)(3)(4)&(8), OAR 836-053-0060(4)&(5), OAR 836-053-0230(6)(7)(8)&(9), OAR 836-053-0250(2)&(3)

**Quality Assurance**

<b>#</b>	<b>Standard</b>	<b>Regulatory Authority</b>
1	The Company maintains a written quality assessment program to evaluate, maintain and improve the quality of health services provided to enrollees.	ORS 743.814(1)
2	The Company provides, upon request, a description of the insurer's efforts, if any, to monitor and improve the quality of health services.	ORS 743.804(6)(e)
3	The Company annually files the required quality assessment reports.	ORS 743.814(2)&(3), OAR 836-053-1000(3)(c)(d)&(e), OAR 836-053-1170(1)(2)&(3)
4	The health carrier monitors the activities of the entity with which it contracts to perform quality assessment or quality improvement functions and ensures that all the applicable laws, rules and regulations are met.	ORS 746.240

**Underwriting**

<b>#</b>	<b>Standard</b>	<b>Regulatory Authority</b>
	<b><i>Large Group Insurance</i></b>	
1	The Company verifies that all groups are bonafide groups and not subject to small employer provisions.	ORS 743.522, ORS 743.730(29)
2	The Company used the correct underwriting criteria and procedures when evaluating and rating group applications.	ORS 743.751, ORS 743.752(1), ORS 746.015, OAR 836-053-0230(3)
3	The Company renews all plans except for the approved reasons.	ORS 743.754(6)
	<b><i>Small Employer Groups 26-50</i></b>	
4	The Company correctly identifies all small employer groups 26-50 and verifies the numbers of employees in accordance with Oregon law.	ORS 743.733, ORS 743.746
5	The Company underwriting practices meet the applicable rules and requirements.	ORS 743.736(4)&(10), ORS 746.015, OAR 836-053-0050(1)-(4)

<b>#</b>	<b>Standard</b>	<b>Regulatory Authority</b>
6	All Plans are guarantee issue.	ORS 743.736(5)
7	The Company renews all plans except for the approved reasons.	ORS 743.754(6)
	<b>Small Employer Groups 2-25</b>	
8	The Company correctly identifies all Oregon small employer groups and verifies the numbers of employees annually.	ORS 743.730(29), ORS 743.733
9	The Company's underwriting practices meet the applicable rules and requirements.	ORS 743.736(4)&(10), ORS 746.015, OAR 836-053-0050(1)-(4)
10	All Plans are guarantee issue.	ORS 743.736(5)
11	The Company renews all plans except for the approved reasons.	ORS 743.754(6)
12	The Company rates all Oregon Small Employer groups according to the applicable laws and rules.	ORS 743.737(10)(a),(b)(A)(i)&(B)(c)&(d)
	<b>Individual Plans</b>	
13	The Company provides the appropriate disclosures to applicants seeking individual health insurance.	ORS 743.412(1), ORS 746.620, ORS 746.630
14	The Company uses an individual application form containing all the required information.	OAR 836-053-0430
15	The Company uses health statements for underwriting individual application forms that meet all applicable requirements.	OAR 836-053-0510
16	The Company uses only appropriate underwriting information for purposes of accepting or denying the policy.	ORS 746.135(3), OAR 836-050-0240(4), OAR 836-050-0250(2), OAR 836-050-0255
17	The Company does not unfairly discriminate when underwriting individual applications for health insurance.	ORS 746.015, OAR 836-050-0237, OAR 836-050-0240(1)(2)&(3), OAR 836-050-0245(1), OAR 836-081-0030
18	Rejection of individual plans is handled in accordance with the applicable rules and regulations.	ORS 743.769(4), ORS 746.650(2)(b)(B), ORS 746.660

#	<b>Standard</b>	<b>Regulatory Authority</b>
19	The Company renews all individual plans except for the reason allowed by the applicable rules and regulations.	ORS 743.766(5)
20	The Company uses filed and approved rates on individual plans. <b>Medicare Supplements</b>	OAR 836-053-0465(1)(2)(3)(4)
21	All applicants for Medicare supplements receive an outline of coverage when application is made.	ORS 743.685(1)(2), OAR 836-052-0160(3)
22	All Medicare supplement policies are guarantee issue.	OAR 836-052-0138, OAR 836-052-0142
23	All Medicare supplement policies include a guarantee renewal or continuation provision.	OAR 836-052-0160(1)(a)
24	All Medicare supplement policies must include the required provisions. <b>Associations and Trusts</b>	ORS 746.683, ORS 743.686, OAR 836-052-0160
25	If the Company offers group insurance to an association or trust, it files with and receives approval of these entities from the Insurance Division.	ORS 743.524, ORS 743.526
26	Individuals within a subgroup of an association or trust are treated as group certificate holders and may not be underwritten individually. <b>Forms</b>	ORS 743.524, ORS 743.526
27	Policy forms are filed with and approval obtained from the Oregon Insurance Division prior to use in this state.	ORS 742.003, OAR 836-010-0011
28	Each policy form that has not been filed with the Oregon Insurance Division because it qualifies as a negotiated form is only issued to one group, has a company-assigned form number, and contains the mandated benefits.	ORS 742.003(1)(c), OAR 836-010-0011(1)(j), Oregon Insurance Division Bulletin 98-3
29	The Company's marketing practices do not permit illegal rebating, commission cutting or inducements.	ORS 746.045

**Utilization Review**

#	<b>Standard</b>	<b>Regulatory Authority</b>
1	The health carrier files with the commissioner an annual summary report of its utilization review activities.	ORS 743.807(1), OAR 836-053-1000(3)(b), ORS 836-053-1130(1)
2	The health carrier provides information about its utilization review program to members in a timely manner and in compliance with statutes, rules and regulations.	ORS 743.804(5)(j)
3	The health carrier provides 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.	ORS 743.804(7)
4	The health carrier makes 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.	ORS 743.807(2)(b)
5	The health carrier makes available qualified health care personnel for same-day telephone responses to inquiries concerning certification of continued length of stay.	ORS 743.807(2)(d)
6	The health carrier provides an appropriate appeal system when an adverse utilization review determination is made.	ORS 743.807(2)(c), OAR 836-053-1140
7	The health carrier monitors the activities of the utilization review organization or entity with which the carrier contracts and ensures the contracting organization complies with applicable laws, rules and regulations.	ORS 731.302(1), ORS 746.240

## **Claims**

<b>#</b>	<b>Standard</b>	<b>Regulatory Authority</b>
1	The initial contact by the Company with the claimant is within 30 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 Company responds to claim correspondence in 30 days.	ORS 746.230(1)(b), OAR 836-080-0225(3)
5	Claim files are adequately documented.	ORS 733.170, OAR 836-080-0215
6	Claims are not denied without first conducting a reasonable investigation.	ORS 746.230(1)(c)&(d)
7	The Company promptly and in good faith equitably settles claims in which liability has become reasonably clear.	ORS 746.230(1)(f)(h)&(L)
8	The Company did not misrepresent the facts or policy provisions while settling a claim.	ORS 746.230(1)(a)
9	The Company 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)
10	The Company pays (or denies) claims in accordance with policy provisions and in compliance with the applicable laws, rules and regulations.	ORS 746.240, ORS 743.695 through ORS 743.729
11	The Company did not fail to promptly provide the proper explanation of the basis relied on in the insurance policy in relation to facts or applicable laws for the denial of claim.	ORS 746.230(1)(m)

<b>#</b>	<b>Standard</b>	<b>Regulatory Authority</b>
12	Denied and closed-without-payment claims are handled in accordance with policy provisions and state law.	OAR 836-080-0235(1)
13	Canceled benefit checks and drafts reflect appropriate claim handling practices.	ORS 746.240
14	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)
15	All claims that are subject to the application of Coordination of Benefits provisions are processed in accordance with all applicable rules and regulations.	OAR 836-020-0735(3), OAR 836-020-0740(3)
16	The Company 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)
17	The Company processes all requests for prior authorizations in compliance with applicable laws, rules and regulations.	ORS 743.807(2)(d), ORS 743.837(1)&(2), OAR 836-053-1200(6)(9)
18	The group health plan adjudicates all mental health and behavioral health claims in accordance with all applicable laws, rules and regulations.	ORS 743.556(group), OAR 836-052-0220 through OAR 836-052-0245, Oregon Insurance Division Bulletin 90-6

***Provider Treatment***

<b>#</b>	<b>Standard</b>	<b>Regulatory Authority</b>
1	The Company disclosures to providers are in compliance with the applicable laws, rules and regulations.	ORS 743.804(2), ORS 743.807(2)(a), OAR 836-053-1020(5)
2	The Company does not terminate or financially penalize providers for the reasons prohibited by the applicable laws, rules or regulations.	ORS 743.834(1)(a)(b)(c), ORS 743.834(2)(a)
3	The provider contract holds enrollees harmless and prohibits balance billing.	ORS 743.821, ORS 750.095