



STATE OF OREGON

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

INSURANCE DIVISION

REPORT OF TARGET MARKET CONDUCT EXAMINATION

OF

**PROVIDENCE HEALTH PLAN  
BEAVERTON, OREGON**

**NAIC COMPANY CODE 95005**

AS OF

**DECEMBER 31, 2002**

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December 1, 2004

Honorable Cory Streisinger, Director  
State of Oregon  
Department of Consumer and Business Services  
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 Boulevard, Suite 10  
Beaverton, OR 97005**

**NAIC Company Code 95005**

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

## EXECUTIVE SUMMARY

The focus of this targeted market conduct examination is to determine if Providence Health Plan (the Company) is in compliance with the Prompt Pay laws and rules prescribed under ORS 743.866, ORS 743.868, OAR 836-080-0080, and OAR 836-080-0085.

The following report attempts to provide a comprehensive summary of the findings discovered during this examination of the Company's efforts to promptly pay claims under the Prompt Pay laws.

To measure the Company's compliance, the following four standards were applied to the Company's claims operation:

Prompt Pay Standard #1 – The Company processes all claims that are subject to the application of prompt payment requirements in accordance with all applicable rules and regulations.

Prompt Pay Standard #2 – The Company's provider contracts are in compliance with applicable statutes, rules and regulations.

Prompt Pay Standard #3 – The Company's disclosures to providers are in compliance with applicable statutes, rules and regulations.

Prompt Pay Standard #4 – The Company files the required annual claims processing information in compliance with applicable statutes, rules and regulations.

To determine the Company's fulfillment to the above-mentioned standards required a review of the following materials: Company's claims manual, claims workflow, provider contracts,

provider manuals, and random samples of 50 claims selected from two populations.

In review of the materials examined, the findings for this targeted market conduct examination has been determined as follows:

- Company passed Prompt Pay Standard #2 and #3 without comment.
- Company failed Prompt Pay Standard #1 and #4.

Furthermore, the following additional findings were discovered during the examination of the claim files provided for review:

It was discovered that the Company is not in compliance with ORS 743.866(1), ORS 743.230(1)(b), OAR 836-080-0225(1)(4), and OAR 836-080-0235. The Company has contractual language within its provider contracts that allowed for unfair claim settlement practices relating to timely claims processing. The Company is also not in compliance with OAR 836-020-0725 and OAR 836-020-0735 regarding its claims processing procedures pertaining to secondary claims for covered services under Coordination of Benefit (COB) situations.

### **SCOPE OF EXAMINATION**

The market conduct examination of the Company was conducted as of December 31, 2002, covering the period of January 1, 2002 through December 31, 2002, and included a review of material transactions or events which occurred subsequent to the examination cut-off date and were noted during the examination.

The purpose of the examination was to determine if the Company was in compliance with Prompt Pay statutes, rules and regulation. It was further intended to identify and assess the practices and procedures implemented by the Company to comply with Prompt Payment statutes. The findings in this examination demonstrate that the Company needs to develop an action plan to ensure they comply with Prompt Pay statutes.

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 (NAIC) to the extent that it is consistent with Oregon law.

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 examination was comprised of the following two phases:

- Company Operations/Management
- Prompt Payment of Claims

The Company’s underlying data was measured against an established standard. A list of all standards considered can be found in Appendix A at the end of the report. The examiner used the following three classifications to disclose the examination results:

Passed without Comment	The standards the Company passed are displayed in a chart at the beginning of the Findings section of each phase. Items included in this category passed the standard and the examiner did not find it necessary to comment on the findings.
Passed with Comment	Standards the Company passed with some errors noted are included in this classification. Items in this category are not considered to be indicative of a general business practice of noncompliance. Usually, a recommendation is not warranted, but in certain instances a recommendation might be made.
Failed	The Company has not demonstrated compliance with standards that fall into this category. A recommendation for compliance is usually made for each standard the Company fails.

Information regarding some items might be noted in the examination report without remarks.

Some unacceptable or non-complying practices may not have been discovered in the course of this examination. Additionally, findings may not be material to all areas which would serve to assist the Director. Failure to identify or criticize specific Company practices does not constitute acceptance by the Oregon Insurance Division. Examination findings may result in administrative action or further inquiry.

Other areas of concern discovered during the examination that do not fall within the scope of the standards might appear in the report as the last section of each phase and titled Additional Findings and Procedures.

## **COMPANY OPERATIONS/MANAGEMENT**

### **Company History**

The Company is an Oregon non-profit corporation, whose sole voting member is Providence Plan Partners (the Plan). The Plan is a federally qualified, state registered health maintenance organization. It was incorporated under the laws of the State of Oregon on February 1, 1984. The original certificate of authority was issued by the Oregon Insurance Division on September 5, 1984, authorizing the Company to transact the business of accepting the prepayment of health care benefits under ORS 750.055 and ORS 731.354. In June 1985, the Plan became a federally qualified health maintenance organization. On January 15, 1987, the Plan's name was changed from Sisters of Providence Physician InterHospital Health Plan to Sisters of Providence Good Health Plan of Oregon, Inc. On November 29, 1994, the Plan's name was changed from Sisters of Providence Good Health Plan of Oregon, Inc., to Providence Health Plans dba Providence Good Health Plan. On October 14, 1997, the Plan's name was changed from Providence Health Plans, dba Providence Good Health plan to Providence Health Plan.

On November 24, 1997, the director of the Department of Consumer and Business Services (DCBS) approved a merger whereby Providence Plan Partners (a Washington Mutual and Miscellaneous corporation) acquired control of the Plan, SelectCare Health Plan and the Good Health Plan of Washington (GHPW) with Providence Health Plan being the surviving entity. This transaction occurred on January 1, 1998.

The Plan is affiliated with Providence Plan Partners (PPP). PPP in turn is controlled by Sisters of Providence of Oregon, which is ultimately controlled by Sisters of Providence Congregation in Montreal, Canada.

The Plan is part of a holding company system, whereby it is affiliated with a preferred provider organization (Providence Preferred) and various hospitals and medical facilities.

**Management and Control**

***Board of Directors***

The Board of Directors is comprised of 12 directors that serve three-year terms. The Board has three categories of directors: provider directors, consumer representative directors, and member directors.

Members of the Board of Directors serving as of September 30, 2002 were:

<b>NAME</b>	<b>LOCATION</b>	<b>PRINCIPAL AFFILIATION</b>
Sister Karin Dufault, S.P.	Seattle, WA	Chair of the Board
Don Blem	Seattle, WA	Director
John J. Collins, Jr., M.D.	Seattle, WA	Director
Barbara Donaho	Seattle, WA	Director
Kay Stepp	Seattle, WA	Director
Kevin Fickenscher, M.D.	Seattle, WA	Director
Orcilia Zuniga Forbes, M.D.	Seattle, WA	Director
Sister Lucille Dean, S.P.	Seattle, WA	Director
Sister Lynn Chappell, S.P.	Seattle, WA	Director
Carol Pacini, LCM	Seattle, WA	Director
Dana Rasmussen	Seattle, WA	Director
Al Parrish	Seattle, WA	Director

## *Officers*

The principal officers of the Company as of September 30, 2002 were as follows:

<b>NAME</b>	<b>OFFICE/POSITION</b>
Henry G. Walker	President/CEO
Jeffrey W. Rogers	Corporate Secretary
Mike Butler	Vice President/Finance and Treasurer
John F. Koster, M.D.	Executive Vice President

## **CLAIMS**

The examination of this phase included a review of the Company's claims manual, claims flow, provider contracts, a provider manual, and random samples of 50 claims selected from two populations.

In accordance to ORS 743.866(5) and OAR 836-080-0085, the Company is required to annually report and file specific claims information pertaining to claims in which final disposition had been made by the insurer during the immediate preceding calendar year. The filing of this information by an insurer must be submitted to the Department of Consumer and Business Services (DCBS) by March 1<sup>st</sup> each year.

The Company submitted the required filing of its claims information in which final disposition had been made by the Company during the immediate preceding 2002 calendar year to DCBS on March 3, 2003. This was acceptable as March 1<sup>st</sup> for the 2003 calendar year was subsequently on a Saturday. Data collected from the Company's filing of claims information to DCBS was recorded into a database at the Oregon Insurance Division.

The information filed and collected from the Company indicates 777,048 claims in which final disposition had been made by the Company during the 2002 calendar year. Within this population, the Company reported that 23,105 claims were processed 30 days after the Company was in receipt of them.

From the population of 23,105 claims that were processed 30 days after their receipt date, the Oregon Insurance Division produced a random sample of 378 (1.6%) claims and requested that the Company provide specific detailed claims information from this sample and in a format established by the Oregon Insurance Division. The Company was required to provide the claims filing information from this sample to DCBS by May 5, 2003. The Company provided this information on April 17, 2003. The data collected from this sample would be used to test the Company's compliance to Standard #1 and Standard #4.

From the random sample of 378 claims that were paid past 30 days from their received dates, another random sample of 25 (6.6%) claims was produced from this population. This provided the first 25 random sample of claims the examiner reviewed for compliance under this phase. The second random sample of 25 (.003%) claims were retrieved from the 777,048 claims in which final disposition had been made by the Company during the preceding 2002 calendar year.

The random sample of 50 claims selected for review under this phase is as follows:

<b>POPULATION REVIEWED</b>	<b>POPULATION SIZE</b>	<b>SAMPLE SIZE</b>	<b>SAMPLING PERCENTAGE</b>
Claims Finalized After 30 Days	378	25	6.6%
Total Claims Finalized in 2002	777,048	25	.003%

**Findings**

The following standards passed without comment:

<b>STANDARD</b>	<b>REGULATORY AUTHORITY</b>
<u>Prompt Pay Standard #2</u> - The Company's provider contracts are in compliance with applicable statutes, rules and regulations.	ORS 743.866(2)
<u>Prompt Pay Standard #3</u> - The Company's disclosures to providers are in compliance with applicable statutes, rules and regulations.	ORS 743.866(3) and OAR 836-080-0080(3)

Prompt Pay Standard #1 – The Company processes all claims that are subject to the application of prompt pay requirements in accordance with all applicable rules and regulations. Reference: ORS 743.866(1), ORS 743.868(1) and (2), and OAR 836-080-0080(1) and (2).

Findings: Failed. 48% compliance. To examine the Company’s compliance for this standard, random samples were drawn and reviewed from two different populations (claims finalized after 30 days and total claims finalized in 2002) and combined to illustrate the following findings:

<b>REASON</b>	<b>CLAIMS FINALIZED AFTER 30 DAYS</b>	<b>TOTAL CLAIMS FINALIZED IN 2002</b>	<b>% OF TOTAL (50)</b>
Claim paid past 30 days and no delay letter or request(s) for additional information sent to member or provider.	20	1	42%
Claim paid past 30 days and delay letter sent to member and provider was sent 30 days after the Company received the claim.	5	0	10%
<b>Total</b>	<b>25</b>	<b>1</b>	<b>52%</b>

The Company indicated that their Amisys claims system that was in effect during 2002 had certain gaps that existed in its configuration system, which caused the printing of delay letters to be delayed or missed. The gaps, which caused this error, have been corrected. Currently, the Company's Facets claim system, which took effect on September 1, 2003, has been configured for daily processing of delay letters that should prevent any delay or missed printing of letters.

**I recommend the Company process all claims that are subject to the application of prompt pay requirements in accordance with all applicable rules and regulations, as prescribed under ORS 743.866(1), ORS 743.868(1) and (2), and OAR 836-080-0080(1) and (2).**

Prompt Pay Standard #4 – The Company files the required annual claims processing information in compliance with applicable statutes, rules, and regulations. Reference: ORS 743.866(5) and OAR 836-080-0085.

Findings: Failed. 80% compliance. To examine the Company's compliance under this standard, the examiner reviewed the first 25 (7%) random sample of claims collected from the sample of 378 claims, which were finalized 30 days after the Company received them. The examiner reviewed the 25 sample claims and compared the information examined to the data the Company submitted for the 378 claims to DCBS on April 17, 2003.

The examiner discovered that out of the 25 claims, five (20%) had incorrect received dates recorded and reported by the Company. These were electronically submitted claims, which were received by the Company's EDI claims system. The EDI claims system indicated all five of these claims were actually received a day earlier than what the Company had recorded in its claims processing system.

**I recommend the Company accurately file the required annual claims processing information in compliance with applicable statutes, rules, and regulation as specified under ORS 743.866(5) and OAR 836-080-0085.**

***Additional Findings and Procedures***

The Company provided its 2003 provider contracts for review. While reviewing the provider contracts, the examiner discovered contractual language under the OBLIGATIONS OF HEALTH PLAN section of the contracts, which states the following: *Health Plan shall pay a Clean Claim within the time period mandated by applicable state and federal law. Health Plan will pay ninety percent (90%) of clean claims submitted electronically within thirty (30) days of submissions.*

This language does not comply with ORS 743.866(1), ORS 746.230(1)(b), OAR 836-080-0225(1) (4), and OAR 836-080-0235, which stipulates that claims must be paid or denied no later than 30 days after the date on which the insurer receives the claim. If an insurer needs more time to determine whether the claim should be accepted or denied; or, if additional information is needed to determine payment of the claim, it shall so notify the claimant or provider no later than the 30<sup>th</sup> day on which the insurer received the claim. An insurer is not entitled to stipulate a contractual language, which allows for a percentage of noncompliance. The Company must establish contractual language, which emphasizes procedural efforts to process all claims within 30 days from which it was in receipt of it.

In response to the examiner's discovery regarding the above-mentioned, the Company proposed the following revision in the next updating of their provider contracts: "Health plan will pay

ninety percent (90%) of claims submitted electronically within thirty (30) days of submission.” Although this language removes references to “clean” claims, it still does not comply with ORS 743.866(1), ORS 746.230(1)(b), OAR 836-080-0225(1)(4), and OAR 836-080-0235. Again, an insurer is not entitled to stipulate a contractual language that allows for any percentage of noncompliance regardless if it’s a “clean” claim or not and insurers are also mandated to process all claims received within 30 days of its receipt date.

**I recommend the Company process all claims received within 30 days of its receipt date and cease contractual language within provider contracts which allows for unfair claim settlement practices, as prescribed under ORS 743.866(1), ORS 746.230(1)(b), OAR 836-080-0225(1)(4), and OAR 836-080-0235.**

In addition, the Company’s provider 2002 and 2003 contracts contained the following contractual language under its COMPENSATION section: *Health Plan shall have no obligation to pay any amount that together with all other payments to and contractual adjustments made by the Provider, exceeds the amount allowable by Health Plan for the service as set forth in the Attachment.*

This contractual language does not comply with OAR 836-020-0725 in regards to an allowable expense for an insurer in the position as a secondary payor. The Company is obligated to pay any amount that is recognized as an allowable expense as long as it does not exceed what it would have paid as a primary payor.

OAR 836-020-0725 defines an “allowable expense” as: *...any necessary, reasonable, and customary item of expense for health care, when the item of expense is covered at least in part by*

*one or more Plans covering the person for whom the claim is made.* Therefore, the Oregon Insurance Division has interpreted the preceding definition of an “allowable expense” to represent any expense covered by either Plan, which would require the health care plan functioning in the secondary payor position to recognize the higher of the two allowable amounts by both plans to be the “allowable expense” when calculating the payable benefit.

If a primary plan pays an amount that is equal to or above the Company’s allowable rate for a provider, the Company cannot deem it is not obligated to make any payments as it assumes the liability has been met—with or without a hold-harmless provision. The Company cannot limit payments to its own allowable rate, it must recognize the higher allowable and make payments as long as it is not more than what it would have paid if it were the primary insurance carrier for the member. A hold-harmless provision does not preclude the Company from meeting the higher allowable and its obligation as the secondary payor.

The Company has proposed it would revise the language under this language to state the following: “Health Plan shall have no obligation to pay any amount that together with all other Health Plan payments to and contractual adjustments made by the Provider, exceeds the amount allowable by Health Plan for the service as set forth in the Attachment.”

**I recommend the Company process all secondary claims for covered services under a Coordination of Benefit (COB) situation in accordance with all applicable rules and regulations, as prescribed under OAR 836-020-0725 and OAR 836-020-0735.**

## CONCLUSIONS/RECOMMENDATIONS

#	RECOMMENDATION	PAGE
1	I recommend the Company process all claims that are subject to the application of prompt pay requirements in accordance with all applicable rules and regulations, as prescribed under ORS 743.866(1), ORS 743.868(1) and (2), and OAR 836-080-0080(1) and (2).	13
2	I recommend the Company accurately file the required annual claims processing information in compliance with applicable statutes, rules, and regulation as specified under ORS 743.866(5) and OAR 836-080-0085.	14
3	I recommend the Company process all claims received within 30 days of its receipt date and cease contractual language within provider contracts which allows for unfair claim settlement practices, as prescribed under ORS 743.866(1), ORS 746.230(1)(b), OAR 836-080-0225(1)(4), and OAR 836-080-0235.	15
4	I recommend the Company process all secondary claims for covered services under a Coordination of Benefit (COB) situation in accordance with all applicable rules and regulations, as prescribed under OAR 836-020-0725 and OAR 836-020-0735.	16

## **ACKNOWLEDGMENT**

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

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

Respectfully submitted,

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Cindy J. Jones, AIE, CPCU, CRM  
Manager, Market Surveillance  
Insurance Division  
Department of Consumer and Business Services  
State of Oregon



**APPENDIX A**

**OREGON INSURANCE DIVISION  
MARKET CONDUCT EXAMINATION  
PROVIDENCE HEALTH PLAN**

**Claims Prompt Pay**

<b>#</b>	<b>Standard</b>	<b>Regulatory Authority</b>
1	The Company processes all claims that are subject to the application of prompt payment requirements in accordance with all applicable statutes, rules and regulations.	ORS 743.866(1), ORS 743.868(1) and (2), OAR 836-080-0080(1) and (2)
2	The Company's provider contracts are in compliance with applicable statutes, rules and regulations.	ORS 743.866(2)
3	The Company's disclosures to providers are in compliance with applicable statutes, rules and regulations.	ORS 743.866(3) and OAR 836-080-0080(3)
4	The Company files the required annual claims processing information in compliance with applicable statutes, rules and regulations.	ORS 743.866(5) and OAR 836-080-0085