STATE OF OREGON

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

DIVISION OF FINANCIAL REGULATION

MARKET CONDUCT EXAMINATION REPORT

REPRODUCTIVE HEALTH EQUITY ACT

OF

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST

NAIC COMPANY CODE: 95540

AS OF

DECEMBER 31, 2020

TABLE OF CONTENTS

FOREWORD

January 23, 2023

Honorable Andrew Stolfi
Director, Insurance Commissioner
Department of Consumer and Business Services
Division of Financial Regulation
350 Winter Street NE
Salem, Oregon 97301-3883

Dear Director Stolfi:

This market conduct examination report of KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST (insurer) was prepared by independent examiners contracting with the Oregon Division of Financial Regulation (division). A market conduct examination is conducted for the purpose of examining certain business practices of insurers licensed to conduct business in the state of Oregon. The examiners conducted the examination of the insurer in accordance with the Oregon Revised Statutes (ORS) 731.300. All work papers and data developed in the production of this report are the sole property of the division. The examiner in charge was Heather Harley, AMCM, FLMI, HIA.

Certain unacceptable or noncomplying practices may not have been discovered in the course of this examination. Additionally, findings may not be material to all areas that would serve to assist the Commissioner. Failure to identify or criticize specific insurer practices does not constitute acceptance of those practices by the division.

Respectfully Submitted,
Tashia Sizemore
Tashia Sizemore
Life and Health Program Manager

Signed and acknowledged before me on January 24, 2023 by Janet Vitus as notary in Marion County, State of Oregon.
Janet Vitus

OFFICIAL STAMP
JANET VITUS
NOTARY PUBLIC - OREGON
COMMISSION NO. 1030442
MY COMMISSION EXPIRES NOVEMBER 21, 2026

EXECUTIVE SUMMARY

In 2017, Oregon enacted House Bill (HB) 3391, known as The Reproductive Health Equity Act (RHEA). HB 3391 is now codified, in part, as Oregon Revised Statutes (ORS) 743A.067. RHEA requires, among other things, that a health benefit plan may not impose on an enrollee a deductible, coinsurance, copayment or any other cost-sharing requirements on the specific reproductive health services.

The focus of this targeted market conduct examination includes, but was not limited to, both insurer policyholder services and complaints and claims as related to cost-sharing provisions of state and federal law.

This report is generally written in a "report by error" format. The report does not present a comprehensive overview of the insurer's practices. The report provides details of the noncompliant or problematic practices that were discovered during the course of the examination. All unacceptable or noncompliant activities may not have been discovered. Failure to identify, comment upon or criticize noncompliant practices does not constitute acceptance of such practices.

The examiners concluded that claims processing systems and procedures did not identify all claims which should have been considered under ORS 743A.067. Specific findings related to the examination are summarized below:

- **Noncompliance with ORS 743A.067 relating to the processing of claims** – Claims samples reviewed by examiners indicated that the insurer failed to consistently process claims according to RHEA by improperly applying cost share in the initial adjustment and payment.

- **Failure to resolve complaints and maintain records as required by ORS 733.170 and OAR 836-053-1080** – The insurer failed to consistently properly resolve complaints that would result in inaccurate reporting of grievances. The insurer failed to maintain its records in such manner that the director may readily ascertain whether the insurer has given proper treatment to policyholders and has complied with the Insurance Code by not providing the examiners with evidence that the various controls over the complaint, appeals or grievance processes monitor and ensure compliance with RHEA.

This report is intended to provide a summary of the findings discovered during this targeted examination. Findings observed during the examination are included in the body of the report as well as collected in the comments, findings, and recommendations sections.

This examination report, relating to RHEA claims for the period of January 1, 2019, to December 31, 2020, may be forwarded to the division's enforcement unit for enforcement consideration while the insurer responds to the corrective actions identified in the examination report.

SCOPE OF EXAMINATION

A targeted market conduct examination of Kaiser Foundation Health Plan of the Northwest (the insurer) was completed pursuant to Oregon Revised Statutes (ORS) 731.300 and in accordance with the procedures and guidelines as established by the Oregon Division of Financial Regulation (DFR). The examination protocols generally follow the market regulation handbook as adopted by the National Association of Insurance Commissioners (NAIC) to the extent that it is consistent with Oregon laws. The focus of the examination was to determine if the insurer was in compliance with both federal and state law requiring proper cost sharing in health claims. The time period for review purposes covered dates of service between January 1, 2019, and December 31, 2020. Representatives from the firm of INS Regulatory Insurance Services, Inc. (INS) were engaged to administer the examination.

The insurer provides health insurance in Oregon. It is part of Kaiser Permanente, a national health care group that provides a range of services including insurance and provider services. The insurer writes lines of business subject to the scope of this examination including individual health benefit plans, small group health benefit plans and large group plans.

This targeted market conduct examination evaluated the insurer's compliance with the Oregon Insurance Code within the statutes and Oregon Administrative Rules (OAR) in fulfilling its contractual obligations to policyholders relating to both policyholder services and complaints and claims. In the review of policyholder services and complaints, the examination focused on the procedures for complaints to be recorded in compliance with state and federal law, specifically OAR 836-053-1080, in facilitating proper compliance with cost sharing. The scope of the claims examination specifically reviewed compliance by the insurer for proper cost sharing for all claims including not imposing cost-sharing on preventive services, as defined by the U.S. Department of Health and Human Services (HHS) and the U.S. Health Resources and Services Administration (HRSA) and for reproductive health and related preventive services required under Section 2 of the Oregon Reproductive Health Equity Act enacted in Oregon House Bill 3391 (2017) and codified at ORS 743A.067.

The examination was remotely conducted in two phases. Phase I of the examination focused on review of the insurer's administrative functions and operations and provided the examination team a chance to become familiar with its operation. In Phase II, the examination team focused on the insurer's procedures and practices as it relates to administration of benefits required under RHEA. The insurer provided read-only access for the claims and complaints systems as well as a "virtual walkthrough" of files using computer screen sharing and video conferencing. During these phases, the following procedures were performed:

1. The insurer responded to initial and subsequent interrogatories, inquiries, and possible findings.
2. The insurer provided documents.
3. The insurer provided defined universes of files as requested.
4. The examiners selected random samples of files from those universes and reviewed those files for compliance.

FINDINGS AND OBSERVATIONS – CLAIMS

Finding 1: Noncompliance with ORS 743A.067 relating to the processing of claims

a. Interrogatory analysis and observations

The insurer was asked various questions about its claim functions. Examples of inquiry included description of the claims department, workflow charts, description of computer systems used, sample documents such as the explanation of benefits (EOB), walk through of the claims submission process and other information and documents.

No errors were noted in this review.

b. Data analysis and observations

The examiners requested claims that had been paid or denied (both RHEA-related claims and all claims) during the examination period to include claims from individual health benefit plans, small group health benefit plans and large group, associations, trusts, MEWAs, and others. The scope of the claims examination specifically reviewed compliance by the insurer for proper cost sharing for all claims including the insurer not imposing cost-sharing on preventive services, as defined by the U.S. Department of Health and Human Services (HHS) and the U.S. Health Resources and Services Administration (HRSA) and for reproductive health and related preventive services required under Section 2 of RHEA.

Paid RHEA-related claims

The insurer provided a listing of 647,401 paid RHEA-related claims for the examination period. A random sample of 109 paid RHEA related claims was requested, received, and reviewed by the examiners in accordance with the NAIC Market Regulation Handbook Sampling Guidelines. In reviewing the original 109 claim sample, it was determined that 13 of the claims were not RHEA related. The misidentification of claims being RHEA-related claims when they were not resulted from the insurer engaging in inadequate medical management. The claims that were not RHEA related were replaced by randomly selected sample files.

In two instances out of 109 paid RHEA related claim files reviewed, for an error percentage of 1.8 percent, the insurer failed to adopt and implement reasonable standards for the prompt investigation of claims by improperly applying cost share in the adjustment and payment of the claims. This is in violation of RHEA.

Sample size	# Errors	% Errors
109	2	1.8%

In two instances out of 109 paid RHEA related claim files reviewed, for an error percentage of 1.8 percent, the insurer failed to promptly, timely and conveniently make available information to readily ascertain treatment of policyholders by not providing requested file information. This is in violation of ORS 731.296, 731.308, 733.170, and OAR 836-080-0188.

Denied RHEA-related claims

The insurer provided a listing of 15,748 denied RHEA related claims for the examination period. A random sample of 109 denied RHEA related claims was requested, received, and reviewed by the examiners in accordance with the NAIC Market Regulation Handbook sampling guidelines. In reviewing the original 109 claim sample, it was determined that nine of the claims were not RHEA related. The misidentification of claims being RHEA-related claims when they were not resulted from the insurer engaging in inadequate medical management. The claims that were not RHEA related were replaced by randomly selected sample files.

In five instances out of 109 denied RHEA related claim files reviewed, for an error percentage of 4.6 percent, the insurer failed to adopt and implement reasonable standards for the prompt investigation of claims by improperly applying cost share in the adjustment and payment of the claims. This is in violation of RHEA.

Sample size	# Errors	% Errors
109	5	4.6%

All Paid Claims

The insurer provided a listing of 11,136,240 paid claims which included both RHEA-related claims and non-RHEA-related claims for the examination period. A random sample of 109 all paid claims was requested, received, and reviewed by the examiners in accordance with the NAIC Market Regulation Handbook Sampling Guidelines.

In one instance out of 109 all paid claim files reviewed, for an error percentage of 0.9 percent, the insurer failed to adopt and implement reasonable standards for the prompt investigation of claims by improperly applying cost share in the initial adjustment and payment. This is in violation of RHEA.

Sample size	# Errors	% Errors
109	1	0.9%

c. "Virtual onsite" observations

The examiners provide the following observations regarding the review of claim processes of the insurer.

1. The insurer failed to provide RHEA related specific universes of claims when requested for both paid RHEA-related claims (11.9 percent error rate in sample) and denied RHEA-related claims (8.2 percent error rate in sample). The misidentification of claims being RHEA-related claims when they were not resulted from the insurer engaging in inadequate medical management. The claims that were not RHEA related were required to be replaced for the review.

2. Systemic errors for improper cost share were identified in two claims (Sample 34 in paid RHEA-related claims for contraceptive pharmacy claim and Sample 102 in denied RHEA related claims for mammogram).

3. In the 109 sample sizes for both paid RHEA-related claims and all paid claim files, the examiners reviewed 25 pharmacy claims in the paid RHEA claims and 43 pharmacy claims in the all claims paid. All these claims were from insurer owned pharmacies except for two paid RHEA-related claims and one all paid claims. All three of these claims have resulted in the insurer being delayed in furnishing claims information including date paid and evidence of payment.

FINDINGS AND OBSERVATIONS – POLICYHOLDER SERVICES AND COMPLAINTS

a. Interrogatory analysis and observations

OAR 836-053-1060 follows the NAIC definition of a complaint as an "expression of dissatisfaction." The insurer generally defines a grievance as a complaint as outlined in ORS 743B.001(7) and sets forth a process to handle grievances, as well as appeals. However, there is no complaint or grievance process specific for RHEA related matters.

Different processes were documented, and types of reports were provided to examiners. These reports related to various matters such as trends, complaints compared to lines of business and department comparisons. However, none of these reports showed a specific breakout for RHEA-related claims.

Finding 2: Failure to resolve complaints and maintain records as required by ORS 733.170 and OAR 836-053-1080 – The insurer has failed to maintain its records in such manner that the director may readily ascertain whether the insurer has given proper treatment to policyholders and has complied with the Insurance Code by not providing the examiners with evidence that the various controls over the complaint, appeals or grievance processes monitor and ensure compliance with RHEA. The insurer was unable to readily separate complaints, appeals, or grievances in its systems relating to RHEA without manual intervention.

As part of data analysis and observations of the examination, the examiners requested complaint files. If requested, the insurer stated that it would not be able to separate RHEA complaints from others without manual intervention.

b. Data analysis and observations

The examiners requested complaints that had been closed or received during the examination period. The review evaluated the insurer's policies and procedures for compliance with Oregon statutes and rules, specifically RHEA and OAR 836-053-1080.

The insurer identified a universe of 17,827 complaints that had been closed or received during the examination period. A random sample of 116 complaints was selected. This sample was requested, received, and reviewed by the examiners. One of the complaints involved a claim that was subject to RHEA, or 0.9 percent of the sample. In four instances out of 116 files reviewed, for an error percentage of 3.4 percent, the insurer failed to properly facilitate the examination and make available requested and accurate information. This is in violation of ORS 731.296, 731.308, 733.170 and OAR 836-080-0188.

In two instances out of 116 files reviewed for an error percentage of 1.7 percent, the insurer failed to properly resolve complaints that would result in inaccurate reporting of grievances.

c. "Virtual onsite" observations

The examiners provide the following observations regarding the review of policyholder services and complaints processes of the insurer:

1. The insurer did not provide the examiners with evidence that the various controls over the complaint, appeal or grievance processes such as reports are used to monitor and ensure compliance with RHEA.
2. The insurer would not be able to separate, in its systems, the complaints, appeals or grievances relating to RHEA without manual intervention.
3. In 3.4 percent of the complaints, the insurer provided inaccurate data information to the examiners.
4. In 1.7 percent of the complaints, the insurer failed to properly resolve the complaints.

RECOMMENDATIONS

Claims

As a result of the examiners' observations, it is recommended that the insurer should ensure that the following claim processes and procedures are implemented:

1. The insurer identify all pertinent CPT codes for services, drugs, devices, products, and procedures listed in ORS 743A.067, and where applicable diagnosis codes required to properly adjudicate RHEA claims. The insurer should also consider that the purpose of ORS 743A.067 is to improve access the services identified in statute and limit medical management of those services to ensure access consistent with the purpose.

2. The insurer review its claims adjudication system and make all necessary adjustments to assure that claims are adjudicated in accordance with Oregon insurance law, including but not limited to, ORS 743A.067.
3. The insurer submit accurate, timely, and complete information to claim inquiries by the director of the Department of Consumer and Business Services or their delegate.
4. The insurer provide education for personnel to be trained in all RHEA requirements for proper non-cost sharing requirements and payments for RHEA related services.
5. The insurer provide a report to DFR of claims that are readjusted due to systemic findings that were discovered in this examination.
6. The insurer provide necessary mechanisms to obtain claim information relating to pharmacies that are not insurer owned.

Policyholder service and complaints

As a result of the examiners' observations, it is recommended that the insurer should ensure that the following processes and procedures are implemented:

1. The insurer provide proper monitoring of the complaint and grievance systems for trend analysis and proper compliance including the following:
    a) All complaints related to RHEA are identified.
    b) Proper controls over the complaint and grievance processes to track benefit compliance.
2. The insurer provide education for personnel to be trained in all RHEA requirements for proper non-cost sharing requirements and payments for RHEA-related services.
3. Underlying claims are properly resolved in the complaint and grievance process for proper treatment of consumers and accurate reporting to the director.
4. The insurer submit accurate, timely, and complete information is provided to claim inquiries by the director of the Department of Consumer and Business Services or their delegate.
5. The insurer adheres to its complaint and grievance process to timely resolve complaints within 30 calendar days.
6. The complaint and grievance processes include timely written resolution letters and closing communications.

This report is respectfully submitted to the Oregon Department of Consumer and Business Services, Division of Financial Regulation. The courtesy and cooperation of the officers and employees of the insurer during the examination are gratefully acknowledged.

APPENDIX

Table 1: Overview of examination sampling

Universe	Sample	Examiner comments
Complaints		
17,827	116	None
Paid RHEA-related claims		
647,401	109	13 of 109 sample files not RHEA related that required replacement files
Denied RHEA-related claims		
15,748	109	9 of 109 sample files not RHEA related that required replacement files.
All paid claims		
11,136,240	109	None
All denied claims		
401,247	109	None

Table 2: diagnosis and CPT codes with inappropriate cost sharing

Population: paid or denied	Examination review item (sample)	Diagnosis code	CPT/ HCPCS code	Finding
Paid	34	unav.	unav.	Improper cost share
Paid	84	Z12.4	99213	Improper cost share
Denied	26	Z11.3	87389	Improper cost share
Denied	27	Z01.419	99203	Improper cost share
Denied	85	Z3A.39	G0463	Improper cost share
Denied	102	Z12.31	77067	Improper cost share
Denied	105	Z11.3	86695	Improper cost share
Paid All	26	N39.0	81001	Improper cost share