STATE OF OREGON

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

DIVISION OF FINANCIAL REGULATION

MARKET CONDUCT EXAMINATION REPORT

OF

KAISER FOUNDATION HEALTHPLAN OF THE NORTHWEST
DBA KAISER PERMANENTE
PORTLAND, OREGON

NAIC COMPANY CODE 95540

AS OF

April 24, 2018

Salutation

June 21, 2018

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

Dear Director:

In accordance with the Director's instructions and the guidelines in the National Association of Insurance Commissioners (NAIC) Examiners Handbook we have completed a targeted market conduct examination of

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST
DBA KAISER PERMANENTE
500 NE Multnomah Street, Suite 100
Portland, OR 97232

NAIC Company Code 95540

hereinafter referred to as the "Company". The targeted market conduct examination was conducted pursuant to ORS § 731.300, which authorizes the Insurance Director to examine health insurance companies. The examination was conducted onsite at the Company's location, 500 NE Multnomah Street, Portland, Oregon 97232.

The following report of the results of the examination is respectfully submitted.

Examiner in Charge:
John Hardiman CLU, ChFC, AIE, MCM

Examiners:
Scott D. Martin MBA, PIR, AIE, MCM
Colette Hittner D.C.

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COMPANY PROFILE

The plan was incorporated May 1, 1942 as Kaiser Foundation Health Plan of Oregon, a non-profit corporation in the State of Washington. On October 19, 1981, it domesticated in Oregon under the provisions of Oregon Revised Statutes (ORS) Chapter 65. On December 30, 1981, it received its Certificate of Authority and became authorized to transact insurance as a health care service contractor in Oregon and Washington. Kaiser Foundation Health Plan of the Northwest (Company) is a subsidiary of Kaiser Foundation Health Plan, Inc. (KFHP) and is affiliated with Kaiser Foundation Hospitals. Kaiser Foundation Health Plan is a non-profit charitable corporation and is generally exempted from federal and state income taxes. The Company contracts with hospitals, Northwest Permanente, P.C. and Permanente Dental Associates (Medical Groups) to provide or arrange hospital, medical and dental services for its members. Kaiser Foundation Health Plan offers traditional copayment plans covering medical and pharmacy claims expenses.

EXECUTIVE SUMMARY

The focus of this targeted market conduct examination includes but was not limited to company Operations and Management, Quality Assessment and Improvement, Claims, Grievance Procedures, Utilization Review, Network Adequacy, Affordable Care Act (ACA), the Federal Mental Health Addiction and Equity Act (MHPAEA) and Oregon Mental Health Parity Statutes.

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

This report is intended to provide a summary of the findings discovered during this targeted examination. The examination team experienced some challenges in obtaining requested sample populations and multiple requests were made to get samples resulting in delays. The onsite portion of the examination commenced on September 6, 2017. It was discovered on January 17, 2018, that full access to Mental Health/Behavioral Health records had not been granted as requested. Some samples needed to be reviewed again or were reviewed without the Mental Health/Behavioral Health information. The challenges observed in obtaining sample populations and access to records did not alter the findings in this report.

Findings observed during the examination included:

- Failing to answer providers requests for prior authorization of non-emergency services within two days;
- Listing administrative staff in the provider directory;
- Failing to provide medically necessary Speech Therapy (ST) benefits to members within a reasonable time frame;
- Misrepresenting the Company's provider network;
- Using letters directing members to "preferred providers" for Applied Behavior Analysis (ABA) services when the Company had no participating providers in-network;
- Denying medically necessary benefits when a member selects non-participating providers whom the Company had not recognized as "preferred providers";
- Misrepresenting the Company's network and evidence of coverage (EOC) in denial letters for ABA services; and
- Providing inconsistent access to providers for medically necessary ABA services.

SCOPE OF THE EXAMINATION

A targeted market conduct examination of the Company was completed. The time period for review purposes covered January 1, 2016 to December 31, 2016 pursuant to ORS 731.300 and in accordance with the procedures and guidelines as established by the Division of Financial Regulation (DFR). The examination protocols used 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 Laws. The purpose of the targeted market conduct examination was to evaluate the Company's compliance with the Oregon Insurance Code and Administrative Rules in fulfilling its contractual obligations to policyholders. The scope of the examination includes a review of the Company's Operations and Management practices, Quality Assessment and Improvement, Claims, Grievance Procedures, Utilization Review, Network Adequacy, and compliance with the Mental Health Parity and Addictions Equity Act (MHPAEA) and Oregon Mental Health Parity.

In order to determine the practices and procedures of the Company, one or more of the following procedures were performed:

1. A random sample of files was selected from defined populations and reviewed.
2. Medical records and communications from the member, Company and providers were reviewed.
3. Medical policies, procedures manuals and/or memorandums were evaluated.
4. The Company responded to a series of inquiries regarding each area examined.

FINDINGS

Prior Authorizations

NAIC Standard 1: The health carrier establishes and maintains a utilization review program in compliance with applicable statutes, rules and regulations.

ORS 743B.423(2)(d) states, a provider request for prior authorization of nonemergency service must be answered within two business days, and qualified health care personnel must be available for same-day telephone responses to inquiries concerning certification of continued length of stay.

The Company's Utilization Review Policy for Oregon pre-service authorizations requires decision and notification within two (2) business days from the receipt of request. An exception was noted by the examiners for the sample population of children 17 and under, with a diagnosis of Autism Spectrum Disorder (ASD). The dates of authorization requests from providers were not being recorded on the date the request was received by the Company and decisions were not consistently made in the two day time limit. The examination team reviewed a random sample of 110 provider prior authorization requests for ABA services and noted 46 confirmed violations of ORS 743B.423(2)(d).

Recommendation: The Company makes changes to ensure recording of all provider requests on the day that the prior authorization request is received. All providers must be notified within two business days when requesting prior authorization.

Provider Directory

NAIC Standard 8: The health carrier provides at enrollment a provider directory that lists all providers who participate in its network. It also makes available, on a timely and reasonable basis, updates to its directory.

ORS 743B.250(1)(e) states, "A list of network providers and how the enrollee can obtain current information about the availability of providers and how to access and schedule services with providers, including clinic and hospital networks. The list must be available online and upon request in printed format."

The Company's online provider directory does not accurately reflect in-network providers available to members for scheduling medical services. The provider directory made available to enrolled members includes the Company's staff licensed as medical providers but working in an administrative capacity

only. In response to an inquiry, the Company provided to the examiners that, "There are some internal providers that function in an administrative capacity only or are not actively treating patients (e.g. Pathologists). All internal providers are listed in the provider directory. We are currently working on developing a process to remove providers who only function in an administrative capacity."

Recommendation: Remove all administrative staff from the directory. Make monthly updates to this directory to properly reflect participating providers available to enrolled members.

Network Adequacy *(Speech Therapy and Applied Behavior Analysis)*

NAIC Standard 1: The health carrier demonstrates, using reasonable criteria that it maintains a network that is sufficient in number and types of providers to ensure that all services to covered persons will be accessible without unreasonable delay.

The Company advised the examiners that network adequacy analysis was based on the Company's policy and procedure for National Committee for Quality Assurance (NCQA) reporting for the examination period of 2016. The Company's definition of unreasonable delay is based on a policy and procedure for NCQA reporting. For Primary Care providers, the Company's definition of unreasonable delay regarding member access to care is over 30 calendar days for preventive non-symptomatic appointments, and over 48 hours for urgent appointments. For Specialty Care providers, the Company's definition of unreasonable delay regarding member access to care for routine, non-urgent symptomatic care appointments is over 14 calendar days. For Mental Health/Substance Use Disorder providers, the Company's definition of unreasonable delay regarding member access to care is over 14 calendar days for routine appointments and over 48 hours for urgent appointments.

Speech Therapy

In the sample population of children with Pervasive Development Disorder (PDD) who required prior authorization for medically necessary ST, the examination team observed documentation in the member files indicating they were not able to obtain appointments in a reasonable time of 30 days. In the random

sample of ST utilization review population of children with a PDD diagnosis, 24 of 50 reviewed authorization requests contained documentation indicating unreasonable delay for in-network ST benefits.

Recommendation: The Company needs to increase their network panel for ST services. If they are unable to provide the medically necessary services using participating providers the evidence of coverage for commercial plans requires that they provide an authorization for an external or non-participating provider. The Market Analysis unit within the DFR will investigate this issue to quantify the length and duration of wait times as well as identification of the number of members who were entitled to ST benefits but were unable to receive these benefits or paid out of pocket due to extensive wait times.

Applied Behavior Analysis

In order for members to receive benefits, they must receive services determined to be medically necessary from participating providers and facilities unless otherwise specified in the contract. The EOC does not require the use of a "preferred provider" nor are "preferred providers" defined in the EOC.

The following definitions were from the Company's 2016 EOC:

"Participating Provider (a) A person regulated under state law to practice health or health-related services or otherwise practicing health care services consistent with state law; or (b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment either of whom, under a contract directly or indirectly with Company, has agreed to provide covered Services to Members with an expectation of receiving payment, other than Deductible, Copayment, or Coinsurance, from Company rather than from the member."

"Non-Participating Provider. Any Non-Participating Physician or any other person who is not a Participating Provider and who is regulated under state law to practice health or health-related services or otherwise practicing health care services consistent with state law."

"Participating Physician. Any licensed physician who is an employee of the Medical Group, or any licensed physician who, under a contract directly or indirectly with Company, has agreed to provide covered Services to Members with an expectation of receiving payment, other than Deductible, Copayment, or Coinsurance, from Company rather than from the Member."

"Non-Participating Physician. Any licensed physician who is not a Participating Physician."

The company reported to the examiners that they do not have any providers in their network that provide ABA services that meet their definition of a “Participating Provider”. After a diagnosis of Autism Spectrum Disorder (ASD), some children were approved and received a referral for external medically necessary ABA services. The Company sent a letter directing them to contact a “preferred provider” listed in the letter. The letter directed the member to get on as many wait lists with these “preferred providers” as possible due to the limited capacity to provide ABA services. Members were instructed to contact the Company when they found a “preferred provider” who had an opening to provide ABA services and have them submit a request for prior authorization.

The Company acknowledged in a response to the examiner’s inquiries that none of the “preferred providers” listed in their letters were “participating providers” or “in-network providers”.
The Company communicated to the examination team that there were 274 unique individuals with an ASD diagnosis, who received medically necessary ABA services in 2016; 212 of these were sent a letter by the Company directing them to a limited number of “preferred providers”.

The Company provided ABA services with providers not on their “preferred provider” lists for at least 16 members and denied at least two other members for not using “preferred providers”. The two denial letters identified by the Company were submitted to the examiners. The denials resulted from individuals requesting ABA services from providers who were not on the list of “preferred providers”. These denial letters made reference to the language of the EOC and a network of the Company approved and preferred in-network ABA programs. Language from one of the denial letters states “the requested services are available via the network of preferred Kaiser Permanente preferred Applied Behavioral Analysis (ABA) programs. Please follow up with the Developmental Pediatric Department regarding the list of preferred ABA network providers that were previously provided to you. Our physician believes our internal specialists have the skills and experience to address the patient’s needs. As stated in your Evidence of Coverage (your member contract) referrals to providers outside of Kaiser Permanente are approved when services are medically necessary and are not available at Kaiser Permanente”. The

second denial letter used similar language, stating "The requested service is available via the network of Kaiser Permanente approved and preferred Applied Behavioral Analysis (ABA) programs." This statement was also followed by references to EOC requirements for referrals to providers outside of Kaiser Permanente.

The medically necessary benefits were not applied consistently. Any non-participating provider should have been an eligible provider if they were properly licensed to deliver ABA services since the Company did not have any in-network participating providers.

The examiners identified one individual in the sample who was unable to obtain ABA services from a provider who was removed from the "preferred providers" list in 2016. The ABA provider requested had immediate availability and familiarity with the member. This member was denied ABA benefits for 14 months and paid out of pocket while the member's sibling received ABA benefits from the same provider, under the same health plan. The members' parents filed a complaint with the DFR. The Company responded to the DFR complaint that ABA services were available from their ABA network program providers.

Recommendation: The Company should immediately cease using a letter directing members to a limited number of determined "preferred providers" when the EOC allows for authorization of services from non-participating providers. Any letter sent to members for ABA services should instruct them they do not have any participating providers who can deliver ABA services and that they should seek a licensed provider of their choice. Once a member's choice has been made they will work with them to authorize their benefits with the appropriate deductible and co-payments.

The findings disclosed in this report will be referred to the Market Analysis unit of the DFR for further investigation and quantification of consumer harm, any violations of the Oregon Insurance Code will be pursued.