Department of Consumer
and Business Services

STATE OF OREGON

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

DIVISION OF FINANCIAL REGULATION

MARKET CONDUCT EXAMINATION

REPRODUCTIVE HEALTH EQUITY ACT

OF

HEALTH NET HEALTH PLAN OF OREGON, INC.

AS OF

DECEMBER 31, 2020

NAIC COMPANY CODE: 12257

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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:

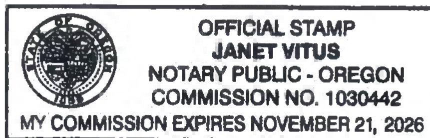
This market conduct examination report of HEALTH NET HEALTH PLAN OF OREGON, INC. (insurer) was prepared by independent examiners contracting with the Oregon Division of Financial Regulation (division). A market conduct examination is conducted for the purpose of examining certain business practices of 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
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's 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 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. It is noted that the examination team experienced some challenges in obtaining requested sample populations and multiple requests were made to get samples resulting in delays and additional findings.

- **Noncompliance with ORS 743A.067 relating to the processing of claims** – The insurer failed to adopt and implement reasonable standards for the prompt investigation of claims by improperly applying cost share such as copays, coinsurance, and deductible in the adjustment and payment of the claims. This occurred in multiple instances for paid and denied medical and pharmacy claims.

- **Failure to resolve complaints and maintain records as required by ORS 733.170 and OAR 836-053-1080** – The insurer failed to demonstrate that it adequately resolved complaints in some instances. 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. The insurer failed to maintain 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 (a) not having a mechanism for the reporting of complaints relating to inquiries on covered benefits including RHEA, and (b) by not providing the examiners with evidence that the various controls over the complaint, appeals or grievance processes that monitor and ensure compliance with RHEA.

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 Health Net Health Plan of Oregon, Inc. (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 was initially incorporated as a nonprofit corporation on June 1, 1989. Through various corporate restructuring, it is now a subsidiary of Health Net, LLC and held under the umbrella of a Fortune 500 health services company, Centene Corporation. The company writes lines of business subject to the scope of this examination including individual health benefit plans, small and large group health benefit plans, associations, trusts, MEWAs, and others.

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 company 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 (hereinafter also known as RHEA) 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 walk through" 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

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.

During the examination the insurer failed to provide accurate information. The company failed to conveniently make available information to readily ascertain treatment of policyholders by not providing accurate data and files to the examiners as required under ORS 731.296, 731.308, 733.170, and OAR 836-080-0188.

Examples include incorrectly identifying RHEA claims and payment dates. The misidentification of claims being RHEA-related claims when they were not, which resulted from the company engaging in inadequate medical management. The claims that were not RHEA-related were replaced by randomly selected sample files.

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

Paid RHEA related claims

The company provided a listing of 43,252 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 28 of the claims were not RHEA related.[1] The claims that were not RHEA related were replaced by randomly selected sample files.

In 22 instances out of 109 paid RHEA-related claim files reviewed, for an error percentage of 20.2 percent, or 22 instances out of the 22 pharmacy claims for an error percentage of 100 percent, the company failed to promptly, timely, and conveniently make available information to readily ascertain treatment of policyholders by not providing data responsive to the examiners' requests. This is in violation of ORS 731.296, 731.308, 733.170, and OAR 836-0800188.

In eight instances out of 109 paid RHEA-related claim files reviewed, for an error percentage of 7.3 percent, the company 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. The application of cost share does not comply with RHEA.

Sample size	# Errors	% Errors
109	8	7.3%

In 23 instances out of 109 paid RHEA related claim files reviewed, for an error percentage of 21.1 percent, the company failed to timely pay the proper amount. This is in violation of ORS 746.230 and OAR 836-080-0235 and RHEA.

Denied RHEA-related claims

The company provided a listing of 7,950 denied RHEA related claims for the examination period. A random sample of 108 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 25 of the claims were not

[1] More information on the sampling errors are found in Appendix B.

RHEA related. The misidentification of claims being RHEA-related claims when they were not resulted from the company engaging in inadequate medical management. The claims that were not RHEA-related were replaced by randomly selected sample files.

In 25 instances out of 108 denied RHEA related claim files reviewed, for an error percentage of 23.1 percent, the company failed to make available information to readily ascertain treatment of policyholders by not providing accurate files to the examiners.

In eight instances out of 108 denied RHEA related claim files reviewed, for an error percentage of 7.4 percent, the company 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 ORS 746.230(c) and RHEA.

Sample size	# Errors	% Errors
108	8	7.4%

In eight instances out of 108 denied RHEA related claim files reviewed, for an error percentage of 7.4 percent, the company failed to timely pay the proper amount. This is in violation of ORS 746.230 and OAR 836-080-0235.

All paid claims
The company provided a listing of 489,956 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 six instances out of 109 all paid claims reviewed, for an error percentage of 5.5 percent, or six instances out of the 67 pharmacy claims for an error percentage of 8.9 percent, the company failed to make available information to readily ascertain treatment of policyholders by not providing accurate data to the examiners.

A total of 67 all paid claim files of the 108 files in the sample were pharmacy claims. On review of these claim files, it was revealed that the company provided the incorrect listing for claim paid date in response to data requests in six of the files.

In two instances out of 109 all paid claim files reviewed, for an error percentage of 1.8 percent, the company 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 ORS 746.230(c) and RHEA.

Sample size	# Errors	% Errors
109	2	1.8%

All denied claims
The company provided a listing of 151,898 denied claims which included both RHEA-related claims and non-RHEA-related claims for the examination period. A random sample of 109 all denied claims was requested, received, and reviewed by the examiners in accordance with the NAIC Market Regulation Handbook sampling guidelines.

In two instances out of 109 files of all denied claims reviewed, for an error percentage of 1.8 percent, the company failed to adopt and implement reasonable standards for the prompt investigation of claims by improperly applying a cost share. This is in violation of ORS 746.230 and non-cost sharing for services as required under RHEA.

Sample size	# Errors	% Errors
109	2	1.8%

c. "Virtual onsite" observations
The examiners provide the following observations regarding the review of claim processes of the company:

1. In paid RHEA-related claims, the insurer was found to have violated the non-cost share provisions with a 7.3 percent error rate. It is also noted that both cost share exceptions in the all paid claims sample and one of two of the exceptions in the denied all claims sample were RHEA-related claims.
2. In paid RHEA-related claims, the insurer was found to have violated the prompt pay provisions with a 21.1 percent error rate.
3. In denied RHEA-related claims, the insurer was found to have violated the non-cost share provisions with a 7.4 percent error rate.
4. In denied RHEA-related claims, the insurer was found to have violated the prompt pay provisions with a 7.4 percent error rate.
5. The insurer failed to provide RHEA-related specific universes of claims when requested for both paid (25.6 percent error rate in sample) and denied claims (23.1 percent error rate in sample). The misidentification of claims being RHEA-related claims when they

were not resulted from the company engaging in inadequate medical management. The claims that were not RHEA related were required to be replaced for the review.

6. In the paid RHEA-related claim files reviewed, the insurer failed to provide the correct data for the claims paid date for all 22 pharmacy claims within the sample. In the all paid claims data, the company failed to furnish the correct claims paid date in six of the 67 pharmacy claims in the sample.
7. It is standard practice for a claim to be delayed or denied for persons 65 years of age to determine Medicare coverage. RHEA provides payment without cost sharing, restrictions, or delays (RHEA Section 2(3) and 2(4)).

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 in compliance as outlined in ORS 743B.001(7) and sets forth a process to handle grievances. Complaints are also handled as appeals. However, the insurer makes a distinction between complaints on covered benefits as the insurer considers a coverage inquiry as a written or verbal request for information or clarification about any subject matter related to the enrollee's health benefit plan. All coverage benefit inquiries are documented in computer systems and attached to the individual's account. Telephone calls are recorded and stored in a call recording software program. The insurer did not provide information or examples for reports or summaries related to coverage inquiries.

Different procedure documents were provided to examiners. A quality improvement committee receives compliance reports quarterly and a monthly report is generated. These reports monitor regulatory timeframes, as well as provide insurer timeframe goals and summarizes information by different product offerings. The reports are broken out by medical appeals, pharmacy, grievances, and complaints. However, none of these reports or summaries contain information that identify RHEA related complaints.

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 (a) not having a mechanism for the reporting of complaints relating to inquiries on covered benefits including RHEA, and (b) by not providing the examiners with sufficient evidence that the various controls over the complaint, appeals or grievance processes that monitor and ensure compliance with RHEA.

Finally, as part of data analyses and observations of the examination, the examiners requested complaint files. The company was not able to provide a separate listing of complaints related to RHEA.

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 92 complaints that had been closed or received during the examination period. A random sample of 79 complaints was selected. This sample was requested, received, and reviewed by the examiners. Five of the complaints involved claims that were subject to RHEA, or 6.3 percent of the sample.

Finding 2: Failure to resolve complaints and maintain records as required by ORS 733.170 and OAR 836-053-1080 – In two instances out of 79 files reviewed for an error percentage of 2.5 percent, the company failed to adopt and implement reasonable standards for the prompt investigation of claims in not resolving improper cost sharing for the purposes of RHEA within the complaints process. This is in violation of ORS 746.230(c), OAR 836-053-1080, and RHEA.

In two instances out of 79 files reviewed, for an error percentage of 2.5 percent, the company failed to properly facilitate the examination and make available requested and accurate information.

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 sufficient evidence that it has adequate processes in place for reporting complaints, appeals, or grievances relating to covered benefit inquiries.
2. The insurer did not provide the examiners with sufficient evidence that the various controls over the complaint, appeal, or grievance processes such as reports are used to monitor and ensure compliance with RHEA.
3. The insurer was not able to separate, in its systems, the complaints, appeals, or grievances relating to RHEA.
4. The insurer instituted a system claim review after systemic failures in handling RHEA-related claims were identified after the Reproductive Health Equity Act Data Call, dated June 18, 2020, was made by the Oregon Department of Consumer and Business Services.
5. The insurer did not provide sufficient evidence that personnel involved with complaints, appeals, and grievances are aware of the requirements related to RHEA.
6. In 2.5 percent of the complaints, the insurer provided inaccurate information to the examiners.

RECOMMENDATIONS

Claims

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

1. The insurer review its policies and procedures to assure that all claims are adjudicated in accordance with Oregon insurance law, including but not limited to, ORS 743A.067.
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 is provided to claim inquiries by the director of the Department of Consumer and Business Services or their delegate.
4. Insurer personnel be trained in all RHEA requirements for proper non-cost sharing requirements and payments for RHEA-related services without other restrictions or delays.
5. The company provide a report to DFR of claims that are readjusted due to systemic findings that were discovered in this examination.

Policyholder service and complaints

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

1. The insurer provides proper monitoring of the complaint, appeal 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, appeals, or grievance processes to track RHEA compliance.
    c) Process put in place generally, and specifically related to RHEA, to identify complaints related to coverage benefit inquiries.

2. Insurer personnel are properly trained and knowledgeable in RHEA requirements.
3. Underlying claims are properly resolved in the complaint, appeal, or 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.

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		
92	79	None
Paid RHEA-related claims		
43,252	109	28 sample files not RHEA related that required replacement files
Denied RHEA-related claims		
7,950	108	25 sample files not RHEA related that required replacement files
All paid claims		
489,956	109	None
All denied claims		
151,898	109	None

Table 2: Summary of claim sample errors with diagnosis and CPT codes.

Population: Paid or Denied	Examination Review Item (Sample)	Diagnosis Code	CPT Code	Finding
Paid	8	R079	85025	Improper cost share
Paid	13	Z30430	58300	Improper cost share
Paid	R20	Z331	84702	Improper cost share
Paid	28	O039	84702	Improper cost share
Paid	30	Z124	87624	Improper cost share
Paid	35	A549	96372	Improper cost share
Paid	39	R350	87088	Improper cost share
Paid	R54	Z124	88175	Improper cost share
Paid	3	Z130	85018	Improper cost share
Paid	4	R1013	85025	Improper cost share
Paid	12	L709	81025	Improper cost share
Paid	16	N939	81025	Improper cost share
Paid	R29	Z01419	87624	Improper cost share

Table 2 continued: Summary of claim sample errors with diagnosis and CPT codes.

Population: Paid or Denied	Examination Review Item (Sample)	Diagnosis Code	CPT Code	Finding
Paid	31	R42	83036	Improper cost share
Paid	32	Q208	85027	Improper cost share
Paid	33	Z124	87624	Improper cost share
Paid	47	Z148	85018	Improper cost share
Paid	49	Z3401	87491	Improper cost share
Paid	51	R300	87086	Improper cost share
Paid	R52	Z7252	87491	Improper cost share
Paid	R53	L700	81025	Improper cost share
Paid	R58	O039	84702	Improper cost share
Paid	62	R350	87086	Improper cost share
Paid	64	N401	87086	Improper cost share
Paid	69	Z113	87591	Improper cost share
Paid	72	Z01419	99395	Improper cost share
Paid	R74	Z3401	87491	Improper cost share
Paid	R75	R350	87088	Improper cost share
Paid	81	Z113	87491	Improper cost share
Paid	82	Z113	86592	Improper cost share
Paid	85	Z1231	85025	Improper cost share
Denied	16	J432	99406	Improper cost share
Denied	31	Z01419	99386	Improper cost share
Denied	44	Z124	88175	Improper cost share
Denied	45	Z803	81162	Improper cost share
Denied	R56	Z01419	88142	Improper cost share
Denied	92	Z124	88142	Improper cost share
Denied	94	Z391	E0603	Improper cost share
Denied	R17	Z113	87491	Improper cost share
Denied	R19	Z1231	77067	Improper cost share
Denied	R22	Z113	86592	Improper cost share
Denied	39	Z113	80074	Improper cost share
Denied	71	Z113	87591	Improper cost share
Denied	88	Z206	87806	Improper cost share
Denied	90	N739	87088	Improper cost share
Denied	100	Z0000	99396	Improper cost share
Denied	108	N760	87801	Improper cost share
Paid All	5	R102	76830	Improper cost share
Paid All	38	N938	99213	Improper cost share
Denied All	26	F321	99213	Improper cost share
Denied All	35	N50812	81003	Improper cost share