STATE OF OREGON

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

DIVISION OF FINANCIAL REGULATION

MARKET CONDUCT EXAMINATION

REPRODUCTIVE HEALTH EQUITY ACT

OF

MODA HEALTH PLAN INC.

AS OF

DECEMBER 31, 2020

NAIC No. 47098

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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 Moda Health Plan, 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 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 J Timothy R. Nutt CIE, AIRC, MCM.

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 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, insurer policyholder services and complaints and claims as related to the coverage and cost-sharing provisions of RHEA, other state laws, 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.

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.

The examination covered claims identified by the insurer as subject to RHEA to assess whether the insurer was in compliance with the cost sharing requirements established under RHEA for the time period under review. The examination findings indicate that the insurer's claims processing system is not paying all RHEA claims correctly.

Examiners identified instances of noncompliance with RHEA in the insurer's administration of claims. The examiners concluded that claims processing systems and procedures did not identify all claims which should have been considered under ORS 743A.067. The examination team found that the insurer's claims processing system did not accurately adjudicate all RHEA claims and applied improper cost sharing. The results of the examination and related findings are discussed in more detail in the sections below.

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** – 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 claims.

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

The Oregon Division of Financial Regulation (division) called a targeted market conduct examination of Moda Health Plan, Inc. to determine compliance with Oregon's RHEA. The examination was called pursuant to Oregon Revised Statutes (ORS) 731.308. The targeted market conduct examination of the insurer was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (NAIC) and under the authority set forth in ORS 731.300 and direction from the division.

Moda was formed in 1988 and is a provider of group medical insurance coverage to large-, mid- and small-size public and private employers in Oregon and Alaska. The company is also a provider of medical insurance to individuals in Alaska, Oregon and Texas. In addition, Moda has certificates of authority to transact insurance in Idaho, Washington, and California.

As of December 31, 2021, Oregon represents approximately 98 percent of the total insured premium written. MHP is a wholly owned subsidiary of Moda Partners, Inc. (MPI), formerly Health Services Group, Inc. and Moda, Inc. On September 24, 2021, Moda Holdings Group, Inc. (MHG) reacquired 49.5 percent ownership in MPI from Delta Dental of California and as a result wholly owns MPI. MHG is wholly owned by Oregon Dental Service (ODS). ODS was formed in 1955 by the Oregon Dental Association (ODA) as a provider of group dental plans.

This targeted market conduct examination evaluated the company'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. 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 the reproductive health and related preventive services required under Section 2 of RHEA enacted in Oregon House Bill 3391 (2017) and codified at ORS 743A.067. 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 examination covered claims and complaints with dates of service between January 1, 2019, and December 31, 2020. To determine compliance with RHEA, the following examination procedures were used:

- Issued interrogatories concerning the insurer's business practices.

- Reviewed the insurer's financial information.
- Requested data files of the following populations:
    - All paid claims for the examination period;
    - All denied claims for the examination period;
    - All paid RHEA claims (as identified by the insurer) for the examination period; and
    - All denied RHEA claims (as identified by the insurer) for the examination period.
- Performed sample testing of paid and denied RHEA claims (please note: the insurer provided remote access to accomplish the testing).
- Reviewed the insurer's complaint log.

FINDINGS AND OBSERVATIONS - CLAIMS

- **Interrogatory analysis and observations**

The insurer's medical claims department consists of a director, four managers, and 13 supervisors. Each supervisor manages a team of 10-20 processors. There are specialized processors including those employed for support, inpatient hospital, subrogation, pricing, and claim integrity.

The insurer uses a third-party claims eligibility and processing system. The insurer also has a separate system, to generate explanation of benefits (EOB) documents. A configuration department is responsible for building benefit plans, providers, and pricing into the claims processing system.

Claims are generally auto adjudicated. If there are no system errors or warning messages, a claim will complete the adjudication process automatically and without intervention. Claims that did not auto adjudicate proceed to processing work queues manual adjudication. A processor reviews the claim documents and determines next steps based on the applicable system error or warning message. At this stage, a claim may be referred to a supervisor or otherwise directed as appropriate.

To comply with changes in applicable law, a cross departmental committee reviews applicable laws and provides guidance required changes. The committee is run by the compliance/regulatory affairs department, but also includes employees from the system configuration, pharmacy, and medical claims departments.

30-day letters

When claims are expected to take longer than 30 days to process, the insurer sends the insured a claims acknowledgement letter. That letter advises the insured that their claim "will take longer than the standard 30 days to process each claim," that no action is required by the policyholder, that once the claim is processed the results will be shared in an EOB statement, and that the policyholder may check the status of that statement online at any time.

Prompt payment law
The insurer's claim system is configured to apply interest penalties based on Oregon prompt payment legislation. The insurer's system calculates how may days' interest is due and applies the appropriate percentage.

Pharmacy claims
The insurer states that its pharmacy claims are processed through a PBM vendor, MedImpact. MedImpact processes pharmacy-submitted electronic claims in real time through a custom, proprietary claims adjudication system at the point of sale. MedImpact also processes pharmacy and member-submitted paper claims.

- **Data analysis and observations**

The claims data[1] provided by the insurer indicated the following total and RHEA claims[2]:

		Paid claims	Denied claims
Individual market	All claims	781,371	73,793
	RHEA claims	45,263	3,102
Small group market	All claims	117,760	7,082
	RHEA claims	5,299	118
Large group market	All claims	2,160,495	151,193
	RHEA claims	81,197	2,463
Totals	All claims	3,059,626	232,068
	RHEA claims	131,759	5,683

The examination data analysis was performed utilizing Microsoft Excel and Audit Command Language (ACL) Analytics. Sample sizes were calculated using the NAIC handbook sampling criteria, which provides two scenarios: for populations of 50,000 and less, the Acceptance Samples Table (AST) may be used to determine sample sizes; for populations greater than 50,000, ACL may be used to generate sample sizes by utilizing a 95 percent confidence level, a 5 percent upper error limit, and 2 percent expected error rate. Using sample sizes as determined by the NAIC handbook for these total populations, our calculated sample sizes were 184 paid claims and 108 denied claims.

The examiners ensured equitable representation of the three markets (individual, small group and large group) in the samples by proportional selection based on total population. Therefore, the samples selected were as follows:

[1] All references to data are specific to the examination period (January 1, 2019 through December 31, 2020).
[2] RHEA claims as identified by the insurer.

	Paid RHEA claim samples	Denied RHEA claim samples
Individual market	63	59
Small group market	25	25
Large group market	113	47
Total	201	131

All sampling utilized for the Oregon RHEA exams was based on the Market Regulation Handbook guidance using a random selection methodology and following the acceptance sample tables and/or ACL calculations as appropriate. Note that the total sample size is larger than the NAIC recommendation. Sampling strictly based on a proportional representation would have limited our small group samples to eight paid claims and three denied claims. The examiners employed a minimum sample size of 25 for the smaller groups to ensure examination integrity.

The samples were selected from claims for services specific to RHEA only, as provided by the insurer. However, 21 paid claims and 19 denied claims were replaced with new claim samples during claims testing, as the initial sampled claims were for services other than the RHEA covered services as stated in ORS 743A.067.

- **"Virtual onsite" observations**

The Insurer's claims processing and a benefit tracker systems were made accessible to the examination team. The systems contained sufficient detail to understand the line-item diagnosis codes, CPT codes, price adjustments, and cost sharing (if any) applied.

The Insurer states that its claims adjudication system is configured to interrogate claims on a code-by-code basis. For some codes, the code itself drives to the application of zero cost share without any other requirements. For other codes, the current configuration requires the presence of specific diagnosis codes in order to apply zero cost share (an example would be preventive diagnosis codes). Regarding claims with multiple CPT codes, the system interrogates each line of the claim separately to determine if the service qualifies to apply zero cost share. The system does not automatically consider all lines of a claim as RHEA because one line qualified as such, each line must qualify independently.

FINDINGS AND OBSERVATIONS - POLICYHOLDER SERVICES AND COMPLAINTS

- **Interrogatory analysis and observations**

The insurer does not use a third-party administrator (TPA) to administer reproductive benefits. The insurer tracks risk trends through multiple channels, including through their claims system, quarterly reports, appeal audits, and quarterly reviews of trends and compliance concerns.

All written member complaints and coverage inquiries are recorded in the insurer's claims system. Written responses are sent to the member in the timeframe allotted by the plan as outlined in the member handbooks.

The insurer prepares quarterly reports to monitor trends or areas of concern. The reports focus on first level appeals filed by or on behalf of members enrolled on Oregon-based plans. Any trends, issues, or concerns noted are shared with the insurer's leadership. Additionally, an appeals quality specialist audits random cases each week to ensure accuracy, completeness, and overall quality. The results are shared with appeal coordinators. Finally, on a quarterly basis, the appeals team meets with the compliance department to review trends and discuss potential compliance concerns.

The insurer represents that "no trends related to (RHEA) have been identified" but did not assert that it tracks RHEA claims separately from other claims. The complaint policy and procedure neither states that the insurer will separately track RHEA claims nor explicitly addresses such claims.

- **Data analysis and observations, and "virtual on-site" observations**

The insurer tracks and records inquiries and complaints on covered benefits. Each quarter, a grievance and complaint report is generated for the purpose of identifying trends and areas of concern. However, the results of the examination indicate that complaints and grievances related to RHEA claims are not tracked separately. The complaint policy and procedure does not state that the insurer will separately track RHEA claims. Furthermore, a review of the quarterly reports and the supplied complaint log show no RHEA-specific complaint/grievance tracking in place.

Finding 1: Improper cost share for RHEA services required by ORS 743A.067

The specific focus of this examination was to determine the insurer's compliance with RHEA requirements. The insurer indicated that a process had been implemented to properly adjudicate RHEA claims by configuring its claims adjudication system to interrogate CPT codes specific to RHEA services. After review of the insurer's systems and sample claim files, the examination team found that the system does not accurately adjudicate all RHEA claims. Of the 201 paid samples reviewed, 49 claims had improper cost sharing under RHEA. Additionally, 22 of the 131 denied claims reviewed had improper cost sharing under RHEA[3].

All of the random sampling was done from populations which the insurer stated contained RHEA claims. As noted above, some of the sample files were replaced as the initial samples contained no RHEA services. Much like improper cost sharing, this indicates that the insurer's claims adjudication method does not properly identify claims containing RHEA services.

[3] Some claims in the denied population contained a mixture of denied and paid lines, which the insurer included in the denied population as there were elements of the claims which were denied.

Examination of the claims samples identified the inability of the insurer to consistently identify and correctly adjudicate claims subject to RHEA requirements. The Facets claims system is either not configured properly or unable to separate RHEA claims from other claims. In some instances, the insurer did not identify a CPT code for RHEA adjudication. Other claims had more complexity, usually due to a CPT code which is not explicitly a RHEA service. For example, the examiners observed claims which contained lines for venipuncture (blood sampling) which could be a RHEA covered service depending on the reason for the blood draw. Another common example was urine collection. Depending on the reason for the collection, RHEA may or may not apply. However, the CPT codes for venipuncture or urine collection were not flagged in the Facets system for proper claim adjudication and appropriate cost sharing, as these services are not always RHEA services. As a result of the Facets configuration for these CPT codes, improper cost-sharing was applied to these services.

There are conditions under RHEA requirements that will allow an insurer to impose cost sharing on the cost of the office visit but not on certain RHEA services delivered during that office visit. For example, review item 68 from the denied population has a primary diagnosis of Z3201, which is "encounter for pregnancy test, result positive." Two procedures are attached to that diagnosis code:

1. 99213: Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and a low level of medical decision making.
2. 81025: Urine pregnancy test.

Procedure code 81025 applied $8.67 to the patient's deductible. The insurer agreed that the cost sharing for code 81025 was incorrectly applied. However, the larger amount for the visit had cost sharing as well. Procedure code 99213 applied $147.29 to the patient's deductible. As currently written, RHEA covers the actual test (81025), but not the charge for the office visit (99213)[4].

Another example involved two diagnosis codes and the corresponding procedure codes:

Diagnosis code	Diagnosis	Procedure code	Procedure
N939	Abnormal uterine and vaginal bleeding, unspecified	99214	Office or other outpatient visit for the evaluation and management of an established patient
Z3202	Encounter for pregnancy test, result negative	81025	Urine pregnancy test

Procedure code 81025 applied $8.61 to the patient's deductible. The insurer agreed that the cost sharing for code 81025 was incorrectly applied. However, the larger amount for the visit had cost sharing as well. Procedure code 99214, the office visit CPT code, required a $60 copay.

Please see Appendix A for a complete list of diagnosis and CPT codes identified from the sample populations which contained cost sharing for RHEA services.

The total sample population (paid and denied) was 332 claims. In that sample, 71[5] claims (21 percent of the sample) contained RHEA services with improper cost sharing applied. As noted above, the total claims identified as RHEA by the insurer is 137,442. Based on the examination's results of the sample population, applying improper cost sharing to 21 percent of total claims during the examination period results.

Total number improper cost sharing	Total RHEA claims	Percentage of total RHEA claims with improper cost sharing
71	137,442	21%

RECOMMENDATIONS

1. The insurer review its policies and procedures to assure that all claims are adjudicated in accordance with the Oregon Insurance Code, 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 the Oregon Insurance Code, including but not limited to, ORS 743A.067.

3. 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.

The examination revealed that the insurer does not comply with all requirements of RHEA. The lack of compliance seems to stem from the automated claims adjudication systems. The claims system does not appear capable to differentiate RHEA claims from other claims. Furthermore, the complaint log does not collect any diagnosis or CPT code information. Therefore, any complaint trends related to RHEA are not apparent based on the information collected in the complaint log. The insurer will need to reevaluate its complaint and claims handling processes and procedures to ensure compliance with the requirements of RHEA.

APPENDIX

Appendix A – Definitions

Definitions:

i. The insurer defines a complaint as an oral or written expression of dissatisfaction regarding: 1) the availability, delivery, or quality of a healthcare service; 2) the claims payment, handling, or reimbursement for a healthcare service when the member is not disputing an adverse benefit determination; or 3) matters pertaining to the contractual relationship between the member and the insurer.

ii. A coverage inquiry is an inquiry for anything outside of the above definition of complaint, which would generally be a request for information or clarification about a member's health plan. The insurer tracks and records inquiries and complaints for covered benefits.

iii. An appeal is a written request to review an adverse benefit determination made by the insurer.

iv. An external review is the final adverse benefit determination review which is completed by an Independent Review Organization as assigned by the Department of Financial Regulation.

Appendix B – Diagnosis and CPT codes with improper cost sharing

Population: paid or denied	Examination review item	Diagnosis code	CPT code
Denied	10	N390	81000
Denied	10	N390	87210
Denied	10	Z3202	84703
Denied	10	N390	99214
Denied	20R	F1121	87491
Denied	20R	F1121	87591
Denied	32R	Z206	87806
Denied	32R	Z206	87491
Denied	32R	Z206	87591
Denied	33	E1122	87340
Denied	33	E1122	86706
Denied	33	E1122	86704
Denied	33	E1122	86803
Denied	52R	Z7251	87389
Denied	68	Z3201	81025

Denied	72	R310	87186
Denied	77R	T39312A	84703
Denied	78	N920	84703
Denied	79	R300	81001
Denied	79	R300	87086
Denied	79	R300	87077
Denied	81	R109	87088
Denied	81	R109	87086
Denied	82	O209	84702
Denied	84	N926	84702
Denied	87	Z3200	84702
Denied	91	O039	84702
Denied	96	L700	84703
Denied	97	N939	84703
Denied	98	Z3202	84703
Denied	99	R55	81025
Denied	100	Z3480	87389
Denied	101	Z3689	86592
Denied	117	R399	87086
Population: paid or denied	**Examination review item**	**Diagnosis code**	**CPT code**
Paid	4	Z992	86803
Paid	7	N939	81002
Paid	7	Z3202	81025
Paid	11	R102	87625
Paid	11	R102	88175
Paid	11	R102	88141
Paid	11	R102	87624
Paid	12	D259	84703
Paid	15	Z113	87340
Paid	15	Z113	86780
Paid	15	Z113	86803
Paid	19	Z3689	87081
Paid	20	R109	87338
Paid	20	R109	77067
Paid	23	R300	87086
Paid	23	R300	87077
Paid	23	R300	87186
Paid	30	N6320	77066

Paid	44	R300	87086
Paid	44	R300	87088
Paid	44	R300	87186
Paid	44	R300	87480
Paid	44	R300	87510
Paid	44	R300	87660
Paid	48	Z3480	81001
Paid	48	Z3480	85025
Paid	48	Z3480	86780
Paid	48	Z3480	82728
Paid	48	Z3480	86762
Paid	48	Z3480	87389
Paid	50	Z3049	A4267
Paid	53	R82998	87086
Paid	54	Z01419	36415
Paid	74	R300	81001
Paid	89	Z01419	87661
Paid	91	Z3201	84702
Paid	92	R1011	87491
Paid	92	R1011	87591
Paid	93	L700	81025
Population: paid or denied	**Examination review item**	**Diagnosis code**	**CPT code**
Paid	96	E782	87389
Paid	103	E785	86803
Paid	106	Z202	87491
Paid	107	R300	87077
Paid	107	R300	87086
Paid	107	R300	87186
Paid	115	Z202	87491
Paid	116	R300	87086
Paid	116	R300	87491
Paid	119	L700	81025
Paid	121	R300	87086
Paid	122	N644	77065
Paid	122	N644	76642
Paid	124	Z392	88142
Paid	124	Z392	87625
Paid	124	Z392	87624

Paid	128	N644	G0279
Paid	128	N644	77065
Paid	132	R87610	81025
Paid	136-R	Z3202	81025
Paid	144	N920	81025
Paid	148	Z3481	88142
Paid	148	Z3481	87624
Paid	153	Z79899	81025
Paid	154-R	Z3481	86592
Paid	154-R	Z3481	87389
Paid	154-R	Z3481	86803
Paid	155	Z3200	81025
Paid	162	R928	77065
Paid	169	N920	84702
Paid	170	R300	87086
Paid	172	L508	84703
Paid	179	O99810	36415
Paid	183	O26899	36415
Paid	183	O26899	84702
Paid	184	R300	87086
Paid	185	R079	86803
Paid	193	Z3202	81025
Paid	196	R300	87210
Population: paid or denied	**Examination review item**	**Diagnosis code**	**CPT code**
Paid	196	R300	87086
Paid	196	R300	87088
Paid	196	R300	87186
Paid	197	Z202	87510
Paid	197	Z202	87660
Paid	201	R399	87088