STATE OF OREGON

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

DIVISION OF FINANCIAL REGULATION

REPORT OF TARGET MARKET CONDUCT EXAMINATION

OF

PROVIDENCE HEALTH PLAN
3601 SW Murray BLVD
BEAVERTON, OREGON 97005

National Association of Insurance Commissioners (NAIC)
COMPANY CODE 95005
Providence Health Group 4788

AS OF

DECEMBER 31, 2018

April 17, 2023

Honorable Andrew Stolfi, Director
Department of Consumer and Business Services
State of Oregon
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
Portland, Oregon 97201
NAIC Company Code 95005

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

EXECUTIVE SUMMARY

On March 18, 2019 examination staff from the Division of Financial Regulation (division) arrived at Providence Health Plan (Providence, company) to complete a targeted Market Conduct Examination on Mental Health and Substance Use Disorder (MH/SUD) coverage. The division examined the company on five areas: Operations Management, Claims, Grievance Procedures, Network Adequacy, and Utilization Review. The examination team concluded the on-site portion of the targeted examination on August 15, 2019. Of the fifteen examination standards applied to the company, the company passed 13 and passed three with comment.

Noncompliant practices were identified, some of which may extend to other jurisdictions. The company is directed to take immediate corrective action to demonstrate its ability and intention to conduct business according to Oregon insurance laws and regulations. When applicable, corrective action for other jurisdictions should be addressed. Please find the attached Report by Exception, which reports only on areas of noncompliance identified during the examination.

Examination Standards Passed without Comment
The company passed the following examination standards without comment.

Oregon Standard 1 NAIC Operations/Management Standard 6	Monitoring outsourced services.	ORS 744.720, ORS 744.740
Oregon Standard 2 NAIC Operations/Management Standard 9	Cooperation with examiners.	ORS 731.308, ORS 732.584
Oregon Standard 3 NAIC Operations/Management Standard 18	Complete and accurate reporting.	ORS 731.296 ORS 732.584
Oregon Standard 4 NAIC Claims Standard 1	Handling claims files.	ORS 743B.450, ORS 743B.452, ORS 746.230, OAR 836-080-0080, OAR 836-080-0215, OAR 836-080-0225, OAR 836-080-0230, OAR 836-836-080-0235
Oregon Standard 6 NAIC Grievance Procedures Standard 1	The health carrier treats as a grievance any written complaint, and any oral complaint that involves an urgent care request, submitted by or on behalf of a covered person regarding: (1) the availability, delivery, or quality of health care services, including a complaint regarding an	ORS 743B.001(7), ORS 743B.250, OAR 836-053-1060

	adverse determination made pursuant to utilization review; (2) claims payment, handling, or reimbursement for health care services; or (3) matters pertaining to the contractual relationship between a covered person and the health carrier.	
Oregon Standard 7 NAIC Grievance Procedures Standard 2	Documentation, maintenance and reporting of grievances.	OAR 836-053-1060, OAR 836-053-1070, OAR 836-053-1090, OAR 836-053-1110
Oregon Standard 8 NAIC Grievance Procedures Standard 3	Implementation and disclosure and filing of grievance procedures.	ORS 743B.250, OAR 836-053-1070
Oregon Standard 9 NAIC Network Adequacy 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 covered persons will be accessible without unreasonable delay.	ORS 743B.505, OAR 836-053-1190
Oregon Standard 10 NAIC Network Adequacy Standard 8	The health carrier provides at enrollment a provider directory listing all providers participating in its network. It also makes available, on a timely and reasonable basis, updates to its directory.	OAR 836-053-0350
Oregon Standard 11 NAIC Utilization Review Standard 1	The health carrier establishes and maintains a utilization review program in compliance with statutes, rules and regulations.	ORS 743B.420, ORS 743B.422, ORS 743B.423, OAR 836-053-1130, OAR 836-053-1200
Oregon Standard 12 NAIC Utilization Review Standard 2	The health carrier operates its utilization review program in accordance with the applicable state statutes, rules and regulations (	ORS 743B.422, OAR 836-053-1200
Oregon Standard 13 NAIC Utilization Review Standard 4	The health carrier makes standard utilization benefit determinations in a timely manner and as required by applicable state statutes, rules and regulations, as well as the provisions of HIPAA.	ORS 743B.420, ORS 743B.422, ORS 743B.423

Examination Standards Passed with Comment
The company passed three examination standards with comment.

Oregon Standard 5 (NAIC Claims Standard 3)	The group health plan complies with the requirements of the federal Mental health Parity Act of 1996 (MHPA) and the revisions made in the Mental Health Parity and Addiction Equity Act of 2008.	45 CFR 146.136, ORS 743A.168, OAR 836-053-1408
Oregon Standard 14 (NAIC Utilization Review Standard 5)	The health carrier provides written notices of an adverse determination of standard utilization review and benefit determinations in compliance with applicable statutes, rules, and regulations.	ORS 743B.001, ORS 743B.250, ORS 743B.252, OAR 836-053-1200 OAR 836-080-0235
Oregon Standard 15 (NAIC Utilization Review Standard 7)	The health carrier monitors the activities of the utilization review organization or entity with which the carrier contracts and ensures that the contracting organization complies with applicable state provisions equivalent to the Utilization Review and Benefit Determination Model Act (#73) and accompanying regulations.	ORS 743B.422 ORS 743B.423 ORS 744.740

Recommendations

- The company should make any necessary revision to algorithms, or other automated claims management and utilization review systems, to ensure that algorithms used for MH/SUD utilization management are applied consistently in operation for both MH/SUD and medical service claims.
- While the division permits the use of medical management during Utilization Review, the company must provide adverse benefit determination notices, including grievance and appeals information, when the medical management decision results in a reduction or denial of items or services from what was originally requested.
- The company should be reexamined to ensure that recommended changes are implemented.

INTRODUCTION

This is a report of the Market Conduct activities of Providence Health Plan (Providence, company). Authority for this examination is granted by ORS 731.300. Market Conduct Examiners from the Oregon Department of Consumer and Business Services Division of Financial Regulation (division) conducted the examination. The examination team consisted of Market Conduct Examiners from the division. The examiners present their findings and recommendations in this report as a result of their market conduct examination of the company.

Scope of Examination

The examination focused on Mental Health and Substance Use Disorder (MH/SUD) coverage in the areas of Claims, Grievance Procedures, Network Adequacy, Utilization Review and Operations and Management. The sample population for this examination is isolated to claims and utilization reviews for MH/SUD items and services. All reviewed documents were selected for the period starting January 1, 2018 and ending December 31, 2018.

Operations/Management

Pursuant to ORS 731.260, ORS 731.296, ORS 731.300, ORS 731.308, ORS 744.720, ORS 744.722, ORS 744.740 insurers are required to cooperate with division examination proceedings and records requests; report complete and accurate data to the division; and adequately monitor the activities of any contracted third party administrator (TPA). Division examiners reviewed TPA contracts, internal and external audit reports, claim files, data request responses, and materials provided by the TPA relevant to the examination. The examiners considered 1.) the extent to which the company cooperated with the examiners performing the examination, 2.) the completeness and accuracy of documents and annual reports to the division; and 3.) and the extent to which MH/SUD claims were resolved in accordance with state and federal regulation.

Claims

ORS 743B.450, ORS 743B.452, OAR 836-080-0080, OAR 836-080-0215, OAR 836-080-0230, OAR 836-080-0235 prescribe claims processing requirements including standards for prompt claim payment, and insurer communication to consumers and providers. 45 CFR 146.136, ORS 743A.168, and OAR 836-053-1408 prescribe requirements for providing coverage of mental health and substance use disorder services. The targeted Market Conduct Examination focused on the adjudication of claims for mental and nervous conditions and substance use disorders (MH/SUD). Division examiners reviewed a random selection of MH/SUD claim files; TPA procedures; company claims procedures; company medical policies and procedures; and responses to inquiries. The examiners reviewed each claim file and related communication for compliance.

Grievances Procedures

Pursuant to ORS 743B.001, ORS 743B.250, and OAR 836-053-1060 through 836-053-1110 insurers are required to establish and maintain grievance procedures that comply with state regulation. The examiners reviewed a random selection of grievances; annual grievance report; grievance and appeals notices; internal company grievance and appeals processes and procedures; the timeliness of notification; internal grievance appeal categorization and tracking; and sample letters for compliance with applicable regulation; training agendas; company training manuals; and responses to targeted inquiries.

Network Adequacy

Pursuant to ORS 743B.505, OAR 836-053-0350, and OAR 836-053-1190, health benefit plan insurers are required to maintain a provider network sufficient in size, geographic distribution, and provider type to ensure access to covered services. Examiners reviewed documentation related to network adequacy, relevant definitions, the online provider directory, company networking practices, company procedures for maintaining and updating provider directories; responses to inquiries; and reports demonstrating adherence to national accreditation standards for compliance with state law.

Utilization Review
ORS 743B.001, ORS 743B.420, ORS 743B.422, ORS 743B.423, OAR 836-053-1130, and OAR 836-053-1200, prescribe requirements for insurers that provide utilization review, including the rights and responsibilities of insurers, consumers, and providers impacted by a company decision that resulted in a reduction of medically necessary items or services from what was originally requested. Examiners reviewed a sample of utilization review cases[1]; company procedures and practices relevant MH/SUD; company definitions; form letters used by the company; certificates of adherence to national accreditation standards for compliance with state and federal law; training agendas; annual reports submitted to the division; company guidance documents, and inquiry responses.

Error Testing
Consistent with National Association of Insurance Commissioners (NAIC) guidelines, the examiners applied a benchmark error rate of 7 percent on claims and utilization review samples and a 10 percent threshold for all other tests.

Company History
Providence Health Plan, an Oregon licensed health care service contractor, was formed as The Good Health Plan in 1984 by Providence Portland Medical Center and Providence St. Vincent Hospital. In 1997, the company was renamed Providence Health Plan following a merger between The Good Health Plan of Washington and SelectCare Health Plan of Southern Oregon. Following a 2016 merger between Providence Health and Services and St. Joseph Health the division authorized a corporate reorganization to facilitate the consolidation of the hospital systems with the insurance company. Providence Health Plan is now part of the integrated delivery system of Providence St. Joseph Health, a not-for-profit health and social services system.

The Company operates in seven states, Alaska, California, Montana, New Mexico, Oregon, Texas, and Washington. In Oregon the company offers a variety of health insurance products, including health benefit plans in the individual market, the small group market, and the large group market. Providence Health Plan currently serves more than 640,000 members across these lines of business. The company contracts with some third party administrators (TPA) for administration of some business processes.

Findings

The Company's underlying data was measured against established standards communicated to the company on February 13, 2019. The examiners used the following three classifications to disclose the examination results:

[1] Samples reviewed by examiners include: requests for prior authorization and concurrent review submitted by in and out of network providers on behalf of enrolled members.

Passed	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.
Failed	The Company has not demonstrated compliance with standards that fall into this category

Finding One

Phase Claims

Applicable Standard Standard 5, Compliance with the Mental Health Parity Acts (NAIC Standard 3)

Result Passed with Comment

Based on information provided by the company, the division identified MH/SUD claims administered by the contracted TPA were subject to more stringent review than claims administered by the company. Compliance with state and federal MH/SUD regulation require that the plan cost share (e.g. copay and coinsurance) and treatment limitations for MH/SUD benefits cannot be more restrictive than the same limitations that apply to medical services.[2]

This standard is listed as "Pass with Comment" because the company received general examination guidelines prepared by the NAIC that do not reference updates in state and federal law. The division provided resource list[3] indicated the company would be examined under NAIC Claims Standard 5 which states "The group health plan complies with the requirements of the federal Mental Health Parity Act of 1996 (MHPA) and the revisions made in the Mental Health Parity and Addiction Equity Act of 2008." The guideline, as written in the 2018 NAIC Market Regulation Handbook, does not address the expansion of MH/SUD coverage pursuant to the Patient Protection and Affordable Care Act.[4]

Although the intention of the exam was to review the company's compliance with state and federal MH/SUD requirements in place for the 2018 plan year, the division felt the examination standard did not adequately inform the company of the scope of compliance requirements to be examined. The division's decision to use Standard 5 was intended to target claims associated with MH/SUD services across the individual market, small group market, and large group market. The sample of claims selected by the division covered all markets and the division's examination did not further differentiate claims by market type.

The division identified concerns with the company's MH/SUD Utilization Review process, as implemented by the TPA. Details of those concerns are presented as Additional Findings.

[2] Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), limits on the scope or duration of treatment that are not expressed numerically are called non-quantitative treatment limitations (NQTL).

[3] February 13, 2019 letter to Eda Johnson. Re: Market Conduct Examination.

[4] Market Regulation Handbook, 2018. Volume IV of IV. Page 580.

Finding Two

Phase	Utilization Review
Applicable Standard	Standard 15, The health carrier monitors the activities of the utilization review organization or entity with which the carrier contracts and ensures that the contracting organization complies with applicable state provisions. (NAIC standard 7)
Result	Passed with Comment

The division determined that while the company had a monitoring system in place for TPAs, the system failed to identify that the TPA did not provide adverse benefit determination notices when the company's decision resulted in a reduction of services or items from what was requested required by ORS 743B.250.

Finding Three

Phase	Utilization Review
Applicable Standard	Standard 14, Providing written notice of adverse benefit determination of standard utilization review (NAIC standard #5)
Result	Passed with comment

When a prior authorization request for medically necessary item or service is reduced from the original amount requested, an adverse benefit notification to the member is required. Without this notification consumers are not notified of their appeal and grievance rights as required by ORS 743B.250. Without this notification the consumer would be unaware that the items or services requested by their provider had been reduced. The definition of an adverse benefit determination in ORS 743B.001 includes a reduction of items or services.

The TPA acting on behalf of the company did not provide these adverse determination notices when a prior authorization request was approved, but with a reduction to the originally requested amount of medically necessary items or services.

Additional Findings

Phase	Utilization Review

The division identified that the company's TPA utilizes a system of alert algorithms for administration of MH/SUD prior authorizations and concurrent care reviews that are not used by the company for medical services. The algorithms used by the TPA generate concurrent review referrals more frequently, and with shorter review periods, than those presented as the equivalent for medical services. The company presented "outlier management of recurring outpatient visits" as "comparable" to the TPA's algorithms for administering prior authorization and concurrent care reviews.

The company is responsible for administering benefits in compliance with state and federal mental health parity regulations. The tests performed by the division were not designed to substantiate/validate noncompliance with non-quantitative treatment limits (NQTLs). Federal guidance provided to regulators and insurers note that identification of NQTL violations requires further evaluation.

The division identified MH/SUD claims administered by the contracted TPA were subjected to a more stringent review criteria than claims administered by the company. Compliance with state and federal MH/SUD regulation requires that the requirements (e.g. copay and coinsurance) and treatment limits imposed on MH/SUD benefits cannot be more restrictive than the limitations that apply to medical services.

Recommendations

Based on the findings of the examination the examination team has identified the following recommendations that the company should implement for compliance with state and federal regulation.

Recommendation: All algorithms used to for MH/SUD utilization management should be applied the same in operation for MH/SUD and medical services

Recommendation: The company shall send adverse benefit determination notices, including grievance and appeals information, when the medical management decision results in a reduction or denial of items or services from what was originally requested.

Recommendation: The company should be reexamined to ensure that recommended changes are implemented.

AFFIDAVIT

STATE OF OREGON }
} ss
County of Marion }

The examination was conducted under Oregon Department of Consumer and Business Services and Department of Financial Regulation procedures.

Tashia Sizemore
Life and Health Program Manager
Division of Financial Regulation, Department of Consumer and Business Services
State of Oregon

APPENDIX A

OREGON DIVISION OF FINANCIAL REGULATION
TARGET MARKET CONDUCT EXAMINATION
PROVIDENCE HEALTH PLAN

#	Standard	Regulatory Authority
	Phase 1 Operations/Management	
1	Monitoring outsourced services (NAIC Standard 6)	ORS 744.720, ORS 744.740
2	Cooperation with examiners (NAIC Standard 9)	ORS 731.308, ORS 732.584
3	Complete and accurate reporting (NAIC Standard 18)	
	Phase 2 Claims	
4	Handling claims files (NAIC Standard 1)	ORS 743B.450, ORS 743B.452, ORS 746.230, OAR 836-080-0080, OAR 836-080-0215, OAR 836-080-0225, OAR 836-080-0230, OAR 836-836-080-0235
5	Compliance with the Mental Health Parity Acts (NAIC Standard 3)	MHPEAE, CFR 146.136, ORS 743A.168, OAR 836-053-1405
	Phase 3 Grievance Procedures	
6	The health carrier treats as a grievance any written complaint, and any oral complaint that involves an urgent care request, submitted by or on behalf of a covered person regarding: (1) the availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; (2) claims payment, handling, or reimbursement for health care services; or (3) matters pertaining to the contractual relationship between a covered person and the health carrier. (NAIC Standard 1)	ORS 743B.001(7), ORS 743B.250, OAR 836-053-1060
7	Documentation, maintenance and reporting of grievances (NAIC Standard 2)	OAR 836-053-1060, OAR 836-053-1070, OAR 836-053-1090,OAR 836-836-053-1110
8	Implementation and disclosure and filing of grievance procedures (NAIC Standard 3)	ORS 743B.250, OAR 836-053-1070
	Phase 4 Network Adequacy	
9	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 covered persons will be accessible without unreasonable delay. (NAIC Standard 1)	ORS 743B.505, OAR 836-053-1190

10	The health carrier provides at enrollment a provider directory listing all providers participating in its network. It also makes available, on a timely and reasonable basis, updates to its directory. (NAIC Standard 8)	OAR 836-053-0350
	Phase 5 Utilization Review	
11	The health carrier establishes and maintains a utilization review program in compliance with statutes, rules and regulations. (NAIC Standard 1)	ORS 743B.420, ORS 743B.422, ORS 743B.423, OAR 836-053-1130, OAR 836-053-1200
12	The health carrier operates its utilization review program in accordance with the applicable state statutes, rules and regulations (NAIC standard 2)	ORS 743B.422, OAR 836-053-1200
13	The health carrier makes standard utilization benefit determinations in a timely manner and as required by applicable state statutes, rules and regulations, as well as the provisions of HIPAA. (NAIC Standard 4)	ORS 743B.420, ORS 743B.422, ORS 743B.423
14	Providing written notice of adverse benefit determination of standard utilization review (NAIC Standard 5)	ORS 743B.001, OAR 836-053-1200
15	The health carrier monitors the activities of the utilization review organization or entity with which the carrier contracts and ensures that the contracting organization complies with applicable state provisions. (NAIC Standard 7)	ORS 743B.422, ORS 743B.423