STATE OF OREGON

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

DIVISION OF FINANCIAL REGULATION

MARKET CONDUCT EXAMINATION

REPRODUCTIVE HEALTH EQUITY ACT

OF

SAMARITAN HEALTH PLANS, 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 SAMARITAN HEALTH PLANS, 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
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 the RHEA as required by the 2017 Oregon House Bill 3391 codified at ORS 743A.067.

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. 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 maintain records as required by ORS 733.170 and OAR 836-053-1080** 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 Samaritan Health Plans, 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 used 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 no cost-sharing in applicable 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 as part of a larger organization known as Samaritan Health Services, Inc. that is described on its website as a not-for-profit regional health system that brings together community hospitals, physician clinics, and health insurance plans to serve Oregon's Benton, Lincoln, and Linn counties. The insurer does not provide individual plans within the scope of this examination but insures on average 2,000 lives within commercial small and large groups.

This targeted market conduct examination evaluated the insurer's compliance with the Oregon Insurance Code in the Oregon Revised Statutes (ORS) and Administrative Rules (OAR) in fulfilling its contractual obligations to policyholders relating to both policyholder services and complaints and claims. In the review of policyholder services and complaints, the examination focused on the procedures for complaints to be recorded in compliance with state and federal law, specifically OAR 836-053-1080 in facilitating proper compliance with cost sharing. The scope of the claims examination specifically reviewed compliance by the insurer for proper cost sharing for all claims including not imposing cost sharing on preventive services, as defined by the U.S. Department of Health and Human Services (HHS) and the U.S. Health Resources and Services Administration (HRSA) and for reproductive health and related preventive services required under Section 2 of the RHEA enacted in Oregon House Bill 3391 (2017) and codified at Oregon Revised Statutes (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 the RHEA. The insurer provided read-only access for the claims and complaints systems as well as a "virtual walkthrough" of files using computer screen sharing and video conferencing. During these phases, the following procedures were performed:

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

FINDINGS AND OBSERVATIONS – CLAIMS

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 exceptions were noted in this review.

b. Data analysis and observations

The examiners requested claims that had been paid or denied (both all claims and RHEA-related 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 insurer does not write individual policies, so it provided small and large group claims. 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 HHS and the HRSA and for reproductive health and related preventive services required under Section 2 of the RHEA enacted in Oregon House Bill 3391 (2017) and codified at ORS 743A.067.

Under ORS 731.296, 731.308, 733.170, and OAR 836-080-0188, insurers are required to facilitate examinations and make available requested and accurate information. On multiple occasions the insurer failed to promptly, timely, and conveniently make available information to readily ascertain treatment of policyholders by not providing data and files responsive to the examiners' requests.

Paid RHEA-related claims

The insurer provided a listing of 43,343 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 109 claims, plus 20 replacement files, it was determined that 81 of the claims were not RHEA related. The insurer explained the reason for inclusion of the non-RHEA claims: "The RHEA legislation was fairly broad in its language around reproductive health, and Samaritan wanted to cast as wide a net as possible to incorporate all the potential claims that could be considered under the legislation." In further discussions with the insurer, it was revealed that the majority, if not all, of the files provided in error were medical files rather than pharmacy files.

The insurer provided a second listing of 7,116 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 that included 81 medical claims, and 28 pharmacy claims. There were no findings related to the pharmacy claims.

Finding 1: Non-compliance with ORS 743A.067 relating to the processing of claims
In nine instances out of 109 paid RHEA-related claim files reviewed, for an error percentage of 8.26 percent, the insurer failed to adopt and implement reasonable standards for the prompt investigation of claims by improperly applying cost share in the initial adjustment and payment.

Sample size	# Errors	% Errors
109	9	8.3%

In five instances out of 109 paid RHEA-related claim files reviewed, for an error percentage of 4.59 percent, the insurer failed to timely pay the proper amount. This is in violation of OAR 836-080-0235.

Denied RHEA-related claims
The insurer provided a listing of 10,050 denied RHEA related claim files for the examination period. A random sample of 109 denied RHEA related claims was requested, received, and reviewed by the examiners in accordance with the NAIC Market Regulation Handbook Sampling Guidelines. In reviewing the 109 claims, plus 20 replacement files, it was determined that 42 of the claims were not RHEA related. The insurer explained the reason for inclusion of the non-RHEA claims: "The RHEA legislation was fairly broad in its language around reproductive health, and Samaritan wanted to cast as wide a net as possible to incorporate all the potential claims that could be considered under the legislation." In further discussions with the insurer, it was revealed that the majority, if not all, of the files provided in error were medical files rather than pharmacy files.

In reviewing the denied RHEA-related claim samples, the examiners were unable to ascertain that certain files were properly denied because the insurer was slow to provide access to a required databases. The claims as provided did not show effective dates, so the examiners excepted these files as improper. The examiners were then provided access to the eligibility information and determined that 17 claims in the initial sample and 24 claims in the second sample described below had been properly handled so the exceptions were removed. (It is noted that this same issue was found in 12 of the denied all claims review below). However, this delayed

the reviews by examiners not being initially provided proper databases.

In two instances out of 109 denied RHEA-related claims reviewed, for an error percentage of 1.8 percent, the insurer failed to adopt and implement reasonable standards for the prompt investigation of claims by improperly applying cost share for payment. The application of cost-sharing on these claims does not comply with ORS 743A.067.

Sample size	# Errors	% Errors
109	2	1.8%

All paid claims

The insurer provided a listing of 225,703 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. There were 43 medical claims, and 66 pharmacy claims in the sample. No errors were noted.

All denied claims

The insurer provided a listing of 71,891 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. There were 80 medical claims, and 29 pharmacy claims in the sample.

In one instance out of 109 files of all denied claims reviewed, for an error percentage of 0.9 percent, the insurer failed to adopt and implement reasonable standards for the prompt investigation of claims by improperly applying a cost share for a RHEA related service.

Sample size	# Errors	% Errors
109	1	0.9%

c. "Virtual onsite" observations

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

1. In paid RHEA-related claims, the insurer was found to have violated the non-cost share provisions with an 8.26 percent error rate that exceeds the acceptable NAIC suggested tolerance level of 7 percent.
2. Although the insurer provided an explanation, it failed to provide RHEA-related specific universes of claims when requested for both paid and denied claims. In the second corrected sample of RHEA-related denied claims, an additional four claims were determined not to be RHEA-related claims and nine of the claims were not denied claims,

all requiring replacement files. In addition, the insurer stated that CPT codes were not properly built into the systems contributing to the reasons for the insurer errors.

3. The examiners were required to re-examine certain RHEA-related denied claims and all claims denied files because the insurer did not provide the relevant databases showing eligibility involving 17 claims in the initial denied RHEA-related claim sample, 24 claims in the second denied RHEA-related claim sample and in 12 of all denied claims sample.

FINDINGS AND OBSERVATIONS – POLICYHOLDER SERVICES AND COMPLAINTS

a. Interrogatory analysis and observations

The Oregon Administrative Rule 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 provided no evidence that there is any complaint process for inquiries relating to consumer coverage benefits including the RHEA or otherwise. The insurer will notate a member's coverage inquiry and resolve it only within the file. Complaint numbers are assigned only when forwarded to the grievance team or if an appeal; items handled strictly by customer service are not assigned complaint numbers.

Three different procedure documents were provided to examiners. These were the grievance-complaint policy, commercial plans appeal work instructions, and the dissatisfaction resolution team grievance/complaint process. The quality management committee and quality improvement committee provide a qualitative analysis of the grievances or complaints system on an annual basis. The health assessment subcommittee provides a qualitative analysis of the grievances/complaints system on a quarterly basis. The insurer indicated that grievances or complaints are audited according to regulatory standards by the appropriate staff within the insurer's appeals and grievances department. The manager of appeals and grievances and the director and compliance review the Grievance Annual Report that is submitted to DFR. No information was provided on how the insurer would use any of the reports to monitor compliance with RHEA. The insurer failed to demonstrate that personnel involved with appeals and grievances were adequately trained on the requirements related to RHEA.

Finding 2: Failure to maintain records as required by ORS 733.170 and OAR 836-053-1080

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.

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

the 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 the RHEA and OAR 836-053-1080.

The insurer's identified a universe of 329 complaints that had been closed or received during the examination period. A random sample of 84 complaints was selected. This sample was requested, received, and reviewed by the examiners. Five of the complaints involved claims that were subject to the RHEA, or a percentage of 6 percent of the sample. Exceptions were found in three of the five RHEA related complaints.

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 provided no evidence that it has processes in place for reporting complaints, appeals, or grievances relating to covered benefit inquiries (including RHEA). There is no mechanism to assign a complaint number to track these items.
2. 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 the RHEA.
3. The insurer was not able to separate in its systems the complaints, appeals or grievances relating to the RHEA. The insurer initially incorrectly reported that it had no RHEA-related complaints.
4. The insurer failed to provide adequate evidence that personnel involved with complaints, appeals, and grievances were adequately trained on the requirements related to the RHEA.
5. The insurer does not have a chat feature that would allow a member to submit a complaint, nor does the website have the ability for members to submit complaints.
6. The system for maintaining grievances does not include identification of the underlying claim(s) as evidence by not supplying that data for the initial request by the examiners. The insurer states that it has now updated its policy and procedure to ensure that it aligns with the grievance processes required by the state rules and regulations.
7. The insurer reports an inconsistent processing time depending on whether a complaint is categorized as a grievance or an appeal. For example, by the 10th day of an appeal, a coordinator will contact the appellant and ask for any additional evidence that could support the case. For a grievance, the standard timeframe for a reply is five business days but in the dissatisfaction resolution team grievance/complaint process the timeframe can be extended 30 additional calendar days if more time is needed to obtain information or documents; the grievance-complaint policy indicates it is an additional 25 calendar days.
8. The definition of grievance in the operating procedure of the insurer (GA-03 Grievance-Complaint Policy- SHP, Version #2 Approved 2/18/19) is inconsistent with the definition in its member certificate (SGP_1008_2021a dated 6.2020). For example, the operating

procedure of the insurer makes allowance for an oral communication with no definition of appeal while the member certificate does not provide for oral communications but has a definition of an appeal.

RECOMMENDATIONS

Claims

As a result of the examiners' observations, it is recommended:

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 to claim inquiries by the director of the Department of Consumer and Business Services or their delegate.

4. 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.

Policyholder service and complaints

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

1. The insurer provides proper monitoring of the complaint, appeal, and grievance systems for trend analysis and proper compliance by establishing a process to identify complaints related to coverage benefit inquiries.

2. The insurer provide education for insurer personnel to be trained in all RHEA requirements for proper non-cost sharing requirements and payments for RHEA related services.

3. A process for ensuring underlying claims identified in the complaint, appeals, and grievances process are resolved and accurately reported to the division and their delegates.

4. The insurer assist consumers in providing easy access to initiating complaints with the insurer by improving online access.

5. The insurer submit accurate, timely, and complete information to claim inquiries by the division and their delegates.

6. The definition of grievance in the procedure policy should be consistent with the definition in coverage certificates.

7. The insurer provides a proper, consistent and minimum timeframe for the handling of complaints regardless of being characterized as a grievance or an appeal.

This report is respectfully submitted to the Oregon Department of Consumer and Business Services, Division of Financial Regulation.

APPENDIX

Table 1: Overview of examination sampling

EXAMINATION UNIVERSES AND SAMPLES					
Universe	Sample 1	Examiner comments	Universe sample 2	Sample 2	Examiner comments
Complaints					
329	84	5 files were RHEA related	NA	NA	NA
Paid RHEA-related claims					
43,343	109	81 sample files not RHEA related so new universe requested	7,116	109	NA
Denied RHEA-related claims					
10,050	109	42 sample files not RHEA related so new universe requested	1,779	109	13 sample files not RHEA related or not denials, replacements required
All paid claims					
225,703	109	NA	NA	NA	NA
All denied claims					
71,891	109	NA	NA	NA	NA

Table 2: Diagnosis and CPT codes with inappropriate cost sharing

Population: paid or denied	Examination review item (sample)	Diagnosis code	CPT/ HCPCS code	Finding
Paid	4	R102	81025	Improper cost share
Paid	9	O039	84702	Improper cost share
Paid	29	N390	81002	Improper cost share
Paid	30	O09521	84702	Improper cost share
Paid	38	Z3202	81025	Improper cost share
Paid	49	O209	84702	Improper cost share
Paid	57	Z3202	81025	Improper cost share
Paid	80	Z3042	J1050	Improper cost share
Paid	89	O200	84702	Improper cost share
Denied	61	Z113	86780	Improper cost share
Denied	75	Z332	84702	Improper cost share
Denied All	1	O034	85025	Improper cost share