



STATE OF OREGON

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

INSURANCE DIVISION

REPORT OF MARKET CONDUCT EXAMINATION

OF

**PACIFIC HOSPITAL ASSOCIATION
DBA PACIFICSOURCE HEALTH PLANS
SPRINGFIELD, OREGON**

NAIC COMPANY CODE 54976

AS OF

DECEMBER 31, 2005

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May 10, 2006

Honorable Cory Streisinger, Director
State of Oregon
Department of Consumer and Business Services
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

**Pacific Hospital Association
dba PacificSource Health Plans
110 International Way
Springfield, Oregon 97477**

NAIC Company Code 54976

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

EXECUTIVE SUMMARY

The focus of this examination was limited to the review of a selected item in regard to claim handling on which a recommendation was made during the follow-up market conduct examination for the examination period ending June 30, 2002, along with a review of the Company's grievance procedures pertaining to external review and their policyholder service procedures pertaining to continuity of care.

The following report is intended to provide a comprehensive summary of the findings discovered during this examination of the Company's efforts to comply with the selected recommendation from the prior follow-up market conduct examination and requirements pertaining to external review and continuity of care.

To measure the Company's compliance with the selected recommendation from the prior follow-up market conduct examination, the following recommendation was applied to a random sample of denied claims for emergency services and to the Company's policies and procedures for handling claims for emergency services:

- Recommendation #3 – I recommend the Company conduct a reasonable investigation prior to denying claims in accordance with ORS 746.230(1)(c) and (d).

To measure the Company's compliance with requirements pertaining to external review and continuity of care, the following Standards were applied to the Company's written policies and procedures:

- Grievance Procedure Standard #10 – The Company has an external review program that complies with all applicable statutes, rules and regulations.
- Policyholder Service Standard #9 – The Company provides for continuity of care in accordance with applicable statutes, rules and regulations.

The Company passed Recommendation #3 and Grievance Procedure Standard #10 without comment. The Company passed Policyholder Service Standard #9 with comment.

SCOPE OF EXAMINATION

The market conduct examination of the Company was conducted as of December 31, 2005, covered the period from July 1, 2005 through December 31, 2005 and included a review of material transactions or events that occurred subsequent to the examination cut-off date that were noted during the examination.

One portion of the examination was a follow-up examination limited to a review of the item on which a recommendation was made during the follow-up market conduct examination for the examination period ending June 30, 2002 that was specifically referenced in the Stipulation and Final Order for Case No. INS 03-08-022 dated May 23, 2005. That recommendation can be found in Appendix A immediately following this report.

The other portion of the examination was a target examination to determine the Company's compliance with standards pertaining to external review and continuity of care. Those standards can be found in Appendix B immediately following this report.

The examination of the Company was conducted pursuant to ORS 731.300 and in accordance with procedures and guidelines established by the Oregon Insurance Division Market Conduct Program. The program generally follows the Market Conduct Examination Handbook as adopted by the National Association of Insurance Commissioners (NAIC) to the extent that it is consistent with Oregon law. The purpose was to determine the Company's ability to fulfill and manner of fulfillment of its obligations, the nature of its operations, whether it has given proper treatment to policyholders, and its compliance with the Oregon Insurance Code and Administrative Rules.

In order to determine the practices and procedures of the Company's operations, one or more of the following procedures were performed in each phase:

- A sample of files was selected from listings provided by the Company. The examiner then reviewed each file.
- The procedure manuals and/or memorandum were evaluated.
- The Company responded to a series of questions regarding the phase being examined.

The examination was comprised of the following phases:

- Claims
- Grievance Procedures
- Policyholder Service

The Company's underlying data was measured against the selected prior examination recommendation and external review and continuity of care standards. A list of all recommendations and standards considered can be found in the Appendixes at the end of the report. The examiner used the following three classifications to disclose the examination results:

Passed without Comment	Recommendations and standards the Company passed without comment are displayed in a chart at the beginning of the Findings section of each phase. Items included in this category passed the recommendation or standard, and the examiner did not find it necessary to comment on the findings.
Passed with Comment	Recommendations and standards the Company passed with some errors noted are included in this classification. Items in this category are not considered to be indicative of a general business practice of noncompliance. Usually, a recommendation is not warranted, but in certain instances a recommendation might be made. This category may also include recommendations or standards the examiner determined to not apply to the Company with an explanation of the reasons for such determination.
Failed	The Company has not demonstrated compliance with recommendations and standards that fall into this category. A recommendation for compliance is usually made for each recommendation and standard the Company failed.

Information regarding some items might be noted in the examination report without remarks.

Other areas of concern discovered during the examination that do not fall within the scope of the recommendations or standards might appear in the report as the last section of each phase and titled Additional Findings and Procedures.

Certain unacceptable or non-complying practices may not have been discovered in the course of this examination. Failure to identify or criticize specific Company practices does not constitute

acceptance or approval by the Oregon Insurance Division. Examination findings may result in administrative action or further inquiry.

In this report, recommendations or standards with 100% compliance are identified as passed without comment. Exceptions include recommendations or standards with less than 100% compliance that either warranted a recommendation or where errors were noted but a recommendation was not made as well as recommendations or standards determined to not apply to the Company. If the examiner notes a material finding not included in the established recommendations or standards, it is noted under the additional findings section of the specific phase.

CLAIMS

The Company provided a list of 76 claims for emergency services denied during the examination period. From that list, a random sample of 50 claims was selected for review. One of the claims initially selected for review was determined to be under a plan administered, but not insured, by the Company. Since self-funded single employer plans are not subject to state regulation, that claim was eliminated from the sample and replaced with another claim.

In addition, the Company provided written policies and procedures in regard to the handling of claims for emergency services. Since the last examination, the Company had revised those procedures. The revised procedures require all claims for services provided in an emergency room setting to be reviewed prior to denial. That review includes investigation by a Claims Research Analyst in situations involving the possibility of denial for any of the following reasons:

- Preventive care services are not a covered benefit on this plan;
- Member has used maximum benefits available for this service;
- Pre-existing condition waiting period has not been satisfied;
- Waiting period for this condition/service has not been satisfied;
- Cosmetic or reconstructive services/supplies are not a covered benefit on this plan;
- Dental exams/treatment is not a covered benefit on this plan;
- Infertility services/supplies are not a covered benefit on this plan;
- Services or supplies for jaw/temporomandibular joint disorders are not a covered benefit on this plan;
- Services/supplies for obesity/weight control are not a covered expense on this plan;
- Services/supplies for comfort, convenience, education or environmental control are not a covered benefit on this plan;
- Treatment to modify tobacco use or promote general fitness is not a covered benefit on this plan;
- This condition/diagnosis is not a covered benefit on this plan; and
- This service/supply is not a covered benefit on this plan.

The revised procedures also require the Claims Research Analyst to review chart notes before any claim for emergency room services is denied.

The Company had also created a flow chart with a series of questions, one of which asks if additional information is needed to determine whether a prudent person would expect that failure to receive immediate medical attention would jeopardize the person's health. If that question is answered yes, the flow chart indicates the next step is to request chart notes from the provider.

Findings

The Company passed the following standard without comment:

Recommendation
<u>Recommendation #3</u> – I recommend the Company conduct a reasonable investigation prior to denying claims in accordance with ORS 746.230(1)(c) and (d).

GRIEVANCE PROCEDURES

The Company provided written policies and procedures outlining their system for resolving grievances and appeals, including those in regard to their external review program.

Those procedures indicate the Company has a four-level system for addressing and resolving inquiries, requests, concerns, complaints and grievances that provide the following internal reviews:

- 1) Informal review of non-written concerns or complaints;
- 2) Initial formal review of a grievance, i.e. a written complaint;

- 3) Review of the 1st level appeal of the initial grievance determination; and
- 4) Review of the 2nd level appeal of the initial grievance determination.

The Company also established a separate operational policy for “Independent External Review” provided in addition to the above that includes procedures for the following:

- Receiving and Reviewing Applications for External Review;
- Acknowledging Requests for Independent Review;
- Forwarding the Request to the Director of DCBS;
- Collecting and Forwarding Documents to the Independent Review Organization;
- Providing Information Requested by a Member;
- Reporting and Implementing the Decision of an Independent Review Organization;
- Fees for Independent Reviews; and
- Record Keeping.

Findings

The Company passed the following standard without comment:

Standard
<u>Grievance Procedure Standard #10</u> – The Company has an external review program that complies with all applicable statutes, rules and regulations.

POLICYHOLDER SERVICE

The Company provided written policies and procedures for providing continuity of care, specimen copies of notices regarding continuity of care and the procedure for use of such notices. Those procedures include a notification process whereby, when the Company's contractual relationship with an individual provided terminates, the Company notifies members who received treatment from that provider within the preceding three months that the provider is no longer considered a participating provider. The specimen notices provided for review indicate, as of either two weeks from the date of the notice or the date as of which the provider in question is no longer a participating provider, charges from that provider will be paid at the non-participating provider level.

The Company's continuity of care procedures were not reviewed for compliance with specific statutory continuity of care requirements because those requirements do not apply to the plans provided by the Company during the examination period for the reasons indicated below.

Findings

The following exception was noted:

Policyholder Service Standard #9 – The Company provides for continuity of care in accordance with applicable statutes, rules and regulations.

Findings: Passed with comment.

ORS 743.854 indicates, as used therein, “continuity of care” means “the feature of a health benefit plan under which an enrollee who is receiving care from an individual provider is entitled to continue with care with the individual provider for a limited period of time after the medical services contract terminates” if the insurer “does not cover services when services are provided to enrollees by the individual provider or covers services at a benefit level *below* the benefit level specified in the plan for *out-of-network* providers.”

The Company indicated all of their health benefit plans include out-of-network benefits for services of individual providers. If a preferred provider’s contract terminates and the provider no longer participates in the provider network, services of that provider may continue to be covered at the participating provider benefit level, but only for a very limited time period. However, after that limited period, the terminated provider’s services are covered indefinitely at the out-of-network benefit level specified in the plan, not below such level.

Since plan provisions that cause continuity of care requirements to apply, i.e. either not covering services of providers whose contractual relationship with the Company terminates or covering such services at a benefit level below the benefit level specified in the plan for out-of-network providers, are not included in the Company’s health benefit plans, statutory continuity of care requirements do not apply to their plans.

ACKNOWLEDGMENT

The cooperation and assistance rendered by the officers and employees of the Company during this examination are hereby acknowledged and appreciated.

A special thanks is extended to the examination coordinator for his courtesy and assistance providing, correlating, or coordinating all requested documents and statistics necessary to ensure a smooth transition during the overall examination process. The responsibilities that were undertaken during this examination were in addition to the scope of his regular assigned duties.

In addition to the undersigned, Kathleen Kalk, AIE, participated in this examination.

Respectfully submitted,

Cindy J. Jones, AIE, CPCU, CRM
Manager, Market Surveillance
Insurance Division
Department of Consumer and Business Services
State of Oregon

APPENDIX A

PacificSource Health Plans
Market Conduct Follow-up Examination

#	Phase	Recommendation	Findings
3	Claims	I recommend the Company conduct a reasonable investigation prior to denying claims in accordance with ORS 746.230(1)(c) and (d).	Passed

APPENDIX B

PacificSource Health Plans
Market Conduct Target Examination

Grievance Procedures

#	Standard	Regulatory Authority
10	The Company has an external review program that complies with all applicable statutes, rules and regulations.	ORS 743.804(3)(f)(A), ORS 743.857, ORS 743.859, ORS 743.861, OAR 836-053-1337, OAR 836-053-1340(1),(2)&(6), OAR 836-053-1342(1)

Policyholder Service

#	Standard	Regulatory Authority
9	The Company provides for continuity of care in accordance with applicable statutes, rules and regulations.	ORS 743.854