STATE OF OREGON
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
INSURANCE DIVISION

In the Matter of **ODS Health Plan, Inc.**	) **EXHIBIT A** to) **STIPULATION** and) **FINAL ORDER**) Case No. INS 03-08-014

Standard Emphasis Market Conduct Examination for the period ending September 30, 1997

The final report of the standard emphasis market conduct examination of the Company contained 31 recommendations. In the follow up examination as of 9/30/01, the Insurance Division found that the Company complied with 16 of those 31 recommendations. The 14 repeat failures were:

Recommendation #5 - The Company shall send notices of proposed replacement to prior carriers within 10 working days after applications are received in accordance with OAR 836-052-0830. Notices must be retained by the Company as documentation of compliance.

> Company Response to Prior Exam Report: ODS Health Plans does send the notices of proposed replacement to prior carriers. We have been keeping copies of these notices in our marketing files for approximately the last 18-24 months.

The examiner reviewed ten cases during the follow up exam and found no evidence that the notice was sent to prior carriers for seven (70%) of these groups.

Subsequent to the follow up examination, the Company indicated that it does have written procedures in place to fax the required notice to the prior carrier. The Company stated that training has been provided to appropriate staff on this issue and a review of this area will be included in the Company's auditing process.

Recommendation #6 - The Company shall send a notice of termination to the group policyholder, the Bureau of Labor and Industries and the Department of Consumer and Business Services no more than 10 working days after a policy is terminated and the coverage is not replaced, as required by ORS 743.560 and OAR 836-052-0840.

> Company Response to Prior Exam Report: ODS Health Plans does send a notice of termination to the group policyholder, the Bureau of Labor and Industries and the Department of Consumer and Business Service when policies terminate and

are not replaced by the group policyholder. We have been keeping copies of these notices in our marketing files for approximately the last 18-24 months.

During the follow up exam, the examiner reviewed 11 groups and found that eight (73%) of the groups failed the recommendation. No notice was sent for seven of these groups and the other notice was sent, but not within the required time frame.

Subsequent to the follow up exam, the Company indicated it has taken corrective action to address the deficiencies noted in this area.

Recommendation #7 - The Company shall determine the number of employees working 17.5 or more hours per week at the time of issuance and annually thereafter in keeping with the requirements of ORS 743.730(9).

Company Response to Prior Exam Report: The Company is in the process of developing a report to be used annually in keeping with the requirements of the Insurance Division. This form will be implemented in 2000.

The corrective action taken by the Company following the prior examination only addressed the Company's action at policy renewal. The Company failed to create procedures that allow for compliance at the time of issuance.

Subsequent to the follow up exam, the Company indicated that after the previous market conduct examination, the Company established procedures to request information from small employers regarding the number of employees working 17.5 hours per week during the preceding year. The Company stated that it would also require employer groups and their agents to certify that the employer meets the definition of "small employer" at the time a premium quote is provided and again at the time the policy is issued.

Recommendation #9 - The Company shall insure only associations that have been filed and approved in compliance with ORS 743.524 and ORS 743.526.

Company Response to Prior Exam Report: ODS Health Plans contacted Maxi McKibben from DCBS to discuss this filing process in April of 1998. Maxi indicated that we could ask the group (association) for a copy of its' filing with DCBS and send it to DCBS along with a filing form for approval. We have since learned that our process should be to call DCBS and obtain approval date from DCBS for the association, along with approval number.

During the follow up exam, the examiner found that four (80%) of the five associations and trusts insured by the Company as of September 30, 2001 had not been approved by the Insurance Division as group policyholders.

Subsequent to the examination, the Company indicated that it is reviewing all association groups to determine whether any have not been filed with the Insurance Division. The Company stated that it would file those that are not currently showing as approved on the Insurance Division website. The Company stated that the process has begun with a target completion date of the second quarter of 2003.

<u>Recommendation #10</u> - The Company shall provide an explanation of portability coverage directly to all eligible individuals who lose group coverage within 10 days after taking administrative action to initiate or document the loss of coverage, as required by OAR 836-053-0750(3) and (4) (renumbered to OAR 836-053-0750(1) and (2) respectively).

> Company Response to Prior Exam Report: Prior to the Senate Bill 21 examination in May 1999, we were sending this information to eligible individuals who lose group coverage only as requested. Since that time we are sending it when the individual terminates.

At the time of the prior examination, the Company included portability information in the member handbook distributed at enrollment, but was not sending portability information to individuals when their coverage terminated unless such information was requested. Since then, the Company established procedures to send portability information to terminated individuals. However, the information sent during the follow up examination period did not include all of the required information. Additionally, the Company was not sending portability information to individuals with an out-of-state address.

Subsequent to the follow up exam, the Company indicated that in May 2002, during the follow up exam, the Company revised its portability letter to include all of the required information. The Company stated that as of October 25, 2002, it has changed its procedures and is now mailing letters to all individuals whose coverage terminated, even those with an out-of-area address.

<u>Recommendation #12</u> - All negotiated contracts shall be amended to include the applicable mandates in compliance with the mandates to be found generally in Chapter ORS 743.

> Company Response to Prior Exam Report: This will occur beginning with groups issued or renewed on or after January 1, 2000.

During the follow up exam, the examiner reviewed ten negotiated contracts and found nine (90%) of them to be out of compliance.

Subsequent to the follow up exam, the Company indicated that it is reviewing all of its current negotiated contracts and that all mandates would be added to these

contracts as the groups renew. The Company indicated that it has already added these mandates to some groups as they renewed during 2002. The Company stated that in some cases, the contracts would be revised as soon as approval is obtained in discussions with the appropriate union.

<u>Recommendation #13</u> - All agreements shall provide "insurance against the risk of economic loss assumed under a less than fully insured employee health benefit plan" be revised to comply with the requirements of ORS 742.065. In the alternative, all such agreements that do not comply with ORS 742.065 shall be revised to comply with all requirements of ORS chapter 743, including the provision of all mandated benefits.

> Company Response to Prior Exam Report: The Company had wording reviewed by Jann Goodpaster in July. We will issue separate stop loss contracts on ASO agreements as the contracts are issued or renewed on or after January 1, 2000.

During the follow up exam, the examiner identified seven contracts for review. Of these, five (71%) failed the recommendation because the Individual Stop Loss provisions indicated "ODS shall pay from its own funds all claims on account of an individual eligible employee or dependent" in excess of a specified amount. ORS 742.065 requires payments made by an insurer under stop-loss policies to be made to the employer, trustee, plan, or other plan sponsor, but not to employees members, participants or health care providers.

Two of the five agreements that failed this recommendation were amended to correct the stop loss provision, but the effective date of the amendment was after the end of the follow up examination period. The Company advised that it intended to amend the remaining three agreements at the next renewal, but had not yet done so.

Subsequent to the follow up exam, the Company informed the examiner that it has already begun to issue separate stop loss contracts to self-funded groups. The Company stated that the process would be completed in December 2002.

<u>Recommendation #14</u> - The Company shall provide employees covered under self-funded plans for which ODS provides administration services with information indicating that ODS is just administering the plan and that their employer is liable for benefits in compliance with ORS 746.240.

> Company Response to Prior Exam Report: This information will be provided to self-funded groups whose policies are issued or renewed on or after January 1, 2000.

During the follow up exam, the examiner found seven of the ten accounts reviewed (70%) failed the recommendation. In one case the information provided to

employees did not specifically address the issue of who is liable for benefits. The other six cases indicated benefits are provided in accordance with a policy of insurance between the Company and the employer.

Subsequent to the follow up exam, the Company stated that it did make revisions to the administrative agreements to indicate ODS provides administrative services only. However, there were some provisions within the agreements that the Company failed to change. The Company indicated that it would make these changes by February 1, 2003. The Company also stated that these changes would be included in contracts as they renew or are issued after that date.

Recommendation #18 - The Company's claim files shall be adequately documented and that records are accessible and readily verifiable in accordance with the provisions of ORS 733.170 and OAR 836-080-0215.

> Company Response to Prior Exam Report: We believe our existing procedures provide adequate documentation and accessibility.

During the follow up exam, the examiner reviewed 50 files and found six (12%) claims that failed this recommendation because the Company's documentation did not explain why certain action was taken on each of the six files.

Subsequent to the exam, the Company indicated that it has established a Process Improvement Team of employees who will evaluate, recommend, and implement improvements to ensure adequate documentation and that records are accessible and readily verifiable. The Company stated that this team would begin meeting in November 20002 and has a target completion date of the second quarter of 2003.

Recommendation #19 - The Company shall establish and implement procedures to ensure claim payments are not delayed by more than 14 days due to application of a coordination of benefits (COB) provision in accordance with OAR 836-020-0740(3).

> Company Response to Prior Exam Report: The Company will establish and implement procedures that will be documented in our coordination of benefits guidelines. This will be in place by the end of January 2000.

Since the last exam, the Company did implement written COB procedures that include a 44-day completion requirement on claims involving COB. However, the Company advised it denies claims if hasn't received a response to the question of whether the insured has other coverage.

Subsequent to the follow up exam, the Company indicated that the Process Improvement Team consisting of representatives from the claims, customer service, group integration, and corporate compliance departments will evaluate,

recommend, and implement improvements to ensure the Company's COB administration meets the requirements of OAR 836-020-0740. The Company anticipated completion of its review and implementation of revised procedures by January 1, 2003.

<u>Recommendation #20</u> - The Company shall pay claims in accordance with the contract and the claims handling procedures of the Company pursuant to the provisions of ORS 731.300 and ORS 733.170.

> Company Response to Prior Exam Report: Our existing procedures provide adequate documentation and accessibility.

Ten (20%) of the 50 claims reviewed during the follow up exam failed this recommendation. It appears these failures were due to claims processor error and not a systemic problem within the Company's claims procedures.

Subsequent to the follow up examination, the Company informed the examiner that most of the claims cited were the result of a variety of human errors. The Company stated it would evaluate current processes and implement improvements where appropriate. The Company indicated the target completion date is January 1, 2003.

<u>Recommendation #22</u> - The Company shall not refuse to pay claims without conducting a reasonable investigation in accordance with ORS 746.230(1)(d).

> Company Response to Prior Exam Report: We will conduct reasonable investigations and document our procedures in the coordination of benefits guidelines.

The examiner reviewed 25 denied claims during the follow up exam and found nine of the claims (36%) failed the recommendation.

Subsequent to the follow up exam, the Company indicated the Process Improvement Team will also focus on establishing procedures for claims support and other departments to follow when documenting the reasons for their actions, revise the Company's COB administration so the Company does not deny claims for not receiving other insurance information, and establish a procedure for documenting receipt of unsolicited refunds.

<u>Recommendation #23</u> - The Company's claim denials shall include a proper explanation of the basis relied on in the insurance policy and are made in writing in accordance with the provisions of ORS 746.230(1)(m) and OAR 836-080-0235(1) and (2).

Company Response to Prior Exam Report: We are in the process of reviewing our denial explanations (for other than eligibility) and will have revisions in place by the end of June 2000.

Six (24%) of the denied claims reviewed during the follow up exam failed this recommendation. Two of the claims did not reference the policy provision upon which the denial was based and the other four were denied because requested information was not received. Those four denials did not explain what information was required or when it was originally requested, nor did they reference the basis relied on in the insurance policy.

Subsequent to the follow up exam, the Company indicated that under the ERISA new claim procedures effective July 1, 2002, the Company now provides more detailed information regarding claim denials. The Company stated it is also evaluating all of its EOB codes to ensure they are HIPAA compliant. The Company has scheduled the new codes to go into production on or before October 16, 2003.

Recommendation #24 - The Company shall revise its COB claim processing procedures to ensure compliance with the provisions of OAR 836-020-0740.

Company Response to Prior Exam Report: We will change our User Procedure Manual (UPM) to reflect that a reasonable effort to investigate claims prior to making estimations is required. If no information is received the Company will estimate primary payment at 80%.

The follow up exam revealed that the Company is not following the process outlined in the response to the prior exam report. Seven (54%) of the 13 COB claims reviewed during the follow up exam were denied because COB information had not been received.

If the Company has not determined it is secondary to other coverage, it is supposed to pay as primary. If the Company has determined it is in the secondary position, but has not determined the other carrier's benefits within 44 days of receipt of the claim, the Company is supposed to either pay as primary or provide benefits based on an estimate of the other carrier's benefits.

Subsequent to the follow up examination, the Company indicated the Process Improvement Team will address all COB claim processing issues.

Patient Protection Act Special Target Market Conduct Examination for the period ending March 31, 1999

The final report of the Patient Protection Act special target market conduct examination of the Company contained 13 recommendations. In the follow up

examination as of 9/30/01, the Insurance Division found that the Company complied with 11 of those 13 recommendations. The two repeat failures were:

<u>Recommendation #1</u> - The Company shall respond to grievances and appeals within the timeliness standards required by OAR 836-053-1100.

> The Company's response to the prior exam report stated that ODS used business days instead of calendar days based on NCQA guidelines. The Company indicated it believed both NCQA and the State used the same standard. The Company reported that effective January 1, 2000, ODS is using calendar days.

Five (20%) of the 25 cases reviewed during the follow up exam failed this recommendation.

The Company response to the follow up exam report indicates in April 2002, during the follow up exam, the Company's Medical Review and Appeals Unit revised the Company's process to track and improve the Company's timelines for responding to complaints. The Company stated this action was a direct result of the initial findings of the Market Conduct examination.

<u>Recommendation #5</u> - The Company shall respond to first appeals of decisions to deny treatment or payment of services as not medically necessary or experimental in compliance with OAR 836-053-1140(1)(a).

> The Company's response to the prior exam report stated that ODS does send a letter within seven days of receipt of an appeal stating that it has been received and is being reviewed.

Ten (20%) of the 51 appeals reviewed during the follow up exam failed this recommendation because the Company did not resolve the appeals within the required amount of time and the Company did not follow the requirements for sending delay letters.

The Company response to the follow up exam report indicates in April 2002, during the follow up exam, the Company's Medical Review and Appeals Unit revised the Company's process to track and improve the Company's timelines for responding to complaints. The Company stated this action was a direct result of the initial findings of the Market Conduct examination.