STATE OF OREGON
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
DIVISION OF FINANCIAL REGULATION

In the Matter of:	Case No. INS-17-0151
MODA HEALTH PLAN, INC., Respondent.	ORDER TO CEASE AND DESIST, FINAL ORDER ASSESSING CIVIL PENALTY AND CONSENT TO ENTRY OF ORDER
	THIS IS A FINAL ORDER

The Director of the Department of Consumer and Business Services for the State of Oregon ("Director"), acting in accordance with Oregon Revised Statutes ("ORS") chapters 731, 732, 733, 734, 735, 737, 742, 743, 743A, 743B, 744, 746, 748 and 750 ("Insurance Code"), has conducted an investigation into the insurance related activities of Moda Health Plan, Inc. ("Respondent").

Respondent submits to the Director's jurisdiction and agrees to waive its rights to notice and an administrative hearing that arise under ORS 183.415 and wishes to resolve this matter by consenting to entry of this Final Order.

Now, therefore, as evidenced by the authorized signatures subscribed on this document, the Director issues the following Findings of Fact, Conclusions of Law, and Final Order.

Division of Financial Regulation
Labor and Industries Building
350 Winter Street NE, Suite 410
Salem, OR 97301-3881
Telephone: (503) 378-4387

FINDINGS OF FACT

The Director FINDS that:

1. Respondent has been licensed by the Director, by and through the Division of Financial Regulation, previously known as the Insurance Division (collectively the "Division"), as a health care service contractor since January 1, 1999. Respondent's

principal place of business is 601 SW Second Avenue, Portland, OR 97204. Respondent's National Association of Insurance Commissioners number is 47098.

Prompt and Fair Settlements

2. Respondent failed to pay clean claims not later than the 30th day after the claims were submitted to Respondent by the providers as follows:

A. Respondent received 585,343 clean claims for individual policy holders during 2016. Respondent paid 447,043 of the clean claims later than the 30th day after the claims were submitted to Respondent by the providers.

B. Respondent received 250,813 clean claims for individual policy holders during 2017. Respondent paid 231,243 of the clean claims later than the 30th day after the claims were submitted to Respondent by the providers.

C. Respondent received 427,916 clean claims for individual policy holders during 2018. Respondent paid 3,503 of the clean claims later than the 30th day after the claims were submitted to Respondent by the providers. Respondent paid 424,413 (99.2%) of the clean claims on or before the 30th day after the claims were submitted to Respondent by the providers, demonstrating a significant improvement from 23.6% in 2016 and 7.8% in 2017.

Delay Notification Letters

3. When payments of clean claims were delayed beyond 30 days, Respondent failed to provide notification as follows:

A. During 2016, of the 447,043 delayed clean claims described in Paragraph 2A above, Respondent failed to provide any delay notification for 252,906 of the delayed clean claims.

B. During 2017, of the 231,243 delayed clean claims described in Paragraph 2B above, Respondent failed to provide any delay notification for 23,625 of the delayed clean claims.

Division of Financial Regulation
Labor and Industries Building
350 Winter Street NE, Suite 410
Salem, OR 97301-3881
Telephone: (503) 378-4387

C. During 2018, of the 3,503 delayed clean claims described in Paragraph 2C above, Respondent failed to provide any delay notification for 294 of the delayed clean claims.

4. On January 14, 2019, the Division requested that Respondent provide the current version(s) of the letter used when clean claims payments are delayed beyond 30 days ("Delay Notification Letters").

5. On February 1, 2019, Respondent provided the following Delay Notification Letters to the Division:

A. A letter template to an enrollee dated January 31, 2019 which stated that the enrollee's claims were being processed, but that it would take longer than the standard 30 days to process each claim. The letter gave no reason for the delay.[1]

B. A letter template to a provider dated January 31, 2019 which stated that the provider's claims for its patients were being processed, but that it would take longer than the standard 30 days to process each claim. The letter gave no reason for the delay.[2]

Colorectal Cancer Screenings

6. Respondent improperly applied a deductible to claims for colorectal cancer screening as follows:

A. During 2014, Respondent applied a deductible to 384 claims for colorectal cancer screening for insureds that were 50 years of age or older.

B. During 2015, Respondent applied a deductible to 251 claims for colorectal cancer screening for insureds that were 50 years of age or older.

C. During 2016, Respondent applied a deductible to 339 claims for colorectal

[1] The letter to the enrollee stated the following: "At times, processing claims correctly and properly may take extra time. This letter is to notify you that claims for you or your family are currently being processed. It will take us longer than the standard 30 days to process each claim."

[2] The letter to the provider stated the following: "At times, processing claims correctly and properly may take extra time. This letter is to notify you that claims for your patients are currently being processed. It will take us longer than the standard 30 days to process each claim."

Division of Financial Regulation
Labor and Industries Building
350 Winter Street NE, Suite 410
Salem, OR 97301-3881
Telephone: (503) 378-4387

cancer screening for insureds that were 50 years of age or older.

D. During 2017, Respondent applied a deductible to 942 claims for colorectal cancer screening for insureds that were 50 years of age or older.

Incorrect Processing of In-Network Claims

7. From January 1, 2016 through July 19, 2017, Respondent received 352 claims under health benefit plans for services delivered by in-network providers. Respondent applied out-of-network benefits to each of the 352 claims.

8. On July 19, 2017, Respondent became aware that it incorrectly applied out-of-network benefits to each of the 352 claims.

9. Respondent did not begin reprocessing the 352 claims with in-network benefits until January 2, 2018.

Incorrect Processing of ESRD Claims

10. From 2015 through 2017, Respondent failed to notify four consumers that each of the respective consumers was eligible for enrollment in Medicare Part B.

11. Each of the four consumers received end stage renal disease ("ESRD") benefits from Respondent. Respondent paid the ESRD benefits as the primary insurer.

12. After discovering that each of the four consumers was eligible for enrollment in Medicare Part B, Respondent performed a retroactive adjustment as the secondary insurer and clawed back benefits that had been paid.

13. Each of the four consumers was then balance billed by their respective ESRD provider.

Processing of Prior Authorizations

14. From January 1, 2017 through February 21, 2019, Respondent received 187,233 prior authorization requests from providers.

15. On 15,777 occasions, Respondent took longer than two business days to respond to the provider.

Division of Financial Regulation
Labor and Industries Building
350 Winter Street NE, Suite 410
Salem, OR 97301-3881
Telephone: (503) 378-4387

CONCLUSIONS OF LAW

The Director CONCLUDES that:

16. Pursuant to ORS 731.252(1), whenever the Director has reason to believe that any person has been engaged or is engaging or is about to engage in any violation of the Insurance Code, the Director may issue an order, directed to such person, to discontinue or desist from such violation or threatened violation.

Prompt and Fair Settlements

17. Pursuant to ORS 743B.450(1), when a claim under a health benefit plan is submitted to an insurer by a provider on behalf of an enrollee, the insurer shall pay a clean claim or deny the claim not later than 30 days after the date on which the insurer receives the claim. If an insurer requires additional information before payment of a claim, not later than 30 days after the date on which the insurer receives the claim, the insurer shall notify the enrollee and the provider in writing and give the enrollee and the provider an explanation of the additional information needed to process the claim. The insurer shall pay a clean claim or deny the claim not later than 30 days after the date on which the insurer receives the additional information.

18. Pursuant to OAR 836-080-0080(1)(a), "clean claim" means a claim under a health benefit plan that has no defect, impropriety, lack of any required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment.

19. Respondent violated ORS 743B.450(1) on each of the 678,286 occasions as described in Paragraph 2A and Paragraph 2B above by failing to pay a clean claim or denying the claim not later than 30 days after the date on which Respondent received the claim.[3]

[3] Considering Respondent's significant improvement with timely payments beginning in January 2018, this Order does not include the 3,503 violations of ORS 743B.450(1) during 2018.

Division of Financial Regulation
Labor and Industries Building
350 Winter Street NE, Suite 410
Salem, OR 97301-3881
Telephone: (503) 378-4387

Delay Notification Letters

20. Pursuant to OAR 836-080-0235(4), if an insurer needs more time to determine whether the claim of a first party claimant should be accepted or denied, it shall so notify the claimant not later than the 30th day after receipt of the proofs of loss, giving the reason more time is needed.

21. Respondent violated OAR 836-080-0235(4) on each of the 276,825 occasions as described in Paragraph 3 above by failing to provide notification not later than the 30th day after receipt of the proofs of loss that more time is needed to determine whether the claim should be accepted or denied.

22. Respondent violated OAR 836-080-0235(4) by sending Delay Notification Letters without giving the reason more time is needed as described in Paragraph 5 above.

Colorectal Cancer Screenings

23. Pursuant to ORS 743A.124(1), a health benefit plan, as defined in ORS 743B.005, shall provide coverage for all colorectal cancer screening examinations and laboratory tests assigned either a grade of A or a grade of B by the United States Preventive Services Task Force.[4]

24. Pursuant to ORS 743A.124(2), if an insured is 50 years of age or older, an insurer may not impose cost sharing on the coverage required by subsection (1) of this section and the coverage shall include, at a minimum: (a) fecal occult blood tests, colonoscopies, including the removal of polyps during a screening procedure, or double contrast barium enemas; and (b) a colonoscopy, including the removal of polyps during the procedure, if the insured has a positive result on any fecal test assigned either a grade of A or a grade of B by the United States Preventive Services Task Force.

Division of Financial Regulation
Labor and Industries Building
350 Winter Street NE, Suite 410
Salem, OR 97301-3881
Telephone: (503) 378-4387

[4] Colorectal cancer screening has been assigned a grade of A according to the United States Preventive Services Task Force website (https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/#more) and the USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.

25. Respondent violated ORS 743A.124(2) on 1,916 separate occasions as described in Paragraph 6A through Paragraph 6D above by applying a deductible to claims for colorectal cancer screening.

Incorrect Processing of In-Network Claims

26. Pursuant to ORS 746.230(1)(d), no insurer shall refuse to pay claims without conducting a reasonable investigation based on all available information.

27. Respondent violated ORS 746.230(1)(d) on 352 separate occasions as described in Paragraph 7 through Paragraph 9 above by refusing to pay claims for services delivered by in-network providers with in-network benefits due to its failure to conduct a reasonable investigation based on all available information.

Incorrect Processing of ESRD Claims

28. Pursuant to ORS 746.240, no person shall engage in this state in any trade practice that, although not expressly defined and prohibited in the Insurance Code, is found by the Director to be an unfair or deceptive act or practice in the transaction of insurance that is injurious to the insurance-buying public.

29. Respondent engaged in an unfair act or practice in the transaction of insurance that was injurious to the insurance-buying public as described in Paragraph 10 through Paragraph 13 above by failing to timely notify consumers about their eligibility for enrollment in Medicare Part B and later applying retroactive adjusts to previously processed claims.

Processing of Prior Authorizations

30. Pursuant to ORS 743B.423(2)(d), a provider request for prior authorization of nonemergency service must be answered within two business days.

31. Respondent violated ORS 743B.423(2)(d) on 15,777 occasions as described in Paragraph 15 above.

/ / /

Division of Financial Regulation
Labor and Industries Building
350 Winter Street NE, Suite 410
Salem, OR 97301-3881
Telephone: (503) 378-4387

Civil Penalties

32. Pursuant to ORS 731.988(1), the Director may impose a civil penalty of up to $10,000 per violation upon any individual who violates a provision of the Insurance Code.

ORDERS

Now therefore, the Director issues the following Orders:

33. As authorized by ORS 731.252(1), the Director ORDERS Respondent to CEASE AND DESIST from violating any provision of the Insurance Code or the administrative rules promulgated thereunder.

Civil Penalties

34. Based upon the foregoing and in accordance with ORS 731.988(1), the Director ORDERS Respondent pay a CIVIL PENALTY of $200,000 as follows:

A. A CIVIL PENALTY of $100,000 for violations of ORS 743B.450(1) as described in Paragraph 19 above.

B. A CIVIL PENALTY of $50,000 for violations of OAR 836-080-0235(4) as described in Paragraph 21 and Paragraph 22 above.

C. A CIVIL PENALTY of $10,000 for violations of ORS 743A.124(2) as described in Paragraph 25 above.

D. A CIVIL PENALTY of $20,000 for violations of ORS 746.230(1)(d) as described in Paragraph 27 above.

E. A CIVIL PENALTY of $10,000 for violations of ORS 746.240 as described in Paragraph 29 above.

F. A CIVIL PENALTY of $10,000 for violations of ORS 743B.423(2)(d) as described in Paragraph 31 above.

35. The Director SUSPENDS the collection of the $100,000 CIVIL PENALTY assessed for violations of ORS 743.450(1) as described in Paragraph 34A above, so long

Division of Financial Regulation
Labor and Industries Building
350 Winter Street NE, Suite 410
Salem, OR 97301-3881
Telephone: (503) 378-4387

as Respondent complies with all terms and conditions of this Order and all requirements of the Insurance Code and any administrative rules promulgated thereunder. If, during the two year period following the effective date of this Order, Respondent complies with the terms of this Order and the Director has not initiated an enforcement action for new violations of the same provisions of the Insurance Code identified in this Order, the Director WAIVES the collection of the suspended CIVIL PENALTY assessed herein.

36. The remaining $100,000 total CIVIL PENALTY assessed above, as described in Paragraph 34B through Paragraph 34F, is not suspended and is due and payable at the time this Order is returned to the Division.

Remedial Measures

37. Not later than 60 days from the date of execution of this Order, Respondent will make changes to its claims processing procedures to ensure compliance with ORS 743B.450(1) and OAR 836-080-0235(4) and address the violations described in Paragraphs 3 through 5 and 20 through 22 above. Such changes include, but are not limited to, the following:

A. When there will be an initial delay in processing a claim within the time required by Oregon law (currently not later than the 30th day after its receipt), Respondent will provide written notification to the enrollee and provider concerning the delay ("Initial Notification"). The Initial Notification will include the reason more time is needed and an explanation of any additional information needed to process the claim in accordance with OAR 836-080-0235(4) and ORS 743B.450(1).

B. When there will be an additional delay in processing a claim within the time required by Oregon law (currently 45 days from the Initial Notification and every 45 days thereafter), Respondent will send written notification concerning the delay ("Additional Notification"). The Additional Notification will give the reason additional time is needed for investigation in accordance with OAR 836-080-0235(4).

Division of Financial Regulation
Labor and Industries Building
350 Winter Street NE, Suite 410
Salem, OR 97301-3881
Telephone: (503) 378-4387

Final Order

38. This Order is a "Final Order" under ORS 183.310(6)(b). Subject to that provision, entry of this Order in no way limits or prevents further remedies, sanctions, or actions which may be available to the Director under Oregon law to enforce this Order, for violations of this Order, for conduct or actions of Respondent that are not covered by this Order, or against any party not covered by this Order.

SO ORDERED this 30th day of September, 2019.

CAMERON C. SMITH, Director
Department of Consumer and Business Services

/s/ Dorothy Bean
Dorothy Bean, Chief of Enforcement
Division of Financial Regulation

[The remainder of this page intentionally left blank.]

Division of Financial Regulation
Labor and Industries Building
350 Winter Street NE, Suite 410
Salem, OR 97301-3881
Telephone: (503) 378-4387

CONSENT TO ENTRY OF ORDER

I, Thomas J. Bikales, state that I am an officer of Moda Health Plan, Inc. and I am authorized to act on its behalf. I have read the foregoing Order, and I know and fully understand the contents hereof. I have been advised of the right to a hearing and of the right to be represented by counsel in this matter. Moda Health Plan, Inc. voluntarily and without any force or duress consents to the entry of this Order, expressly waiving any right to a hearing in this matter. Moda Health Plan, Inc. understands that the Director reserves the right to take further actions to enforce this Order or to take appropriate action upon discovery of other violations of the Insurance Code. Moda Health Plan, Inc. will fully comply with the terms and conditions stated herein.

Moda Health Plan, Inc. understands that this Order is a public document.

/s/ Thomas J. Bikales
Signature

Thomas J. Bikales
Printed name

Secretary, General Counsel
Office held

ACKNOWLEDGMENT

There appeared before me this 11 day of September, 2019, Thomas J. Bikales, who was first duly sworn on oath, and stated that she/he was and is an officer of Moda Health Plan, Inc. and that she/he is authorized and empowered to sign this Consent to Entry of Order on behalf of Moda Health Plan, Inc. and to bind Moda Health Plan, Inc. to the terms hereof.

/s/ Rozalyn Larson
Signature of Notary Public

Division of Financial Regulation
Labor and Industries Building
350 Winter Street NE, Suite 410
Salem, OR 97301-3881
Telephone: (503) 378-4387