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

In the Matter of:	Case No. INS-18-0047
PROVIDENCE HEALTH PLANS, 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 Providence Health Plans, 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.

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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 September 5, 1984 with its principle

place of business at 3601 SW Murray Boulevard, Suite 10, Beaverton, OR 97005. Respondent's National Association of Insurance Commissioners company number is 95005.

2. Respondent is a health care service contractor that, at relevant times, provided health benefit plans to Oregon consumers through individual and group plans.

Claims Denials

3. Between January 1, 2013 and July 1, 2016, Respondent denied 208 claims ("Claim Denials") from members ("Covered Members") for procedures that Respondent considered to be elective in nature. The Covered Members were insured by Respondent policies ("Providence Policies") that contained a 12 month exclusion period ("Exclusion Period") under which certain procedures would not be covered because the procedures were considered elective in nature.

4. For any of the Covered Members that provided proof of insurance coverage ("Prior Coverage") prior to the effective date of their Providence Policy without more than a 63 day break without coverage, the Providence Policy provided that Respondent would reduce the duration of the Exclusion Period by the amount of the Prior Coverage.[1] Included in Respondent's Explanation of Benefits ("EOB") was the following: "The Member is responsible for furnishing proof of Creditable Coverage and evidence of the terms of benefits under the previous coverage." Respondent's EOB further instructed the member to "[c]ontact your prior health plan to request a Certificate of Creditable Coverage."[2]

5. For each of the 208 Claim Denials, Respondent sent the Covered Member a

[1] Respondent's policy wording for the Exclusion Period stated the following: "We will reduce the duration of the Exclusion Period by the amount of the Member's prior Creditable Coverage if the most recent period of Creditable Coverage ended within 63 days of the Effective Date of Coverage under this Individual Contract."

[2] Pursuant to 45 CFR § 146.115, beginning on December 31, 2014, health plans are no longer required to provide certificates of creditable coverage.

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letter requesting that they provide evidence of creditable coverage ("Creditable Coverage Request"). Each of the 208 Creditable Coverage Requests was sent on or after the day of the respective Claim Denial.

6. For each of the 208 Claim Denials, Respondent was in possession of an application from the respective Covered Member that indicated the existence of Prior Coverage. Each of the applications contained one or more of the following: (i) complete name of the prior carrier, (ii) policy number of the prior policy, or (iii) effective date of the Prior Coverage.

Incorrect Premium Quotes

7. In September 2017, Respondent sent 2,803 renewing members ("Renewing Members") that were known to be smokers a renewal notice ("Renewal Notice") that provided the Renewing Members with an estimated monthly premium payment amount for the 2018 plan year. The Renewal Notice erroneously estimated the premium for a non-tobacco user rather than a tobacco user.

8. On December 18, 2017, Respondent became aware of its error, realizing that the known smokers should have received a Renewal Notice with a higher estimated premium for a tobacco user. When Respondent discovered its error, invoices for the January premium had already been sent to members with the higher rate.

Delay Notification Letters

9. From January 1, 2015 to January 1, 2018, Respondent sent 154,997 initial delay notification letters ("30-Day Letters") to enrollees and providers notifying the enrollees and providers of a delay in processing claims. The 30-Day Letters gave no reason for the delay other than that additional time was needed for processing.

10. Of the 154,997 claims described in Paragraph 10 above, 46,662 claims were delayed an additional 45 days ("Additionally Delayed Claims").

11. For the Additionally Delayed Claims, Respondent sent additional delay

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notification letters ("45-Day Letters") to enrollees, notifying the enrollees of an additional delay in processing the claims. The 45-Day Letters gave no reason for the delay other than that additional time was needed for processing.

Delay after IRO Overturn Decision

12. On July 26, 2016, Respondent denied mental health outpatient services ("Denial of Mental Health Services") requested by the parents of Oregon consumer "BR."

13. On January 23, 2017, Respondent received a request for external review of the Denial of Mental Health Services.

14. On January 30, 2017, Respondent requested independent external review by the Independent Review Organization IPRO[3] of the Denial of Mental Health Services.

15. On February 16, 2017, IPRO found in favor of BR and reversed ("IRO Overturn") Respondent's Denial of Mental Health Services.

16. On February 20, 2017, Respondent provided the IRO Overturn to its mental health claims processing delegate.

17. On February 22, 2017, Respondent's delegate took action to effectuate the IRO Overturn, but did not do so accurately. The delegate issued two conflicting letters as to the scope of services authorized.

18. Adequate steps to remedy the resulting confusion and authorize services for BR were not completed until April 29, 2017, 72 days after the IRO Overturn.

Failure to Respond to the Director

19. In the course of the market conduct inquiry described in Paragraph 12 through Paragraph 18 above entitled "Delay after IRO Overturn Decision," the Division requested certain documents, including written or telephonic communication between Respondent

[3] The independent third party utilized by Respondent was IPRO (https://ipro.org/).

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and all other parties related to the IRO Overturn and the underlying requested services. Respondent failed to produce certain documents in a timely manner that were relevant to the Division's inquiry.

CONCLUSIONS OF LAW

The Director CONCLUDES that:

Cease and Desist

20. 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.

Claims Denials

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

22. For each Covered Member, Respondent was in possession of specific information, as described in Paragraph 6, that indicated that the Covered Member had Prior Coverage.

23. Including the sentence "[t]he Member is responsible for furnishing proof of Creditable Coverage and evidence of the terms of benefits under the previous coverage" in Respondent's EOB is not equivalent to a reasonable investigation based on all available information.

24. Sending a Creditable Coverage Request on or after the day of the Claim Denial is not equivalent to a reasonable investigation based on all available information.

25. Respondent violated ORS 746.230(1)(d) by failing to conduct a reasonable investigation based on all available information concerning Prior Coverage prior to denying the 208 claims described in Paragraph 3 through Paragraph 6.

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Incorrect Premium Quotes

26. Pursuant to ORS 746.075(2)(a), a person may not engage, directly or indirectly, in making, issuing, circulating or causing to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued.

27. Respondent violated ORS 746.075(2)(a) on 2,803 separate occasions by sending Renewing Members incorrect Renewal Notices as described in Paragraph 7.

Delay Notification Letters

28. 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.

29. 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. Forty-five days from the date of such initial notification and every 45 days thereafter while the investigation remains incomplete, the insurer shall notify the claimant in writing of the reason additional time is needed for investigation.

30. Pursuant to OAR 836-080-0210(3), first party claimant means a person asserting a right to payment under an insurance policy arising out of the occurrence of the contingency or loss covered by the policy.

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31. The enrollees described in Paragraph 9 through Paragraph 11 were asserting a right to payment under an insurance policy arising out of the occurrence of the contingency or loss covered by the policy and therefore are first party claimants as described in OAR 836-080-0210(3).

32. Respondent violated OAR 836-080-0235(4) on 154,997 separate occasions by sending 30-Day Letters without giving any reason for the delay as described in Paragraph 9.

33. Respondent violated OAR 836-080-0235(4) on 46,662 separate occasions by sending 45-Day Letters without giving any reason for the delay as described in Paragraph 11.[4]

Delay after IRO Overturn Decision

34. Pursuant to ORS 743B.257(1), an insurer shall comply in a timely manner with a decision of an independent review organization under ORS 743B.256 that reverses, in whole or in part, an adverse benefit determination.

35. Respondent violated ORS 743B.257(1) by taking 72 days to comply with the decision of an independent review organization as described in Paragraph 15 and Paragraph 18.

Failure to Respond to the Director

36. Pursuant to ORS 731.296, the Director may address any proper inquiries to any insurer, licensee or its officers in relation to its activities or condition or any other matter connected with its transactions. Any such person so addressed shall promptly and truthfully reply to such inquiries using the form of communication requested by the Director.

[4] OAR 836-080-0235(4) requires Respondent to provide 45-Day Letters to enrollees and providers. However, for purposes of this Consent Order, the Division is not asserting any violation for failing to provide the 45-Day Letters to providers because, on March 12, 2018, Respondent stated in a letter that "Providence Health Plan updated its systems to copy providers on the 45-day claim delay letter."

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37. Respondent violated ORS 731.296 by failing to timely provide the requested information described in Paragraph 19.

Civil Penalty

38. 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:

39. 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.

40. Based upon the foregoing and as authorized by ORS 731.988(1), the Director ORDERS that Respondent pay a CIVIL PENALTY of $210,000 as follows:

A. A CIVIL PENALTY of $50,000 for violations of ORS 746.230(1)(d) as described in Paragraph 25.

B. A CIVIL PENALTY of $50,000 for violations of ORS 746.075(2)(a) as described in Paragraph 27.

C. A CIVIL PENALTY of $50,000 for violations of OAR 836-080-0235(4) as described in Paragraph 32.

D. A CIVIL PENALTY of $25,000 for violations of OAR 836-080-0235(4) as described in Paragraph 33.

E. A CIVIL PENALTY of $25,000 for violating ORS 743B.257(1) as described in Paragraph 35.

F. A CIVIL PENALTY of $10,000 for violating ORS 731.296 as described in Paragraph 37.

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41. The $210,000 CIVIL PENALTY assessed above is due and payable at the time this Order is returned to the Division.

42. 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 17th day of July, 2019.

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

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

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CONSENT TO ENTRY OF ORDER

I, Michael L. Cotton, state that I am an officer of Providence 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. Providence 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. Providence 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. Providence Health Plan, Inc. will fully comply with the terms and conditions stated herein.

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

/s/ Michael L. Cotton
Signature

Michael L. Cotton
Printed name

Chief Executive Officer
Office held

ACKNOWLEDGMENT

There appeared before me this 28th day of June, 2019, Michael L. Cotton, who was first duly sworn on oath, and stated that she/he was and is an officer of Providence Health Plan, Inc. and that he is authorized and empowered to sign this Consent to Entry of Order on behalf of Providence Health Plan, Inc. and to bind Providence Health Plan, Inc. to the terms hereof.

/s/ Carol Strong Brandt
Signature of Notary Public

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