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

In the Matter of: PACIFICSOURCE HEALTH PLANS, Respondent.	Case No. INS-19-0097 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 PacificSource Health Plans ("PacificSource" or "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 signatures subscribed in this Order, Respondent hereby consents to entry of this Order upon the Director's Findings of Fact and Conclusions of Law.

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 June 20, 1940 with its principle place of business at 110 International Way, Springfield, Oregon, 97477. Respondent's National

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Association of Insurance Commissioners Number is 54976.

IRO Requests

2. From January 1, 2012 through December, 31 2016, Respondent received 48 requests for independent review ("IRO Requests") of an adverse benefit determination. On 22 occasions, Respondent did not notify the Division within 2 business days of receiving the IRO Request.

3. On March 31, 2017, Respondent explained to the Division that the delayed notifications were the result of a misunderstanding about the timeline for providing notification to the Division after receiving an IRO Request.[1]

4. On June 23, 2017, the Division sent a letter via email to Respondent with clarification and guidance (the "Division's Guidance") regarding the timeline for providing notification to the Division after receiving an IRO Request. The Division's Guidance instructed Respondent that "all member requests for an external review be communicated to the [Division] within two business days."

5. Additionally, the Division required that Respondent provide quarterly reports ("Quarterly Reports") to the Division documenting its compliance with IRO Request reporting requirements. The first Quarterly Report was due on October 13, 2017 and each Quarterly Report thereafter was due on the 15th day of the month following the end of the quarter.

6. Three Quarterly Reports were provided to the Division as follows:

A. The Quarterly Report due on October 13, 2017 was provided to the Division on October 23, 2017, ten days late.

B. After being contacted by the Division, Respondent provided the Quarterly Report for the preceding quarter on January 26, 2018.

[1] Respondent explained that its practice was to provide notification to the Division only after receiving an executed release of protected health information from the member.

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C. Again, after being contacted by the Division, Respondent provided the Quarterly Report for the further preceding quarter on April 20, 2018.

7. The Quarterly Reports documented that, notwithstanding the Division's Guidance, between July 1, 2017 and December 31, 2018, Respondent failed to give the Director notice of an IRO Request in nine different cases not later than the second business day.

Internal Appeals

8. From March 1, 2017 to December 31, 2018, Respondent received 727 appeals of adverse benefit determinations from enrollees ("Enrollee Appeals").

A. On 377 occasions, Respondent failed to provide an acknowledgment to the enrollee not later than the seventh day after receiving the Enrollee Appeal.

B. On 206 occasions, Respondent failed to make a decision ("Enrollee Appeal Decision") on an Enrollee Appeal not later than the 30th day after receiving notice of the appeal.

C. On 120 occasions, Respondent took longer than 30 days after the Enrollee Appeal Decision to provide written notification of the decision to the enrollee.[2]

9. From March 1, 2017 to December 31, 2018, Respondent received 2,831 appeals of adverse benefit determinations from providers ("Provider Appeals").

A. On 2,031 occasions, Respondent failed to provide an acknowledgement to the provider not later than the seventh day after receiving the Provider Appeal.

B. On 939 occasions, Respondent failed to make a decision ("Provider Appeal Decision") on a Provider Appeal not later than the 30th day after receiving notice of the appeal.

C. On 747 occasions, Respondent took longer than 30 days after the Provider

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[2] The notifications were provided after the Enrollee Appeal Decision as follows: between 31 and 45 days (43 occasions), between 46 and 60 days (45 occasions), between 61 and 90 days (32 occasions).

Appeal Decision to provide written notification of the decision to the provider.[3]

D. On two occasions, in response to a Provider Appeal, Respondent sent a letter to the provider explaining that the appeal review would not be completed within 30 days, but gave no explanation for the delay. After inquiries from the Division, on February 1, 2019[4] and March 29, 2019,[5] Respondent described that, for a temporary period of time, it sent appeal acknowledgement letters notifying the provider of a delay of 45 days without providing any justification for the delay.

CONCLUSIONS OF LAW

The Director CONCLUDES that:

Cease and Desist

10. 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 to discontinue or desist from such violation or threatened violation.

IRO Requests

11. 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.

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[3] The notifications were provided after the Provider Appeal Decision as follows: between 31 and 45 days (296 occasions), between 46 and 60 days (247 occasions), between 61 and 90 days (197 occasions), over 90 days (7 occasions).

[4] Respondent explained that "PacificSource had experienced a major influx and high volume of appeals received at a rate never experienced before, we were unable to comply with the standard and notified in writing of our intended timeline. PacificSource has implemented improvements to account for the influx and the 45 day language has been removed from our letter. Only in the event of circumstances beyond the control of PacificSource will any additional time be taken to send appeal determinations, and at the time of discovery of the special circumstance, the timeline extension will be communicated to the provider and/or member."

[5] Respondent stated that "[t]he letter sent on January 29, 2018 was representative of the '45 day' appeal acknowledgment letters that PacificSource was sending out at that point in time. PacificSource acknowledges that letters containing the 45 day response language had inadequate justification for adding the extension."

12. Respondent violated ORS 731.296 by failing to timely provide the required Quarterly Report as described in Paragraph 6 above.

13. Pursuant to ORS 743B.252(1), Respondent was required to have an external review program that allowed enrollees to obtain review by an independent review organization of a dispute relating to an adverse benefit determination by the insurer on one or more of the following: (a) whether a course or plan of treatment is medically necessary, (b) whether a course or plan of treatment is experimental or investigational, (c) whether a course or plan of treatment that an enrollee is undergoing is an active course of treatment for purposes of continuity of care under ORS 743B.225, or (d) whether a course or plan of treatment is delivered in an appropriate health care setting and with the appropriate level of care.

14. Pursuant to Oregon Administrative Rule ("OAR") 836-053-1340(1), an insurer shall give the Director notice of an enrollee's request for independent review by delivering a copy of the request to the Director not later than the second business day of the insurer after the insurer receives the request for the independent review.

15. Respondent violated OAR 836-053-1340(1) by failing to give the Director notice of a request for independent external review not later than the second business day after the request on nine different occasions as described in Paragraph 7 above.

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Internal Appeals

16. Pursuant to OAR 836-053-1100(1), an insurer must acknowledge receipt of an appeal from an enrollee not later than the seventh day after receiving the appeal.

17. Respondent violated OAR 836-053-1100(1) by failing to timely acknowledge receipt of an appeal on 377 occasions as described in Paragraph 8A above.

18. Pursuant to OAR 836-053-1100(2), an insurer must make a decision on an enrollee's appeal not later than the 30th day after receiving notice of the appeal.

19. Respondent violated OAR 836-053-1100(2) by failing to timely make a

decision on an enrollee's appeal on 206 occasions as described in Paragraph 8B above.

20. Pursuant to OAR 836-053-1140(1)(a), when a provider first appeals an insurer denial, the insurer must acknowledge receipt of the notice of appeal not later than the seventh day after receiving the notice.

21. Respondent violated OAR 836-053-1140(1)(a) by failing to acknowledge receipt of the notice of appeal on 2,031 occasions as described in Paragraph 9A above.

22. Pursuant to OAR 836-053-1140(1)(b), an appropriate medical consultant or peer review committee must review a provider's appeal and decide the issue not later than the 30th day after the insurer receives notice of the appeal.

23. Respondent violated OAR 836-053-1140(1)(b) by failing to timely decide the issue on appeal on 939 occasions as described in Paragraph 9B above.

24. Pursuant to ORS 743B.250(2)(a), all insurers offering a health benefit plan in this state shall establish procedures for making coverage determinations and resolving grievances that provide for timely notice of adverse benefit determinations.

25. Pursuant to ORS 743B.250(2)(c), all insurers offering a health benefit plan in this state shall establish procedures for making coverage determinations and resolving grievances that provide for written decisions.

26. Respondent violated ORS 743B.250(2)(a) and 743B.250(2)(c) by failing to provide timely written notice of an appeal decision on 867 occasions as described in Paragraph 8C and Paragraph 9C above.

27. Pursuant to OAR 836-053-1140(2)(c), a standard for timeliness in section (1) of this rule does not apply when circumstances beyond the control of a party prevent that party from complying with the standard, but only if the party who is unable to comply gives notice of the specific circumstances to the other party when the circumstances arise.

28. Respondent violated OAR 836-053-1140(2)(c) by sending appeal letters notifying the provider of a delay of 45 days without providing any justification for the

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delay as described in Paragraph 9D above.[6]

Civil Penalties

29. Pursuant to ORS 731.988(1), the Director may assess CIVIL PENALTIES in an amount not to exceed $10,000 per violation against a person who violates any provision of the Insurance Code or any lawful rule of the Director.

ORDERS

The Director issues the following ORDERS:

30. As authorized by ORS 731.252(1), the Director ORDERS Respondent to CEASE AND DESIST from violating ORS 731.296, OAR 836-053-1340(1), OAR 836-053-1100(1), OAR 836-053-1100(2), OAR 836-053-1140(1)(a), OAR 836-053-1140(1)(b), ORS 743B.250(2)(a), ORS 743B.250(2)(c), and OAR 836-053-1140(2)(c).

31. Based upon the foregoing and in accordance with ORS 731.988(1), the Director ORDERS Respondent pay a CIVIL PENALTY of $135,000 as follows:

A. A CIVIL PENALTY of $5,000 for violating ORS 731.296 as described in Paragraph 12 above.

B. A CIVIL PENALTY of $10,000 for nine violations of OAR 836-053-1340(1) as described in Paragraph 15 above.

C. A CIVIL PENALTY of $20,000 for 377 violations of OAR 836-053-1100(1) as described in Paragraph 17 above.

D. A CIVIL PENALTY of $20,000 for 206 violations of OAR 836-053-1100(2) as described in Paragraph 19 above.

E. A CIVIL PENALTY of $20,000 for 2,031 violations of OAR 836-053-1140(1)(a) as described in Paragraph 21 above.

F. A CIVIL PENALTY of $20,000 for 939 violations of OAR 836-053-1140(1)(b)

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[6] The Division reviewed two letters that violated OAR 836-053-1140(2)(c), but the exact number of violations due to Respondent's business practices at the time is unknown.

as described in Paragraph 23 above.

G. A CIVIL PENALTY of $20,000 for 867 violations of ORS 743B.250(2)(a) and 743B.250(2)(c) as described in Paragraph 26 above.

H. A CIVIL PENALTY of $20,000 for violations of OAR 836-053-1140(2)(c) as described in Paragraph 28 above.

32. The $135,000 CIVIL PENALTY assessed above is due and payable at the time this Order is returned to the Division.

SO ORDERED this 24th day of August, 2020.

ANDREW R. STOLFI, Director
Department of Consumer and Business Services

Dorothy Bean, Chief of Enforcement
Division of Financial Regulation

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CONSENT TO ENTRY OF ORDER

I, Kenneth P. Provencher, state that I am an officer of PacificSource Health Plans and I am authorized to act on its behalf. I have read the foregoing Consent 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. PacificSource Health Plans voluntarily and without any force or duress consents to the entry of this Consent Order expressly waiving any right to a hearing in this matter. PacificSource Health Plans understands that the Director reserves the right to take further actions to enforce this Consent Order or to take appropriate action upon discovery of other violations of the Insurance Code. PacificSource Health Plans will fully comply with the terms and conditions stated herein.

PacificSource Health Plans understands that this Consent Order is a public document.

Signature

Kenneth P. Provencher

Printed name

President and CEO

Office held

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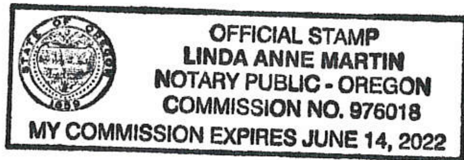
ACKNOWLEDGMENT

There appeared before me this 7th day of August, 2020, Kenneth P. Provencher, who was first duly sworn on oath, and stated that she/he was and is an officer of PacificSource Health Plans and that she/he is authorized and empowered to sign this Consent to Entry of Order on behalf of PacificSource Health Plans and to bind PacificSource Health Plans to the terms hereof.

Linda Anne Martin

Signature of Notary Public



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