STATE OF OREGON

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

DIVISION OF FINANCIAL REGULATION

REPORT OF TARGET MARKET CONDUCT EXAMINATION

OF

PROVIDENCE HEALTH PLAN
3601 SW Murray BLVD
BEAVERTON, OREGON 97005

National Association of Insurance Commissioners (NAIC)
COMPANY CODE 95005
Providence Health Group 4788

AS OF

DECEMBER 31, 2018

EXECUTIVE SUMMARY

On March 18, 2019 examination staff from the Division of Financial Regulation (division) arrived at Providence Health Plan (Providence, company) to complete a targeted Market Conduct Examination on Mental Health and Substance Use Disorder (MH/SUD) coverage. The division examined the company on five areas: Operations Management, Claims, Grievance Procedures, Network Adequacy, and Utilization Review. The examination team concluded the on-site portion of the targeted examination on August 15, 2019. Of the fifteen examination standards applied to the company, the company passed 13 and passed three with comment.

Noncompliant practices were identified, some of which may extend to other jurisdictions. The company is directed to take immediate corrective action to demonstrate its ability and intention to conduct business according to Oregon insurance laws and regulations. When applicable, corrective action for other jurisdictions should be addressed. Please find the attached Report by Exception, which reports only on areas of noncompliance identified during the examination.

Examination Standards Passed without Comment
The company passed the following examination standards without comment.

Oregon Standard 1 NAIC Operations/Management Standard 6	Monitoring outsourced services.	ORS 744.720, ORS 744.740
Oregon Standard 2 NAIC Operations/Management Standard 9	Cooperation with examiners.	ORS 731.308, ORS 732.584
Oregon Standard 3 NAIC Operations/Management Standard 18	Complete and accurate reporting.	ORS 731.296 ORS 732.584
Oregon Standard 4 NAIC Claims Standard 1	Handling claims files.	ORS 743B.450, ORS 743B.452, ORS 746.230, OAR 836-080-0080, OAR 836-080-0215, OAR 836-080-0225, OAR 836-080-0230, OAR 836-836-080-0235
Oregon Standard 6 NAIC Grievance Procedures Standard 1	The health carrier treats as a grievance any written complaint, and any oral complaint that involves an urgent care request, submitted by or on behalf of a covered person regarding: (1) the availability, delivery, or quality of health care services, including a complaint regarding an	ORS 743B.001(7), ORS 743B.250, OAR 836-053-1060

Examination Standards Passed with Comment
The company passed three examination standards with comment.

Oregon Standard 5 (NAIC Claims Standard 3)	The group health plan complies with the requirements of the federal Mental health Parity Act of 1996 (MHPA) and the revisions made in the Mental Health Parity and Addiction Equity Act of 2008.	45 CFR 146.136, ORS 743A.168, OAR 836-053-1408
Oregon Standard 14 (NAIC Utilization Review Standard 5)	The health carrier provides written notices of an adverse determination of standard utilization review and benefit determinations in compliance with applicable statutes, rules, and regulations.	ORS 743B.001, ORS 743B.250, ORS 743B.252, OAR 836-053-1200 OAR 836-080-0235
Oregon Standard 15 (NAIC Utilization Review Standard 7)	The health carrier monitors the activities of the utilization review organization or entity with which the carrier contracts and ensures that the contracting organization complies with applicable state provisions equivalent to the Utilization Review and Benefit Determination Model Act (#73) and accompanying regulations.	ORS 743B.422 ORS 743B.423 ORS 744.740

Recommendations

- The company should make any necessary revision to algorithms, or other automated claims management and utilization review systems, to ensure that algorithms used for MH/SUD utilization management are applied consistently in operation for both MH/SUD and medical service claims.
- While the division permits the use of medical management during Utilization Review, the company must provide adverse benefit determination notices, including grievance and appeals information, when the medical management decision results in a reduction or denial of items or services from what was originally requested.
- The company should be reexamined to ensure that recommended changes are implemented.

Pursuant to ORS 743B.505, OAR 836-053-0350, and OAR 836-053-1190, health benefit plan insurers are required to maintain a provider network sufficient in size, geographic distribution, and provider type to ensure access to covered services. Examiners reviewed documentation related to network adequacy, relevant definitions, the online provider directory, company networking practices, company procedures for maintaining and updating provider directories; responses to inquiries; and reports demonstrating adherence to national accreditation standards for compliance with state law.

Utilization Review
ORS 743B.001, ORS 743B.420, ORS 743B.422, ORS 743B.423, OAR 836-053-1130, and OAR 836-053-1200, prescribe requirements for insurers that provide utilization review, including the rights and responsibilities of insurers, consumers, and providers impacted by a company decision that resulted in a reduction of medically necessary items or services from what was originally requested. Examiners reviewed a sample of utilization review cases[1]; company procedures and practices relevant MH/SUD; company definitions; form letters used by the company; certificates of adherence to national accreditation standards for compliance with state and federal law; training agendas; annual reports submitted to the division; company guidance documents, and inquiry responses.

Error Testing
Consistent with National Association of Insurance Commissioners (NAIC) guidelines, the examiners applied a benchmark error rate of 7 percent on claims and utilization review samples and a 10 percent threshold for all other tests.

Company History
Providence Health Plan, an Oregon licensed health care service contractor, was formed as The Good Health Plan in 1984 by Providence Portland Medical Center and Providence St. Vincent Hospital. In 1997, the company was renamed Providence Health Plan following a merger between The Good Health Plan of Washington and SelectCare Health Plan of Southern Oregon. Following a 2016 merger between Providence Health and Services and St. Joseph Health the division authorized a corporate reorganization to facilitate the consolidation of the hospital systems with the insurance company. Providence Health Plan is now part of the integrated delivery system of Providence St. Joseph Health, a not-for-profit health and social services system.

The Company operates in seven states, Alaska, California, Montana, New Mexico, Oregon, Texas, and Washington. In Oregon the company offers a variety of health insurance products, including health benefit plans in the individual market, the small group market, and the large group market. Providence Health Plan currently serves more than 640,000 members across these lines of business. The company contracts with some third party administrators (TPA) for administration of some business processes.

Findings

The Company's underlying data was measured against established standards communicated to the company on February 13, 2019. The examiners used the following three classifications to disclose the examination results:

[1] Samples reviewed by examiners include: requests for prior authorization and concurrent review submitted by in and out of network providers on behalf of enrolled members.

Finding Two

Phase	Utilization Review
Applicable Standard	Standard 15, The health carrier monitors the activities of the utilization review organization or entity with which the carrier contracts and ensures that the contracting organization complies with applicable state provisions. (NAIC standard 7)
Result	Passed with Comment

The division determined that while the company had a monitoring system in place for TPAs, the system failed to identify that the TPA did not provide adverse benefit determination notices when the company's decision resulted in a reduction of services or items from what was requested required by ORS 743B.250.

Finding Three

Phase	Utilization Review
Applicable Standard	Standard 14, Providing written notice of adverse benefit determination of standard utilization review (NAIC standard #5)
Result	Passed with comment

When a prior authorization request for medically necessary item or service is reduced from the original amount requested, an adverse benefit notification to the member is required. Without this notification consumers are not notified of their appeal and grievance rights as required by ORS 743B.250. Without this notification the consumer would be unaware that the items or services requested by their provider had been reduced. The definition of an adverse benefit determination in ORS 743B.001 includes a reduction of items or services.

The TPA acting on behalf of the company did not provide these adverse determination notices when a prior authorization request was approved, but with a reduction to the originally requested amount of medically necessary items or services.

Additional Findings

Phase Utilization Review

The division identified that the company's TPA utilizes a system of alert algorithms for administration of MH/SUD prior authorizations and concurrent care reviews that are not used by the company for medical services. The algorithms used by the TPA generate concurrent review referrals more frequently, and with shorter review periods, than those presented as the equivalent for medical services. The company presented "outlier management of recurring outpatient visits" as "comparable" to the TPA's algorithms for administering prior authorization and concurrent care reviews.

The company is responsible for administering benefits in compliance with state and federal mental health parity regulations. The tests performed by the division were not designed to substantiate/validate noncompliance with non-quantitative treatment limits (NQTLs). Federal guidance provided to regulators and insurers note that identification of NQTL violations requires further evaluation.

AFFIDAVIT

STATE OF OREGON }
} ss
County of Marion }

The examination was conducted under Oregon Department of Consumer and Business Services and Department of Financial Regulation procedures.

Tashia Sizemore
Life and Health Program Manager
Division of Financial Regulation, Department of Consumer and Business Services
State of Oregon

BEFORE ME, the undersigned authority, on this 27th day of April, 2023 personally appeared Tashia Sizemore, proven to me to be the person whose name is subscribed to the fore going document and acknowledged to me that she executed the same for the purposes and consideration therein expressed.

Janet Vitus
Janet Vitus
Date: 04/27/2023

OFFICIAL STAMP
JANET VITUS
NOTARY PUBLIC - OREGON
COMMISSION NO. 1030442
MY COMMISSION EXPIRES NOVEMBER 21, 2026

10	The health carrier provides at enrollment a provider directory listing all providers participating in its network. It also makes available, on a timely and reasonable basis, updates to its directory. (NAIC Standard 8)	OAR 836-053-0350
	Phase 5 Utilization Review	
11	The health carrier establishes and maintains a utilization review program in compliance with statutes, rules and regulations. (NAIC Standard 1)	ORS 743B.420, ORS 743B.422, ORS 743B.423, OAR 836-053-1130, OAR 836-053-1200
12	The health carrier operates its utilization review program in accordance with the applicable state statutes, rules and regulations (NAIC standard 2)	ORS 743B.422, OAR 836-053-1200
13	The health carrier makes standard utilization benefit determinations in a timely manner and as required by applicable state statutes, rules and regulations, as well as the provisions of HIPAA. (NAIC Standard 4)	ORS 743B.420, ORS 743B.422, ORS 743B.423
14	Providing written notice of adverse benefit determination of standard utilization review (NAIC Standard 5)	ORS 743B.001, OAR 836-053-1200
15	The health carrier monitors the activities of the utilization review organization or entity with which the carrier contracts and ensures that the contracting organization complies with applicable state provisions. (NAIC Standard 7)	ORS 743B.422, ORS 743B.423