DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

OREGON DIVISION OF FINANCIAL REGULATION

TARGETED MARKET CONDUCT EXAMINATION

REPRODUCTIVE HEALTH EQUITY ACT

OF

BRIDGESPAN HEALTH COMPANY

AS OF

DECEMBER 31, 2020

NAIC No. 95303

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FOREWORD

January 23, 2023

Honorable Andrew Stolfi
Director, Insurance Commissioner
Department of Consumer and Business Services
350 Winter Street NE
Salem, Oregon 97301-3883

Dear Director Stolfi:

This market conduct examination report of BridgeSpan Health Company (insurer) was prepared by independent examiners contracting with the Oregon Division of Financial Regulation (division). A market conduct examination is conducted for the purpose of examining certain business practices of insurers licensed to conduct business in Oregon. The examiners conducted the examination of the insurer in accordance with the Oregon Revised Statutes (ORS) 731.300. All work papers and data developed in the production of this report are the sole property of the division. The examiner in charge was Jimmy R Potts, CIE, MCM, FLMI, CLU, AIRC.

Certain unacceptable or noncomplying practices may not have been discovered in the course of this examination. Additionally, findings may not be material to all areas that would serve to assist the commissioner. Failure to identify or criticize specific insurer practices does not constitute acceptance of those practices by the division.

Respectfully submitted,
Tashia Sizemore
Tashia Sizemore
Tashia Sizemore
Life and Health Program Manager

Signed and acknowledged before me on January 24, 2023 by Janet Vitus as notary in Marion County, State of Oregon.
Janet Vitus

EXECUTIVE SUMMARY

In 2017, Oregon enacted House Bill (HB) 3391, known as The Reproductive Health Equity Act (RHEA). HB 3391 is now codified, in part, as Oregon Revised Statutes (ORS) 743A.067. RHEA requires, among other things, that a health benefit plan may not impose on an enrollee a deductible, coinsurance, copayment or any other cost-sharing requirements on the specific reproductive health services.

The focus of this targeted market conduct examination includes, but was not limited to, both insurer's claims and complaints as related to the RHEA codified at ORS 743A.067. The examiners identified instances where the insurer was not in compliance with RHEA laws in its administration of claims. Additionally, the insurer's policyholder services and complaints were reviewed with regard to RHEA.

The examiners, as set forth in detail in this examination report, concluded that the insurer's claims processing systems and procedures did not identify all claims which should have been considered under ORS 743A.067.Examiners identified instances of noncompliance with RHEA in the insurer's administration of claims. The examiners concluded that claims processing systems and procedures did not identify all claims which should have been considered under ORS 743A.067. Specific findings related to the examination are summarized below:

- **Non-compliance with ORS 743A.067 relating to the processing of claims** – The insurer failed to equitably settle claims when the insurer applied member cost share to services or supplies where such services or supplies are required to be provided without member cost share under Oregon law. The insurer's claims processing system failed to accurately pay claims according to RHEA. The insurer did not consider certain services subject to RHEA when those services were billed using certain CPT codes or received in specific settings. In some instances, even though the Insurer acknowledged that the underlying service was subject to RHEA, the insurer inappropriately applied criteria that limited when RHEA services were paid without member cost share, resulting in member cost share being applied inappropriately.

- **Noncompliance with the requirement to reimburse 12-month contraceptive prescription refills as required by ORS 743A.066 and noncompliance with contraception coverage requirements under 743A.067** – The insurer failed to provide coverage for prescription contraceptive drugs which did not have a therapeutic equivalent and provided inconsistent access to 12 month refills of contraception.[1]

This examination report, relating to RHEA claims for the period of January 1, 2019, to December 31, 2020, may be forwarded to the division's enforcement unit for enforcement consideration while the insurer responds to the corrective actions identified in the examination report.

[1] The insurer provided information to demonstrate in some cases 12-month contraceptives fill requests were approved, however, the division has remaining questions and will be requesting additional information to understand the insurer's handling of 12-month contraceptive fill requests.

SCOPE AND METHODOLOGY

The targeted market conduct examination of the insurer was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (NAIC) and under the authority set forth in ORS 731.300 and direction from the division. The examination of the insurer covered the period of time from January 1, 2019, to December 31, 2020, for business reviewed. The purpose of the examination was to determine the insurer's compliance with ORS 743A.067, Oregon's Reproductive and Health Equity Act.

The following is taken directly from written documentation provided by BridgeSpan Health insurer:

> BridgeSpan Health insurer (BridgeSpan) is a Utah for-profit taxable HMO and was registered with the Utah Secretary of State on August 10, 1982 and is a subsidiary of: Regence BlueShield (RBS), 44.7 percent; Regence BlueCross BlueShield of Oregon (RBCBSO), 19.2 percent; Regence BlueCross BlueShield of Utah (RBCBSU), 17.0 percent; and Regence BlueShield of Idaho, Inc. (RBSI), 19.1 percent.
>
> RBS (a Washington nonprofit taxable HCSC), RBCBSO (an Oregon nonprofit taxable HCSC), and RBCBSU (a Utah nonprofit taxable HCSC), all are 100 percent owned by Regence Insurance Holding Corporation (RIHC), its sole member. RIHC is an Oregon nonprofit non-insurance holding insurer, and its sole member is Cambia Health Solutions, Inc. (Cambia), an Oregon nonprofit non-insurer holding insurer.
>
> Cambia is the ultimate parent of RBS, RBCBSO, RBCBSU, and BridgeSpan.
>
> RBSI is an Idaho mutual insurer owned by its members and affiliated with Cambia Health Solutions, Inc., through a Management and Administrative Services Agreement.
>
> BridgeSpan is licensed with the state of Utah as a Health Maintenance Organization under a Certificate of Authority issued April 22, 1981. BridgeSpan is also licensed with the following: (i) state of Idaho as a Managed Care Organization under a Certificate of Authority issued January 18, 2013; (ii) state of Oregon as a Health Care Services Contractor under an insurer's Certificate of Authority issued January 7, 2013; and (iii) state of Washington as a Health Care Service Contractor under a Certificate of Registration issued March 27, 2013.
>
> BridgeSpan also holds foreign authority to conduct business with the Secretary of State in the following states: (i) state of Idaho on April 1, 2016; (ii) state of Oregon on April 4, 2016; and (iii) state of Washington on April 1, 2016.
>
> Cambia is a fully taxed, nonprofit corporation that traces its history back to 1917 and, together with its affiliates, serves as a catalyst to transform health care, creating a person-focused and economically sustainable for its customers and their families.

The examiners utilized examinations by test and by sample. Examination by test involves the review of all records within the populations, while examination by sample involves the review of a selected number of records from within the population. File sampling was based on a review of complaints and RHEA medical and prescription drug claims, as identified by the insurer, incurred during the period under examination and selected at random using computer software applied to data files provided by the insurer. Samples are tested for compliance with standards established by the NAIC and adopted by the division.

FINDINGS AND OBSERVATIONS – COMPLAINT REVIEW

The examiners reviewed the entire population of complaints identified by the insurer and did not find any reportable exceptions.

FINDINGS AND OBSERVATIONS – CLAIMS

Medical claims review

The examiners reviewed paid and denied medical claims on the insurer's claim processing system to determine if the claim was properly adjudicated in accordance with Oregon's RHEA law. Where apparent violations were noted the examiners issued findings, by line of business and by paid or denied status.[2] The examiners found that the claims adjudication was fairly consistent, i.e., if a certain CPT code was subject to member cost share in one instance it would most likely be subject to member cost share in other files reviewed. However, no assumptions were made that this would be true, and each identified apparent violation was carefully reviewed by the examiners.

For each violation noted, the examiners requested the insurer provide a PDF copy of the claim form submitted and all applicable explanation of benefits (EOB) related to that particular claim. Further, the examiners generally asked that the insurer provide a written response to any claims where the examiners had questions regarding the processing of such claim prior to the examiners determining if such claim was processed incorrectly and a finding of noncompliance was issued regarding that claim.

In instances where the primary diagnosis code would indicate that the reason for the visit was a women's well woman, preventive, or gynecological visit, the examiners required RHEA listed services to be paid without member cost share. In other instances, the examiners determined that the primary reason for the visit was not related to RHEA and a member cost share could be applied to services that were not specific to RHEA. However, without regard to the listed diagnostic code, if a service was performed that was listed in ORS 743A.067, including screenings and services identified by the US Preventive Services Task Force (USPSTF) or the Health Resources and Services Administration of the US Department of Health and Human

[2] See Tables 2 and 3 in Appendix. Table 2 sets forth for each line of business the frequency that Oregon law was violated across all lines of business. The examiners specific findings are found under each finding listed after Table 2. Table 3 sets forth for each line of business the population, sample size and financial impact of the claims which were not properly adjudicated

Services (HRSA) as a recommended preventive service, and member cost share was applied to that service, then such claims were identified as an apparent violation. Further, there could be multiple apparent violations identified and reported in a single file, however, for reporting of overall violations noted, each file is only counted once by the examiners.

EXAMINER COMMENT

The examiners reviewed a sample of 105 paid RHEA claims from a population of 1,451 paid claims. The examiners determined that the insurer incorrectly processed 17 of those claims.

The examiners submitted specific questions regarding the processing of claims identified as possibly noncompliant to the insurer for its response. The insurer provided various explanations for not processing a claim without cost share as required under Oregon law. The insurer referenced in numerous responses that coverage was not required by ACA. The insurer did not appear to have made the requisite adjustments to process claims under Oregon's RHEA law, which, in many instances required more coverage than is afforded under ACA.

The examiners are of the opinion that the automated claims adjudication mapping used by the insurer to determine whether or not a claim should be subject to member cost share is not robust enough to capture all of the instances where member cost share should be waived.

Provider billing using generic CPT and diagnosis codes

In determining whether claims should be subject to RHEA, the examiner considered CPT codes and stated diagnosis codes. Where the examiners cited a violation of member cost share requirements it is because the examiners reviewed the claim in totality and determined that certain services, giving deference to the stated diagnosis codes, should have been paid without member cost share. In many instances the entire claim was comprised of services which were required to be covered without member cost share, but member cost share was applied to one or more of the subject services. Where the examiners concluded that the claim was subject to RHEA and the insurer assessed member cost share, those claims were cited as being in violation of Oregon law.

Preventive vs. diagnostic

The examiners conducted this review in accordance with the coverage requirements under ORS 743A.067, which requires coverage for specific services performed by the health care provider, including screening tests where a specific ACA diagnosis for that condition is not necessarily provided. For instance, if a person went in for treatment of nausea and a screening for anemia was conducted, such screening is a covered service under RHEA. The requirement of providing benefits without member cost share is not limited to services considered preventative care under the ACA.

The examiners, in addition to ORS 743A.067, reviewed 45 CFR Part 147.130(a)(2)(i) which addresses the application of member cost share under ACA solely to the office visit. Specifically, it states:

(i) If an item or service described in paragraph (a)(1) of this section is billed separately (or is tracked as individual encounter data separately) from an office visit, then
a plan or issuer may impose cost-sharing requirements with respect to the office visit.

(ii) If an item or service described in paragraph (a)(1) of this section is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then
a plan or issuer may not impose cost-sharing requirements with respect to the office visit.

Further, if a woman went in for a preventive visit and tests are conducted which would not normally be considered RHEA tests, i.e., blood panels, labs, etc., such services would still need to be covered under the preventive requirements under the RHEA law as they are preventive in nature. In reviewing the quoted federal law, it appears that the law is silent on the carrier's ability to apply member cost share to preventive/screening lab tests. Absent law to the contrary, the examiners assert that the insurer should have considered preventive/screening lab tests conducted in conjunction with women's preventive or gynecological visits without applying member cost share.

Inadequacies in claims processing system

Using statutory language that outlines required services the examiners identified certain CPT codes that alone, or when combined with certain diagnosis codes, would require that the subject claims be paid without member cost share under ORS 743A.067. In some instances, the entire claim, including the physician office visit, should be paid without member cost share while in other instances only certain services submitted on the claim would need to be covered without member cost share. The insurer's claims process, including system and programming, would need to be robust enough to identify, by CPT and diagnosis codes, which services should be covered without member cost share. The examiners observed during their review of sampled claims that it appeared the Insurer failed to consider all pertinent regulatory requirements when determining if a service should be considered without applying member cost share. Further, there are certain covered RHEA items that are to be paid without member cost share without consideration of the reason for the visit and any associated diagnosis codes, specifically abortion and contraception.

There are other services which may not on their face be subject to RHEA but when considered in the context of the claim would need to be covered without member cost share. For instance, when the purpose of the visit is for a well woman or gynecological checkup then related labs would need to be covered without member cost share as part of the preventive visit.

Further, while the examiners identified certain CPT codes that in their opinion represent services that need to be covered without cost share to comply with RHEA the list of CPT codes utilized by the examiners may not have been exhaustive. The insurer is responsible to assure that all claims are adjusted in accordance with Oregon law and the insurer's policy provisions.

The examiners conducted an analysis of codes they identified as RHEA codes and found that the insurer had not identified all potential codes in its universe of claims which should have been

covered without member cost share. The insurer was not in compliance with ORS 743A.067 as it did not capture all CPT codes subject to RHEA. Although there are multiple instances of non-compliance the examiners are citing the failure to identify all RHEA CPT codes as one (1) violation of ORS 743A.067.

Finding 1: Noncompliance with ORS 743A.067 relating to the processing of claims

The insurer was not in compliance with 743A.067 in that the insurer applied member cost share to services or supplies where such services or supplies are required to be provided without member cost share by Oregon law.

There were 62violations noted which affected 17 paid claims, however each claim is only considered an error one time.

Paid claims – Individual

Population	Sample size	Number of errors	Error rate
1,451	105	17	16%

Finding 2: Noncompliance with the requirement to reimburse 12-month contraceptive prescription refills as required by ORS 743A.066 and noncompliance with contraception coverage requirements under 743A.067

Prescription drug review

The examiners reviewed paid and denied prescription drug claims on the insurer's claim processing system to determine if the claim was properly adjudicated in accordance with Oregon's RHEA law. A frequent reason for the insurer's denial of a prescription claim was that the prescription was not eligible for refill at the time of request due to an insufficient amount of time passing since the previous dispensing of that drug. In some instances, claims were denied even though the claims were made after the date of eligibility listed in the denial code.

In other instances, the eligibility date was found to be inappropriate. The examiners found evidence that the insurer uses standard utilization edits at the point-of-sale, such as a "refill too soon" denial. This limits access to contraceptives if the member has not used at least 75 percent of their current prescription. In the case of oral contraceptives, several products utilize a 28-day cycle where the first 21 pills contain hormonal drugs and the last 7 pills are a placebo sugar pill. Individuals may choose or are counseled by their provider to skip the placebo week, which could result in finishing their prescribed oral contraceptive sooner than permitted by the insurer's point-of-sale claims adjudication. While a "refill too soon" denial may catch fraud or misuse of other prescription drugs, the examination found that these denials may have resulted in limiting access to oral contraceptives.

Other reasons provided for inappropriate denials included that the drug was not in the insurer's

formulary, the dosage amount was not consistent with the amounts in the formulary, and the pharmacy had entered the members' demographic information incorrectly.

The examiners generally asked that the insurer provide a written response to any claims where the examiners had questions regarding the processing of such claim prior to the examiners determining if such claim was processed incorrectly and a finding of noncompliance was issued regarding that claim.

EXAMINER COMMENT

The examiners reviewed a sample of 109 denied individual prescription claims out of a population of 109 denied individual prescription claims.

The insurer was not in compliance with ORS 743A.066, and 743A.067 in that the insurer failed in nine instances to provide coverage for prescription contraceptive drugs which did not have a therapeutic equivalent, and in41 instances the insurer wrongfully denied a claim for being refilled too soon since the last dispensing.

There were 41 violations noted which affected 41 denied Individual prescription claims, however each claim is only considered an error one time.

Denied individual prescription claims

Population	Sample size	Number of errors	Error rate
109	109	41	37%

Complaint review

The examiners reviewed the entire population of complaints identified by the insurer and did not find any reportable errors.

RECOMMENDATIONS

The examiners recommend:

1. The insurer review its policies and procedures to assure that all claims are adjudicated in accordance with Oregon insurance law, including but not limited to, ORS 743A.067.

2. The insurer review all paid and denied prescription contraceptive claims to assure that all contraceptive claims, which are not in the formulary, were appropriately adjudicated. If there is not a therapeutic equivalent, then such contraceptive drugs should be covered without member cost share.

3. The insurer provide further information to the Division demonstrating handling of 12-month contraceptive claims to ensure compliance with refill requirements.

4. The insurer identify all pertinent CPT codes for services, drugs, devices, products and procedures listed in ORS 743A.067, and where applicable diagnostic codes required to properly adjudicate RHEA claims. The insurer should also consider that the purpose of ORS 743A.067 is to improve access the services identified in statute and limit medical management of those services to ensure access consistent with the purpose.

APPENDIX

Table 1: Errors by line of business

Line of business	Total claims	Sample claims	Number of errors	Error rate
Individual paid medical claims	1,451	105	17	16%
Individual denied prescription claims	109	109	41	37%
Failure to identify all pertinent RHEA Codes	N/A	N/A	1	N/A

Table 2: Violations found for paid claims by statutory reference

Statute	Finding	Number of violations – individual paid
743A.067(2)(a)	Well woman care	5
743A.067(2)(c)(A)	Chlamydia	2
743A.067(2)(c)(B)	Gonorrhea	2
743A.067(2)(c)(G)	Syphilis	2
743A.067(2)(c)(H)	Anemia	15
743A.067(2)(c)(I)	Urinary tract infection	3
743A.067(2)(c)(J)	Pregnancy	2
743A.067(2)(c)(K)	RH incompatibility	1
743A.067(2)(c)(O)	Cervical cancer	1
743A.067(2)(l)(A)	Education/counseling sterilization and contraception	3
743A.067(3)	Improper cost share	26
Total violations count		62

Table 3: Population, sample size, and financial impact of the paid claims improperly adjudicated

	Underpayment – individual paid
RHEA POPULATION	1,451
RHEA SAMPLE	105
TOTAL VIOLATIONS	137
NUMBER OF CLAIMS AFFECTED	26
PERCENTAGE VIOLATION	24.76%

Table 4: Violations found for denied prescription claims by statutory reference

Statute	Finding	Number of violations – individual denied
743A.066	Contraceptive drugs delaying access	32
743A.067(2)(j)	Contraceptive drugs, devices or product	9
Total Violations Count		41

Table 5: Population, sample size and financial impact of the denied prescription claims improperly adjudicated

	Undercharge – individual denied
RHEA CLAIMS POPULATION	109
RHEA SAMPLE	109
TOTAL VIOLATIONS	9
NUMBER OF CLAIMS AFFECTED	9
PERCENTAGE VIOLATION	8.26%

Table 6: Sets forth findings for samples from the paid individual market claims population.

Population:	Examination review item (sample)	Diagnosis code	CPT code	Finding
Paid individual	3	Z0000	85027	Improper cost share
Paid individual	7	B20	86593	Improper cost share
Paid individual	20	Z01419	36415	Improper cost share
Paid individual	24	Z0000	84443; 80053; 85025	Improper cost share
Paid individual	27	Z01419	87480; 87510; 87660	Improper cost share
Paid individual	37	B20	85025	Improper cost share
Paid individual	40	Z3009	99214	Improper cost share
Paid individual	43	Z01419	81002	Improper cost share
Paid individual	44	T8332XA	80053; 85025; 87210; 87491; 87591; 87798; 81001; 72170; 76830; 76856; 58301; 96374; 99284	Improper cost share
Paid individual	48	Z3A01	80053; 84443; 84702; 86900; G0123	Improper cost share
Paid individual	63	Z3202; Z3009	81025; 99204	Improper cost share
Paid individual	69	Z124	87491; 87591	Improper cost share
Paid individual	70	Z0001	80053; 84443; 85027	Improper cost share
Paid individual	76	Z119	86592	Improper cost share
Paid individual	77	Z0000	81002	Improper cost share
Paid individual	87	Z0000	85025	Improper cost share
Paid individual	102	Z0000	85025	Improper cost share

Table 7 sets forth findings for samples from the denied individual RHEA prescription population.

Population:	Examination review item (sample)	Diagnosis code	CPT code	Finding
Denied individual RHEA Prescriptions	2	N/A	N/A	Improper denial – dispensing limits
Denied individual RHEA Prescriptions	3	N/A	N/A	Improper denial – dispensing limits
Denied individual RHEA prescriptions	12	N/A	N/A	Improper denial – dispensing limits
Denied individual RHEA Prescriptions	15	N/A	N/A	Improper denial – dispensing limits
Denied individual RHEA Prescriptions	21	N/A	N/A	Improper denial – dispensing limits
Denied individual RHEA Prescriptions	22	N/A	N/A	Improper Denial - Not in formulary
Denied individual RHEA Prescriptions	24	N/A	N/A	Improper Denial - Not in formulary
Denied individual RHEA Prescriptions	25	N/A	N/A	Improper Denial - Not in formulary
Denied individual RHEA Prescriptions	26	N/A	N/A	Improper Denial - Not in formulary
Denied individual RHEA Prescriptions	27	N/A	N/A	Improper denial – dispensing limits
Denied individual RHEA prescriptions	29	N/A	N/A	Improper Denial - Not in formulary
Denied individual RHEA Prescriptions	32	N/A	N/A	Improper Denial - Not in formulary
Denied individual RHEA Prescriptions	37	N/A	N/A	Improper denial – dispensing limits
Denied individual RHEA Prescriptions	44	N/A	N/A	Improper denial – dispensing limits
Denied individual RHEA Prescriptions	47	N/A	N/A	Improper denial – dispensing limits
Denied individual RHEA Prescriptions	48	N/A	N/A	Improper denial – dispensing limits
Denied individual RHEA Prescriptions	49	N/A	N/A	Improper Denial - Not in formulary
Denied individual RHEA Prescriptions	51	N/A	N/A	Improper Denial - Not in formulary
Denied individual RHEA Prescriptions	52	N/A	N/A	Improper Denial - Not in formulary

Population:	Examination review item (sample)	Diagnosis code	CPT code	Finding
Denied individual RHEA Prescriptions	70	N/A	N/A	Improper denial – dispensing limits
Denied individual RHEA Prescriptions	72	N/A	N/A	Improper denial – dispensing limits
Denied individual RHEA Prescriptions	75	N/A	N/A	Improper denial – dispensing limits
Denied individual RHEA Prescriptions	85	N/A	N/A	Improper denial – dispensing limits
Denied individual RHEA Prescriptions	86	N/A	N/A	Improper denial – dispensing limits
Denied individual RHEA Prescriptions	88	N/A	N/A	Improper denial – dispensing limits
Denied individual RHEA Prescriptions	90	N/A	N/A	Improper denial – dispensing limits
Denied individual RHEA prescriptions	92	N/A	N/A	Improper denial – dispensing limits
Denied individual RHEA Prescriptions	95	N/A	N/A	Improper denial – dispensing limits
Denied individual RHEA Prescriptions	96	N/A	N/A	Improper denial – dispensing limits
Denied individual RHEA Prescriptions	101	N/A	N/A	Improper denial – dispensing limits
Denied individual RHEA Prescriptions	102	N/A	N/A	Improper denial – dispensing limits
Denied individual RHEA prescriptions	103	N/A	N/A	Improper denial – dispensing limits