STATE OF OREGON

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

DIVISION OF FINANCIAL REGULATION

MARKET CONDUCT EXAMINATION

REPRODUCTIVE HEALTH EQUITY ACT

OF

PACIFICSOURCE HEALTH PLANS

AS OF

DECEMBER 31, 2020

NAIC No. 54976

Table of Contents

FOREWORD

January 23, 2023

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

Dear Director Stolfi:

This market conduct examination report of PacificSource Health Plans (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 J Timothy R. Nutt CIE, AIRC, MCM.

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

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

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 Statue (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 for medical services, drugs, devices, products and procedures in accordance with the identified in Oregon statute.

The focus of this targeted market conduct examination includes, but was not limited to, insurer policyholder services and complaints and claims as related to the coverage and cost-sharing provisions of RHEA, and other state laws and federal law, during the period January 1, 2019 to December 31, 2020.

This report is generally written in a "report by error" format. The report does not present a comprehensive overview of the insurer's practices. The report provides details of the noncompliant or problematic practices that were discovered during the course of the examination. All unacceptable or noncompliant activities may not have been discovered. Failure to identify, comment upon or criticize noncompliant practices does not constitute acceptance of such practices.

This report is intended to provide a summary of the findings discovered during this targeted examination. Findings observed during the examination are included in the body of the report as well as collected in the Comments, Findings, and Recommendations section.

The examination covered claims identified by the insurer as subject to RHEA to assess whether the insurer was in compliance with the cost sharing requirements established under RHEA for the time period under review. The examination findings indicate that the insurer's claims processing system is not paying all RHEA claims correctly.

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. Claims systems were either not configured properly or unable to separate RHEA claims from other claims. The results of the examination and related findings are discussed in more detail in the sections below.

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:

- **Noncompliance with ORS 743A.067 relating to the processing of claims** – The insurer failed to adopt and implement reasonable standards for the prompt investigation of claims by improperly applying cost share such as copays, coinsurance, and deductible in the

adjustment and payment of the claims. This occurred in multiple instances for paid and denied claims.

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 thise examination report.

SCOPE OF EXAMINATION

The Oregon Division of Financial Regulation (division) called a targeted market conduct examination of PacificSource Health Plans to determine compliance with Oregon's Reproductive Health Equity Act (RHEA). The examination was called pursuant to Oregon Revised Statutes (ORS) 731.308.

PacificSource Health Plans is an independent, not-for-profit health plan serving the Pacific Northwest. Founded in 1933, PacificSource Health Plans provides medical and dental insurance across the Pacific Northwest. PacificSource is the parent company of insurer, PacificSource Administrators, Inc., PacificSource Assurance, Inc. (fka Primary Health Inc.), and PacificSource Community Health Plans. PacificSource Health Plans is licensed as a healthcare services contractor in the states of Oregon, Idaho, Montana, and Washington.

This targeted market conduct examination evaluated the insurer's compliance with the Oregon Insurance Code within the statutes and Oregon Administrative Rules (OAR) in fulfilling its contractual obligations to policyholders relating to both policyholder complaints and claims.

In the review of policyholder services and complaints, the examination focused on the procedures for complaints to be recorded in compliance with state and federal law, specifically OAR 836-053-1080, in facilitating proper compliance with cost-sharing.

The scope of the claims examination specifically reviewed compliance by the company for proper cost sharing for all claims including not imposing cost-sharing on preventive services, as defined by the U.S Department of Health and Human Services (HHS) and the U.S. Health Resources and Services Administration (HRSA) and for the reproductive health and related preventive services required under Section 2 of RHEA enacted in Oregon House Bill 3391 (2017) and codified at ORS 743A.067.

The examination covered claims and complaints with dates of service between January 1, 2019 and December 31, 2020.

To determine compliance with RHEA, the following examination procedures were used:

- Issued interrogatories concerning the insurer's business practices.
- Reviewed the insurer's financial information.
- Requested data files of the following populations:
    - All paid claims for the examination period;

    - All denied claims for the examination period;
    - All paid RHEA claims (as identified by the insurer) for the examination period; and
    - All denied RHEA claims (as identified by the insurer) for the examination period.
- Performed sample testing of paid and denied RHEA claims (please note: the insurer provided remote access to accomplish the testing).
- Reviewed the insurer's complaint log.

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 company responds to the corrective actions identified in the examination report.

FINDINGS AND OBSERVATIONS - POLICYHOLDER SERVICES AND COMPLAINTS

a. Interrogatory analysis and observations

The insurer tracks and records complaints and inquiries related to covered benefits. Complaints and inquiries received directly from members, member's authorized representatives, or providers are recorded in the insurer's claims processing system. The insurer records details of each complaint and inquiry, including the date that the communication was received and the reason for the communication. If necessary, the complaint or inquiry can be escalated to a department team lead or department manager for review.

General inquiries or complaints are typically resolved at the time of the call. Agent coordinators follow up with the caller via phone or email if additional research is required after the initial inquiry.

The insurer identified multiple complaint reports utilized throughout the organization to identify trends, improvement actions, and compliance risks associated with state regulations.

The examination also included a review to determine how the insurer tracks appeals. Appeals are logged into the central IT system platform. A letter of acknowledgement is sent after receipt of the appeal. Appeals are reviewed and investigated by the assigned insurer staff. An appeal determination letter is then sent to the member or member representative.

The insurer does not use a third-party administrator (TPA) to administer reproductive benefits.

b. Data analysis and observations, and "virtual onsite" observations

Consumer complaints are tracked and responded to by the insurer's appeals and grievance team or the corporate compliance department. It is each department's responsibility to complete each column of the complaint log as outlined by insurers process.

The insurer's complaint policies and procedures do not require that RHEA complaints be tracked separately and the insurer does not track RHEA complaints separately. There are no fields in the complaint log, such as CPT code or diagnosis code, which would allow for analysis of RHEA-related complaints.

FINDINGS AND OBSERVATIONS - CLAIMS

a. Interrogatory analysis and observations

The insurer uses a third-party claims system for its claims eligibility and processing system. The insurer processes both electronic and paper claims in the third-party claims system. Paper claims are scanned by an external vendor before being uploaded. If auto-adjudication is not possible, the claim is sent to adjudicators for further processing. After claims are finalized, an explanation of benefits is sent to the member and any applicable benefit payment is sent to the provider or member.

System updates
The software developer is responsible for all aspects of configuration of the claims system. For system updates needed to comply with Oregon law, the claims system developer receives the requirements from the insurer's compliance department. Upon confirmation that the interpretation of the law is accurate, the developer will create a configuration plan to implement the necessary changes. The insurer also manages an annual claims system upgrade project.

30-day letters
The insurer's process is to pay or deny claims within 30 days of receipt. In situations for which more time is needed by the insurer to investigate a claim, the insurer sends a notice of claim status letter to the member. The notice acknowledges the receipt of the claim and reason for the delay in the resolution of the claim.

Prompt payment
Interest payments are automatically initiated by the claims system in accordance with the insurer's commercial prompt pay policy. Interest is paid to providers on clean claims (both original and adjusted claims) which are not paid within the applicable calendar days. Interest is paid to providers of nonclean claims (both original and adjusted claims) beginning with the date that the requested information was received.

Pharmacy claims

Caremark serves as is the insurer's pharmacy benefit manager. Claim files are received by Caremark on a daily basis and loaded into the Insurer's claims system.

Changes to claims procedures

Starting in October of 2019, EOBs are made available only online in the member portal. The insurer now sends members a "consolidated EOB" that starts a three-week cycle in which claims are consolidated and sent in one statement, three weeks after the first claim for that cycle is processed.

b. Data analysis and observations

The claims data[1] provided by the insurer indicated the following total and RHEA claims[2]:

		Paid claims	Denied claims
Individual market	All claims	654,022	174,907
	RHEA claims	31,760	4,781
Small Employer market	All claims	259,471	299,400
	RHEA claims	12,793	7,619
Group[3] market	All claims	1,519,992	216,874
	RHEA claims	75,550	7, 758
Totals	All claims	2,433,485	691,181
	RHEA claims	120,103	20,158

The examination data analysis was performed utilizing Microsoft Excel and Audit Command Language (ACL) Analytics. Sample sizes were calculated using the NAIC handbook sampling criteria, which provides two scenarios: for populations of 50,000 and less, the Acceptance Samples Table may be used to determine sample sizes; for populations greater than 50,000, ACL may be used to generate sample sizes by utilizing a 95 percent confidence level, a 5 percent upper error limit, and 2 percent expected error rate. Using sample sizes as determined by the NAIC handbook for these total populations, our calculated sample sizes were 190 paid claims and 109 denied claims.

The examiners ensured equitable representation of the three markets (individual, small employer, and group) in the samples by proportional selection based on total population. Therefore, the samples selected were as follows:

[1] All references to data are specific to the examination period (January 1, 2019 through December 31, 2020)
[2] RHEA claims as identified by the insurer
[3] Does not include Small Employer Market claims

	Paid RHEA claim samples	Denied RHEA claim samples
Individual market	49	26
Small employer market	25	41
Group market	116	42
Total	190	109

All sampling utilized for the Oregon RHEA exams was based on the NAIC market regulation handbook guidance using a random selection methodology and following the acceptance sample tables and/or ACL calculations as appropriate. Note that the total sample size is larger than the NAIC recommendation. Sampling strictly based on representation would have limited our small employer samples to 19 paid claims. The examiners employed a minimum sample size of 25 for the small employer market to ensure examination integrity.

The samples were selected from claims for services specific to RHEA only, as identified by the insurer. However, 20 paid claims and nine denied claims were replaced with new claim samples during claims testing, as the initial sampled claims were for services other than the RHEA covered services, as stated in ORS 743A.067.

c. "Virtual onsite" observations

As described above, the insurer uses a third-party claims system for its claims processing. The system was made accessible to the examination team, and contained sufficient detail to understand the line item diagnosis codes, CPT codes, price adjustments, and cost sharing (if any) applied.

The insurer has configured the claims system to apply health plan benefits in accordance to the CPT code submitted by the billing provider. The insurer reviews the statutory requirements of ORS 743A.067 and identifies CPT and diagnosis codes interpreted as applicable under the statute. The claims system is then configured to apply no cost sharing to those CPT and diagnosis codes identified by the insurer. The exception for no cost sharing under ORS 742.008 only applies to a health benefit plan that is eligible for a health savings account.

The insurers states that a claim with multiple CPT codes would not cause different processing. The insurer processes claims based upon each line billed by the provider. Each line would contain a diagnosis code and a code for the medical care provided.

Finding #1 – Non-compliance with ORS 743A.067 relating to the processing of claims

The specific focus of this exam was to determine the insurer's compliance with RHEA's requirements. The insurer indicated that a process had been implemented to properly

adjudicate RHEA claims by configuring the claims system to identify CPT and diagnosis codes specific to RHEA services. After review of the insurer's systems and sample claim files, the examination team found that the system does not accurately adjudicate all RHEA claims. Of the 190 paid samples reviewed, 37 claims had improper cost sharing under RHEA. Additionally, six of the 109 denied claims reviewed had improper cost sharing under RHEA.[4]

All of the random sampling was done from populations which the insurer stated contained RHEA claims. As noted above, 29 total sample files were replaced as the initial samples contained services not subject to ORS 743A.067. This indicates that the insurer's claims adjudication method does not properly identify claims containing RHEA services.

Examination of the claim samples identified the inability of the insurer to consistently identify and correctly adjudicate claims subject to RHEA requirements. In some instances, the insurer did not identify a CPT code within claims system for RHEA adjudication. Other claims had more complexity, usually due to a CPT code which is not explicitly a RHEA service. For example, the examiners observed claims which contained lines for venipuncture (blood sampling) which could be a RHEA covered service depending on the reason for the blood draw. Another common example was urine collection. Depending on the reason for the collection, RHEA may or may not apply. However, the CPT codes for venipuncture or urine collection were not flagged in the claims system for proper claim adjudication and appropriate cost-sharing, as these services are not always RHEA services. As a result of the claims system configuration for these CPT codes, improper cost-sharing was applied to these services.

Please see Appendix B for a complete list of CPT and diagnosis codes identified from the sample populations which contained improper cost sharing for RHEA services. Appendix A also contains a list of improperly denied claims. For example, claims erroneously identified as not medically necessary, or claims where "coding is not industry standard."

During the examination, the insurer based a majority of its objections to the examination's criticisms on diagnosis codes. Regarding many disputed claims, the insurer stated:

> [The diagnosis code] indicates the patient had a known problem or condition. Therefore, the claim [...] does not qualify as preventative service under RHEA [...]. Preventive screenings are performed when the patient has no known symptoms, signs, or prevailing medical history of a disease or condition for care and there is no cost share to the member.

The division stated that RHEA does not limit the required coverage to specific diagnoses. The statute's focus is on improving access to reproductive health services. Therefore, the statute applies to all screenings subject to ORS 743A.067 regardless of diagnosis code.

---

[4] Some claims in the denied population contained a mixture of denied and paid lines of service, which the insurer included in the denied population as there were elements of the claims which were denied.

The total sample population (paid and denied) was 299 claims. In that sample, 43[5] claims (14 percent of the sample) contained RHEA services with improper cost sharing applied. As noted above, the total claims identified as RHEA by the insurer (paid and denied) was 140,261.

Total number improper cost sharing	Total RHEA claims	Percentage of total RHEA claims with improper cost sharing
43	140,261	14%

RECOMMENDATIONS

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

2. The insurer review its claims adjudication system and make all necessary adjustments to assure that claims are adjudicated in accordance with the Oregon Insurance Code, including but not limited to, ORS 743A.067.

3. The insurer identify all pertinent CPT codes for services, drugs, devices, products and procedures listed in ORS 743A.067, and where applicable diagnosis 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.

The examination revealed that the insurer does not comply with all requirements of RHEA. The lack of compliance seems to stem from the interpretation of the statute that led to the incorrect adjudication of claims by automated claims processing systems. The claims system has not been configured to differentiate RHEA claims from other claims. Furthermore, the complaint log does not collect any diagnosis or CPT code information. Therefore, any complaint trends related to RHEA, or other benefits and services, are not apparent based on the information collected in the complaint log. The insurer will need to reevaluate its complaint and claims handling processes and procedures to ensure compliance with benefit requirements.

[5] Out-of-network (OON) claims with cost sharing were excluded from the error population due to the language in RHEA which allows for cost sharing in limited situations.

APPENDIX

Appendix A – Definitions

Definitions:

i. A "complaint" is considered an oral or written statement of dissatisfaction with the insurer and a request for redetermination of an adverse benefit determination from a member, member authorized representative, or provider. A complaint may include an oral or written statement of dissatisfaction from an agent or their representative, concerning but not limited to, producer appointments, website access, producer of record changes, and commissions.

ii. A "consumer complaint," occurs when a member or third party submits a complaint to a state regulatory agency regarding an adverse benefit determination or dissatisfaction with a health insurance plan.

iii. A "coverage inquiry" is a request for information related to a member's health plan coverage.

Appendix B – Diagnosis and CPT codes with improper cost sharing and improper denial

Population: paid or denied	Examination review item	Diagnosis code	CPT code	Finding
Paid	2	B20	87536	Improper cost share
Paid	2	B20	86361	Improper cost share
Paid	2	B20	80053	Improper cost share
Paid	2	B20	85025	Improper cost share
Paid	2	B20	86592	Improper cost share
Paid	2	B20	35415	Improper cost share
Paid	10	N946	86901	Improper cost share
Paid	10	N946	36415	Improper cost share
Paid	10	N946	86850	Improper cost share
Paid	10	N946	86900	Improper cost share
Paid	10	N946	85025	Improper cost share
Paid	12	F411	80307	Improper cost share
Paid	12	R350	87491	Improper cost share
Paid	12	R350	87591	Improper cost share
Paid	12	R350	87086	Improper cost share
Paid	12	R350	81001	Improper cost share
Paid	14	M159	87340	Improper cost share

Population: paid or denied	Examination review item	Diagnosis code	CPT code	Finding
Paid	14	M159	86803	Improper cost share
Paid	14	M159	86705	Improper cost share
Paid	14	M159	86706	Improper cost share
Paid	17	Z3689	80055	Improper cost share
Paid	17	Z3689	87591	Improper cost share
Paid	17	Z3689	89491	Improper cost share
Paid	21	N3090	87077	Improper cost share
Paid	21	N3090	87086	Improper cost share
Paid	23	R32	99213	Improper cost share
Paid	33	R309	87077	Improper cost share
Paid	33	R309	87086	Improper cost share
Paid	33	R309	87186	Improper cost share
Paid	33	R309	87077	Improper cost share
Paid	36	Z202	86695	Improper cost share
Paid	36	Z202	86696	Improper cost share
Paid	36	Z202	86803	Improper cost share
Paid	36	Z202	86704	Improper cost share
Paid	36	Z202	86706	Improper cost share
Paid	36	Z202	84389	Improper cost share
Paid	36	Z202	87340	Improper cost share
Paid	36	Z202	86780	Improper cost share
Paid	39	Z3491	86803	Improper cost share
Paid	39	Z3491	87340	Improper cost share
Paid	39	Z3491	87389	Improper cost share
Paid	39	Z3491	86780	Improper cost share
Paid	42	R350	87086	Improper cost share
Paid	42	R350	87800	Improper cost share
Paid	45	B20	80061	Improper cost share
Paid	45	B20	80053	Improper cost share
Paid	45	B20	87536	Improper cost share
Paid	52	A64	87491	Improper cost share
Paid	52	A64	87591	Improper cost share
Paid	53	R509	81001	Improper cost share
Paid	53	R509	87086	Improper cost share
Paid	56	R300	81015	Improper cost share
Paid	56	R300	87086	Improper cost share
Paid	73	Z302	55250	Improper cost share
Paid	76	Z3A13	83036	Improper cost share

Population: paid or denied	Examination review item	Diagnosis code	CPT code	Finding
Paid	76	Z3A13	84443	Improper cost share
Paid	76	Z3A13	85027	Improper cost share
Paid	76	Z3A13	86762	Improper cost share
Paid	76	Z3A13	86780	Improper cost share
Paid	76	Z3A13	87340	Improper cost share
Paid	76	Z3A13	87389	Improper cost share
Paid	77	B20	87536	Improper cost share
Paid	77	B20	86360	Improper cost share
Paid	77	B20	86359	Improper cost share
Paid	77	B20	87491	Improper cost share
Paid	77	B20	87591	Improper cost share
Paid	77	B20	83516	Improper cost share
Paid	77	B20	36415	Improper cost share
Paid	77	B20	80053	Improper cost share
Paid	77	B20	85025	Improper cost share
Paid	77	B20	81001	Improper cost share
Paid	82	R1030	87086	Improper cost share
Paid	85	Z202	86592	Improper cost share
Paid	85	Z202	86803	Improper cost share
Paid	85	Z202	87521	Improper cost share
Paid	87	R300	87086	Improper cost share
Paid	87	R300	87186	Improper cost share
Paid	87	R300	81001	Improper cost share
Paid	87	R300	87088	Improper cost share
Paid	94	Z3202	81025	Improper cost share
Paid	98	N390	87088	Improper cost share
Paid	101	R300	87086	Improper cost share
Paid	101	R300	87186	Improper cost share
Paid	101	R300	87077	Improper cost share
Paid	101	R300	81001	Improper cost share
Paid	102	N926	99203	Improper cost share
Paid	102	N926	81025	Improper cost share
Paid	105	R1031	99213	Improper cost share
Paid	105	R1031	87800	Improper cost share
Paid	105	R1031	81025	Improper cost share
Paid	114	R300	87086	Improper cost share
Paid	126	Z789	86704	Improper cost share
Paid	126	Z789	86706	Improper cost share

Population: paid or denied	Examination review item	Diagnosis code	CPT code	Finding
Paid	126	Z789	87340	Improper cost share
Paid	126	Z789	36514	Improper cost share
Paid	130	N12	84703	Improper cost share
Paid	133	R300	81001	Improper cost share
Paid	133	R300	87077	Improper cost share
Paid	133	R300	87086	Improper cost share
Paid	133	R300	87088	Improper cost share
Paid	134	Z8543	86304	Improper cost share
Paid	146	N760	87491	Improper cost share
Paid	146	N760	87591	Improper cost share
Paid	147	Z780	77080	Improper cost share
Paid	174	R1031	81001	Improper cost share
Paid	174	R1031	84703	Improper cost share
Paid	174	R1031	87086	Improper cost share
Paid	188	R319	87086	Improper cost share
Paid	189R	R3915	87086	Improper cost share
Paid	190R	Z3481	87491	Improper cost share
Paid	190R	Z3481	87591	Improper cost share
Paid	190R	Z3481	88142	Improper cost share
Denied	3R	Z780	77080	Improper cost share
Denied	18	Z87440	87086	Improper cost share
Denied	28	R300	87186	Improper cost share
Denied	28	R300	87088	Improper cost share
Denied	28	R300	87077	Improper cost share
Denied	28	R300	87086	Improper cost share
Denied	28	Z7251	87491	Improper cost share
Denied	28	Z7251	87591	Improper cost share
Denied	30	Z7189	99497	Improper denial
Denied	38	Z01419	99395	Improper denial
Denied	39	B1910	86706	Improper cost share
Denied	43	Z209	87491	Improper denial
Denied	43	Z209	87591	Improper denial
Denied	48R	Z7189	99401	Improper denial
Denied	81R2	Z202	86696	Improper cost share
Denied	81R2	Z202	87491	Improper denial
Denied	81R2	Z202	87591	Improper denial
Denied	81R2	Z202	86592	Improper cost share
Denied	81R2	Z202	87389	Improper cost share

Population: paid or denied	Examination review item	Diagnosis code	CPT code	Finding
Denied	83	Z113	99211	Improper cost share