



STATE OF OREGON

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

INSURANCE DIVISION

REPORT OF TARGET MARKET CONDUCT EXAMINATION

OF

**CENTRAL OREGON INDEPENDENT HEALTH SERVICES, INC.
dba CLEAR CHOICE HEALTH
BEND, OREGON**

NAIC COMPANY CODE 47087

AS OF

DECEMBER 31, 2002

TABLE OF CONTENTS

| | |
|--|-----------|
| EXECUTIVE SUMMARY | 4 |
| SCOPE OF EXAMINATION..... | 4 |
| COMPANY OPERATIONS/MANAGEMENT | 7 |
| COMPANY HISTORY | 7 |
| MANAGEMENT AND CONTROL..... | 7 |
| <i>Board of Directors</i> | 7 |
| <i>Officers</i> | 8 |
| CLAIMS | 8 |
| FINDINGS | 9 |
| CONCLUSIONS/RECOMMENDATIONS | 12 |
| ACKNOWLEDGMENT | 13 |
| AFFIDAVIT | 14 |
| APPENDIX A..... | 15 |
| CLAIMS PROMPT PAY | 15 |

December 1, 2004

Honorable Cory Streisinger, Director
State of Oregon
Department of Consumer and Business Services
350 Winter Street, NE, Room 440
Salem, OR 97301-3883

Dear Director:

In accordance with your instructions and pursuant to ORS 731.300, we have examined the business affairs of

**Central Oregon Independent Health Services, Inc.
dba Clear Choice Health
2650 NE Courtney Drive
Bend, OR 97701**

NAIC Company Code 47087

hereinafter referred to as the “Company.” The following report of examination is respectfully submitted.

EXECUTIVE SUMMARY

The focus of this target market conduct examination is to determine if Central Oregon Independent Health Services, Inc. dba Clear Choice Health (the Company) is in compliance with the Prompt Pay statutes, rules and regulations, specifically ORS 743.866, ORS 743.868, OAR 836-080-0080, and OAR 836-080-0085.

The following report provides a summary of the findings discovered during this examination of the Company's efforts to process claims in accordance with the Prompt Pay laws.

To measure the Company's compliance, the following four standards were applied to the Company's claims operation:

Prompt Pay Standard #1 – The Company processes all claims that are subject to the application of Prompt Payment requirements in accordance with all applicable rules and regulations.

Prompt Pay Standard #2 – The Company's provider contracts are in compliance with applicable statutes, rules and regulations.

Prompt Pay Standard #3 – The Company's disclosures to providers are in compliance with applicable statutes, rules and regulations.

Prompt Pay Standard #4 – The Company files the required annual claims processing information in compliance with applicable statutes, rules and regulations.

The Company passed standards #2 and #3 and failed standards #1 and #4 referenced above.

SCOPE OF EXAMINATION

The market conduct examination of the Company was conducted as of December 31, 2002, covering the period of January 1, 2002 through December 31, 2002, and included a review of

material transactions or events which occurred subsequent to the examination cut-off date and were noted during the examination.

A target market conduct emphasis examination was performed. The examination of the Company was conducted pursuant to ORS 731.300 and in accordance with procedures and guidelines established by the Oregon Insurance Division Market Conduct Program. The program generally follows the Market Conduct Examination Handbook as adopted by the National Association of Insurance Commissioners (NAIC) to the extent that it is consistent with Oregon law. The purpose of the examination was to determine if the Company was in compliance with Prompt Pay statutes, rules and regulations. It was further intended to identify and assess the practices and procedures implemented by the Company to comply with Prompt Pay statutes. The findings in this examination demonstrate that the Company needs to develop an action plan to ensure they comply with Prompt Pay statutes

In order to determine the practices and procedures of the Company's operations, one or more of the following procedures was performed in each phase:

1. A sample of files was selected from listings provided by the Company. The examiner then reviewed each file.
2. The procedure manuals and/or memorandum were evaluated.
3. The Company responded to a series of questions regarding the phase being examined.

The examination was comprised of the following two phases:

| | |
|-------------------------------|--------------------------|
| Company Operations/Management | Prompt Payment of Claims |
|-------------------------------|--------------------------|

The Company’s underlying data was measured against an established standard. A list of all standards considered can be found in Appendix A at the end of the report. The examiner used the following three classifications to disclose the examination results:

| | |
|------------------------|---|
| Passed without Comment | The standards the Company passed are displayed in a chart at the beginning of the Findings section of each phase. Items included in this category passed the standard and the examiner did not find it necessary to comment on the findings. |
| Passed with Comment | Standards the Company passed with some errors noted are included in this classification. Items in this category are not considered to be indicative of a general business practice of noncompliance. Usually, a recommendation is not warranted, but in certain instances a recommendation might be made. |
| Failed | The Company has not demonstrated compliance with standards that fall into this category. A recommendation for compliance is usually made for each standard the Company fails. |

Information regarding some items might be noted in the examination report without remarks.

Some unacceptable or non-complying practices may not have been discovered in the course of this examination. Additionally, findings may not be material to all areas which would serve to assist the Director. Failure to identify or criticize specific Company practices does not constitute acceptance by the Oregon Insurance Division. Examination findings may result in administrative action or further inquiry.

Other areas of concern discovered during the examination that do not fall within the scope of the standards might appear in the report as the last section of each phase and titled Additional Findings and Procedures.

COMPANY OPERATIONS/MANAGEMENT

Company History

Central Oregon Independent Health Services (COIHS) was established in 1995 to administer the Oregon Health Plan (OHP). COIHS is owned by provider members of Central Oregon Independent Physicians Association (COIPA) and the Central Oregon Hospital Network (CONet). COIHS began administering the Oregon Health Plan in Lake, Grant, and Wheeler Counties. In 1996 COIHS expanded its service area to serve Crook, Deschutes, Harney, and Jefferson Counties. In February 2003, COIHS opted out of the Standard OHP population but continued to enroll and provide services to the Plus OHP population.

In 1998, COIHS applied for and received a Health Care Services Contractor license from the state of Oregon doing business as Clear Choice Health Plans. In 1998, Clear Choice Health Plans' application for Medicare + Choice contract was approved by the Center for Medicare and Medicaid Services. In that year, Clear Choice Health Plan M+C began marketing activities to Medicare eligible beneficiaries.

Clear Choice Health Plans began marketing to large employer groups in 2001. Clear Choice Select, the commercial offering, represents five employer groups in Central Oregon. The Plan also acts as a Third Party Administrator for four large employers in Central Oregon.

Management and Control

Board of Directors

The Board of Directors is made up of at least 12 individuals. Directors serve for a term of three years.

Members of the Board of Directors serving as of December 31, 2002 were:

| <u>NAME</u> | <u>LOCATION</u> | <u>PRINCIPAL AFFILIATION</u> |
|-------------------------|-----------------|------------------------------|
| Michael M. Kendrick, MD | Bend, OR | President |
| Jeffrey Drutman, MD | Bend, OR | Sec/Treasurer |
| F. Peter Boehm, MD | Bend, OR | Director |
| Eric W. Alexander | Bend, OR | Director (CONet) |
| Thomas Carlsen, MD | Bend, OR | Director |
| Jerol E. Andres | Redmond, OR | Director (Public) |
| Stuart Garrett, MD | Bend, OR | Director |
| Duane W. Francis | The Dalles, OR | Director (CONet) |
| Patricia L. Moss | Bend, OR | Director (Public) |
| Craig W. Moore | Bend, OR | Director (Public) |
| Thomas E. Safley | Bend, OR | Director (CONet) |
| David L. Harman | Burns, OR | Director (CONet) |
| Beverly A. Clarno | Salem, OR | Director (Public) |
| Neil R. Bryant | Bend, OR | Director (Public) |

Officers

The principal officers of the Company as of December 31, 2002 were as follows:

| <u>NAME</u> | <u>OFFICE</u> |
|---------------------|--|
| P. Gibford | CEO |
| K. Lindsey, MD | Medical Director |
| G. Hansen, CPA | CFO |
| C. Kane, PhD | COO |
| P. Johnson | Director of Regulatory Affairs and Compliance |
| H. Pfeiffer | Director of Actuarial Underwriting and Corp. Reporting |
| P. Gibford (Acting) | Director of Info Services |
| D. Hines | Operations Manager |
| M. Jacobson | Director of Human Resources |

CLAIMS

The examination of this phase included a review of the Company's claims manual, claims workflow, provider contracts, provider manual, and random samples of claims from two populations.

In accordance with ORS 743.866(5) and OAR 836-080-0085, the Company is required to report specific claims information with the Insurance Division by March 1st of each year.

The Company submitted the required filing on February 28, 2003. The filing was timely; however, it did not include all of the required information and was, therefore, found to be unacceptable.

The chart below lists the random samples reviewed:

| POPULATION | POPULATION SIZE | SAMPLE SIZE | PERCENTAGE |
|--------------------------------|-----------------|-------------|------------|
| Claims Finalized after 30 days | 237 | 25 | 10.5% |
| Total Claims Finalized in 2002 | 11,459 | 25 | .2% |

Findings

The Company passed the following standards without comment:

| <u>Standard</u> |
|---|
| <u>Prompt Pay Standard #2</u> – The Company's provider contracts are in compliance with applicable statutes, rules and regulations. |
| <u>Prompt Pay Standard #3</u> – The Company's disclosures to providers are in compliance with applicable statutes, rules and regulations. |

The following exceptions were noted:

Prompt Pay Standard #1 - The Company processes all claims that are subject to the application of prompt payment requirements in accordance with all applicable rules and regulations.

Reference: ORS 743.866(1), ORS 743.868(1) & (2), OAR 836-080-0080(1) & (2).

Findings: Failed. 57% compliance. Nineteen (43%) out of the 44 claims reviewed failed this standard because the claims were not settled within the mandatory time frames and the provider

and enrollee were not informed of the reason for the delay. The total population reviewed was reduced from 50 to 44 as six of the files originally provided by the Company did not actually represent true claims, but were simulated claims retained within the processing system.

The Company stated that in the vast majority of these claims, the provider did not bill with sufficient information to easily identify their commercial claims which are subject to the Prompt Payment regulations. The majority of the Company's business is related to the Office of Medical Assistance Program (OMAP). OMAP has a Prompt Pay requirement of 45 days. The Company's claims system conversion caused a backlog and by the time these claims were processed and identified as commercial, it was past the mandated time frame for notification. Rather than send a notice and then process the claims, the Company decided to process these claims and send the Explanation of Benefits (EOBs) forms.

The Company has since implemented a process for scanning and electronic data entry of claims within 48 hours of receipt. The Company believes this procedure will enable the Company to run a system report to identify all commercial claims and process them within the mandated time frame or notify the provider and the enrollee of the reason for the delay.

| Population Reviewed | # of Units | # Not Applicable (N/A) | # Passed | # Failed |
|--------------------------------|-------------------|-------------------------------|-----------------|-----------------|
| Claims Finalized after 30 days | 25 | 6 | 0 | 19 |
| Total Claims Finalized in 2002 | 25 | 0 | 25 | 0 |
| Subtotal | 50 | 6 | 25 | 19 |
| Less N/A Files | (6) | | | |
| Totals | 44 | | 25 | 19 |

I recommend the Company process all claims that are subject to the application of Prompt Payment requirements in accordance with ORS 743.866(1), ORS 743.868(1) & (2), and OAR 836-080-0080(1) & (2).

Prompt Pay Standard #4 - The Company files the required annual claims processing information in compliance with applicable statutes, rules and regulations. ORS 743.866(5), OAR 836-080-0085.

Findings: Failed. 76% compliance. Six (24%) of the 25 claims reviewed failed this standard because they should not have been included in the data submitted to the Insurance Division.

Although the selection criteria for reporting Prompt Pay data as of March 1st and for providing the population of claims from which to draw a random sample for this exam was the same, the total number of claims reported by the Company was not the same. With the Prompt Pay data, the Company reported 12,256 claims and for the random sample, 11,459 claims were identified. The Company explained that the population reported in the filing was defined by date paid and the population reported for sampling was defined by date of receipt.

Regarding the six files included in the claim sample, the Company stated that these were dummy claims that should not have been reported. In addition, the Company reported that they have discontinued the use of dummy claims.

| Population Reviewed | # Units | # Not Applicable (NA) | # Passed | # Failed |
|--------------------------------|----------------|------------------------------|-----------------|-----------------|
| Claims Finalized After 30 Days | 25 | 0 | 19 | 6 |

I recommend the Company file the required annual claims processing information in compliance with ORS 743.866(5) and OAR 836-080-0085.

CONCLUSIONS/RECOMMENDATIONS

| <u>No.</u> | <u>Recommendation</u> | <u>Page</u> |
|-------------------|---|--------------------|
| 1 | I recommend the Company process all claims that are subject to the application of Prompt Payment requirements in accordance with ORS 743.866(1), ORS 743.868(1) & (2), and OAR 836-080-0080(1) & (2). | 11 |
| 2 | I recommend the Company file the required annual claims processing information in compliance with ORS 743.866(5) and OAR 836-080-0085. | 12 |

ACKNOWLEDGMENT

The cooperation and assistance rendered by the officers and employees of the Company during this examination is hereby acknowledged and appreciated.

A special thanks is extended to the Examination Coordinators for their courtesy and assistance providing, correlating, or coordinating all requested documents and statistics necessary to ensure a smooth transition during the overall examination process. The responsibilities that were undertaken during this examination were in addition to the scope of their regular assigned duties.

Respectfully submitted,

Cindy J. Jones, AIE, CPCU, CRM
Manager, Market Surveillance
Insurance Division
Department of Consumer and Business Services
State of Oregon

Oregon Insurance Division
Market Conduct Examination
Central Oregon Independent Health Services, Inc.
dba Clear Choice Health

APPENDIX A

Claims Prompt Pay

| <u>#</u> | <u>Standard</u> | <u>Regulatory Authority</u> |
|-----------------|--|---|
| 1 | The Company processes all claims that are subject to the application of prompt payment requirements in accordance with all applicable statutes, rules and regulations. | ORS 743.866(1), ORS 743.868(1) & (2), OAR 836-080-0080(1) & (2) |
| 2 | The Company's provider contracts are in compliance with applicable statutes, rules and regulations. | ORS 743.866(2) |
| 3 | The Company's disclosures to providers are in compliance with applicable statutes, rules and regulations. | ORS 743.866(3), OAR 836-080-0080(3) |
| 4 | The Company files the required annual claims processing information in compliance with applicable statutes, rules and regulations. | ORS 743.866(5), OAR 836-080-0085 |