



Department of Consumer
and Business Services

**Preliminary Marketwide Compliance Report on
Implementation of the Reproductive Health Equity Act**

June 21, 2022

About DCBS: The Department of Consumer and Business Services is Oregon's largest business regulatory and consumer protection agency. For more information, visit <https://www.oregon.gov/dcbs/>.

About Oregon DFR:

The Division of Financial Regulation protects consumers and regulates insurance, depository institutions, trust companies, securities, and consumer financial products and services and is part of the Department of Consumer and Business Services. Visit dfr.oregon.gov.

This report is based on information and data provided by insurance companies from 2019-2020 experience as it related to claims and services provided within the scope of ORS 743A.067. Findings are preliminary as of the publication of this report and will be finalized following the conclusion of the market examination process.

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Executive summary

In 2017, the Oregon Legislature passed House Bill 3391 – known as the Reproductive Health Equity Act (RHEA).¹ The law requires health insurers to provide, with no cost share, a specified list of reproductive health, sexual health, preventive care, and other health care services – including contraception and abortion. Several services required by RHEA are also required coverage without cost sharing as a preventive service under the Affordable Care Act.² Health benefit plans, such as individual, small group, and large group, are subject to RHEA. Other plans, such as those offered by a self-insured employers and Medicare, are not subject to RHEA. RHEA is applicable to commercial health insurance plans issued, renewed, modified, or extended on or after Jan. 1, 2019.

A June 2020 industry data call on a subset of insurer-reported RHEA claims revealed variations in coverage and indications of potential widespread noncompliance with the law – specifically the impermissible application of cost sharing for some services covered by RHEA. Following the data call, the Division of Financial Regulation initiated a targeted market conduct examination to review individual claims data, determine the scope and cause of noncompliance, and begin corrective action with insurers. The examination, which is similar to an audit, covered all 12 insurers in the individual, small group, and large group markets for the period of claims adjudicated from Jan. 1, 2019, to Dec. 31, 2020. All claims with services covered by RHEA were subject to sample testing in the examination. Due to the COVID-19 pandemic, the majority of examinations were performed remotely and insurers had to provide system access to examination staff to review claims subject to examination.

The examinations have provisionally confirmed that insurers across the market failed to fully comply with RHEA for a combination of reasons. Marketwide issues found through examination and other division compliance work in implementing RHEA included:

- Failure to implement claims adjudication processes that identify services covered;
- Failure to pay claims according to the requirements of the law;
- Misinterpretation of cost-share requirements;
- Improper application of medical management during claims adjudication; and
- Failure to update claims adjudication systems resulting in improper consumer cost share for RHEA services.

The data collection and analysis portion of the examinations concluded in March 2022, and the division is finalizing insurer-level examination reports for public release. As part of that process, the Insurance Code requires the division to provide an opportunity for insurers to review and comment on specific examination findings in a hearing with the division.³ Once finalized, the individual insurer examination reports will be published and made available to the public. In the interest of transparency during this regulatory process, the division is releasing this report to summarize preliminary compliance findings. Generally, these examinations have revealed that full compliance with RHEA will require changes to the programming of claims processing systems and other actions to be taken by all insurers offering health benefits plans.

¹ See ORS 743A.067.

² See 42 U.S.C. 300gg-13 and 45 CFR 147.130.

³ See ORS 731.312.

Background on DFR regulatory oversight

One of the main functions of the division is to monitor compliance with Oregon laws among all insurance companies in Oregon. By monitoring compliance, the division helps protect consumers, ensures a level playing field for all market participants, and helps prevent insurance companies from jeopardizing their financial position through non-compliance with relevant laws and subsequent regulator or legal action. The division takes several different types of actions to monitor compliance, such as conducting regular stakeholder engagement and outreach events, reviewing and approving health benefit plan policies, collecting data, receiving and responding to consumer complaints, and examining the conduct of insurance companies. For example, the division hosts monthly industry communications meetings to discuss changing requirements, market trends, and other issues related to Oregon's commercial health insurance market. We also closely monitor consumer complaints for trends or indications of insurer and marketwide noncompliance.

An important function of this regulatory oversight is the review and approval of insurance policies before they are sold to Oregon consumers. Insurance policies are reviewed against product standards, which are a list of statutes, rules, and sub-regulatory guidance specific to each product line. In preparation for RHEA becoming effective, the division published an updated product standards checklist to reflect the changes required by RHEA for plans starting in 2019. Division employees work with insurance companies to amend policy language if it does not reflect coverage requirements in Oregon law.

Finally, the division can issue a data call or initiate a market conduct examination to review data from insurers on a specific topic. Targeted market conduct examinations were initiated in response to findings from a 2020 data call that revealed indications of widespread noncompliance with RHEA in all regulated health benefit plan markets.⁴ The data call focused on a limited set of benefits: abortion, birth control, Hepatitis C screening, pregnancy screening, and voluntary sterilization. It requested limited claims data, such as date of service, the amount billed, and the amount paid. While likely compliance issues were identified in the data submitted by insurers, much of the data was also unusable because insurers did not follow reporting instructions when self-reporting.

This market conduct examination, which is described more fully below, was structured to review all services covered under RHEA, identify root causes of noncompliance, and limit data and reporting errors. Insurers were also clearly and repeatedly instructed to come into full compliance with RHEA, including instructions to reprocess any improperly paid claims and not await the results of this examination. This preliminary marketwide report on RHEA compliance focuses on the process and findings from the market examinations, as well as complaint information, to fully evaluate implementation of the law.

Examination process

A market conduct examination is similar to an audit. It requires division employees and contracted independent professionals to individually review a subset of individual claim files to determine if an insurer's actions comply with the law. Generally, market conduct examinations initiated by state insurance regulators take between one and two years to complete depending upon the complexity of the examination. The division retains a staff of four examiners to conduct field and desk examinations on an ongoing basis to monitor compliance with relevant laws.

⁴ See Appendix A and B for more information on the RHEA data call.

In order to perform simultaneous RHEA market conduct examinations for all 12 insurers in Oregon's market, the division contracted with three examination companies. Per state law, the division was required to conduct a competitive bidding process before hiring these companies. Initial work on procurement and requirements for the market conduct examination began in late 2020. The official procurement process was initiated May 13, 2021, and concluded Aug. 6, 2021, when the companies were placed on contract.

Each company was asked to examine four insurers under the division's oversight, with related insurers assigned to the same examination company.⁵ To ensure consistency between the contracted independent professionals and among all 12 companies, the division prepared a detailed Coordinator's Handbook that described required exam elements and examination instructions. The division provided all insurers with a draft copy of the Coordinator's Handbook in July 2021, with the final Coordinator's Handbook and examination call letter sent Aug. 30, 2021, to all insurers to formally launch the examinations.⁶ At that time, the division anticipated that data collection would conclude by the end of December 2021 and that corrective action orders could be issued by the second quarter of 2022.

The division regularly communicated with insurers leading up to the launch of the market conduct examinations, including by providing the draft Coordinator's Handbook in July 2021 to allow for preparation of the upcoming examinations. Despite giving insurers several months to prepare, and more than a month with examination documents, most insurers were unprepared for the examination to start Sept. 1, with some requesting more time before submitting required documentation. Delays in receiving examination documentation resulted in data review not beginning until November for many insurers.

Remote claims system access

The examination required insurers to provide remote claims systems access to the assigned examiners, an issue that several insurers first protested and continued to well after receiving their call letter. Insurers were notified of remote system access requirements months before the exam and again in the call letter and related materials. Some insurers expressed concern that remote system access violated the Health Insurance Portability and Accountability Act (HIPAA) or presented arguments regarding security risks.

Three insurers willingly provided remote claims system access without examination delays. Other insurers were initially reluctant to provide remote claims system access; however, most insurers cooperated with this examination requirement after discussion with the division. This cooperation from most insurers allowed for examinations to continue while maintaining safety precautions for the examination teams during the COVID-19 pandemic. Insurers used a variety of methods that met their information security policies during the remote examination.⁷ Issues related to remote claims system access added a total of two months to the initially estimated examination timeline.

⁵ Some insurance companies are affiliates to each other. These companies were examined by the same examination company to maintain consistency.

⁶ See Appendix C for the sample Coordinator's Handbook and call letter.

⁷ Examples of remote claims system access included insurers that sent company laptops to examiners; VPN access; insurer monitoring of examiner actions through screen sharing; and partitioned system access. Insurers that did not have existing capacity to provide system access also experienced supply chain constraints and delays providing secure computers.

Once the examiners had access to the insurer claims systems, they found some claims systems were limited in their data storage and retrieval capacity, resulting in some requested information being unavailable. Claims systems data storage and retrieval limitations also extended to other company systems that lacked sophisticated internal system collaboration. This resulted in manual input (or organization) and human error. A practical application explaining the significance of this was that claims systems were found to be usually separate from appeal and grievance systems, requiring a manual analysis of necessary changes. Some insurers had not developed internal processes for evaluating complaint data – demonstrating an organizational blind spot for the insurer.

Documents and information requested

The Coordinator’s Handbook required insurers to provide substantial information about claims incurred during the exam period and supporting information, including company practices and procedures. The claims data from 2019 to 2020 were used to pull a sample of claims for the examination in accordance with NAIC market examination principles. However, ultimately the examination was largely influenced by the hands-on claims system review due to the systems issues articulated above. Although the company practices and procedures were not used centrally in the examination, it may be useful in further understanding trends, patterns, or issues in our insurance markets.⁸

Insurers’ inability to populate some required claims data fields did provide useful early insight into how insurers programmed and designed claims systems to populate information. Some insurers reported they could provide the level of data requested with substantial additional time and manual completion. However, given the expedited exam timeline and possibility for errors, the division elected to have insurers leave those fields blank, with any blanks considered a preliminary finding for the examination.

Examination components

The examinations were structured to focus on RHEA claims and complaint handling. However, as noted above, a range of data was collected related to RHEA and other claims incurred during the examination period. Using the information submitted, the examiners focused on three general examination components:

Paid claims

Paid claims were reviewed to evaluate timely claims payment and correctly paid claims, which for RHEA means without cost share. In the paid claims portion of the examination, examiners identified many instances when insurers paid a portion of the claim, but processing errors resulted in inappropriate application of cost sharing.

Denied claims

The examiners considered denied claims independently from paid claims to determine patterns in denials and review whether members received notice of the right to appeal the insurer’s decision.

⁸ ORS 731.312(6) and ORS 705.137 generally make all work papers, recorded information, documents, and copies obtained during the examination are confidential and exempt from public inspection and disclosure.

Complaint monitoring

The examination also looked at insurers' complaint handling and monitoring. This was due to concerns brought to the division by consumers and providers regarding RHEA coverage issues not being resolved by insurance companies.

Preliminary examination findings

Each insurer examined was found to have one or more instances of noncompliance, which are called "findings" in the exam context. As noted above, each insurer is entitled to review and comment on the examiner's findings before they are finalized and can be publicly released.

Preliminary findings indicate that insurers marketwide incorrectly and inconsistently implemented RHEA. Examinations also uncovered noncompliance in other areas, including with existing Affordable Care Act (ACA) coverage requirements. The four preliminary findings below appeared in many, but not all, insurer examinations:

Failure to implement RHEA – All preliminary insurer examinations included a finding related to inappropriate claims adjudication and failure to implement RHEA. These findings may include:

- Impermissible application of cost sharing,
- Denial of RHEA services, or
- Unreasonable medical management policies on RHEA services such as requiring service limitations.

Missing exam data – Insurers failed to provide required claims-level details outlined in the Coordinator's Handbook.

Failure to comply with exam requirements – Several insurers violated examination requirements resulting in examination delays. A finding related to failure to comply with examination requirements includes barriers to providing examination access and providing incorrect examination data.

Inadequate complaint handling – The examinations determined that all insurers had systems to accept, respond to, and log consumer complaints. However, some insurers did not use complaint data for monitoring potential claims issues, and complaint records were often inadequate and poorly maintained. Insurer complaint monitoring practices were limited by system management by individual insurers and did not represent an area of routine monitoring for most insurers. Although insurers provided a complaint log, in compliance with Oregon law, further identification of complaint details was often impossible without substantial effort from insurers.

Claims system examination

Several insurers in the Oregon market use the same third-party program as their base claims system. The claim system has a variety of modules for insurer compliance monitoring and more accurate reporting, but not all insurers have selected those modules. Differences in insurer programming and understanding of their internal claims systems also resulted in functional differences in claims processing for RHEA

services. For example, some insurers assert that their systems are proprietary and that it is difficult to code new benefit requirements into their claims systems.

Ultimately, the claims systems that allowed for easier examination of the insurers' claims systems provided a more complete understanding of claims administration and allowed examiners time to explore reasons for inappropriate claims administration. Remote access, once established, also provided quick and cost-effective examination without the cost of travel. However, because not all insurers have systems that include functionality to easily allow remote audits, this portion of the exam took longer to kick off as insurers worked internally to overcome access barriers.

Effect of noncompliance

How consumers and providers were affected by the marketwide noncompliance with RHEA varied widely by insurer, market, and service. Sometimes, a consumer appealed decisions and insurers changed internal policies and procedures resulting in re-adjudicated claims in compliance with the law. Information about complaint resolution was incomplete in some cases and it is unclear if complaints were resolved once submitted to an insurer. An example of this is some insurers did not always check to see if there were other incorrectly processed claims for a specific service once a complaint was received. This would be a proactive measure that insurers could take to monitor and determine compliance with state law. Described below is the effect of noncompliance, such as incorrect processing of claims, that was captured within the examination process.

Consumer experience

For Oregonians who received reproductive health care during the exam period, experience may have varied widely depending on the insurer and provider. RHEA requires insurers to make accessible to consumers information about RHEA coverage.⁹ In several instances, consumers were not provided with adequate, timely information to understand their coverage of RHEA services. Consumers who called their insurer to ask about RHEA coverage may have received inaccurate information about their plan's coverage limitations. All insurers must accept, respond to, and log consumer complaints. Insurer complaint monitoring practices are limited by system management and design. Insurers provided a complaint log, in compliance with the examination. However, further identification of complaint details was often impossible. For insurers with more advanced complaint monitoring, this is not an area of routine oversight.

Provider experience

The effect RHEA noncompliance had on health care providers was important to the proper adjudication of claims. The market variations described above would have also resulted in a variety of experiences for providers, depending on insurer and service. Unfortunately, the exam does not reveal how often the provider or facility billed the consumer for incorrectly processed RHEA claims. The exam uncovered no special claims submission instructions to providers that may have been helpful to ensure correct claims payment, and a few claims illustrated multiple attempts at claims submission before insurers paid the claim.

⁹ ORS 743A.067(11).

Benefit-based experience

As highlighted throughout this marketwide report, inconsistencies between insurers resulted in a variety of effects for consumers and providers. The examinations identified that insurers incorrectly interpreted RHEA or incorrectly programmed claims processing systems to properly adjudicate claims.

Most insurer claims systems were programmed to identify and automatically process claims when specific information is present. For example, if a claim for pregnancy screening required certain diagnostic codes for the claim to process as no cost share to consumers, absence of those codes consistently resulted in inappropriate claims adjudication for all claims that fit the same criteria.

Some insurers failed to identify services required by RHEA that are considered preventive services by the U.S. Preventive Services Taskforce (USPSTF) and other ACA frameworks. USPSTF, the U.S. Health Resources and Services Administration (HRSA), and related guidelines are different than RHEA and allow limitations on coverage that are impermissible under Oregon law. Examples of this include gender and age limitations, which are prohibited under RHEA.¹⁰ Insurers that continued to apply these limitations after 2018 were found to be noncompliant with RHEA. Further, a subset of insurers also failed to provide coverage of certain benefits until 2020, or later, when the USPSTF updated requirements related to HIV screening. Outlined below is further information about specified services required to be covered without cost share by RHEA.

Abortion

The exams identified inappropriate denials and application of cost sharing for abortion services in violation of RHEA. Of the 12 abortion claims sampled by examiners, 5 claims were improperly adjudicated.¹¹

Anemia screening

RHEA requires coverage of anemia screening, one area most insurers failed to program with no cost share in claims systems. Noncompliance of anemia screening was identified in both paid and denied claims samples and included a variety of services and tests that screen for anemia.

Contraception

The exams identified noncompliance in the coverage of contraception required under RHEA. Insurer application of state and federal law related to contraception was inconsistent during the exam period. Noncompliance with RHEA includes inappropriate denials of certain contraceptives without alternatives in the same prescription drug category and class.

Further, insurers have failed to provide coverage information to consumers about choice of contraception device or product, including emergency contraception (“Plan B”) and other over-the-counter (OTC) contraceptive methods (condoms). The examinations did not clearly determine the frequency of OTC contraceptive use. However, the lack of clear and consistent information about this benefit demonstrates that insurers need to increase visibility of this benefit and ensure compliant coverage of contraceptive drug, device, and product choice.

¹⁰ 2017 OL Ch. 721, Sec. 7.

¹¹ While samples reviewed by examiners demonstrate RHEA compliance issues across the market, sample sizes may not be large enough to draw conclusions about individual types of services.

Pregnancy screening

RHEA requires coverage of pregnancy screening, one area most insurers failed to program with no cost share following passage of the law. Coverage limitations resulted in numerous denials or the application of cost sharing for pregnancy screenings, despite some insurers providing coverage when the service was performed with well-woman visits.

Sterilization

The exams identified inconsistent insurer coverage of sterilization, including vasectomies. Before passage of RHEA, vasectomies were typically excluded from coverage.

Sexually transmitted infection (STI) screening

Insurers incorrectly covered STI screenings – commonly restricting coverage based on service location and gender. Since 2017, Oregon law requires coverage of STI screenings not required by HRSA and the USPSTF guidelines. Insurers should update STI screening coverage to remove limitations based on gender and ensure other medical management of screenings comply with Oregon requirements – regardless of the absence of similar requirements through the USPSTF or other federal guidelines sources.

Next steps

Insurers have an opportunity to review their individual examination reports and determine whether they want to comment on the findings. As part of that process, the Insurance Code allows insurers the opportunity to present their comments in a hearing.¹² Once finalized, the individual insurer examination reports will be published and made available to the public. At that time, the division will also update this marketwide report to reflect comments received and add recommended marketwide corrective actions.

As noted above, the division has been clearly and consistently instructing insurers to fully comply with RHEA since its passage and with increased focus and specificity since the initial data call results were received. Based on the findings and individual claims data reviewed as part of this examination, the division is also preparing appropriate formal enforcement actions, which can include restitution orders as well as fines. Final orders issued as part of a formal enforcement process, whether mutually agreed Consent Orders or contested case orders, will be made publicly available. As this examination, by design, tested a subset of all RHEA files the division will also initiate regular targeted data collections of RHEA claims to further monitor compliance and enable us to order corrective actions.

¹² See ORS 731.312.

Appendix A – Instructions for completing Reproductive Health Equity Act (RHEA) Data Call

Definitions - For purposes of the data call and these instructions, the following terms have the meanings provided below.

- **Abortion** refers to abortion procedures and drugs. See CPT Codes S0199 and 59812 through 59857.
- **Birth control** refers to oral contraceptive pills. See CPT Code S4993.
- **Cost sharing** refers to any out-of-pocket charges that a member is responsible for when receiving a covered service under the terms of a health benefit plan. The term includes deductibles, co-insurance, co-payments, and similar charges. The term does not include premium amounts, balance billing charges from out-of-network providers, or any amounts paid by a member for services that are not covered under the health benefit plan.
- **Covered service** refers to any service, drug, device, product, or procedure required to be covered under the Section 2(2) of the Oregon Reproductive Health Equity Act (2017 Oregon House Bill 3391). Appendix A provides an illustrative list of these services. Companies are required to report information on all covered services described in RHEA, regardless of whether those services are required to be covered under other state or federal laws and regardless of whether the company was voluntarily covering the services prior to the effective date of RHEA.
- **Hepatitis C screening** refers to screenings to determine the presence of the Hepatitis C virus. See CPT Codes 86803, 86804, 87520, 87521, and 87522.
- **High deductible health plan or HDHP** is a plan that satisfies the requirements of Section 223 of the internal revenue code. These plans are often paired with a health savings account (HSA).
- **Individual market** refers to the market in which health benefit plans are offered to individual policyholders to provide coverage to a specific person and their dependents.
- **In-network** refers to services performed by a provider or provider group that has directly contracted with the insurer to provide services under the plan.
- **Large-group market** refers to the market in which health benefit plans are offered to group policyholders other than small employers. The term includes policies offered to large employers and associations, trusts, and fully insured multiple employer welfare arrangements that act as the policyholder on a similar basis.
- **Member** refers to a person enrolled in a health benefit plan offered by the insurer.
- **Out-of-network** refers to services performed by a provider or provider group that has not contracted or has indirectly contracted with the insurer to provide services under the plan.
- **Pregnancy screening** refers to tests to determine whether a patient is pregnant. See CPT Codes 81025, 84702, 84703, and 84704.
- **Small-group market** refers to the market in which health benefit plans are offered to small employers (as defined under ORS 743B.001 and rules adopted by the division) to provide coverage to employees of the small employer and their eligible dependents.
- **Voluntary sterilization** refers to vasectomy and tubal ligation. See CPT Codes 55200 and 55250 (vasectomy) and 58600, 58605, 58611 and 58615 (tubal ligation).

Instructions for sheet 1 – Company Info

- Provide the name, address, and NAIC number for the company and the name, phone, and email for the person who prepared the data call. The person identified as preparing the data call

should be someone familiar with the response and available to answer follow-up inquiries from the division.

Instructions for sheet 2A – Totals

- This sheet requests the total number of claims for covered services. For each column, enter the information requested for the calendar quarter indicated.
- Data definitions:
 - *Total number of claims incurred* – The total number of claims incurred for all covered services during the quarter. For purposes of the data call, a claim is incurred on the date the covered service was provided to a member, regardless of when the company received the claim for reimbursement or made payment.
 - *Total number of claims paid with no member cost sharing* – The number of claims incurred during the quarter for which the member did not owe any cost sharing (i.e., the company paid the total amount due without any member responsibility).
 - *Total number of claims paid with member cost sharing* – The number of claims incurred during the quarter for which the member owed a co-payment, co-insurance, deductible or other cost sharing (i.e., the company paid the claim in part, with the remainder becoming the member’s responsibility).
 - *Total dollar amount of member cost sharing* – The total dollar amount of cost sharing required of members for all covered services incurred during the relevant quarter under the plan. The term includes all amounts attributed to deductible, co-payment, and co-insurance under the terms of the health benefit plan, regardless of whether the amounts were actually paid to the provider.
 - *Total number of claims denied* – The total number of claims received for covered services during the relevant quarter that were denied (i.e., the company did not provide any reimbursement).

Instructions for sheet 2B and 2C – Reason codes

- These sheets request aggregate information about the reasons that covered services were either denied or subjected to cost sharing between Jan. 1, 2019, and March 31, 2020.
- Sheet 2B (Denials) – For each row, enter the total number of claims for covered services denied during the applicable quarter for the reason listed in column B.
- Sheet 2C (Cost sharing) – For each row, enter the total number of claims for covered services subject to cost sharing during the applicable quarter for the reason listed in column B.
- For any claims reported on the row labeled “Other,” include a narrative explaining any additional reasons claims were denied or subjected to cost sharing. If claims were denied or subjected to cost sharing for multiple reasons not listed in Appendix B, indicate the number of claims denied or subject to cost sharing for each additional reason.
- Data definitions – *See Appendix B – Reason codes for Reproductive Health Equity data call.*

Instructions for remaining sheets (3A to 7C)

- These sheets requests claim-level info about specific covered services by market. Companies must provide the information below for each claim received for the applicable covered service with a date of service between Oct. 1, 2018, and March 31, 2020.
- Data Definitions

- *Claim number* – A unique identifying number for the claim.
- *Date of service* – The date when the covered service was provided to the member.
- *Male/female* – Indicate the member’s biological sex as indicated by the claim information. This field is required only for sterilization services.
- *Amount billed* – The dollar amount the provider billed to the insurer for the covered service.
- *Amount paid* – The dollar amount the insurer paid on a claim for a covered service. This amount may be less than the amount billed by the provider, even if the member was not subject to cost sharing. If the insurer determined that it had no obligation to reimburse the claim (the claim was denied), enter “0.”
- *Deductible* – The dollar amount of the claim that was subject to the plan’s deductible. If no portion of the claim was subject to deductible (or if the deductible had already been satisfied when the covered service was provided), enter “0.”
- *Co-payment* – The dollar amount of any co-payment required of the member with respect to the claim for the covered service. If the member was not subject to a co-payment for the covered service, enter “0.”
- *Co-insurance* – The dollar amount of any co-insurance required of the member for the claim. If the member was not subject to co-insurance on the claim, enter “0.”
- *In-network or outof-network* – If the covered service was provided by an in-network provider, enter “IN.” If the covered service was provided by an out-of-network provider, enter “OUT.”
- *Reason code* – If the claim was denied (the amount paid on the claim was zero) or was subject to cost sharing (a dollar amount was entered under deductible, co-payment, or co-insurance), indicate the reason code from Appendix B that best describes the primary reason why the claim was denied or subjected to cost sharing. If the date of service for the claim was before Jan. 1, 2019, you may enter “2” (Plan not yet Subject to RHEA) in this field.

Appendix B – Reason codes for Reproductive Health Equity data call

1. *Member not enrolled* – The member who received the services described in the claim was not enrolled in the plan on the date of service. This includes, but is not limited to, instances in which the member was terminated from the plan with an end date before the date of service, the member enrolled in a different plan before the date of service, or the member failed to complete requirements to enroll in the plan as of the date of service.
2. *Plan not yet subject to RHEA* - The claim was made under a policy that was issued before Jan. 1, 2019, and had not been renewed, modified, or extended on the date of service.
3. *Religious employer* – The claim was for contraception or abortion and was made under a policy issued to a religious employer that excludes such coverage.
4. *Out-of-network* – Services were provided by an out-of-network provider under a plan that limits to coverage to in-network providers (and in-network providers were available, geographically accessible, and willing and able to provide the service a timely manner.)
5. *Not medically necessary* – The insurer determined the service was not medically necessary.
6. *Experimental or investigational* – The insurer determined the service was experimental or investigational.
7. *Clinical trial* – Services were provided as part of a clinical trial or demonstration project that was outside the scope of ORS 743A.192.
8. *Insurer exempt from abortion coverage* – The claim was for abortion and the insurer qualifies for the exemption under ORS 743A.067(7)(e).
9. *Noncompliance with RHEA* – The claim was for a covered service under a plan that was subject to the Oregon Reproductive Health Act on the date of service, but the claim was denied or subjected to cost sharing.
10. *HDHP* – The claim was incurred under a plan that satisfies the requirements to be a high deductible health plan.
11. *Other* – The claim was denied or subjected to cost sharing for a reason not described above. Include a narrative explanation with your submission, specifying any additional reasons and the total number of claims that were affected by each additional reason.

Oregon

Division of Financial Regulation Insurance Product Regulation and Compliance – Life and Health Program

Market Conduct

Examination

Reproductive Health

Equity Coordinator’s

Handbook

Prepared for [Insurer name]

[Month Day, Year]

Coordinator Name

Title

Insurer Name

Address

City, State, Zip

Re: Market Conduct Examination – Oregon Operations Only
Insurer Name

Dear [Coordinator Name]:

The Oregon Division of Financial Regulation (division) examination call letter has notified you that a target examination of [Insurer Name] will commence on [Month Day, Year]. It is the goal of the division to perform examinations as quickly and efficiently as possible. This handbook is designed to provide procedural guidelines for the insurer. The handbook includes general information regarding the examination process and includes a non-inclusive list of items required by the insurer.

Based on a recent data related to HB 3391 (2017), known as the Reproductive Health Equity Act (RHEA), the division will review individual and group health benefit plan claims and complaints for compliance with HB 3391.

I will contact you to schedule the pre-examination conference. The purpose of this conference is to discuss the information outlined in the handbook, as well as establish lines of communication. All issues and concerns are encouraged for discussion at this time.

We ask that the insurer include in the meeting those members of management, other personnel, or both who have daily contact with Oregon operations in claims. Personnel from the Management Information Systems Department, responsible for creating the electronic policy and claim data file submissions, must also be in attendance.

The timely receipt of complete and accurate complaint and claim data is an integral part of the examination process. The failure of the insurer to provide such data as outlined and requested in the coordinator's handbook could result in an apparent violation of Oregon Revised Statutes (ORS) 731.296 and 731.308.

You are encouraged to distribute copies of the handbook to appropriate company personnel involved in the examination. If you have any questions about the above, please contact me at 971-283-0102 or by email.

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Examination authority

Under Oregon Revised Statutes (ORS) 731.308, the Director of the Oregon Department of Consumer and Business Services (Director) requests that the insurer make specified items available to authorized representatives of the department's Division of Financial Regulation (division). The requested items will reference transactions occurring during the examination period. The examination will cover claims and complaints with dates of service between January 1, 2019 and December 31, 2020, unless agreed to otherwise by the division and the insurer at the pre-examination conference.

SAMPLE

Examination chronology

Notice of examination

Issue of notice examination letter to insurer president.

Coordinator contact and requirement

Delivery of coordinator's handbook Scheduling of the pre-examination conference Completion of interrogatories

Pre-examination conference

The pre-examination conference is held to discuss examination requirements and establish lines of communication. This conference is scheduled before starting Phase I of the examination.

Phase I

The work performed before the starting date of Phase II will take place remotely.

Phase II

Due to COVID-19, Phase II will continue virtually with screen-sharing between contractor staff and insurer staff. The examination team conducts an open examination and encourages discussion of any developing issues.

Wrap-up conference

A wrap-up conference is initiated by the examination team at the completion of the examination. The insurer is encouraged to include all affected management in this conference. The examiners will summarize their findings and discuss pertinent issues that will appear in the examination report.

Report drafting

Upon completion of the examination, the team will prepare the preliminary examination report. The report drafting process is normally completed within two weeks of exam completion. Before completion, the preliminary report is reviewed and approved at various levels within the division, including review by the Life and Health Program manager, exam supporting staff, and the division administrator and deputy administrators.

Preliminary report: insurer review

The completed preliminary examination report is given to the director for review. The contractor will provide a copy of the preliminary examination report to the Insurer for review. At this time, the director may request more information or meet with the insurer to resolve questions or get more information and may direct the examination team to consider more information for inclusion in the report.

Finalizing the report

ORS 731.312(3) provides insurers an opportunity for a hearing before finalizing the examination report and the publication of the report. Beginning on the date the division mails a copy of the preliminary report, with amendments or changes if applicable, the insurer will be given 30 calendar days to request a hearing. If the insurer doesn't request a hearing by the end of the 30th day, the examination report will be considered finalized after the contractor mails a certified copy of the report to the insurer.

Formal acceptance of report

If, upon review of the report, the insurer agrees with its contents, the division requests both of the following:

- A formal letter of acceptance
- A statement of corrective action for noncompliance identified through the examination

Upon formal acceptance of the report, the division will make the report public.

Requesting a hearing

The insurer may request a hearing no later than the 30th day after the date the report was mailed. The request should be made in writing to Tashia Sizemore, Life and Health Program manager, tashia.sizemore@oregon.gov.

Market conduct examination interrogatories

Insurer must provide the requested material below to division no later than seven calendar days following the pre-examination conference.

Policyholder service and complaints

1. Define the items or correspondence that are considered “complaints” by insurer. Provide a copy of insurer’s guidelines containing the definition.
 - a. Does insurer track and record inquiries on covered benefits?
 - b. How does the insurer distinguish between a complaint and a coverage inquiry?
2. Describe how complaints and inquiries are recorded and handled.
3. What complaint reports and summaries are prepared? Who reviews them? Provide an example of each complaint report and summary used by the insurer.
4. Describe how insurer uses complaint and inquiry reports to monitor compliance with House Bill 3391 (2017).
5. If insurer uses a third-party administrator (TPA) to administer reproductive benefits, provide a flowchart of how complaint information is shared between the insurer and the TPA.

Claims

1. Provide a written description or overview of the Claims Department’s responsibilities, staffing, and reporting structures, including organizational chart.
2. Provide claims administration workflow charts illustrating how claims are handled from inception through final disposition.
3. Provide written description of computer systems with regards to claims processing. The explanation should include, but is not limited to, the following information:
 - a. The name of your claim administration system.
 - b. The frequency of security updates of the claims administration system.
 - c. The process for changing and updating the claims system, including enhancements to comply with new or revised Oregon law.
 - d. Was the claims processing program developed in-house or purchased and adapted? If the program was purchased, who is the developer and what ability does your insurer have to make corrections?
 - e. Does the claims administration system handle the claim from inception to payment and closure? If not, explain the other systems involved and how they interact.

- f. If applicable, are contracted TPAs responsible for administering claims payment use the same claims administration system? If the TPA uses a different claims administration system, what is the name of the system?
 - g. Explain how insurer monitors claims administration compliance with the TPA.
 - h. Does the claims administration system handle pharmacy claims? If not, explain how pharmacy claims are adjudicated.
4. Provide a sample Explanation of Benefits form.
5. Provide a sample claims acknowledgement letter (or electronic notice) for claims not processed within 30 days.
6. Provide read-only access to the claim submission system applicable during the examination period.
7. Prepare to complete a walk through of the claim submission system applicable during the examination period.
8. Describe how interest payments claims subject to prompt pay requirements are initiated and calculated.
9. Describe changes in claims procedures occurring during the examination period.
 - a. Explain any reason for change in procedures.

General procedures

The examination is conducted in two sections: Phase I and Phase II.

Phase I of the examination focuses on review of the insurers administrative functions and operations and provides the examination team a chance to become familiar with insurer's operation.

Specifically, this segment of the examination will concentrate on the following areas:

- Interrogatories
- Data files
- Insurer financial information (previously filed with the division)

Items identified for Phase I section of the examination should be provided to the examination team by the date determined by the examiner-In-charge during the pre- examination conference.

In Phase II, the examination team will focus on the insurer's procedures and practices as it relates to administration of benefits required under HB 3391(2017). At this point, various electronic data files submitted by the insurer have been reduced to random selections by the division. This segment of the examination will focus on the following areas:

- Consumer complaints and coverage inquiries
- Claims practices

Items identified for review during Phase II of the examination must be made available by the starting date of the examination. During the process of reviewing sample observations, the examiner will communicate noted exceptions to the insurer. The insurer will have 24 hours to respond to examiner comments.

In order to maximize clarity of the examination process, we request that you present any questions or concerns about this handbook or examination procedures at the pre- examination conference.

Findings

The division will notify the insurer of findings of noncompliance with applicable statutes and rules. Upon completion of the examination, the division will send the examination report to the division's chief enforcement officer for consideration.

Phase I

The following information should be delivered electronically to the division no later than seven days after the pre-examination conference.

Please identify each item using the identification number and the title of each section.

Consumer complaints and policyholder treatment

1. A copy of the insurer's complaint-handling procedures.
2. A copy of the Oregon complaint record. This record should include complaints closed from the Oregon Division of Financial Regulation and complaints

received directly on behalf of Oregon consumers during the examination period. [See data collection template.]

Claim practices

A random selection of the insurer's claims will be made from the electronic data files provided by the insurer. The claims will be examined for benefit payment accuracy, consistency, and compliance with Oregon regulation. Data should be in the format referenced in Appendix A and include transactions during the examination period.

1. A separate Excel document that includes data of *all* paid claims for Oregon policy and certificate holders. Lines of business to include:
 - a. Individual health benefit plans
 - b. Small group health benefit plans
 - c. Large group, associations, trusts, MEWAs, and other
2. A separate Excel document that includes data of *all* denied claims for Oregon policy and certificate holders. Lines of business to include:
 - a. Individual health benefit plans
 - b. Small group health benefit plans
 - c. Large group, associations, trusts, MEWAs, and other
3. A separate Excel document that includes data on *all* paid RHEA claims for Oregon policy and certificate holders. Lines of business to include:
 - a. Individual health benefit plans
 - b. Small group health benefit plans
 - c. Large group, associations, trusts, MEWAs, and other
4. A separate Excel document that includes data on *all denied RHEA* claims for Oregon policy and certificate holders. Lines of business to include:
 - a. Individual health benefit plans
 - b. Small group health benefit plans
 - c. Large group, associations, trusts, MEWAs, and other

Phase II

The following items are to be made available to the examiners by the starting date of the examination.

Consumer complaints and policyholder treatment

1. All selected consumer complaint files available for review

Claims practices

1. All selected claims files available for review
2. Access to all claims manuals in use during the examination period

During Phase II, the examiners will conduct a “virtual walk through” of insurer claims screens electronically using screen sharing and video conference. The insurer will also be required to provide examination staff read-only access for the claims and complaints systems.

SAMPLE

Standards under examination

Complaint handling standards

1. All complaints received by the insurer are recorded in compliance with state and federal law [Oregon Administrative Rules (OAR) 836-053-1080].

Claims

1. The insurer does not impose cost-sharing on preventive services, as defined by the United States Department of Health and Human Services (HHS) and the United States Health Resources and Services Administration (HRSA). The insurer does not impose cost-sharing for services required under the Reproductive Health Equity Act (RHEA).
 - a. For HSA plans only: Non-ACA preventive services, those services required under Oregon law but not by HHS and HRSA, may be subject to cost-sharing before meeting the deductible.

SAMPLE

Appendix A: Instruction for preparing electronic files

The attached file layouts are to be used for building the electronic files/records requested by the Oregon Division of Financial Regulation. Submit data only subject to this examination.

Files must be submitted via secure email. The division uses Biscom to share files between the division and insurer.

All files/record must correspond to the appropriate layout prescribed in this handbook. Do not submit 'backed-up' files. The data must be formatted in an .xls document. Interrogatory responses must be submitted in an .pdfa document.

Formatting data

- The records must contain data only. Insurer must include column titles/field names, do not omit any columns. Do not include any blank records, header or trailer records, total or subtotal records, etc.
- With the exception of a leading dash in the first position of the field to represent a negative amount and a decimal when permitted, numeric fields must not contain any punctuation (commas, dollar signs, percent signs, etc).
- Numeric fields must be right justified.
- Alpha fields must be left justified.
- Alphanumeric fields must be left justified.
- Each market segment must be submitted as its own individual file for the claims examination items. (e.g., individual, small group, large group)
- Multiple rows should be used when claims have multiple CPT, HCPCS, etc. codes.
- Claims that are partially paid and partially denied should be included in the *denied claims* files.
- If there are any fields you are unable to populate, contact the division in writing as soon as possible. These fields need to be accounted for in the file through the use of blank fill. **Do not use Tab characters, "0," or Not Applicable (NA).**

Sampling

The insurer will be supplied with a list of the records selected as a representative sample of the total population submitted for each specific examination item. The selected records will be reviewed, in detail, by the division's examiners; therefore, the associated insurer files must be made available to the examiners to verify electronically submitted data. Failure or refusal to provide requested files may result in an examination failure and may result in referral to Enforcement.

Please forward the files when ALL are completed; do not send in completion stages.

Missing or incomplete records

Files not received in good order by the division before the start of the examination will be deemed in violation.

Failure or refusal to provide requested files may result in an examination failure and may result in referral to Enforcement.

Submission of All Payer All Claims data not permitted

The division has determined that data submitted to the All Payer All Claims (APAC) data does not include the level of claims specificity the division believes necessary to evaluate compliance with RHEA and ensure appropriate claims handling procedures.

The data submitted to APAC was not intended to substitute for data necessary for compliance examinations. Many of the specific fields required by the division for determining market conduct are omitted or captured differently in the APAC data. These differences could result in an incomplete or unfavorable analysis of compliance with RHEA and general insurance regulation.

File naming

Interrogatories

Policyholder service and complaints

[naicno].interpsc.pdf

Claims

[naicno].interclaims.pdf

Consumer complaints and policyholder treatment

Insurer's complaint handling procedures

[naicno].hbpcomplaintproc.pdf

Oregon complaint record

[naicno].hbpcomplaintrec.xls

Claims

Note: Claims that are partially paid, partially denied should be included in the appropriate denied claims file.

All paid claims: Individual Health Benefit Plans

[naicno].pdclmsind.xls

All paid claims: Small Group Health Benefit Plans

[naicno].pdclmssg.xls

All paid claims: Large Group, Associations, Trusts, MEWAs, and other

[naicno].pdclmslg.xls

All denied claims: Individual Health Benefit Plans.

[naicno].denclmsind.xls

All denied claims: Small Group Health Benefit Plans.

[naicno].denclmssg.xls

All denied claims: Large Group, Associations, Trusts, MEWAs, and other.

[naicno].denclmslg.xls

All paid RHEA claims: Individual Health Benefit Plans

[naicno].pdrheaclmsind.xls

All paid RHEA claims: Small Group Health Benefit Plans

[naicno].pdrheaclmssg.xls

paid RHEA claims: Large Group, Associations, Trusts, MEWAs, and other.

[naicno].pdrheaclmslg.xls

All denied RHEA claims: Individual Health Benefit Plans

[naicno].denrheaclmsind.xls

All denied RHEA claims: Small Group Health Benefit Plans

[naicno].denrheaclmssg.xls

All denied RHEA claims: Large Group, Associations, Trusts, MEWAs, and other.

[naicno.]denrheaclmslg.xls

Supporting documentation

The following files may be required to support the claims files.

ClmDisp – List of claim status codes

[naicno].clmdispcodes.pdfa

DnlRes – List of denial codes if used

[naicno].dnlrescodes.pdfa

CmpRes – List of complaint reason codes with meaning

[naicno].cmprescodes.pdfa

CmpSubRs – List of sub-reason codes with meaning

[naicno].cmpsubrscodes.pdfa

CmpRsl – List of complaint resolution codes with meaning if applicable.

[naicno]cmprslcodes.pdfa

Data fields

Included below are the specific data fields required for submission, including the field name, length, type, and description.

Claims

Field Name	Field Length	Field Type	Decimals	Description
ClmNo	20	AN		Claim number.
ClmIncDt	8	N		Claim incurred date [CCYYMMDD].
ClmDisp	6	A		Claim status as of the end of the exam period. Provide a list of claim status codes along with their meanings. Example: Paid, denied, pending, etc.
ClmPdDt	8	N		Claim paid date [CCYYMMDD], if applicable.
ClmDnyDt	8	N		Claim denial date [CCYYMMDD], if applicable.
DnlRes	10	A		Reason for denial. If codes are used, provide a list of the codes, including their meaning.
ClmZip	5	A		ZIP code for where the claim occurred.
Dup	1	A		Duplicate claim? (Y or N)
ClmTp	4	A		Type of claim. Laboratory (LAB), Radiology (RAD), Prescription Drug (RX), Emergency Services (ER), Provider (PROV), Hospital (HOS), Other (OTH)
BillAmt	10	N	2	Total amount charged by provider.
AprAmt	10	N	2	The approved amount, typically the usual and customary, reasonable and customary, or other charge limitations (maximum allowable charge) applied to this claim.
ClmPdAmt	10	N	2	Amount of claim payment.
TtlPmt	20	N	2	Total payment for this claim.
CoInsPct	5	N		Co-insurance percentage applied (e.g., 15%).
CoPayAmt	10	N	2	Co-pay amount applied, if applicable.
DedAmt	10	N	2	Deductible amount applied, if applicable.
ClmPtRsp	10	N	2	Amount of claim that is the patient's responsibility.
AutoPay	1	A		Was claim processed automatically by claim system? (Y or N)
RXCUII	8	N		For pharmacy-related claims, provide the associated RXCUII of prescriptions.
CPTCode	10	N		CPT code(s) for the charges incurred on this claim, if applicable.
HCPCS	10	N		HCPCS codes for the charges incurred on this claim, if applicable.
DxCode	10	N		Diagnosis code for this claim.
IssSt	2	A		State for which policy was issued.

Field Name	Field Length	Field Type	Decimals	Description
GrpInd	3	A		Group (GRP) or individual (IND).
PolNo	10	A		Policy number.
EffDt	8	N		Policy effective date [CCYYMMDD].
CertNo	10	A		Certificate number, when applicable.
HIOSID	14	AN		Fourteen-character alpha-numeric code that identifies the insurance plan in the Health Insurance Oversight System.
ProdName	15	A		Product marketing name.
PlanCode	12	A		Required if the company assigns plans a distinct internal plan code separate from the HIOS Plan ID.
PlanAV	5	N	2	The actuarial value of the plan. [XX.XX]
PolForm	10	AN		Policy form number as filed with the Division of Financial Regulation.
PolType	5	A		Type of policy: Exclusive provider organizations (EPO), preferred provider organizations (PPO), point of service (POS)
GF	1	A		Is this product a grandfathered plan under the ACA? (Y or N)
WaitPer	5	N		Waiting or elimination period.
HSA	1	A		Is this an HSA-eligible policy or certificate? (Y or N)
OPM	10	N	2	Yearly out-of-pocket maximum.
ClmAckDt	8	N		Date claim was acknowledged [CCYYMMDD].
ClmAdJDt	8	N		Claim adjudication/process date [CCYYMMDD].
ClmClnDt	8	N		Date claim was deemed clean, if applicable. [CCYYMMDD]
ClmClsDt	8	N		Date claim closed [CCYYMMDD].
ClmDlyDt	8	N		Date the company sent a delay notice to the insured/member explaining why the claim was still pending [CCYYMMDD].
ClmInvDt	8	N		Date company requested more information [CCYYMMDD].

Field Name	Field Length	Field Type	Decimals	Description
ClmRepDt	8	N		Claim notification date [CCYYMMDD]. Date company or its agent received notification of claim.
FPmtDt	8	N		Date of first payment for this claim [CCYYMMDD].
LPymntDt	8			Date of last payment for this claim, if applicable [CCYYMMDD].
ClmAthNo	15	N		Authorization number for services performed on this claim, if applicable.
ClmRefNo	15	N		Referral number for the provider performing the services on this claim, if applicable.
COB	1	A		Coordination of benefits applied on this claim. (Y or N)
CrSvAmt	10	N	2	Amount of credit savings after coordination of benefits was applied, if applicable.
ClmCobSt	9	A		Carrier's COB status. Primary or secondary?
IntRev	1	A		Was the claim subject to an internal review?
ExtRev	1	A		Did the outcome of this claim result in a request for external review? (Y or N)
ClmDecChg	1	A		Did the internal or external appeal result in a claim decision change?
EmpName	40	A		Name of employer.
EmpType	1	A		Is the employer a religious employer eligible for exemption for contraceptive and reproductive coverage? (Y or N)
GrpNo	10	N		Group number.
GrpType	5	A		Group type code. EMP for employer groups that are not MEWAs; MEWA; ASSOC for non-MEWAs association groups; TRUST for non-MEWA trusts.
MbrCity	20	A		Member city.
MbrZip	9	A		Member ZIP code.
InsGen	1	A		Member gender (M/F/X).
MemID	10	N		Member's identification number.
MemDOB	8	N		Member date of birth [CCYYMMDD].
IntDt	8	N		Date interest paid [CCYYMMDD].
IntPaid	10	N	2	Amount of interest paid.
ProvID	15	A		Provider's identification number (NPI).

Field Name	Field Length	Field Type	Decimals	Description
PrvDisc	10	N	2	Provider discount applied to this claim, if applicable.
PrvStat	3	A		Provider status. In-network (IN) or out-of-network (OUT)?
PrvType	10	AN		Provider type. Use the Provider Taxonomy Code List: https://taxonomy.nucc.org/
PsCode	3	A		Numeric codes on professional claims that identify where a service was rendered. A listing of these codes can be found on the CMS website. The specific link is https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set
ClmFacNm	35	A		The name of the facility associated with the claim.
ClmFacCty	20	A		The city where the facility is located.
ClmFacZip	5	N		The ZIP code where the facility is located.
FacStat	3	A		The network status of the facility where the service was performed. Use IN for in-network facilities and OUT for out-of-network facilities.
EndRec	1	A		End of record marker. Place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.

Complaints

Field Name	Field Length	Field Type	Decimals	Description
CoCode	5	A		NAIC company code.
PolNo	10	A		Policy number.
ClmNo	10	A		Claim numbers involved in complaint.
CertNo	10	A		Certificate number, if applicable.
CmpCsNo	10	A		Company complaint case number for the complaint.
DFRCasNo	10	A		Division of Financial Regulation case number for the complaint if the complaint is or has been reviewed by the division.
CmpSt	2	A		Complaint state abbreviation.
CmpTyp	20	A		Complainant type (provider, producer, member agency, including insurance department etc.).

Field Name	Field Length	Field Type	Decimals	Description
CmpOrg	20	A		Origin of complaint: Company phone: CoPhone Company chat bot or chat feature: CoChat Company website: CoWeb Social media: CoSoMed Oregon DFR: ORDFR, Better Business Bureau: BBB Other governmental agency: OthGov
CmpFirst	15	A		First name of complainant.
CmpMid	15	A		Middle name of complainant.
CmpLast	20	A		Last name of complainant.
InsFirst	15	A		First name of member.
InsMid	15	A		Middle name of member.
InsLast	20	A		Last name of member. If group, record name of the group here.
InsZip	2	A		Member's resident ZIP code.
CmpCvgTp	10	A		Type of coverage as defined by the appropriate TOI. Please use appropriate TOI, as defined by the State Filing Matrix.
CmpRes	30	A		Reason for complaint. If codes are used, include a list of complaint reason codes along with their meanings.
CmpSubRs	30	A		Sub-reason for complaint. If codes are used, include a list of complaint sub-reason codes along with their meanings.
CmpRecDt	10	D		Date complaint received [MM/DD/YYYY].
Status	1	A		Complaint status (O = Open, C = Closed).
CmpRsl	30	A		Complaint resolution. If codes are used, include a list of complaint resolution codes along with their meanings.
CmpRslDt	10	D		Date complaint resolved, if applicable [MM/DD/YYYY].
CmpLtrDt	10	D		Date complaint resolution letter sent, if applicable [MM/DD/YYYY].
EndRec	1	A		End of record marker. Place an asterisk in this field to indicate the end of the record. This must be in the same character position for every record in this table.

Appendix B: Format of examination report

- I. Table of contents
- II. Salutation
- III. Scope of examination
- IV. Executive summary
- V. Policyholder services and complaints
 - a. Interrogatory analysis and observations
 - b. Data analysis and observations
 - c. "Virtual on-site" observations
- VI. Claims
 - a. Interrogatory analysis and observations
 - b. Data analysis and observations
 - c. "Virtual on-site" observations
- VII. Comments, findings, and recommendations
- VIII. Conclusion
- IX. Appendix

SAMPLE