Before the Insurance Commissioner
Of the State of Arkansas

IN THE MATTER OF A LIMITED SCOPE MARKET CONDUCT EXAMINATION OF QCA HEALTH PLAN, INC. AID NO. 2007-079

ORDER

Now on this day the matter of the Report of Examination of QCA HEALTH PLAN, INC., NAIC # 95448 (hereafter, the "Company") is taken under consideration by Julie Benafield Bowman, Insurance Commissioner for the State of Arkansas (the "Commissioner"). From the facts before her, the Commissioner finds as follows:

1. The Company is licensed by the Arkansas Insurance Department (the "Department") to operate in this State as a health maintenance organization under Ark. Code Ann. §23-76-108.

2. Pursuant to Ark. Code Ann. § 23-61-201(a)(1), the Arkansas Insurance Department (the "Department") began a limited scope, market conduct examination of the Company to determine if the Company complied with the Arkansas "Any Willing Provider Law," Ark. Code Ann. §23-99-201, et. seq. and Ark. Code Ann. §23-99-801, et. seq., ("AWP") in its payments to an "in-network" hospital of the Company, Arkansas Surgical Hospital, of North Little Rock, Arkansas (the "Complainant"). The basis of this examination derived from a January 29, 2007 complaint (the "Complaint"), filed at the Department by the Complainant against three health insurers, Arkansas Blue Cross & Blue Shield,

United HealthCare of Arkansas Inc., and QCA Health Plan Inc. (collectively, the "Respondent Health Insurers"). The Complainant requested that the Department compare the Complainant's payment rates with other "in-network" hospitals of each Respondent Health Insurer from a "selected list of procedures."

The Complainant requested that, if the payment rates for the procedures were in fact different, the Department should require that "the insurance providers pay affected hospitals the incremental amount necessary to correct discriminatory payment rates for all cases served in-network retroactive to the contract beginning date." As the basis of the Complaint, the Complainant cited AWP.

3. The examination began on April 30, 2007 and was completed on or about October 24, 2007. A verified report of examination (the "Report") was filed at the Department on or about October 24, 2007 and was forwarded by certified mail to the Company on October 27, 2007, return receipt requested. The Company received the Report on October 29, 2007 and made a December 11, 2007 written response or rebuttal to the Department about the Report and its findings.

4. The Report contains the following comments and discrepancies concerning the Company's operations:

A. The examiner noted that, in a sampled comparison of reimbursement amounts for similarly performed "outpatient" and "inpatient" procedures, performed by other member hospital providers of the Company, the Company did provide "reduced reimbursement" to the Complainant, in

comparison to two (2) other member hospitals; however, the examiner noted that the "reduced reimbursement" did not constitute a "monetary disadvantage or penalty" under Ark. Code Ann. §23-99-204(a)(1)(B)(ii) without information that the reimbursement differences affected, either directly or indirectly, a beneficiary's choice to continue to use the Complainant as an in-network hospital. The examiner relied on the language in Ark. Code Ann. §23-99-204(a)(1) which describes a "monetary advantage or penalty" as one "that would affect a beneficiary's choice among those health care providers who participate in the health benefit plan according to the terms offered."

B. The examiner noted that, in analyzing whether "reduced reimbursement" acts as an improper "monetary advantage or penalty" under Ark. Code Ann. §23-99-204(a)(1)(B)(ii), the "penalty" must "affect a beneficiary's choice among those health care providers who participate in the health plan according to the terms offered." The examiner further stated that, even if there exists a "monetary advantage or penalty," a health insurer is not deemed to have committed a violation of AWP under Ark. Code Ann. §23-99-206 and Ark. Code Ann. §23-99-204(b) as long as it is an action taken by the health benefit plan to maintain quality, enforce utilization regulations, and to control costs. The examiner concluded that the Company was not saved from a violation of Ark. Code Ann. §23-99-204(a)(1)(B)(ii) because its "reduced reimbursement" to the Complainant was due to cost or quality actions instituted by the health insurer. The examiner stated that the Complainant was paid less for the sampled "outpatient" and "inpatient services," compared to two (2) other member

hospitals, because the Company considered the Complainant to be a "limited scope facility" with "different cost structures which, although they may be providing some of the same services, they do not have to cover the costs of providing a greater breadth of service or more intensive services for more complex cases."

The Company justified its overall compensation differences as taking into account "quality of care" and "cost" differences between "limited scope hospitals" versus "full scope hospitals," e.g., the availability of critical care, anticipated response times to conditions, the complexity of the patient's condition requiring additional services necessitating transfer, the anticipated degree of progression of the patient's illness or injury which results in the need for equipment not available and technology and or special equipment not available.

The examiner however contended in the Report that these circumstances were not measures of the health insurer instituted to control costs or to maintain quality under Ark. Code Ann. §23-99-204(b) nor actions by the health insurer to control costs or maintain quality standards under Ark. Code Ann. §23-99-206. The examiner noted that he was unable to determine how such size and service characteristics of the hospital operated specifically as "the health benefit plan instituting measures designed to control costs and maintain quality standards" in each of the sampled procedures themselves. Finally, the examiner noted that in analyzing whether "reduced reimbursement" acts as an improper "monetary advantage or penalty" under Ark. Code Ann. §23-99-204(a)(1)(B)(ii), in terms of how medical providers are to be "grouped" or "classed" for purposes of

comparing reimbursement within "classes", that there exists no separate class for "specialty hospitals," but instead there exists one class as "hospitals" in Ark. Code Ann. §23-99-203(d)(11) and Ark. Code Ann. §23-99-802(4)(K). The Company disagreed that the two (2) member hospitals of the Company, which were reimbursed more than the Complainant for similarly performed procedures as "full scope hospitals," were in the same class of hospitals as those members because the Complainant was a "limited scope facility."

5. On December 11, 2007, the Company filed a rebuttal or response to the findings as stated in the Report, maintaining the following in response to the discrepancies listed in paragraph four (4) of this Order:

A. The Company agreed with the examiner's conclusion that the reimbursement differences did not constitute a "monetary penalty" or "advantage" under Ark. Code Ann. §23-99-204(a)(1)(B)(ii) in the absence of evidence that such reimbursement directly or indirectly "affected a beneficiary's choice to continue to use Complainant as an in-network provider."

B. The Company stated that the examiner did not fully consider or express the legislative intent in AWP in Ark. Code Ann. §23-99-202. Ark. Code Ann. §23-99-202 states that "the General Assembly finds that patients should be given the opportunity to see the health care provider of their choice. In order to assure the citizens of the State of Arkansas the right to choose the provider of their choice, it is the intent of the General Assembly to provide the opportunity of providers to participate in health benefit plans." The Company stated that it is the

legislative intent of AWP that it is patient protection legislation not provider protection legislation.

C. The Company stated that Ark. Code Ann. §23-99-206 permits the Company to "maintain quality, enforce utilization regulations, or to control costs." The Company stated that it is not necessary for a health benefit plan to show that the terms and conditions, including reimbursement amounts, within the health benefit plan are intended to maintain quality, enforce utilization regulations or to control costs unless those differences are first found to affect a beneficiary's choice among healthcare providers in the plan.

D. The Company stated that the examiner failed to consider that Medicare reimburses the Complainant for various services at lower reimbursement rates than it pays to larger full service hospitals, even though the Complainant states that CMS (Centers for Medicaid & Medicare Services) "accredits" the Complainant as a full service, acute care hospital.

E. The Company stated that the examiner stated that simply comparing reimbursement rates for DRG's and CPT's does not mean that exactly the same services were performed by the healthcare providers. The Company stated that it is more accurate to look at the "average allowed per admission" for each of the providers to make a better determination about the differences, if any, in reimbursed amounts.

F. The Company stated that the "reimbursement" to the Complainant is not significantly below the "reimbursement" amounts paid by the Company to full-service hospitals; in fact, as the Report reflects, the Complainant's

"reimbursement" is more than the "reimbursement" to Baptist Hospital in Little Rock for certain DRG codes on average per admission, and it is, in some instances, the same amount paid to St. Vincent in Little Rock and the Surgical Hospital of Jonesboro, Arkansas.

THEREFORE, pursuant to the provisions of Ark. Code Ann. § 23-61-205, et seq., the Commissioner hereby orders:

1. That the Report filed with the Department is hereby adopted with the following modifications as provided in this Order;

2. That, for the purposes of AWP, particularly Ark. Code Ann. § 23-99-204(a)(1)(B)(ii), the Commissioner interprets the term "reimbursement" to mean what is traditionally understood by the term "reimbursement," in the insurance industry, payment made to an insured or beneficiary to repay money the insured or beneficiary has expended for services received from a medical service provider, as distinguished from payments made by an insurer directly to a medical service provider pursuant to the insurance policy or health maintenance organization contract. The Commissioner therefore rejects references in the Report which compares the Complainant's "reimbursement" under a network provider agreement with other in-network member medical providers. The Commissioner modifies such references to mean a comparison of medical provider "payments";

3. That, as to the provider payment of sampled "outpatient" and "inpatient" services examined, the Complainant was paid less for certain sampled services compared to two (2) other member hospitals, however the Company did

not impose upon the Complainant a "monetary penalty" under Ark. Code Ann. §23-99-204 because there is no evidence that beneficiary choice or patient choice to access the Complainant is affected;

4. That the examiner's finding that the Company was not instituting a measure or action to control costs or quality when a health insurer takes into consideration the additional services of a member hospital, or other unique characteristics of a hospital, in its calculation for reimbursement, is rejected. The Commissioner finds that under Ark. Code Ann. §23-99-204(b) a health insurer may take into consideration the unique service and size characteristics of a hospital in its negotiation of individual provider payment rates because these directly affect the costs a health plan absorbs. The Commissioner finds that AWP does not require identical payment to hospitals for similarly performed services. A health insurer may vary payment for similarly performed services because of cost or quality reasons related to the different size and scope of services provided by other member hospitals under Ark. Code Ann. §23-99-204(b) and Ark. Code Ann. §23-99-206;

5. That the examiner's finding that there exists no separate class for "specialty hospitals" but instead there exists one class as "hospitals" in Ark. Code Ann. §23-99-203(d)(11) and Ark. Code Ann. §23-99-802(4)(K) is rejected. A health insurer may categorize hospitals differently due to size, location, scope of services, and other distinguishing or unique factors in order to control costs, regulate utilization, or maintain quality as contemplated in Ark. Code Ann. §23-99-204(b) and Ark. Code Ann. §23-99-206. The statutes listing medical providers

entitled to participate in AWP (Ark. Code Ann. §23-99-203 and Ark. Code Ann. §23-99-802(4)(K)) do not require "hospitals" to be classified as a single, indivisible class any more than "physicians or surgeons" are restricted from further classification, under its general class, according to their specialties in determining payment;

6. That the Department shall forward a copy of this Order to the company via certified mail;

7. That within twenty (20) days of receipt of this Order, the company shall file with the Department affidavits executed by each of its directors stating under oath that they have received a copy of this Order; and

8. That the Adopted Examination Report will be open for public inspection upon the expiration of thirty (30) days from the date of this Order.

IT IS SO ORDERED this 14th day of December, 2007.

Julie Benafield Bowman

JULIE BENAFIELD BOWMAN
INSURANCE COMMISSIONER
STATE OF ARKANSAS