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September 18, 2019

The Honorable Delores G. Kelley
Miller Senate Office Building
11 Bladen Street, Suite 3 East
Annapolis, MD 21401

Re: Senate Bill 586 of 2015- Summary of Survey Three Analysis

Dear Senator Kelley:

The purpose of this letter is to provide you with an update on the results from the third survey conducted by the Maryland Insurance Administration ("MIA" or "Administration") to verify that contracts offered by health maintenance organizations, insurers, and nonprofit health service plans ("carriers") are in compliance with the federal Mental Health Parity and Addiction Equity Act ("MHPAEA") and applicable State mental health and substance use disorder parity laws.

Initially, Senate Bill 586 of 2015 required carriers subject to the MHPAEA to submit a report certifying that, and outlining how, contracts or health benefit plans offered for the next plan year complied with the MHPAEA and applicable State mental health and substance use disorder parity laws. After further testimony and discussion on the Bill, however, the MIA was asked to: (1) conduct a survey each year over a three year period to verify that contracts offered by carriers are in compliance with the MHPAEA and applicable State mental health and addiction parity laws; and (2) provide the committee with a summary of the survey analysis after it is completed each year.

In August 2014, the MIA's Compliance and Enforcement Division surveyed carriers issuing fully insured group and individual health benefit plans ("2014 Survey"). (*See Attachment A*). The surveys revealed violations and the MIA issued six administrative orders. The MIA worked with the carriers subject to those orders to resolve the violations. On June 29, 2016, the MIA submitted a summary of the 2014 Survey findings to your attention. (*See Attachment B*).

In October 2015, the second survey was sent to carriers. (*See Attachment C*). The second survey revealed violations and the MIA issued two administrative orders. The MIA worked with the carriers subject to those orders to resolve the violations. On June 30, 2017, and January 26,

2018, the MIA submitted summaries of the 2015 Survey findings to your attention. (See Attachment D and E).

In preparation for developing and issuing the third survey ("2017 Survey"), the MIA invited stakeholders to provide input at a meeting held on August 21, 2017. The 2017 Survey was sent to the carriers on October 6, 2017, and is attached for your review. (See Attachment F). All of the carriers responded.

Responses were requested of and provided by the following carriers:

- Aetna/Coventry ("Aetna/Coventry")- including Aetna Health Inc., Aetna Life Insurance Company, Coventry Health Care of Delaware, Inc., and Coventry Health and Life Insurance Company;
- CareFirst ("CareFirst")- including CareFirst BlueChoice, Inc., CareFirst of Maryland Inc., and Group Hospitalization & Medical Services Inc., ("GHMSI");
- Cigna Health and Life Insurance Company ("Cigna");
- Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., ("Kaiser);
- United Healthcare ("UHC")- including MAMSI Life and Health Insurance Company, Optimum Choice, Inc., UnitedHealthcare Insurance Company, All Savers Insurance Company, and UnitedHealthcare of the Mid-Atlantic, Inc.

The MIA has completed its review of the survey results for all of the above listed carriers. The Administration did not identify any violations of MHPAEA or the applicable state mental health and substance use disorder parity laws during its investigations of Kaiser and CareFirst. The investigation of UHC is ongoing and the results of that investigation will be reported when complete.

Orders Issued

Aetna

Aetna's responses revealed the following:

- Aetna's internal policy document governing the assessment and credentialing of organizational providers required inpatient and outpatient behavioral health facilities to complete detailed Personnel Review assessments that were not required to be completed by Medical/Surgical inpatient and outpatient facilities.

The MIA asked Aetna to explain the difference in the credentialing requirements for behavioral health and M/S facilities. Aetna responded that it agreed there was a discrepancy and that Aetna would add a Personnel Review section to the Medical/Surgical facility assessments. The MIA found that Aetna's written policy did not comply with MHPAEA. As a result of these findings, Consent Order # MIA-2018-10-037 was issued to Aetna by the MIA. The MIA directed Aetna to provide a correct internal policy document including a Personnel Review section for credentialing Medical/Surgical facilities simultaneously with executing the consent order. Additionally, the MIA fined Aetna \$1,500 for the three

behavioral health facilities that have undergone the more burdensome Personnel Review assessment as a part of Aetna's facility credentialing process since the final MHPAEA rules went into effect. Aetna paid the fine and submitted a corrected policy to the MIA, resolving the consent order.

Cigna

Cigna's responses revealed the following:

- In 2017, Cigna denied five of the thirteen behavioral health facilities that applied to join its network for the reason that "no network need identified." Cigna did not deny any of the 122 medical/surgical facilities that applied from 2015-2017 for that reason.

The MIA asked Cigna to explain what factors and evidentiary standards it used to determine "no network need identified," for behavioral health facility applications and to demonstrate that those factors and evidentiary standards were applied comparably and just as stringently to medical/surgical facility applications. Cigna was not able to provide support for why five behavioral health facilities but no medical/surgical facilities were denied for this reason, based on the factors that Cigna considers when admitting a facility to its network. Cigna stated that its decision to admit or deny a facility entrance to its network is based in part on discretion. The MIA found that Cigna more stringently applied discretion in determining that "no network need identified" for five behavioral health facilities that applied to join its network in 2017.

As a result of these findings, Consent Order # MIA-2019-06-012 was issued to Cigna by the MIA. The MIA directed Cigna to provide a corrective action plan for its review and admission of facility applications to its network that demonstrates that behavioral health and medical/surgical facilities are reviewed in a parity compliant manner. That corrective action plan is due to the MIA in September 2019. Additionally, the MIA fined Cigna \$25,000 for having a process that violated MHPAEA. Cigna signed the Consent Order and paid the fine.

Issues Corrected During the Investigation

As a result of the survey and resulting investigations, a number of issues were identified and corrected. The Administration determined not to issue orders in these instances because the carriers were found to be administering the health benefit plans in compliance with the law despite errors in written documents. The following errors were corrected:

- An internal concurrent review policy stated that for Indemnity and Traditional Choice plans, "[c]oncurrent review is not a requirement for medical inpatient admissions. Behavioral health inpatient and residential admissions for [carrier] members do include concurrent review." The carrier explained that "[t]his policy statement was in error and was not in keeping with operational practices. . .both medical/surgical and behavioral health [] perform concurrent review if notified of an inpatient admission." The carrier provided a copy of the updated policy with the correction and data supporting that

concurrent review did occur for medical/surgical inpatient admissions for Indemnity and Traditional Choice plans during the examination period.

- An internal policy which contained a list of services that require pre-authorization stated that “All Behavior [sic] Health Services” required pre-authorization. There was no similar requirement of pre-authorization for all medical/surgical services. The carrier explained that the policy was misleading and that pre-authorization requirements are identical for medical/surgical and behavioral health services. All inpatient services require pre-authorization (with the exception of emergency services). Outpatient services require pre-authorization depending on the product the member purchased and the network with which the provider participates, not based on the services provided. The carrier corrected its internal policy to clarify that medical/surgical and behavioral health services have identical pre-authorization requirements.
- An internal policy describing when an exception will be approved to access care out-of-network under Maryland Insurance Article § 15-830(d) did not include an exception for when an appropriate provider is not available without unreasonable delay. The carrier explained that it does consider this fact when granting out-of-network exceptions and supported its position by providing data that showed the number of exception requests granted for the reason that an appropriate provider was not available without unreasonable delay during the examination period. The carrier corrected its internal policy document to include this exception.
- An internal policy describing the requirements and standards for facility credentialing of MH/SUD facilities stated that all such facilities would be interviewed as a part of the credentialing process. No similar interview requirement was included in the internal policy document describing the requirements and standards for facility credentialing of M/S facilities. The carrier explained that the MH/SUD should not have had an interview requirement as that does not accurately reflect the credentialing process. The carrier attested that both MH/SUD and M/S facilities are contacted during contracting to clarify the services the facility provides for reimbursement purposes. The carrier corrected its internal policy document to remove all mention of an interview requirement.
- An internal policy describing the requirements and standards for facility credentialing of MH/SUD facilities did not include a similar process for obtaining an exception to the requirements of submitting a malpractice history or meeting the liability insurance requirements as are contained in the M/S facility credentialing policy. The carrier explained that this was inadvertent and that the exception processes are similarly available for all facility types. The carrier provided a corrected facility credentialing policy for MH/SUD facilities that included descriptions of the exception process. The carrier noted that the exception process is not disclosed to the facilities in the credentialing application; therefore, no facilities were unfairly notified of the availability of an exception process. The carrier confirmed that most facilities utilized the exception process for disclosing malpractice history based on advice of legal counsel and zero facilities utilized the exception process for the liability insurance requirements during the survey period.
- An internal concurrent review form for inpatient mental health services contained an authorization guideline that stated the maximum number of days the clinical reviewer could approve was 7 days per utilization review. No similar maximum day cap was mentioned in any of the provided internal utilization review forms for medical/surgical

services. The carrier explained that there is no actual cap on the number of days the clinical reviewer can approve at one time for any behavioral health inpatient services. The carrier attested that both the M/S inpatient Goal Length of Stay and MH/SUD inpatient limit to a maximum number of days that can be approved are developed based on evidence based treatment guidelines. Both are guidelines and not rules, and exceptions to both M/S and MH/SUD suggested number of inpatient days can be made when the individual member's circumstances demonstrate that a different number of days are medically necessary. There is no operational/computer barrier to approving more than the maximum number of days suggested for MH/SUD inpatient services.

Internal Review Process for MHPAEA Compliance

In the 2017 Survey, the MIA asked carriers about the delegation of development/management of behavioral health benefits to another entity, the oversight the carrier exercised over that entity, the audits the carrier conducted to determine compliance with nonquantitative treatment limitation (NQTL) rules, specifically utilization management standards, both as written and in operation.¹

All of the carriers who reported delegating the management of behavioral health services to another entity provided the delegation agreements which established routine audits of the delegate's internal policies and processes. None of these delegation agreements specifically addressed assessing MHPAEA compliance.

All of the carriers reported at least an annual review of plan documents and internal policies and procedures for MHPAEA compliance. However, the stringency of the MHPAEA review varied between carriers. Some carriers reported MHPAEA assessments but were not able to provide any written policies establishing such an assessment or any written reports documenting the results of such an assessment. Other carriers produce an annual MHPAEA document, focusing on a side-by-side comparison of medical/surgical and behavioral health NQTLs based on review of plan documents and internal policies and procedures. However, most of those carriers were not able to provide any written policies establishing the processes undertaken to produce this side-by-side comparison and lacked any review of MHPAEA compliance in operation. A couple of the carriers attested that the companies were working to establish a team to conduct MHPAEA audits, focusing on determining whether NQTLs were no more stringent in operation, which has not yet been assessed by most carriers. One carrier does have a team that conducts at least annual MHPAEA compliance review of written policy documents and reviews operational data to determine whether NQTLs are applied more stringently in operation.

Denial and Appeal Rates

The MIA asked the carriers to provide data on utilization review denials and appeals based on medical necessity between January 1, 2015 and December 31, 2017. *See* Attachment F, Question 6.

¹ *See* Attachment F, Questions 1 and 2.

Overall, the data carriers provided demonstrated that the number of MH/SUD utilization review requests is significantly lower than the number of M/S utilization review requests at every level of care. For example, one carrier reported that behavioral health utilization review requests made up only .2% of utilization review for all outpatient services.

The data provided by most of the carriers demonstrated comparable rates of utilization review denials within a particular classification of benefits,² or, the percentage and number of MH/SUD denials were significantly lower than M/S denials. One carrier did report data that demonstrated that a higher percent of MH/SUD (more frequently SUD) services in the inpatient classification were denied based on medical necessity than M/S services in the same classification. However, overall, MH/SUD utilization review requests for that carrier were denied far less frequently than M/S utilization review requests. The MIA conducted a thorough review of the carrier's internal policies and procedures regarding utilization review and development of medical necessity criteria and did not identify any MHPAEA violations. Although this data may indicate a more stringent application of utilization review to inpatient MHPAEA services in operation, federal guidance on MHPAEA cautions that "[d]isparate results alone do not mean that the NQTLs in use do not comply with [MHPAEA] requirements."³ However, the most recent guidance released by the federal Department of Labor explains, "[w]hile outcomes are NOT determinative of compliance, rates of denials may be reviewed as a warning sign, or indicator of a potential operational parity noncompliance."⁴ The Administration has taken this guidance into consideration for future focused examinations of the carrier.

Credentialing Data

Some carriers reported data that demonstrated that it took longer to credential a MH/SUD facility than a M/S facility between 2015 and 2017. When asked to explain why this occurs, carriers provided the following reasons:

- Agreements with MH/SUD providers each require individual negotiation based on the unique set of services offered by that provider. Each MH/SUD provider's program varies based on the credentials of the individuals providing services (i.e., MD, LSW, RN, etc.), the ratio of providers to patients (i.e., individual versus group and size of group), and the program length of time. Accordingly, unlike for medical/surgical providers who predominantly provide the same type, credentials, ratio and program length, there is little to no industry standard reimbursement rates available for these MH/SUD services. Provider-specific rate negotiations are therefore required and may extend the negotiation period.
- MH/SUD facilities did not submit complete applications.
- MH/SUD facilities required site visits because the facility was not accredited.

² MHPAEA dictates that the parity analysis be conducted with each of six classifications: in-patient in-network; in-patient out-of-network, out-patient in-network, out-patient out-of-network, emergency, and pharmacy. 45 C.F.R. § 146.136(c)(2)(ii).

³ 78 FR 68245.

⁴ *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*, U.S. Dep't of Labor, Spring 2018, page 17, available at, <https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-a-mhpaea.pdf>

Importantly, there was not a unanimous trend of carriers taking longer to credential MH/SUD facilities than M/S facilities. Some carriers took far longer to credential M/S facilities than MH/SUD facilities.

As a part of the MIA's work on the Finance Subcommittee for the Governor's Commission to Study Mental and Behavioral Health, the MIA is looking at all aspects of network inadequacies, including barriers to providers and facilities credentialing with carriers. The MIA plans to incorporate what it learned from this survey into the work of the Subcommittee and hopes to address timeliness of credentialing for behavioral health facilities through its work on the Commission.

Out-of-Network Utilization

All of the carriers reported data demonstrating that members accessed behavioral health services out-of-network more frequently than medical/surgical services between 2015 and 2017. Tables showing the top three services and top three diagnoses, for each carrier, that accessed care out-of-network are included in Appendix A. When asked about the higher out-of-network utilization for behavioral health, the carriers provided the following reasons:

- Despite best efforts, MH/SUD providers are less likely to want to join any commercial carrier network than M/S providers. This is a national problem (citing JAMA Psychiatry, 2014 Feb; 71(2): 176-188 as supporting that nationally approximately 50 percent of psychologists do not contract with any insurer, including Medicare).
- Mental Health practices tend to be smaller and do not have the administrative support to file claims or the capacity to accept new patients for extended periods of time, therefore, they do not contract with any insurer.
- Many of the out-of-network claims are laboratory tests.
- There has been growth of a significant industry of SUD providers who offer out-of-network services that are not evidence based treatment and who engage in recruitment practices that prey on vulnerable populations and lure them out-of-network.
- Members may have out-of-network benefits and choose to seek treatment from an out-of-network provider.

On December 8, 2017, the Administration published final regulations for network sufficiency standards.⁵ These regulations require carriers to annually report to the Administration how their various networks meet the standards as detailed in the regulations. The regulation includes standards for behavioral health facilities and providers.⁶ The standards became effective on January 1, 2018, and the Administration is hopeful that these requirements for behavioral health providers and facilities will address the concerns about inadequate networks for behavioral health services. The Administration plans to continue working on this issue through its enforcement of the Network Adequacy regulations.

⁵ <http://www.mdinsurance.state.md.us/Documents/newscenter/legislativeinformation/31.10.44-NetworkAdequacy-FinalPublished1282017.pdf>

⁶ COMAR 31.10.44.04-06.

Utilization Management and Prescription Drugs

All of the carriers surveyed demonstrated compliance with Md. Ins. Art. §§ 15-850 and 851, by providing coverage for at least one formulation of an opioid antagonist without prior authorization and not having prior authorization requirements for any prescription included in the carrier's formulary that is used to treat opioid use disorder and contains methadone, buprenorphine or naltrexone.

The Administration asked the carriers to provide data from 2015- 2017 regarding prior authorization requirements and denials for SUD, MH, and M/S prescriptions. Additionally, the carriers were asked for data reflecting how many prescription requests were dispensed as a different medication than the medication described. Some carriers provided data that indicated that a higher percentage of SUD prescriptions were subject to utilization review than M/S prescriptions. The instances of utilization review plummeted in 2017, as a result of §§ 15-850 and 15-851, to below or equal to the frequency of M/S prescription utilization review.

One carrier reported data that demonstrated that MH prescriptions were more frequently dispensed as alternate medications than M/S or SUD. This number changed in 2017 to be more equitable between M/S, MH and SUD. The carrier explained that it had moved from an open formulary to a closed formulary and it took providers some time to learn to prescribe medications contained in the closed formulary. The carrier maintained that this is why the numbers leveled out in 2017.

The Administration has reviewed the carriers' utilization review policies for their pharmacy benefits and found that the carriers use the same processes for developing the utilization review requirements and implementing those requirements for M/S and MH/SUD benefits. Although the frequency of SUD prescription utilization review appears to have been corrected by §§ 15-850 and 15-851, further investigation of utilization review files with the assistance of a pharmacist with experience in behavioral health would be necessary to determine if the carrier applied utilization review requirements more stringently to behavioral health medications in operation. The Administration is working on a Request for Proposals to contract with a clinician group who can provide clinical expertise on a variety of Administration examinations, including further review of this issue.

Other State MHPAEA Compliance Efforts

California

The MIA was also asked to monitor and update the Committee on efforts in other states to verify MHPAEA compliance, in particular California. In its last Summary Letter the MIA explained that on April 1, 2016, following a desk audit, California's Department of Managed Health Care ("DMHC") began on-site surveys of insurers' records documenting each plan's utilization management process for authorizing and denying benefits. The DMHC also looked at

plan cost-sharing based on results of the desk audit which determined that insurers did not understand how to analyze financial requirements for parity compliance.⁷

The DMHC finished its first round of plan audits in early 2017. It issued reports to the carriers in the fall of 2017 and spring of 2018.⁸ Preliminary findings released by the DMHC included continued cost-sharing issues even with plans that had been corrected during the desk audit. Additionally, DMHC identified inaccuracies between what plans report to use for utilization management standards and what standards are actually used in practice. DMHC found that these inaccuracies increased when outsourcing behavioral health services to a behavioral health organization or delegating utilization management to medical/surgical groups who may not use the standards specified by the plans.

The Administration reviewed seventeen reports issued by DMHC. Of those seventeen reports, five noted potential MHPAEA violations that were addressed with the company. All of the concerning practices noted involved a carrier that delegated the utilization management of its behavioral health benefits to a third party. The issues included (1) using different definitions of medical necessity for M/S and MH/SUD services, (2) using varied medical necessity criteria for M/S services but only one set of criteria for MH/SUD services, (3) use of prior authorization and/or concurrent review for outpatient MH/SUD office visits but not for M/S office visits, (4) auto-authorization for M/S inpatient services but not for MH/SUD inpatient services, (5) no concurrent review for skilled nursing stays but requiring concurrent review for MH/SUD residential treatment stays, and (6) visit limits per authorization on MH/SUD office visits but not M/S visits.

The identification of these issues led some of the companies to correct the criteria, processes or utilization review requirements applied to behavioral health services. Other companies failed to make corrections and DMHC noted in the reports that review of the companies for corrective action addressing these issues would be conducted at the plan's next routine survey. None of the carriers were fined for violations of MHPAEA as a result of the surveys that were available for the Administration's review.

Other States

A number of other states are conducting comprehensive market conduct examinations to determine compliance with MHPAEA. Many of these examinations include the assistance of clinicians.

In 2018, Pennsylvania released two examination reports, one of Blue Cross of Northeastern Pennsylvania ("BCNP") d/b/a First Priority Health Insurance, Co., and one of Aetna.⁹ See Attachment G. The BCNP report identified issues of parity coverage for behavioral

⁷ Clinical consultants, including nurses, psychologists, and licensed clinical social workers are in the process of performing on-site audits of plans' utilization management records focusing on denied claims. Survey teams are interviewing clinical, utilization management, provider relations, and member services directors for both the plan and plan delegates. The survey team includes three attorneys and one survey analyst.

⁸ The DMHC has been making the final reports available to the public on the DMHC's website.

⁹ The Aetna examination included Aetna Health Insurance Company, Aetna Health, Inc., Health America, Inc., Health Assurance PA, Inc., and Aetna Life Insurance Company.

health services, as well as coverage issues for substance use disorder inpatient detox, nonhospital residential treatment and outpatient services. BCNP paid restitution and took corrective action. The Aetna report identified issues with coverage for autism spectrum disorder and substance use disorder. Pennsylvania concluded that Aetna used confusing policy language that implied there was no coverage for certain substance use disorder services. Aetna also applied incorrect copays, coinsurance and visit limits and had violations for prior authorization requirements and step therapy. Pennsylvania ordered restitution, corrective action and payment of a fine.

In August 2018, Rhode Island released its examination report of Blue Cross Blue Shield of Rhode Island (“BCBS”). *See* Attachment H. With the assistance of clinicians, Rhode Island assessed BCBS’s behavioral health benefits for compliance with a variety of Rhode Island laws and regulations as well as the federal MHPAEA. The targeted examination focused on non-quantitative treatment limitations and utilization review policies, procedures and their implementation. The examination found that BCBS was using clinically inappropriate utilization review criteria for behavioral health service, which was also applied inappropriately. The examination also found that BCBS’s utilization review was applied more stringently to behavioral health services and coverage exclusions applied to behavioral health services that were found to be in violation of MHPAEA. Rhode Island instructed BCBS to revise its behavioral health utilization review criteria, establish revised policies and procedures for utilization review of behavioral health services, and revise and narrow the scope of behavioral health services subject to prior authorization.

The Massachusetts Office of the Attorney General brought legal action against Aetna claiming violations of state law by maintaining inaccurate and deceptive provider directories and inadequacy provider networks. *See* Attachment I. Additionally, the AG alleged that Aetna violated state law by unfairly denying or impeding member coverage for substance use disorder treatments. In December 2018, Aetna entered into a settlement whereby it agreed to a number of terms, including covering specific medically necessary substance use disorder services and not requiring members to obtain preauthorization for specific substance use disorder services.

The Administration will submit the final results of the investigations into UnitedHealthcare entities upon their conclusion.

If you have any further questions, do not hesitate to contact me.

Sincerely,



Al Redmer, Jr.
Insurance Commissioner

Cc: Delegate Shane Pendergrass, Chairman, House Health and Government Operations
Committee and Lisa Simpson, Committee Counsel
Patrick Carlson, Committee Counsel for Senate Finance
Nancy Grodin, Deputy Insurance Commissioner

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August 13, 2014

Sent Via E-Mail and Via Certified Mail

[Address of Carrier]

RE: Mental Health Parity Survey – Maryland Business Only

Dear [Carrier]:

Pursuant to §§ 2-108 and 2-205 of the Insurance Article, Annotated Code of Maryland, the Maryland Insurance Administration is gathering information to verify compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Please provide a detailed response to the following questions as they relate to fully-insured group and individual health benefit plans. Do not include any self-funded groups or federal programs. When referencing small and large groups, the employer/group contract must be situated in the state of Maryland with one or more Maryland employees.

1. List all markets in which you currently write business subject to MHPAEA (individual/small group/large group).
 - a. Do you have the same or different requirements for MHPAEA compliance within each market?
 - b. If the requirements are different between markets, describe the differences.
2. The MHPAEA final rule¹ differentiates between six different classifications of benefits: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs.² MHPAEA

¹ See “Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program; Final Rule.” 78 F.R. 219 at 68240 (Wednesday, November 13, 2013).

² See 45 C.F.R. 146.136(c)(2)(ii).

requires that services within a particular classification be treated the same for mental illness and substance use disorders as they would be treated for medical and surgical conditions.

- a. How do you determine into which classification a particular benefit belongs?
 - b. Please provide a detailed description of the process you utilize in categorizing benefits into the six different classifications.
3. To comply with MHPAEA's general parity requirement,³ a plan may not apply any "financial requirement"⁴ or "treatment limitation"⁵ to mental health or substance use disorder benefits in any classification that is more restrictive than the "predominant"⁶ financial requirement or treatment limitation of that type applied to "substantially all"⁷ medical/surgical benefits in the same classification.
- a. Please describe the process that you use to determine whether the "substantially all" test is met.
 - b. Please describe the process that you use when developing a plan design to determine the predominant financial requirements and treatment limitations applied to substantially all medical/surgical benefits in each classification. Include an explanation of how you ensure that financial limitations and treatment limitations are not more restrictive for mental health/substance use disorder benefits than limitations for medical/surgical benefits in the same classification.
 - c. Provide a detailed example of your process using your plan with the most enrollees in Maryland (please specify market).
4. Under MHPAEA, a plan may not impose a nonquantitative treatment limitation (NQTL) with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with

³ See 45 C.F.R. 146.136(c)(2)(i).

⁴ *Financial requirements* include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits. See 45 C.F.R. 146.136(a).

⁵ *Treatment limitations* include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations (NQTLs), which otherwise limit the scope or duration of benefits for treatment under a plan or coverage (see question 4 below for an illustrative list of NQTLs). A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition. See 45 C.F.R. 146.136(a).

⁶ A financial requirement or treatment limitation is "predominant" if it applies to more than one-half of substantially all of the medical/surgical benefits in the same classification. See 45 C.F.R. 146.136(c)(3)(i)(B).

⁷ A financial requirement or treatment limitation applies to "substantially all" medical/surgical benefits in a classification if it applies to at least two-thirds of all medical/surgical benefits in the classification. See 45 C.F.R. 146.136(c)(3)(i)(A).

respect to medical/surgical benefits in the classification.⁸ Under MHPAEA, NQTLs include:

- (A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
 - (B) Formulary design for prescription drugs;
 - (C) For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
 - (D) Standards for provider admission to participate in a network, including reimbursement rates;
 - (E) Plan methods for determining usual, customary, and reasonable charges;
 - (F) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
 - (G) Exclusions based on failure to complete a course of treatment; and
 - (H) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.⁹
- a. Provide a description of how you develop NQTLs applicable to mental health and substance use disorders. Include in this description a demonstration of how the processes, strategies, evidentiary standards and other factors used in applying an NQTL to mental health/substance use disorder benefits are comparable to and applied no more stringently than medical/surgical benefits in each classification.
 - b. How do you provide the policyholder with information pertaining to NQTLs?

5. Medical Necessity Criteria

- a. Do you use a Private Review Agent (PRA) to determine the medical necessity or appropriateness of mental health/substance use disorder benefits? If so, what company do you use?
- b. Is that company different than the PRA you use for medical/surgical benefits? If so, what steps does your company take to ensure that the medical necessity or appropriateness criteria used by your PRA for mental health/substance use disorder benefits is consistent with the necessity or appropriateness criteria used by your PRA for medical/surgical benefits?

6. Formulary Design for Prescription Drugs

- a. Describe your process for placing mental health/substance use disorder and medical/surgical medications into tiers.

⁸ See 45 C.F.R. 146.136(c)(4)(i).

⁹ See 45 C.F.R. 146.136(c)(4)(ii).

- b. Explain how you determine when to apply each NQTL to mental health/substance use disorder and medical/surgical medications.

7. Provider Networks

- a. Provide a description of your network admission, credentialing, and network closure standards for mental health/substance use disorder providers and medical/surgical providers.
- b. Provide a description of your process for determining the fee schedule and reimbursement rates for mental health/substance use disorder providers and medical/surgical providers.

Pursuant to COMAR 31.04.20.05 E, the Company is required to confirm the accuracy of all information provided and submit a "Certificate of Compliance" signed by an officer of the Company acknowledging in a written certification that the information provided is, "to the best of the individual's knowledge, information, and belief, a full, complete, and truthful response to the Commissioner's response," and that the "individual making the certification was undertaken an adequate inquiry to make the required certification."

The response to this survey along with the Certificate of Compliance must be provided to Salama Karim-Camara, Market Data Analyst, no later than close of business on September 30, 2014. If you have any questions or concerns, please contact Nour Benchaaboun, Chief, Market Analysis at (410) 468-2222 or by e-mail at nour.benchaaboun@maryland.gov.

Thank you for your time and consideration in this matter.

Sincerely,

Nour E. Benchaaboun, AIRC, MCM
Chief, Market Analysis

Page 1
LAWRENCE J. HOGAN, JR.
Governor

BOYD K. RUTHERFORD
Lt. Governor



AL REDMER, JR.
Commissioner

NANCY GRODIN
Deputy Commissioner

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June 29, 2016

The Honorable Thomas McLain Middleton
Miller Senate Office Building
11 Bladen Street, Suite 3 East
Annapolis, MD 21401

Re: Senate Bill 586 of 2015 - Final Summary of Survey One Analysis

Dear Senator Middleton:

In light of testimony and discussion of Senate Bill 586 (2015), the Maryland Insurance Administration ("MIA") was requested to (1) conduct a survey each year over a three year period to verify that contracts offered by carriers are in compliance with MHPAEA and applicable State mental health and addiction parity laws and (2) provide the committee with a summary of the survey analysis after it is completed each year.

In August 2014, the MIA's Compliance and Enforcement Division sent a survey to carriers issuing fully-insured group and individual qualified health benefit plans on the Maryland Health Benefit Exchange (*See* Attachment A). All carriers responded, and subsequent investigations were opened. As all the pending hearings and matters have been resolved, we now can provide the committee with a summary of the 2014 survey results.

Responses were requested and provided from the following carriers:

- Aetna/Coventry ("Aetna/Coventry")- including Aetna Health Inc., Aetna Life Insurance Company, Coventry Health Care of Delaware, Inc. and Coventry Health and Life, Insurance Company,
- CareFirst- including CareFirst BlueChoice, Inc. ("BlueChoice"), CareFirst of Maryland, Inc. and Group Hospitalization & Medical Services ("CareFirst/GHMSI"),
- Cigna ("Cigna")- including Cigna Health and Life, Insurance Company, and Connecticut General Life Insurance Company,
- Evergreen Health Cooperative Inc. ("Evergreen"),

- Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (“Kaiser”),
- United Healthcare (“United Healthcare”)- including MAMSI Life and Health Insurance Company, Optimum Choice, Inc., United Healthcare Insurance Company, All Savers Insurance Company , and United Healthcare of the Mid-Atlantic, Inc., and
- Freedom Life Insurance Company of America (“Freedom”).

The MIA issued six administrative orders based on its investigation findings. Three of the carriers did not contest the orders (Cigna, Aetna/Coventry and Evergreen), and three carriers requested hearings (BlueChoice, CareFirst/GHMSI, and Kaiser). Copies of the orders are attached (*See Attachment B*).

The MIA provides the following summary of the findings, actions taken, and outcome for each carrier referenced above:

Aetna/Coventry:

Coventry’s responses revealed the following:

- Aetna/Coventry had no in network psychologists in all of Western Maryland (including Garrett, Allegheny, Washington and Frederick counties). Coventry only had one in-network psychiatrist in Washington County, and no in-network psychiatrists in either Garrett or Allegheny counties. Additionally, there were no in-network licensed professional counselors or licensed clinical social workers in Garrett County.
- There were no in-network methadone treatment centers in the state for Coventry, and only one in-network for Aetna.

The MIA found Aetna’s/Coventry’s network was insufficient. As a result of these findings, Order# MIA-2015-12-035 was issued to Coventry by the MIA. The MIA directed Coventry to provide quantitative goals for psychiatrists, psychologists, licensed professional counselors and licensed clinical social workers for Garrett County within 90 days to ensure an adequate network, to provide a written update whether the goal had been met in six months, and to provide documentation within 90 days demonstrating in-network access to methadone treatment. Coventry provided the required follow-up documentation. It indicated that Coventry conducted a thorough review of all clinic locations and in-network providers and identified 12 additional in-network methadone treatment clinics. Additionally Coventry provided analysis demonstrating that they met their network accessibility standards with regards to the other provider types.

CareFirst:

For CareFirst, who insured the most Marylanders, the MIA analyzed the responses for both BlueChoice and CareFirst/GHMSI.

BlueChoice’s responses revealed the following:

- There were no in-network methadone treatment centers in the state for BlueChoice.
- BlueChoice used a separate vendor to manage the mental health/substance abuse disorder network and therefore there were concerns that reimbursement rates were different than for somatic illness providers.
- Geofactors applied to somatic illness providers were not applied to mental health/substance abuse disorder providers.

The MIA found BlueChoice's network was insufficient. As a result of these findings, Order# MIA-2015-10-036 was issued to BlueChoice by the MIA. The MIA directed BlueChoice to provide documentation within 90 days demonstrating in-network access to methadone treatment, to provide documentation within 90 days outlining the underlying factors used to calculate reimbursement rates for all types of providers, and imposed an administrative penalty of \$30,000.00. BlueChoice requested a hearing.

The MIA and BlueChoice negotiated a Consent Order (*See Attachment C*). In response to the Order, BlueChoice entered into a contract with a methadone treatment provider with multiple locations as of December 2015. BlueChoice also provided a notice explaining that mental health/substance use disorder providers are treated as in-network providers for the purpose of reimbursement of this benefit. Finally, it was determined that BlueChoice's policy to apply geofactors on reimbursement rates to providers treating somatic illness and not to mental health/substance abuse disorder providers actually benefitted Maryland consumers. The application of the geofactors would be detrimental and result in lower reimbursement rates for mental health/substance abuse disorder providers, which may discourage new providers to join BlueChoice's network.

CareFirst/GHMSI responses revealed the following:

- CareFirst/GHMSI's availability plan filed with the MIA identified that they had not met the stated goals for network adequacy in two mental health/substance abuse disorder provider groups.

As a result of this finding, Order# MIA-2015-10-034 was issued to CareFirst/GHMSI by the MIA to bring them into compliance. The MIA directed CareFirst/GHMSI to provide documentation within 90 days demonstrating an increase in the number of both neuropsychological doctors, and geriatric psychiatrists in its provider panel, to provide a written update in six months of CareFirst/GHMSI's effort to contract with additional providers.

The MIA entered into a Consent Order (*See Attachment D*), which required CareFirst/GHMSI to provide an updated availability plan that showed members were able to obtain the mental health benefits despite not meeting standards in the identified provider groups. The MIA received the necessary information and has determined that CareFirst/GHMSI is now in compliance.

Cigna:

Cigna's responses revealed the following:

- While Cigna was using the Uniform Credentialing Application for both somatic illness and mental health/substance use disorder providers, they also were requiring screening interviews for the mental health/substance use disorder providers. Section 15-112.1(b) of the Insurance Article requires that the Uniform Credentialing Form be the sole application to become credentialed.
- Additionally, Cigna required mental health/substance use disorder provider applicants who had undergone treatment for substance abuse, to be sober for two years. This was not required for somatic illness providers. This information was captured outside of the Uniform Credentialing Application, which does not require such information.
- Cigna required mental health/substance use disorder providers shorter response timeframes to respond to inquiries as opposed to their somatic illness provider counterparts. This finding also indicated that the credentialing was more burdensome for mental health/substance abuse disorder providers.

The MIA found the credentialing differences were more burdensome for providers of mental health/substance abuse disorders. As a result of these findings, Order# MIA-2015-10-007 was issued to Cigna by the MIA. The Order required corrective action within ten (10 days) to eliminate the practice of screening interviews for providers, to allow mental health/substance abuse disorder providers the same amount of time (30 days) to respond to written requests as somatic illness providers, and to pay an administrative penalty of \$9,000.00. Cigna filed a corrective action plan, providing documentation that they made the changes to their credentialing standards, removed the prescreening form from the credentialing policy and procedure, revised their policy to allow behavioral practitioners 30 days to respond to written requests for additional information consistent with medical/surgical providers, and paid the administrative penalty.

Evergreen:

Evergreen's responses revealed the following:

- Evergreen utilized two vendors; one vendor for somatic illness providers, and one for mental health/substance abuse disorder providers.
- There was no coordination between the two vendors to ensure that credentialing standards were no less stringent for their somatic illness vendors than their mental health/substance abuse disorder vendors.
- Evergreen did not use the same factors when setting reimbursement rates. Providers who treated somatic illnesses were treated consistently, with reimbursement pricing generally based on a percentage of Medicare rates. Mental health/substance abuse disorder provider reimbursement pricing included a factor relating to a CPT code which was not factored into the reimbursement rate in the same manner for providers who treated somatic illnesses.
- Evergreen reported no in-network psychiatrists, psychologists, licensed clinical social workers or certified professional counselors in Garrett County, Maryland, which demonstrated that their network was insufficient.

As a result of these findings, Order# MIA-2015-10-033 was issued to Evergreen by the MIA. The MIA directed Evergreen to provide a quantitative goal for in-network providers for mental health and substance use disorder benefits within 90 days to ensure an adequate network, to provide a written update whether the goal had been met in six months, and to provide documentation within 90 days of changes to their methodology for provider credentialing and provider reimbursement to comply with the MHPAEA.

The MIA received documentation from Evergreen that their behavioral health provider network (Beacon) includes providers whose offices are located within the required geographical proximity of members who reside in Garrett County. Evergreen permitted members who were unable to access a participating provider within the required geographic proximity, to be treated by an out-of-network provider while utilizing in-network benefits. The mental health vendor contacted 15 mental health/substance use disorder providers within Garrett County in an effort to enlarge the number of in-network providers, with limited success. They also reported that while their two vendors use different methodologies to negotiate rates with providers, they apply the same reimbursement factors in the same fashion. The MIA received the information it requested from Evergreen.

Kaiser:

Kaiser's initial responses indicated the following:

- Kaiser had 28 in-network licensed professional counselors for their entire Maryland service area which resulted in a provider to member ratio of 1/5,927. This ratio was less favorable to members than for other mental health/substance abuse disorder provider types within Kaiser's network.

As a result, Order#MIA-2015-10-035 was issued by the MIA to Kaiser. The MIA directed Kaiser to provide numeric goals for in-network licensed professional counselors within 90 days to ensure an adequate network, and to provide a written update whether the goal had been met in six months. Kaiser provided the MIA additional information that illustrated that there was no unreasonable delay to receive care. The MIA concluded that Kaiser's network was not insufficient. The MIA rescinded its Order.

United Healthcare:

The MIA's review of United Healthcare's practices revealed no MHPAEA violations based on the Maryland Insurance Article.

Freedom:

In its response to Survey One, Freedom disclosed that it did offer qualified health plans in the individual or group markets in Maryland. The survey questions were therefore not applicable to Freedom and the Administration closed its investigation.

We hope this summary information is helpful and we would be glad to provide any further information about the results of Survey One upon request.

In addition, you asked that the MIA monitor and update the committee on efforts in other states, in particular California. California's Department of Managed Health Care ("DMHC") requires full service health plans (that offer commercial coverage for individuals, small groups, or large groups in 2015) to submit filings that demonstrate their compliance with the MHPAEA. In 2014, the DMHC provided insurers with detailed instructions that required them to complete worksheets that compare their behavioral health coverage to other medical coverage, and required them to complete another worksheet comparing their application of non-quantitative treatment limitations for behavioral health coverage and other medical coverage.

In 2013, the DMHC fined Kaiser \$4 million, in part, because the DMHC found Kaiser and its providers were informing consumers that certain mental health services were not covered, which was in direct violation of the parity sections of California's state laws. In this follow-up report the DMHC determined that Kaiser had not adequately corrected this violation. The Department found that while Kaiser had corrected this information on its website and in its explanation of benefits documents, its providers were still telling consumers that certain medically necessary services were not covered, like long-term therapy. The report indicated that the Department is considering further disciplinary action.

In 2014, the DMHC reached a settlement with Health Net of California for \$300,000 after initially issuing a cease and desist order in November 2013. Among other accusations, Health Net was accused of "failure to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, as specified, under the same terms and conditions applied to other medical conditions." This was in violation of the parity provisions within the Health and Safety Code.

Several fines were levied due to carriers' behavioral health coverage practices, notably: Oregon's Department of Consumer and Business Services fined Health Net of Oregon \$5,000 dollars for denying coverage for behavioral health services because the patients did not get prior authorization from Health Net; Missouri's Department of Insurance, Financial Institutions and Professional Registration reached a \$4.5 million settlement with Aetna for its continued failure to provide coverage for autism services in compliance with state law; the Connecticut Insurance Department recovered \$1.3 million for consumers from insurance plans after investigating complaints about health insurance coverage - some of these complaints were about behavioral health coverage, and Vermont's Department of Financial Regulation fined Cigna Behavioral Health \$392,500 after it was found that Cigna had used the recommendations of "unlicensed review agents" in making coverage determinations.

Other states are initiating other action, including:

- Connecticut is creating a short consumer guide and a behavioral health consumer toolkit to help consumers navigate the appeals process and better understand how to get quality behavioral healthcare through their insurance plans,

- Rhode Island's Office of the Health Insurance Commissioner, after receiving complaints from consumers that insurance plans were not covering needed behavioral health services, initiated market conduct examinations on four insurers to see if they are violating parity laws, and
- the Massachusetts Division of Insurance ("DOI") commissioned a report that found that behavioral health patients on average have to wait much longer for follow-up care than non-behavioral health patients, and, although the delays were not necessarily caused by federal or state parity law violations, the report recommended that the DOI should create standards for the detail required in insurance company records about follow-up care so that it is easier to see if there are differences in the utilization management process for behavioral health patients versus non-behavioral health patients. We are monitoring this action.

We hope this information is helpful.

Finally, you asked that the MIA examine the extent to which contract and plan benefit design features, financial requirements, treatment limitations, and utilization review requirements, as well as carrier processes, standards, and factors used to administer benefits, change from year-to-year to evaluate the feasibility of the prospective reporting that would have been required under SB 586. Please note that MIA staff reviews annually on a prospective basis many of the items listed in SB 586. Under MHPAEA, the financial requirements are required to be based on assumptions for the next year, so annual verification is needed and is performed during the annual contract review in the individual and small group markets. Also, due to the filing requirements under the Affordable Care Act, we are seeing new cost-sharing requirements for benefits being filed for the individual and small group markets annually so that the plans can continue to meet to required metal levels. Therefore, for contract review, MIA staff is already reviewing prospectively contracts for approval, including the contract and plan benefit designs, financial requirements, and permissible exclusions and limitations.

The MIA worked with the various interested parties to develop a second survey to address additional concerns regarding compliance with MHPAEA. Survey Two was sent to the health insurance carriers on October 20, 2015. (See Attachment E.) The MIA is currently analyzing those results and opening investigations where indicated. Under the MIA's current policy, specifics of ongoing investigations are not shared until they have been finalized. We look forward to providing a final summary of the Survey Two analysis once it has been completed. We will be working with interested parties to develop a third survey to be sent out this year.

If you have any further questions, please do not hesitate to contact me.

Sincerely,

Al Redmer
Insurance Commissioner

Cc: Delegate Peter A. Hammen, Chairman, House Health and Government Operations
Committee

Cc: Patrick Carlson, Senate Finance Committee Staff

Cc: Linda Stahr, HGO Committee Staff

Cc: Nancy J. Egan, Esq., Director of Government Relations, MIA

Attachments: (5)

LARRY HOGAN
Governor

BOYD K. RUTHERFORD
Lt. Governor



AL REDMER, JR.
Commissioner

NANCY GRODIN
Deputy Commissioner

VICTORIA AUGUST
Associate Commissioner

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(Date)

Sent Via E-Mail and Via Certified Mail

(Insert Address)

RE: (Insert Company)
2015 Mental Health Parity Survey – Maryland Business Only

Dear (Insert Name):

Pursuant to §§ 2-108 and 2-205 of the Insurance Article, Annotated Code of Maryland, the Maryland Insurance Administration (“Administration”) is gathering information to verify compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The Administration will be conducting these surveys on a yearly basis for the next three years. Please provide a detailed response to the following questions as they relate to fully-insured group and individual health benefit plans. Do not include any self-funded groups or federal programs. When referencing small and large groups, the employer/group contract must be situated in the state of Maryland with one or more Maryland employees.

Financial Testing

- 1) To comply with MHPAEA’s general parity requirement,¹ a plan may not apply any “financial requirement”² or “treatment limitation”³ to mental health or substance use disorder benefits in

¹ See 45 C.F.R. 146.136(c)(2)(i).

² *Financial requirements* include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits. See 45 C.F.R. 146.136(a).

³ *Treatment limitations* include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations (NQTLs), which otherwise limit the scope or duration of

any classification that is more restrictive than the “predominant”⁴ financial requirement or treatment limitation of that type applied to “substantially all”⁵ medical/surgical benefits in the same classification.

- a) Do you currently write business subject to MHPAEA in the large group market?
- b) If so, provide the financial testing explained above for the large group plan with the most enrollees in Maryland.

Nonquantitative Treatment Limitations

Under MHPAEA, a plan may not impose a nonquantitative treatment limitation (NQTL) with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.⁶

- 2) Do you have a fail first requirement for any prescription medications on any formulary the Company employs? If so, provide the following for each formulary:
 - a) A description of the terms of the fail first requirement.
 - b) A list identifying all mental health/substance use drugs vs. somatic drugs that have this requirement and which drug an individual is required to try first.
 - c) A detailed description of how you determine a particular drug should be given a fail first requirement.
 - d) Specifically identify if Vivitrol and Suboxone are included in the formulary and if they have a fail first requirement.
- 3) When creating your provider panel, how do you determine the level of need for a type of provider? Are there parameters or formulas used for mental health/substance use providers and for medical providers? If so, what are they? How do you determine if you have sufficient number of providers in a geographic area to meet the level of need for the type of provider?
- 4) Provide a detailed description of the processes that are used to determine the length of stay for inpatient/residential treatment for mental health/substance use conditions and for medical/surgical conditions. For example, do you approve only one day at a time for all types of inpatient or residential care, or do different processes for approving inpatient or residential care apply to different conditions?
- 5) Identify the percentage of total requests for inpatient admissions (including residential treatment services) for which you denied a requested level of care, but authorized a lower level of care for:
 - i) mental health diagnoses

benefits for treatment under a plan or coverage (see question 4 below for an illustrative list of NQTLs). A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition. *See* 45 C.F.R. 146.136(a).

⁴ A financial requirement or treatment limitation is “predominant” if it applies to more than one-half of substantially all of the medical/surgical benefits in the same classification. *See* 45 C.F.R. 146.136(c)(3)(i)(B).

⁵ A financial requirement or treatment limitation applies to “substantially all” medical/surgical benefits in a classification if it applies to at least two-thirds of all medical/surgical benefits in the classification. *See* 45 C.F.R. 146.136(c)(3)(i)(A).

⁶ *See* 45 C.F.R. 146.136(c)(4)(i) and for a description of what is included in NQTL’s *see* 45 C.F.R. 146.136(c)(4)(ii).

- ii) substance use disorder diagnoses, and
- iii) somatic diagnoses.

Specify the numbers by market segment (individual/small group/large group) for admission authorizations requested between January 1, 2014 and March 31, 2015. Include prior and concurrent authorization requests. Describe the processes, strategies, and evidentiary standards used to determine when lower levels of care are authorized in place of inpatient admissions for MH/SA vs. medical/surgical conditions.

- 6) a) Please specify if the following levels of care are available in your network for the following conditions and services:
- i) in regard to the treatment of heroin and opioid abuse disorders:
 - (1) Inpatient services in a hospital;
 - (2) Inpatient services in a facility other than a hospital;
 - (3) Intensive Outpatient services;
 - (4) Outpatient services.
 - ii) In regard to the treatment of diabetes:
 - (1) Inpatient services in a hospital;
 - (2) Inpatient services in a facility other than a hospital;
 - (3) Intensive Outpatient services;
 - (4) Outpatient services, e.g. outpatient self-management training and educational services.
 - ii) In regard to the treatment of stroke:
 - (1) Inpatient services in a hospital;
 - (2) Inpatient services in a facility other than a hospital;
 - (3) Intensive Outpatient services;
 - (4) Outpatient services.
 - iii) In regard to treatment of bipolar disorder:
 - (1) Inpatient services in a hospital;
 - (2) Inpatient services in a facility other than a hospital;
 - (3) Intensive Outpatient services;
 - (4) Outpatient services.
- b) Provide the number of providers for each level of care for each condition listed in 6(a) and their distribution by geographic area.
- c) Explain how the number of providers at each level of care has been adjusted based on changes in demand for the services over the past three years and the anticipated demand for services in the next three years for each condition listed in 6(a).
- d) If you do not have sufficient providers at a given level of care in a geographic area, how do you determine the amount of reimbursement for an out-of-network provider for each condition? Describe the processes, strategies, evidentiary standards, and other factors considered by the plan in determining the fee schedule on which reimbursement is based.
- e) Explain the processes used to determine the adequacy of the network for each of the four conditions listed in 6(a), including any rules, formulas, and algorithms.
- f) List which drugs are covered at each level of care for each condition listed in 6(a), and how are they tiered. Include limitations on dosage. Describe the processes, strategies, evidentiary standards, and other factors considered by the plan in placing drugs in tiers and determining limitations on dosage.
- g) Provide the requirements for utilization review for each level of treatment for the conditions listed in 6(a) above. Include limitations on length of treatment for each such condition.

Describe the processes, strategies, evidentiary standards, and other factors considered by the plan in determining the requirements for utilization review and the limitations on length of treatment.

- h) Provide the medical necessity criteria used for utilization review for each level of treatment for the conditions listed in 6(a) above. Describe the processes, strategies, evidentiary standards, and other factors considered by the plan in determining the medical necessity criteria.

Pursuant to COMAR 31.04.20.05 E, the Company is required to confirm the accuracy of all information provided and submit a "Certificate of Compliance" signed by an officer of the Company acknowledging in a written certification that the information provided is, "to the best of the individual's knowledge, information, and belief, a full, complete, and truthful response to the Commissioner's response," and that the "individual making the certification has undertaken an adequate inquiry to make the required certification."

The response to this survey along with the Certificate of Compliance must be provided to me no later than close of business on November 30, 2015. If you have any questions or concerns, please call or e-mail me at nour.benchaaboun@maryland.gov.

Thank you for your time and consideration in this matter.

Sincerely,

Nour E. Benchaaboun, AIRC, MCM
Chief, Market Analysis

LARRY HOGAN
Governor

BOYD K. RUTHERFORD
Lt. Governor



AL REDMER, JR.
Commissioner

NANCY GRODIN
Deputy Commissioner

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June 30, 2017

The Honorable Thomas McLain Middleton
Miller Senate Office Building, 3 East Wing
11 Bladen Street
Annapolis, Maryland 21401

Re: Senate Bill 586 of 2015- Update Summary of Survey Two Analysis

Dear Senator Middleton:

The purpose of this letter is to provide you with an update on the results from the second survey conducted by the Maryland Insurance Administration ("MIA" or "Administration") to verify that contracts offered by health maintenance organizations, insurers, and nonprofit health service plans ("carriers") are in compliance with the federal Mental Health Parity and Addiction Equity Act ("MHPAEA") and applicable State mental health and addiction parity laws.

Initially, Senate Bill 586 of 2015 required carriers subject to the MHPAEA to submit a report certifying that, and outlining how, contracts or health benefit plans offered for the next plan year complied with the MHPAEA and applicable State mental health and addiction parity laws. After further testimony and discussion on the Bill, however, the MIA was asked to: (1) conduct a survey each year over a three year period to verify that contracts offered by carriers are in compliance with the MHPAEA and applicable State mental health and addiction parity laws; and (2) provide the committee with a summary of the survey analysis after it is completed each year.

In August 2014, the MIA's Compliance and Enforcement Division surveyed carriers issuing fully-insured group and individual health benefit plans ("2014 Survey"). (See Attachment A). The surveys revealed violations and the MIA issued six administrative orders. The MIA worked with the carriers subject to those orders to resolve the violations. On June 29, 2016, the MIA submitted a summary of the 2014 Survey findings to your attention. (See Attachment B).

In preparation for developing and issuing the second survey ("2015 Survey"), the MIA invited stakeholders to provide input at a meeting held on August 26, 2015. The 2015 Survey was sent to the carriers on October 20, 2015, and is attached for your review. (See Attachment C). All of the carriers responded.

Responses were requested of and provided by the following carriers:¹

- Aetna/Coventry (“Aetna/Coventry”)- including Aetna Health Inc., Aetna Life Insurance Company, Coventry Health Care of Delaware, Inc., and Coventry Health and Life Insurance Company;
- CareFirst- including CareFirst BlueChoice, Inc., CareFirst of Maryland Inc., and Group Hospitalization & Medical Services Inc., (“GHMSI”);
- Cigna Health and Life Insurance Company (“Cigna”);
- Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., (“Kaiser”);
- United Healthcare (“UHC”)- including MAMSI Life and Health Insurance Company, Optimum Choice, Inc., UnitedHealthcare Insurance Company, All Savers Insurance Company, and UnitedHealthcare of the Mid-Atlantic, Inc.; and
- Freedom Life Insurance Company of America (“Freedom”).

In October, 2016, the MIA was awarded a federal grant which funded an extra staff member to continue the second MHPAEA survey analysis and to conduct investigations of possible violations. The MIA has completed its review of the survey results for Aetna, Cigna, Kaiser, and Freedom. A review of Aetna’s, Cigna’s and Kaiser’s practices revealed no violations of the MHPAEA or applicable state mental health and substance use disorder parity laws. In its response to the 2015 Survey, Freedom disclosed that it did not offer qualified health plans in the individual or group markets in Maryland. The survey questions therefore were not applicable to Freedom and the Administration closed its investigation.

The MIA has not yet completed its review of UHC and CareFirst. The MIA will provide you with its findings when these reviews are completed.

Issues Corrected During the Investigation

As a result of the survey, a number of issues were identified and corrected during the Administration’s investigation. The Administration determined not to issue orders in these instances because the carriers were found to be administering the health benefit plans in compliance with the law despite errors in written documents and/or no harm to consumers was identified. The following errors were corrected:

- Internal medical review policy limited disclosure of the medical/surgical medical necessity guidelines to three guidelines at a time to a provider/member. The carrier believed that its licensing agreement for the guidelines required it to limit disclosure of the guidelines. As a result of the MIA’s investigation, the carrier reviewed its licensing agreement and determined that the limitation was not in the agreement. The carrier removed the limitation from its internal medical review policy. The carrier informed the MIA that it was not aware of any requests for the guidelines that had been denied or limited because of the internal policy.
- Financial testing for a large group plan did not account for all of its outpatient benefits in the “all other outpatient” category nor preventative benefits in the out-of-network outpatient office visits category. As a result of the MIA’s investigation, the carrier corrected its financial testing and

¹ Evergreen Health Cooperative Inc., was also surveyed and provided a response to the 2015 Survey. Due to the Company’s ongoing efforts to remain viable in the marketplace during the span of the 2015 Survey, Evergreen was removed from examination. As a result, no further investigation was conducted following Evergreen’s initial survey response. The MIA will consider reopening investigations upon commencement of the third parity survey.

demonstrated that the exclusions of certain benefits did not change the results of the cost-sharing that could be applied to mental health/substance use disorder benefits in those classifications.

- An online provider directory indicated that it did not have any in-network inpatient facilities that could treat mental health illnesses. As a result of the MIA's investigation, the carrier corrected its online directory to reflect that there are in-network inpatient facilities to treat mental health illnesses.
- A publically available document demonstrating compliance with MHPAEA ("MHPAEA Summary") provided that the carrier's credentialing process for medical/surgical providers required the provider to agree to a site visit *if* required by the credentialing committee. In contrast, the carrier's managed behavioral health organization ("MBHO") *required* a site visit for each mental health/substance use disorder provider applying to be credentialed. The carrier informed the MIA that the information contained in its MHPAEA Summary was not accurate as to site visits for credentialing. The carrier and MBHO confirmed that they do not require site visits as part of credentialing for their commercial networks. As a result of the MIA's investigation, the carrier corrected its MHPAEA Summary to reflect this information.
- The MHPAEA Summary also provided that for out-of-network inpatient scheduled admissions there are two different notice requirements to obtain prior authorization, (1) "as soon as possible" and (2) "5 days before receiving the benefit." The MHPAEA Summary stated that all scheduled admissions for inpatient mental health/substance use disorder treatment must obtain prior authorization "as soon as possible." In contrast, the only example of a medical/surgical treatment that was held to that requirement was transplants. The carrier informed the MIA that the information contained in its MHPAEA Summary was not accurate as to out-of-network inpatient prior authorization requirements. The carrier confirmed that all scheduled out-of-network admissions for medical/surgical and mental health/substance use disorder benefits were required to obtain prior authorization "as soon as possible." As a result of the MIA's investigation, the carrier corrected its MHPAEA Summary to accurately reflect its procedure.

Provider and Facility In-Network Adequacy

In the 2015 Survey, the MIA requested responses to the following questions regarding in-network providers for inpatient and outpatient treatment of heroin and opioid abuse disorders, diabetes, stroke, and bipolar disorders:

- a) Provide the number of providers for each level of care for each condition listed in 6(a) and their distribution by geographic area.
- b) Explain how the number of providers at each level of care has been adjusted based on changes in demand for the services over the past three years and the anticipated demand for services in the next three years for each condition listed in 6(a).
- c) If you do not have sufficient providers at a given level of care in a geographic area, how do you determine the amount of reimbursement for an out-of-network provider for each condition? Describe the processes, strategies, evidentiary standards, and other factors considered by the plan in determining the fee schedule on which reimbursement is based.
- d) Explain the processes used to determine the adequacy of the network for each of the four conditions listed in 6(a), including any rules, formulas, and algorithms.

Some carriers reported that they do not have in-network non-hospital facilities for the treatment of heroin/opioid abuse disorders and bipolar disorder in certain counties of Maryland.² Other plans did not have any in-network inpatient hospitals, inpatient non-hospital facilities, or intensive outpatient treatment for substance use disorder treatment or bipolar disorder treatment in certain counties.³

As a result of the MIA's investigation, some carriers entered into new contracts with facilities located in counties lacking in-network providers. However, carriers advised the MIA that although they continue efforts to recruit providers and facilities in these counties, there do not appear to be any licensed non-hospital based behavioral health inpatient facilities that are willing to contract with managed care plans in many counties. Some carriers also provided information demonstrating that they meet their network accessibility standards with regards to all provider and facility types despite the lack of in-network facilities in certain counties. Other carriers address the shortage of in-network providers by (1) allowing members to access out-of-network providers at their in-network cost-sharing rate and (2) authorizing continued acute inpatient care until it is safe to transition the patient to partial hospitalization or intensive outpatient treatment.

Other State MHPAEA Compliance Efforts

California.

The MIA was also asked to monitor and update the Committee on efforts in other states to verify MHPAEA compliance, in particular California. In its last Summary Letter the MIA explained that California's Department of Managed Health Care ("DMHC") required full service health plans (that offer commercial coverage for individuals, small groups, or large groups) to submit filings in 2014 that demonstrate the carriers' compliance with the MHPAEA for health plans sold in 2015.⁴ In 2014 and 2015, the DMHC penalized two insurers for violations of state and federal parity laws. Those actions were addressed in more detail in the MIA's Summary Letter for the 2014 Survey, included as an attachment for your convenience. (*See* Attachment B). Additionally, the DMHC conducted a desk audit to review the filings. The desk audit resulted in 24 plans out of 25 lowering MH/SUD cost-sharing in one or more products; 3 plans eliminating impermissible day or visit limits on MH/SUD benefits; 12 plans modifying or clarifying prior or concurrent authorization requirements; and all 25 plans revising their evidence of coverage text to more clearly describe MH/SUD benefits.

On April 1, 2016, following the desk audit, the DMHC began on-site surveys of insurers' records documenting each plan's utilization management process for authorizing and denying benefits. The DMHC is also looking at plan cost-sharing based on results of the desk audit which determined that insurers did not understand how to analyze financial requirements for parity compliance.⁵

² Counties reportedly lacking in-network heroin/opioid treatment facilities: Calvert, Charles, St. Mary's, Allegany, Garret, and Washington counties. Counties lacking in-network bipolar treatment facilities: Calvert, Caroline, Charles, Kent, Dorchester, Queen Anne's, Somerset, St. Mary's, Wicomico, Worchester and Talbot counties.

³ Counties reportedly lacking in-network heroin/opioid providers: Garrett, Queen Anne's and Worchester counties. Counties lacking in-network bipolar disorder providers: Charles, Garrett, Kent, Queen Anne's, Somerset, Talbot and Worchester counties.

⁴ New Hampshire and the federal Center for Medicare and Medicaid Services have used the workbooks developed by DMHC when conducting their own market conduct exams.

⁵ Clinical consultants, including nurses, psychologists, and licensed clinical social workers are in the process of performing on-site audits of plans' utilization management records focusing on denied claims. Survey teams are interviewing clinical, utilization management, provider relations, and member services directors for both the plan and plan delegates. The survey team includes three attorneys and one survey analyst.

The DMHC finished its first round of audits in early 2017. It plans to issue reports to the carriers in the first half of 2017.⁶ Preliminary findings released by the DMHC include continued cost-sharing issues even with plans that had been corrected during the desk audit. Additionally, DMHC identified inaccuracies between what plans report to use for utilization management standards and what standards are actually used in practice. DMHC found that these inaccuracies increased when outsourcing behavioral health services to a behavioral health organization or delegating utilization management to medical/surgical groups who may not use the standards specified by the plans.

Beginning in 2016, the California Department of Insurance (CA DOI) required carriers to complete Parity Workbooks as part of each carrier's 2017 plan filing. The Workbook provides insurers with detailed instructions that require them to complete worksheets that compare financial and quantitative treatment limitations applied to their behavioral health coverage to other medical coverage. Another required worksheet compares the insurers' application of non-quantitative treatment limitations for behavioral health coverage and other medical coverage.

Checklists and Carrier Attestations.

Many states, including Maryland, rely on checklists and carrier attestations that plans are complying with state and federal parity laws.⁷ These checklists and attestations are required as a part of a state DOI form review prior to the plan being sold on the market. Some checklists are simple, merely stating that the plan must comply with state and federal parity laws and providing a box in which the carrier is meant to cite to the form page that supports this requirement. Others require more in-depth information be provided including a narrative description of the methodology used to determine plan parity compliance and completed worksheets demonstrating parity compliance for financial and quantitative treatment limitations.⁸ Fewer states conduct a comprehensive review of non-quantitative treatment limitations during form review.

Data Collection and Targeted Market Conduct Examinations.

Nine states undertake targeted market conduct examinations ("MCEs") focused on behavioral health benefits and initiated as the result of consumer complaints or information collected during form review.⁹ These MCEs have resulted in penalties and corrective action plans.¹⁰ Some states have completed MCEs focusing on compliance with federal and state parity laws. Notably, New Hampshire's DOI completed

⁶ The DMHC will make final reports available to the public on the DMHC's website. The DMHC intends to complete the remaining 20 surveys in June 2017.

⁷ States with this requirement include Alabama, Alaska, California, Colorado, Connecticut, Delaware, Indiana, Maine, Maryland, Massachusetts, Nebraska, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Utah, Virginia, and Washington.

⁸ California, Connecticut, Maryland, Massachusetts, Rhode Island.

⁹ California, Connecticut, New Hampshire, New York, North Dakota, Pennsylvania, Rhode Island, Washington, West Virginia.

¹⁰ In 2011, West Virginia's Office of the Insurance Commissioner fined insurance plans \$115,305.79 for violations related to the state parity law discovered during market conduct exams. In 2014, North Dakota DOI determined that its BlueCross BlueShield improperly denied 63 MH/SUD claims because it failed to comply with utilization review guidelines, medical necessity guidelines, and/or its contracts and state law. BCBS agreed to correct its procedures. In 2015, Connecticut DOI fined United Behavioral Health \$8,500 and required United to submit a plan for compliance within 90 days after a MCE determined that 2 appeal determinations were not reviewed by an appropriate clinical peer for the service requested. Other MCE and resulting fines were detailed in the MIA's 2014 Survey Summary, attached for your convenience. (See Attachment B).

three MCEs of Anthem Health Plans of New Hampshire, Inc. (“Anthem”), Cigna Life and Health Insurance Company (“Cigna”), and Harvard Pilgrim Health Care of New England, Inc. (“Harvard Pilgrim”).¹¹ These targeted MCEs included review of issuer compliance with MHPAEA and focused on substance use disorder benefits. In 2017, the New Hampshire DOI ordered Anthem, Cigna, and Harvard Pilgrim to correct various issues including inadequate provider networks for MH/SUD services, inaccurate provider directories, and accessibility problems. As a result, Anthem added 100 new MH/SUD provider contacts and developed the Aware Recovery Care Program, a team-based approach to treat substance use disorder. Additionally, Anthem and Harvard’s improper dosage limitation on Evizo, the naloxone auto-injector used to prevent overdoses, was highlighted for correction. New Hampshire’s DOI plans to open targeted MCEs into Anthem’s credentialing criteria and an additional follow up examination of Harvard’s reimbursement methodology and rates.

Another developing method used by states to monitor parity compliance is data collection and examination.¹² The data is examined for patterns that may indicate an underlying parity violation that should be investigated through an MCE. There were two states that had significant findings. In 2016, New Hampshire’s DOI used its all-payer claims database to analyze provider reimbursement rates for substance use disorder services for 2014 and 2015. New Hampshire determined that commercial carriers consistently paid health care providers less than Medicare rates for treating patients with substance use disorders. The New York Office of the Attorney General (“NY OAG”) examined denial rate data as part of its investigations into carrier compliance with state and federal parity laws. The denial rate data showed that carriers denied some behavioral health claims up to seven times as often as medical/surgical claims in the same category.¹³ Based in part on the data it reviewed, the NY OAG issued an order against Excellus Health Plan, Inc. (“Excellus”) finding, among other parity violations, that it “applies more rigorous—and frequent—utilization review for inpatient substance use disorder treatment than for inpatient medical/surgical treatment.” The NY OAG made the same determination about ValueOptions’ utilization review practices, finding that it issued denials for behavioral health claims twice as often and addiction recovery services four times as often as medical/surgical claims. At least four New York health plans subcontract with ValueOptions to administer their member’s behavioral health benefits. Between 2014 and 2015, the NY OAG reached settlements with six health insurance carriers, ordering corrective action and assessing approximately \$4.6 million dollars in fines and penalties.

Massachusetts requires carriers to annually submit data that compares MH/SUD services and M/S services in areas including number of requests for authorization of services and type of services; authorization requests approved, modified, and denied; the number of internal appeals and outcome; and number of appeals sent to external review and outcome. Representatives of the Massachusetts Department of Insurance advised the MIA that the data is being used to track areas of concern for future MCEs.

Utilization and Medical Necessity Review Criteria.

There is an emerging trend in the states focused on standardizing utilization review criteria for substance use disorder benefits. At least four states now require carriers to use the nationally recognized

¹¹ In order to conduct these MCE, New Hampshire DOI contracted with an IRO and a pharmacist to assist with review of medical necessity denials and prescription formularies.

¹² States that have employed this method include Connecticut, Massachusetts, New Hampshire, New York, and Vermont.

¹³ Excellus Health Plan, Inc. issued denials in 48% of the inpatient substance use disorder treatment reviews it conducted for preauthorization compared to less than 20% of the inpatient medical/surgical requests. Additionally, 29% of outpatient behavioral health services were denied compared to 13% of outpatient medical/surgical services.

American Society of Addiction Medicine (“ASAM”) utilization review criteria and medical necessity review criteria when managing substance use disorder benefits for private insurance products.¹⁴ Connecticut also requires carriers to use criteria established by the American Academy of Child and Adolescent Psychiatry’s Child and Adolescent Service Intensity Instrument when reviewing requests/claims for child/adolescent mental disorder services, and the American Psychiatric Association Guidelines or Standards and Guidelines of the Association for Ambulatory Behavioral Healthcare for adult mental disorder services.¹⁵ The Connecticut law does allow carriers to develop their own criteria or purchase criteria from other qualified vendors approved by the DOI in order to address advancements in technology/types of care that are not covered in the most recent guidelines/criteria listed in the statute.

Future Plans.

The MIA is currently developing a template for future parity MCEs by drawing from its own experience with the parity surveys and investigations, other states’ MCEs, and the NAIC’s Market Regulation Handbook. A third parity survey is also under development. The MIA intends to invite interested parties to a meeting on August 21, 2017, to engage in a discussion regarding the third survey.

If you have any questions about this summary letter or any other activities undertaken by the MIA with reference to the parity surveys, please call me.

Sincerely,



Al Redfem
Insurance Commissioner

Cc: Delegate Shane Pendergrass, Chairman, House Health and Government Operations Committee
Linda Stahr, Committee Counsel
Partick Carlson, Committee Counsel for Senate Finance
Nancy Grodin, Deputy Insurance Commissioner

¹⁴ Connecticut, Illinois, New Hampshire, Rhode Island.

¹⁵ S.B. No. 372, effective January 1, 2017 and codified at § 38a0591c of Connecticut’s insurance law.

LARRY HOGAN
Governor

BOYD K. RUTHERFORD
Lt. Governor



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AL REDMER, JR.
Commissioner

NANCY GRODIN
Deputy Commissioner

August 13, 2014

Sent Via E-Mail and Via Certified Mail

[Address of Carrier]

RE: Mental Health Parity Survey – Maryland Business Only

Dear [Carrier]:

Pursuant to §§ 2-108 and 2-205 of the Insurance Article, Annotated Code of Maryland, the Maryland Insurance Administration is gathering information to verify compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Please provide a detailed response to the following questions as they relate to fully-insured group and individual health benefit plans. Do not include any self-funded groups or federal programs. When referencing small and large groups, the employer/group contract must be situated in the state of Maryland with one or more Maryland employees.

1. List all markets in which you currently write business subject to MHPAEA (individual/small group/large group).
 - a. Do you have the same or different requirements for MHPAEA compliance within each market?
 - b. If the requirements are different between markets, describe the differences.
2. The MHPAEA final rule¹ differentiates between six different classifications of benefits: (1) inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient, out-of-network; (5) emergency care; and (6) prescription drugs.² MHPAEA

¹ See "Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program; Final Rule." 78 F.R. 219 at 68240 (Wednesday, November 13, 2013).

² See 45 C.F.R. 146.136(c)(2)(ii).

requires that services within a particular classification be treated the same for mental illness and substance use disorders as they would be treated for medical and surgical conditions.

- a. How do you determine into which classification a particular benefit belongs?
 - b. Please provide a detailed description of the process you utilize in categorizing benefits into the six different classifications.
3. To comply with MHPAEA's general parity requirement,³ a plan may not apply any "financial requirement"⁴ or "treatment limitation"⁵ to mental health or substance use disorder benefits in any classification that is more restrictive than the "predominant"⁶ financial requirement or treatment limitation of that type applied to "substantially all"⁷ medical/surgical benefits in the same classification.
- a. Please describe the process that you use to determine whether the "substantially all" test is met.
 - b. Please describe the process that you use when developing a plan design to determine the predominant financial requirements and treatment limitations applied to substantially all medical/surgical benefits in each classification. Include an explanation of how you ensure that financial limitations and treatment limitations are not more restrictive for mental health/substance use disorder benefits than limitations for medical/surgical benefits in the same classification.
 - c. Provide a detailed example of your process using your plan with the most enrollees in Maryland (please specify market).
4. Under MHPAEA, a plan may not impose a nonquantitative treatment limitation (NQTL) with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with

³ See 45 C.F.R. 146.136(c)(2)(i).

⁴ *Financial requirements* include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits. See 45 C.F.R. 146.136(a).

⁵ *Treatment limitations* include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations (NQTLs), which otherwise limit the scope or duration of benefits for treatment under a plan or coverage (see question 4 below for an illustrative list of NQTLs). A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition. See 45 C.F.R. 146.136(a).

⁶ A financial requirement or treatment limitation is "predominant" if it applies to more than one-half of substantially all of the medical/surgical benefits in the same classification. See 45 C.F.R. 146.136(c)(3)(i)(B).

⁷ A financial requirement or treatment limitation applies to "substantially all" medical/surgical benefits in a classification if it applies to at least two-thirds of all medical/surgical benefits in the classification. See 45 C.F.R. 146.136(c)(3)(i)(A).

respect to medical/surgical benefits in the classification.⁸ Under MHPAEA, NQTLs include:

- (A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- (B) Formulary design for prescription drugs;
- (C) For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
- (D) Standards for provider admission to participate in a network, including reimbursement rates;
- (E) Plan methods for determining usual, customary, and reasonable charges;
- (F) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
- (G) Exclusions based on failure to complete a course of treatment; and
- (H) Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.⁹

- a. Provide a description of how you develop NQTLs applicable to mental health and substance use disorders. Include in this description a demonstration of how the processes, strategies, evidentiary standards and other factors used in applying an NQTL to mental health/substance use disorder benefits are comparable to and applied no more stringently than medical/surgical benefits in each classification.
- b. How do you provide the policyholder with information pertaining to NQTLs?

5. Medical Necessity Criteria

- a. Do you use a Private Review Agent (PRA) to determine the medical necessity or appropriateness of mental health/substance use disorder benefits? If so, what company do you use?
- b. Is that company different than the PRA you use for medical/surgical benefits? If so, what steps does your company take to ensure that the medical necessity or appropriateness criteria used by your PRA for mental health/substance use disorder benefits is consistent with the necessity or appropriateness criteria used by your PRA for medical/surgical benefits?

6. Formulary Design for Prescription Drugs

- a. Describe your process for placing mental health/substance use disorder and medical/surgical medications into tiers.

⁸ See 45 C.F.R. 146.136(c)(4)(i).

⁹ See 45 C.F.R. 146.136(c)(4)(ii).

- b. Explain how you determine when to apply each NQTL to mental health/substance use disorder and medical/surgical medications.

7. Provider Networks

- a. Provide a description of your network admission, credentialing, and network closure standards for mental health/substance use disorder providers and medical/surgical providers.
- b. Provide a description of your process for determining the fee schedule and reimbursement rates for mental health/substance use disorder providers and medical/surgical providers.

Pursuant to COMAR 31.04.20.05 E, the Company is required to confirm the accuracy of all information provided and submit a "Certificate of Compliance" signed by an officer of the Company acknowledging in a written certification that the information provided is, "to the best of the individual's knowledge, information, and belief, a full, complete, and truthful response to the Commissioner's response," and that the "individual making the certification was undertaken an adequate inquiry to make the required certification."

The response to this survey along with the Certificate of Compliance must be provided to Salama Karim-Camara, Market Data Analyst, no later than close of business on September 30, 2014. If you have any questions or concerns, please contact Nour Benchaaboun, Chief, Market Analysis at (410) 468-2222 or by e-mail at nour.benchaaboun@maryland.gov.

Thank you for your time and consideration in this matter.

Sincerely,

Nour E. Benchaaboun, AIRC, MCM
Chief, Market Analysis

LAWRENCE J. HOGAN, JR.
Governor

BOYD K. RUTHERFORD
Lt. Governor



AL REDMER, JR.
Commissioner

NANCY GRODIN
Deputy Commissioner

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June 29, 2016

The Honorable Thomas McLain Middleton
Miller Senate Office Building
11 Bladen Street, Suite 3 East
Annapolis, MD 21401

Re: Senate Bill 586 of 2015 - Final Summary of Survey One Analysis

Dear Senator Middleton:

In light of testimony and discussion of Senate Bill 586 (2015), the Maryland Insurance Administration ("MIA") was requested to (1) conduct a survey each year over a three year period to verify that contracts offered by carriers are in compliance with MHPAEA and applicable State mental health and addiction parity laws and (2) provide the committee with a summary of the survey analysis after it is completed each year.

In August 2014, the MIA's Compliance and Enforcement Division sent a survey to carriers issuing fully-insured group and individual qualified health benefit plans on the Maryland Health Benefit Exchange (*See Attachment A*). All carriers responded, and subsequent investigations were opened. As all the pending hearings and matters have been resolved, we now can provide the committee with a summary of the 2014 survey results.

Responses were requested and provided from the following carriers:

- Aetna/Coventry ("Aetna/Coventry")- including Aetna Health Inc., Aetna Life Insurance Company, Coventry Health Care of Delaware, Inc. and Coventry Health and Life, Insurance Company,
- CareFirst- including CareFirst BlueChoice, Inc. ("BlueChoice"), CareFirst of Maryland, Inc. and Group Hospitalization & Medical Services ("CareFirst/GHMSI"),
- Cigna ("Cigna")- including Cigna Health and Life, Insurance Company, and Connecticut General Life Insurance Company,
- Evergreen Health Cooperative Inc. ("Evergreen"),

- Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (“Kaiser”),
- United Healthcare (“United Healthcare”)- including MAMSI Life and Health Insurance Company, Optimum Choice, Inc., United Healthcare Insurance Company, All Savers Insurance Company , and United Healthcare of the Mid-Atlantic, Inc., and
- Freedom Life Insurance Company of America (“Freedom”).

The MIA issued six administrative orders based on its investigation findings. Three of the carriers did not contest the orders (Cigna, Aetna/Coventry and Evergreen), and three carriers requested hearings (BlueChoice, CareFirst/GHMSI, and Kaiser). Copies of the orders are attached (*See Attachment B*).

The MIA provides the following summary of the findings, actions taken, and outcome for each carrier referenced above:

Aetna/Coventry:

Coventry’s responses revealed the following:

- Aetna/Coventry had no in network psychologists in all of Western Maryland (including Garrett, Allegheny, Washington and Frederick counties). Coventry only had one in-network psychiatrist in Washington County, and no in-network psychiatrists in either Garrett or Allegheny counties. Additionally, there were no in-network licensed professional counselors or licensed clinical social workers in Garrett County.
- There were no in-network methadone treatment centers in the state for Coventry, and only one in-network for Aetna.

The MIA found Aetna’s/Coventry’s network was insufficient. As a result of these findings, Order# MIA-2015-12-035 was issued to Coventry by the MIA. The MIA directed Coventry to provide quantitative goals for psychiatrists, psychologists, licensed professional counselors and licensed clinical social workers for Garrett County within 90 days to ensure an adequate network, to provide a written update whether the goal had been met in six months, and to provide documentation within 90 days demonstrating in-network access to methadone treatment. Coventry provided the required follow-up documentation. It indicated that Coventry conducted a thorough review of all clinic locations and in-network providers and identified 12 additional in-network methadone treatment clinics. Additionally Coventry provided analysis demonstrating that they met their network accessibility standards with regards to the other provider types.

CareFirst:

For CareFirst, who insured the most Marylanders, the MIA analyzed the responses for both BlueChoice and CareFirst/GHMSI.

BlueChoice’s responses revealed the following:

- There were no in-network methadone treatment centers in the state for BlueChoice.
- BlueChoice used a separate vendor to manage the mental health/substance abuse disorder network and therefore there were concerns that reimbursement rates were different than for somatic illness providers.
- Geofactors applied to somatic illness providers were not applied to mental health/substance abuse disorder providers.

The MIA found BlueChoice's network was insufficient. As a result of these findings, Order# MIA-2015-10-036 was issued to BlueChoice by the MIA. The MIA directed BlueChoice to provide documentation within 90 days demonstrating in-network access to methadone treatment, to provide documentation within 90 days outlining the underlying factors used to calculate reimbursement rates for all types of providers, and imposed an administrative penalty of \$30,000.00. BlueChoice requested a hearing.

The MIA and BlueChoice negotiated a Consent Order (*See Attachment C*). In response to the Order, BlueChoice entered into a contract with a methadone treatment provider with multiple locations as of December 2015. BlueChoice also provided a notice explaining that mental health/substance use disorder providers are treated as in-network providers for the purpose of reimbursement of this benefit. Finally, it was determined that BlueChoice's policy to apply geofactors on reimbursement rates to providers treating somatic illness and not to mental health/substance abuse disorder providers actually benefitted Maryland consumers. The application of the geofactors would be detrimental and result in lower reimbursement rates for mental health/substance abuse disorder providers, which may discourage new providers to join BlueChoice's network.

CareFirst/GHMSI responses revealed the following:

- CareFirst/GHMSI's availability plan filed with the MIA identified that they had not met the stated goals for network adequacy in two mental health/substance abuse disorder provider groups.

As a result of this finding, Order# MIA-2015-10-034 was issued to CareFirst/GHMSI by the MIA to bring them into compliance. The MIA directed CareFirst/GHMSI to provide documentation within 90 days demonstrating an increase in the number of both neuropsychological doctors, and geriatric psychiatrists in its provider panel, to provide a written update in six months of CareFirst/GHMSI's effort to contract with additional providers.

The MIA entered into a Consent Order (*See Attachment D*), which required CareFirst/GHMSI to provide an updated availability plan that showed members were able to obtain the mental health benefits despite not meeting standards in the identified provider groups. The MIA received the necessary information and has determined that CareFirst/GHMSI is now in compliance.

Cigna:

Cigna's responses revealed the following:

- While Cigna was using the Uniform Credentialing Application for both somatic illness and mental health/substance use disorder providers, they also were requiring screening interviews for the mental health/substance use disorder providers. Section 15-112.1(b) of the Insurance Article requires that the Uniform Credentialing Form be the sole application to become credentialed.
- Additionally, Cigna required mental health/substance use disorder provider applicants who had undergone treatment for substance abuse, to be sober for two years. This was not required for somatic illness providers. This information was captured outside of the Uniform Credentialing Application, which does not require such information.
- Cigna required mental health/substance use disorder providers shorter response timeframes to respond to inquiries as opposed to their somatic illness provider counterparts. This finding also indicated that the credentialing was more burdensome for mental health/substance abuse disorder providers.

The MIA found the credentialing differences were more burdensome for providers of mental health/substance abuse disorders. As a result of these findings, Order# MIA-2015-10-007 was issued to Cigna by the MIA. The Order required corrective action within ten (10 days) to eliminate the practice of screening interviews for providers, to allow mental health/substance abuse disorder providers the same amount of time (30 days) to respond to written requests as somatic illness providers, and to pay an administrative penalty of \$9,000.00. Cigna filed a corrective action plan, providing documentation that they made the changes to their credentialing standards, removed the prescreening form from the credentialing policy and procedure, revised their policy to allow behavioral practitioners 30 days to respond to written requests for additional information consistent with medical/surgical providers, and paid the administrative penalty.

Evergreen:

Evergreen's responses revealed the following:

- Evergreen utilized two vendors; one vendor for somatic illness providers, and one for mental health/substance abuse disorder providers.
- There was no coordination between the two vendors to ensure that credentialing standards were no less stringent for their somatic illness vendors than their mental health/substance abuse disorder vendors.
- Evergreen did not use the same factors when setting reimbursement rates. Providers who treated somatic illnesses were treated consistently, with reimbursement pricing generally based on a percentage of Medicare rates. Mental health/substance abuse disorder provider reimbursement pricing included a factor relating to a CPT code which was not factored into the reimbursement rate in the same manner for providers who treated somatic illnesses.
- Evergreen reported no in-network psychiatrists, psychologists, licensed clinical social workers or certified professional counselors in Garrett County, Maryland, which demonstrated that their network was insufficient.

As a result of these findings, Order# MIA-2015-10-033 was issued to Evergreen by the MIA. The MIA directed Evergreen to provide a quantitative goal for in-network providers for mental health and substance use disorder benefits within 90 days to ensure an adequate network, to provide a written update whether the goal had been met in six months, and to provide documentation within 90 days of changes to their methodology for provider credentialing and provider reimbursement to comply with the MHPAEA.

The MIA received documentation from Evergreen that their behavioral health provider network (Beacon) includes providers whose offices are located within the required geographical proximity of members who reside in Garrett County. Evergreen permitted members who were unable to access a participating provider within the required geographic proximity, to be treated by an out-of-network provider while utilizing in-network benefits. The mental health vendor contacted 15 mental health/substance use disorder providers within Garrett County in an effort to enlarge the number of in-network providers, with limited success. They also reported that while their two vendors use different methodologies to negotiate rates with providers, they apply the same reimbursement factors in the same fashion. The MIA received the information it requested from Evergreen.

Kaiser:

Kaiser's initial responses indicated the following:

- Kaiser had 28 in-network licensed professional counselors for their entire Maryland service area which resulted in a provider to member ratio of 1/5,927. This ratio was less favorable to members than for other mental health/substance abuse disorder provider types within Kaiser's network.

As a result, Order#MIA-2015-10-035 was issued by the MIA to Kaiser. The MIA directed Kaiser to provide numeric goals for in-network licensed professional counselors within 90 days to ensure an adequate network, and to provide a written update whether the goal had been met in six months. Kaiser provided the MIA additional information that illustrated that there was no unreasonable delay to receive care. The MIA concluded that Kaiser's network was not insufficient. The MIA rescinded its Order.

United Healthcare:

The MIA's review of United Healthcare's practices revealed no MHPAEA violations based on the Maryland Insurance Article.

Freedom:

In its response to Survey One, Freedom disclosed that it did offer qualified health plans in the individual or group markets in Maryland. The survey questions were therefore not applicable to Freedom and the Administration closed its investigation.

We hope this summary information is helpful and we would be glad to provide any further information about the results of Survey One upon request.

In addition, you asked that the MIA monitor and update the committee on efforts in other states, in particular California. California's Department of Managed Health Care ("DMHC") requires full service health plans (that offer commercial coverage for individuals, small groups, or large groups in 2015) to submit filings that demonstrate their compliance with the MHPAEA. In 2014, the DMHC provided insurers with detailed instructions that required them to complete worksheets that compare their behavioral health coverage to other medical coverage, and required them to complete another worksheet comparing their application of non-quantitative treatment limitations for behavioral health coverage and other medical coverage.

In 2013, the DMHC fined Kaiser \$4 million, in part, because the DMHC found Kaiser and its providers were informing consumers that certain mental health services were not covered, which was in direct violation of the parity sections of California's state laws. In this follow-up report the DMHC determined that Kaiser had not adequately corrected this violation. The Department found that while Kaiser had corrected this information on its website and in its explanation of benefits documents, its providers were still telling consumers that certain medically necessary services were not covered, like long-term therapy. The report indicated that the Department is considering further disciplinary action.

In 2014, the DMHC reached a settlement with Health Net of California for \$300,000 after initially issuing a cease and desist order in November 2013. Among other accusations, Health Net was accused of "failure to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, as specified, under the same terms and conditions applied to other medical conditions." This was in violation of the parity provisions within the Health and Safety Code.

Several fines were levied due to carriers' behavioral health coverage practices, notably: Oregon's Department of Consumer and Business Services fined Health Net of Oregon \$5,000 dollars for denying coverage for behavioral health services because the patients did not get prior authorization from Health Net; Missouri's Department of Insurance, Financial Institutions and Professional Registration reached a \$4.5 million settlement with Aetna for its continued failure to provide coverage for autism services in compliance with state law; the Connecticut Insurance Department recovered \$1.3 million for consumers from insurance plans after investigating complaints about health insurance coverage - some of these complaints were about behavioral health coverage, and Vermont's Department of Financial Regulation fined Cigna Behavioral Health \$392,500 after it was found that Cigna had used the recommendations of "unlicensed review agents" in making coverage determinations.

Other states are initiating other action, including:

- Connecticut is creating a short consumer guide and a behavioral health consumer toolkit to help consumers navigate the appeals process and better understand how to get quality behavioral healthcare through their insurance plans,

- Rhode Island's Office of the Health Insurance Commissioner, after receiving complaints from consumers that insurance plans were not covering needed behavioral health services, initiated market conduct examinations on four insurers to see if they are violating parity laws, and
- the Massachusetts Division of Insurance ("DOI") commissioned a report that found that behavioral health patients on average have to wait much longer for follow-up care than non-behavioral health patients, and, although the delays were not necessarily caused by federal or state parity law violations, the report recommended that the DOI should create standards for the detail required in insurance company records about follow-up care so that it is easier to see if there are differences in the utilization management process for behavioral health patients versus non-behavioral health patients. We are monitoring this action.

We hope this information is helpful.

Finally, you asked that the MIA examine the extent to which contract and plan benefit design features, financial requirements, treatment limitations, and utilization review requirements, as well as carrier processes, standards, and factors used to administer benefits, change from year-to-year to evaluate the feasibility of the prospective reporting that would have been required under SB 586. Please note that MIA staff reviews annually on a prospective basis many of the items listed in SB 586. Under MHPAEA, the financial requirements are required to be based on assumptions for the next year, so annual verification is needed and is performed during the annual contract review in the individual and small group markets. Also, due to the filing requirements under the Affordable Care Act, we are seeing new cost-sharing requirements for benefits being filed for the individual and small group markets annually so that the plans can continue to meet to required metal levels. Therefore, for contract review, MIA staff is already reviewing prospectively contracts for approval, including the contract and plan benefit designs, financial requirements, and permissible exclusions and limitations.

The MIA worked with the various interested parties to develop a second survey to address additional concerns regarding compliance with MHPAEA. Survey Two was sent to the health insurance carriers on October 20, 2015. (See Attachment E.) The MIA is currently analyzing those results and opening investigations where indicated. Under the MIA's current policy, specifics of ongoing investigations are not shared until they have been finalized. We look forward to providing a final summary of the Survey Two analysis once it has been completed. We will be working with interested parties to develop a third survey to be sent out this year.

If you have any further questions, please do not hesitate to contact me.

Sincerely,

Al Redmer
Insurance Commissioner

Cc: Delegate Peter A. Hammen, Chairman, House Health and Government Operations
Committee

Cc: Patrick Carlson, Senate Finance Committee Staff

Cc: Linda Stahr, HGO Committee Staff

Cc: Nancy J. Egan, Esq., Director of Government Relations, MIA

Attachments: (5)

LARRY HOGAN
Governor

BOYD K. RUTHERFORD
Lt. Governor



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Commissioner

NANCY GRODIN
Deputy Commissioner

VICTORIA AUGUST
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(Date)

Sent Via E-Mail and Via Certified Mail

(Insert Address)

RE: (Insert Company)
2015 Mental Health Parity Survey – Maryland Business Only

Dear (Insert Name):

Pursuant to §§ 2-108 and 2-205 of the Insurance Article, Annotated Code of Maryland, the Maryland Insurance Administration (“Administration”) is gathering information to verify compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The Administration will be conducting these surveys on a yearly basis for the next three years. Please provide a detailed response to the following questions as they relate to fully-insured group and individual health benefit plans. Do not include any self-funded groups or federal programs. When referencing small and large groups, the employer/group contract must be situated in the state of Maryland with one or more Maryland employees.

Financial Testing

- 1) To comply with MHPAEA’s general parity requirement,¹ a plan may not apply any “financial requirement”² or “treatment limitation”³ to mental health or substance use disorder benefits in

¹ See 45 C.F.R. 146.136(c)(2)(i).

² *Financial requirements* include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits. See 45 C.F.R. 146.136(a).

³ *Treatment limitations* include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations (NQTLs), which otherwise limit the scope or duration of

any classification that is more restrictive than the “predominant”⁴ financial requirement or treatment limitation of that type applied to “substantially all”⁵ medical/surgical benefits in the same classification.

- a) Do you currently write business subject to MHPAEA in the large group market?
- b) If so, provide the financial testing explained above for the large group plan with the most enrollees in Maryland.

Nonquantitative Treatment Limitations

Under MHPAEA, a plan may not impose a nonquantitative treatment limitation (NQTL) with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.⁶

- 2) Do you have a fail first requirement for any prescription medications on any formulary the Company employs? If so, provide the following for each formulary:
 - a) A description of the terms of the fail first requirement.
 - b) A list identifying all mental health/substance use drugs vs. somatic drugs that have this requirement and which drug an individual is required to try first.
 - c) A detailed description of how you determine a particular drug should be given a fail first requirement.
 - d) Specifically identify if Vivitrol and Suboxone are included in the formulary and if they have a fail first requirement.
- 3) When creating your provider panel, how do you determine the level of need for a type of provider? Are there parameters or formulas used for mental health/substance use providers and for medical providers? If so, what are they? How do you determine if you have sufficient number of providers in a geographic area to meet the level of need for the type of provider?
- 4) Provide a detailed description of the processes that are used to determine the length of stay for inpatient/residential treatment for mental health/substance use conditions and for medical/surgical conditions. For example, do you approve only one day at a time for all types of inpatient or residential care, or do different processes for approving inpatient or residential care apply to different conditions?
- 5) Identify the percentage of total requests for inpatient admissions (including residential treatment services) for which you denied a requested level of care, but authorized a lower level of care for:
 - i) mental health diagnoses

benefits for treatment under a plan or coverage (see question 4 below for an illustrative list of NQTLs). A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition. *See* 45 C.F.R. 146.136(a).

⁴ A financial requirement or treatment limitation is “predominant” if it applies to more than one-half of substantially all of the medical/surgical benefits in the same classification. *See* 45 C.F.R. 146.136(c)(3)(i)(B).

⁵ A financial requirement or treatment limitation applies to “substantially all” medical/surgical benefits in a classification if it applies to at least two-thirds of all medical/surgical benefits in the classification. *See* 45 C.F.R. 146.136(c)(3)(i)(A).

⁶ *See* 45 C.F.R. 146.136(c)(4)(i) and for a description of what is included in NQTL’s *see* 45 C.F.R. 146.136(c)(4)(ii).

- ii) substance use disorder diagnoses, and
- iii) somatic diagnoses.

Specify the numbers by market segment (individual/small group/large group) for admission authorizations requested between January 1, 2014 and March 31, 2015. Include prior and concurrent authorization requests. Describe the processes, strategies, and evidentiary standards used to determine when lower levels of care are authorized in place of inpatient admissions for MH/SA vs. medical/surgical conditions.

- 6) a) Please specify if the following levels of care are available in your network for the following conditions and services:
- i) in regard to the treatment of heroin and opioid abuse disorders:
 - (1) Inpatient services in a hospital;
 - (2) Inpatient services in a facility other than a hospital;
 - (3) Intensive Outpatient services;
 - (4) Outpatient services.
 - ii) In regard to the treatment of diabetes:
 - (1) Inpatient services in a hospital;
 - (2) Inpatient services in a facility other than a hospital;
 - (3) Intensive Outpatient services;
 - (4) Outpatient services, e.g. outpatient self-management training and educational services.
 - ii) In regard to the treatment of stroke:
 - (1) Inpatient services in a hospital;
 - (2) Inpatient services in a facility other than a hospital;
 - (3) Intensive Outpatient services;
 - (4) Outpatient services.
 - iii) In regard to treatment of bipolar disorder:
 - (1) Inpatient services in a hospital;
 - (2) Inpatient services in a facility other than a hospital;
 - (3) Intensive Outpatient services;
 - (4) Outpatient services.
- b) Provide the number of providers for each level of care for each condition listed in 6(a) and their distribution by geographic area.
- c) Explain how the number of providers at each level of care has been adjusted based on changes in demand for the services over the past three years and the anticipated demand for services in the next three years for each condition listed in 6(a).
- d) If you do not have sufficient providers at a given level of care in a geographic area, how do you determine the amount of reimbursement for an out-of-network provider for each condition? Describe the processes, strategies, evidentiary standards, and other factors considered by the plan in determining the fee schedule on which reimbursement is based.
- e) Explain the processes used to determine the adequacy of the network for each of the four conditions listed in 6(a), including any rules, formulas, and algorithms.
- f) List which drugs are covered at each level of care for each condition listed in 6(a), and how are they tiered. Include limitations on dosage. Describe the processes, strategies, evidentiary standards, and other factors considered by the plan in placing drugs in tiers and determining limitations on dosage.
- g) Provide the requirements for utilization review for each level of treatment for the conditions listed in 6(a) above. Include limitations on length of treatment for each such condition.

Describe the processes, strategies, evidentiary standards, and other factors considered by the plan in determining the requirements for utilization review and the limitations on length of treatment.

- h) Provide the medical necessity criteria used for utilization review for each level of treatment for the conditions listed in 6(a) above. Describe the processes, strategies, evidentiary standards, and other factors considered by the plan in determining the medical necessity criteria.

Pursuant to COMAR 31.04.20.05 E, the Company is required to confirm the accuracy of all information provided and submit a "Certificate of Compliance" signed by an officer of the Company acknowledging in a written certification that the information provided is, "to the best of the individual's knowledge, information, and belief, a full, complete, and truthful response to the Commissioner's response," and that the "individual making the certification has undertaken an adequate inquiry to make the required certification."

The response to this survey along with the Certificate of Compliance must be provided to me no later than close of business on November 30, 2015. If you have any questions or concerns, please call or e-mail me at nour.benchaaboun@maryland.gov.

Thank you for your time and consideration in this matter.

Sincerely,

Nour E. Benchaaboun, AIRC, MCM
Chief, Market Analysis

LARRY HOGAN
Governor

BOYD K. RUTHERFORD
Lt. Governor



AL REDMER, JR.
Commissioner

NANCY GRODIN
Deputy Commissioner

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January 26, 2018

Sent Via Certified and Electronic Mail

The Honorable Thomas McLain Middleton
Miller Senate Office Building, 3 East Wing
11 Bladen Street
Annapolis, Maryland 21401

Re: Senate Bill 586 of 2015- Update Summary of Survey Two Analysis

Dear Senator Middleton:

The purpose of this letter is to provide you with the final results from the second survey conducted by the Maryland Insurance Administration ("MIA" or "Administration") to verify that contracts offered by health maintenance organizations, insurers, and nonprofit health service plans ("carriers") are in compliance with the federal Mental Health Parity and Addiction Equity Act ("MHPAEA") and applicable State mental health and addiction parity laws.

On June 30, 2017, the MIA submitted a summary of the 2015 Survey findings to your attention. *See* Attachment A. That summary explained that investigations were ongoing for UnitedHealthcare ("UHC" including MAMSI Life and Health Insurance Company, Optimum Choice, Inc., UnitedHealthcare Insurance Company, All Savers Insurance Company, and UnitedHealthcare of the Mid-Atlantic, Inc.) and CareFirst (including CareFirst BlueChoice, Inc., CareFirst of Maryland Inc., and Group Hospitalization & Medical Services Inc., ("GHMSI")). The MIA has completed those investigations, as detailed below. Information about UHC, BlueChoice, CareFirst of Maryland Inc., and GHMSI's provider networks that was received during the 2015 Survey was included in the letter the Administration sent to your attention on June 30, 2017. *See* Attachment A, Section "Provider and Facility In-Network Adequacy."

UnitedHealthcare ("UHC")

UHC's responses to the MIA's 2015 survey and resulting investigation revealed that UHC's managed behavioral health organization United Behavioral Health Inc., under the brand Optum, reviewed a five year malpractice history for all mental health/substance use disorder facilities applying to be credentialed. UHC collected but did not review a malpractice history for any medical/surgical facilities.

As a result of finding that UHC applied more stringent credentialing requirements to behavioral health facilities than to medical/surgical facilities, Consent Order # MIA-2017-08-009 was issued to UHC by the MIA to bring UHC into compliance. *See* Attachment B. The MIA directed UHC to pay a fine of \$2,000.00 for the four behavioral health facilities affected by this practice, and to submit, within 30 days, a corrective action plan. UHC has paid the fine and has removed the requirement to review a five year malpractice history for mental health/substance use disorder facilities.

CareFirst

On May 1, 2017, the MIA became aware that CareFirst BlueChoice, Inc.'s ("BlueChoice") online provider directory for behavioral health listed only two of the 27 in-network mental health hospitals and two of the seven mental health non-hospital facilities that the Respondents had reported were in-network during the MIA's investigation. The MIA was informed that the 27 hospitals include acute care/general hospitals that were listed under the medical/surgical portion of the provider directory. Additionally, two of the non-hospital facilities that were reported were listed only under the medical/surgical portion of the provider directory. The remaining three non-hospital facilities that were reported were not listed anywhere in the provider directory. In response to the MIA's investigation, BlueChoice corrected the error with its online provider directory. All reported facilities are now listed in the behavioral health provider directory as well as the medical/surgical directory if the facilities provide both services.

On May 1, 2017, the MIA also became aware that CareFirst BlueCross BlueShield's Blue Preferred online behavioral health provider directory did not list any in-network inpatient mental health facilities. The MIA was informed that the inpatient mental health facilities appeared in the directory under the medical/surgical portion of the provider directory. In response to the MIA's investigation, CareFirst BlueCross BlueShield corrected the error with the Blue Preferred online behavioral health provider directory to reflect that there were seven in-network facilities.

As a result of the inaccuracies in BlueChoice and CareFirst BlueCross BlueShield's online provider directories, Consent Order # MIA- was issued to CareFirst by the MIA to bring CareFirst into compliance. *See* Attachment C. The MIA directed BlueChoice to pay an administrative penalty of \$20,250.00 for the violations of Maryland Insurance Article § 15-112 and to correct its directory prior to the execution of the consent order. BlueChoice has paid the fine and corrected its directory as of December 11, 2017. The same consent order directed CareFirst BlueCross BlueShield to pay an administrative penalty of \$4,725.00 for the violations of Maryland Insurance Article § 15-112 and to correct its directory prior to the execution of the consent order. CareFirst BlueCross BlueShield has paid the fine on January 5, 2018, and corrected its directory as of May 5, 2017.

Survey Three

The MIA worked with various interested parties to develop a third survey to address additional concerns regarding compliance with MHPAEA. Survey Three was sent to the health insurance carriers on October 6, 2017. (*See* Attachment C.) The MIA is currently analyzing those results and opening investigations where indicated. Under the MIA's current policy, specifics of ongoing investigations are not shared until they have been finalized. We look forward to providing a final summary of the Survey Three analysis once it has been completed.

If you have any further questions, please do not hesitate to contact me.

Sincerely,



Al Redmer
Insurance Commissioner

Cc: Delegate Shane Pendergrass, Chair, House Health and Government Operations Committee
Lisa Simpson, Committee Counsel
Patrick Carlson, Committee Counsel for Senate Finance
Nancy Grodin, Deputy Insurance Commissioner

LARRY HOGAN
Governor

BOYD K. RUTHERFORD
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June 30, 2017

The Honorable Thomas McLain Middleton
Miller Senate Office Building, 3 East Wing
11 Bladen Street
Annapolis, Maryland 21401

Re: Senate Bill 586 of 2015- Update Summary of Survey Two Analysis

Dear Senator Middleton:

The purpose of this letter is to provide you with an update on the results from the second survey conducted by the Maryland Insurance Administration ("MIA" or "Administration") to verify that contracts offered by health maintenance organizations, insurers, and nonprofit health service plans ("carriers") are in compliance with the federal Mental Health Parity and Addiction Equity Act ("MHPAEA") and applicable State mental health and addiction parity laws.

Initially, Senate Bill 586 of 2015 required carriers subject to the MHPAEA to submit a report certifying that, and outlining how, contracts or health benefit plans offered for the next plan year complied with the MHPAEA and applicable State mental health and addiction parity laws. After further testimony and discussion on the Bill, however, the MIA was asked to: (1) conduct a survey each year over a three year period to verify that contracts offered by carriers are in compliance with the MHPAEA and applicable State mental health and addiction parity laws; and (2) provide the committee with a summary of the survey analysis after it is completed each year.

In August 2014, the MIA's Compliance and Enforcement Division surveyed carriers issuing fully-insured group and individual health benefit plans ("2014 Survey"). (See Attachment A). The surveys revealed violations and the MIA issued six administrative orders. The MIA worked with the carriers subject to those orders to resolve the violations. On June 29, 2016, the MIA submitted a summary of the 2014 Survey findings to your attention. (See Attachment B).

In preparation for developing and issuing the second survey ("2015 Survey"), the MIA invited stakeholders to provide input at a meeting held on August 26, 2015. The 2015 Survey was sent to the carriers on October 20, 2015, and is attached for your review. (See Attachment C). All of the carriers responded.

Responses were requested of and provided by the following carriers:¹

- Aetna/Coventry (“Aetna/Coventry”)- including Aetna Health Inc., Aetna Life Insurance Company, Coventry Health Care of Delaware, Inc., and Coventry Health and Life Insurance Company;
- CareFirst- including CareFirst BlueChoice, Inc., CareFirst of Maryland Inc., and Group Hospitalization & Medical Services Inc., (“GHMST”);
- Cigna Health and Life Insurance Company (“Cigna”);
- Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., (“Kaiser”);
- United Healthcare (“UHC”)- including MAMSI Life and Health Insurance Company, Optimum Choice, Inc., UnitedHealthcare Insurance Company, All Savers Insurance Company, and UnitedHealthcare of the Mid-Atlantic, Inc.; and
- Freedom Life Insurance Company of America (“Freedom”).

In October, 2016, the MIA was awarded a federal grant which funded an extra staff member to continue the second MHPAEA survey analysis and to conduct investigations of possible violations. The MIA has completed its review of the survey results for Aetna, Cigna, Kaiser, and Freedom. A review of Aetna’s, Cigna’s and Kaiser’s practices revealed no violations of the MHPAEA or applicable state mental health and substance use disorder parity laws. In its response to the 2015 Survey, Freedom disclosed that it did not offer qualified health plans in the individual or group markets in Maryland. The survey questions therefore were not applicable to Freedom and the Administration closed its investigation.

The MIA has not yet completed its review of UHC and CareFirst. The MIA will provide you with its findings when these reviews are completed.

Issues Corrected During the Investigation

As a result of the survey, a number of issues were identified and corrected during the Administration’s investigation. The Administration determined not to issue orders in these instances because the carriers were found to be administering the health benefit plans in compliance with the law despite errors in written documents and/or no harm to consumers was identified. The following errors were corrected:

- Internal medical review policy limited disclosure of the medical/surgical medical necessity guidelines to three guidelines at a time to a provider/member. The carrier believed that its licensing agreement for the guidelines required it to limit disclosure of the guidelines. As a result of the MIA’s investigation, the carrier reviewed its licensing agreement and determined that the limitation was not in the agreement. The carrier removed the limitation from its internal medical review policy. The carrier informed the MIA that it was not aware of any requests for the guidelines that had been denied or limited because of the internal policy.
- Financial testing for a large group plan did not account for all of its outpatient benefits in the “all other outpatient” category nor preventative benefits in the out-of-network outpatient office visits category. As a result of the MIA’s investigation, the carrier corrected its financial testing and

¹ Evergreen Health Cooperative Inc., was also surveyed and provided a response to the 2015 Survey. Due to the Company’s ongoing efforts to remain viable in the marketplace during the span of the 2015 Survey, Evergreen was removed from examination. As a result, no further investigation was conducted following Evergreen’s initial survey response. The MIA will consider reopening investigations upon commencement of the third parity survey.

demonstrated that the exclusions of certain benefits did not change the results of the cost-sharing that could be applied to mental health/substance use disorder benefits in those classifications.

- An online provider directory indicated that it did not have any in-network inpatient facilities that could treat mental health illnesses. As a result of the MIA's investigation, the carrier corrected its online directory to reflect that there are in-network inpatient facilities to treat mental health illnesses.
- A publically available document demonstrating compliance with MHPAEA ("MHPAEA Summary") provided that the carrier's credentialing process for medical/surgical providers required the provider to agree to a site visit *if* required by the credentialing committee. In contrast, the carrier's managed behavioral health organization ("MBHO") *required* a site visit for each mental health/substance use disorder provider applying to be credentialed. The carrier informed the MIA that the information contained in its MHPAEA Summary was not accurate as to site visits for credentialing. The carrier and MBHO confirmed that they do not require site visits as part of credentialing for their commercial networks. As a result of the MIA's investigation, the carrier corrected its MHPAEA Summary to reflect this information.
- The MHPAEA Summary also provided that for out-of-network inpatient scheduled admissions there are two different notice requirements to obtain prior authorization, (1) "as soon as possible" and (2) "5 days before receiving the benefit." The MHPAEA Summary stated that all scheduled admissions for inpatient mental health/substance use disorder treatment must obtain prior authorization "as soon as possible." In contrast, the only example of a medical/surgical treatment that was held to that requirement was transplants. The carrier informed the MIA that the information contained in its MHPAEA Summary was not accurate as to out-of-network inpatient prior authorization requirements. The carrier confirmed that all scheduled out-of-network admissions for medical/surgical and mental health/substance use disorder benefits were required to obtain prior authorization "as soon as possible." As a result of the MIA's investigation, the carrier corrected its MHPAEA Summary to accurately reflect its procedure.

Provider and Facility In-Network Adequacy

In the 2015 Survey, the MIA requested responses to the following questions regarding in-network providers for inpatient and outpatient treatment of heroin and opioid abuse disorders, diabetes, stroke, and bipolar disorders:

- a) Provide the number of providers for each level of care for each condition listed in 6(a) and their distribution by geographic area.
- b) Explain how the number of providers at each level of care has been adjusted based on changes in demand for the services over the past three years and the anticipated demand for services in the next three years for each condition listed in 6(a).
- c) If you do not have sufficient providers at a given level of care in a geographic area, how do you determine the amount of reimbursement for an out-of-network provider for each condition? Describe the processes, strategies, evidentiary standards, and other factors considered by the plan in determining the fee schedule on which reimbursement is based.
- d) Explain the processes used to determine the adequacy of the network for each of the four conditions listed in 6(a), including any rules, formulas, and algorithms.

Some carriers reported that they do not have in-network non-hospital facilities for the treatment of heroin/opioid abuse disorders and bipolar disorder in certain counties of Maryland.² Other plans did not have any in-network inpatient hospitals, inpatient non-hospital facilities, or intensive outpatient treatment for substance use disorder treatment or bipolar disorder treatment in certain counties.³

As a result of the MIA's investigation, some carriers entered into new contracts with facilities located in counties lacking in-network providers. However, carriers advised the MIA that although they continue efforts to recruit providers and facilities in these counties, there do not appear to be any licensed non-hospital based behavioral health inpatient facilities that are willing to contract with managed care plans in many counties. Some carriers also provided information demonstrating that they meet their network accessibility standards with regards to all provider and facility types despite the lack of in-network facilities in certain counties. Other carriers address the shortage of in-network providers by (1) allowing members to access out-of-network providers at their in-network cost-sharing rate and (2) authorizing continued acute inpatient care until it is safe to transition the patient to partial hospitalization or intensive outpatient treatment.

Other State MHPAEA Compliance Efforts

California.

The MIA was also asked to monitor and update the Committee on efforts in other states to verify MHPAEA compliance, in particular California. In its last Summary Letter the MIA explained that California's Department of Managed Health Care ("DMHC") required full service health plans (that offer commercial coverage for individuals, small groups, or large groups) to submit filings in 2014 that demonstrate the carriers' compliance with the MHPAEA for health plans sold in 2015.⁴ In 2014 and 2015, the DMHC penalized two insurers for violations of state and federal parity laws. Those actions were addressed in more detail in the MIA's Summary Letter for the 2014 Survey, included as an attachment for your convenience. (*See Attachment B*). Additionally, the DMHC conducted a desk audit to review the filings. The desk audit resulted in 24 plans out of 25 lowering MH/SUD cost-sharing in one or more products; 3 plans eliminating impermissible day or visit limits on MH/SUD benefits; 12 plans modifying or clarifying prior or concurrent authorization requirements; and all 25 plans revising their evidence of coverage text to more clearly describe MH/SUD benefits.

On April 1, 2016, following the desk audit, the DMHC began on-site surveys of insurers' records documenting each plan's utilization management process for authorizing and denying benefits. The DMHC is also looking at plan cost-sharing based on results of the desk audit which determined that insurers did not understand how to analyze financial requirements for parity compliance.⁵

² Counties reportedly lacking in-network heroin/opioid treatment facilities: Calvert, Charles, St. Mary's, Allegany, Garret, and Washington counties. Counties lacking in-network bipolar treatment facilities: Calvert, Caroline, Charles, Kent, Dorchester, Queen Anne's, Somerset, St. Mary's, Wicomico, Worcester and Talbot counties.

³ Counties reportedly lacking in-network heroin/opioid providers: Garrett, Queen Anne's and Worcester counties. Counties lacking in-network bipolar disorder providers: Charles, Garrett, Kent, Queen Anne's, Somerset, Talbot and Worcester counties.

⁴ New Hampshire and the federal Center for Medicare and Medicaid Services have used the workbooks developed by DMHC when conducting their own market conduct exams.

⁵ Clinical consultants, including nurses, psychologists, and licensed clinical social workers are in the process of performing on-site audits of plans' utilization management records focusing on denied claims. Survey teams are interviewing clinical, utilization management, provider relations, and member services directors for both the plan and plan delegates. The survey team includes three attorneys and one survey analyst.

The DMHC finished its first round of audits in early 2017. It plans to issue reports to the carriers in the first half of 2017.⁶ Preliminary findings released by the DMHC include continued cost-sharing issues even with plans that had been corrected during the desk audit. Additionally, DMHC identified inaccuracies between what plans report to use for utilization management standards and what standards are actually used in practice. DMHC found that these inaccuracies increased when outsourcing behavioral health services to a behavioral health organization or delegating utilization management to medical/surgical groups who may not use the standards specified by the plans.

Beginning in 2016, the California Department of Insurance (CA DOI) required carriers to complete Parity Workbooks as part of each carrier's 2017 plan filing. The Workbook provides insurers with detailed instructions that require them to complete worksheets that compare financial and quantitative treatment limitations applied to their behavioral health coverage to other medical coverage. Another required worksheet compares the insurers' application of non-quantitative treatment limitations for behavioral health coverage and other medical coverage.

Checklists and Carrier Attestations.

Many states, including Maryland, rely on checklists and carrier attestations that plans are complying with state and federal parity laws.⁷ These checklists and attestations are required as a part of a state DOI form review prior to the plan being sold on the market. Some checklists are simple, merely stating that the plan must comply with state and federal parity laws and providing a box in which the carrier is meant to cite to the form page that supports this requirement. Others require more in-depth information be provided including a narrative description of the methodology used to determine plan parity compliance and completed worksheets demonstrating parity compliance for financial and quantitative treatment limitations.⁸ Fewer states conduct a comprehensive review of non-quantitative treatment limitations during form review.

Data Collection and Targeted Market Conduct Examinations.

Nine states undertake targeted market conduct examinations ("MCEs") focused on behavioral health benefits and initiated as the result of consumer complaints or information collected during form review.⁹ These MCEs have resulted in penalties and corrective action plans.¹⁰ Some states have completed MCEs focusing on compliance with federal and state parity laws. Notably, New Hampshire's DOI completed

⁶ The DMHC will make final reports available to the public on the DMHC's website. The DMHC intends to complete the remaining 20 surveys in June 2017.

⁷ States with this requirement include Alabama, Alaska, California, Colorado, Connecticut, Delaware, Indiana, Maine, Maryland, Massachusetts, Nebraska, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Utah, Virginia, and Washington.

⁸ California, Connecticut, Maryland, Massachusetts, Rhode Island.

⁹ California, Connecticut, New Hampshire, New York, North Dakota, Pennsylvania, Rhode Island, Washington, West Virginia.

¹⁰ In 2011, West Virginia's Office of the Insurance Commissioner fined insurance plans \$115,305.79 for violations related to the state parity law discovered during market conduct exams. In 2014, North Dakota DOI determined that its BlueCross BlueShield improperly denied 63 MH/SUD claims because it failed to comply with utilization review guidelines, medical necessity guidelines, and/or its contracts and state law. BCBS agreed to correct its procedures. In 2015, Connecticut DOI fined United Behavioral Health \$8,500 and required United to submit a plan for compliance within 90 days after a MCE determined that 2 appeal determinations were not reviewed by an appropriate clinical peer for the service requested. Other MCE and resulting fines were detailed in the MIA's 2014 Survey Summary, attached for your convenience. (See Attachment B).

three MCEs of Anthem Health Plans of New Hampshire, Inc. (“Anthem”), Cigna Life and Health Insurance Company (“Cigna”), and Harvard Pilgrim Health Care of New England, Inc. (“Harvard Pilgrim”).¹¹ These targeted MCEs included review of issuer compliance with MHPAEA and focused on substance use disorder benefits. In 2017, the New Hampshire DOI ordered Anthem, Cigna, and Harvard Pilgrim to correct various issues including inadequate provider networks for MH/SUD services, inaccurate provider directories, and accessibility problems. As a result, Anthem added 100 new MH/SUD provider contacts and developed the Aware Recovery Care Program, a team-based approach to treat substance use disorder. Additionally, Anthem and Harvard’s improper dosage limitation on Evizo, the naloxone auto-injector used to prevent overdoses, was highlighted for correction. New Hampshire’s DOI plans to open targeted MCEs into Anthem’s credentialing criteria and an additional follow up examination of Harvard’s reimbursement methodology and rates.

Another developing method used by states to monitor parity compliance is data collection and examination.¹² The data is examined for patterns that may indicate an underlying parity violation that should be investigated through an MCE. There were two states that had significant findings. In 2016, New Hampshire’s DOI used its all-payer claims database to analyze provider reimbursement rates for substance use disorder services for 2014 and 2015. New Hampshire determined that commercial carriers consistently paid health care providers less than Medicare rates for treating patients with substance use disorders. The New York Office of the Attorney General (“NY OAG”) examined denial rate data as part of its investigations into carrier compliance with state and federal parity laws. The denial rate data showed that carriers denied some behavioral health claims up to seven times as often as medical/surgical claims in the same category.¹³ Based in part on the data it reviewed, the NY OAG issued an order against Excellus Health Plan, Inc. (“Excellus”) finding, among other parity violations, that it “applies more rigorous—and frequent—utilization review for inpatient substance use disorder treatment than for inpatient medical/surgical treatment.” The NY OAG made the same determination about ValueOptions’ utilization review practices, finding that it issued denials for behavioral health claims twice as often and addiction recovery services four times as often as medical/surgical claims. At least four New York health plans subcontract with ValueOptions to administer their member’s behavioral health benefits. Between 2014 and 2015, the NY OAG reached settlements with six health insurance carriers, ordering corrective action and assessing approximately \$4.6 million dollars in fines and penalties.

Massachusetts requires carriers to annually submit data that compares MH/SUD services and M/S services in areas including number of requests for authorization of services and type of services; authorization requests approved, modified, and denied; the number of internal appeals and outcome; and number of appeals sent to external review and outcome. Representatives of the Massachusetts Department of Insurance advised the MIA that the data is being used to track areas of concern for future MCEs.

Utilization and Medical Necessity Review Criteria.

There is an emerging trend in the states focused on standardizing utilization review criteria for substance use disorder benefits. At least four states now require carriers to use the nationally recognized

¹¹ In order to conduct these MCE, New Hampshire DOI contracted with an IRO and a pharmacist to assist with review of medical necessity denials and prescription formularies.

¹² States that have employed this method include Connecticut, Massachusetts, New Hampshire, New York, and Vermont.

¹³ Excellus Health Plan, Inc. issued denials in 48% of the inpatient substance use disorder treatment reviews it conducted for preauthorization compared to less than 20% of the inpatient medical/surgical requests. Additionally, 29% of outpatient behavioral health services were denied compared to 13% of outpatient medical/surgical services.

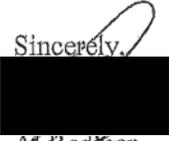
American Society of Addiction Medicine ("ASAM") utilization review criteria and medical necessity review criteria when managing substance use disorder benefits for private insurance products.¹⁴ Connecticut also requires carriers to use criteria established by the American Academy of Child and Adolescent Psychiatry's Child and Adolescent Service Intensity Instrument when reviewing requests/claims for child/adolescent mental disorder services, and the American Psychiatric Association Guidelines or Standards and Guidelines of the Association for Ambulatory Behavioral Healthcare for adult mental disorder services.¹⁵ The Connecticut law does allow carriers to develop their own criteria or purchase criteria from other qualified vendors approved by the DOI in order to address advancements in technology/types of care that are not covered in the most recent guidelines/criteria listed in the statute.

Future Plans.

The MIA is currently developing a template for future parity MCEs by drawing from its own experience with the parity surveys and investigations, other states' MCEs, and the NAIC's Market Regulation Handbook. A third parity survey is also under development. The MIA intends to invite interested parties to a meeting on August 21, 2017, to engage in a discussion regarding the third survey.

If you have any questions about this summary letter or any other activities undertaken by the MIA with reference to the parity surveys, please call me.

Sincerely,


Al Redfner
Insurance Commissioner

Cc: Delegate Shane Pendergrass, Chairman, House Health and Government Operations Committee
Linda Stahr, Committee Counsel
Partick Carlson, Committee Counsel for Senate Finance
Nancy Grodin, Deputy Insurance Commissioner

¹⁴ Connecticut, Illinois, New Hampshire, Rhode Island.

¹⁵ S.B. No. 372, effective January 1, 2017 and codified at § 38a0591c of Connecticut's insurance law.

LARRY HOGAN
Governor

BOYD K. RUTHERFORD
Lt. Governor



AL REDMER, JR.
Commissioner

NANCY GRODIN
Deputy Commissioner

200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202
Direct Dial: 410-468-2009 Fax: 410-468-2020
Email: melaniegross@maryland.gov
1-800-492-6116 TTY: 1-800-735-2258
www.insurance.maryland.gov

August 10, 2017

CERTIFIED MAIL
RETURN RECEIPT REQUESTED
REGULAR MAIL

MAMSI Life and Health Insurance Company
Attn: Joe Stangl
800 King Farm Boulevard
Rockville, MD 20850

UnitedHealthcare Insurance Company
Attn: Joe Stangl
185 Asylum Avenue
Hartford, Connecticut 06103

Optimum Choice, Inc.
Attn: Joe Stangl
800 King Farm Boulevard, MD051-1000
Rockville, MD 20850

UnitedHealthcare of the Mid-Atlantic, Inc.
Attn: Joe Stangl
800 King Farm Boulevard, MD051-1000
Rockville, MD 20850

All Savers Insurance Company
Attn: Joe Stangl
7440 Woodland Drive
Indianapolis, IN 46278

Re: MIA v. MAMSI, Optimum Choice, Inc, UnitedHealthcare Insurance Company, UnitedHealthcare of the Mid-Atlantic, Inc. and All Savers Insurance Company
Case No.: MIA-2017-08-009

Dear Mr. Stangl:

This will acknowledge receipt of your check in the amount of \$2,000.00 representing the administrative penalty regarding the above captioned case.

A copy of the fully executed Consent Order is enclosed for your records.

Sincerely,

Melanie Gross
Executive Assistant to the Deputy Commissioner

Enclosure

cc: Al Redmer, Jr., Commissioner
Nancy Grodin, Deputy Commissioner
J. Van Lear Dorsey, Principal Counsel
Lisa Hall, Deputy Counsel
Tracy Imm, Director of Public Affairs
Darci Smith, Special Assistant

MARYLAND INSURANCE COMMISSIONER *
200 ST. PAUL PLACE, SUITE 2700 *
BALTIMORE, MARYLAND 21401 *

1000/7924
1000/7924
2000.00
54889

V. *

CASE NO: MIA-2017-08-009

MAMSI LIFE AND HEALTH INSURANCE *
COMPANY, *
800 KING FARM BLVD. *
ROCKVILLE, MARYAND 20850 *
NAIC# 60321 *

OPTIMUM CHOICE, INC. *
800 KING FARM BLVD., MD051-1000 *
ROCKVILLE, MARYLAND 20850 *
NAIC # 96940 *

UNITEDHEALTHCARE INSURANCE *
COMPANY, *
185 ASYLUM AVENUE *
HARTFORD, CONNECTICUT 06103 *
NAIC# 79413 *

UNITEDHEALTHCARE OF THE MID- *
ATLANTIC, INC., *
800 KING FARM BLVD., MD051-1000 *
ROCKVILLE, MARYLAND 20850 *
NAIC # 95025 *

ALL SAVERS INSURANCE COMPANY *
7440 WOODLAND DRIVE *
INDIANAPOLIS, INDIANA 46278 *
NAIC# 82406 *

* * * * *

CONSENT ORDER

This Consent Order is entered into by the Maryland Insurance Commissioner and MAMSI Life and Health Insurance Company, Optimum Choice, Inc., UnitedHealthcare Insurance Company, UnitedHealthcare of the Mid-Atlantic, Inc., and All Savers Insurance Company ... (collectively "Respondents" or "UHC") pursuant to §§ 2-108 and 2-204 of the Insurance Article,

Annotated Code of Maryland, to resolve the matter, in lieu of litigation, before the Insurance Administration (“Administration”).

Facts

(1) At all times relevant to this Order, MAMSI Life and Health Insurance Company, UnitedHealthcare Insurance Company, and All Savers Insurance Company have held and currently hold Certificates of Authority from the Administration to act as an insurer in the State of Maryland.

(2) At all times relevant to this Order, UnitedHealthcare of the Mid-Atlantic States and Optimum Choice, Inc., have held and currently hold Certificates of Authority to act as health maintenance organizations in the State of Maryland.

(3) At all times relevant to this Order, United Behavioral Health, Inc., under the brand Optum, acted as the Managed Behavioral Health Organization for the Respondents.

(4) A survey was sent in October 2015 to the Respondents regarding compliance with the federal Mental Health Parity and Addiction Equity Act (“MHPAEA”).¹ After receiving the survey response from the Respondents, the Administration opened investigation MCLH-57-2016-I to gather additional information necessary to determine compliance with the federal rule.

Findings

(5) On November 20, 2015, in response to the Administration’s survey, the Respondents provided an excerpt from a document entitled “Summary of Various Non-Quantitative Treatment Limitations Mental Health Parity and Addiction Equity Act.” The excerpt addressed Network Admission Criteria for providers and facilities.

¹ See Federal Register, Volume 78, No. 219, published November 13, 2013.

(6) Under the facility credentialing section the document provided that behavioral health facilities (providing treatment for mental health and substance use disorder illnesses) are subjected to a malpractice history review. A similar requirement was not indicated for credentialing general medical/surgical facilities.

(7) On April 26, 2017, in response to the Administration's investigation, a representative of United stated, in pertinent part:

[Mental health and substance use disorder] facilities have a malpractice history review in the same fashion as individual providers. [Medical/surgical] gathers a history where required by law or regulation (such as in [Maryland]) but does not include this history in review as it is not a requirement under NCQA credentialing standards. This does constitute a difference in the two processes but we believe the processes are sufficiently comparable to constitute parity particularly given both [medical/surgical] and [mental health/substance use disorder] facilities are subjected to review for credentialing and quality issues of which the malpractice history is just one component.

(8) Since applicable MHPAEA rules went into effect, four mental health/substance use disorder facilities have applied to Optum for credentialing and had their malpractice history reviewed.

(9) On May 9, 2017, in response to the Administration's letter advising UHC of the violations it identified, the Respondents informed the Administration that they had temporarily suspended the review of malpractice history for mental health and substance use disorder facilities since the medical/surgical process does not currently involve this review. The Respondents are undertaking a review of the process to determine the best practice moving forward.

Conclusions of Law

(10) Based on the results of the Investigation, the Administration concluded the Respondents violated § 15-802(d)(2)(ii) by failing to comply with 45 C.F.R. § 146.136(c)(4).

(11) Section 15-802 of the Maryland Insurance Article states, in pertinent part:

(b) With the exception of small employer grandfathered health plan coverage, this section applies to each individual, group, and blanket health benefit plan that is delivered or issued for delivery in the State by an insurer, a nonprofit health service plan, or health maintenance organization.

(c) A health benefit plan subject to this section shall provide at least the following benefits for the diagnosis and treatment of a mental illness, emotional disorder, drug abuse disorder, or alcohol abuse disorder:

(1) inpatient benefits for services provided in a licensed or certified facility, including hospital inpatient benefits;

(2) partial hospitalization benefits; and

(3) outpatient benefits, including all office visits and psychological and neuropsychological testing for diagnostic purposes.

* * * *

(2) The benefits required under this section:

* * * *

(ii) shall comply with 45 C.F.R. § 146.136(a) through (d)[.]

(12) 45 C.F.R. § 146.136(c)(4) provides in pertinent part:

(i) A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

(ii) Nonquantitative treatment limitations include –

(D) Standards for provider admission to participate in a network[.]

Order

WHEREFORE, for the reasons set forth above, it is **ORDERED** by the Commissioner and consented to by the Respondent, that

A. Respondent shall pay an administrative penalty of two thousand dollars (\$2,000.00) contemporaneously with Respondents' execution of this Order. Administrative

penalties shall be made payable to the Maryland Insurance Administration and shall identify the case by number MCLH-57-2016-I. Unpaid penalties will be referred to the Central Collection Unit for collections.

B. Within thirty (30) days of the date of this order, Respondents shall provide a corrective action plan to the Administration indicating that facility credentialing procedure requirements for mental health and substance use disorder facilities are developed based on the application of the same or similar factors that are applied to medical/surgical facilities credentialed by the Respondents.

Other Provisions

C. The executed Order and any administrative penalty shall be sent to the attention of: Associate Commissioner, Compliance and Enforcement, 200 St. Paul Place, Suite 2700, Baltimore, MD 21202.

D. For the purposes of the Administration and for any subsequent administrative or civil proceedings concerning Respondent, whether related or unrelated to the foregoing paragraphs, and with regard to requests for information about the Respondent made under the Maryland Public Information Act, or properly made by governmental agencies, this Order will be kept and maintained in the regular course of business by the Administration. For the purposes of the business of the Administration, the records and publications of the Administration will reflect this Order.

E. The parties acknowledge that this Order resolves all matters relating to the factual assertions and agreements contained herein and are to be used solely for the purposes of this proceeding brought by or on behalf of the Administration. Nothing herein shall be deemed a waiver of the Commissioner's right to proceed in an administrative action or

civil action for violations not specifically identified in this Order, including, but not limited to, specific consumer complaints received by the Administration, nor shall anything herein be deemed a waiver of the right of the Respondent to contest other proceedings by the Administration. This Order shall not be construed to resolve or preclude any potential or pending civil, administrative, or criminal action or prosecution by any other person, entity or governmental authority, including but not limited to the Insurance Fraud Division of the Administration, regarding any conduct by the Respondent including the conduct that is the subject of this Order.

F. Respondent has had the opportunity to have this Order reviewed by legal counsel of its choosing, and is aware of the benefits gained and obligations incurred by the execution of the Order. Respondent waives any and all rights to any hearing or judicial review of this Order to which it would otherwise be entitled under the Insurance Article with respect to any of the determinations made or actions ordered by this Order.

G. This Order contains the entire agreement between the parties relating to the administrative actions addressed herein. This Order supersedes any and all earlier agreements or negotiations, whether oral or written. All time frames set forth in this Order may be amended or modified only by subsequent written agreement of the parties.

H. This Order shall be effective upon signing by the Commissioner or her designee, and is a Final Order of the Commissioner under § 2-204 of the Insurance Article.

I. Failure to comply with the terms of this Order may subject Respondent to further legal and/or administrative action.

ALFRED W. REDMER, JR.
Insurance Commissioner



By: Nancy Grodin
Deputy Commissioner

Date: 8/10/17

RESPONDENT'S CONSENT

RESPONDENT hereby CONSENTS to the representations made in, and to the terms of, the above Consent Order. On behalf of Respondent, the undersigned hereby affirms that he or she has taken all necessary steps to obtain the authority to bind Respondent to the obligations stated herein and does in fact have the authority to bind Respondent to the obligations stated herein.

Name: Christopher John Mullins Sr.

Signature: 
[Handwritten signature]

Title: CEO – Optimum Choice, Inc., MD-Individual Practice Association, Inc., MAMSI Life and Health Insurance Company, and UnitedHealthcare of the Mid-Atlantic, Inc.

Date: 8/2/17

ALFRED W. REDMER, JR.
Insurance Commissioner



By: Nancy Grodin
Deputy Commissioner

Date: 8/1/17

RESPONDENT'S CONSENT

RESPONDENT hereby CONSENTS to the representations made in, and to the terms of, the above Consent Order. On behalf of Respondent, the undersigned hereby affirms that he or she has taken all necessary steps to obtain the authority to bind Respondent to the obligations stated herein and does in fact have the authority to bind Respondent to the obligations stated herein.

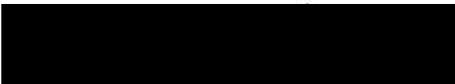
Name: Jeffrey Donald Alter

Signature: 


Title: CEO - UnitedHealthcare Insurance Company

Date: 8/1/17

ALFRED W. REDMER, JR.
Insurance Commissioner



By: Nancy Grodin
Deputy Commissioner

Date: 8/10/17

RESPONDENT'S CONSENT

RESPONDENT hereby CONSENTS to the representations made in, and to the terms of, the above Consent Order. On behalf of Respondent, the undersigned hereby affirms that he or she has taken all necessary steps to obtain the authority to bind Respondent to the obligations stated herein and does in fact have the authority to bind Respondent to the obligations stated herein.

Name: Patrick Francis Carr



Signature: *Patrick Francis Carr*

Title: CEO – All Savers Insurance Company

Date: 8/2/17

LARRY HOGAN
Governor

BOYD K. RUTHERFORD
Lt. Governor



AL REDMER, JR.
Commissioner

NANCY GRODIN
Deputy Commissioner

200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202
Direct Dial: 410-468-2009 Fax: 410-468-2020
Email: melaniegross@maryland.gov
1-800-492-6116 TTY: 1-800-735-2258
www.insurance.maryland.gov

January 11, 2018

CERTIFIED MAIL
RETURN RECEIPT REQUESTED
REGULAR MAIL

Ms. Jenene Lyn Williams, Director, External Audit
CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065

CareFirst of Maryland, Inc.
1501 S. Clinton Street
Baltimore, MD 21224

Group Hospitalization and Medical Services, Inc.
840 First Street, NE
Washington, DC 20065

Re: MIA v. CareFirst BlueChoice, Inc.; CareFirst of Maryland, Inc.;
Group Hospitalization and Medical Services, Inc.
Case No.: MIA-2018-01-023

Dear Ms. Williams:

This will acknowledge receipt of your check in the amount of \$24,975.00 representing the administrative penalty regarding the above captioned case.

A copy of the fully executed Consent Order is enclosed for your records.

Sincerely,


Melanie Gross
Executive Assistant to the Deputy Commissioner

Enclosure

cc: Al Redmer, Jr., Commissioner
Erica J. Bailey, Associate Commissioner
J. Van Lear Dorsey, Principal Counsel
Lisa Hall, Assistant Attorney General
Tracy Imm, Director of Public Affairs
Darci Smith, Special Assistant

(3) At all times relevant to this Order, Magellan Healthcare, Inc., ("Magellan") managed and currently manages the Respondents' behavioral health benefits as a managed behavioral healthcare organization ("MBHO").

(4) The Respondents offer individual and group health plans in Maryland on and off the Maryland Health Benefit Exchange.

(5) A survey ("Second Parity Survey") was sent in October 2015 to the Respondents regarding compliance with the federal Mental Health Parity and Addiction Equity Act ("MHPAEA").¹ After receiving the Second Parity Survey response from the Respondents, the Administration opened investigation MCLH-141-2015-1 to gather additional information necessary to determine compliance with MHPAEA.

Findings

1. BlueChoice Online Provider Directory

(6) On May 1, 2017, the Administration became aware that BlueChoice's online provider directory for behavioral health listed only two of the 27 in-network mental health hospital and two of the seven non-hospital facilities that the Respondents had reported were in-network during the Administration's investigation.

(7) On October 19, 2017, in response to the Administration's investigation, a representative of the Respondents stated, in pertinent part regarding the BlueChoice directory for in-network inpatient mental health hospital facilities:

...Magellan reported the 27 inpatient [mental health] hospital facilities and 7 inpatient non-hospital [mental health] facilities [for BlueChoice]. The 27 include Acute Care/General Hospitals that treat Inpatient Psychiatric/Mental Health patients. Since they are general/acute care, they are included in the directory under the medical facility search — not Mental Health. Recognizing this may not be apparent to a member or provider searching the directory, I have shared this observation with the CareFirst team that maintains the directory.

¹ See Federal Register, Volume 78, No. 219, published November 13, 2013.

(8) On October 24 and 26, 2017, in response to the Administration's investigation, a representative of the Respondents stated, in pertinent part regarding the seven reported BlueChoice in-network inpatient non-hospital mental health facilities:

For the providers being displayed, we have the same issue that they are listed under "hospitals"; [two] under medical, [two] under mental health. Recognizing that this may not be apparent to a member or a provider searching the directory, I asked my colleagues to add this to the list of follow up. . . .

...Three providers [] are in-network but are not being displayed in the directory. [The Provider Relations Department] has linked with the information technology team that supports them to identify why the facilities are not displaying and the appropriate remediation.

II. CareFirst BlueCross BlueShield's Online Provider Directory

(9) On May 1, 2017, the Administration became aware that CareFirst BlueCross BlueShield's BluePreferred online provider directory did not list any in-network inpatient behavioral health facilities,

(10) On May 5, 2017, in response to the Administration's investigation, a representative of the Respondents stated, in pertinent part:

Thank you for bringing this to our attention. [CareFirst BlueCross BlueShield] has reviewed its online provider directory and has corrected the technological errors that incorrectly made it appear that there were no in-network behavioral health facilities.

(11) On May 5, 2017, the BluePreferred online provider directory displayed seven in-network inpatient behavioral health facilities.

(12) On November 7, 2017, in response to the Administration's investigation, a representative of the Respondents stated, in pertinent part:

My colleague has confirmed that the BluePreferred inpatient mental health facilities appeared in the directory under the "medical" hospital search [prior to correction on May 5, 2017].

Conclusions of Law

(13) Section 15-1 12 of the Insurance Article states, in pertinent part:

(n)(l) A carrier shall make the carrier's network directory available to prospective enrollees on the Internet and, on request of a prospective enrollee, in printed form.

* * * *

(p)(2)(ii) 1. Information provided on the Internet under subsection (n) of this section shall be accurate on the date of initial posting and any update.

2. In addition to the requirement to update its provider information under subsection (t)(l) of this section, a carrier shall update the information provided on the Internet at least once every 15 days.

(14) Based on the results of the Investigation, the Administration concluded the BlueChoice and CareFirst BlueCross BlueShield violated §15-112 by failing to have an accurate online provider directory.

(15) Based on the information provided in response to the Second Parity Survey, the Administration did not identify any violation of MHPAEA.

Order

WHEREFORE, for the reasons set forth above, it is **ORDERED** by the Commissioner and consented to by Respondents:

A. That pursuant to §4-113 of the Insurance Article, Respondents, prior to execution of this Order, correct their online provider directories for mental health providers to include the in-network mental health hospital and non-hospital facilities that the Respondents had reported were in-network during the Administration's investigation.

B. That, pursuant to §19-730 of the Health-General Article, based on consideration of COMAR 31.02.04.02, BlueChoice pay an administrative penalty of Twenty Thousand Two Hundred and Fifty Dollars (\$20,250.00) for violation of §15-112 of the Insurance Article, simultaneously with the execution of this Order.

C. That, pursuant to §4-113 of the Insurance Article, based on consideration of COMAR 31,02.04.02, CareFirst BlueCross BlueShield pay an administrative penalty of Four Thousand Seven Hundred and Twenty-Five Dollars (\$4,725.00) for violation of §15-112 of the Insurance Article, simultaneously with the execution of this Order.

Other Provisions

D. The executed Order and any administrative penalty shall be sent to the attention of: Erica J. Bailey, Associate Commissioner, Compliance and Enforcement, 200 St. Paul Place, Suite 2700, Baltimore, MD 21202.

E. For the purposes of the Administration and for any subsequent administrative or civil proceedings concerning Respondents, whether related or unrelated to the foregoing paragraphs, and with regard to requests for information about the Respondents made under the Maryland Public Information Act, or properly made by governmental agencies, this Order will be kept and maintained in the regular course of business by the Administration. For the purposes of the business of the Administration, the records and publications of the Administration will reflect this Order.

F. The parties acknowledge that this Order resolves the Second Parity Survey, Investigation MCLH-141-2015-I and all matters relating to the factual assertions and agreements contained herein and are to be used solely for the purposes of this proceeding brought by or on behalf of the Administration. Nothing herein shall be deemed a waiver of the Commissioner's right to proceed in an administrative action or civil action for violations not specifically identified in this Order, including, but not limited to, specific consumer complaints received by the Administration, nor shall anything herein be deemed a waiver of the right of the Respondents to contest other proceedings by the Administration. This Order shall not be construed to resolve or preclude any potential or pending civil, administrative, or criminal action or prosecution by any other person, entity or governmental authority, including but not limited to the Insurance Fraud Division of the Administration, regarding any conduct by the Respondents including the conduct that is the subject of this Order.

G. Respondents have had the opportunity to have this Order reviewed by legal counsel of its choosing, and is aware of the benefits gained and obligations incurred by the execution of the Order. Respondents waive any and all rights to any hearing or

judicial review of this Order to which it would otherwise be entitled under the Insurance Article with respect to any of the determinations made or actions ordered by this Order.

H. This Order contains the entire agreement between the parties relating to the administrative actions addressed herein. This Order supersedes any and all earlier agreements or negotiations, whether oral or written. All time frames set forth in this Order may be amended or modified only by subsequent written agreement of the parties,

I. This Order shall be effective upon signing by the Commissioner or her designee, and is a Final Order of the Commissioner under §2-204 of the Insurance Article.

J. Failure to comply with the terms of this Order may subject Respondents to further legal and/or administrative action.

ALFRED W. REDMER, JR.
Insurance Commissioner



By: Erica J. Bailey
Associate Commissioner
Compliance & Enforcement

Date: 1/11/2018

RESPONDENTS' CONSENT

RESPONDENTS hereby CONSENT to the representations made in, and to the terms of, the above Consent Order. On behalf of Respondents, the undersigned hereby affirms that he or she has taken all necessary steps to obtain the authority to bind Respondents to the obligations stated herein and does, in fact, have the authority to bind Respondents to the obligations stated herein.

Name: Jonathan D. Blum

Signature:  _____

Title: Executive Vice President, Medical Affairs

Date: December 21, 2017



**COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT**

MARKET CONDUCT EXAMINATION REPORT

OF

**AETNA HEALTH INSURANCE COMPANY (AHIC, #72052),
AETNA HEALTH INC., PA CORP. (AHI, #95109), HEALTH
AMERICA, INC. (HAPA, #15827), HEALTH ASSURANCE PA,
INC. (HASPA, #11102), AND AETNA LIFE INSURANCE
COMPANY (ALIC, #60054)
c/o Aetna Inc., Hartford, CT**

**As of: July 18, 2018
Issued: November 5, 2018**

**BUREAU OF MARKET ACTIONS
LIFE AND HEALTH DIVISION**

VERIFICATION

Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. § 4903 (relating to false swearing).

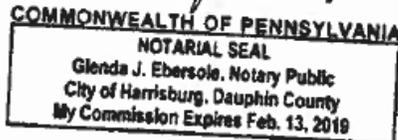
Lindsi Swartz

Lindsi Swartz, Examiner-In-Charge

Sworn to and Subscribed Before me

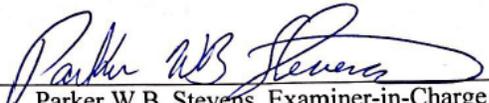
This 1st Day of November, 2018

Glenda J. Ebersole
Notary Public

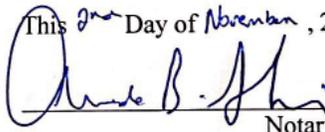


VERIFICATION

Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. § 4903 (relating to false swearing).


Parker W.B. Stevens, Examiner-in-Charge

Sworn to and Subscribed Before me

This 2nd Day of November, 2018

Notary Public



AETNA, INC.

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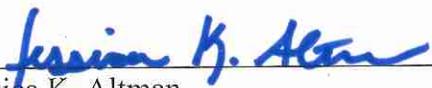
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BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 28th day of March, 2018, in accordance with Section 905(c) of the Pennsylvania Insurance Department Act, Act of May 17, 1921, P.L. 789, as amended, P.S. § 323.5, I hereby designate Christopher R. Monahan, Deputy Insurance Commissioner, to consider and review all documents relating to the market conduct examination of any company and person who is the subject of a market conduct examination and to have all powers set forth in said statute including the power to enter an Order based on the review of said documents. This designation of authority shall continue in effect until otherwise terminated by a later Order of the Insurance Commissioner.





Jessica K. Altman
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
AETNA HEALTH INSURANCE	:	40 P.S. §323.3(a)
COMPANY	:	
	:	40 P.S. §323.4(b)
and	:	
	:	40 P.S. §477a
AETNA HEALTH INC., PA CORP.	:	
	:	40 P.S. §752(A)(4)
and	:	
	:	40 P.S. §753(B)(8)
HEALTH AMERICA, INC.	:	
	:	40 P.S. §761
and	:	
	:	40 P.S. §764h(a), (b), & (f)(3)
HEALTH ASSURANCE PA, INC.	:	
	:	40 P.S. §§908-1 <u>et seq.</u>
and	:	
	:	40 P.S. §§908-11 <u>et seq.</u>
AETNA LIFE INSURANCE COMPANY	:	
	:	40 P.S. §991.2116
C/O Aetna Inc.	:	
151 Farmington Avenue	:	40 P.S. §991.2166(a), (b)
Hartford, Connecticut 06156	:	
	:	40 P.S. §1171.5(a)(1)(i)
	:	
	:	40 P.S. §1171.5(a)(7)(ii)
	:	
	:	40 P.S. §1171.5(a)(10)(i), (iv), (v), (vi), (x)
	:	
	:	40 P.S. §3042
	:	
	:	40 P.S. §3801.310
	:	
	:	31 Pa. Code §51.4
	:	
	:	31 Pa. Code §51.5
	:	

: 31 Pa. Code §89b.11
:
: 31 Pa. Code §146.3
:
: 31 Pa. Code §146.4(b)
:
: 31 Pa. Code §146.5(a)
:
: 31 Pa. Code §146.6
:
: 31 Pa. Code §146.7(a)(1)
:
: 31 Pa. Code §146.7(c)(1)
:
: 31 Pa. Code §152.20
:
: 31 Pa. Code §154.18(a), (c), (d)
:
: 31 Pa. Code §301.82
:
: 42 U.S.C. §300gg-4(a)
:
: 42 U.S.C. §300gg-19(a)(1)(c)
:
: 42 U.S.C. §300gg-19a(b) & (b)(1)(C)(ii)(II)
:
: 45 C.F.R. §146.136(c)(2)(i) & (c)(4)
:
: 45 C.F.R. §147.104
:
: 45 C.F.R. §147.138(b)
:
: 45 C.F.R. §155.310(e)
:
: 45 C.F.R. §156.125
:
:
Respondent. : Docket No. MC18-07-0014

CONSENT ORDER

AND NOW, this 12th day of November, 2018, this Order is hereby issued by the Insurance Department of the Commonwealth of Pennsylvania pursuant to the statutes cited above and in disposition of the matter captioned above.

1. Respondent hereby admits and acknowledges that it has received proper notice of its rights to a formal administrative hearing pursuant to the Administrative Agency Law, 2 Pa.C.S. §101, et seq., or other applicable law.
2. Respondent hereby waives all rights to a formal administrative hearing in this matter and agrees that this Consent Order shall have the full force and effect of an order duly entered in accordance with the adjudicatory procedures set forth in the Administrative Agency Law, supra, or other applicable law.

FINDINGS OF FACT

3. The Insurance Department finds true and correct each of the following Findings of Fact:
 - (a) Respondent is Aetna Health Insurance Company, Aetna Health Inc., PA Corp., Health America, Inc., Health Assurance PA, Inc., and Aetna Life Insurance Company, collectively Aetna Inc., and maintains its address at 151 Farmington Avenue, Hartford, Connecticut 06156.
 - (b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from January 1, 2015 to March 31, 2016.

- (c) On November 5, 2018, the Insurance Department issued a Market Conduct Examination Report to Respondent.
- (d) No company response was provided to the Examination Report.
- (e) The Examination Report notes violations of the following:
 - (i) 40 P.S. §§323.3(a) and 323.4(b) require that every company or person from whom information is sought must provide the examiners timely, convenient and free access to all books, records, accounts, papers, documents and any and all computer or other recording relating to the property, assets business and affairs of the company being examined;
 - (ii) 40 P.S. §§477a, 761, and 1171.5(a)(7)(ii) state that unfair discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of life, health and accident insurance, covered by this act, or in the benefits payable thereon, or in any of the terms or conditions of such policy, or in any other manner whatsoever, is prohibited. Discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of insurance covered by this act, or in the benefits payable thereon, or in any of the terms or conditions of such policy, or in any other manner whatsoever, is prohibited. Unfairly discriminating by means of:
Making or permitting any unfair discrimination between individuals of the same class

and of essentially the same hazard in the amount of premium, policy, fees or rates charged for any policy or contract of insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever, is prohibited;

- (iii) 40 P.S. §752(A)(4) and 31 Pa. Code §89b.11 require that each form shall state the full corporate or legal name of the company, association, exchange or society. However, the name need appear for filing purposes only on a rider, endorsement, amendment, agreement or insert page. If added for filing purposes only, the name may be added by any legible means. If more than one insurer is using an application, a multi-company application providing for the designation of the applicable insurer and available coverages, if applicable, may be used. A policy, contract or fraternal certificate shall state a current address for the insurer, consisting of at least a city and state or province. Conditions subject to which policies are to be issued. No such policy shall be delivered or issued for delivery to any person in this Commonwealth unless: the style, arrangement and over-all appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lower-case unspaced alphabet length not less than 120-point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions;

(iv) 40 P.S. §753(B)(8) states that the insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to his last address as shown by the records of the insurer, stating when, not less than five days thereafter such cancellation shall be effective; and after the policy has been continued beyond its original term, the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro-rata;

(v) 40 P.S. §764h(a) & (b) state that a health insurance policy or government program covered under this section shall provide to covered individuals or recipients under 21 years of age coverage for the diagnostic assessment of autism spectrum disorders and for the treatment of autism spectrum disorders. Coverage provided under this section by an insurer shall be subject to a maximum benefit of thirty-six thousand dollars (\$36,000) per year but shall not be subject to any limits on the number of visits to an autism service provider for treatment of autism spectrum disorders;

(vi) 40 P.S. §764h(a) & (f)(3) state that health insurance policy or government program covered under this section shall provide to covered individuals or recipients under 21 years of age coverage for the diagnostic assessment of autism spectrum disorders and for

the treatment of autism spectrum disorders. As used in this section: “Autism spectrum disorders” means any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or its successor, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified;

(vii) 40 P.S. §§908-1 et seq. require group health insurance policies to provide coverage of inpatient detoxification, nonhospital residential and outpatient services for alcohol or other substance use and dependency, with a certification and referral by a licensed physician or psychologist controlling both the nature and duration of treatment to the extent of the mandate;

(viii) 40 P.S. §§908-11 et seq. and 45 C.F.R. §146.136(c)(2)(i) state that licensed insurers are required to provide mental health and substance use disorder benefits in parity with medical/surgical benefits. For quantitative treatment limitations, this means that a licensed insurer may not apply any quantitative treatment limitation (QTL) to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification;

(ix) 40 P.S. §§908-11 et seq. and 45 C.F.R. §§146.136(c)(4) and 156.115(a)(3) state that licensed insurers are required to provide mental health and substance use disorder benefits in parity with medical/surgical benefits. For NQTLs, this means that a licensed

insurer may not apply any NQTL in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying that limitation to MH/SUD benefits within that classification are “comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the classification.”

(x) 40 P.S. §991.2116 requires that if an enrollee seeks emergency services and the emergency health care provider determines that emergency services are necessary, the emergency health care provider shall initiate necessary intervention to evaluate and, if necessary, stabilize the condition of the enrollee without seeking or receiving authorization from the managed care plan. The managed care plan shall pay all reasonably necessary costs associated with the emergency services provided during the period of the emergency;

(xi) 40 P.S. §§991.2116 and 3042, 42 U.S.C. §300gg-19a(b), and 45 C.F.R. §147.138(b) state that if an enrollee seeks emergency services and the emergency health care provider determines that emergency services are necessary, the emergency health care provider shall initiate necessary intervention to evaluate and, if necessary, stabilize the condition of the enrollee without seeking or receiving authorization from the managed care plan. The managed care plan shall pay all reasonably necessary costs associated with the emergency services provided during the period of the emergency. When processing a reimbursement claim for emergency services, a managed care plan shall consider both the presenting symptoms and the services provided. An insurer shall reimburse an

insured or provider for medically necessary services that are provided in a hospital emergency facility due to a medical emergency. A hospital emergency facility shall provide to an insurer, with any claim for reimbursement of services, information on the presenting symptoms of the insured as well as the services provided. An insurer shall consider both the presenting symptoms and the services provided in processing a claim for reimbursement of emergency services. A plan or issuer subject to the requirements of this paragraph must provide coverage for emergency services in the following manner: without the need for any prior authorization determination, even if the emergency services are provided on an out-of-network basis; without regard to whether the health care provider furnishing the emergency services is a participating network provider with respect to the services; if the emergency services are provided out of network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from in-network providers; if the emergency services are provided out of network, by complying with the cost-sharing requirements of paragraph (b)(3) of this section;

(xii) 40 P.S. §991.2166(a) and 31 Pa. Code §154.18(a) state that a licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim. Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim under subsection (d) submitted by a health care provider for services provided on or after January 1, 1999, within 45 days of the licensed insurer's or managed care plan's receipt of the claim from the health care provider;

- (xiii) 40 P.S. §991.2166(b) and 31 Pa. Code §154.18(c) state that if a licensed insurer or a managed care plan fails to remit payment as provided under subsection (a), interest at 10% per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid;
- (xiv) 40 P.S. §§1171.5(a)(1)(i) and 1171.5(a)(10)(i) state that “unfair methods of competition” and “unfair or deceptive acts or practices” in the business of insurance means: making, publishing, issuing or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which: misrepresents the benefits, advantages, conditions or terms of any insurance policy. Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue;
- (xv) 40 P.S. §1171.5(a)(7)(ii) prohibits making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy, fees or rates charged for any policy or contract of insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever;

- (xvi) 40 P.S. §1171.5(a)(10)(iv) prohibits the refusal to pay claims without conducting a reasonable investigation based upon all available information, if committed or performed with such frequency as to indicate a business practice in claims settlement practices;
- (xvii) 40 P.S. §1171.5(a)(10)(v) requires an insurer to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the insurer or its representative, if committed or performed with such frequency as to indicate a business practice in claims settlement practices;
- (xviii) 40 P.S. §1171.5(a)(10)(vi) prohibits the failure to attempt in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear, if committed or performed with such frequency as to indicate a business practice in claims settlement practices;
- (xix) 40 P.S. §1171.5(a)(10)(x) prohibits making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made, if committed or performed with such frequency as to indicate a business practice in claims settlement practices;
- (xx) 40 P.S. §3801.310 states that upon request, the Department shall be provided a copy of any form being issued in this Commonwealth. Insurers shall maintain complete and accurate specimen or actual copies of all forms which are issued to Pennsylvania residents, including copies of all applications, certificates and endorsements used with

policies. Retention of the forms may be kept on diskette, microfiche or any other electronic method. Specimen copies shall also indicate the date the form was first issued in this Commonwealth. The records shall be maintained until at least two years after a claim can no longer be reported under the form;

(xxi) 31 Pa. Code §51.4 states that a company shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its individual contracts and typical printed, published or prepared advertisements of its blanket, franchise and group contracts hereafter disseminated in this or another state whether or not licensed in the other state;

(xxii) 31 Pa. Code §51.5 states that a company required to file an annual statement which is now or which hereafter becomes subject to this chapter shall file with the Department with its Annual Statement a Certificate of Compliance executed by an authorized officer of the company wherein it is stated that to the best of his knowledge, information and belief the advertisements which were disseminated by the company during the preceding statement year complied or were made to comply in all respects with the provisions of the insurance laws and regulations of this Commonwealth;

(xxiii) 31 Pa. Code §146.3 requires an insurer's claim files to be subject to examination by the Commissioner or by her appointed designees, with the files containing notes and work papers pertaining to the claim in sufficient detail that pertinent events and the dates of the events can be reconstructed;

- (xxiv) 31 Pa. Code §146.4(b) states that an insurer or agent may not fail to fully disclose to first-party claimants benefits, coverages or other provisions of an insurance policy or insurance contract when the benefits, coverages or other provisions are pertinent to a claim;
- (xxv) 31 Pa. Code §146.5(a) states every insurer, upon receiving notification of a claim, shall acknowledge receipt of the notice or pay the claim within 10 working days;
- (xxvi) 31 Pa. Code §146.6 requires an insurer, if an investigation cannot be completed within 30 days, and if it is not completed, then every 45 days thereafter, to provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected;
- (xxvii) 31 Pa. Code §146.7(a)(1) requires the first-party claimant to be advised of the acceptance or denial of the claim by the insurer within 15 working days after receipt by the insurer of properly executed proofs of loss;
- (xxviii) 31 Pa. Code §146.7(c)(1) requires an insurer, if it cannot make a determination of acceptance or denial of a first-party claim within 15 days of receipt of a properly executed proof of loss, to notify the first-party claimant within 15 working days after receipt of the proof of loss giving the reasons;

(xxix) 31 Pa. Code §§152.20 and 301.82 state that the Commissioner and the Secretary may investigate a preferred provider organization in order to determine whether it is complying with this chapter, and that the Commissioner or an agent shall have free access to the books, records, papers and documents that relate to the business of the HMO;

(xxx) 31 Pa. Code §154.18(d) requires clean claims to be paid within 45 days pursuant to the interest provisions of the act, and states if a paid claim is to be re-adjudicated due to additional information, a new 45-day period for the prompt pay provision begins at the time such additional information is provided;

(xxxi) 42 U.S.C. §300gg-19(a)(1)(c) requires a group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan shall have at a minimum:

an internal claims appeal process, provide notice to enrollees in a culturally and linguistically appropriate manner of available internal and external appeals processes, the availability of any applicable office insurance consumer assistance and allow an enrollee to review their file, to present evidence and testimony as part of the appeals process and to receive continued coverage pending the outcome of the appeals process;

(xxxii) 40 P.S. §§477a, 761, and 1171.5(a)(7)(ii); 42 U.S.C. 300gg-4(a); and 45 C.F.R.

§§147.104 and 156.125 state that an issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions;

(xxxiii) 42 U.S.C. §300gg-19a(b)(1)(C)(ii)(II) and 45 C.F.R. §147.138 state that if a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides any benefits with respect to services in an emergency department of a hospital, the plan or issuer must cover emergency services (as defined in 45 C.F.R.

§147.138(b)(4)(ii)) consistent with the rules of that paragraph (b). In general, if a group health plan, or a health insurance issuer offering group or individual health insurance issuer, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in 42 U.S.C. §300gg-19a(b)(2)(B)) —(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee— (II) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

(xxxiv) 45 C.F.R. §155.310(e) states that the Exchange must determine eligibility promptly and without undue delay. The Exchange must assess the timeliness of eligibility determinations based on the period from the date of application or transfer from an

agency administering an insurance affordability program to the date the Exchange notifies the applicant of its decision or the date the Exchange transfers the application to another agency administering an insurance affordability program, when applicable.

CONCLUSIONS OF LAW

4. In accord with the above Findings of Fact and applicable provisions of law, the Insurance Department makes the following Conclusions of Law:

- (a) Respondent is subject to the jurisdiction of the Pennsylvania Insurance Department, violated the laws referenced in the Findings of Fact, and is subject to penalties, including those set forth in these Conclusions of Law.

- (b) Respondent's violations of Sections 40 P.S. §§752(a)(4), 753(b)(8), 761, 764h(a), (b) & (f)(3), and 31 Pa. Code §152.20 are punishable by the following under 40 P.S. §763:
 - (1) License revocation.
 - (2) Imposition of a penalty of not more than one thousand dollars (\$1,000.00) for each violation.

- (c) Respondent's violations of 40 P.S. §§991.2116, 991.2116(b), 991.2166(a), 991.2166(b), and 31 Pa. Code §154.18 are punishable by the following under 40 P.S. §991.2182:
 - (1) Imposition of a penalty of not more than five thousand dollars (\$5,000.00) for each violation.

- (2) An action in which the Commonwealth Court may impose an injunction to prohibit any activity that violates the act.
 - (3) An order temporarily prohibiting respondent from enrolling new members.
 - (4) A requirement to develop and adhere to a plan of correction.
- (d) Respondent's violations of 40 P.S. §§1171.5(a)(1)(i) and (10)(i), 1171.5(a)(7)(ii), 1171.5(a)(10)(iv), 1171.5(a)(10)(v), 1171.5(a)(10)(vi), and 1171.5(a)(10)(x) are punishable by the following under 40 P.S. §1171.9:
- (1) An order to cease and desist.
 - (2) License suspension or revocation.
- (e) In addition to any penalties imposed by the Commissioner for Respondent's violations of 40 P.S. §§1171.5(a)(1)(i) and (10)(i), 1171.5(a)(7)(ii), 1171.5(a)(10)(iv), 1171.5(a)(10)(v), 1171.5(a)(10)(vi), and 1171.5(a)(10)(x) the Commissioner may, under 40 P.S. §§1171.10, 1171.11, file an action in which the Commonwealth Court may impose the following civil penalties:
- (1) An injunction.
 - (2) For each method of competition, act or practice which the company knew or should have known was in violation of the law, a penalty of not more than five thousand dollars (\$5,000.00) for each violation but not to exceed an aggregate penalty of fifty thousand dollars (\$50,000) in any six-month period.
 - (3) For each method of competition, act or practice which the company did not know nor reasonably should have known was in violation of the law, a penalty of not

more than one thousand dollars (\$1,000.00) for each violation but not to exceed an aggregate penalty of ten thousand dollars (\$10,000) in any six-month period.

- (f) Respondent's violations of 31 Pa. Code §§51.5, 146.3, 146.4(b), 146.5(a), 146.6, 146.7(a)(1), and 146.7(c)(1) are punishable by the following under 40 P.S. §1171.9:
 - (1) An order to cease and desist.
 - (2) License suspension or revocation.

- (g) In addition to any penalties imposed by the Commissioner for Respondent's violations of 31 Pa. Code §§51.5, 146.3, 146.4(b), 146.5(a), 146.6, 146.7(a)(1), and 146.7(c)(1), the Commissioner may, under 40 P.S. §§1171.10 and 1171.11 file an action in which the Commonwealth Court may impose the following civil penalties:
 - (1) An injunction.
 - (2) For each method of competition, act or practice which the company knew or should have known was in violation of the law, a penalty of not more than five thousand dollars (\$5,000.00) for each violation but not to exceed an aggregate penalty of fifty thousand dollars (\$50,000) in any six-month period.
 - (3) For each method of competition, act or practice which the company did not know nor reasonably should have known was in violation of the law, a penalty of not more than one thousand dollars (\$1,000.00) for each violation but not to exceed an aggregate penalty of ten thousand dollars (\$10,000) in any six-month period.

- (h) Respondent's violations of 31 Pa. Code §301.82 are punishable under 40 P.S. §1565 by imposition of a penalty of not more than one thousand dollars (\$1,000.00) for each violation.

(i) Respondent's violations of 40 P.S. §908-11 et seq. are punishable by the following under 40 P.S. §908-15:

- (1) License suspension, revocation, or refusal to renew.
- (2) Imposition of a penalty of not more than five thousand dollars (\$5,000.00) for each violation.
- (3) Imposition of a penalty of not more than ten thousand dollars (\$10,000.00) for each violation.
- (4) Provided that the total penalty imposed thereunder shall not exceed \$500,000 in the aggregate during a single calendar year.

ORDER

5. In accord with the above Findings of Fact and Conclusions of Law, the Insurance Department orders and Respondent consents to the following:

- (a) Respondent shall cease and desist from engaging in the prohibited activities described herein in the Findings of Fact and Conclusions of Law.
- (b) Respondent shall file an affidavit stating under oath that it will provide each of its directors, at the next scheduled directors meeting, a copy of the adopted Report and related Orders. Such affidavit shall be submitted within thirty (30) days of the date of this Order.
- (c) Respondent shall comply with all recommendations contained in the attached Report.
- (d) Respondent shall pay One Hundred and Ninety Thousand Dollars (\$190,000.00) to the Commonwealth of Pennsylvania **in settlement of the violations** pertaining to, *inter alia*, the prompt payment of claims, the retention of records, **autism spectrum disorders coverage, drug and alcohol abuse coverage** and Pennsylvania's requirement for **compliance with the Federal Mental Health Parity and Addiction Equity Act.**
- (e) Payment of this matter shall be made by check payable to the Commonwealth of Pennsylvania. Payment should be directed to April Phelps, Bureau of Market Actions,

1227 Strawberry Square, Harrisburg, Pennsylvania 17120. Payment must be made no later than thirty (30) days after the date of this Order.

6. In the event the Insurance Department finds that there has been a breach of any of the provisions of this Order, based upon the Findings of Fact and Conclusions of Law contained herein may pursue any and all legal remedies available, including but not limited to the following: The Insurance Department may enforce the provisions of this Order in the Commonwealth Court of Pennsylvania or in any other court of law or equity having jurisdiction; or the Department may enforce the provisions of this Order in an administrative action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

7. Alternatively, in the event the Insurance Department finds that there has been a breach of any of the provisions of this Order, the Department may declare this Order to be null and void and, thereupon, reopen the entire matter for appropriate action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

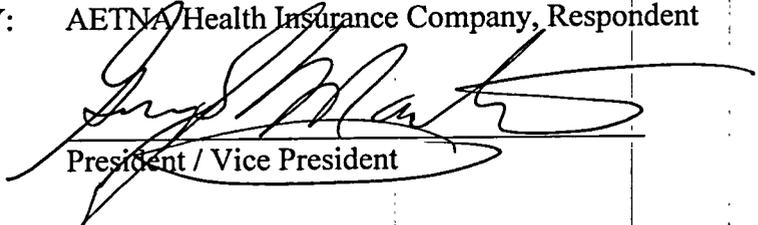
8. In any such enforcement proceeding, Respondent may contest whether a breach of the provisions of this Order has occurred but may not contest the Findings of Fact and Conclusions of Law contained herein.

9. Respondent hereby expressly waives any relevant statute of limitations and application of the doctrine of laches for purposes of any enforcement of this Order.

10. This Order constitutes the entire agreement of the parties with respect to the matters referred to herein, and it may not be amended or modified except by an amended order signed by all the parties hereto.

11. This Order shall be final upon execution by the Insurance Department. Only the Insurance Commissioner or a duly authorized delegee is authorized to bind the Insurance Department with respect to the settlement of the alleged violations of law contained herein, and this Consent Order is not effective until executed by the Insurance Commissioner or a duly authorized delegee.

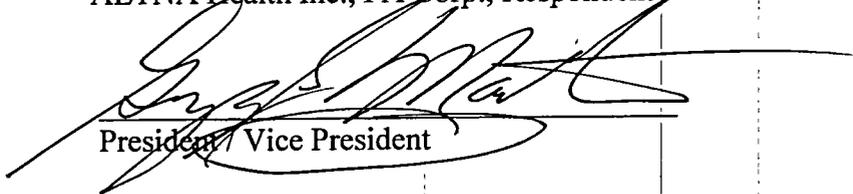
BY: AETNA Health Insurance Company, Respondent



President / Vice President

Secretary / Treasurer

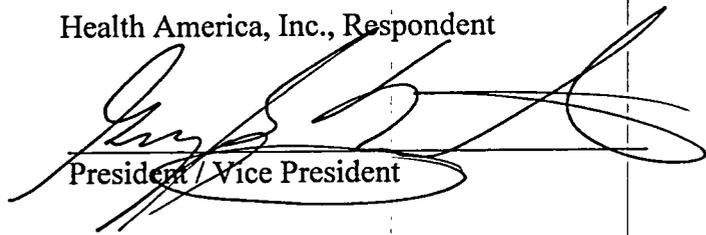
AETNA Health Inc., PA Corp., Respondent



President / Vice President

Secretary / Treasurer

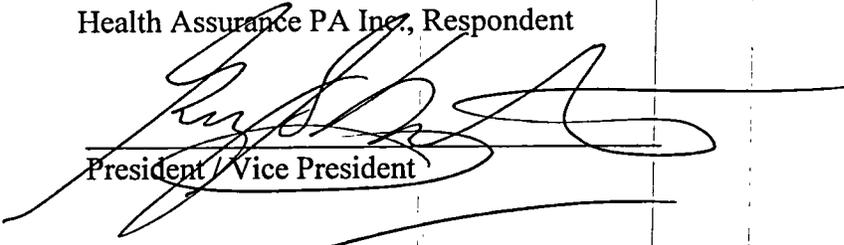
Health America, Inc., Respondent



President / Vice President

Secretary / Treasurer

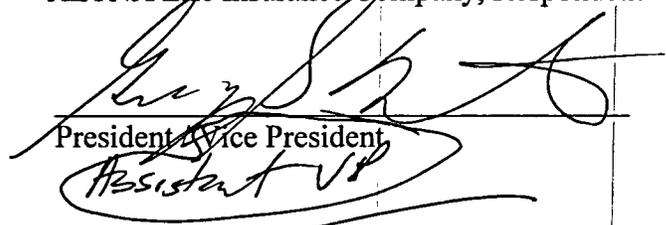
Health Assurance PA Inc., Respondent



President / Vice President

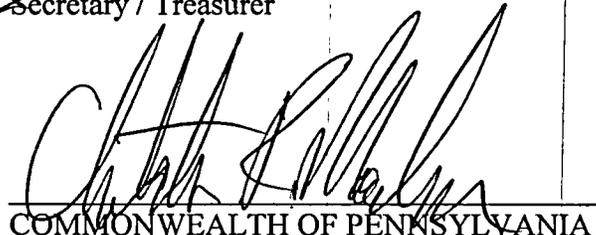
Secretary / Treasurer

AETNA Life Insurance Company, Respondent



President / Vice President

Secretary / Treasurer



COMMONWEALTH OF PENNSYLVANIA
Christopher R. Monahan
Deputy Insurance Commissioner

I. INTRODUCTION

The Market Conduct Examination was conducted on Aetna Inc.'s subsidiaries Aetna Health Insurance Company (AHIC), Aetna Health Inc., PA Corp. (AHI), Health America, Inc. (HAPA), Health Assurance PA, Inc. (HASPA), and Aetna Life Insurance Company (ALIC), hereafter collectively referred to as "Company." The Company's corporate headquarters are located in Hartford, Connecticut. The examination reviews were conducted in the offices of the Pennsylvania Insurance Department and off-site locations from August of 2016 through April of 2018.

Pennsylvania Market Conduct Examination Reports generally note the items that have been reviewed and whether or not a violation of law or regulation exists. A violation is any instance of Company activity that does not comply with an insurance statute or regulation. Violations contained in the Report may result in imposition of penalties. This Examination Report also includes management recommendations addressing areas of concern noted by the Department, but for which no statutory violation was identified. This enables Company management to review these areas of concern in order to determine the potential impact upon Company operations or future compliance. Summaries issued to the Company throughout the examination process are included in this Examination Report; however, in some instances, the content of multiple summaries may be combined into a single report section. This only applies to sections in which no violations were found.

It is also noted that certain areas subject to examination are and will continue to be the focus of ongoing compliance emphasis by the Department. These areas reflect developments in complex areas of health insurance regulation at both the national and state levels, such as, for example, discrimination in formulary design and parity for nonquantitative treatment limitations in mental health and substance use disorder coverage. The Department anticipates providing more specific guidance to the industry with respect to these areas, and also appreciates and anticipates the continued cooperation of the Company in providing coverage consistent with the laws and regulations governing these complex areas.

Throughout the course of the examination, Company officials were provided status memoranda, which referenced specific policy numbers with citation to each section of law violated. Additional information was requested to clarify apparent violations. An exit conference was conducted with

Company officials to discuss the various types of violations identified during the examination and review written summaries provided on the violations found.

The courtesy and cooperation extended by the Officers and employees of the Company during the course of the examination is acknowledged.

The following examiners participated in the Examination and in the preparation of this Report:

Donna Fleischauer
Market Conduct Division Chief
Pennsylvania Insurance Department

Parker Stevens, FLMI, AIRC, CCP, CIE, MPM, AMCM
Co-Examiner-in-Charge

Sam Binnun, LUTCF, MCM
Co-Examiner-in-Charge

Lindsi Swartz, MBA
Market Conduct Examiner
Pennsylvania Insurance Department

Ernest L. Nickerson, FLMI, ACS, AIRC, ARM, RHU, AIE, AMCM
Contract Examiner

Marc Springer, CIE, CPCU, MCM
Contract Examiner

Jo-Anne Fameree, AMCM, CIE, FLMI, AIRC, ACS
Contract Examiner

Pat Lee, MCM, AIE, FLHC, AIRC, ACS, ALMI
Contract Examiner

II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted pursuant to the authority granted by Sections 903 and 904 (40 P.S. §§ 323.3 and 323.4) of the Insurance Department Act and covered the experience period of January 1, 2015, through March 31, 2016, unless otherwise noted. The purpose of the examination was to ensure compliance with Pennsylvania insurance laws and regulations, as well as federal laws and regulations not superseded by state law.

The examination focused on the Company's policies and procedures in the following areas: Operations and Management, Complaints, Producer Licensing, Policyholder Services, Underwriting and Rating, Claims, Grievances, Network Adequacy, Provider Credentialing, Quality Assessment and Improvement, and Utilization Review.

Examiners requested that the Company identify the universe of files for each segment of the review. Based on the universe sizes identified, random sampling was utilized to select the files reviewed for examination.

For control purposes, some of the review segments identified in this Examination Report may be broken down into various sub-categories by line of insurance or Company administration. These specific sub-categories, if not reflected individually in the Examination Report, are included and grouped within the respective categories of the Examination Report. All reviews conducted throughout the examination included consideration of company responses to examiner requests pursuant to 40 P.S. §§ 323.3 and 323.4, as well as 31 Pa. Code §§ 152.20 and 301.82. While included in all reviews completed during the examination, the Examination Report only notes when examiners found a violation of these sections in a particular area.

Within the duration of the market conduct examination, the Company provided the examiners with multiple positive process improvements from the 2015 to 2016 benefit period, including the restructure and change in formulary benefit design for certain plan types, which placed fewer restrictions on some therapeutic drug categories and classes, and the removal of potentially discriminatory language from certificates of coverage. In addition, the Company demonstrated enhanced external audit practices including on-site visits to third party administrator (TPA) locations. The Company remains dedicated to continuous improvement, which is noted throughout their policies and procedures. The Company also utilized federal and state guidance, including

FAQs released by HHS and Bulletins released by the Department, and updated their policies and processes according to the clarified interpretations of the law.

III. COMPANY HISTORY AND LICENSING

A. Aetna Health Inc., a Pennsylvania corporation (“AHI”) (NAIC #95109)

AHI was incorporated in the Commonwealth of Pennsylvania on May 7, 1981 and acquired the net assets and operations of a prepaid health care plan, which had operated as a health maintenance organization (HMO) in southeastern Pennsylvania since 1976. The Company commenced HMO operations in Pittsburgh in 1987 and in central Pennsylvania in 1994.

In March 2002, the Company changed its name from United States Health Care Systems of Pennsylvania, Inc. to Aetna Health of Pennsylvania, Inc., and then to Aetna Health Inc., in May 2002.

AHI is a wholly-owned subsidiary of Aetna Health Holdings, LLC, whose ultimate parent is Aetna Inc.

AHI is also licensed in the following states: Arizona, Colorado, District of Columbia, Delaware, Illinois, Indiana, Kansas, Kentucky, Maryland, Massachusetts, Missouri, Nebraska, Nevada, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, Virginia, Washington and West Virginia.

In 2015, based on the annual statements submitted for business in the state of Pennsylvania, AHI had health premiums written in the amount of \$1,087,587,631, under comprehensive (hospital and medical) for individual and group, Federal Employees Health Benefits plan, and Title XIX Medicare lines of business. In 2016, for business in the state of Pennsylvania, AHI had health premiums written in the amount of \$1,712,246,768, under comprehensive (hospital and medical) for individual and group, Federal Employees Health Benefits plan, and Title XIX Medicare lines of business.

B. Aetna Health Insurance Company, a Pennsylvania corp. (NAIC #72052)

This entity was incorporated in 1938 and commenced business in 1956. Previous names of the Company included St. Paul Health & Accident Company, St. Paul Hospital and Casualty Company and, in 1977, Omaha Financial Life Insurance Company.

In 1989, this entity entered into an assumption agreement and transferred and assigned all its in-force credit life business and mortgage policies to its former parent company, United Omaha Life

Insurance Company and two unaffiliated companies. This entity ceased writing business prior to the transfer and remained inactive until its purchase by U.S Healthcare, Inc., on January 6, 1993.

This entity adopted a new name, Corporate Health Insurance Company, on February 4, 1993.

This entity was a Minnesota domiciled insurer until July 20, 1997, when it became a Pennsylvania domiciled insurer pursuant to an order of the Pennsylvania Insurance Commissioner, based on an application received April 9, 1997.

The ultimate parent of this entity was U.S. Healthcare, Inc., from January 6, 1993 until July 18, 1996 when U.S. Healthcare, Inc. merged with Aetna Inc. in 1996. The surviving company was Aetna Inc.

Effective January 1, 2008, this entity adopted its present name, Aetna Health Insurance Company (AHIC).

AHIC is also licensed in the following states: Alabama, Alaska, Arizona, Arkansas, Colorado, District of Columbia, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, **Maryland**, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming.

In 2015, based on the annual statements submitted for business in the state of Pennsylvania, AHIC had health premiums written in the amount of \$3,161,093, under comprehensive (hospital and medical) for group lines of business. In 2016, for business in the state of Pennsylvania, AHIC had health premiums written in the amount of \$5,837,060, under comprehensive (hospital and medical) for group lines of business.

C. HealthAmerica Pennsylvania, Inc. (NAIC #95060)

On October 1, 1988, Penn Group Corporation purchased all of the stock (five shares) of Maxicare/HealthAmerica Pennsylvania, Inc., from Maxicare Health Plans, Inc. Penn Group Corporation, a Delaware corporation, was 80% (800 shares) owned by Coventry Corporation and 20% (200 shares) owned by Montefiore Hospital Association of Western Pennsylvania.

On November 21, 1988, this entity changed its name from Maxicare/HealthAmerica Pennsylvania, Inc., to HealthAmerica Pennsylvania, Inc. (HAPA). On October 31, 1994, Coventry Corporation purchased the 20% ownership of Penn Group Corporation from University of Pittsburgh Medical Center, formerly, Montefiore Hospital Association of Western Pennsylvania.

On December 18, 1997, and effective December 31, 1997, HAPA's direct parent, Penn Group Corporation, entered into a plan of merger with Coventry Corporation, leaving Coventry Corporation the surviving entity and ceased the existence of Penn Group Corporation. As of December 31, 1997, HAPA's direct parent was Coventry Corporation. Coventry Corporation was merged into Coventry Health Care, Inc. (CHC), on June 30, 2000.

On April 5, 1999, The Medical Center HPJV, Inc. was merged into HAPA, with HAPA as the surviving corporation.

On May 1, 2002, HAPA purchased New Alliance Health Plan, a managed care organization that services members in Pennsylvania and Ohio. All of New Alliance Health Plan's HMO business was retained by HAPA, and the POS and PPO business was merged into HAPA's affiliate, HealthAssurance Pennsylvania, Inc. (HASPA). After the merger, New Alliance Health Plan ceased to exist.

HAPA was authorized to transact business under 40 P.S. §§1551 et seq. and under Ohio Revised Code §1751. HAPA operated as an HMO serving Pennsylvania and Ohio. HAPA stopped writing new business in Ohio in January 1, 2014 and surrendered its Ohio license.

HAPA was wholly owned by its direct parent, CHC.

CHC was acquired by Aetna Inc. May 7, 2013. CHC was later merged into Aetna Inc.'s subsidiary Aetna Health Holdings, LLC (AHH) January 1, 2014. HAPA became the wholly owned subsidiary of AHH. HAPA was later merged into AHH's subsidiary Aetna Health Inc. (AHI-PA), a Pennsylvania corporation, January 1, 2016. AHI-PA is the surviving entity and HAPA ceased to exist after the merger.

In 2015, based on the annual statements submitted for business in the state of Pennsylvania, HAPA had direct premiums written in the amount \$837,846,074 for comprehensive health coverage (individual, small group, and large group) and Medicare Advantage Part C and Medicare Part D

Stand-Alone Subject to ACA lines of business.

D. HealthAssurance Pennsylvania, Inc. (NAIC #11102)

HealthAssurance PA, Inc. (HASPA) was incorporated on September 10, 1985. HASPA became a part of the CHC insurance holding company system on May 14, 2001 upon receipt of the Pennsylvania Department of Insurance Certificate of Authority to Operate a Risk-Assuming Preferred Provider Organization Not a Licensed Insurer (RANLI).

On May 7, 2013, Aetna Inc. (Aetna) a Pennsylvania corporation, acquired CHC, and, as a result, transferred CHC and its subsidiaries under AHH, a wholly-owned subsidiary of Aetna. Aetna is the Ultimate Parent Company and owns 100% of the outstanding common stock of HASPA.

On January 1, 2014, CHC merged with and into AHH and as a result, Coventry Health Care, Inc. was eliminated as a legal entity and AHH is the direct parent and owns 100% of the outstanding common stock of HASPA.

In 2015, based on the annual statements submitted for business in the state of Pennsylvania, HASPA had health premiums written in the amount of \$1,249,233,601, under comprehensive (hospital and medical) for group employers and Title XVIII Medicare lines of business. In 2016, for business in the state of Pennsylvania, HASPA had health premiums written in the amount of \$1,032,647,329, under comprehensive (hospital and medical) for group employers and Title XVIII Medicare lines of business.

E. Aetna Life Insurance Company (NAIC #60054)

Aetna Life Insurance Company (ALIC) was incorporated in Connecticut on June 14, 1853. In 1951, ALIC introduced major medical coverage. ALIC is licensed in all 50 states, the District of Columbia, Canada, Guam, Northern Mariana Islands, Puerto Rico, and Virgin Islands. All Aetna products are sold by licensed agents.

In 2015, based on the annual statements submitted for business in the state of Pennsylvania, ALIC had premiums written in the amount of \$16,440,818,014 for group accident and health and other individual contract(s) lines of business. In 2016, for business in the state of Pennsylvania, ALIC had premiums written in the amount of \$17,931,462,260 for group accident and health and other

individual contract(s) lines of business.

IV. COMPANY OPERATIONS AND MANAGEMENT

Examiners requested documentation relating to internal audit and compliance procedures. The audits and procedures were reviewed to assure best practices. Documents requested dealt with information technology protection, anti-fraud policies and procedures, disaster recovery plans, monitoring business functions, record retention policies and procedures, company management and governance, privacy protections and notices, and standards for handling non-public personal information. Unless noted, all documents identified in the universe by the Company were requested, received and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review.

A. Audits Conducted

Examiners requested a list of audits performed during the experience period. The Company identified a universe of 23 audits performed. In accordance with the requirements of the examination, the information provided by the Company was reviewed to ensure compliance with applicable state law using the guidelines set forth in Chapter 16, Section B, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Policies and Procedures for Information Technology Protection

Examiners requested documentation demonstrating that the Company had controls, safeguards and procedures for protecting the integrity of computer information in place during the experience period. The Company identified a universe of three documents, which were reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code Ch. 146a, 146b, 146c, using the guidelines set forth in Chapter 16, Section A, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Anti-Fraud Procedures

Examiners requested documentation demonstrating that the Company had anti-fraud initiatives in place during the experience period that were reasonably calculated to detect, prosecute and prevent fraudulent insurance acts. The Company identified a universe of three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with

applicable state laws and regulations using the guidelines set forth in Chapter 16, Section A, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

D. Disaster Recovery Plan and Procedures

Examiners requested documentation demonstrating that the Company had a valid disaster recovery plan in place during the experience period. The Company identified a universe of three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section A, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

E. Third-Party Agreements

Examiners requested copies of contracts between the Company and any third-party entity, including managing general agents, general agents, third-party administrators, and vendors that conducted activities on behalf of the Company during the experience period. The Company provided four vendor contracts including CVS Pharmacy (CVS), Express Scripts (ESI), Eye Med and Group Dental Service (GDS), which were used to process Pharmacy, Prescription Drug Program, Pediatric Vision and Group Dental benefits. In accordance with the requirements of the examination, the contracts were reviewed to ensure compliance with state and federal laws and regulations, including 45 C.F.R. § 156.340, using the guidelines set forth in Chapter 16, Section A, Standard 5 of the *NAIC Market Regulation Handbook*. The Company explained that it conducts on-site external audits with all vendors to ensure compliance with contract provisions and state requirements. The Company supplied examples of audits conducted on two vendors, CVS and Eye Med. The audits demonstrated the comprehensive and detailed oversight the Company conducts on vendors with delegated services. It was further noted that GDS is an Aetna affiliate; all employees of GDS are Aetna employees, and no delegated audits are deemed necessary by the Company. Additionally, the Company represented the same type of oversight conducted for CVS was also exercised for ESI. No violations were noted.

F. Contracted-Entity Activity Monitoring

Examiners requested documentation demonstrating that the Company adequately monitored the

activities of entities that contractually assumed a business function or acted on behalf of the Company during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. § 156.340, using the guidelines set forth in Chapter 16, Section A, Standard 6 of the *NAIC Market Regulation Handbook*. No violations were noted.

G. Record Retention

Examiners requested copies of the records retention policies and procedures for assurance that Company records are adequate, accessible, consistent and orderly, and comply with state retention requirements for the experience period. The Company identified a universe of three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section A, Standard 7 of the *NAIC Market Regulation Handbook*. No violations were noted.

H. Written Overview of Operations

Examiners requested a written overview of the Company's operations including management structure, type of carrier, states where the Company is licensed and the major lines of business the Company had written for the experience period, including information if a regional office handled any portion of the Pennsylvania business. The Company identified a universe of 12 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code §§ 152.3 and 301.42, using the guidelines set forth in Chapter 16, Section A, Standard 8 of the *NAIC Market Regulation Handbook*. No violations were noted.

I. Response Requests

Examiners requested documentation demonstrating that the Company recognized it was required to respond to requests from the examiners in a timely manner during the experience period. The Company identified a universe of three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code §§ 152.3 and 301.42, using the guidelines set forth in Chapter

16, Section A, Standard 9 of the *NAIC Market Regulation Handbook*. In addition to the review of policies and procedures, the Department analyzed the Company's timeliness of responses for items requested by the Department during the market conduct examination. One general data integrity violation was noted for the Company's failure to provide timely access to all requests made by the Department during the course of the examination. In addition to the data integrity violation, the following violation was noted:

1 Violation – 31 Pa. Code §§ 152.20 and 301.82

The Commissioner and the Secretary may investigate a preferred provider organization in order to determine whether it is complying with this chapter. The Commissioner or an agent shall have free access to the books, records, papers and documents that relate to the business of the HMO. The Company provided policies and procedures for the Regulatory Compliance Unit on examination management. Examiners noted, however, that during the course of the examination, the Company requested numerous extensions or failed to provide requested documentation in a timely manner.

J. Privacy Policies and Procedures

Examiners requested documentation demonstrating that the Company assured that the collection, use and disclosure of information gathered in connection with insurance transactions was performed in a manner that minimizes any improper intrusion into the privacy of applicants and policyholders during the experience period. The Company identified a universe of 16 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code Ch. 146a, 146b, 146c, using the guidelines set forth in Chapter 16, Section A, Standard 10 of the *NAIC Market Regulation Handbook*. No violations were noted.

K. Insurance Information Security

Examiners requested documentation demonstrating that the Company developed and implemented written policies, standards and procedures for the management of insurance information for the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state laws and regulations, including and 31 Pa. Code Ch. 146a, 146b, 146c, using the guidelines

set forth in Chapter 16, Section A, Standard 11 of the *NAIC Market Regulation Handbook*. No violations were noted.

L. Security Protection of Non-Public Information

Examiners requested documentation indicating that, for the experience period, the Company had policies and procedures in place to protect the privacy of non-public personal information relating to its customers, former customers, and consumers that were not customers. The Company identified a universe of nine documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code Ch. 146a, 146b, and 146c, using the guidelines set forth in Chapter 16, Section A, Standard 12 of the *NAIC Market Regulation Handbook*. No violations were noted.

M. Privacy Notices

Examiners requested documentation demonstrating that the Company provided privacy notices to its customers and, if applicable, to its consumers who are not customers regarding treatment of non-public personal financial information. The Company identified a universe of five documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code Ch. 146a, 146b, and 146c, using the guidelines set forth in Chapter 16, Section A, Standard 13 of the *NAIC Market Regulation Handbook*. No violations were noted.

N. Opt-Out Notices

Examiners requested documentation demonstrating that the Company disclosed information subject to an opt-out right, that the Company had policies and procedures in place so that non-public personal financial information would not be disclosed when a consumer who was not a customer had opted out, and that the Company provided opt-out notices to its customers and other affected consumers during the experience period. The Company identified a universe of five documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code Ch. 146a, using the guidelines set forth in Chapter 16, Section A, Standard 14 of the *NAIC Market Regulation Handbook*. No violations were noted.

O. Non-Public Personal Financial Information

Examiners requested documentation demonstrating that the Company's collection, use and disclosure of non-public personal financial information were in compliance with policy provisions, and state and federal laws and regulations applicable during the experience period. The Company identified a universe of two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code Ch. 146a, using the guidelines set forth in Chapter 16, Section A, Standard 15 of the *NAIC Market Regulation Handbook*. No violations were noted.

P. Non-Public Personal Health Information Disclosure

Examiners requested documentation that the Company had policies and procedures in place during the experience period so that non-public personal health information would not be disclosed, except as permitted by law, unless a customer or a consumer who is not a customer has authorized the disclosure. The Company identified a universe of nine documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code Ch. 146a and 146b, using the guidelines set forth in Chapter 16, Section A, Standard 16 of the *NAIC Market Regulation Handbook*. No violations were noted.

Q. Written Information Security Program

Examiners requested documentation demonstrating that, during the experience period, the Company implemented a comprehensive written information security program for the protection of non-public customer information. The Company provided a copy of the Company's Security Policies document for review by the examiners. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code Ch. 146c, using the guidelines set forth in Chapter 16, Section A, Standard 17 of the *NAIC Market Regulation Handbook*. No violations were noted.

R. Data Submission to Regulator – Policies and Procedures

Examiners requested documentation demonstrating that the Company's data that was required to be reported to the Pennsylvania Insurance Department were complete and accurate for the

experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state laws and regulations, including 40 P.S. § 1171.5(a)(5) and 31 Pa. Code §§ 146.1 et seq., using standards set forth in Chapter 16, Section A, Standard 18 of the *NAIC Market Regulation Handbook*. Examiners also analyzed the Company's timeliness and completeness of responses for items requested by the Department. As noted above, one general data integrity violation was noted for the Company's failure to submit complete responses in a timely manner and failure to provide timely access to data and documentation for all requests made by the Department during the course of the examination.

S. Management of Compliance Division

Examiners requested a description of the management structure of the Company as it relates to Major Medical Health insurance, including the management structure that handled compliance issues during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code §§ 152.3 and 301.42. No violations were noted.

T. External Audits and Examinations

Examiners requested a list of all examination fines, penalties, and recommendations from any state for the last five years, as well as copies of all Financial and Market Conduct Examination reports issued during the last five years. The Company identified a universe of six documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

U. Annual Statements and Related Schedules

Examiners requested copies of the annual statements for the prior three years and any Accident and Health related schedules or statements for the experience period. The Company identified a universe of 54 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

V. CONSUMER COMPLAINTS

Examiners requested documentation relating to consumer complaints. Unless noted, all documents identified in the universe by the Company were requested, received, and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with 40 P.S. §§ 1171.5, and 991.2141 through 991.2143, as well as 42 U.S.C. § 300gg-19 and 45 C.F.R. § 147.136.

A. Complaint Handling

Examiners requested all consumer complaints and copies of consumer complaint logs for the experience period. The Company provided all requested materials including the complaint handling policies and procedures and the complaint log. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 16, Section B, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Complaint Handling Procedures

Examiners requested documentation demonstrating that the Company had adequate complaint handling procedures in place and communicated such procedures to policyholders. The Company identified a universe of three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. § 156.1010, using the guidelines set forth in Chapter 16, Section B, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Complaint Resolution

Examiners requested documentation demonstrating that the Company took adequate steps to finalize and resolve complaints in accordance with contract language, and state and federal laws and regulations applicable during the experience period. The Company identified a universe of 12 documents. In accordance with the requirements of the examination, the documents were reviewed

to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 16, Section B, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

D. Complaint Response Time

Examiners requested documentation demonstrating that the timeframe within which the Company responded to complaints during the experience period was in accordance with applicable state and federal laws and regulations. The Company identified a universe of 12 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 16, Section B, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

E. Complaint Disposal

Examiners requested documentation demonstrating that the Company took adequate steps to finalize and dispose of complaints in accordance with policy provisions, and state and federal laws and regulations applicable during the experience period. The Company provided 12 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 16, Section B, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

F. Definition of Complaint

Examiners requested documentation regarding complaint handling policies, including the Company's definition of what constitutes a complaint. The Company provided 12 documents. In accordance with requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations. No violations were noted.

G. Complaint Summaries

The Company was asked to describe the complaint reports and summaries prepared on a recurring basis and identify the recipients of those reports. The Company identified a universe of 12

documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations. No violations were noted.

H. Pennsylvania Insurance Department Complaints

Examiners requested that the Company identify all complaints received from the Insurance Department during the experience period. The Company identified 158 consumer complaints received during the experience period. A random sample of 50 complaint files was requested. The documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 31 Pa. Code § 146.5. The following substantive violations of state law were noted in the universe of complaints to the Insurance Department:

1 Violation – 40 P.S. § 753(B)(8)

The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to his last address as shown by the records of the insurer, stating when, not less than five days thereafter such cancellation shall be effective; and after the policy has been continued beyond its original term, the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro-rata. The Company failed to retain records to demonstrate prompt notification to the member of the policy cancellation.

2 Violations – 45 C.F.R. § 155.310(e)

The Exchange must determine eligibility promptly and without undue delay. The Exchange must assess the timeliness of eligibility determinations based on the period from the date of application or transfer from an agency administering an insurance affordability program to the date the Exchange notifies the applicant of its decision or the date the Exchange transfers the application

to another agency administering an insurance affordability program, when applicable. The Company failed to promptly notify the members of the eligibility determination.

VI. PRODUCER LICENSING

Examiners requested documentation relating to producer licensing. Unless noted, all documents identified in the universe by the Company were requested, received and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with the Producer Licensing Act, 40 P.S. §§ 310.1 et seq.

A. Active Producers

Examiners requested a list of all producers active during the experience period. The Company identified a universe of 62,035 active producers during the experience period. A random sample of 50 producers was selected, and a subsample of 20 producers from the new business underwriting sample, were reviewed. The records were compared to Department records of producers to verify appointments, terminations, and licensing, as well as the Federally-facilitated Marketplace Registration Status List. In accordance with the requirements of the examination, the records were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. § 310.71(f), 31 Pa. Code §§ 152.20 and 301.82, and 45 C.F.R. §155.220, using the guidelines set forth in Chapter 16, Section D, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Account Balances Policies and Procedures

Examiners requested policies and procedures requiring that producer contracts' account balances were in accordance with producer contracts for the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section D, Standard 6 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Description of Agency System

Examiners requested a description of the type of agency system utilized by the Company during the experience period, e.g., independent, direct or exclusive. The Company responded that the type

of agency system utilized for their group sponsored business is an independent agency. The direct to consumer system is used for the Company's Individual business. No violations were noted.

D. Licensing and Appointment Verification

Examiners requested a description of how the Company verified that all business accepted from producers was written by individuals who were duly licensed and appointed to represent the Company during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state laws and regulations using standards set forth in Chapter 16, Section D, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

VII. POLICYHOLDER SERVICES

Examiners requested documentation relating to policyholder services. Specifically, the documents were reviewed to ensure policyholder service guidelines were in place and being followed in a uniform and consistent manner, and that no policyholder service practices or procedures were in place that could be considered discriminatory in nature, or specifically prohibited by statute or regulation. Unless noted, all documents identified in the universe by the Company were requested, received and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with 40 P.S. §§ 477a, 753, 761, 991.2152, and 1171.5; 42 U.S.C. § 300gg-4(a); and 45 C.F.R. §§ 146.121, 147.110, and 155.430.

A. Collection and Billing Practices

Examiners requested policies and procedures used for collection/billing practices describing requirements for issuances of notices with required advance notice. The Company identified a universe of eight documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section E, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Timely Issuance and Insured-Requested Cancellations

Examiners requested documentation describing requirements for timely policy issuance, insured-requested cancellations, and all correspondence directed to the Company during the experience period. The Company identified a universe of seven documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section E, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Department Correspondence

Examiners requested documentation describing the requirements for timely and responsive

answers by appropriate Company departments to all correspondence directed to the Company during the experience period. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section E, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

D. Assumption Reinsurance Agreements

Examiners requested documentation demonstrating that, whenever the Company transferred the obligation of its contracts to another regulated entity pursuant to an assumption reinsurance agreement during the experience period, the Company had sent required notices to affected policyholders. The Company did not identify any pertinent documents and stated “the Company had no such arrangements in place during the examination timeframe. While the Company has no written policy, the PID has created “Guidelines” to be followed in the event of a withdrawal or transition [and] that the Company follows [those Guidelines].” Chapter 16, Section E, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

E. Individual Policy Additions

Examiners requested a list of individual policy addition requests received during the experience period to verify that policy transactions are processed accurately and completely. The Company identified a universe of 209 transactions. A random sample of 25 transaction files was requested. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, including 40 P.S. §§ 477a and 761, 42 U.S.C. § 300gg-4(a), and 45 C.F.R. §§ 146.121 and 147.110, using the guidelines set forth in Chapter 16, Section E, Standard 5 of the *NAIC Market Regulation Handbook*, and. No violations were noted.

F. Individual Drops

The Company was asked to provide a list of all dropped policy transactions during the experience period to verify that policy issuance and insured-requested cancellations were timely. The Company identified a universe of 243 dropped transactions. A random sample of 25 transaction files was requested. In accordance with the requirements of the examination, the files were

reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 477a and 761; 42 U.S.C. § 300gg-4(a)(1), and 45 C.F.R. §§ 146.121 and 147.110, using the guidelines set forth in Chapter 16, Section E, Standard 5 of the *NAIC Market Regulation Handbook*. No violations were noted.

G. Individual ID Changes

Examiners requested a list of all Individual ID Change transactions for the experience period to verify that policy transactions were processed accurately and completely. The Company identified a universe of 4,345 Individual ID Change transactions. A sample of 25 transaction files was requested. In accordance with the requirements of the examination, the files were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 16, Section E, Standard 5 of the *NAIC Market Regulation Handbook*. No violations were noted.

H. Premium Refunds

Examiners requested a list of policies for which premium refunds were issued during the experience period to verify that unearned premiums were correctly calculated and returned to the appropriate party in a timely manner and in accordance with policy provisions and applicable state and federal laws and regulations. The Company identified a universe of 1,494 refund transactions. A random sample of 60 files was requested. In accordance with the requirements of the examination, the files were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. § 753(B)(8), using the guidelines set forth in Chapter 16, Section E, Standard 7 of the *NAIC Market Regulation Handbook*. No violations were noted.

I. Reinstatement Policies and Procedures

Examiners requested documentation demonstrating how the Company monitored and assured that reinstatement was applied consistently and in accordance with policy provisions. The Company identified a universe of 17 documents. The Company subsequently located and provided one additional document specifically for the purpose of explaining reinstatement and how it was applied consistently and in accordance with policy provisions. In accordance with the requirements of the examination, all 18 documents were reviewed to ensure compliance applicable

state laws and regulations, including 40 P.S. § 753(A)(4), using guidelines set forth in Chapter 16, Section E, Standard 5 of the *NAIC Market Regulation Handbook*. No violations were noted.

J. Unearned Premium and Refunds

Examiners requested documentation demonstrating how the Company handled unearned premium calculation and refunds during the experience period. The Company identified a universe of five documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section E, Standard 7 of the *NAIC Market Regulation Handbook*. No violations were noted.

K. Premium and Billing Notices

Examiners requested a sample of premium and billing notices used during the experience period. The Company identified a universe of 19 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 16, Section E, Standard 1 of the *NAIC Market Regulation Handbook*. Examiners noted that the Company's Policyholder Services policies and procedures were easily accessed by Examiners. No violations were noted.

L. Cancellations and Non-Renewals

Examiners requested a list of cancellations and non-renewals for the experience period to verify that policy issuance and insured-requested cancellations were processed timely. The Company identified a universe of 2,684 cancellation and non-renewal transactions. A random sample of 114 files was requested. In accordance with the requirements of the examination, the policies were reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. § 155.430, using guidelines set forth in Chapter 16, Section E, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

M. Reinstatements

Examiners requested a list of reinstatements requested during the experience period. The Company identified a universe of 2,518 reinstatement transactions. A random sample of 70 files was

requested. In accordance with the requirements of the examination, the files were reviewed to ensure compliance with applicable state and federal laws and regulations. No violations were noted.

VIII. UNDERWRITING AND RATING

Examiners requested documentation relating to underwriting and rating. Specifically, the documents were reviewed to ensure underwriting and rating guidelines were in place and being followed in a uniform and consistent manner, and that no underwriting practices or procedures were in place that could be considered discriminatory in nature, or specifically prohibited by statute or regulation. Unless noted, all documents identified in the universe by the Company were requested, received and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with 40 P.S. §§ 3801.301 et seq., as well as 42 U.S.C. § 300gg and 45 C.F.R. § 147.102.

A. Rating Schedules

Examiners requested rating schedules for Affordable Care Act Major Medical Health Individual, Small Group and Large Group plans effective during the experience period. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 16, Section F, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Mandated Disclosures

Examiners requested documentation demonstrating how the Company assured that all mandated disclosures were issued in accordance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using guidelines set forth in Chapter 16, Section F, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Prohibition of Illegal Rebating

Examiners requested documentation demonstrating how the Company assured that it did not permit illegal rebating, commission cutting or inducements during the experience period. The

Company identified a universe of two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 310.45, 310.46, and 471, using the guidelines set forth in Chapter 16, Section F, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

D. Underwriting Practices

Examiners requested documentation demonstrating that the Company's underwriting practices were not unfairly discriminatory and that the Company adhered to state and federal laws and regulations applicable during the experience period. Examiners also reviewed Company guidelines relating to the selection of risks. The Company identified a universe of 43 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. §§ 146.121 and 147.110, using the guidelines set forth in Chapter 16, Section F, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

E. Form Filing

Examiners requested documentation establishing the Company's processes to assure that all forms, including policies, contracts, riders, amendments, endorsement forms and certificates, were filed with the Department for the experience period. The Company provided 105 sample forms of individual, small group, and large group filings. Of the 105 sample forms provided, 12 forms (individual market) were selected and reviewed to ensure compliance with applicable state and federal laws and regulations, including 31 Pa. Code §§ 152.3 and 301.42, using the guidelines set forth in Chapter 16, Section F, Standard 5 of the *NAIC Market Regulation Handbook*. No violations were noted.

F. Issue and Renewal

Examiners requested documentation demonstrating that policies, contracts, riders, amendments and endorsements were issued or renewed accurately, timely and completely during the experience period. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and

federal laws and regulations, including 45 C.F.R. §§ 147.104 and 147.106, using the guidelines set forth in Chapter 16, Section F, Standard 6 of the *NAIC Market Regulation Handbook*. No violations were noted.

G. Policy Rejections and Declinations

Examiners requested documentation demonstrating the Company's rejections and declinations during the experience period were not unfairly discriminatory. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. §§ 146.121 and 147.110, using the guidelines set forth in Chapter 16, Section F, Standard 7 of the *NAIC Market Regulation Handbook*. No violations were noted.

Examiners requested a list of all declinations issued during the experience period. The Company identified a universe of 17 declination transactions. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with 42 U.S.C. § 300gg-4(a)(1), and 45 C.F.R. §§ 146.121 and 147.110. No violations were noted.

H. Cancellation Notices

Examiners requested documentation demonstrating that cancellation/nonrenewal, discontinuance and declination notices complied with policy and contract provisions, Company guidelines, and state and federal laws and regulations applicable during the experience period. The Company identified a universe of two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. § 155.230, using the guidelines set forth in Chapter 16, Section F, Standard 8 of the *NAIC Market Regulation Handbook*. No violations were noted.

I. Rescissions

Examiners requested documentation demonstrating that rescissions were not made for non-material misrepresentation during the experience period. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. § 147.128, using the guidelines set forth in Chapter 16, Section F, Standard 9 of the

NAIC Market Regulation Handbook. No violations were noted.

J. Cancellation Practices

Examiners requested documentation demonstrating that cancellation practices complied with policy provisions, and state and federal laws and regulations applicable during the experience period. The Company identified a universe of two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. § 147.128, using the guidelines set forth in Chapter 20, Section F, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

K. Information on Policy Forms

Examiners requested documentation demonstrating that pertinent information on applications that formed a part of the policy in use during the experience period were complete and accurate. The Company provided one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with state and federal laws and regulations, including 40 P.S. § 753(A), using the guidelines set forth in Chapter 20, Section F, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

L. COBRA and Mini-COBRA

Examiners requested documentation demonstrating that the Company complied with the provisions of COBRA and/or continuation of benefits procedures contained in policy forms and state and federal laws and regulations applicable during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. § 764j, as well as 29 U.S.C. §§ 1161 et seq., using the guidelines set forth in Chapter 20, Section F, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

M. Genetic Information Nondiscrimination Act Compliance

Examiners requested documentation demonstrating that the Company complied with the Genetic

Information Nondiscrimination Act of 2008 and Pennsylvania law. The Company identified a universe of three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 908-11 et seq., as well as 45 C.F.R. §§ 146.121 and 146.122, using the guidelines set forth in Chapter 20, Section F, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

N. Health Information Protection

Examiners requested documentation demonstrating that the Company complied with proper use and protection of health information in accordance with state laws and regulations applicable during the experience period. The Company identified a universe of seven documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 31 Pa. Code Ch. 146b, using the guidelines set forth in Chapter 20, Section F, Standard 5 of the *NAIC Market Regulation Handbook*. No violations were noted.

O. Pre-existing Conditions

Examiners requested documentation demonstrating that the Company complied with state and federal laws and regulations regarding limits on the use of pre-existing exclusions during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. §§ 146.111 and 147.108, using the guidelines set forth in Chapter 20, Section F, Standard 6 and Chapter 20A, Prohibitions on Preexisting Condition Exclusions for Individuals under 19 Years of Age, Standards 1 and 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

P. Coverage Discrimination Based on Health Status

Examiners requested documentation demonstrating that the Company did not improperly deny coverage or discriminate based on health status in the group market or against eligible individuals in the individual market in conflict with the requirements of state and federal laws and regulations applicable during the experience period. The Company identified a universe of one document. In

accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 908-11 et seq., as well as 45 C.F.R. §§ 146.121 and 147.110, using the guidelines set forth in Chapter 20, Section F, Standard 7 of the *NAIC Market Regulation Handbook*. No violations were noted.

Q. Compliance with Guaranteed Issuance

Examiners requested documentation demonstrating that the Company issued coverage that complied with the guaranteed-issue requirements of state and federal laws and regulations applicable during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 1302.1 et seq., as well as 42 U.S.C. § 300gg-1 and 45 C.F.R. § 147.104, using the guidelines set forth in Chapter 20, Section F, Standard 8 and Chapter 20A, Guaranteed Availability of Coverage, Standards 1 and 2, of the *NAIC Market Regulation Handbook*. No violations were noted.

R. Individual Portability

Examiners requested documentation demonstrating that the Company, when issuing individual insurance coverage to eligible individuals, entitled enrollees to portability under the provisions of federal laws and regulations and in compliance with state laws and regulations applicable during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. § 147.104, using the guidelines set forth in Chapter 20, Section F, Standard 9, and Chapter 20A, Guaranteed Availability of Coverage of the *NAIC Market Regulation Handbook*. No violations were noted.

S. Clinical Trials

Examiners requested documentation demonstrating that the Company did not deny or restrict coverage for qualified individuals, as defined in state and federal laws and regulations, who participated in approved clinical trials during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations,

including 42 U.S.C. § 300gg-8, using the guidelines set forth in Chapter 20A, Coverage for Individuals Participating in Approved Clinical Trials, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

T. Dependent Coverage

Examiners requested documentation demonstrating that the Company made available dependent coverage for children until attainment of 26 years of age during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations, including 42 U.S.C. § 300gg-14, and 45 C.F.R. § 147.120, using the guidelines set forth in Chapter 20A, Extension of Dependent Coverage to Age 26, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

U. Group Health Plan Renewability

Examiners requested documentation demonstrating that, during the experience period, the Company renewed or continued in force coverage, at the option of the policyholder, in accord with final regulations established by the United States Department of Labor (DOL), the United States Department of Health and Human Services (HHS), and the United States Department of the Treasury (Treasury). The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. § 147.106, using the guidelines set forth in Chapter 20A, Guaranteed Renewability of Coverage, Standards 1 and 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

V. Lifetime Limits

Examiners requested documentation demonstrating that the Company did not establish lifetime or annual limits on the dollar amount of essential health benefits (EHBs) for any individual, in accordance with the final regulations established by HHS, DOL, and Treasury during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations, including 42 U.S.C. § 300gg-11 and 45 C.F.R. § 147.126,

using the guidelines set forth in Chapter 20A, Lifetime/Annual Benefits Limits, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

W. Cost Sharing Requirements

Examiners requested documentation demonstrating that, during the experience period, the Company did not impose cost-sharing requirements upon preventive services, as defined in, and in accordance with, final regulations established by HHS, DOL, and Treasury. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations, including 42 U.S.C. § 300gg-13 and 45 C.F.R. § 147.130, using the guidelines set forth in Chapter 20A, Preventive Health Services, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

X. Rescissions

Examiners requested documentation demonstrating that the Company did not retrospectively rescind coverage unless the individual (or a person seeking coverage on behalf of the individual) performed an act, practice or omission that constitutes fraud, or made an intentional misrepresentation of material fact during the experience period. The Company identified a universe of three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. § 147.128, using the guidelines set forth in Chapter 20A, Rescissions, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

Y. 30-Day Notice

Examiners requested documentation that showed that, before coverage was rescinded during the experience period, the Company provided at least 30 days' advance written notice to each plan enrollee (or, in the individual market, primary subscriber) who would be affected. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. § 147.128, using the guidelines set forth in Chapter 20A, Rescissions, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

Z. Group New Business Policies

Examiners requested a list of group new business policies issued during the experience period. The Company identified a universe of 1,978 small and large group policies. A random sample of 113 underwriting files was requested. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 908-11 et seq. and 3801.310; 42 U.S.C. §§ 300gg-1, 300gg-3(a) and (d), 300gg-4, 300gg-7, 300gg-26, and 300gg-53; 45 C.F.R. §§ 146.111, 146.121, 146.122, 147.104, 147.108, 147.110, and 147.116. The following violation and concern were noted:

1 Violation – 40 P.S. § 3801.310

Upon request, the Department shall be provided a copy of any form being issued in this Commonwealth. Insurers shall maintain complete and accurate specimen or actual copies of all forms which are issued to Pennsylvania residents, including copies of all applications, certificates and endorsements used with policies. Retention of the forms may be kept on diskette, microfiche or any other electronic method. Specimen copies shall also indicate the date the form was first issued in this Commonwealth. The records shall be maintained until at least two years after a claim can no longer be reported under the form. The Company failed to provide policy issue records including the original rate approval form.

Concern: The Company was unable to provide one of the requested files' group applications. Examiners were unable to review the application for compliance with 40 P.S. §§ 908-11 et seq. and 3801.310; 42 U.S.C. §§ 300gg-1, 300gg-3, 300gg-4, 300gg-7, 300gg-26, and 300gg-53; and 45 C.F.R. §§ 146.121, 147.104, 147.108, 147.110, 146.111, 147.116, and 146.122.

AA. Individual New Business Policies

Examiners requested a list of all individual new business policies issued during the experience period. The Company identified a universe of 63,015 individual new business policies. A random sample of 116 new business underwriting files was requested. Of the 116 new business underwriting files provided, 20 files were not considered new business. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws, including 40 P.S. §§ 908-11 et seq., 3801.310; 31 Pa. Code §§

152.15 and 301.62(c); 42 U.S.C. §§ 300gg-1, 300gg-3, 300gg-4, 300gg-7, 300gg-26, 300gg-53; and 45 C.F.R. §§ 146.111, 146.121, 146.122, 147.104, 147.108, 147.110, and 147.116. No violations were noted.

BB. Terminations

Examiners requested a list of on- and off-exchange terminations during the experience period. The Company identified a universe of 24,701 terminations. A random sample of 10 on-exchange and 10 off-exchange termination transactions were requested. Of the 20 sample files selected for review, two files were not terminations. In accordance with the requirements of the examination, the files were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. § 753(B)(8); and 45 C.F.R. § 156.270. No violations were noted.

CC. Formulary

Examiners requested all commercial formularies utilized during the experience period. The Company identified 14 formularies applicable to the experience period: six formulary designs during the 2015 benefit period and eight formulary designs during the 2016 benefit period. In accordance with the requirements of the examination, all 14 formularies were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 477a, 761, and 1171.5; 42 U.S.C. §§ 300gg-4(a) and 18022; and 45 C.F.R §§ 147.104, 147.150 and 156.125. The following violations and concern were noted:

2 Violations – 40 P.S. §§ 477a, 761, & 1171.5(a)(7)(ii); 42 U.S.C. §300gg-4(a); and 45 C.F.R. §§ 147.104(e) & 156.125

An issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. While the Department did not see evidence of discriminatory intent, it did appear that the formulary benefit package the Company designed nevertheless resulted in discrimination against certain individuals based on health status, medical/health condition, and degree of medical dependency. The potentially discriminatory benefit design may have also discouraged certain individuals from participation in the plan.

Concern: Examiners have concerns regarding the practices of (1) failing to place widely used and preferred drug agents intended for treatment on Tier 1 and 2; and (2) placing an excessive amount of drug agents that are clinically appropriate and considered preferred treatment on Tier 3 or Tier 4 Non-Preferred and Specialty Tiers, and (3) implementing stringent step therapy and reauthorization requirements. The specific therapeutic drug categories affected were Antipsychotics/Antimanic, Analgesics-Opioid, Antianxiety Agents, Anticonvulsants, Antidepressants, ADHD/Anti-Narcolepsy/Anti-Obesity/Anorexiant, Antidotes and Hypnotics. The Department is continuing to review this issue through other initiatives and more guidance will be forthcoming.

IX. CLAIMS PROCEDURES

Examiners requested documentation relating to claims procedures. Unless noted, all documents identified in the universe by the Company were requested, received and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documentation in this section was reviewed to ensure compliance with the Unfair Insurance Practices Act (40 P.S. § 1171.5), 31 Pa. Code Ch. 146.

A. Claimant Contact

Examiners requested documentation demonstrating that the initial contact with the claimant occurred within the required timeframe applicable during the experience period. The Company identified a universe of two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. § 155.230, using the guidelines set forth in Chapter 16, Section G, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Timely Investigations

Examiners requested documentation demonstrating that investigations were conducted timely during the experience period. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. §§ 147.136 and 156.1010, using the guidelines set forth in Chapter 16, Section G, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Timely Claims Resolution

Examiners requested documentation demonstrating that claims were resolved in a timely manner during the experience period. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. §§ 147.136 and 156.1010, using the guidelines set forth in Chapter 16, Section G, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

D. Claims Handling

Examiners requested a brief description of how claims were handled during the experience period from the date received through closure, including timeliness requirements. Further, examiners requested documentation demonstrating that claims were handled in accordance with policy provisions, and state and federal laws and regulations applicable during the experience period. The Company identified a universe of five documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations using guidelines set forth in Chapter 16, Section G, Standard 6 and Chapter 20, Section G, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

E. Claims Forms

Examiners requested documentation demonstrating that the Company's claims forms were appropriate for the type of product for which they were used during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section G, Standard 7 of the *NAIC Market Regulation Handbook*. No violations were noted.

F. Claim Reserves

Examiners requested documentation demonstrating files were reserved in accordance with the Company's established procedures during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section G, Standard 8 of the *NAIC Market Regulation Handbook*. No violations were noted.

G. Denied and Closed-without-Payment Claims

Examiners requested documentation demonstrating how denied and closed-without-payment claims were handled during the experience period in accordance with policy provisions and state and federal laws and regulations. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure

compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 16, Section G, Standard 8 of the *NAIC Market Regulation Handbook*. No violations were noted.

H. Cancelled Benefit Checks

Examiners requested documentation demonstrating that cancelled benefit checks and drafts from the experience period reflected appropriate claims handling practices. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state laws and regulations, using the guidelines set forth in Chapter 16, Section G, Standard 10 of the *NAIC Market Regulation Handbook*. No violations were noted.

I. Claims Closing Practices

Examiners requested documentation demonstrating that claims handling practices did not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than was due under the policy during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section G, Standard 11 of the *NAIC Market Regulation Handbook*. No violations were noted.

J. Claims Handling Practices

Examiners requested documentation demonstrating that claim files were handled in accordance with policy provisions, and state and federal laws and regulations applicable during the experience period. The Company identified a universe of six documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section G, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

K. Newborns' and Mother's Health Protection Act

Examiners requested documentation demonstrating that the Company complied with the

requirement of the federal Newborns' and Mothers' Health Protection Act of 1996 and the Pennsylvania Health Security Act. The Company identified a universe of five documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 1581 through 1584, as well as 42 U.S.C. § 300gg-25, using the guidelines set forth in Chapter 20, Section G, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

L. Compliance with Mental Health Parity and Addiction Equity Act

Examiners requested documentation demonstrating that the Company complied with the requirements of the federal Mental Health Parity and Addiction Equity Act of 2008 and the Pennsylvania Health Insurance Coverage Parity and Nondiscrimination Act. **The Company identified a universe of two documents.** In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 908-11 et seq., 42 U.S.C. § 300gg-26, and 45 C.F.R § 146.136, using standards set forth in Chapter 20, Section G, Standard 3 of the *NAIC Market Regulation Handbook*. **Violations relating to compliance with mental health parity provisions were noted; however, those violations and concerns relating to the processing and payment of mental health and substance use disorder claims have been addressed in other sections of this report.**

M. Women's Health and Cancer Rights Act of 1998

Examiners requested documentation demonstrating that group health plans complied with the requirements of the federal Women's Health and Cancer Rights Act of 1998 and corresponding state law during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 764d and 1571.5 and 42 U.S.C. §300gg-27, using the guidelines set forth in Chapter 20, Section G, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

N. Group Coverage Replacements

Examiners requested documentation demonstrating that the Company complied with state laws and regulations for group coverage replacement applicable during the experience period. The

Company identified a universe of 10 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code § 89.93, using the guidelines set forth in Chapter 20, Section G, Standard 5 of the *NAIC Market Regulation Handbook*. No violations were noted.

X. COMPLAINTS AND GRIEVANCES

Examiners requested documentation relating to complaints and grievances filed during the experience period. Unless noted, all documents identified in the universe by the Company were requested, received and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with 40 P.S. §§ 1171.5 and 991.2101 et seq., and 31 Pa. Code § 154.13, as well as 42 U.S.C. § 300gg-19 and 45 C.F.R. § 147.136, incorporating 29 C.F.R. § 2560.503-1.

A. Grievances

Examiners requested documentation demonstrating that the Company treated as a grievance any written complaint, or any oral complaint that involved an urgent care request, submitted by or on behalf of a covered person regarding: 1) the availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; 2) claims payment, handling or reimbursement for health care services; or 3) matters pertaining to the contractual relationship between a covered person and the health carrier during the experience period. The Company identified a universe of three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using guidelines set forth in Chapter 20, Section H, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Complaint and Grievance Procedures

Examiners requested documentation demonstrating that the Company documented, maintained, and reported complaints and grievances, and established and maintained complaint and grievance procedures in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of five documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using guidelines set forth in Chapter 20, Section H, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Grievance Procedure Disclosure

Examiners requested documentation demonstrating how the Company implemented complaint and grievance procedures and how these procedures were disclosed to covered persons in compliance with state and federal laws and regulations applicable during the experience period. Examiners requested copies of files showing the Company's complaint and grievance procedures, including all forms used to process grievances during the experience period, that were filed with the Department. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws using the guidelines set forth in Chapter 20, Section H, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

D. First-Level Reviews of Grievances Involving Adverse Benefit Determinations

Examiners requested documentation demonstrating that the Company had procedures for and conducted first-level reviews of grievances involving adverse determinations in compliance with state and federal rules and regulations applicable during the experience period. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section H, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

E. Grievance Reviews Not Involving Adverse Determination

Examiners requested documentation demonstrating the Company had procedures for and conducted standard reviews of grievances not involving adverse determinations in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section H, Standard 5 of the *NAIC Market Regulation Handbook*. No violations were noted.

F. Second-Level Reviews of Complaints and Grievances

Examiners requested documentation demonstrating the Company had procedures for second-level

reviews of complaints and grievances, and that the Company conducted voluntary reviews of complaints and grievances in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws using the guidelines set forth in Chapter 20, Section H, Standard 6 of the *NAIC Market Regulation Handbook*. No violations were noted.

G. Expedited Review of Grievances

Examiners requested documentation demonstrating the Company had procedures for and conducted expedited reviews of grievances involving adverse determinations in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws using guidelines set forth in Chapter 20, Section H, Standard 7 and Chapter 20A, Grievance Procedures Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

H. Complaint and Grievance Procedures Comply with Federal Law

Examiners requested documentation demonstrating that the Company's complaint and grievance procedures were properly handled in accordance with policy provisions and federal laws and regulations applicable during the experience period. The Company identified a universe of three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable federal laws and regulations. No violations were noted.

Examiners also requested documentation demonstrating that the Company's grievance procedures were properly handled in accordance with federal laws and regulations requiring a health carrier to conduct first-level reviews of grievances involving adverse determinations in accordance with the final regulations promulgated under the Affordable Care Act (ACA) by HHS, DOL and Treasury. The Company identified a universe of three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable federal laws and regulations using the guidelines set forth in Chapter 20A, Grievance Procedures, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

I. Expedited Reviews of Urgent Care Requests

Examiners requested documentation demonstrating that grievance procedures were properly handled in accordance with federal laws and regulations requiring a health carrier to conduct expedited reviews of urgent care requests for grievances involving adverse determinations and in compliance with the final regulations promulgated under the ACA by HHS, DOL, and Treasury. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws using guidelines set forth in Chapter 20, Section H, Standard 7 and Chapter 20A, Grievance Procedures Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

J. Appeals

Examiners requested all appeals received during the experience period. The Company identified a universe of 114 appeals received during the experience period. In accordance with the requirements of the examination, the appeals files were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in, Chapter 20A, Grievance Procedures Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

XI. NETWORK ADEQUACY

Examiners requested documentation relating to network adequacy. Unless noted, all documents identified in the universe by the Company were requested, received and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with 40 P.S. § 991.2111, 31 Pa. Code §§ 152.1 et seq. and 301.42, and 45 C.F.R. § 156.230.

A. Access Plan Filed

Examiners requested documentation demonstrating that the Company filed an access plan for each managed care plan that the Company offered in the state and filed updates whenever it made a material change to an existing managed care plan during the experience period. The Company must make the access plans available: 1) on its business premises; 2) to regulators; and 3) to interested parties, absent proprietary information, upon request. The Company identified a universe of documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section I, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Contract Forms Filed

Examiners requested documentation demonstrating that the Company filed all required contract forms and any material changes to a contract proposed for use with its participating providers and intermediaries during the experience period. The Company identified a universe of two documents. In accordance with the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 20, Section I, Standards 3, 5, 6, and 7 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Access to Emergency Services

Examiners requested documentation demonstrating that, during the experience period, the Company ensured covered persons had access to emergency services 24 hours per day, seven

days per week within its network and provided coverage for emergency services outside of its network, pursuant to state and federal laws and regulations applicable during the experience period. The Company identified a universe of six documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 31 Pa. Code § 152.15 and 301.62(c), and 45 C.F.R. § 147.138, using the guidelines set forth in Chapter 20, Section I, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

D. Accrediting Certification

Examiners requested a copy of the Company's HHS-recognized accrediting entity certification. The Company provided a National Committee for Quality Assurance certificate of accreditation. In accordance with the requirements of the examination, the certificate was reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. § 156.275. No violations were noted.

E. Provider Directory

Examiners requested documentation demonstrating that the Company provided at enrollment a provider directory that listed all providers who participated in its network during the experience period and that it provided updates to its directory during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section I, Standard 8 of the *NAIC Market Regulation Handbook*. No violations were noted.

XII. PROVIDER CREDENTIALING

Examiners requested documentation relating to provider credentialing. Unless noted, all documents identified in the universe by the Company were requested, received and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with 40 P.S. § 991.2121, 28 Pa. Code § 9.761, and 45 C.F.R. § 156.275.

A. Credentialing and Re-credentialing Program

Examiners requested documentation demonstrating that the Company established and maintained a program for credentialing and re-credentialing in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section J, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Accrediting Verification

Examiners requested documentation demonstrating that the Company verified the credentials of health care professionals before entering into a contract with the health care professionals during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section J, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Primary Verification

Examiners requested documentation demonstrating that the Company obtained primary or secondary verification of the information required by state laws and regulations applicable during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with

applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section J, Standards 3 and 5 of the *NAIC Market Regulation Handbook*. No violations were noted.

D. Provider Notification of Changes in Status

Examiners requested documentation demonstrating that the Company required all participating providers to notify the Company's designated individual of any changes in the status of information that is required to be verified by the Company for the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 991.2117 and 1171.5; 31 Pa. Code §§ 154.15, 152.6 and 301.42, using the guidelines set forth in Chapter 20, Section J, Standard 6 of the *NAIC Market Regulation Handbook*. No violations were noted.

E. Provider Opportunity to Review

Examiners requested documentation demonstrating that the Company provided to health care professionals the opportunity to review and correct information submitted in support of their credentialing verification for the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section J, Standard 7 of the *NAIC Market Regulation Handbook*. No violations were noted.

F. Contractor Credentialing Monitoring

Examiners requested documentation demonstrating that the Company monitored the activities of any entity with which it contracted to perform credentialing functions and ensured the requirements of state laws and regulations applicable during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section J, Standard 8 of the *NAIC Market Regulation Handbook*. No violations were noted.

XIII. QUALITY ASSESSMENT AND IMPROVEMENT

Examiners requested documentation relating to quality assessment and improvement. Unless noted, all documents identified in the universe by the Company were requested, received and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with 42 U.S.C. § 18031 and 45 C.F.R. §§ 155.200(d) and 156.1105 et seq.

A. Quality Assessment

Examiners requested documentation demonstrating that the Company developed and maintained a quality assessment program in compliance with state and federal rules and regulations applicable during the experience period. The Company identified a universe of two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable federal laws and regulations using the guidelines set forth in Chapter 20, Section K, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Quality Assessment Filing

Examiners requested documentation demonstrating that the Company filed a written description of the quality assessment program in the prescribed format, which included a signed certification by a corporate officer of the Company that the filing met federal requirements applicable during the experience period. The Company identified a universe of two documents.

The Company also verified the following: for HAPA/HAPSA, regulatory reviews were performed in the Northeast Region. State regulatory reviews were performed in March 2015, PA Coventry Annual Status Report (included HealthAmerica, HealthAssurance and Coventry Cares); in April 2015, Pennsylvania HMO Annual QM Policy Listing Filing; and on a monthly basis, Pennsylvania QM Credentialing Policy Filings. In addition, UR license/accreditation filings and/or reports were submitted for the following states: Pennsylvania and West Virginia. The Company submitted a copy of the Annual Quality Assurance Report documenting it was reviewed and signed by the Chief Medical Officer along with members of the Board of Directors who are ultimately

responsible for its validity. 2015 QM Work Plan includes Commercial (including Exchanges), Medicare (including Special Needs Plans [SNPs]) and Medicaid Business. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable federal laws and regulations using the guidelines set forth in Chapter 20, Section K, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Quality Improvement Program

Examiners requested documentation demonstrating that the Company developed and maintained a quality improvement program in compliance with state and federal laws and regulations applicable during the experience period.

The Company's quality management improvement manual, titled *HAPA-HASPA Quality Management Program*, states, "The organization utilizes continuous quality improvement (CQI) techniques and tools to improve the quality and safety of clinical care and service delivered to members. This includes systematic and periodic follow-up on the effect of interventions which allows for correction of problems identified through internal surveillance, analysis of complaints or other mechanisms. Quality improvement is implemented through a cross functional team approach, as evidenced by multidisciplinary committees. Quality reports are used to monitor, communicate and compare key indicators. The QM Program is designed to comply with all applicable state laws and regulations and with Centers for Medicare & Medicaid Services (CMS) requirements. The QM department, in collaboration with the Medicare Compliance department and the Business Integrity Unit, monitors CMS/ Federal laws and regulations specific to quality. QM and business units are accountable for implementation of actions needed to assure compliance." The Company identified a universe of two documents. In accordance with the requirements of the examination, the documentation provided was reviewed to ensure compliance with applicable federal laws and regulations using the guidelines set forth in Chapter 20, Section K, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

D. Reports to Appropriate Licensing Authority

Examiners requested documentation demonstrating that the Company reported to the appropriate licensing authority any persistent pattern of problematic care provided by a provider that was sufficient to cause the Company to terminate or suspend contractual arrangements with the

provider during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable federal laws and regulations using the guidelines set forth in Chapter 20, Section K, Standard 4 of *the NAIC Market Regulation Handbook*. No violations were noted.

E. Quality Assessment Program Communication

Examiners requested documentation that the Company documented and communicated information about its quality assessment improvement program and its quality improvement program to covered persons and providers. The Company identified a universe of two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable federal laws and regulations using the guidelines set forth in Chapter 20, Section K, Standard 5 of the *NAIC Market Regulation Handbook*. No violations were noted.

F. Annual Certification of Program

Examiners requested documentation demonstrating that the Company annually certified that its quality assessment and quality improvement program, along with the materials provided to providers and consumers, met federal requirements applicable during the experience period. The Company identified a universe of 19 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable federal laws and regulations using the guidelines set forth in Chapter 20, Section K, Standard 6 of the *NAIC Market Regulation Handbook*. No violations were noted.

G. Quality Assessment and Improvement Entity Monitoring

Examiners requested documentation demonstrating that the Company monitored the activities of the entity with which it contracted to perform quality assessment or quality improvement functions and ensured they met federal requirements applicable during the experience period were met. The Company identified a universe of two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable federal laws and regulations using the guidelines set forth in Chapter 20, Section K, Standard 7 of the *NAIC Market Regulation Handbook*. No violations were noted.

XIV. UTILIZATION REVIEW

Examiners requested documentation relating to utilization review. Unless noted, all documents identified in the universe by the Company were requested, received and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with 40 P.S. §§ 991.2136, 991.2151, and 991.2152, as well as federal standards found at 45 C.F.R. § 156.275.

A. Utilization Review Program

Examiners requested documentation demonstrating that the Company established and maintained a utilization review program in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section L, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Annual Report

Examiners requested documentation demonstrating that the Company filed an annual summary report of its utilization review activities and maintained records of all benefit requests, claims and notices associated with utilization review and benefit determinations in accordance with state and federal laws and regulations applicable during the experience period. The Company provided four documents. The documents were reviewed to ensure compliance with applicable state and federal laws and regulations. No violations were noted.

C. Utilization Review Program Operation

Examiners requested documentation demonstrating the Company operated its utilization review program in accordance with state and federal laws and regulations applicable during the experience period. The Company provided four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with the applicable state and

federal laws and regulations, including 40 P.S. § 991.2152 and 45 C.F.R. § 147.136, using the guidelines set forth in Chapter 20, Section L, Standard 2 of the *NAIC Market Regulations Handbook*. No violations were noted.

D. Utilization Review Disclosure

Examiners requested documentation demonstrating the Company disclosed information about its utilization review and benefit determination procedures to covered persons or, if applicable, to the covered person's authorized representative, in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section L, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

E. Timely Standard Utilization Review

Examiners requested documentation demonstrating that the Company made standard utilization review and benefit determinations in a timely manner and as required by state and federal laws and regulations applicable during the experience period. The Company identified a universe of two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section L, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

F. Adverse Determination of Utilization Review

Examiners requested documentation demonstrating the Company provided written notice of adverse determinations of standard utilization review and benefit determinations in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section L, Standard 5 of the *NAIC Market Regulation Handbook*. No violations were noted.

G. Expedited Utilization Review and Benefit Determinations

Examiners requested documentation demonstrating that the Company conducted expedited utilization review and benefit determinations in a timely manner and in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section L, Standard 6 of the *NAIC Market Regulation Handbook*. No violations were noted.

H. Emergency Services Utilization Reviews

Examiners requested documentation demonstrating the Company conducted utilization reviews or made benefit determinations for emergency services in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of two documents. The documents were reviewed for compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20A, Utilization Review, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

I. Monitoring Utilization Review Entity

Examiners requested documentation demonstrating that the Company monitored the activities of the utilization review organization or entity with which the Company contracted and ensured that the contracting organization complied with state and federal laws and regulations applicable during the experience period. The Company identified a universe of six documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section L, Standard 7 of the *NAIC Market Regulation Handbook*. No violations were noted.

XV. MARKETING AND SALES

Examiners requested documentation relating to marketing and sales. Unless noted, all documents identified in the universe by the Company were requested, received and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with 40 P.S. § 1171.5 and 31 Pa. Code §§ 51.4 and 51.5.

A. Advertising and Sales Materials

Examiners requested copies of the 2015 and 2016 Annual Statement Advertising Certificate of Compliance for each company being examined. Additionally, Examiners requested a list of all marketing and sales materials for the Company. The Company identified a universe of 578 pieces of marketing and sales material. A random sample of 50 pieces of marketing and sales material was requested. For each of the 50 sample files, a copy of the advertising file annotations and control sheets denoting the manner and extent of distribution was requested along with the form number of the contract advertised. The Company also provided three documents in response to the request for the 2015 and 2016 Annual Statement Advertising Certificate of Compliance for each company being examined. In accordance with the requirements of the examination, the sample files were reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section C, Standard 1 of the *NAIC Market Regulation Handbook*. The following violations were noted:

5 Violations – 31 Pa. Code § 51.5

A company required to file an annual statement which is now or which hereafter becomes subject to this chapter shall file with the Department with its Annual Statement a Certificate of Compliance executed by an authorized officer of the company wherein it is stated that to the best of his knowledge, information and belief the advertisements which were disseminated by the company during the preceding statement year complied or were made to comply in all respects with the provisions of the insurance laws and regulations of this Commonwealth. The Company failed to provide proof that the 2015 Annual Statement Advertising Certificate of Compliance was filed on behalf of Aetna Health Inc., Health America, Inc., Aetna Health Insurance Company and Health

Assurance PA, Inc. Additionally, the Company failed to provide proof that the 2016 Annual Statement Advertising Certificate of Compliance was filed on behalf of Health America, Inc.

1 Violation – 31 Pa. Code § 51.4

A company shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its individual contracts and typical printed, published or prepared advertisements of its blanket, franchise and group contracts hereafter disseminated in this or another state whether or not licensed in the other state. An advertisement included in this advertising file shall be annotated as to the manner and extent of distribution and the form number of the contract advertised. The Company failed to maintain the appropriate file documentation.

XVI. MEDICAL AND PHARMACY CLAIMS REVIEW

Examiners requested a list of all medical and pharmacy claims paid, denied, and partially paid during the experience period. The Company identified a universe of 9,326,788 medical and pharmacy claims. For each of the sections listed below, a random sample was requested, received and reviewed.

A. Serious Mental Health Claims

B. Habilitative Services Claims

C. Midwifery Services Claims

D. Pediatric Vision Claims

E. Pediatric Dental Claims

F. Mammography Claims

G. Pharmacy Claims

H. General Medical Claims

I. Dental Anesthesia Claims

J. Medical Food Claims

K. Autism Spectrum Disorder Claims

L. Emergency Room Claims

M. Ambulance Transport Claims

N. Substance Use Disorder and Chemical Recovery Claims

O. Mental Health Claims

P. Behavioral Health Claims

Q. HIV/AIDS Claims

R. Inpatient and Outpatient High Dosage Opioid Addiction Treatment Claims

In accordance with the requirements of the examination, all claims files were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 991.2166 and 1171.5; 31 Pa. Code §§ 146.3, 146.4, 146.5, 146.6, 146.7, and 154.18; 18 Pa. C.S. § 4117; 42 U.S.C. § 300gg-6, 300gg-13, and 18022; and 45 C.F.R. §§ 147.130, 147.150, and 156.110. Claims files were also reviewed to ensure compliance with topic-specific laws and regulations. To the extent unfair trade practice violations were identified across multiple types of claims, the Department determined that there was evidence of such frequency as to constitute a business practice.

A. Serious Mental Health Claims

Examiners requested a list of all serious mental health claims (as defined in 40 P.S. § 764g(a)(1)) received during the experience period. The Company identified a universe of 299,616 serious mental health claims. A random sample of 100 claim files was requested. In accordance with the requirements of the examination, the claims files were reviewed to ensure compliance with 40 P.S. §§ 477a, 761, 764g, and 1171.5; 31 Pa. Code Ch. 146 and 154; 45 CFR §§ 146.136 and 156.110. No violations were noted.

B. Habilitative Services Claims

Examiners requested a list of all habilitative service claims received during the experience period. The Company identified a universe of 155,902 habilitative service claims. A random sample of 150 claim files was requested. In accordance with the requirements of the examination, the claim files were reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. § 147.150. No violations were noted.

C. Midwifery Services Claims

Examiners requested a list of all midwifery service claims received during the experience period. The Company identified a universe of 2,596 midwifery service claims. A random sample of 50 claim files was requested. In accordance with the requirements of the examination, the claim files were reviewed to ensure compliance with applicable state and federal laws and regulations. The following violations were noted:

4 Violations – 40 P.S. § 991.2166(a) and 31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim under subsection (d) submitted by a health care provider for services, within 45 days of the licensed insurer's or managed care plan's receipt of the claim from the health care provider. The four claims noted were not paid within 45 days of the licensed insurer's or managed care plan's receipt of the claim.

1 Violation – 40 P.S. § 991.2166(b) and 31 Pa. Code § 154.18(c)

If a licensed insurer or a managed care plan fails to remit payment as provided under subsection (a), interest at 10% per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer or managed care plan shall not be required to pay any interest calculated to be less than \$2. The interest due of \$2 or more on the one claim was not paid.

4 Violations – 40 P.S. § 1171.5(a)(10)(vi)

“Unfair methods of competition” and “unfair or deceptive acts or practices” in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear. The Company improperly denied the claims noted when the Company's liability under the policy was reasonably clear. The Company later paid the overdue claims.

4 Violations – 31 Pa. Code § 154.18(d)

Claims paid by a licensed insurer or managed care plan are considered clean claims and are subject to the interest provisions of the act. If a paid claim is re-adjudicated by the licensed insurer or managed care plan, a new 45-day period for the prompt payment provision begins again at the time additional information prompting the re-adjudication is provided to the plan.

Additional moneys which are owed or paid to the health care provider are subject to the prompt payment provisions of the act and this chapter. The prompt payment requirement of the act also

applies to the uncontested portion of a contested claim. A contested claim is a claim for which required substantiating documentation for the entire claim has been supplied to the licensed insurer or managed care plan, but the licensed insurer or managed care plan has determined that it is not obligated to make payment. Uncontested claims were adjudicated then reprocessed after initial adjudication due to Company error. The delay in payment is subject to prompt pay requirements of state law and regulation.

D. Pediatric Vision Claims

Examiners requested a list of all pediatric vision claims paid and denied during the experience period. In accordance with the requirements of the examination, the claim files were reviewed to ensure compliance with applicable state and federal laws and regulations.

The Company identified a universe of 8,065 paid claims and 137 denied claims. A random sample of 50 paid claims and all denied claims were requested. The Company determined there were no reviewable denied pediatric vision claims available from the experience period. The paid claim files were reviewed, and no violations were noted.

E. Pediatric Dental Claims

Examiners requested a list of all pediatric dental claims received during the experience period. The Company identified a universe of 5,230 claims. A random sample of 50 claims was requested. In accordance with the requirements of the examination, the claim files were reviewed to ensure compliance with applicable state and federal laws and regulations. No violations were noted.

F. Mammography Claims

Examiners requested a list of all mammography claims received during the experience period. The Company identified a universe of 3,957 mammography claims. A random sample of 150 claims was requested. The claim files were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. § 764c. No violations were noted.

G. Pharmacy Claims

Examiners requested a list of all pharmacy claims received during the experience period. The Company identified a universe of 1,915,203 paid claims and a universe of 867,127 denied claims.

A random sample of 50 paid claims and 50 denied claims was requested. In accordance with the requirements of the examination, the claim files were reviewed to ensure compliance with applicable state and federal laws and regulations. No violations were noted.

H. General Medical Claims

Examiners requested a list of all medical claims received during the experience period. The Company identified a universe of 1,003,930 paid medical claims, a universe of 1,818,296 denied medical claims, and a universe of 1,016,766 partially paid medical claims. A random sample of 150 paid claims was requested in each section. In accordance with the requirements of the examination, the claim files were reviewed to ensure compliance with applicable state and federal laws and regulations. The examiners found the following violations:

3 Violations – 40 P.S. § 1171.5(a)(10)(vi)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. **Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear.** For two of the violations noted, the Company improperly denied a portion of the claim when the liability under the policy should have been reasonably clear based on its agreement with the provider. For one of the violations noted, the Company incorrectly applied the coverage to the out-of-network benefit, when it should have been processed as in-network. In two cases, the Company was not prompt in their payment even though the liability under the policy should have been reasonably clear on the original claim submission date and based on its agreement with the provider. In a third case, the Company improperly applied the coverage to an out-of-network benefit, when it should have been processed as in-network, resulting in the Company not promptly paying the claim.

1 Violation – 40 P.S. § 991.2166(a) and 31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim under subsection (d) submitted by a health care provider for services, within 45 days of the licensed insurer's or managed care plan's receipt of the claim from the health care

provider. The one claim noted was not paid within 45 days of the licensed insurer's or managed care plan's receipt of the claim.

1 Violation – 40 P.S. § 991.2166(b) and 31 Pa. Code § 154.18(c)

If a licensed insurer or a managed care plan fails to remit payment as provided under subsection (a), interest at 10% per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer or managed care plan shall not be required to pay any interest calculated to be less than \$2. The interest due of \$2 or more on the one claim was not paid.

1 Violation – 31 Pa. Code § 146.5(a)

Failure to acknowledge pertinent communications. Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice. The Company failed to acknowledge the claim submitted by the claimant within 10 working days.

I. Dental Anesthesia Claims

Examiners requested a list of all dental anesthesia claims received during the experience period. The Company identified a universe of 429 paid claims, a universe of 527 denied claims, and a universe of 168 partially-paid claims. A random sample of 10 claim files was requested for each section. In accordance with the requirements of the examination, the claim files were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. § 3510.3. No violations were noted.

J. Medical Food Claims

Examiners requested a list of all medical food claims received during the experience period. The Company identified a universe of 2,414 paid claims, a universe of 1,027 denied claims, and a universe of 258 partially paid claims. A random sample of 10 claim files was requested for each

section. In accordance with the requirements of the examination, the claim files were reviewed to ensure compliance with 40 P.S. §§ 991.2166 and 1171.5, 31 Pa. Code §§ 146.7, 154.18, 42 U.S.C. § 18022, and 45 C.F.R. § 146, 147 and 156. The following violations and concern were noted:

1 Violation – 40 P.S. § 991.2166(a) and 31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim under subsection (d) submitted by a health care provider for services, within 45 days of the licensed insurer's or managed care plan's receipt of the claim from the health care provider. The claim noted was not paid within 45 days of the licensed insurer's or managed care plan's receipt of the claim.

1 Violation – 31 Pa. Code § 146.7(c)(1)

The following provisions govern acceptance or denial of a claim where additional time is needed to make a determination: If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the proof of loss giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the date of the initial notification and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation and state when a decision on the claim may be expected. The Company failed to send a written explanation within 15 working days after receipt giving the reason more time was needed.

Concern: The Company failed to fully disclose to the member within the Certificate of Coverage and/or Schedule of Benefits that coverage was available under the policy for infants and children for Amino acid-based elemental medical formula ordered by a physician as medically necessary and administered orally or enterally for food protein allergies, food protein-induced enterocolitis syndrome, eosinophilic disorders and short-bowel syndrome as mandated by 40 P.S. § 3904(b). Additionally, the Certificate of Coverage Limitations and Exclusions may have caused confusion for members relating to the coverage available for Amino acid-based elemental medical formula.

K. Autism Spectrum Disorder Claims

Examiners requested a list of all autism claims received during the experience period. The Company identified a universe of 39,861 paid claims, a universe of 3,358 denied claims, and 1,203

partially paid claims. A random sample of 10 claims was requested for each section. In accordance with the requirements of the examination, the files were reviewed to ensure compliance with 40 P.S. §§ 477a, 761, 764h, 908-11 et seq., and 1171.5; and 45 C.F.R § 146.136. The examiners found the following violations and concerns:

8 Violations – 40 P.S. §§ 477a, 761, and 1171.5(a)(7)(ii)

Unfair discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of life, health and accident insurance, covered by this act, or in the benefits payable thereon, or in any of the terms or conditions of such policy, or in any other manner whatsoever, is prohibited. Discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of insurance covered by this act, or in the benefits payable thereon, or in any of the terms or conditions of such policy, or in any other manner whatsoever, is prohibited. Unfairly discriminating by means of: Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy, fees or rates charged for any policy or contract of insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever. According to policy documents, the Company excludes coverage of Autism Spectrum Disorders unless the “child is diagnosed with Autism Spectrum Disorder with onset prior to age three.” Members with a diagnosis of Asperger’s Disorder, Childhood Disintegrative Disorder or Pervasive Developmental Disorder, Not Otherwise Specified are unfairly discriminated against and may not have coverage under the plan based on the noted policy provision and exclusion because they could have onset after age three. While the Department did not see evidence of discriminatory intent, the benefit design for the plans noted appeared to be discriminatory toward those insureds who may have relied on this policy language, especially when applied to services that have been found clinically effective for members with onset of the condition beyond the age of three. To the extent the Company demonstrated that, despite the noted policy language, the Company did not impose this limitation when adjudicating claims, the Department recognizes that this discrimination was unintentional.

2 Violations – 40 P.S. § 764h(a) and (b)

A health insurance policy or government program covered under this section shall provide to

covered individuals or recipients under 21 years of age coverage for the diagnostic assessment of autism spectrum disorders and for the treatment of autism spectrum disorders. Coverage provided under this section by an insurer shall be subject to a maximum benefit of \$36,000 per year (as adjusted) but shall not be subject to any limits on the number of visits to an autism service provider for treatment of autism spectrum disorders. The Company failed to provide coverage without limits for the assessment and treatment of Autism Spectrum Disorders.

8 Violations – 40 P.S. § 764h(a) and (f)(3)

A health insurance policy or government program covered under this section shall provide to covered individuals or recipients under 21 years of age coverage for the diagnostic assessment of autism spectrum disorders and for the treatment of autism spectrum disorders. As used in this section: “Autism spectrum disorders” means any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or its successor, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified. According to policy documents, the Company excludes coverage of Autism Spectrum Disorders unless the “child is diagnosed with Autism Spectrum Disorder with onset prior to age three.” Members with a diagnosis of Asperger’s Disorder, Childhood Disintegrative Disorder or Pervasive Developmental Disorder, Not Otherwise Specified may not have coverage under the plan based on the noted policy provision and exclusion because they could have onset after age three. While the language noted may have caused confusion for some enrollees, it appears that the Company did not impose this limitation when adjudicating claims, i.e., no claims were denied due to this age restriction.

1 Violation – 40 P.S. §§ 908-11 et seq. and 45 C.F.R. § 146.136(c)(2)(i)

Licensed insurers are required to provide mental health and substance use disorder benefits in parity with medical/surgical benefits. For quantitative treatment limitations, this means that a licensed insurer may not apply any quantitative treatment limitation (QTL) to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. Examiners requested the Company to provide proof of compliance for each plan type affected, each classification of benefits and for each type

of QTL separately. The Company imposed a QTL with respect to mental health benefits not in parity with medical/surgical benefits. It was noted that the Company did not demonstrate compliance with the substantially all or predominant level tests within the specified classifications of benefits; however, this appears to have been due to the Company's mis-classification of the benefit as a medical benefit, for which no parity test would have been required.

13 Violations – 40 P.S. §§ 908-11 et seq. and 45 C.F.R. § 146.136(c)(4)

Licensed insurers are required to provide mental health and substance use disorder benefits in parity with medical/surgical benefits. For nonquantitative treatment limitations (NQTL), this means that a licensed insurer may not apply any NQTL in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying that limitation to MH/SUD benefits within that classification are “comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the classification.” The Company imposed a nonquantitative treatment limitation with respect to mental health benefits not in parity with medical/surgical benefits. The Company is limiting the scope and duration of treatment for the noted claims in a manner that was applied more stringently than medical/surgical benefits within the classification.

3 Violations – 40 P.S. § 991.2166(a) and 31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim under subsection (d) submitted by a health care provider for services, within 45 days of the licensed insurer's or managed care plan's receipt of the claim from the health care provider. The noted claims were not paid within 45 days of the licensed insurer's or managed care plan's receipt of the claim.

2 Violations – 40 P.S. § 991.2166(b) and 31 Pa. Code § 154.18(c)

If a licensed insurer or a managed care plan fails to remit payment as provided under subsection (a), interest at 10% per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer or managed care plan shall not be required to pay any interest calculated to be less than \$2. The interest due of \$2 or more on the two claims was not paid.

1 Violation – 40 P.S. § 1171.5(a)(10)(vi)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear. The Company improperly denied a portion of the claim when the liability under the policy should have been reasonably clear based on its agreement with the provider.

L. Emergency Room Claims

Examiners requested a list of all emergency room claims received during the experience period. The Company identified a universe of 253,118 paid claims, a universe of 232,285 denied claims, and a universe of 333,770 partially paid claims. A random sample of 10 claims was requested for each section. In accordance with the requirements of the examination, the claim files were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. § 3042, 31 Pa. Code §§ 152.15 and 301.62(c), 42 U.S.C. § 300gg-19, and 45 C.F.R. § 147.138. The following violations and concern were noted:

2 Violations – 31 Pa. Code § 146.4(b)

An insurer or agent may not fail to fully disclose to first-party claimants benefits, coverages or other provisions of an insurance policy or insurance contract when the benefits, coverages or other provisions are pertinent to a claim. The Company mailed out an explanations of benefits (EOB) that misrepresented the activity of the claim.

1 Violation – 40 P.S. §§ 991.2116 & 3042, 42 U.S.C. § 300gg-19a(b), & 45 C.F.R. § 147.138(b)

An insurer shall reimburse an insured or provider for medically necessary services that are provided in a hospital emergency facility due to a medical emergency. An insurer shall consider both the presenting symptoms and the services provided in processing a claim for reimbursement of emergency services. The Company failed to pay all reasonably necessary costs associated with the emergency services provided during the period of an emergency, based on both presenting symptoms of the insured as well as the services provided.

1 Violation – 40 P.S. § 991.2166(a) and 31 Pa. Code § 154.18(a)

A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim. Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim under subsection (d) submitted by a health care provider for services provided on or after January 1, 1999, within 45 days of the licensed insurer's or managed care plan's receipt of the claim from the health care provider. The noted clean claim was not paid within 45 days of receipt.

1 Violation – 40 P.S. § 1171.5(a)(10)(v)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative. The Company failed to affirm or deny coverage of the claim within a reasonable time after proof of loss for the claim listed.

1 Violation – 31 Pa. Code § 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to complete the investigation of the claim within 30 days after notification of the claim

1 Violation – 31 Pa. Code § 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the proofs of loss giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the date of the initial notification and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation and state when

a decision on the claim may be expected. The Company failed to complete the investigation of the claim within 30 days after notification of the claim and status letters were not timely mailed to notify the member and provider of the pending status.

Concern: The Company applied two different cost-sharing requirements for Emergency Services based on designated network provider status and non-designated network provider status. During the period of an emergency, a member may not be able to determine whether an Emergency facility is designated or non-designated. A member should not be penalized, i.e., pay more out-of-pocket, when receiving services during the period of an emergency from a non-designated network provider.

M. Ambulance Transport Claims

Examiners requested a list of all ambulance transport claims received during the experience period. The Company identified a universe of 28,163 paid claims, a universe of 12,235 denied claims, and a universe of 4,890 partially paid claims. A random sample of 10 claims was requested for each section. In accordance with the requirements of the examination, the claim files were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. § 3042, 42 U.S.C. § 300gg-19a, and 45 C.F.R. § 147.138. The following violations were noted:

1 Violation – 40 P.S. § 991.2116

If an enrollee seeks emergency services and the emergency health care provider determines that emergency services are necessary, the emergency health care provider shall initiate necessary intervention to evaluate and, if necessary, stabilize the condition of the enrollee without seeking or receiving authorization from the managed care plan. The managed care plan shall pay all reasonably necessary costs associated with the emergency services provided during the period of the emergency. When processing a reimbursement claim for emergency services, a managed care plan shall consider both the presenting symptoms and the services provided. The Company failed to pay all reasonably necessary costs associated with the emergency services provided during the period of the emergency.

1 Violation – 40 P.S. §§ 1171.5(a)(1)(i) and 1171.5(a)(10)(i)

“Unfair methods of competition” and “unfair or deceptive acts or practices” in the business of

insurance means: Making, publishing, issuing or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which: Misrepresents the benefits, advantages, conditions or terms of any insurance policy. Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue. The Company misrepresented pertinent facts or policy or contract provisions for the claim noted, including the failure to treat this emergency ambulance transportation as in-network and the failure to apply out-of-pocket amounts for essential health benefits to the deductible and maximum out-of-pocket accumulators.

1 Violation – 40 P.S. § 1171.5(a)(10)(v)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative. The Company failed to affirm or deny coverage of the claim within a reasonable time after proof of loss for the claim listed.

1 Violation – 31 Pa. Code § 146.6

Standards for prompt investigation of claims. Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected.

1 Violation – 31 Pa. Code § 146.7(a)(1)

Acceptance or denial of a claim shall comply with the following: Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to the provision,

condition or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to advise the acceptance or denial of the claim by the insurer within 15 working days after receipt of properly executed proofs of loss.

1 Violation – 31 Pa. Code § 146.7(c)(1)

The following provisions govern acceptance or denial of a claim where additional time is needed to make a determination: If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the proofs of loss giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the date of the initial notification and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation and state when a decision on the claim may be expected. The Company failed to complete the investigation of the claim within 30 days after notification of the claim and status letters were not timely mailed to notify the member/provider of the pending status.

2 Violations – 42 U.S.C. § 300gg-19a(b) and 45 C.F.R. § 147.138(b)

If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides any benefits with respect to services in an emergency department of a hospital, the plan or issuer must cover emergency services (as defined in paragraph (b)(4)(ii) of this section) consistent with the rules of this paragraph (b). In general, if a group health plan, or a health insurance issuer offering group or individual health insurance issuer, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee— (II) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network. The Company failed to pay an out-of-network claim for emergency services at the in-network level of benefits.

N. Substance Use Disorder and Chemical Recovery Claims

Examiners requested a list of all substance use disorder and chemical recovery received during the experience period. The Company identified a universe of 61,661 paid claims, a universe of 48,155 denied claims, and a universe of 52,259 partially paid claims. A random sample of 10 paid claims was requested for section. In accordance with the requirements of the examination, the claim files were reviewed to ensure compliance with applicable state and federal law, including 40 P.S. §§ 752, 908-1 et seq., and 908-11 et seq.; 31 Pa. Code § 89b.11; 42 U.S.C. § 300gg-26; and 45 C.F.R § 146.136. The following violations were noted:

2 Violations – 40 P.S. § 752(a)(4) and 31 Pa. Code § 89b.11

Each form shall state the full corporate or legal name of the company, association, exchange or society. However, the name need appear for filing purposes only on a rider, endorsement, amendment, agreement or insert page. If added for filing purposes only, the name may be added by any legible means. If more than one insurer is using an application, a multi-company application providing for the designation of the applicable insurer and available coverages, if applicable, may be used. A policy, contract or fraternal certificate shall state a current address for the insurer, consisting of at least a city and state or province. Conditions subject to which policies are to be issued. No such policy shall be delivered or issued for delivery to any person in this Commonwealth unless: the style, arrangement and over-all appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lower-case unspaced alphabet length not less than 120-point (the “text” shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions. The Company gave undue prominence to Aetna Life Insurance Company when the member had coverage under Aetna Health Inc. The Company was inconsistent with the labeling of the legal entity providing coverage on its policy forms, provider remittance and/or explanation of benefits.

8 Violations – 40 P.S. §§ 908-1 et seq.

Licensed insurers are required to provide, in group policies, inpatient detoxification, nonhospital

residential and outpatient services for alcohol or other substance use and dependency. A certification and referral by a licensed physician or psychologist controls both the nature and duration of treatment to the extent of the mandate. Based on the noted policy provisions, the Company failed to provide coverage for substance use disorder benefits that met the requirements of the Act; however, for certain categories of claims noted herein, despite policy language to the contrary, based on claims files provided, it appears that the Company did not impose this limitation when adjudicating claims.

21 Violations – 40 P.S. §§ 908-11 et seq., 45 C.F.R. §§ 146.136(c)(4) & 156.115(a)(3)

Licensed insurers are required to provide mental health and substance use disorder benefits in parity with medical/surgical benefits. For NQTLs, this means that a licensed insurer may not apply any NQTL in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying that limitation to MH/SUD benefits within that classification are “comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the classification.” The Company imposed a nonquantitative treatment limitation with respect to mental health and substance use disorder benefits not in parity with medical/surgical benefits. It was noted that the Company limited the scope and duration of treatment for the claims listed in a manner that was applied more stringently than medical/surgical benefits within the classification in the claims noted. For certain categories of claims noted herein, however, despite policy language to the contrary, based on claims files provided, it appears that the Company did not impose this limitation when adjudicating claims.

3 Violations – 40 P.S. § 991.2166(a) and 31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim under subsection (d) submitted by a health care provider for services, within 45 days of the licensed insurer’s or managed care plan’s receipt of the claim from the health care provider. The claims noted were not paid within 45 days of the licensed insurer’s or managed care plan’s receipt of the claim.

3 Violations – 40 P.S. § 991.2166(b) and 31 Pa. Code § 154.18(c)

If a licensed insurer or a managed care plan fails to remit payment as provided under subsection (a), interest at 10% per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer or managed care plan shall not be required to pay any interest calculated to be less than \$2. The interest due of \$2 or more on the three claims was not paid.

1 Violation – 40 P.S. § 1171.5(a)(10)(iv)

“Unfair methods of competition” and “unfair or deceptive acts or practices” in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. Refusing to pay claims without conducting a reasonable investigation based upon all available information. The Company failed to conduct a reasonable investigation, which resulted in an improper denial of services.

1 Violation – 40 P.S. § 1171.5(a)(10)(vi)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear. The Company improperly denied the claim noted when the Company's liability under the policy was reasonably clear. The Company later paid the overdue claim based on additional information supplied by the provider (which was consistent with the original claim submission), indicating coverage was available when the claim originally denied. Additionally, once the information was received by the Company and liability was again reasonably clear, the Company did not promptly issue payment to the provider for the services rendered.

1 Violation – 40 P.S. § 1171.5(a)(10)(x)

“Unfair methods of competition” and “unfair or deceptive acts or practices” in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices.

Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made. The final processing of the claim did not include a statement setting forth the coverage under which payments were made, as the claim originally denied on 10/29/2015, then reprocessed to pay on 4/25/2016 permitting balance billing of amounts not covered, and then reprocessed again on 10/1/2016 allowing payment for one-hundred percent of the billed charges without balance billing the member. There was nothing included in the explanation of benefits that explained the reprocessing of this claim.

O. Mental Health Claims

Examiners requested a list of all mental health claims received during the experience period. The Company identified a universe of 509,608 paid mental health claims, a universe of 272,055 denied mental health claims, and a universe of 258,728 mental health partially paid claims. A random sample of 10 files was requested for each section. In accordance with the requirements of the examination, the claim files were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 908-1 et seq., 908-11 et seq., and 1171.5, 31 Pa. Code Ch. 146 and 154, 42 U.S.C. § 300gg-26, and 45 C.F.R §§ 146.136. The following violations were noted:

4 Violations – 40 P.S. §§ 908-11 et seq. and 45 C.F.R. §§ 146.136(c)(2)(i) & 156.115(a)(3)

Licensed insurers are required to provide mental health and substance use disorder benefits in parity with medical/surgical benefits. For quantitative treatment limitations, this means that a licensed insurer may not apply any quantitative treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. Examiners requested the Company to provide proof of compliance for each plan type affected, each classification of benefits and for each type of quantitative treatment limitation separately. The Company imposed a QTL with respect to mental health and substance use disorder benefits not in parity with medical/surgical benefits. It was noted that the Company did not demonstrate compliance with the substantially all or predominant level tests within the specified classifications of benefits. For certain categories of claims noted herein, despite policy language to the contrary, based on claims files provided, it appears that the Company

did not impose this limitation when adjudicating claims.

1 Violation – 40 P.S. § 1171.5(a)(10)(vi)

“Unfair methods of competition” and “unfair or deceptive acts or practices” in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company’s liability under the policy has become reasonably clear. The Company improperly denied the claim noted when the Company’s liability under the policy was reasonably clear.

1 Violation – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in the detail that pertinent events and the dates of the events can be reconstructed. Failure to maintain a complete claim file.

1 Violation – 31 Pa. Code § 146.5(a)

Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice. The Company failed to acknowledge the claim submitted by the claimant within 10 working days.

P. Behavioral Health Claims

Examiners requested a list of all behavioral health claims received during the experience period. The Company identified a universe of 464,055 paid claims, a universe of 219,212 denied claims, and a universe of 263,197 partially paid claims. A random sample of 10 claims was requested for each section. In accordance with the requirements of the examination, the claims were reviewed to ensure compliance with applicable state and federal laws and guidance, including 40 P.S. §§ 991.2166, 908-11 et seq., and 1171.5, 31 Pa. Code Ch. 146 and 154, 42 U.S.C. § 300gg-26, and

45 C.F.R. § 146.136. The following violations were noted:

1 Violation – 40 P.S. § 991.2166(a) and 31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim under subsection (d) submitted by a health care provider for services, within 45 days of the licensed insurer's or managed care plan's receipt of the claim from the health care provider. The noted claim was not paid within 45 days of the licensed insurer's or managed care plan's receipt of the claim.

1 Violation – 40 P.S. § 991.2166(b) and 31 Pa. Code § 154.18(d)

If a licensed insurer or a managed care plan fails to remit payment as provided under subsection (a), interest at 10% per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer or managed care plan shall not be required to pay any interest calculated to be less than \$2. The interest due of \$2 or more on the one claim was not paid.

1 Violation – 31 Pa. Code § 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to send a written explanation of the reason for delay at the end of 30 days and every 45 days thereafter until completed.

Q. HIV/AIDS Claims

Examiners requested a list of all HIV/AIDS claims received during the experience period. The Company identified a universe of 6,829 paid claims, a universe of 2,265 denied claims, and a universe of 2,845 partially paid claims. A random sample of 10 files was requested for each section. In accordance with the requirements of the examination, the claims were reviewed to ensure compliance with applicable state and federal laws and regulations. The following violation was noted:

1 Violation – 31 Pa. Code § 146.5(a)

Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice. The Company failed to issue a 10-day acknowledgement notice for one claim.

R. Inpatient and Outpatient High Dosage Opioid Addiction Treatment Claims

Examiners requested a list of all inpatient and outpatient high dosage opioid addiction treatment claims received during the experience period. The Company identified a universe of 30,219 paid claims, a universe of 28,704 denied claims, and a universe of 19,559 partially paid claims. A random sample of 10 claims was requested for each section. In accordance with the requirements of the examination, the claims were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 752(a), 991.2166, 908-1 et seq., 908-11 et seq., and 1171.5, 31 Pa. Code Ch. 146 and 154 and § 89b.11, 42 U.S.C. § 300gg-26, and 45 C.F.R § 146.136. The following violations were noted:

3 Violations – 40 P.S. § 752(a)(4) and 31 Pa. Code § 89b.11

Each form shall state the full corporate or legal name of the company, association, exchange or society. However, the name need appear for filing purposes only on a rider, endorsement, amendment, agreement or insert page. If added for filing purposes only, the name may be added by any legible means. If more than one insurer is using an application, a multi-company application providing for the designation of the applicable insurer and available coverages, if applicable, may be used. A policy, contract or fraternal certificate shall state a current address for the insurer, consisting of at least a city and state or province. Conditions subject to which policies are to be issued. No such policy shall be delivered or issued for delivery to any person in this Commonwealth unless: the style, arrangement and over-all appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lower-case unspaced

alphabet length not less than 120-point (the “text” shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions. The Company gave undue prominence to Aetna Life Insurance Company when the member has coverage under Aetna Health Inc. The Company was inconsistent with the labeling of the legal entity providing coverage on its policy forms, provider remittance and/or explanation of benefits.

7 Violations – 40 P.S. §§ 908-1 et seq.

Licensed insurers are required to provide, in group policies, inpatient detoxification, nonhospital residential and outpatient services for alcohol or other substance use and dependency. A certification and referral by a licensed physician or psychologist controls both the nature and duration of treatment to the extent of the mandate. Based on the noted policy provision, the Company failed to provide coverage for substance use disorder benefits that met the requirements of the Act.

13 Violations – 40 P.S. §§ 908-11 et seq. and 45 C.F.R. § 146.136(c)(4)

Licensed insurers are required to provide mental health and substance use disorder benefits in parity with medical/surgical benefits. For NQTLs, this means that a licensed insurer may not apply any NQTL in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying that limitation to MH/SUD benefits within that classification are “comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the classification.” The Company imposed a nonquantitative treatment limitation with respect to mental health and substance use disorder benefits not in parity with medical/surgical benefits. It was noted that the Company limited the scope and duration of treatment for the claims listed in a manner that is applied more stringently than medical/surgical benefits within the classification in the claims noted. For certain categories of claims noted herein, despite policy language to the contrary, based on claims files provided, it appears that the Company did not impose this limitation when adjudicating claims.

2 Violations – 40 P.S. § 991.2166(a) and 31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim under subsection (d) submitted by a health care provider for services, within 45 days of the licensed insurer's or managed care plan's receipt of the claim from the health care provider. The claim noted was not paid within 45 days of the licensed insurer's or managed care plan's receipt of the claim.

2 Violations – 40 P.S. § 1171.5(a)(10)(v)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative. The Company failed to affirm or deny coverage of the claim within a reasonable time after proof of loss for the claim listed.

1 Violation – 40 P.S. § 1171.5(a)(10)(vi)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear. The Company denied the claim in which the Company's liability under the policy was reasonably clear.

1 Violation – 31 Pa. Code § 146.5(a)

Failure to acknowledge pertinent communications. (a) Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice. The Company failed to acknowledge the receipt of the claim within 10 days.

2 Violations – 31 Pa. Code § 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to complete the investigation of the claim within 30 days after notification of the claim.

2 Violations – 31 Pa. Code § 146.7(c)(1)

The following provisions govern acceptance or denial of a claim where additional time is needed to make a determination: If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the proofs of loss giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the date of the initial notification and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation and state when a decision on the claim may be expected. The Company failed to complete the investigation of the two noted claims within 30 days after notification of the claim and status letters were not mailed out on the 30th day to notify the claimant of the pending status.

XVII. DATA INTEGRITY

As part of the examination, the Company was sent a preliminary examination packet in accordance with National Association of Insurance Commissioners uniformity standards. The purpose of the packet was to provide certain basic examination information, identify preliminary requirements, and to provide specific requirements for requested data call information. Once the Company provided all requested information and data contained within the data call, the Department reviewed and validated the data to ensure accuracy and completeness, and to determine compliance with The Insurance Department Act of 1921, Section 904 (40 P.S. §323.4). Several data integrity issues were found during the examination. The data integrity issues from each area of review are identified below.

Data Submission to the PID During the Course of the Examination

Situation: Examiners requested documentation demonstrating the intent to respond to all requests from the examiners in a timely manner during the relevant experience period. In addition to the review of policies and procedures, the Department analyzed the Company's timeliness of responses for items requested by the Department during the market conduct examination. The Department recorded the length of time for Company responses to Information Requests (IR), Initial Summaries (IS) and Exit Summaries (ES) and took into account any extension requests made by the Company throughout the course of the examination.

Finding One: During the examination, a total of 194 IRs were issued to the Company. Of those, a total of 50 IRs were responded to on-time or within three business days. The Company provided a late response to 144 IRs. Therefore, 74% of the IRs were not responded to in a timely manner. Of the 144 IRs that were submitted after the due date, the Company averaged 29 days to reply.

Finding Two: During the examination, a total of 180 ISs were issued to the Company. Of those, 116 ISs were responded to on-time or within 10 business days. The Company provided a late response to 64 ISs. Therefore, 36% of the ISs were not responded to in a timely manner. Of the 64 ISs that were submitted after the due date, the Company averaged 12 days to reply.

Finding Three: During the examination, a total of 180 ESs were issued to the Company. Of those, a total of 162 ESs were responded to on-time or within five business days. The Company provided

a late response to 18 ESs. Therefore, 10% of the ESs were not responded to in a timely manner. Of the 18 ESs that were submitted after the due date the Company averaged 11 days to reply.

Policies/Procedures for Data Submission to the PID

Situation: Examiners requested documentation demonstrating that the Company's data reported to the Department was complete and accurate. In addition to the review of policies and procedures, the Department analyzed the Company's timeliness and completeness of responses for items requested by the Department during the market conduct examination.

Finding: Throughout the course of the market conduct examination, the Company failed to provide to the Department complete responses in a timely manner and timely access to data and documentation. For some of the items noted, the Company failed to supply the requested data until the Exit Summary phase of the examination, although it was requested in earlier phases.

Group New Business Underwriting

Situation: As the examiners reviewed the Group New Business Underwriting files, it was noted that not all of the 113 files were complete.

Finding: Of the 113 group new business underwriting files reviewed, 11 files were missing the underwriting approval form, the approved rates of the policy, or the new business application.

Pediatric Vision Paid Claims

Situation: As the examiners reviewed the Pediatric Vision Paid Claims, it was noted that 20 of the files were incomplete, were not associated with pediatric patients, and may have been associated with coverage other than pediatric vision coverage under a comprehensive health insurance policy.

Finding: Upon discussion with the Company, the Company confirmed that the original denied pediatric vision claim population was invalid. The script used to identify the population neglected to filter claims based on diagnosis and patient age. The Company provided a revised population that contained only a single claim, which was for an Aetna Vision Preferred plan (vision only plan) issued by Aetna Life Insurance Company. Since the Vision Preferred plan is a vision only plan, it was not within the scope of the examination.

Marketing and Advertising Sample

Situation: As the examiners reviewed the Marketing and Advertising Sample, not all of the 50 files were provided or the files that were provided did not contain all of the components of a complete file.

Finding: Of the 50 sample files reviewed, 11 files were missing the 2015 or 2016 Annual Statement Advertising Certificate of Compliance a copy of the advertisement, a copy of the quote form, or the referenced website URL.

The following violation was noted:

General Violation 40 P.S. §§ 323.3(a) and 323.4(b)

Requires every company or person from whom information is sought must provide the examiners timely, convenient and free access to all books, records, accounts, papers, documents and any and all computer or other recording relating to the property, assets business and affairs of the company being examined. The violation was the result of a failure to exercise sufficient due diligence to ensure compliance with the Insurance Department Act of 1921.

XVIII. RECOMMENDATIONS

The recommendations below identify corrective measures the Department finds necessary as a result of the number of some violations, or the nature and severity of other violations, noted in the Examination Report.

1. The Company must review and revise internal control procedures to ensure compliance with the mental health and substance use disorder parity requirements of 40 P.S. §§ 908-11 et seq. and 45 C.F.R. §§ 146.136(c)(4) and 156.115(a)(3) relating to nonquantitative treatment limitations.
2. The Company must review and revise internal control procedures to ensure compliance with the mental health and substance use disorder parity requirements of 40 P.S. §§ 908-11 et seq. and 45 C.F.R. §§ 146.136(c)(2)(i) and 156.115(a)(3) relating to quantitative treatment limitations.
3. The Company must implement procedures to ensure compliance with the requirements of 40 P.S. §§ 1171.5(a)(1)(i) and 1171.5(a)(10)(i). The Company must not misrepresent pertinent facts or policy or contract provisions.
4. The Company must review and revise internal control procedures to ensure compliance with anti-discrimination requirements of 40 P.S. §§ 477a, 761, and 1171.5(a)(7)(ii); 42 U.S.C. § 300gg-4(a); and 45 C.F.R. §§ 147.104 and 156.125.
5. The Company must review and revise its internal controls to ensure that all records and documents are maintained in accordance with 40 P.S. § 323.4 so that the violation noted in the Examination Report does not occur in the future.
6. The Company must implement procedures to ensure compliance with the requirements of 40 P.S. § 1171.5(a)(10)(v). The Company must affirm or deny coverage of claims within 45 days after proof of loss for the claims is received.
7. The Company must comply with 40 P.S. § 1171.5(a)(10)(vi) and ensure prompt, fair and equitable settlements are being provided to claimants.
8. The Company must implement procedures to ensure compliance with the requirements

of 40 P.S. § 1171.5(a)(10)(x). The Company must include a statement setting forth the coverage under which payments are being made to accompany claim payments to insureds or beneficiaries.

9. The Company must implement procedures to ensure compliance with the requirements of 31 Pa. Code § 146.3 to maintain complete claim files and documentation.
10. The Company must review and revise internal control procedures to ensure compliance with the claims handling requirements of 31 Pa. Code, Chapter 146, so that the violations relating to claim acknowledgement, status letters, and acceptance or denials, as noted in the Examination Report, do not occur in the future.
11. The Company must comply with 40 P.S. § 991.2166(a) and 31 Pa. Code § 154.18(a), and ensure that all clean claims are paid within 45 days of receipt. The Company shall also provide documentation to the Department within 30 days demonstrating that all claims found in violation during the examination were processed and paid including due interest and restitution.
12. The Company must comply with 40 P.S. § 991.2166(b) and 31 Pa. Code § 154.18(c), and ensure all requirements are met related to interest payments. The Company shall also provide documentation to the Department within 30 days demonstrating that all claims found in violation during the examination were processed and paid including due interest and restitution.
13. The Company must comply with 31 Pa. Code § 154.18(d) and ensure clean claims are paid according to timelines outlined in state laws and regulations.
14. The Company must review and revise internal control procedures to ensure compliance with 40 P.S. § 752(A)(4) and 31 Pa. Code § 89b.11 relative to undue prominence and form requirements.
15. The Company must comply with 40 P.S. § 753(B)(8) and ensure prompt notifications to the member of policy cancellations.
16. The Company must comply with 45 C.F.R. § 155.310(e) and ensure prompt notifications

to the member regarding eligibility determinations.

17. The Company must comply with 40 P.S. §§ 908-1 et seq. and ensure substance use disorder benefits claims are paid in accordance with state and federal laws and regulations. The Company shall also provide documentation to the Department within 30 days demonstrating that all claims found in violation during the examination were processed and paid including due interest and restitution.
18. The Company must comply with 40 P.S. § 764h and ensure diagnostic assessment of autism spectrum disorders and treatment of autism spectrum disorders are covered for covered individuals under 21 years of age. The Company shall also provide documentation to the Department within 30 days demonstrating that all claims found in violation during the examination were processed and paid including due interest and restitution.
19. The Company must comply with 40 P.S. §§ 991.2116 and 3042, 42 U.S.C. § 300gg-19a(b), 45 C.F.R. § 147.138(b) and ensure emergency services are covered in accordance with state and federal laws and regulations. The Company shall also provide documentation to the Department within 30 days demonstrating that all claims found in violation during the examination were processed and paid including due interest and restitution.
20. The Company must comply with 42 U.S.C. § 300gg-19a(b)(1)(C)(ii)(II) and 45 C.F.R. § 147.138 and ensure that ambulance and emergency services are covered in accordance with federal laws and regulations. The Company shall also provide documentation to the Department within 30 days demonstrating that all claims found in violation during the examination were processed and paid including due interest and restitution.
21. The Company must comply with 40 P.S. § 3801.310 and ensure policy issue records are compliant with state laws and regulations.
22. The Company must implement procedures to ensure compliance with 31 Pa. Code § 51.4 and maintain appropriate file documentation.

XIX. COMPANY RESPONSE

LARRY HOGAN
Governor

BOYD K. RUTHERFORD
Lt. Governor



AL REDMER, JR.
Commissioner

NANCY GRODIN
Deputy Commissioner

ERICA BAILEY
Associate Commissioner

200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202
Direct Dial: 410-468-2299 Fax: 410-468-2245
Email: darcim.smith@maryland.gov
410-468-2000 1-800-492-6116
TTY: 1-800-735-2258
www.insurance.maryland.gov

October 6, 2017

Sent Via E-Mail and Via Certified Mail

[CARRIER/ADDRESS]

RE: [CARRIER NAME]
2017 Mental Health Parity Survey – Maryland Business Only
[INVESTIGATION No.]

Dear [CONTACT]:

Pursuant to §§ 2-108 and 2-205 of the Insurance Article, Annotated Code of Maryland, the Maryland Insurance Administration (“Administration”) is gathering information to verify compliance with the Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”). This is the last of the three surveys the Administration began in 2014. Please provide a detailed response to the following questions by November 13, 2017, as they relate to fully-insured group and individual health benefit plans. Do not include any self-funded groups or federal programs. When referencing small and large groups, the employer/group contract must be situated in the state of Maryland with one or more Maryland employees. Provide requested data regarding mental health and substance use disorder benefits directly from any contracted managed behavioral health organization (“MBHO”) that manages plan behavioral health benefits.

Nonquantitative Treatment Limitations

Under MHPAEA, a plan may not impose a nonquantitative treatment limitation (“NQTL”) with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.¹

¹ See 45 C.F.R. 146.136(c)(4)(i) and for a description of what is included in NQTL’s see 45 C.F.R. 146.136(c)(4)(ii).

Delegation Contracts

1. MHPAEA does not prohibit the use of separate managed behavioral health organizations to provide utilization review and other services with respect to mental health and/or substance abuse benefits.² However, to comply with MHPAEA, group health plans, their health issuers, and other service providers should work together to ensure that they are complying with MHPAEA.³
 - a. Do you delegate the development and/or management of plan behavioral health benefits to another entity? If yes, please provide the name of that entity, a copy of the delegation contract, a list of which products the entity provides/administers the behavioral health benefit for (if less than all of the products offered by the carrier) and an explanation of the scope of the entity's responsibility (i.e. sets network access standards and manages the network of behavioral health providers, credentials behavioral health providers, develops and applies utilization review criteria, etc.).
 - b. What processes are in place for overseeing the behavioral health entity to verify MHPAEA compliance as to nonquantitative treatment limitations in writing and in operation?
 - i. What audits are conducted to determine compliance with NQTL rules and how frequently?
 - ii. What documents, algorithms and evidentiary standards do you obtain from the MBHO in order to complete this review?

Utilization Review

2. Describe the process you have implemented to evaluate whether the utilization management standards imposed on mental health and substance use disorder services are, *as written and in operation*, comparable to and applied no more stringently than the utilization management standards for medical/surgical services.
 - a. Provide any internal policy documents establishing this review process.
 - b. Provide a description of all audits the carrier conducts to assess compliance.
 - c. Does the utilization reviewer's discretion factor into the utilization review determination for medical/surgical and mental health/substance use disorder services? How does a utilization reviewer allow deviations from the norm when justified on a case by case basis?
 - d. Where the reviewer's discretion is a factor (such as when determining whether a service is medically necessary or which level of care to approve) how do you determine that such discretion is not resulting in a more stringent application of utilization review to mental health and substance use disorder services than to medical/surgical services?
 - e. Provide a copy of your written administrative processes and safeguards to ensure and to verify that benefit claim determinations are made in accordance with the insurance policy provisions and utilization review guidelines and that, where appropriate, the insurance policy guidelines are applied consistently with respect to similarly situated covered individuals.
3. Utilization Review Process
 - a. Provide a detailed explanation of the utilization review process in each of the six MHPAEA classifications⁴ (if it differs) for each type of utilization review conducted (prior authorization and certification, concurrent review, retrospective review, etc.) for both medical/surgical and mental health/substance use disorder services. Identify who (contracting utilization review organization, MBHO, provider, etc.) conducts utilization

² See Understanding Implementation of the Mental Health Parity and Addiction Equity Act of 2008, Question 5, May 9, 2012.

³ *Id.*

⁴ See 45 C.F.R. 146.136(c)(2)(ii).

- review in each classification for medical/surgical and mental health and substance use disorder services.
- b. Please identify any information that is requested to be submitted by a mental health and substance use disorder provider at each step of the utilization review process for mental health and substance use disorder services and any information that is requested to be submitted by a medical/surgical provider at each step of the utilization review process for medical/surgical services.
 - i. Provide copies of any treatment request forms used in this process.
 - ii. Provide screen shots of each information gathering step in any systems used during the processing of a utilization review request and/or any worksheets completed by staff while gathering information during the utilization review process.
 - c. Identify the systems (*e.g.* mailed claim forms, telephone, e-mail, internet portal) that your organization or contracting utilization review organization use for mental health and substance use disorder providers and for medical/surgical providers to submit requests for services. If any of the systems are different depending on the type of service requested, including, for example, the use of different internet portals, please explain why your organization finds this to be appropriate under MHPAEA.
 - d. Identify the methods used by your organization or a contracting utilization review organization to communicate to a provider the information that the provider must submit so that the carrier/utilization review entity can conduct its utilization review of the request for services. If any of the methods used to communicate information to medical/surgical and mental health and substance use disorder providers are different, please explain why your organization finds this to be appropriate under MHPAEA.
 - e. Explain how your company instructs medical/surgical providers to communicate with your company (or the contracted utilization review organization) to complete the utilization review process and how your company instructs mental health and substance use disorder providers to communicate with your company (or the contracted utilization review organization) to complete the utilization review process.
 - f. Identify the methods used by your organization or contracting utilization review organization to notify a mental health and substance use disorder provider that the utilization reviewer needs additional information that is necessary for the carrier to complete its utilization review of the request for services. Please identify the methods used by your organization or a contracting utilization review organization to notify a medical/surgical provider that the utilization reviewer needs additional information that is necessary for the carrier to complete its utilization review of the request for services. If any of the methods used to communicate information is different, please explain why your organization finds this to be appropriate under MHPAEA.
 - g. If the utilization review process is different when a member is accessing benefits from an out-of-network provider, provide the above information for the out-of-network utilization review process. Provide separate answers for medical/surgical and mental health and substance use disorder benefits.
 - iii. Is the member responsible for collecting documentation or communication to receive services? Provide a separate answer for medical/surgical and mental health and substance use disorder benefits.
 - iv. Does the carrier contact the provider if any required information is missing during utilization review? Provide a separate answer for medical/surgical and mental health and substance use disorder benefits.

Level of Care

4. Identify the number and percentage of total requests that were initiated for inpatient services (including residential treatment services) for medical/surgical, mental health or substance use

services that were approved at a lower level/less intensive level of care. Provide the data separately for 2015, 2016, and 2017 (please indicate what dates the 2017 data encompasses).

- a. In providing the data, identify both the requested and authorized level of care and separate out the medical/surgical, mental health and substance use disorder determinations.
 - b. In providing the data, separate the data into those requests that were denied and later approved at a lower level of care and requests that were not denied but resulted in a lower level of care approved than the inpatient level of care initially requested.
5. Identify the number and percentage of total requests that were initiated for partial hospitalization/day treatment or intensive outpatient treatment for medical/surgical, mental health or substance use services that were authorized at a lower level/less intensive level of care. Provide the data separately for 2015, 2016, and 2017 (please indicate what dates the 2017 data encompasses).
- a. In providing the data, identify both the requested and authorized level of care and separate out the medical/surgical, mental health and substance use disorder determinations.
 - b. In providing the data, separate the data into those requests that were denied and later approved at a lower level of care and requests that were not denied but resulted in a lower level of care approved than the level of care initially requested.

Adverse Decisions and External Review

6. Complete Attachment A- Adverse Decision and Appeals Data. Provide the data separately for 2015, 2016, and 2017 (please indicate what dates the 2017 data encompasses).

Facility Credentialing

7. Provide a detailed explanation of the facility credentialing process for medical facilities, MH facilities, and SUD facilities. If the process differs based on the facility type (hospital vs nonhospital facility vs community behavioral health facilities) please explain those differences.
 - a. Identify how facilities are instructed to contact the carriers to begin the credentialing process.
 - b. Explain the requirements, processes and standards used in the carrier's facility credentialing process for mental health, substance use disorder, and medical facilities, and provide documentation, such as audits, to demonstrate the carrier implements these requirements to mental health and substance use disorder facilities in a manner that is comparable to and no more restrictive than the implementation process for facilities that provide medical services.
 - c. Provide copies of all required credentialing forms for facilities and any guidance documents used by staff to complete the credentialing process.
 - d. If you delegate management of your behavioral health network to another entity, is the facility required to be credentialed by both you and the contracted entity? Provide a description of any such requirement.
8. Complete Attachment B- Facility Credentialing Data for all facilities that contacted the carrier to begin the credentialing process. You should include all facilities that did not submit an application because they were informed the network was closed. Provide a separate chart for requests that began in 2015, 2016, and 2017 (please indicate what dates the 2017 data encompasses).

Reimbursement Rates

9. Identify and provide documents that describe the criteria/data the carrier considers and the rules the carrier implements to determine the allowable amount for out-of-network mental health, substance

use disorder and medical/surgical services, respectively, for the following classifications including any reductions made in the allowable amounts for specific providers/services and provide all audits the carrier conducts to assess compliance with its rules:

- a. Outpatient
- b. Inpatient
- c. Sub-acute residential services

Out-of-Network Access

10. Complete the following chart for each out-of-network level of care: Inpatient, Residential (non-hospital facility), Intensive Outpatient, and Outpatient. Please provide a list of the services that you are including in each classification for the purposes of this data reporting. Provide the data separately for 2015, 2016, and 2017 (please indicate what dates the 2017 data encompasses).

Classification (example: Inpatient- OON)						
	Total # of claims (IN and OON) for this level of care.	# of OON claims for this level of care.	% of total claims that were OON for this level of care	# of OON claims approved for this level of care	% of OON claims approved for this level of care	# approved because no provider available in-network
M/S						
MH						
SUD						

11. Explain how members access out-of-network benefits for each product subject to this survey. For the products where prior authorization or an exception is required to access out-of-network benefits, provide the specific criteria that must be met to approve out-of-network access. Provide the following data for each level of care (Inpatient hospital, Residential non-hospital facility, Intensive Outpatient, Outpatient). Provide the data separately for 2015, 2016, and 2017 (please indicate what dates the 2017 data encompasses):

- a. The number of requests for approval to access an out-of-network provider for each of medical/surgical, mental health and substance use disorder services.
- b. The number of those requests made for each of the following reasons:⁵ (1) there was no available in-network provider, (2) the wait time to see an in-network provider was too long or (3) the distance to travel to an in-network provider was too far, and (4) Other (please describe the type of requests that fall under this category).
- c. The number of requests that were denied for each of medical/surgical, mental health and substance use disorder services and a list of the reasons for the denials and the number of denials which correlate with each reason.
- d. The number of requests that were approved for each of medical/surgical, mental health and substance use disorder services and a list of the reasons for the approvals (such as no in-network provider) and the number of approvals that correlate with each reason for each of medical/surgical, mental health and substance use disorder services.

⁵ This data should be based on the reason the member provided in the request, regardless of whether the carrier ultimately found that the reason provided was correct (i.e. no in-network provider was the reason for the request and should be included in this data regardless of whether the carrier was able to locate five providers that could provide the service).

Prescription Drugs

12. Provide a copy of each current formulary that the company uses. If the formulary document does not indicate where prior authorization requirements apply please advise where the prior authorization requirement is noted for prescription drugs and please provide the documents that include that requirement.
 - a. Demonstrate compliance with HB 887 which became effective May 25, 2017.
 - b. Explain how the company plans to comply with HB 1329/SB 967 starting January 1, 2018. Provide any final contract provisions, directions to pharmacists, and formularies that demonstrate compliance.

13. Provide the following information regarding utilization management requirements for prescription drugs for mental health medications (as a group), substance use disorder medications (as a group), and medications for somatic conditions (as a group), and separated by brand and generic drugs. Provide the data separately for 2015, 2016, and 2017 (please indicate what dates the 2017 data encompasses).
 - a. Number of pharmacy inquiries, as defined by Maryland Insurance Article § 15-10D-01(n), received by any method, including computer, fax or phone.
 - b. Number and percentage of pharmacy inquiries for prescriptions that required pre-authorization and number and percentage of inquiries for prescriptions that did not require preauthorization.
 - c. Number and percentage of pharmacy inquiries for prescriptions that required pre-authorization that were approved and denied.
 - d. Number and percentage of pharmacy inquiries for prescriptions that were dispensed as a different medication than ordered due to carrier authorization, fail first or formulary tiering policies.

Pursuant to COMAR 31.04.20.05 E, the Company is required to confirm the accuracy of all information provided and submit a "Certificate of Compliance" signed by an officer of the Company acknowledging in a written certification that the information provided is, "to the best of the individual's knowledge, information, and belief, a full, complete, and truthful response to the Commissioner's response," and that the "individual making the certification has undertaken an adequate inquiry to make the required certification."

Please return your response to this survey along with the Certificate of Compliance to me no later than close of business on November 13, 2017. If you have any questions or concerns, please call or e-mail Darci Smith, MHPAEA Special Assistant at 410-468-2299 or darcim.smith@maryland.gov.

Thank you in advance for your timely response to this request.

Sincerely,

Joseph Fitzpatrick
Supervisor
Compliance and Enforcement
Maryland Insurance Administration

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

**OFFICE OF THE HEALTH INSURANCE COMMISSIONER
1511 PONTIAC AVENUE, BLDG 69-1
CRANSTON, RI 02920**

**In Re: Examination of Health Insurance Carrier Compliance)
With Mental Health and Substance Abuse Disorder) OHIC-2014-3
Laws and Regulations)**

**Examination Report of Blue Cross Blue Shield of Rhode Island, in accordance with
R.I.G.L. § 27-13.1-5(b).**

In re Examination of Health Insurance Carrier Compliance with Mental Health and Substance Abuse Laws and Regulations, Docket No. OHIC-2014-3

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Blue Cross Consent	Page 38
Response of BCBSRI	Attachment

In re Examination of Health Insurance Carrier Compliance with Mental Health and Substance Abuse Laws and Regulations, Docket No. OHIC-2014-3

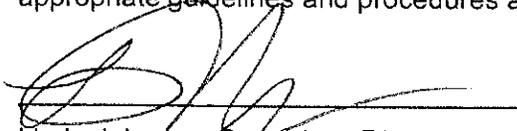
August 2, 2018

Honorable Marie Ganim
Health Insurance Commissioner
State of Rhode Island

Dear Commissioner Ganim:

In accordance with your instructions and pursuant to statutes of the State of Rhode Island, a targeted Market Conduct Examination was conducted in order to ascertain compliance with applicable statutes and regulations relating to mental health and substance use disorders by all four major health insurance carriers in Rhode Island. This Examination Report addresses compliance by Blue Cross Blue Shield of Rhode Island. Other Examination Reports address compliance by the other carriers.

The examination was conducted by Linda Johnson, OHIC Operations Director, and Herbert W. Olson, Esq. (former OHIC General Counsel), with the assistance of staff of the RI Office of the Health Insurance Commissioner, and the RI Executive Office of Health and Human Services, and with clinical expertise from behavioral health clinicians associated with the Law and Psychiatry Service at Massachusetts General Hospital. In conducting the examination, the Examiners observed those guidelines and procedures set forth in the Examiners' Handbook adopted by the National Association of Insurance Commissioners, together with other appropriate guidelines and procedures as the Commissioner has deemed appropriate.

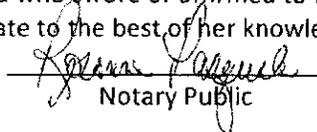


Linda Johnson, Operations Director
RI Office of the Health Insurance Commissioner

Herbert W. Olson, Esq.
Hillsboro Mountain PLC



On this 7th day of August, 2018, before me, the undersigned notary public, personally appeared Linda Johnson, personally known to the notary to be the person who signed the Examination Report in my presence, and who swore or affirmed to the notary that the contents of the document are truthful and accurate to the best of her knowledge and belief.


Notary Public

On this ___ day of _____, 20___, before me, the undersigned notary public, personally appeared Herbert W. Olson, personally known to the notary to be the person who signed the Examination Report in my presence, and who swore or affirmed to the notary that the contents of the document are truthful and accurate to the best of his knowledge and belief.

Notary Public

In re Examination of Health Insurance Carrier Compliance with Mental Health and Substance Abuse Laws and Regulations, Docket No. OHIC-2014-3

August 1, 2018

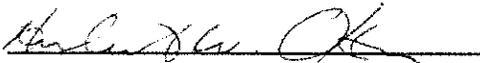
Honorable Marie Ganim
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Linda Johnson, Operations Director
RI Office of the Health Insurance Commissioner

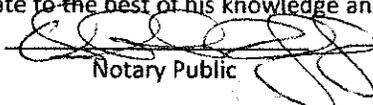


Herbert W. Olson, Esq.
Hillsboro Mountain PLC

On this 3 day of _____, 2018, before me, the undersigned notary public, personally appeared Linda Johnson, personally known to the notary to be the person who signed the Examination Report in my presence, and who swore or affirmed to the notary that the contents of the document are truthful and accurate to the best of her knowledge and belief.

Notary Public

On this 31st day of July, 2018, before me, the undersigned notary public, personally appeared Herbert W. Olson, personally known to the notary to be the person who signed the Examination Report in my presence, and who swore or affirmed to the notary that the contents of the document are truthful and accurate to the best of his knowledge and belief.



Notary Public

DEBBIE RIGGS
Notary Public of RI
ID# 757854
My commission expires
May 1, 2019

In re Examination of Health Insurance Carrier Compliance with Mental Health and Substance Abuse Laws and Regulations, Docket No. OHIC-2014-3

1. Introduction.

This market conduct examination ("Examination") commenced with a Warrant of Examination issued by the Commissioner of the Office of the Health Insurance Commissioner ("OHIC") on January 8, 2015. The Commissioner appointed as Examiners (among others) Linda Johnson, OHIC Operations Director, and Herbert W. Olson, Esquire (former OHIC General Counsel). The Examination is a targeted examination of the four largest health insurance carriers in the Rhode Island insured market: Blue Cross Blue Shield of Rhode Island ("Blue Cross"), Neighborhood Health Plan of RI ("Neighborhood"), Tufts Insurance Company and Tufts Associated Health Maintenance Organization (collectively "Tufts"), and UnitedHealthcare Insurance Company and UnitedHealthcare of New England, Inc. (collectively "United") (collectively "the Carriers").

The purpose of the Examination is to review compliance by the Carriers with federal and state laws and regulations relating to health insurance coverage of mental health and substance use disorder benefits (collectively, mental health and substance use are referred to in this Report as "behavioral health", or "BH").

This Examination Report addresses compliance by Blue Cross. Other Examination Reports address compliance by the other Carriers.

The Examination targeted two broad areas of regulatory compliance: First, compliance with federal and state behavioral health parity laws and regulations, with particular focus on what are referred to as "non-quantitative treatment limitations" ("NQTL's"). NQTL's include important features of any health insurance plans, including but not limited to utilization review procedures, network adequacy, and provider reimbursement. The second targeted area of regulatory compliance for the Examination has been utilization review policies, procedures, and their implementation.

The Examination initially targeted Carrier records and operations during the 2014 calendar year period; however, where necessary because of limited numbers of records available for review in connection with some Carriers, the Examination also included a review of records and operations during 2015 and 2016.

Initial requests for information were submitted to the Carriers in September 2015. The Examination was suspended in June 2016 following adjournment of the Rhode Island Legislature, and was re-commenced in December, 2016.

In re Examination of Health Insurance Carrier Compliance with Mental Health and Substance Abuse Laws and Regulations, Docket No. OHIC-2014-3

2. Applicable statutes and regulations

- a. Carriers must use clinically appropriate utilization review criteria. Carriers are obligated to provide coverage for members with behavioral health conditions by virtue of their obligation to comply with their approved health benefit plan forms. RIGL §§ 27-18-8, 27-19-7.2, 27-20-6.2, and 27-41-29.2. The approved health benefit plans of Blue Cross promise to cover behavioral health services, including a continuum of care for members with mental health and substance abuse disorder conditions. Carriers are also obligated to provide coverage for members with behavioral health conditions by virtue of RIGL § 27-38.2-1(a), which includes both an obligation to provide coverage for the treatment of mental health and substance use conditions and disorders defined and identified in the Diagnostic and Statistical Manual of Mental Disorders, as well as an obligation that coverage be provided under the same terms and conditions as coverage is provided for medical and surgical conditions. Typical "terms and conditions" of coverage include the utilization review process.

The utilization review process can be a legitimate affordability mechanism designed to allocate finite insurance carrier premium revenue in a cost-effective manner, for the benefit of all consumers; however, when utilization review procedures are applied to potentially limit the underlying obligation to provide behavioral health coverage, the utilization review process must be fair and equitable, and must be applied in accordance with reasonable standards. RIGL § 27-9-4-(3) and (4) (the Unfair Claims Settlement Practices Act). In order to fulfill those obligations, the Carrier must use clinically appropriate criteria when making its utilization review determinations. If inappropriate clinical criteria were used, the utilization review process would be neither fair nor equitable, and would not use reasonable standards in making claims determinations. Instead, the Carrier would be acting in an arbitrary manner to deny coverage for behavioral health services that are otherwise required by law to be covered.

The Title 27 obligation to use clinically appropriate utilization review criteria is consistent with RI Department of Health Regulation R23-17.12 (DOH Utilization Review Regulation) § 3.2.20, which requires utilization review agents

In re Examination of Health Insurance Carrier Compliance with Mental Health and Substance Abuse Laws and Regulations, Docket No. OHIC-2014-3

to use "written medically acceptable screening criteria." Thus, the obligation to use clinically appropriate criteria in determining whether to approve or deny behavioral health services is independently grounded in both Title 27, RIGL, and in the DOH Utilization Review Regulation. Since the commencement of this Examination, authority for enforcement of these Department of Health Regulations has been transferred to the Office of the Health Insurance Commissioner.

- b. Carriers must apply their utilization review criteria in a clinically appropriate manner. Based upon the statutory analysis set forth in Para. 3(a), above, Carriers are also obligated to apply utilization review criteria in a clinically appropriate manner. If criteria are not applied in a clinically appropriate manner, the utilization review process would be neither fair nor equitable, nor use reasonable standards and procedures in making utilization review decisions. RIGL section 27-9-4(3) and (4) (the Unfair Claims Settlement Practices Act). The obligation to apply utilization review criteria in a clinically appropriate manner is consistent with the legal obligation under the DOH Utilization Review Regulation to use and apply utilization review criteria and procedures in a clinically appropriate manner. DOH Utilization Review Regulation § 3.2.20. Thus, the obligation to apply clinically appropriate criteria in determining whether to approve or deny behavioral health services is independently grounded both in Title 27, RIGL, and in the DOH Utilization Review Regulation.
- c. Carriers must adopt and implement reasonable utilization review standards and procedures. Carriers must make prompt, fair and equitable utilization review decisions. Health insurance companies are subject to the Unfair Claims Settlement Practices Act. The Act in particular prohibits "[f]ailing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies." RIGL § 27-9.1-4(a)(3). The Act also prohibits "[n]ot attempting in good faith to effectuate prompt, fair, and equitable settlement of [valid] claims". RIGL § 27-9.1-4(a)(3). Together, the Act as applied to the utilization review process requires Carriers to establish reasonable utilization review standards, and to act in a prompt, fair, and equitable manner in reviewing

In re Examination of Health Insurance Carrier Compliance with Mental Health and Substance Abuse Laws and Regulations, Docket No. OHIC-2014-3

requests for approval of coverage for behavioral health services. The Examiners observe that the DOH Utilization Review Regulation and the RI Department of Health Regulation R23-17.13 (DOH Health Plan Certification Regulation) prohibits many practices which also constitute violations of the Unfair Claims Settlement Practices Act. Thus, Carriers' obligation to establish reasonable utilization review standards, and to act in a prompt, fair, and equitable manner in acting upon requests for approval of coverage for behavioral health services is independently grounded in both Title 27, RIGL, and in RI Department of Health Regulations.

- d. Carriers must provide coverage of benefits and services without unreasonable delay and without impeding care. A Carrier must provide coverage of benefits described and promised in a member's health benefit plan. RIGL §§ 27-18-8, 27-19-7.2, 27-20-6.2, and 27-41-29.2. Coverage must be provided in a reasonably prompt manner. RIGL § 27-9.1-4(3). The Examiners observe that the DOH Utilization Review Regulation and the DOH Health Plan Certification Regulation similarly prohibit many practices which would also constitute violations of Carriers' obligation to provide coverage of benefits and services without unreasonable delay and without impeding care. Thus, Carriers' obligation to cover services provided for in the member's health benefit plan without impeding care, and in a reasonably prompt manner is independently grounded in both Title 27, RIGL, and in RI Department of Health Regulations.
- e. Carriers must maintain documentation of utilization review decisions sufficient to allow the Commissioner to determine compliance with legal obligations. A Carrier must provide documentation of its operations in a manner so that the Commissioner can readily ascertain the Carrier's compliance with RI insurance laws and regulations. RI Insurance Regulation 67, § 4.A ("Regulation 67"). In the case of health insurance companies, the obligation includes maintaining documentation of the practices of the Carrier regarding utilization review and network adequacy. Regulation 67 § 4.B. A health claims file must contain communications to and from members or their provider representatives, health facility pre-admission certification or utilization review documentation, any

In re Examination of Health Insurance Carrier Compliance with Mental Health and Substance Abuse Laws and Regulations, Docket No. OHIC-2014-3

documented or recorded telephone communication relating to the handling of the claim, and any other documentation necessary to support claim handling activity. Regulation 67, § 6.A. Thus, the regulation makes clear that a Carrier's utilization review documentation must be sufficient to demonstrate to the Commissioner during a market conduct examination that the Carrier is in compliance with its state insurance laws, including laws and regulations within Title 27, and health insurance laws and regulations authorized under Title 23.

- f. Mental health and substance use disorder coverage must be provided at parity with medical-surgical coverage. State law requires parity in coverage for mental health and substance use conditions with medical-surgical conditions. Rhode Island's parity law was originally enacted in 1994, and amended in 2014 to reflect the federal behavioral health parity law enacted in 2008, and to reflect final federal regulations adopted in 2013. The core legal principals and parity obligations for carriers have remained the same throughout the examination period: (1) carriers must provide coverage for the treatment of mental health and substance use disorders, and (2) such coverage must be provided under the same terms and conditions as coverage is provided for other illnesses and diseases. RIGL § 27-38.2-1(a).

Federal law also requires parity in coverage for mental health and substance abuse disorder conditions with medical-surgical conditions. Among other requirements, federal law prohibits the application of non-quantitative treatment limitations unless the behavioral health limitation is comparable to, and no more stringently applied than the treatment limitation applicable to medical-surgical treatment. 42 U.S.C. § 300gg-26.

Federal regulation further requires coverage of medically necessary behavioral health services in the individual and small group markets. 45 C.F.R. § 156.110(a)(5).

Utilization review standards and procedures are considered "non-quantitative treatment limitations" ("NQTL's") which may not be imposed on coverage of behavioral health services unless the behavioral health utilization review standards and procedures, and the manner in which they are developed,

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are comparable to, and applied no more stringently than utilization review standards and procedures applied to medical-surgical benefits and coverage. RIGL § 27-38.2-1(d). 45 C.F.R. § 146.136(c)(4). Utilization review programs administered for behavioral health services are not "comparable to" medical-surgical services: (i) if prior authorization is required or recommended in a pervasive manner for behavioral health services as compared to medical-surgical services, (ii) if prior authorization is required or recommended for a medically necessary continuum of care for chronic behavioral health conditions, but is not required or recommended for comparable chronic medical conditions, (iii) if prior authorization is applied in a more stringent manner to behavioral health conditions than for medical-surgical conditions, and (v) if benefit plan exclusions apply exclusively to behavioral health conditions or services. 45 C.F.R. § 146.136(c)(4)(examples 9 and 10).

g. Other applicable statutes. RIGL §§ 27-13.1-1 et seq. (Examination Act).

3. Examination methodology and process.

- a. The Commissioner initially appointed Linda Johnson, OHIC Operations Director, Herbert W. Olson, Esq. (former OHIC General Counsel), Jack Broccoli, Chief Insurance Financial Examiner, RI Department of Business Regulation, and Charles DeWeese, OHIC actuary, as Examiners. Linda Johnson and Herbert Olson were in charge of the Examination. Linda Johnson can be reached at Linda.Johnson@ohic.ri.gov. Herbert Olson can be reached at herb.olson123@gmail.com. Assisting the Examiners were the following OHIC staff: Emily Maranjian, OHIC Legal Counsel, John Garrett, Health Reform Specialist, Cheryl Del Pico, Special Projects Coordinator, Victor Woods, Health Economics Specialist, Alyssa Metivier, Health Economics Specialist, and James Lucht, RI EOHHS Deputy Director of Analytics.
- b. The Examiners reviewed the policies and procedures of the Carriers related to utilization review and behavioral health parity, with an emphasis on policies and procedures already submitted to the RI Department of Health in connection with the Health Plan Certification and Utilization Review regulatory programs.

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- c. The Examiners requested and received from the Carriers case records of utilization review decisions (Case Records). Case Records are an important feature of the Examination, because they permit the Examiners to measure the actual implementation of a Carrier's policies and procedures against their legal obligations relating to utilization review and parity. The Examiners reviewed the Case Records for compliance with procedural or non-clinical requirements. The Examiners also identified Case Records which needed review by behavioral health clinicians in order to evaluate the clinical appropriateness of Carrier utilization review criteria, utilization review decisions, and other matters requiring clinical judgment.
- d. In accordance with the Examination Act, the Examiners retained expert clinicians in behavioral health associated with Massachusetts General Hospital (MGH Clinicians), under the direction of Ronald Schouten, MD, JD, Director, Law and Psychiatry Service. The Examiners listed the clinical issues to be reviewed by the MGH Clinicians, and instructions for the review process. The Examiners' findings related to clinical issues are based in part on the clinical review of Case Records by the MGH Clinicians.
- e. The Examiners' data sampling methodology was developed by James Lucht, RI EOHHS Deputy Director of Analytics, in consultation with the Insurance Division of the RI Department of Business Regulation. The essential elements of the sampling methodology is described below:

In order to produce a random representative sample of cases for examination, a Random Stratified Sample with Proportional Distribution was used. For behavioral health claims, the main factors were disposition (approved vs. denied), client age, diagnosis, and setting. For prescription drug claims the main factors were disposition, diagnosis, and drug type. Basic steps are as follows:

1. Create aggregate columns for diagnosis, age, setting, and drug type to lessen the number of unique sampling categories. See appendix for specifics on how each column was grouped. Also add Random and Sample columns.
2. Create pivot table that counts each unique combination of categories for approvals and denials.
3. Determine sample size for approvals and denials.
4. Using the pivot table, determine percentage of approval and denials in each unique combination category. Multiply this

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percentage by the sample size. Results with a value less than one were rounded up to one. If key categories of interest have very low numbers (<3) add one or more cases (oversampling).

5. Sort by Date of Service
6. Generate random number column in Excel using RAND function.
7. Sort by key categories (Setting, Simplified Dx, Age Category) and random number.
8. Choose the specified number of cases from each category starting from the top of each grouping in the spreadsheet, mark new Sample column with a 1.
9. Filter on Sample =1 and copy/paste into new sheet.
10. Pare down number of columns to just the number needed for the carrier to identify the case.

The biggest challenge was to get a representative sample among smaller case groupings. For example, juvenile cases and some combinations of diagnoses and settings are so few that we can't hope to say anything about that class of case unless we greatly oversample. To overcome this, we began with a random proportional sample, assessed classes of cases with low numbers, and then combined categories based on similarity.

- f. Blue Cross was being very cooperative and professional in its responses to information requested by the Examiners. At the conclusion of the Examination, the Examiners met with Blue Cross to discuss the Examiners' proposed findings and recommendations. In response, Blue Cross offered some truly innovative and ground-breaking initiatives – such as elimination of utilization review for in-network behavioral health services - to mitigate utilization review as a potential barrier to medically necessary behavioral health services. Blue Cross also proposed major investments in infrastructure to address gaps in behavioral health service resources in Rhode Island. The Examiners acknowledge Blue Cross' positive efforts to improve coverage of behavioral health services to residents of Rhode Island.
- g. A confidential version of this Report includes confidential Working Papers. The Working Papers Appendices consist of Case Record Summaries with Findings of Fact and Conclusions of Law derived from the review of Case Records of specific utilization review events by the Examiners, and by the expert clinicians engaged by the Examiners to assist with the Examination. Working Papers Appendix A consists of Behavioral Health Case Record Summaries. Working Papers Appendix B consists of Prescription Drug Case Record Summaries. The Working

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Papers are confidential in accordance with RIGL § 27-13.1-5. Among other confidentiality provisions, RIGL § 27-13.1-5 prohibits the disclosure of confidential working papers to anyone for any purpose, other than state or federal insurance regulators that agree to maintain the confidentiality of the documents.

Summary of Findings and Recommendations.

Behavioral health findings

4. In accordance with the methodology described in Para. 3, above, the Examiners selected 269 BH utilization review case records relating to requests for approval of behavioral health services made on behalf of Blue Cross members. Of those 269 BH case records, 145 cases resulting in an authorization of the request were reviewed by the Examiners. Of those 145 BH authorization cases, 10 were forwarded to the MGH Clinicians for review of clinically-related issues. Of those 269 BH case records, 124 were cases resulting in denial of the request. Of those 124 BH case records, 29 were forwarded to the MGH Clinicians for review of clinically-related issues. All 269 BH case records (authorizations and denials), were reviewed by the Examiners for process-related issues.

5. During the 2014 calendar year, Blue Cross delegated administration of its utilization review program for behavioral health services to ValueOptions. Currently, Beacon Health Options, a company formed by a merger between ValueOptions and Beacon Health Strategies, administers Blue Cross' utilization review programs for behavioral health services.

6. ValueOptions administered Blue Cross' utilization review program for behavioral health services pursuant to ValueOptions policies and procedures approved by Blue Cross. Oversight of ValueOptions by Blue Cross was conducted by means of periodic reporting and joint company meetings. Despite such oversight activities, ValueOptions had significant discretion in terms of its utilization review criteria, and the day-to-day administration of the program. At all times, Blue Cross remained fully responsible for compliance with state and federal laws and regulations.

7. The Examiners find that the conduct, policies or procedures described in Paras. 8-19 constitute noncompliant patterns or practices under RIGL Title 27, Chapter 9.1 (Unfair Claims Settlement Practices Act), DOH Utilization Review Regulations, or DOH Plan Certification Regulations.

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8. Blue Cross and its UR Agent used clinically inappropriate utilization review criteria for coverage of behavioral health services. For example:

- a. Utilization review criteria used by Blue Cross and the company contracted with by Blue Cross, and delegated to administer its utilization review program (UR Agent) used circular reasoning in its utilization review criteria by allowing non-clinical considerations embedded in exclusion criteria and discharge criteria to supersede clinical criteria for admission or continued stay. For example, a psychotic patient displaying observable symptoms of being an active danger to self and others was found to meet criteria for admission for treatment in a residential setting, yet was denied treatment based on a generalized exclusion criterion that "the patient can be treated at a lower level of care". Two other Case Records reviewed by the Examiners demonstrate this practice.
- b. Utilization review criteria used by Blue Cross and its UR Agent were not based on objective, measurable, clinical criteria. Instead, the utilization review criteria contained criteria were based on subjective, vague, and generalized conclusions or judgments. For example, a patient with an eating disorder was found to meet objective, measurable clinical criteria for admission to a residential treatment center, yet was denied coverage for treatment because, in the UR Agent's judgment, "the patient can be treated at a lower level of care".
- c. Four (4) other Case Records reviewed by the Examiners demonstrate the use of vague, subjective, or circular criteria.
- d. Five (5) other Case Records reviewed by the Examiners demonstrate the use of clinically inappropriate eating disorder criteria.
- e. Under the utilization review criteria used by Blue Cross and its UR Agent, patients were be denied coverage for a higher level of care recommended by the treating provider without documentation by the UR Agent that the patient met clinical criteria for a lower level of care. In one case, a patient with severe psychosis admitted to in-patient care was recommended for discharge because, in the UR Agent's judgment, the patient was "stable" and could be discharged to home, notwithstanding the patient's continued paranoia and delusions

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concerning the home environment. Two (2) other Case Records reviewed by the Examiners demonstrate this practice.

- f. The utilization review criteria used by Blue Cross and its UR Agent allowed the denial of continued coverage if the UR Agent concluded that the patient had shown "lack of improvement" or insufficient progress", without documentation demonstrating that the clinical circumstances of the patient were taken into consideration. For example, an extremely disturbed patient who was partially adherent to prescribed anti-psychotic medications was denied continued inpatient care because the UR Agent determined that the patient was failing to make sufficient improvement, even though there were sound clinical reasons for gradually introducing a new medication regime for the patient, and notwithstanding that there may have been a clinical rationale for an alternative treatment plan. Eighteen (18) additional Case Records reviewed by the Examiners demonstrate the use of "lack of improvement" or insufficient progress" in making utilization review decisions
 - g. The utilization review criteria used by Blue Cross and its UR Agent allowed the denial of coverage for continued treatment based on the patient's failure to participate in treatment or discharge planning, without properly considering and documenting whether the patient's clinical conditions or other factors beyond the control of the patient might be present. The criteria appeared to permit a patient to be denied coverage for treatment for a mental health condition because the mental health condition itself impaired the patient's ability to make treatment or discharge planning decisions that the UR Agent believed were rational. Four (4) Case Records reviewed by the Examiners demonstrate the use of "failure to participate" in making utilization review decisions.
9. Blue Cross and its UR Agent applied their utilization review criteria in a clinically inappropriate manner. Clinically inappropriate application of the utilization review criteria occurred when:
- a. The observations, conclusions and decisions made, or the facts relied upon by the UR Agent either were not supported in the utilization review case record (Case Record), or were contradicted in the Case Record. In one case, a patient

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with a significant substance use disorder, depression, suicidal ideation, and a long history of treatment, release and relapse was denied residential treatment following in-patient detoxification and stabilization. The treating provider's recommendation was rejected despite documented clinical observations that the patient continued to have suicidal thoughts with the likelihood of relapse given the non-supportive living environment. Eleven (11) Case Records were reviewed by the Examiners where the observations, conclusions and decisions made, or the facts relied upon by the UR Agent either were not supported in the Case Record, or were contradicted in the Case Record.

- b. The UR Agent recommended a shorter length of stay or a lower level of care from that requested by the treating provider, without a documented clinical basis for the recommendation. For example, a UR Agent approved only 4 days of treatment for a patient with an acute eating disorder episode, notwithstanding that the patient's medical complications and the severity of her eating disorder symptoms made a longer length of stay the clinically appropriate course of treatment. Later, the UR Agent denied coverage for continued treatment and the patient was discharged to outpatient care even though the patient was still struggling with the patient's eating disorder, and the patient's home environment posed serious impediments to improvement. Thirty-three (33) Case Records reviewed by the Examiners demonstrate shorter or lower length of stay decisions without adequate clinical basis for the shorter stay of or lower level of care.
- c. The UR Agent applied incorrect utilization review criteria based on the patient's specific behavioral health disorder. For example, a patient with a history of mental illness and homelessness was admitted for alcohol abuse treatment. After detoxification, the UR Agent recommended discharge to an outpatient setting, rather than recommend continued treatment to address the patient's mental condition. If the appropriate mental health criteria had been applied, coverage would have been approved for continued treatment. Five (5) Case Records reviewed by the Examiners demonstrate the use of incorrect utilization review criteria.

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- d. The utilization review process was used to address perceived quality of care issues with the requesting provider's treatment, thereby denying coverage for care for the patient due to the provider's failure to meet the treatment expectations of the UR Agent. Three (3) Case Records reviewed by the Examiners demonstrate this practice.
- e. The requests of the treating provider were discounted or ignored even when there was no dispute as to the facts and circumstances relating to the patient's condition or treatment. For example, a patient with a history of opioid use disorder and frequent relapses was recommended for a series of sequentially lower levels of care in order to mitigate against the risk of relapse. The UR Agent denied coverage for these treatment recommendations, notwithstanding there was no factual dispute upon which the treating provider concluded that (i) the patient had a high risk of relapse, (ii) an abrupt discharge to less intensive treatment settings had a high risk of being unsuccessful, and (iii) the patient's home environment was not conducive to avoiding relapse". Twelve (12) Case Records reviewed by the Examiners demonstrate this practice.
- f. Thirteen (13) additional Case Records reviewed by the Examiners demonstrate the UR Agent's failure to apply its utilization review criteria in a clinically appropriate and consistent manner.

10. Different UR Agent staff reached very different conclusions based on similar facts and clinical circumstances. Such variable decision-making creates the possibility of arbitrary and unwarranted denials of coverage and treatment. Two (2) Case Records reviewed by the Examiners demonstrate this practice.

11. Blue Cross and its UR Agent conducted frequent, short term concurrent reviews of coverage for patients' continued treatment, without an objective or clinical basis for either the frequency of the reviews or their short duration.

- a. For example, a patient was hospitalized with severe and dangerous psychotic symptom requiring a lengthy in-patient stay. The patient and the treating providers were subjected to the following set of concurrent reviews and short duration approvals by the UR Agent:

Initial review for admission, 3 days requested, 3 approved.

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First concurrent review, 7 days requested, 4 approved.

One day approved awaiting a UR Agent physician review.

Denial made by UR Agent physician reviewer due to disagreement with medication treatment.

Case appealed, and 4 days were approved. Documentation is unclear as to what was requested by the facility.

Concurrent review, 5 days requested, 3 approved.

Concurrent review, requested 5 days, 2 approved.

Concurrent review, 6 days requested, 6 approved.

Concurrent review, 4 days requested, 4 approved.

Concurrent review, 5 days requested, 2 approved.

Concurrent review, 5 days requested, 4 approved.

Concurrent review, 4 days requested, 2 approved.

Concurrent review, 3 days requested, 2 approved.

Concurrent review, additional coverage denied.

- b. Thirty-two (32) Case Records reviewed by the Examiners demonstrate the UR Agent's practice of conducting frequent concurrent reviews, where benefits approved were frequently shorter than requested by the patient's treating provider.

12. Blue Cross and its UR Agent did not adequately document their utilization review decisions by:

- a. Failing to collect and maintain adequate documentation of the patient's clinical condition. Case Records that do not contain sufficient documentation of the utilization review process and decisions, and of the patient's condition and circumstances. Seventeen (17) Case Records reviewed by the Examiners demonstrate this practice.
- b. Failing to adequately document the denial rationale, including a response to the provider's rationale for the request, and the specific criteria not met in relation to the patient's clinical condition and circumstances. One (1) Case Record reviewed by the Examiners demonstrates this practice.

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- c. Failing to adequately document the treating provider's rationale and the clinical details supporting the request for coverage. One (1) Case Record reviewed by the Examiners demonstrates this practice.
- d. Failing to adequately document a provider's agreement to a modification or reduction of the treatment request. Seven (7) Case Records reviewed by the Examiners demonstrate this practice.
- e. Failing to provide adequate documentation of the rationale for "updating" its utilization review decision. One (1) Case Record reviewed by the Examiners demonstrates this practice.
- f. Failing to document peer to peer communications. One (1) Case Record reviewed by the Examiners demonstrates this practice.
- g. Poorly organizing its case documentation. One (1) Case Record reviewed by the Examiners demonstrates this practice.
- h. Failing to adequately document events and facts relevant to the utilization review process. Sixteen (16) Case Records reviewed by the Examiners demonstrate this practice.

13. Blue Cross and its UR Agent engaged in unreasonable, and inequitable utilization review procedures by:

- a. Classifying as authorizations utilization review decisions that should have been classified as denials. Nine (9) Case Records reviewed by the Examiners demonstrate this practice.
- b. Attempting to fulfill the provider consultation requirement by making a single call to the treating provider and insisting on an immediate call response. One (1) Case Record reviewed by the Examiners demonstrates this practice.
- c. Failing to use a physician reviewer of the same licensure status as the requesting physician. One (1) Case Record reviewed by the Examiners demonstrates this practice.
- d. Inserting an extra "reconsideration" step in the utilization review process. One (1) Case Record reviewed by the Examiners demonstrates this practice.
- e. Failing to follow the requirements for forwarding a case to external appeal. One (1) Case Record reviewed by the Examiners demonstrates this practice.

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- f. Using denial notifications that contain overly graphic language that might have an adverse impact on the patient's treatment. Nine (1) Case Records reviewed by the Examiners demonstrate this practice.
- g. Using denial notifications that, if the appeal is assigned to the provider, requires the patient to relinquish appeal rights to the provider even if the provider decides to terminate the appeal process. All Case Records reviewed by the Examiners demonstrates this practice.

14. Blue Cross and its UR Agent did not properly consider patients' welfare and safety with respect to appropriate transition of care, and continuity of care. Patients could be discharged from treatment following denial of coverage, contrary to the recommendation of the treating provider, even if necessary socio-economic supports were not available. For example, in one case a patient with diagnoses of opioid dependence and other mental health and substance use disorders, and a history of behavior dangerous to self and others was recommended for residential care following hospitalization. The UR Agent determined that the patient could be treated at a lower level of care, even though the treating provider concluded the patient had nowhere to live that could support the patient's sobriety, and that therefore the patient was at a high risk of relapse. Fourteen (14) Case Records reviewed by the Examiners demonstrate this practice.

15. As a result of the patterns and practices described in Paras. 8-14, above, care was either impeded or delayed, or was potentially impeded or delayed. For example, in one case a patient diagnosed with opioid and cannabis dependence, with a long history of treatment and relapse, was recommended for a gradual series of step-down treatments from hospitalization, including residential care, partial hospitalization, and an intensive outpatient program. Instead, the UR Agent repeatedly and persistently pressured the treatment program to accept a level of care one step lower than was clinically necessary, and for fewer days than requested. Eighteen (18) Case Records reviewed by the Examiners demonstrate this practice.

16. With respect to its behavioral health parity obligations, Blue Cross applied its parity obligations by applying utilization review to a much broader scope of behavioral health services than is the case with medical surgical services. Utilization review was applied to the entire spectrum and continuum of care for patients with behavioral health conditions, excepting only out-patient behavioral health services. In contrast, utilization review of medical-surgical levels of

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care was applied primarily to hospitalization, post-hospital settings, and some intensive hospital outpatient surgery and services, while some intensive procedures conducted in a doctor's office were unaffected by the utilization review process.

17. A review of Blue Cross' silver level health benefit plan issued for use in calendar year 2014 revealed coverage exclusions that were unique to behavioral health conditions or services. As a result, coverage for behavioral health services during calendar year 2014 was not "comparable to", or "subject to the same terms and conditions", as coverage for medical-surgical conditions and services. Since 2014, these improper coverage exclusions have been eliminated from Blue Cross' health benefit plans.

18. The Case Records reviewed by the MGH Clinicians and the Examiners showed that there is reason to believe that utilization review of behavioral health services is applied in a more stringent manner than is the case with medical-surgical services. In response to multiple requests by the Examiners, Blue Cross stated that parity analysis of its utilization review program in 2014 had been conducted, but the parity analysis was not provided to the Examiners. Five (5) Case Records reviewed by the Examiners demonstrate this practice.

Behavioral health recommendations.

19. Blue Cross should implement the following Recommendations in order to remediate the noncompliant patterns and practices found by the Examiners and described in Paras. 8-18. On or before September 28, 2018 Blue Cross should propose a Plan of Correction to implement each of the following behavioral health recommendations set forth in Paras. 20-23.

20. Blue Cross should revise its behavioral health utilization review criteria in the following manner:

- a. Only objective, clinically-based, written criteria should be used to deny requests for behavioral health services.
- b. Level of care criteria should ensure that if clinically-based admission or continued stay criteria have been met, other portions of the criteria (e.g. exclusion criteria or discharge criteria) cannot over-ride the admission or continued stay criteria.
- c. Blue Cross should not deny a request for continued stay based on the rationale that the patient is showing lack of improvement, or the patient is making insufficient progress, or the patient is failing to participate in treatment

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- d. Utilization review criteria should not permit denial of continued stay or care if there is no treatment setting available for the patient on discharge or if there will be a delay in the availability of an essential component of the patient's treatment environment.
- e. The practice of frequent, short duration concurrent reviews unrelated to the clinical condition of the patient should be prohibited. Where available, criteria should include generally accepted "estimate length of stay" components, and concurrent reviews should not be conducted prior to the completion of the ELOS, absent a material change in clinical circumstances. Where ELOS components are not available, concurrent reviews should not be conducted prior to the treating provider's ELOS unless it can be demonstrated and documented that the provider's estimate is clearly unreasonable, based on the clinical condition of the patient. The criteria should permit a change in the ELOS in the case of dually diagnosed patients.
- f. The criteria should include an "exceptions policy" that offers providers an opportunity to request approval of a behavioral health service inconsistent with the national criteria, based on the unique or unusual nature of the patient's clinical condition or circumstances. Such decisions should be considered medical necessity decisions. The UR Agent physician reviewer should consider, address, and document all information submitted by the ordering provider in connection with the exceptions request.
- g. The process for soliciting comments from Rhode Island behavioral health providers and other interested parties concerning behavioral health criteria should be amended to include mechanisms to improve the comment process in order to increase transparency and public engagement. The process should require Blue Cross to consider fully all objections, comments and recommendations concerning the revisions. Prior to the effective date of criteria adoption or revision, Blue Cross should file with the Commissioner and post a statement of the principal reasons for and against the adoption or revision, including Blue Cross' reasons for overruling the objections, comments or recommendations made by providers and other interested parties.

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21. Blue Cross should establish the following revised policies and procedures for utilization review of behavioral health services. Each revised policy should be subject to an explicit component of a utilization review program training manual. Compliance with the policies should be monitored by an oversight policy, conducted by Blue Cross:

- a. There should be a documented and clinically-based rationale to recommend discharge to a lower level of care prior to the estimated length of stay.
- b. If the facts and circumstances presented to the UR Agent suggest reason to believe that necessary clinical information critical to the utilization review decision is missing, such clinical information should be actively solicited from the provider.
- c. When the material facts and circumstances are not in dispute, the utilization review decision should not conflict with the treating provider's level of care or length of stay recommendation unless the provider's recommendation is clearly unreasonable.
- d. Any decision that does not authorize the provider's request, at the level of care and for the number of days requested, should be classified as a denial, absent the provider's documented communication of agreement to modify the request. When the UR Agent suggests a modification of the request, the UR Agent should communicate and document a clinically-based rationale for the suggested modification.
- e. The initial denial must be made independently, by a provider of the same licensure status as the requesting provider. Lower level UR Agent staff should not communicate any recommendations, suggestions, or comments related to disposition of the service request to the UR agent reviewing provider.
- f. The utilization review process should not be used to address quality of care issues. The revised policy should describe alternative means of addressing quality of care issues observed by the UR Agent.
- g. Utilization review denials of a higher level of care should include a clinically-based finding that there is a specific program at a lower level of care which is clinically appropriate and available for the patient.
- h. Review agency/carrier case Managers should not be involved in the utilization review process.

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- i. The utilization review process should require the UR Agent to explicitly consider and document whether or not a potential utilization review denial might impede care, delay care, or lead to an inappropriate transition of care.
- j. Denial notifications should avoid language that might unnecessarily adversely affect the patient, such as overly graphic descriptions of the patient's condition or circumstances, or comments concerning the provider's treatment that might undermine the provider-patient relationship.
- k. Whenever a patient assigns to the provider his or her appeal rights, the utilization review program should prohibit the waiver of the patient's right to pursue a higher level of appeal if the provider declines to pursue the appeal.

22. Blue Cross should establish a revised documentation policy for utilization review records for behavioral health services that includes the following requirements. Compliance with the Case Record documentation policy should be subject to an explicit component of a utilization review program training manual. Compliance with the policy should be monitored by an oversight policy, conducted by Blue Cross:

- a. Case Records should include the date, time and detail of each event in the utilization review process.
- b. Case Records should document in detail all conversations or other communications with the treating provider.
- c. Case Records should document in detail all clinical information offered by the provider, and the complete rationale for the provider's request for approval of services.
- d. Case Records should be maintained by episodes for each level of care from admission to discharge, and not solely by separate requests for approval. Case Records should also be maintained so as to identify and report such episodes. (Blue Cross has proposed a definition of "episode of care" which counts as a single episode an admission and readmission within a 30-day period.)
- e. Case Records should include the actual, independently prepared review of the UR Agent's physician reviewer.
- f. Case Records should include in the UR Agent's physician review documentation that all material clinical information was reviewed, and should include

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documentation of the utilization review criteria not met, and documentation of the reviewer's rationale for rejecting or disagreeing with the requesting provider's clinical judgment or recommendation.

- g. When the UR Agent recommends a modification of the treating provider's request, the Case Record should document a clinically-based rationale for the recommended modification.
- h. The Case Record should document the treating provider's express communication of an agreement to modify the provider's request. The UR Agent's statement of the provider's agreement alone should not satisfy this documentation requirement.
- i. Case Records should be collected, organized, and maintained in a form and in a manner which permits the Commissioner to readily ascertain compliance with state and federal laws and regulations, and implementation of these Recommendations.

23. Blue Cross should revise and narrow the scope of behavioral health services subject to prior authorization. Blue Cross should ensure that its utilization review program is conducted in a manner comparable to, and no more stringent than its utilization review program for medical surgical services. Blue Cross should propose for the Commissioner's approval the form and content of the utilization review parity analysis. If feasible, the analysis should be conducted in the following manner. If Blue Cross believes that some elements of the following are not feasible, Blue Cross should explain its reasoning to the Commissioner's satisfaction:

- a. Identify which mental health, substance use disorder, and medical surgical benefits (excluding prescription drug benefits) are subject to utilization review, and (i) describe the utilization program for each mental health, substance use disorder, and medical surgical benefit, (ii) state the number of requests processed for each mental health, substance use disorder, and medical surgical benefit, and (iii) state the number of denials, appeals, and denials on appeal for those requests processed for each mental health, substance use disorder, and medical surgical benefit.
- b. Identify which mental health, substance use disorder, and medical surgical benefits (excluding prescription drug benefits) were not subject to utilization

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review, and state the number of claims processed for each mental health, substance use disorder, and medical surgical benefit.

- c. For each mental health, substance use disorder, and medical surgical benefit identified in Paras. 20.a and 20.b, above, (i) state the reasons or other factors actually used in deciding whether or not utilization review would apply, (ii) identify and summarize the data and other information used to support the reasons or other factors, and (iii) document the decision process.
- d. For each mental health, substance use disorder, and medical surgical benefit subject to utilization review identified in Paras. 20.a, above, propose a methodology for determining whether utilization review for mental health and substance use disorder benefits are applied no more stringently than utilization review applied to medication surgical benefits. Such a methodology should: (i) use actual utilization review case records in comparing the degree of stringency, (ii) use independent providers to conduct the reviews, (iii) compare the time needed to complete utilization review requests for behavioral health services versus medical surgical services, (iv) compare the complexity of making behavioral health requests versus medical surgical requests and (v) consider any other appropriate factors in determining the comparable rigor of the reviews.

Prescription drug findings

24. In accordance with the examination methodology described in Para. 3, above, the Examiners selected 175 RX utilization review case records, of which 93 were classified as authorizations and 82 RX utilization review case records which were classified as denials relating to requests for approval of prescription drugs for behavioral health conditions. Of those 175 RX case records, 5 cases classified as authorizations and 18 cases classified as denial records were forwarded to the MGH Clinicians for review of clinically-related issues. Of those 175 RX case records, 93 RX case records classified as authorizations and 82 RX case records classified as denials were reviewed by the Examiners for process-related issues.

25. During the 2014 calendar year, Blue Cross delegated administration of its utilization review program for prescription drugs to a UR Agent, the pharmacy benefit management firm Catamaran. Subsequently, Catamaran was acquired by OptumRX, a subsidiary of United

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Healthcare Group, and Blue Cross delegated administration of its utilization review program for prescription drugs to OptumRX.

26. Catamaran administered Blue Cross' utilization review program for prescription drugs pursuant to criteria proposed by Catamaran and approved by Blue Cross, and administered in accordance with Catamaran policies and procedures approved by Blue Cross. Oversight of Catamaran by Blue Cross was conducted by means of periodic reporting and joint company meetings. Despite such oversight activities, Catamaran had significant discretion in terms of its utilization review criteria, and the day-to-day administration of the program. Blue Cross remained fully responsible for compliance with state and federal laws and regulations.

27. The Examiners find that the conduct, policies or procedures described in Paras. 28-35 constitute noncompliant patterns or practices under RIGL Title 27, Chapter 9.1 (Unfair Claims Settlement Practices Act), DOH Utilization Review Regulations, or DOH Plan Certification Regulations.

28. The prior authorization criteria for several prescription drugs used to treat behavioral health conditions were clinically inappropriate; for example, based on the MGH Clinicians observations and conclusions, as set forth in the Report's confidential Working Papers:

- a. Medication assisted treatment.
 - i. The use of prior authorization for medication assisted treatment of opioid dependence disorders is clinically inappropriate.
 - ii. The opioid crisis facing Rhode Island and many other states demands, and has demanded for many years, an urgency by health care providers and health insurance companies that has not always been reflected in their response to the emergency. Whatever value there is in imposing utilization review limitations on treatment for opioid dependency is far outweighed by the risk of harm or death to the patient, and the negative impact on public health from failing to treated opioid dependent patients without delay.
 - iii. The Examiners appreciate the willingness of Blue Cross and the other Carriers to collaborate with the Office during the spring of 2017 to eliminate prior authorization requirements for medication-assisted treatment.

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- b. The requirement of a lengthy trial of an alternative medication, for example 60 days, was excessive for some medications because a clinical determination can be made in a shorter length of time of whether or not the alternative medication is effective.
- c. Some prescription drugs are so much more effective than alternatives that the requirement for two or more trials of alternative medications, and the resulting delay in providing a potentially more effective treatment, is unreasonable.
- d. When certain medications are used as an adjunctive therapy for patients who do not reach full remission, the prior authorization requirement of multiple alternative trials is clinically inappropriate.
- e. For certain drugs already prescribed to patients in an inpatient setting, the utilization review requirement for trials of alternatives may be unreasonable, may improperly impede or delay treatment, and may result in a longer hospital stay than necessary.
- f. The prior authorization criteria for certain drugs fail to allow exceptions for special populations.
- g. Prior authorization criteria fail to include an opportunity for the provider to support a clinically-based exception to the criteria, given the particular patient's condition and treatment needs. Three (3) Case Records reviewed by the Examiners demonstrate this practice.
- h. Suitable alternative medications were sometimes considered insufficient with respect to trial and fail requirements.
- i. Fail first criteria for certain drugs used to treat musculoskeletal pain should not suggest the use of potentially addictive drugs opioids as trial alternative medications.
- j. Prior authorization requirements were imposed even if the patient has been successfully treated in the past on the drug. Two (2) Case Records reviewed by the Examiners demonstrate this practice.
- k. Prior authorization criteria that incorporate and require adherence to FDA guidelines can fail to permit access to off-label, but clinically appropriate, use of prescription drugs. FDA guidelines were used to deny a prescription drug

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request, rather than addressing the patient's actual clinical circumstances. Use of FDA guidelines occurred even if the guidelines were not included in the prior authorization criteria or the prior authorization fax form. Nineteen (1) Case Records reviewed by the Examiners demonstrate this practice.

29. Prior authorization criteria were applied in a clinically inappropriate manner when:
- a. Incorrect facts were used in denying the request. One (1) Case Record reviewed by the Examiners demonstrates this practice.
 - b. There was reason to believe that critical clinical information is missing, but the UR Agent did not solicit the information from the provider, or did not make reasonable attempts to obtain the necessary information. Four (4) Case Records reviewed by the Examiners demonstrate this practice.
 - c. Despite a claims history of the patient having been tried on three alternative medications, the UR Agent did not communicate with the prescriber to ascertain whether the UR Agent's fail first criteria had been met. One (1) Case Record reviewed by the Examiners demonstrates this practice.
 - d. Inconsistent decisions were made in different cases involving similar circumstances. One (1) Case Record reviewed by the Examiners demonstrates this practice.
 - e. The UR Agent denied a request even though the information shows that the request met the UR Agent's prior authorization criteria. One (1) Case Records reviewed by the Examiners demonstrates this practice.
 - f. The UR Agent denied a request using incorrect criteria. One (1) Case Records reviewed by the Examiners demonstrates this practice.
 - g. The utilization review process did not allow an adequate opportunity for the prescriber to request an exception to the prior authorization criteria based on the unique clinical circumstances of the patient. For example, the UR Agent denied a requested medication despite the prescriber's explanation that the patient could not try alternatives because of the patient's unrelated medical disorder. One (1) Case Records reviewed by the Examiners demonstrates this practice.
 - h. The utilization review process improperly applied fail first criteria, and did not adequately consider continuity of care and transitions of care when requests

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were denied for patients already being treated with the prescription drug. For example, when presented with a patient who had been hospitalized for a lengthy period of time, the UR Agent did not adequately consider or investigate whether the patient most likely had been prescribed the requested medication during the lengthy hospitalization. Eleven (11) Case Records reviewed by the Examiners demonstrate that the UR Agent failed to adequately consider the patient's need for continuity of care and transitions of care.

- i. Twenty-two (22) additional Case Records reviewed by the Examiners demonstrate improper application of fail first criteria.
- j. Three (3) additional Case Records reviewed by the Examiners demonstrate the UR Agent's failure to apply its utilization review criteria in a clinically appropriate manner.
- k. The UR Agent did not adequately consider all of the information offered by the prescriber in support of the prior authorization request. Two (2) Case Records reviewed by the Examiners demonstrate this practice.
- l. The UR Agent relied solely on the existence of an opioid claim in the claims system to deny coverage for opioid addiction treatment, without seeking clarification as to whether the patient had actually used the previously prescribed opioid medication. Two (2) Case Records reviewed by the Examiners demonstrate this practice of relying on claim records without outreach to the prescriber.

30. Blue Cross and its UR Agent used outdated or otherwise improper authorization fax forms. For example:

- a. The use of a "wrong" fax form may have influenced an incorrect utilization review decision, even if all necessary information was provided on the form. Two (2) Case Records reviewed by the Examiners demonstrate this practice.
- b. Fax forms did not provide notice to the provider of information needed in order to avoid a prior authorization denial. Two (2) Case Records reviewed by the Examiners demonstrate this practice.
- c. The fax form did not include a list of all approved diagnoses. One (1) Case Records reviewed by the Examiners demonstrates this practice.

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- d. Multiple fax forms remained in use, with different information solicited on different forms. As a result, prescribers understandably could be confused as what is needed to obtain approval for a requested medication. Three (3) Case Records reviewed by the Examiners demonstrate this practice.
- e. Twenty-three (23) additional Case Records reviewed by the Examiners demonstrate the improper use of fax forms.

31. Blue Cross and its UR Agent did not conform to required utilization review procedures by, for example:

- a. Using improper procedures for pending and denying requests, and for appeals. Fifteen (15) Case Records reviewed by the Examiners demonstrate this practice.
- b. Instead of making an independent clinical decision on a prior authorization request, the UR Agent's physician reviewer simply "upheld" the decision of non-physician staff of the UR Agent. Thirteen (13) Case Records reviewed by the Examiners demonstrate this practice.
- c. Unreasonably delaying prior authorization decisions. One (1) Case Records reviewed by the Examiners demonstrates this practice.
- d. When a case was pended for insufficient information, not notifying or seeking clarification from the prescriber concerning what specific information is needed. One (1) Case Records reviewed by the Examiners demonstrates this practice.
- e. Not making reasonable attempts to communicate with the prescriber. One (1) Case Records reviewed by the Examiners demonstrates this practice.
- f. Not issuing a denial notification in a timely manner. One (1) Case Records reviewed by the Examiners demonstrates this practice.
- g. Improperly classifying denials as authorizations.
 - i. Twelve (12) Case Records reviewed by the Examiners demonstrate that the UR Agent classified cases sent to the Examiners as authorizations but which in fact were denials.
 - ii. Five (5) Case Records reviewed by the Examiners demonstrate the practices of classifying cases as authorizations but the quantity of a prescription drug requested by the treating provider was denied by the UR Agent (even though a lower quantity was authorized).

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- h. Forty-eight (48) Case Records reviewed by the Examiners demonstrate the practice of poor communications with the prescriber, or poor documentation of communications with the prescriber.

32. Blue Cross and its UR Agent did not adequately document its utilization review decisions by:

- a. Failing to document events of the prior authorization process correctly.
- b. Failing to clearly document the basis for a denial.
- c. When requests are pended for insufficient information, failing to document what specific information was needed.
- d. Failing to document the UR Agent's consideration of the clinical information and rationale supporting the prescriber's request.
- e. Failing to adequately document communications between the UR Agent and the prescriber.
- f. Failing to adequately document the decision of the UR Agent's physician reviewer, and to document that the physician reviewer (rather than other UR Agent staff) made the decision.

33. A provider's request for prior authorization was subject to multiple utilization review processes when a request for a drug at a particular drug dose or supply is made, but the UR Agent required that separate reviews be conducted for supply limits and dose limits.

34. As a result of the patterns and practices described in Paras. 28-33, above, care was either impeded or delayed, or was potentially impeded or delayed. For example:

- a. A patient was prescribed Suboxone at a dose of 24 mg per day to treat the patient's opioid dependence. The UR Agent denied the prescribed dose, even though the dose was within clinical guidelines, the patient had been prescribed this dose for over 60 days, and the patient had maintained sobriety with this dose.
- b. A UR Agent denied a request for Suboxone for a patient with opioid use disorder, notwithstanding that the UR Agent physician reviewer who should have been conducting an independent clinical review of the quantity limit over-ride request merely "upheld" the decision of a lower level staff person without the clinical expertise to make the decision.

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- c. A patient was hospitalized for a lengthy period of time, during which time the patient had been prescribed a specific antidepressant, and should have been allowed to continue treatment with this medication. The UR Agent denied the request for continued use of the antidepressant, because the UR Agent did not see clear enough evidence that the patient had tried one of the UR Agent's preferred alternative medications.
- d. A patient was denied approval for a prescription drug because of the UR Agent's determination that the patient had not "tried and failed" the UR Agent's preferred alternative medications. The request was denied even though the prescriber justified not engaging in additional trials because the patient's other medical conditions would not permit such trials.
- e. A patient hospitalized and approaching discharge following near a lethal overdose and suicide attempt was denied the opportunity to continue therapy with the prescription drug that had permitted the patient to improve sufficiently to be ready for discharge.
- f. Seventeen (17) Case Records reviewed by the Examiners demonstrate that the UR Agent unreasonably delayed making a prior authorization decision.
- g. Twenty-five (25) Case Records reviewed by the Examiners demonstrate that improper decisions or processes impeded patient care.

Prescription drug recommendations.

35. Blue Cross should implement the following recommendations in order to remediate the noncompliant patterns or practices found by the Examiners and described in Paras. 28-35. On or before September 28, 2018 Blue Cross should propose a Plan of Correction to implement each of the following behavioral health recommendations set forth in Paras. 36-38.

36. Blue Cross should establish the following revised prescription drug utilization review criteria for prescription drugs typically prescribed for behavioral health conditions.

- a. The "trial" period for step therapy criteria should be based on consensus, evidence-based, and should permit the prescriber to determine, based on the prescriber's clinical observations, whether an exception to the trial period should be granted if the patient is not responding appropriately to the alternative medication, or if the patient has adverse consequences to the alternative

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medication. Blue Cross should propose in its Plan of Correction trial periods consistent with the above principles, subject to the approval of the Commissioner.

- b. Step therapy or "fail first" criteria should not be applied unless it is clear that the request is for a new start to the medication. If a patient is being treated with a medication which would otherwise be subject to utilization review, the utilization review request should be approved, including situations where:
 - i. The patient has been prescribed the requested medication during a period of hospitalization.
 - ii. The request is being renewed.
 - iii. Blue Cross should propose in its Plan of Correction policies and procedures satisfactory to the Commissioner in its Plan of Correction how to satisfy the patient's need for continuity and transition of care when: (1) the patient has been prescribed the medication as a member of a different health plan issued by Blue Cross, (2) the patient has been prescribed the medication as a member of a health plan issued by a different carrier, and (3) the patient has been prescribed medication from pharmaceutical company samples.
- c. The criteria should include an "exceptions policy" that offers prescribers an opportunity to request approval of a prescription drug inconsistent with the utilization review criteria, based on the unique or unusual nature of the patient's clinical condition or circumstances. Such decisions should be considered medical necessity decisions. The physician reviewer should consider, address, and document all information submitted by the ordering provider in connection with the exceptions request.
- d. If an FDA guideline is to be used for utilization review of prescription drugs, the guideline should be explicitly incorporated into the utilization review criteria for the specific prescription drug.
- e. Step therapy criteria should not require or suggest a trial of an opioid medication.

37. Blue Cross should establish the following revised policies and procedures for utilization review of prescription drugs typically prescribed for behavioral health conditions. Each revised

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policy and procedure should be subject to an explicit component of a utilization review program training manual. Compliance with the policies should be monitored by an oversight policy, conducted by Blue Cross. Blue Cross' oversight policy should include direct oversight of utilization review functions sub-delegated from its UR Agent to a third party (for example, Medical Review Institute of America, L.L.C.):

- a. If the facts and circumstances presented to the UR Agent suggest reason to believe that clinical information critical to the utilization review decision is missing, the UR Agent should actively solicit the information from the provider, and allow a reasonable period of time for the provider to respond.
- b. When prior approval for medication is being requested for a patient who is being discharged from a hospital, the UR Agent should solicit information concerning medications prescribed to the patient during the hospitalization.
- c. The initial denial should be made independently, by a provider of the same licensure status as the requesting provider. Blue Cross should propose in its Plan of Correction standards and procedures for how it will ensure that: (1) the UR Agent reviewing provider does not rubber-stamp", or give undue weight to the recommendations, suggestions, notes or comments related to disposition of the service request of lower level or previous decision-making staff or reviewers, and (2) the UR Agent reviewing provider explains his or her decision with sufficient detail to understand why the decision was made, and, if applicable, specifically how the prescriber's facts and rationale were considered.
- d. There should be a single process for requesting approval of a medication (including step therapy and fail first requirements), together with requesting approval of the dose or supply of the medication.
- e. Utilization review request forms and protocols (in FAX, digital or telephonic forms) used for the utilization review of prescription drugs should conform to the following requirements:
 - i. The request forms and protocols must incorporate all of the specific criteria for each prescription drug, and must solicit the specific information needed to meet the criteria for that prescription drug.

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- ii. The request forms and protocols should reflect a single process for all types of utilization review, including prior authorization, step therapy, or quantity limits.
- iii. The request forms and protocols should expressly ask the prescriber whether the request is urgent.
- iv. The request forms and protocols should ensure that once the prescriber has demonstrated that the request is for continuation therapy, no additional utilization review questions will be asked or required to be answered, unless in accordance with standards and procedures proposed in Blue Cross' Plan of Correction and approved by the Commissioner.
- v. Blue Cross should develop a process to identify out of date fax forms, consolidate forms where possible, and effectively communicate with providers which fax forms should be used to request prior authorization.
- f. The utilization review process should require explicit, intentional and documented consideration of whether a potential denial might impede care, delay care, or lead to an inappropriate transition of care or lack of continuity of care.
- g. If the UR Agent believes there is insufficient information to make a decision, the prescriber must be notified of what specific information is needed.
- h. The UR Agent should consider the patient's claims history information when reviewing utilization review requests.

38. Blue Cross should establish a revised documentation policy for utilization review records for prescription drugs that includes the following requirements. Compliance with the Case Record documentation policy should be subject to an explicit component of a utilization review program training manual. Compliance with the policy should be monitored by an oversight policy, conducted by Blue Cross. The documentation policy should apply to utilization review functions sub-delegated from Blue Cross' UR Agent to a third party (for example, Medical Review Institute of America, L.L.C.):

- a. Case Records should include the date, time and detail of each event in the utilization review process.
- b. Case Records should document in detail all conversations or other communications with the prescriber, and the prescriber's designee.

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- c. Case Records should document in detail all clinical information offered by the prescriber, and the complete, unabridged rationale for the prescriber's request.
- d. Case Records should include the actual review of the UR Agent's physician reviewer, rather than a note made by some other UR Agent non-physician staff concerning the physician's review.
- e. The Case Record should include in the UR Agent's physician review documentation that all clinical information was reviewed, and documentation of the reviewer's rationale for rejecting or discounting the requesting prescriber's clinical judgment or recommendation.
- f. If a request is pended for insufficient information, the Case Record should document (1) what specific information is needed, (2) communications with the provider, and (3) the provider's response to the communication.
- g. Case Records should be collected, organized, and maintained in a form and in a manner, such that the Commissioner can readily ascertain compliance with state and federal laws and regulations, and implementation of these recommendations.

Wherefore, it is hereby ORDERED:

- A. The Commissioner hereby adopts the Examination Report and Recommendations.
- B. On or before September 28, 2018, Blue Cross shall file with the Commissioner such policies and procedures it intends to use to eliminate utilization review for in-network behavioral health services, and to adopt a Notice of Admission and Discharge Program (NOA/D Program) and a Case Management Program (collectively "Programs"). Blue Cross' shall discontinue its utilization review program for in-network behavioral health services upon the effective date of the Programs. The Programs shall:
 - 1. Not adversely impact access to patient care, or patient continuity and transition of care.
 - 2. Not unreasonably impact provider treatment.
 - 3. Include reasonable standards and procedures for providers to administratively appeal an adverse decision.

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- C. Blue Cross shall report to the Commissioner on January 1, 2019 and July 1, 2019 regarding the implementation of the Programs. Such reports shall include: (i) the number of admissions and discharges under the NOA/D Program, (ii) the number of administrative appeals resulting from the NOA/D Program and the disposition of such appeals, (iii) the number of members in Case Management, (iv) and the number of out of network behavioral health services that were subject to each level of utilization review and the disposition of such reviews. Blue Cross shall provide such other information as the Commissioner may reasonably request related to the Programs.
- D. Blue Cross shall file with the Commissioner by September 28, 2018 a Plan of Correction, approved by the Commissioner, to implement the Recommendations set forth in Paras. 20-24 (behavioral health services), and 36-39 (prescription drugs). Blue Cross shall implement the approved Plan of Correction, within the time frames set forth in the Plan of Correction.
- E. In lieu of a penalty, Blue Cross shall make a behavioral health system infrastructure payment of \$5 million, payable in the amount of \$1 million each year over 5 years beginning January 1, 2019. The payments shall be made to a non-profit Rhode Island organization agreed to by the Commissioner, under terms agreed to by the Commissioner. Payments shall be used to improve the behavioral health system, including improving timely access to needed care and treatment for individuals with mental health and substance use disorder conditions. The behavioral health infrastructure payment shall be separate from, and in addition to Blue Cross' costs of implementing this Report's Recommendations and Orders.
- F. Within 30 days of the issuance of this Order, Blue Cross shall file with the Commissioner affidavits executed by each Director of Blue Cross stating under oath that they have received a copy of the adopted Report and related Orders.
- G. The Commissioner shall retain jurisdiction over this matter to take such further actions, and issue any supplemental orders deemed necessary and appropriate to address the Report's findings, and to implement the Report's Recommendations, and Orders. Such further actions may include but not be limited to validation studies conducted by the Office to verify compliance with these Orders. Blue Cross shall pay the costs of any such further actions or supplemental orders.

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Dated at Cranston, Rhode Island this 15th day of August, 2018.

Marie Ganim

Marie Ganim, Commissioner

THIS ORDER CONSTITUTES A FINAL ADMINISTRATIVE DECISION OF THE OFFICE OF THE HEALTH INSURANCE COMMISSIONER. AS SUCH, THIS ORDER MAY BE APPEALED PURSUANT TO THE ADMINISTRATIVE PROCEDURES ACT, CHAPTER 35 OF TITLE 42 WITHIN THIRTY (30) DAYS OF THE DATE OF THIS ORDER. SUCH APPEAL, IF TAKEN, MAY BE COMPLETED BY FILING A PETITION FOR REVIEW IN SAID COURT.

Consent of Blue Cross and Blue Shield of Rhode Island

I. Blue Cross understands and agrees that this Order constitutes valid obligations of Blue Cross, legally enforceable by the Commissioner.

II. Blue Cross waives its right to judicial review with respect to the above-referenced matter; provided, however, Blue Cross shall have a right to a hearing on any charge or allegation brought by OHIC that Blue Cross failed to comply with, or violated any of its obligations under this Order, and Blue Cross shall have the right to appeal any adverse determination resulting from such charge or allegation.

III. Blue Cross acknowledges and agrees that it consents to the legal obligations imposed by this Order, and that it does so knowingly, voluntarily and unconditionally.

IV. Notwithstanding the foregoing, this consent does not constitute an admission of any statement of fact or conclusions of law contained in the Examination Report or Order.

By: Monica C. Cunha Date: August 8, 2018

Title: V.P. Legal Services

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, SS.

SUPERIOR COURT DEPARTMENT
CIVIL ACTION NO.

COMMONWEALTH OF MASSACHUSETTS,

Plaintiff,

v.

AETNA HEALTH, INC.,
AETNA LIFE INSURANCE COMPANY, and
AETNA HEALTH INSURANCE COMPANY,

Defendants.



**ASSURANCE OF DISCONTINUANCE
PURSUANT TO G.L. CHAPTER 93A, § 5**

I. INTRODUCTION

1. The Commonwealth of Massachusetts, through the Office of the Attorney General (“AGO”), conducted an investigation into certain acts and practices of Aetna concerning its members’ access to Behavioral Health care services.

2. In lieu of litigation, the AGO and Aetna agree to enter this Assurance of Discontinuance (“AOD”) on the terms and conditions contained herein, pursuant to G.L c. 93A, § 5.

3. The AGO and Aetna voluntarily enter into this AOD.

II. DEFINITIONS

1. “Aetna” or “Defendants” shall mean collectively Aetna Health, Inc., Aetna Life Insurance Company, and Aetna Health Insurance Company.

2. “Aetna Member” shall mean an individual who is a Massachusetts resident or member of a group located in Massachusetts enrolled in (i) a commercial individual policy of accident and/or sickness insurance, (ii) a commercial group or blanket policy of accident and/or sickness insurance, or (iii) a commercial health maintenance contract pursuant to which Aetna provides health care coverage.

3. “Audit” shall mean the processes outlined in Section IV.C.3 of this AOD.

4. “Behavioral Health” shall mean the diagnosis, prevention, treatment, cure, or relief of a behavioral health, substance use disorder (“SUD”), or mental health condition, illness, injury, or disease.

5. “Behavioral Health Care Provider” shall mean a Facility or Health Care Professional that provides Behavioral Health services.

6. “Behavioral Health Care Provider Directory” shall mean any Provider Directory of Behavioral Health Care Providers.

7. “Chapter 258” shall mean Chapter 258 of the Acts of 2014: An Act to Increase Opportunities for Long-Term Substance Abuse Recovery.

8. “Clearly and Conspicuously” shall be defined as such term is defined in 940 C.M.R. 6.01.

9. “Closed Network Plan” shall mean a plan where covered services are generally available only through in-network providers and out-of-network benefits are available only in limited circumstances, such as an emergency or when a Member has obtained prior authorization

to go out of network because health care services are not available through an in-network provider. A PPO or POS plan is not a Closed Network Plan.

10. “Effective Date” shall mean 90 days from the execution of this AOD.

11. “Facility” shall mean any health care setting located in Massachusetts, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

12. “Health Care Professional” shall mean any individual physician or other health care practitioner licensed, accredited, or certified in Massachusetts to perform services for the diagnosis, prevention, treatment, cure, or relief of a physical health or Behavioral Health condition, illness, or injury and who provides such services in Massachusetts.

13. “Practice Location” means the physical address(es) where a Health Care Professional regularly provides health care services.

14. “Provider” shall mean a Health Care Professional or Facility.

15. “Provider Directory” or “Directory” shall mean any grouping, compilation, or listing of Aetna’s in-network Providers that Aetna provides or makes available to members, providers, or the public-at-large, electronically or in paper format.

16. “Utilization Management” shall mean any techniques or procedures designed to monitor the use of, or evaluate the clinical necessity, appropriateness, or efficiency of, health care services, including levels of care and settings.

III. ALLEGED VIOLATIONS

1. Aetna publishes online Provider Directories that purport to provide Aetna Members information to help them access health care services, including the phone numbers and

addresses of Providers; whether the Providers are available to see new patients; and whether the Providers are “in network” for an Aetna Member’s plan.

2. Current and prospective plan members rely upon the accuracy of the information in the Directories when choosing health care coverage for themselves and their families and when seeking to obtain in-network Provider services.

3. The Commonwealth contends that Aetna violated and continues to violate M.G.L. c. 93A by publishing Provider Directories that are materially inaccurate and deceptive in a variety of ways that cause harm to consumers. The Commonwealth contends, for example, that these Directories in some instances:

- a. do not accurately reflect certain Health Care Professionals’ availability to see new patients for outpatient services;
- b. contain inaccurate contact information for Providers, which may hinder Aetna Members’ ability to access these Providers for services; and
- c. list Providers at locations where they do not actually provide health care services, which may lead Aetna Members to believe they have more substantial geographic access to Providers than is actually the case.

4. The Commonwealth further contends that Aetna violated its obligations under Chapter 258 by unfairly denying or impeding certain Members’ coverage for SUD treatment services.

IV. ASSURANCES

A. Generally

Aetna shall not engage in any unfair or deceptive acts or practices.

B. Provider Directories and Network Adequacy

1. Generally. Aetna shall comply with all Federal and Massachusetts laws and regulations pertaining to Provider Directories and Provider network adequacy now in effect or later enacted.

2. Provider Directory Contents. Aetna's Provider Directories shall:

a. Clearly and Conspicuously state the circumstances under which a Provider will be designated in the Provider Directories as "accepting new patients."

b. Clearly and Conspicuously disclose the date on which any electronic Directory was last updated, and the date of printing of any paper Directory.

c. Clearly and Conspicuously disclose the manner in which Aetna Members should report Provider Directory inaccuracies, including a customer service telephone number, and an electronic link that Members may use to notify Aetna via e-mail of inaccurate Provider Directory information.

d. Clearly and Conspicuously provide notice to Aetna Members that they may file complaints relating to Provider Directory inaccuracies or Provider network inadequacy to the Commonwealth's Division of Insurance ("DOI"), including the contact information and method for filing such a complaint with DOI.

e. For each Health Care Professional, (i) accurately list his or her Practice Location(s), and (ii) not list that Health Care Professional at other physical addresses of a group practice where he or she does not regularly provide health care services.

3. Provider Directory Updates and Corrections

a. Aetna shall update its online Provider Directories within 30 days of (i) it receiving notice via any source (including without limitation Provider responses, member

complaints, and Audits) of inaccurate information in its Provider Directory and validating such notice where appropriate, provided that Aetna shall undertake such validation within 14 days of receiving the notice, or (ii) the termination of a Provider's agreement with Aetna, by correcting the inaccurate information or removing information in accordance with the provisions of this AOD, including subparagraphs 3(b) – (e) below.

b. Aetna shall remove from its online Provider Directories incorrect information listed for a Provider when (i) Aetna becomes aware, from whatever source, that the telephone number to reach the Provider, the physical address(es) of the Provider's Practice Location, and/or the Aetna plans accepted by the Provider is inaccurate and Aetna is unable to obtain updated information to correct the Directory, or (ii) for Behavioral Health Care Providers, Aetna cannot verify the accuracy of the Provider's telephone number, physical address(es) of the Provider's Practice Location and/or the Aetna plans accepted by the Provider, or obtain updated information, during the course of an Audit.

c. Aetna shall remove from its online Provider Directories any designation that a Provider is "accepting new patients" (in accordance with its definition of that term) as applicable if (i) Aetna becomes aware, from whatever source, that such Provider is not accepting new patients, or (ii) for Behavioral Health Care Providers, Aetna cannot verify that the Provider is accepting new patients in the course of an Audit.

d. Aetna shall remove a Provider listing from its online Provider Directory when as applicable (i) Aetna becomes aware, from whatever source, that the Provider is no longer participating in Aetna's provider network, or (ii) for Behavioral Health Care Providers, Aetna cannot verify that the Provider is still participating in its network in the course of an Audit.

e. Within 3 months of the Effective Date, Aetna shall review its online Provider Directories, and for any Health Care Professional listed at more than one location, Aetna shall (i) identify that Provider's actual Practice Location(s), and (ii) update the Directory in accordance with the terms of this AOD, including removing any listing for a location where the Health Care Professional does not regularly provide health care services.

4. Provider Outreach

a. At least quarterly, Aetna shall contact each network Health Care Professional via a targeted communication that has the sole focus of verifying Provider Directory information. In this communication, Aetna shall (i) request that the Health Care Professional review the information listed in the Provider Directory for that individual, including his or her availability to see new patients, his or her telephone number, physical address for Practice Location(s), and network status; (ii) request that the Health Care Professional verify the accuracy of the information (including whether Practice Locations are accurate), or provide any necessary updates to correct the listings; and (iii) provide instructions as to how the Health Care Professional should verify Provider Directory information or communicate updates. With respect to the Provider outreach described in this Paragraph, it is insufficient for Aetna to determine whether a group practice is accepting new patients; Aetna must seek to verify and obtain updated information for each individual Health Care Professional identified in the Provider Directory.

b. Aetna shall require Provider group practices to promptly notify Aetna whenever a Health Care Professional leaves or joins the group practice or changes his or her Practice Location. Upon receiving notification, Aetna shall update the Provider Directory in accordance with the terms of this AOD.

c. Aetna shall remind Providers at least quarterly that Aetna is obligated to provide members with accurate Provider Directory information and that Providers are required to notify Aetna about any inaccurate information in the Provider Directory so that appropriate corrections may be made. Such reminder may be provided in conjunction with other communications to Providers.

5. Employee Training. Aetna shall train its customer service representatives and other relevant employees regarding how to route issues concerning Provider Directories and Provider network adequacy, including Member complaints, to the appropriate personnel for monitoring and correction of Directory inaccuracies. Within 30 days after the Effective Date, Aetna shall obtain a written or digital certification from all relevant employees that they completed the training, to be retained for four years. Thereafter, Aetna shall re-train each relevant employee at least every two years and conduct the same certification process.

C. Behavioral Health Care Provider Directories and Network Adequacy

1. Generally. Aetna shall maintain a Behavioral Health Care Provider network that is adequate in numbers and types of Behavioral Health Care Providers to assure that all covered Behavioral Health services will be accessible to Aetna Members without unreasonable delay.

2. Contents of Behavioral Health Care Provider Directory. Except where Aetna is required to remove information in accordance with the provisions of this AOD, Aetna shall accurately, Clearly and Conspicuously list, for each network plan, the following in its Behavioral Health Care Provider Directories:

a. For each Health Care Professional,

i. Name;

- ii. Gender;
 - iii. Practice Location(s);
 - iv. Specialty, if applicable;
 - v. Whether he or she is accepting new patients;
 - vi. Medical group and/or facility affiliations, if applicable;
 - vii. Languages spoken other than English, if applicable;
 - viii. Only those categories of service that he or she actually provides to members;
 - ix. Whether he or she offers office visits or outpatient appointments at a Practice Location, or is only available through a hospital or inpatient facility;
 - x. Telephone contact information; and
 - xi. Board certification(s).
- b. For hospitals:
- i. Hospital name;
 - ii. Hospital type;
 - iii. Participating hospital location;
 - iv. Hospital accreditation status; and
 - v. Telephone contact information.
- c. For Facilities other than hospitals:
- i. Facility name;
 - ii. Facility type;
 - iii. Participating Facility location(s); and

iv. Telephone contact information.

d. For electronic Directories, items in (a)(i)-(vii); (b)(i)-(iv); and (c)(i)-(iii) must be made available in a searchable format.

3. Audits

a. Within 3 months of the Effective Date, Aetna shall contact each Health Care Professional in its Behavioral Health Care Provider Directory who has not submitted a claim to Aetna within one year of the Effective Date. In such communication, Aetna shall seek to (i) verify with the Health Care Professional the accuracy of his or her Provider Directory information (including all the information set forth in subparagraph 2(a)) and/or (ii) obtain from the Health Care Professional any updates to make the information in the Provider Directory accurate. If Aetna is unable to either verify the Health Care Professional's information or obtain updated information after reasonable attempts to do so, Aetna shall edit the Directory in accordance with Paragraph IV.B.3. Thereafter, Aetna shall complete this audit process on a quarterly basis for any Health Care Professional who has not submitted a claim to Aetna within one year of the audit date and who has not been audited at any time in the 12 months prior to the audit.

b. Aetna shall conduct a monthly audit of its Behavioral Health Care Provider Directory. The audit shall consist of a representative sample of at least 5% of Behavioral Health Care Providers listed in the Directory (and exclude Providers who have previously been audited at any time in the 12 months prior to the audit). Aetna shall contact each Provider in the audit group and seek to (i) verify with the Provider whether the Provider Directory information (including all the information set forth in subparagraph 2) is accurate; and/or (ii) obtain from the Provider any updates to make the information in the Provider

Directory accurate. If Aetna is unable to either verify the information or obtain updated information after reasonable attempts to do so, Aetna shall edit the Directory in accordance with Paragraph IV.B.3. If the monthly audit process described in this Paragraph finds that at least 98% of the Provider listings examined in the audit were completely accurate for three consecutive months, Aetna may perform the audit process on a quarterly basis thereafter; provided, however, if the results of the quarterly audit process at any time find that less than 98% of the Provider listings examined are completely accurate, Aetna shall immediately reinstate monthly audits.

c. For a period of five years after each Audit, Aetna shall maintain documentation that identifies the Providers who were selected for the Audit and the results of each Audit.

D. Member Complaints Regarding Provider Directory Accuracy and Provider Network Adequacy

1. Aetna shall track and monitor Member complaints, in whatever form, concerning the accuracy of its Provider Directories and/or the adequacy of its Provider networks, including without limitation, complaints concerning inadequate provider networks, timely access to care, and out of network (“OON”) claim disputes. Such tracking and monitoring shall include the date such complaint was submitted, the date such complaint was closed, and a record of actions taken by Aetna in response to such complaint.

2. Aetna shall take appropriate and timely action to resolve Provider Directory and network adequacy issues as they arise, including but not limited to investigating complaints of Provider Directory inaccuracies and updating the Provider Directories in accordance with the terms of this AOD.

E. Utilization Management

1. Generally. Aetna shall comply with all laws and regulations now in effect or later enacted concerning its Utilization Management of Aetna Members' health care.

2. Transparency

a. Aetna shall clearly and accurately disclose its Utilization Management policies and procedures, including requirements relating to prior authorization, notice, and concurrent review, in Member documents, Provider manuals, internal policies, and on its website. These disclosures shall include (but are not limited to) the following:

i. Notification that prior authorization is not required for routine Behavioral Health therapy visits or Behavioral Health medical visits, such as psychopharmacology office visits.

ii. Identification of all Behavioral Health outpatient services that do require prior authorization.

iii. For Aetna plans and Members covered by Chapter 258, notification that Members' coverage for SUD is subject to the provisions of Chapter 258; that initial authorization for SUD treatment is not required; and that Acute Treatment Services ("ATS") and clinical stabilization services ("CSS") treatment will be covered for up to a total of 14 days without authorization or medical necessity review.

b. Aetna shall maintain data sufficient to monitor compliance with the Mental Health Parity and Addiction Equity Act of 2008 and its regulations, including, without limitation: denials and modifications of initial requests for authorization; outcomes resulting from concurrent reviews, including denials and modifications of requests for continued

treatment and days and/or visits authorized at each review; and frequency of concurrent reviews conducted.

F. Compliance with Chapter 258

1. Aetna shall comply with the provisions of Chapter 258.
2. For Aetna Members with plans covered by the statutory provisions of

Chapter 258:

a. Aetna shall cover medically necessary ATS and CSS for up to a total of 14 days without preauthorization and not initiate utilization review procedures until day seven of the treatment. For Members who do not have Closed Network Plans, these obligations apply even when the ATS or CSS is obtained from an OON and/or out-of-state provider.

b. Aetna shall not require a Member to obtain a preauthorization for SUD treatment other than ATS and CSS if the provider is certified or licensed by the Massachusetts Department of Public Health. For Members who do not have Closed Network Plans, this obligation applies even when the treatment is obtained from an OON provider.

G. Payment to the Commonwealth

1. Within fourteen (14) days after filing this AOD with the Superior Court of Suffolk County, Aetna shall pay a total of \$75,000 to the AGO, and such payment shall comprise: (i) \$25,000 to the Commonwealth as civil penalties and (ii) \$50,000 as attorneys' fees and costs. The payment shall be made by electronic funds transfer to the Commonwealth to an account identified by the AGO.

H. General Provisions

1. This AOD represents the entire agreement between the AGO and the Defendants concerning the matters addressed herein. It supersedes any prior agreement, understandings, or stipulations between the parties regarding the subject matter hereof.

2. This AOD shall be binding on the Defendants, as well as their agents, servants, employees, successors, and assigns.

3. This AOD shall be governed by and interpreted in accordance with the laws of the Commonwealth of Massachusetts.

4. This AOD shall be filed in the Superior Court of Suffolk County. The Superior Court of Suffolk County has and shall retain jurisdiction over this AOD.

5. This AOD shall not relieve the Defendants of any obligation to comply with all applicable federal, state, and local laws and regulations.

6. If, after the date of execution of this AOD, the Commonwealth's General Court enacts legislation or amends existing legislation, or if DOI promulgates regulations, that would require Defendants to audit their Provider Directories and/or correct Provider Directory inaccuracies, then Sections IV(B)(2)-(4) ("Provider Directory Contents", "Provider Directory Updates and Corrections", and "Provider Outreach"), and IV(C)(2)-(3) ("Contents of Behavioral Health Care Provider Directory" and "Audits") shall remain effective for five years following the effective date of such legislation or regulations.

7. By virtue of the provisions of G.L. c. 93A, § 5, any violation of the terms of this AOD by the Defendants, their agents, servants, employees, successors, and assigns after the date of this AOD shall constitute prima facie evidence of a violation of G.L. c. 93A, § 2, in any civil action or proceeding commenced by the AGO.

8. The Defendants shall comply with all reasonable inquiries and requests from the AGO regarding the implementation of the terms contained within this AOD.

9. The Defendants hereby accept the terms and conditions of this AOD and waive any right to challenge it in any action or proceeding.

10. Any notices or communications required to be transmitted between the AGO and the Defendants pursuant to this AOD shall be provided in writing by first-class mail, postage prepaid, and by electronic mail to the parties as follows, unless otherwise agreed in writing.

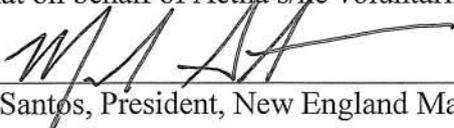
If to the Office of the Attorney General:

Lisa Gaulin, Esq.
Assistant Attorney General
Health Care Division
Office of the Attorney General
One Ashburton Place, 18th Floor
Boston, MA 02108
Lisa.gaulin@massmail.state.ma.us

If to Aetna:

Mark Santos
President, New England Market
151 Farmington Avenue, RS64
Hartford, CT 06156
Santosm1@Aetna.com

11. The undersigned, Mark Santos, represents that s/he is duly authorized to execute this AOD on behalf of Aetna and to bind Aetna to all applicable provisions of the AOD, and that on behalf of Aetna s/he voluntarily enters into this AOD.

By: 
Mark Santos, President, New England Market

Date: 11/7/18

COMMONWEALTH OF MASSACHUSETTS
ATTORNEY GENERAL MAURA HEALEY

By: 
Lisa Gaulin, Assistant Attorney General (BBO# 654655)

Date: 11/16/18