



**COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT**

MARKET CONDUCT EXAMINATION REPORT

OF

AmeriHealth HMO, Inc.,

Keystone Health Plan East, Inc.,

QCC Insurance Co., and

Independence Hospital Indemnity Plan, Inc.

c/o Independence Health Group
1901 Market Street
Philadelphia, PA 19103

As of: December 18, 2019
Issued: December 18, 2019

BUREAU OF HEALTH MARKET CONDUCT

VERIFICATION

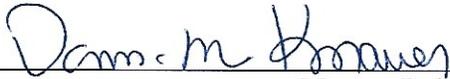
Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. § 4903 (relating to false swearing).



JoAnn Baldo, Examiner-in-Charge

Sworn to and Subscribed Before me

This 13 Day of Dec , 2019



Notary Public

Commonwealth of Pennsylvania - Notary Seal
Donna M. Knauer, Notary Public
BOROUGH of WYOMING Luzerne County
My Commission Expires July 25, 2021
Commission Number 1086948

TABLE OF CONTENTS

CONSENT ORDER..... i

I. INTRODUCTION 1

II. SCOPE OF EXAMINATION 5

III. COMPANY HISTORY 6

 A. Companies..... 6

 B. Insurance Holding Company System..... 9

 C. Territory and Plan of Operations..... 10

IV. COMPANY OPERATIONS AND MANAGEMENT..... 13

 A. Audits Conducted..... 13

 B. Information Technology Protection 13

 C. Anti-Fraud Procedures 14

 D. Disaster Recovery Plan 14

 E. Third-Party Agreements..... 14

 F. Contracted-Entity Activity Monitoring 15

 G. Record Retention..... 15

 H. Written Overview of Operations 15

 I. Response to Requests..... 16

 J. Privacy Policies and Procedures..... 17

 K. Insurance Information Security 17

 L. Security Protection of Non-Public Information..... 17

 M. Privacy Notices 17

 N. Opt-Out Notices 18

 O. Non-Public Personal Financial Information..... 18

 P. Non-Public Personal Health Information Disclosure 18

Q.	Written Information Security Program.....	19
R.	Data Submission to Regulator.....	19
S.	Management of Compliance Division.....	19
T.	External Audits and Examinations.....	20
U.	Annual Statements	20
V.	CONSUMER COMPLAINTS	21
A.	Complaint Handling.....	21
B.	Complaint Handling Procedures	21
C.	Complaint Resolution.....	22
D.	Complaint Response Time	22
E.	Complaint Disposal.....	22
F.	List of Complaints.....	23
G.	Definition of Complaint	23
H.	Complaint Summaries	23
I.	Consumer Complaints Received	23
J.	Pennsylvania Insurance Department Complaints	24
VI.	PRODUCER LICENSING	26
A.	Active Producers	26
B.	Terminated Producers	27
C.	Account Balances.....	27
D.	Description of Agency System.....	28
E.	Licensing and Appointment Verification	28
VII.	POLICYHOLDER SERVICES	29
A.	Collection and Billing Practices	29
B.	Timely Policy Issuance and Insured-Requested Cancellations	29

C.	Correspondence Received by the Company	30
D.	Assumption Reinsurance Agreements.....	30
E.	Policies with Service-Related Transactions	30
F.	Premium Refunds.....	30
G.	Reinstatement.....	31
H.	Policyholder Services.....	31
I.	Unearned Premium and Refunds.....	31
J.	Premium and Billing Notices	32
K.	Cancelled Policies	32
L.	Cancelled Policy Refunds	32
M.	Policy Reinstatements	32
VIII.	UNDERWRITING AND RATING.....	33
A.	Rating Schedules	33
B.	Mandated Disclosures	33
C.	Prohibition of Illegal Rebating.....	33
D.	Underwriting Practices.....	34
E.	Form Filing	34
F.	Issue and Renewal.....	34
G.	Policy Rejections and Declinations	35
H.	Cancellation Notices	35
I.	Rescissions	35
J.	Information on Policy Forms	36
K.	COBRA and Mini-COBRA	36
L.	Genetic Information Nondiscrimination Act Compliance.....	36
M.	Health Information Protection.....	36

N. Pre-existing Conditions	37
O. Coverage Discrimination Based on Health Status.....	37
P. Compliance with Guaranteed Issuance	37
Q. Individual Portability.....	38
R. Clinical Trials.....	38
S. Dependent Coverage	38
T. Group and Individual Health Plan Renewability.....	39
U. Lifetime or Annual Limits.....	39
V. Cost-Sharing Requirements.....	39
W. Mental Health Parity and Addiction Equity Act Compliance	40
X. Rescission of Coverage	40
IX. CLAIMS PROCEDURES.....	41
A. Claimant Contact.....	41
B. Timely Investigations.....	41
C. Timely Claims Resolution.....	42
D. Claims Handling.....	42
E. Claims Forms	42
F. Claim Reserves.....	43
G. Denied and Closed-without-payment Claims.....	43
H. Cancelled Benefit Checks	43
I. Claims-Closing Practices	44
J. Claims-Handling Practices.....	44
K. Newborns' and Mothers' Protection Act.....	44
L. Mental Health Parity and Addiction Equity Act	44
M. Women's Health and Cancer Rights Act of 1998	45

N.	Group Coverage Replacements	45
X.	GRIEVANCES	46
A.	Grievances.....	46
B.	Grievance Procedures.....	46
C.	Grievance Procedure Disclosure	47
D.	First-Level Reviews of Grievances Involving Adverse Benefit Determinations.....	47
E.	Grievance Reviews Not Involving Adverse Determination	47
F.	Voluntary Review of Grievances	48
G.	Expedited Review of Grievances	48
H.	Grievance Procedures Federal Compliance.....	48
I.	Grievance Records Maintenance.....	49
J.	First- and Second-Level Internal Appeals	49
K.	External Reviews	49
XI.	NETWORK ADEQUACY	50
A.	Reasonable Criteria for Network.....	50
B.	Access Plan Filed	50
C.	Contract Forms Filed.....	51
D.	Access to Emergency Services.....	51
E.	Provider Directory.....	51
F.	Accrediting Certification.....	51
G.	Provider Agreements.....	52
XII.	PROVIDER CREDENTIALING.....	53
A.	Credentialing and Recredentialing Program.....	53
B.	Accrediting Verification.....	53
C.	Verification	54

D.	Provider Notification of Changes in Status	54
E.	Provider Opportunity to Review	54
F.	Contractor Credentialing Monitoring	55
XIII.	QUALITY ASSESSMENT AND IMPROVEMENT	56
A.	Quality Assessment Program	56
B.	Written Quality Assessment Program Filing.....	56
C.	Quality Improvement Program.....	56
D.	Reporting of Problematic Providers	57
E.	Quality Assessment and Quality Improvement Program Communication.....	57
F.	Annual Certification of Program	57
G.	Vendor Monitoring.....	58
XIV.	UTILIZATION REVIEW	59
A.	Utilization Review Program.....	59
B.	Annual Report	59
C.	Utilization Review Program Operation	60
D.	Utilization Review Disclosure.....	60
E.	Timely Standard Utilization Review	60
F.	Adverse Determination of Utilization Review	60
G.	Expedited Utilization Review and Benefit Determinations.....	61
H.	Emergency Services Utilization Review	61
I.	Monitoring Utilization Review Entity	61
XV.	CLAIMS REVIEW	63
A.	Medical Claims	64
B.	Mammogram Claims.....	68
C.	Medical Foods Claims.....	70

D. Autism Claims.....	75
E. Emergency Services Claims.....	80
F. Ambulance Claims.....	85
G. Substance Use Disorder Claims.....	88
H. Mental Health Claims.....	94
I. Behavioral Health Claims.....	99
J. HIV/AIDS Claims.....	103
K. Opioid Addiction Claims.....	108
L. Pharmacy Claims.....	113
XVI. FORMULARY REVIEW.....	116
A. Essential Health Benefit Drug Count Tool Results.....	116
B. Clinical Appropriateness Tool.....	116
C. Formulary Outlier Review.....	116
D. Mental Health/Substance Use Disorder and HIV/AIDS Drug Coverage.....	117
E. Single Tablet Drug Regimens or Extended Release Products.....	117
F. Mental Health/Substance Use Disorder Pharmacy and Medical Claims Data.....	117
G. Office Based Opioid Treatment and Opioid Treatment Program.....	117
H. Office Based Opioid Treatment and Opioid Treatment Waiver Program.....	117
I. Urinalysis Criteria for MH/SUD Drugs.....	118
J. MH/SUD Inpatient Admission Criteria.....	118
K. Pharmacy and Therapeutics Committees.....	118
L. Utilization Management or Drug Utilization Committees.....	118
M. Medication Assisted Treatment Processes.....	119
N. Utilization Review or Exclusions.....	119
O. Formulary Design – MH/SUD Drugs.....	119

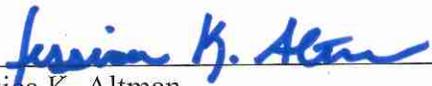
P. Policy Limits on MH/SUD.....	120
Q. Parity Assessment	120
R. Pharmacy Benefit Management	120
S. Drug Information for MH/SUD Claims	120
T. Urine Testing Definition Requirements	121
U. Medical and Clinical Policies.....	121
V. MH/SUD Limits.....	121
W. Medication Assistance Treatment Limits	122
X. Medication Limitations	122
Y. HIV/AIDS Formulary Reviews.....	122
XVII. DATA INTEGRITY	123
XVIII. RECOMMENDATIONS	124
XIX. COMPANY RESPONSE.....	127

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:
: :
AMERIHEALTH HMO, INC, : 40 P.S. §§ 764g(c)(1); 764h(a); 908-11 et seq.;
: 991.2116; 991.2141(b)(4), 991.2166(a), (b);
KEYSTONE HEALTH PLAN EAST, : 1171.5(a)(1)(i), 1171.5(a)(10)(i), (iii), (iv), (v), (vi);
INC. : 3042
: :
QCC INSURANCE COMPANY : 31 Pa. Code §§ 146.3; 146.5(b); 146.6; 154.18(a), (c)
: :
INDEPENDENCE HOSPITAL : 42 U.S.C. §§ 300gg-6; 300gg-13(a)(4); 300gg-
INDEMNITY PLAN, INC. : 19a(b); 300gg-26; 18022(b)(1)(A), (H), (I);
: 18022(b)(4)(e)(i), (ii); 18022(c)(1)(A), (B)
c/o Independence Health Group :
1901 Market Street : 45 C.F.R. §§ 146.136(c)(2)(i); 147.130(a)(1)(iv);
Philadelphia, PA 19103 : 147.136 incorporating 29 C.F.R. § 2560.503-
: 1(i)(2)(ii); 147.138(b); 155.220
: :
Respondent : Docket No. MC19-11-018

CONSENT ORDER

And now, this 31st day of January, 20 20, 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 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) Respondents are Independence Health Group insurance subsidiaries: AmeriHealth HMO, Inc., Keystone Health Plan East, Inc., QCC Insurance Co., and Independence Hospital Indemnity Plan, Inc., hereafter collectively referred to as “Respondent.” Respondent maintains its address at 1901 Market Street, Philadelphia PA 19103.
- (b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from January 1, 2015 to March 31, 2016, and from January 1, 2015 to December 31, 2017 for consumer complaints.
- (c) On December 18, 2019, the Insurance Department issued a Market Conduct Examination Report to Respondent (“Examination Report”).
- (d) Respondent provided to the Insurance Department a response to the Examination Report on January 18, 2020.

- (e) All findings and conclusions in the Examination Report, which is attached hereto, are hereby incorporated into this Consent Order.

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.
- (b) Respondent's violations of Sections 40 P.S. §§ 764g(c)(1) and 764h(a), as contained in the Examination Report, 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. §§ 908-11 et seq., as contained in the Examination Report, 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.
- (d) Respondent's violations of 40 P.S. §§ 991.2116, 991.2141(b)(4), 991.2166(a), and 991.2166(b), as contained in the Examination Report, 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 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.
- (e) Respondent's violations of 40 P.S. §§ 1171.5(a)(1)(i), 1171.5(a)(10)(i), 1171.5(a)(10)(iii), 1171.5(a)(10)(iv), 1171.5(a)(10)(v), and 1171.5(a)(10)(vi), as contained in the Examination Report, are punishable by the following under 40 P.S. § 1171.9:
- (1) An order to cease and desist.
 - (2) License suspension or revocation.
- (f) In addition to any penalties imposed by the Commissioner for violations of 40 P.S. §§ 1171.5(a)(1)(i), 1171.5(a)(10)(i), 1171.5(a)(10)(iii), 1171.5(a)(10)(iv), 1171.5(a)(10)(v), and 1171.5(a)(10)(vi), as contained in the Examination Report, 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.

(g) Respondent's violations of 31 Pa. Code §§ 146.3, 146.5(b), and 146.6, as contained in the Examination Report, are punishable by the following under 40 P.S. §1171.9:

(1) An order to cease and desist.

(2) License suspension or revocation.

(h) In addition to any penalties imposed by the Commissioner for violations of 31 Pa. Code §§ 146.3, 146.5(b), and 146.6, as contained in the Examination Report, 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.

(i) Respondent's violations of 31 Pa. Code §§ 154.18(a), and 154.18(c), as contained in the Examination Report, 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 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.

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 its next scheduled directors meeting, a copy of the adopted Examination Report and any related Orders. Such affidavit shall be submitted within 30 days of the date of this Order.
- (c) Respondent shall comply with all recommendations contained in the Examination Report. This shall include adoption and implementation of enhanced standards and processes relating to customer service, including additional training and communications protocols for complex complaints and grievances.
- (d) Respondent shall report on a quarterly basis, beginning ninety (90) days after the date of this Order, all restitution paid as a result of the reprocessing of those claims as identified in the Examination Report. Each quarterly report shall also include a summary of the current status of enhanced consumer services processes and training.
- (e) Respondent shall pay one hundred sixty-five thousand dollars (\$165,000) to the Commonwealth of Pennsylvania in settlement of the violations contained in the Examination Report.
- (f) Payment of this matter shall be made by check payable to the Commonwealth of Pennsylvania. Payment should be directed to Crystal Welsh, Bureau of Market Regulation, 1209 Strawberry Square, Harrisburg, PA 17120. Payment must be made no later than 30 days after the date of this Order.

(g) To determine Respondent's compliance with the full and timely implementation of all recommendations ("Recommendations") in the Examination Report, the Department may conduct a re-examination of Respondent, beginning no earlier than twenty-four (24) months from the date of this Order. The experience period for the re-examination will commence no earlier than twelve (12) months from 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, the Insurance Department 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 Insurance 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 that Respondent has not remedied after being afforded a reasonable opportunity to do so, the Insurance 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, including those contained in the Examination Report incorporated 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: AMERIHEALTH HMO, INC, Respondent



Michael W. Sullivan
President and Chief Executive Officer



Lilton R. Taliaferro, Jr.
Vice President, General Counsel-AHNJ, and
Corporate Secretary

BY: KEYSTONE HEALTH PLAN EAST, INC,
Respondent

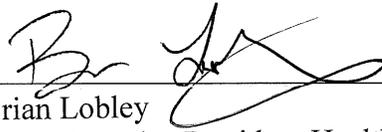


Brian Lobley
Executive Vice President Health Markets



Gregory E. Deavens
Executive Vice President, Chief Financial
Officer and Treasurer

QCC INSURANCE COMPANY,
Respondent



Brian Lobley
Executive Vice President Health Markets

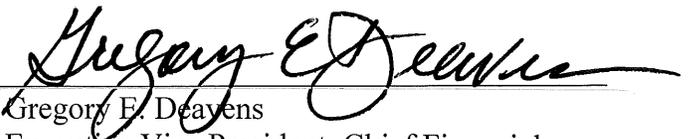


Gregory E. Deavens
Executive Vice President, Chief Financial
Officer and Treasurer

INDEPENDENCE HOSPITAL
INDEMNITY PLAN, INC, Respondent



Brian Lobley
Executive Vice President Health Markets



Gregory E. Deavens
Executive Vice President, Chief Financial
Officer and Treasurer



COMMONWEALTH OF
PENNSYLVANIA
Christopher R. Monahan
Deputy Insurance Commissioner

I. INTRODUCTION

The Market Conduct Examination (Examination) was conducted on the following Independence Health Group insurance subsidiaries: AmeriHealth HMO, Inc., Keystone Health Plan East, Inc., QCC Insurance Co., and Independence Hospital Indemnity Plan, Inc., hereafter collectively referred to as “Company;” at the Company’s offices located in Philadelphia, Pennsylvania, from March 19 through 22, 2018. Subsequent and follow-up reviews were conducted in the offices of the Pennsylvania Insurance Department (the Department) and off-site locations.

Pennsylvania Market Conduct Examination Reports (Examination Report) generally note the items that have been reviewed and whether or not there is a violation of law or regulation. A violation is any instance of Company activity that does not comply with an insurance statute or regulation. Violations contained in the Examination 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. Findings identified in all 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 discrimination in formulary design and parity for treatment limitations in mental health and substance use disorder coverage. The Department anticipates providing ongoing guidance to the industry with respect to those 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 or summaries, which reference specific policy numbers with citations to each section of law violated. Additional information was requested to clarify apparent violations. Multiple conference calls, status meetings, and an exit conference were conducted with Company officials to discuss the

various types of violations identified during the examination and to 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 Examination Report:

Katie Dzurec, JD, MPA, MCM
Acting Director, Bureau of Health Market Actions
Pennsylvania Insurance Department

Donna Fleischauer
Market Conduct Division Chief
Pennsylvania Insurance Department

Heather Harley, AMCM, FLMI, HIA, MHP, DIA, LTCP, ACIP
Contract Supervisory Insurance Examiner

Sean Connolly, AIE, MCM, AIRC
Contract Examiner-in-Charge

JoAnn Baldo, CPA, MCM
Contract Examiner-in-Charge

Lewis Bivona, CPA, AFE
Contract Examiner

Gary Boose, LUTC, MCM
Market Conduct Examiner
PA Insurance Department

Lindsi Swartz, MBA Market
Conduct Examiner PA
Insurance Department

Michael Jones
Market Conduct Examiner
PA Insurance Department

Penny Callihan, MCM
Market Conduct Examiner
PA Insurance Department

Joseph Barrett, MCM, APIR
Market Conduct Examiner
PA Insurance Department

Frank Callihan, MCM
Market Conduct Examiner
PA Insurance Department

Nicole McClain, MCM
Market Conduct Examiner
PA Insurance Department

Ryan Sellers, MCM, APIR
Market Conduct Examiner
PA Insurance Department

II. SCOPE OF EXAMINATION

The 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 applicable federal laws and regulations not superseded by state law.

The Examination focused on the Company's policies, procedures, and processes 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.

III. COMPANY HISTORY

A. Companies

AmeriHealth HMO Inc.

AmeriHealth HMO Inc. was incorporated under the Pennsylvania Not-for-Profit Code on February 18, 1976, as Greater Delaware Valley Health Care, Inc., a health service plan, commonly referred to as an HMO.

Effective May 1, 1984, the Commonwealth of Pennsylvania's Department of State approved the entity's plan of conversion from a non-profit HMO to a for-profit HMO.

On December 23, 1986, AmeriHealth HMO Inc. became a member of an Insurance Holding Company System when, on that date, it was acquired by Independence Blue Cross (Independence), a Pennsylvania Non-Profit Hospital Plan Corporation.

Effective July 1, 1995, AmeriHealth HMO Inc. adopted its current name, AmeriHealth HMO, Inc.

In August 2013, Independence requested approval from the Department to reorganize its holding company system. After receiving approval from the Department, the corporate reorganization became effective on July 1, 2014, and Independence Health Group, Inc. (IHG) became the ultimate parent company for the holding company system. Under the restructuring plan, Independence transferred ownership of all its direct and indirect subsidiaries to IHG, and Independence itself became a controlled affiliate of IHG. As a part of restructuring, Independence's name changed to Independence Hospital Indemnity Plan, Inc. (IHIP).

Keystone Health Plan East, Inc.

KHPE was incorporated on March 27, 1986, as a wholly-owned subsidiary of Keystone Ventures, Inc. (KVI), for the purposes of operating a direct contract independent practice association model health maintenance organization in the Philadelphia area. KVI was, at the time, a wholly-owned subsidiary of Medical Services Association of Pennsylvania, d/b/a Pennsylvania Blue Shield (PBS), a Pennsylvania Non-Profit/Non-Stock Professional Health Service Plan. On December 21, 1990, KHPE entered into an affiliation agreement with Delaware Valley HMO, Inc., a wholly-owned

subsidiary of Independence, a Pennsylvania Non-Profit Hospital Plan Corporation, to form a jointly-owned entity to operate a health maintenance organization in Pennsylvania. The entity was incorporated on February 28, 1991, for this purpose. As a transitional corporation, the entity's objective was to manage the design, development and marketing of a new HMO product and facilitate the affiliation of three health maintenance organizations: the original KHPE, the indirect wholly-owned subsidiary of PBS described above; Delaware Valley HMO, Inc., and Vista Health Plan, Inc., another indirect wholly-owned subsidiary of Independence. The entity was jointly owned by the original KHPE and Delaware Valley HMO, Inc.

On December 31, 1992, the original KHPE transferred its non-new product net liabilities to KVI, and KHPE was merged into Independence. KHPE became the surviving corporation under the joint ownership of KVI and Delaware Valley HMO, Inc.

Effective December 31, 1995, both the Board of Directors and the sole shareholder of KVI, PBS, approved the liquidation of KVI. Accordingly, KVI's assets were distributed to PBS as sole shareholder, including the transfer of KVI's 50% interest in the entity.

Through December 6, 1996, the entity remained a corporate joint venture with the voting stock held equally by AmeriHealth HMO, Inc., formerly Delaware Valley HMO, Inc., and PBS. On that date, PBS and Veritus, Inc., d/b/a Blue Cross of Western Pennsylvania (Western Blue Cross) consolidated their respective operations resulting in a new nonprofit health plan corporation, Highmark, Inc. (Highmark). As a legal effect of the consolidation, all rights, properties, and liabilities of PBS and Western Blue Cross accrued to Highmark, including the stock of the entity directly controlled by PBS.

Also, on this same date, Independence and PBS executed a purchase agreement under which PBS agreed to sell and Independence agreed to purchase, on behalf of AHHMO, the shares of KHPE that were formerly controlled by PBS.

In August 2013, Independence requested approval from the Department to reorganize its holding company system. After receiving approval from the Department, the corporate reorganization became effective on July 1, 2014, and Independence Health Group, Inc. (IHG) became the ultimate parent company for the holding company system. Under the restructuring plan, Independence

transferred ownership of all its direct and indirect subsidiaries to IHG, and Independence itself became a controlled affiliate of IHG. As a part of restructuring, Independence's name changed to Independence Hospital Indemnity Plan, Inc. (IHIP).

AmeriHealth HMO Inc., a licensed health maintenance organization providing comprehensive healthcare benefits to groups and individuals in the states of New Jersey and Pennsylvania, and Keystone Health Plan East, Inc. are HMOs currently authorized to transact the classes of insurance described in 40 P.S. § 1554 (b).

QCC Insurance Co.

Independence Square Life Insurance Company (Independence Square) was incorporated in Pennsylvania on May 13, 1981, licensed by the Department on December 21, 1981, and commenced business on the same day.

Independence Square changed its name to Q-Care Insurance Company on November 30, 1987, then to AmeriHealth Insurance Company on April 3, 1995, and to its current name QCC Insurance Company (QCC) on April 25, 1997.

In August 2013, Independence requested approval from the Department to reorganize its holding company system. After receiving approval from the Department, the corporate reorganization became effective on July 1, 2014, and IHG became the ultimate parent company for the holding company system. QCC is a stock company currently authorized to transact the classes of insurance described in 40 P.S. § 382(a).

Independence Hospital Indemnity Plan, Inc.

Independence Hospital Indemnity Plan Inc. began as the Associated Hospital Service of Philadelphia (AHSC). It was incorporated on August 11, 1938 and became licensed and started business on November 7, 1938. It was the first prepaid hospitalization program in the region.

On October 19, 1973, AHSC changed its name to Blue Cross of Greater Philadelphia (BC) and moved to 1333 Chestnut Street, Philadelphia, PA 19107.

On March 12, 1990, BC changed its name to Independence Blue Cross (Independence) and moved to 1901 Market Street, Philadelphia, PA 19103.

In August 2013, Independence requested approval from the Department to reorganize its holding company system. After receiving approval from the Department, the corporate reorganization became effective on July 1, 2014, and IHG became the ultimate parent company for the holding company system. Under the restructuring plan, Independence transferred ownership of all its direct and indirect subsidiaries to IHG, and Independence itself became a controlled affiliate of IHG. As a part of the restructuring, Independence changed its name to Independence Hospital Indemnity Plan, Inc. (IHIP).

IHIP is currently authorized to transact the classes of insurance described in 40 Pa. C.S.A. § 6101.

B. Insurance Holding Company System

Effective July 1, 2014, the Independence insurance holding company system was reorganized through a plan of division under which IHG became the parent company and “ultimate controlling person” of the system and all of its regulated subsidiaries. Prior to that reorganization, Independence was the parent company and “ultimate controlling person” of the system.

IHG is a nonprofit corporation headquartered in the Commonwealth of Pennsylvania. IHG and its subsidiaries offer health insurance and specialty services in southeastern Pennsylvania and throughout the nation. These products include health, pharmacy, dental, vision and workers’ compensation benefits to individuals and groups. Health insurance coverage is offered through both fully-insured and administrative services products, and includes Preferred Provider Organizations, Health Maintenance Organizations, and traditional indemnity products. Acting as a third-party administrator, certain affiliates provide management services, such as paying claims and providing administrative services to self-insured group health plans. IHG services the Medicaid population through its 61.26% ownership interest in the AmeriHealth Caritas Family of Companies (ACFC).

AmeriHealth HMO Inc., Keystone Health Plan East, Inc., and QCC meet the requirements for filing an insurance holding company system registration statement based upon 40 P.S. § 991.1404. Insurance holding company registration statements have been regularly filed with the Department.

IHG is the ultimate controlling entity in the Holding Company System. Within IHG there are more than 60 companies including Insurance Producers, Insurance Companies, Captive Insurance Companies, HMO's, Professional Health Services Plan Corporations, Hospital Plan Corporations, Third-Party Administrators, Risk Assuming Non-Licensed PPO's, Charitable Foundations, and other companies.

C. Territory and Plan of Operations

AmeriHealth HMO, Inc. is a wholly-owned subsidiary of IBC LLC. IBC LLC is an indirect wholly-owned subsidiary of IHG, a nonprofit corporation headquartered in the Commonwealth of Pennsylvania with a mission to enhance the health and wellness of the people and communities it serves.

AmeriHealth HMO, Inc., domiciled in the Commonwealth of Pennsylvania, is a licensed health maintenance organization providing comprehensive healthcare benefits to groups and individuals in the states of New Jersey, Delaware, and Pennsylvania. As of December 2014, the entity is no longer offering healthcare benefits in the state of Delaware.

KHPE is licensed in and writes business only in Pennsylvania. KHPE is designated as an Individual Practice Association health maintenance organization, operating in the greater Philadelphia area. KHPE provides health insurance coverage for commercial and Medicare products, as well as for the Children's Health Insurance Program (CHIP). KHPE also provides third-party administrative services for self-funded groups.

AH, Inc., a subsidiary of IHG, entered into a joint venture with Healthcare Explorer, LLC, a subsidiary of DaVita HealthCare Partners, LLC, to form Tandigm Health, LLC (Tandigm), a company that promotes high-quality, affordable care to the region. Tandigm partners with primary care physicians in the Philadelphia area and provides enhanced resources to help them deliver more personalized, high quality care. On June 30, 2016, pursuant to a Membership Interest Purchase Agreement, AH, Inc. increased its ownership interest in Tandigm from 50% to 81%. As of April 1, 2018, AH, Inc. purchased Healthcare Explorer's remaining interest (19%) and thereby owns 100% of Tandigm Health, LLC.

Effective January 1, 2015, the entity entered into a Full Risk Global Capitation Agreement with Tandigm for a 5-year initial term with 1-year renewal terms including a 2-year exclusivity period which expired December 31, 2016. Under the terms of the agreement, Tandigm operates as an Integrated Delivery System and assume full financial risk for health care services provided by the entity for its Commercial and Medicare Advantage members. There is no delegation of claims payments to providers and the entity continues to adjudicate claims. As of April 1, 2018, when AH, Inc. purchased the remaining interest from Healthcare Explorer.

QCC is licensed in the following jurisdictions: Arizona, Colorado, Delaware, District of Columbia, Florida, Georgia, Indiana, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Mississippi, Montana, Nebraska, Nevada, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Washington, and West Virginia, and is a qualified insurer in Vermont. It is also authorized to underwrite reinsurance in the Commonwealth of Pennsylvania and underwrites excess of loss reinsurance, in limited instances, for IBC LLC's wholly-owned subsidiary, KHPE.

Despite being licensed or qualified in all of the aforementioned jurisdictions QCC currently only writes business in Pennsylvania.

QCC offers PPO coverage through the “Personal Choice” product line in the five county Philadelphia area. QCC also offers Medigap coverage.

QCC holds a 38.2% interest in International Plan Solutions, LLC (IPS). IPS holds a 34.0% investment in Highway to Health, Inc., which provides insurance placement and administrative services related to health insurance for students, scholars and trainees traveling and/or living abroad and for providers of trip protection insurance.

IHIP is a nonprofit hospital plan corporation in the Commonwealth of Pennsylvania. The entity is a wholly-owned subsidiary of IBC LLC. IBC LLC is an indirect wholly-owned subsidiary of IHG, a nonprofit corporation headquartered in the Commonwealth of Pennsylvania with a mission to enhance the health and wellness of the people and communities it serves.

Health insurance is offered both through fully-insured and administrative services products, and primarily includes Federal Employees Health Benefit Plans as well as Medicare Supplement and traditional indemnity products, sometimes referred to as Comprehensive Major Medical Plans. IHIP and Highmark Inc. (Highmark), an unrelated member of the Blue Cross and Blue Shield Association headquartered in western Pennsylvania, jointly administer or underwrite Major Medical, Comprehensive Major Medical, and Medigap benefits to certain customers.

IHG and Highmark, an unrelated member of the Blue Cross and Blue Shield Association headquartered in western Pennsylvania, jointly market Major Medical, Comprehensive Major Medical, and Medigap benefits to certain customers. During 2012, the parent company and Highmark entered into several new agreements whereby the parent company will purchase services from Highmark as it relates to the enterprise operating platform. Separate Agreements also enhance existing relationships with Highmark in the area of national accounts, dental, vision and stop-loss products.

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 and compliance with applicable laws and regulations. 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 each 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 applicable standards found in 40 P.S. §§ 764a and 1551 et seq., and 31 Pa. Code Ch. 152 and 301.

A. Audits Conducted

Examiners requested a list of all internal audits conducted by the Company during the experience period. The examiners reviewed the audits to ensure they included those completed by an internal audit function within the Company or conducted via a contracted vendor on behalf of the Company. The examiners reviewed documentation ensuring that all internal and external audits are up-to-date. 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 using the guidelines set forth in Chapter 16, Section A, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Information Technology Protection

Examiners requested documentation demonstrating that the Company had controls, safeguards, and policies and procedures in place during the experience period for protecting the integrity of computer information. The Company identified a universe of 178 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations noted above, as well as 31 Pa. Code Ch. 146a, 146b, and 146c,

using the guidelines set forth in Chapters 16, Section A, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Anti-Fraud Procedures

Examiners requested anti-fraud procedures and annual reports 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 nine 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

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 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 A, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

E. Third-Party Agreements

Examiners requested copies of contracts that were in effect during the experience period with any third-party entity, including managing general agents, general agents, third-party administrators, and vendors conducting activities on behalf of the Company. In addition, examiners requested a list of all entities that were involved in the sale or servicing of major medical health products subject to requirements of the Affordable Care Act (ACA) during the experience period, including pharmacy benefit managers, specialty drug vendors, behavioral health vendors, mental health and/or substance use disorder/chemical recovery case management and/or utilization management vendors for the experience period. The Company identified a universe of 125 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. § 156.340, using the guidelines set forth in Chapter 16, Section A, Standard 5 of the *NAIC Market Regulation Handbook*. 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 144 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. §§ 764c and 1551 et seq., 31 Pa. Code §§ 152 and 301, and 45 C.F.R. § 156.340, using the guidelines set forth in Chapters 16, Section A, Standard 6 of the *NAIC Market Regulation Handbook*. No violations were noted.

G. Record Retention

Examiners requested the Company's record retention policies and procedures to ensure records were adequate, accessible, consistent, and orderly, and complied with state retention requirements for 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 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 request included current organizational charts outlining the structure of Pennsylvania operations with respect to management, marketing, customer service, complaints, underwriting, and claims. The request also included any specialty operations conducted separately. 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 laws and regulations, including 40 P.S. §§ 764a and 1551 et seq., as well as 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; however, the following concerns were noted:

Concern 1: The Company failed to issue timely status letters to claimants for certain claim files identified through examiners' review of finalized claims. The Department requests that the Company establish a process of notifying claimants with a reasonable written explanation for the delay in processing claims and state when a decision on the claim may be expected, when claims processing exceeds 30 days and every 45 days thereafter, in compliance with 31 Pa. Code § 146.6. The Company has stated that they are working diligently to enhance this claim notification process.

Concern 2: During the review of complaints received by the Department concerning the Company, Examiners noted that, in a significant number of cases, the Company's members did not receive effective customer assistance when they raised questions or concerns, or when they attempted to resolve enrollment or billing issues. Complaints that could have been resolved at the company level were escalated to the Department. Moreover, incorrect information was provided by the Company to some consumers, which contributed to the overall issue of unresolved customer assistance episodes. While improvement has been noted and the Department is encouraged by the Company's commitment to improving Customer Service, the Department will continue to monitor complaint levels related to customer service to ensure continued positive trends. Additionally, the Department recommends the Company review billing and premium application processes and increase the number of transactions selected for quality assurance review. Notably, the Company has represented that they have made process improvements in their enrollment and billing processes, and their continuing commitment to improve has led to fewer billing and enrollment errors while improving overall member experience.

I. Response to Requests

Examiners requested documentation demonstrating the Company understands that it was required to respond to requests from examiners in a timely manner 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 §§ 152.20 and 301.82, using the guidelines set forth in Chapter 16, Section A, Standard 9 of the *NAIC Market Regulation Handbook*. No violations were noted.

J. Privacy Policies and Procedures

Examiners requested documentation demonstrating that the Company assured the collection, use, and disclosure of information gathered in connection with insurance transactions was performed in a manner that minimized any improper intrusion into the privacy of applicants and policyholders during the experience period. The Company identified a universe of 142 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 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 140 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. 146a, 146b, and 146c; 42 U.S.C. § 1320d-6; and 45 C.F.R. Part 164, 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 the Company had policies and procedures in place during the experience period 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 101 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations noted above, as well as 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 consumers who were not customers, regarding treatment of non-

public personal financial information during the experience period. The Company identified a universe of 17 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 has 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 19 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 applicable state laws and regulations 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 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 noted.

P. Non-Public Personal Health Information Disclosure

Examiners requested documentation demonstrating 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 had authorized the disclosure. The Company identified a universe of 102 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. 146a and 146b, 42 U.S.C. § 1320d-6, and 45 C.F.R. Part 164, 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 the Company implemented a comprehensive written information security program for the protection of non-public customer information during the experience period. The Company identified a universe of 18 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. 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

Examiners requested documentation demonstrating that the Company's data that were required to be reported to the 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 Ch. 146, using the guidelines set forth in Chapter 16, Section A, Standard 18 of the *NAIC Market Regulation Handbook*. No violations were noted.

S. Management of Compliance Division

Examiners requested a description of the management structure of the Company as it relates to major medical health insurance subject to the consumer protection provisions of the ACA, including the management structure that handled compliance issues and mental health parity requirements, 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 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 from the Company of all examination fines, penalties, and recommendations from any state for investigations or examinations conducted during the last five years, and to provide copies of all Financial and Market Conduct Examination reports issued during the last five years. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to determine if the Company had corrected instances of non-compliance identified in the past. No violations were noted.

U. Annual Statements

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 20 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, including policies and procedures for complaint handling, record keeping, dispositions, and timelines. 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. Based on consumer complaints received by the Department during the course of the examination, as well as issues relating to complaints provided for the January 1, 2015, to March 31, 2016 experience period, the experience period for consumer complaints was expanded to cover January 1, 2015 through December 31, 2017. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with applicable standards found in 40 P.S. §§ 991.2141 through 991.2143 and 1171.5, as well as 42 U.S.C. § 300gg-19 and 45 C.F.R. § 147.136.

A. **Complaint Handling**

Examiners requested documentation demonstrating that all complaints were recorded in the required format on the Company's complaint register for the experience period. The Company identified a universe of 49 documents and provided two additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination, all 51 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 policies and procedures related to complaint handling and processes for communicating such procedures to policyholders. The Company identified a universe of 49 documents and provided nine additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination, all 58 documents were reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 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 dispose of complaints in accordance with contract language, as well as state and federal laws and regulations applicable during the experience period. The Company identified a universe of 49 documents and provided nine additional documents in response to an examiner-issued information request. All 58 documents were reviewed to ensure compliance with applicable state and federal laws and regulations noted above 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 that the timeframe within which the Company responded to complaints, including social media complaints, received during the experience period was in accordance with applicable state and federal laws and regulations. The Company identified a universe of 49 documents and provided nine additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination, all 58 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 showing the Company took adequate steps to finalize and dispose of complaints received during the experience period in accordance with policy provisions, as well as applicable state and federal laws and regulations. The Company identified a universe of 10 documents and provided six additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination, all 16 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. List of Complaints

Examiners requested a list of all complaints filed with the Company during the experience period. The list included complaints received from the Department, as well as complaints made directly to the Company on behalf of Pennsylvania consumers. The Company identified a universe of 17 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.

G. Definition of Complaint

Examiners requested that the Company provide the policies, procedures, and guidelines for complaint handling, including the Company's definition of what constitutes a "complaint," that were in effect during the experience period. The Company identified a universe of 50 documents and provided three additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination, all 53 documents were reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

H. Complaint Summaries

Examiners requested a description of the complaint reports and summaries prepared on a regularly recurring basis and a list of the recipients of those reports during the experience period. Examiners also requested an example of each report and/or summary document. The Company identified a universe of 42 documents and provided two additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination, all 44 documents were reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

I. Consumer Complaints Received

Examiners requested that the Company identify all consumer complaints received during the experience period. The Company identified a universe of 3,052 consumer complaints. A random sample of 115 complaints was requested. In accordance with the requirements of the examination, the sample files were reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 31 Pa. Code §§ 146.5 and 154.1. The following violation and concern were noted:

1 Violation – 40 P.S. § 991.2141(b)(4)

A managed care plan shall establish and maintain an internal complaint process with two levels of review by which an enrollee shall be able to file a complaint regarding a participating health care provider or the coverage, operations or management policies of the managed care plan. The complaint process shall consist of an initial review and investigation of the complaint which shall be completed within 30 days of receipt of the complaint. The Company failed to complete the investigation of the noted complaint file in a timely manner.

Concern: The Company’s handling of member complaints during the experience period was inconsistent. It is recommended that the Company continue to pursue consistency in addressing member complaints involving payment for the usage of non-capitated versus capitated labs as referenced in member benefit booklets.

J. Pennsylvania Insurance Department Complaints

Examiners requested that the Company identify all Insurance Department complaints received during the experience period. The Company identified 944 Insurance Department complaints. A random sample of 116 complaint files was requested. In addition, the examiners reviewed nine complaints received by the Department’s Consumer Services Division during the course of the examination. In accordance with the requirements of the examination, a total of 125 complaint files were reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 31 Pa. Code § 146.5. The following violations and concerns were noted:

26 Violations – 40 P.S. § 1171.5(a)(1)(i)

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

AND

40 P.S. § 1171.5(a)(10)(i)

“Unfair methods of competition” and “unfair or deceptive acts or practices” in the business of insurance means the following act 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 failed to properly reflect members’ account information, premium payments, and/or properly process claims in the 26 noted files.

7 Violations – 31 Pa. Code § 146.5(b)

Every insurer, upon receipt of an inquiry from the Department respecting a claim, shall, within 15 working days of receipt of the inquiry, furnish the Department with an adequate response to the inquiry. The Company failed to respond to the Department in a timely manner for the seven noted claim files.

Concerns: Examiners noted that during the experience period some members reported difficulty reaching customer service or getting correct information from customer service and/or getting the information they require via the internet. It is recommended that the Company provide members more access to documents, in writing, upon request.

VI. PRODUCER LICENSING

Examiners requested documentation relating to producer licensing, including policies and procedures regarding systems, record-keeping, and verification. 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 applicable standards found in 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 6,028 active producers. A random sample of 116 records for active producers was requested. The 116 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) 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*. The following violations were noted:

6 Violations – 45 C.F.R. § 155.220

A State may permit agents and brokers to (1) enroll individuals, employers, or employees in any qualified health plan (QHP) in the individual or small group market as soon as the QHP is offered through an Exchange in the State; (2) enroll qualified individuals in a QHP in a manner that constitutes enrollment through the Exchange; and (3) assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs.

When an agent or broker uses the Internet Web site of another agent or broker to help an applicant or enrollee complete a QHP selection in the Federally-facilitated Exchange, and the agent or broker accessing the Web site pursuant to the arrangement is listed as the agent of record on the enrollment, the Company is required to: verify that any agent or broker accessing or using the Web site pursuant to the arrangement is licensed in the State in which the consumer is selecting the QHP; and has

completed training and registration and has signed all required agreements with the Federally-facilitated Exchange; report to HHS and applicable State departments of insurance any potential material breach of the standards outlined in federal regulations, or the agreement entered into by the agent or broker accessing the Internet Web site, should it become aware of any such potential breach.

An agent or broker that enrolls qualified individuals in a QHP in a manner that constitutes enrollment through the Exchange or assists individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs must comply with the terms of an agreement between the agent or broker and the Exchange under which the agent or broker at least: registers with the Exchange in advance of assisting qualified individuals enrolling in QHPs through the Exchange; receives training in the range of QHP options and insurance affordability programs; complies with the Exchange's privacy and security standards. Six active producers were not registered in the Federally-facilitated Marketplace or did not have proper credentialing to sell ACA-related products.

B. Terminated Producers

Examiners requested a list of all producers terminated during the experience period. The Company identified a universe of 2,291 terminated producers. A random sample of 115 records for terminated producers was requested. 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 noted above, as well as 40 P.S. § 310.71(f) and 45 C.F.R. § 155.220, using the guidelines set forth in Chapter 16, Section D, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Account Balances

Examiners requested documentation showing that producer contracts' account balances were in accordance with producer contracts for the experience period. The Company identified a universe of four documents. In accordance with the requirements of the examination, the producer and agency contract agreements and commission schedules were reviewed to ensure compliance with

applicable state and federal 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.

D. Description of Agency System

Examiners requested a description of the type of agency system(s) utilized by the Company 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. No violations were noted.

E. Licensing and Appointment Verification

Examiners requested documentation demonstrating how the Company verified that all business that it 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 six 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. 39a, using the guidelines 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 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 applicable standards found in 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 documentation describing requirements for premium collection and billing used 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 16, Section E, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Timely Policy Issuance and Insured-Requested Cancellations

Examiners requested documentation describing requirements for timely policy issuance and insured-requested cancellations 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 E, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Correspondence Received by the Company

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 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 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 gained prior approval of the Insurance Department, and the Company had sent the required notices to affected policyholders. 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 16, Section E, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

E. Policies with Service-Related Transactions

Examiners requested a list of service-related transactions, including policy addition requests, dropped policy transactions, and Individual ID change transactions, that occurred 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 E, Standard 5 of the *NAIC Market Regulation Handbook*. No violations were noted.

F. 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 two documents. 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. § 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.

G. Reinstatement

Examiners requested documentation demonstrating how the Company monitored and assured that reinstatement was applied consistently and in accordance with policy provisions, as well as state and federal 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 laws and regulations, including 40 P.S. § 753(A)(4), using the guidelines set forth in Chapter 20, Section E, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

H. Policyholder Services

Examiners requested documentation demonstrating that policyholder service is properly handled in accordance with policy provisions and with state and federal laws and regulations applicable during the experience period. The Company identified a universe of 140 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.

I. 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, 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.

J. Premium and Billing Notices

Examiners requested a sample of premium and billing notices used during the experience period. The Company identified a universe of 13 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 45 C.F.R. §§ 156.460 and 156.1255, using the guidelines set forth in Chapter 16, Section E, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

K. Cancelled Policies

Examiners requested a list of policies cancelled 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 noted above using the guidelines set forth in Chapter 16, Section E, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

L. Cancelled Policy Refunds

Examiners requested a list of refunds resulting from cancellations that occurred 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 noted above using the guidelines set forth in Chapter 16, Section E, Standard 5 of the *NAIC Market Regulation Handbook*. No violations were noted.

M. Policy Reinstatements

Examiners requested a list of policy reinstatements requested 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. 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 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 applicable standards found in 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 individual, small group, and large group major medical health plans subject to consumer protection provisions of the ACA effective during the experience period. The Company identified a universe of 17 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 the 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 three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations noted above, as well as 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 selection of risks. 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 noted above, as well as 40 P.S. §§ 477a, 761, and 1171.5(a)(7); and 45 C.F.R. §§ 146.121 and 147.110, using the guidelines set forth in Chapter 16, Section F, Standard 4, and Chapter 20, Section F, Standard 7 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 58 policy forms. In accordance with the requirements of the examination, the policy forms were reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 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 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 noted above, as well as 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 10 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 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 F, Standard 7 of the *NAIC Market Regulation Handbook*. 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 30 documents relating to cancellation practices and cancellation notices. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 45 C.F.R. § 155.230, using the guidelines set forth in Chapter 16, Section F, Standard 8, and Chapter 20, Section F, Standard 1 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 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 noted above, as well as 45 C.F.R. § 147.128, using the guidelines set forth in Chapter 16, Section F, Standard 9, and Chapter 20A, Rescissions, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

J. 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 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 noted above, as well as 40 P.S. § 753, using the guidelines set forth in Chapter 20, Section F, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

K. 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, as well as state and federal 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 noted above, as well as 40 P.S. § 764j and 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.

L. Genetic Information Nondiscrimination Act Compliance

Examiners requested documentation demonstrating that the Company complied with the Genetic Information Nondiscrimination Act of 2008 and state 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 noted above, as well as 40 P.S. § 908-14 and 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.

M. 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 one document. In accordance with

the requirements of the examination, the document was reviewed to ensure compliance with applicable state laws and regulations noted above, as well as 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.

N. 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 49 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 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 Pre-existing Condition Exclusions for Individuals under 19 Years of Age, Standards 1 and 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

O. 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 nine documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 40 P.S. §§ 908-14 and 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.

P. Compliance with Guaranteed Issuance

Examiners requested documentation demonstrating that the Company issued coverage that complied with guaranteed-issue requirements of state and federal laws and regulations applicable during the experience period. The Company identified a universe of 23 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 40 P.S. §§ 1302.1 et seq., 42 U.S.C. 300gg-1, and 45 C.F.R. § 147.104, using the guidelines set forth in Chapter 20, Section

F, Standards 8 and Chapter 20A, Guaranteed Availability of Coverage, Standards 1 and 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

Q. 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 state and federal laws and regulations 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 and federal laws and regulations noted above, as well as 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.

R. 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 three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with state and federal laws and regulations noted above, as well as 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.

S. 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 nine documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 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.

T. Group and Individual 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, subject to final regulations established by the United State Department of Health and Human Services (HHS), the United State Department of Labor (DOL), and the United States Department of the Treasury (Treasury). 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 and federal laws and regulations noted above, as well as 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.

U. Lifetime or Annual 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 final regulations established by HHS, DOL, and Treasury during the experience period. The Company identified a universe of 14 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 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.

V. Cost-Sharing Requirements

Examiners requested documentation demonstrating that, during the experience period, the Company did not impose cost-sharing requirements on preventive services as defined in, and in accordance with, final regulations established by HHS, DOL, and Treasury. 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 noted above, as well as 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 with respect to underwriting and rating practices.

W. Mental Health Parity and Addiction Equity Act Compliance

Examiners requested documentation demonstrating that the Company complied with state law and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which prohibits health insurance issuers that provide mental health or substance use disorder benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits 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 noted above, as well as 40 P.S. §§ 908-1 et seq. and 908-11 et seq., 42 U.S.C. § 300gg-26, and 45 C.F.R. § 146.136. No violations were noted with respect to underwriting and rating practices.

X. Rescission of Coverage

Examiners requested documentation demonstrating that, during the experience period, the Company did not retrospectively rescind individual or group coverage (including family coverage in which the individual is included) unless the individual (or a person seeking coverage on behalf of the individual) performed an act, practice, or omission that constituted fraud, or made an intentional misrepresentation of material fact. Examiners also requested documentation demonstrating that the Company provided at least 30 days' advance written notice to each plan enrollee (in the individual market, primary subscriber) who would be affected before coverage was rescinded. 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 noted above, as well as 45 C.F.R. § 147.128, using the guidelines set forth in Chapter 20A, Rescissions, Standards 1 and 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

IX. CLAIMS PROCEDURES

Examiners requested documentation relating to claims procedures, including policies and procedures for claims handling, record keeping, dispositions, and timelines. 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 applicable standards found in 40 P.S. § 1171.5 and 31 Pa. Code Ch. 146.

A. Claimant Contact

Examiners requested documentation demonstrating that initial contact with claimants occurred within the required timeframe applicable during the experience period. The Company identified a universe of seven documents and provided two additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination, all nine documents were reviewed to ensure compliance with applicable state laws and regulations noted above, specifically 31 Pa. Code § 146.5, as well as 45 C.F.R. § 155.230, using the guidelines set forth in Chapter 16, Section G, Standard 1 of the *NAIC Market Regulation Handbook*. The following concern was noted:

Concern: The Company did not, during the experience period, have a formal guideline that is consistent with 31 Pa. Code § 146.5(a). It is recommended that the Company develop a policy that clearly outlines the timely manner in which initial contacts with claimants are to be made, and related notifications sent, consistent with Pennsylvania regulatory requirements.

B. Timely Investigations

Examiners requested documentation demonstrating that investigations were conducted timely during the experience period. The Company identified a universe of one document and provided one additional document in response to an examiner-issued information request. In accordance with the requirements of the examination, both documents were reviewed to ensure compliance with applicable state laws and regulations noted above, as well as 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 nine documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations noted above, as well as 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. The Company identified a universe of two documents and provided seven additional documents in response to an examiner-issued information request. Further, examiners requested documentation demonstrating that claims were handled in accordance with policy provisions, as well as state and federal laws and regulations applicable during the experience period. The Company identified a universe of nine documents. In accordance with the requirements of the examination, all 18 documents were reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section G, Standard 6, and Chapter 20, Section G, Standard 1 of the *NAIC Market Regulation Handbook*. The following concern was noted:

Concern: As noted above, the Company did not, during the experience period, have a formal claims handling policy or procedure consistent with 31 Pa. Code § 146.5(a). It is recommended that the Company develop a policy and procedure that clearly outlines the timely manner in which claims are to be processed and notifications are sent consistent with Pennsylvania regulatory requirements and to ensure consistency.

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 14 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 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 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 G, Standard 8 of the *NAIC Market Regulation Handbook*. No violations were noted.

G. Denied and Closed-without-payment Claims

Examiners requested documentation demonstrating that denied and closed-without-payment claims were handled in accordance with policy provisions and state 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 using the guidelines set forth in Chapter 16, Section G, Standard 9 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 three documents and provided four additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination, all seven documents were 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 two 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 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 laws and regulations applicable during the experience period. 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 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 Mothers' Protection Act

Examiners requested documentation demonstrating that the Company complied with the requirements of the federal Newborns' and Mothers' Health Protection Act of 1996 and the Pennsylvania Health Security Act. 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 noted above, as well as 40 P.S. §§ 1581 through 1584, and 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. Mental Health Parity and Addiction Equity Act

Examiners requested documentation demonstrating that the Company complied with the requirements of MHPAEA and the Pennsylvania Health Insurance Coverage Parity and Nondiscrimination Act. The Company identified a universe of 14 documents and provided two additional documents in response to an examiner-issued information request. In accordance with

the requirements of the examination, all 16 documents were reviewed to ensure compliance with applicable state laws and regulations noted above and 40 P.S. §§ 908-1 et seq. and 908-11 et seq., as well as 42 U.S.C. § 300gg-26, and 45 C.F.R § 146.136, using the guidelines set forth in Chapter 20, Section G, Standard 3 of the *NAIC Market Regulation Handbook*. Upon review of the written policies and other documentation, no violations with respect to claims procedures.

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 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 noted above and 40 P.S. §§ 764d and 1571, as well as 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 replacements 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 laws and regulations noted above, as well as 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. GRIEVANCES

Examiners requested documentation relating to grievances filed during the experience period, including policies and procedures for grievance handling, record keeping, dispositions, and timelines. 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 applicable standards found in 40 P.S. §§ 991.2101 et seq. and 1171.5, 31 Pa. Code § 154.13, 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 10 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 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Grievance Procedures

Examiners requested documentation demonstrating that the Company documented, maintained, and reported grievances, and established and maintained grievance procedures in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of 15 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 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Grievance Procedure Disclosure

Examiners requested documentation demonstrating how the Company implemented 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 grievance procedures, including all forms that were filed with the Commonwealth used to process grievances during the experience period. 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 and federal laws and regulations 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 in place during the experience period for the proper handling of grievances involving adverse benefit determinations and conducted first-level reviews of such grievances in compliance with applicable state and federal laws and regulations, and in accordance with the final regulations established by HHS, DOL, and Treasury. The Company identified a universe of 23 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, and Chapter 20A, Grievance Procedures, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

E. Grievance Reviews Not Involving Adverse Determination

Examiners requested documentation demonstrating that the Company had procedures for and conducted standard reviews of grievances not involving adverse benefit determinations in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of 11 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. Voluntary Review of Grievances

Examiners requested documentation demonstrating that the Company had procedures for, and that the Company conducted, voluntary reviews of grievances in compliance with state 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 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 that the Company had procedures for and conducted expedited reviews of urgent care requests 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 21 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 7, and Chapter 20A, Grievance Procedures, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

H. Grievance Procedures Federal Compliance

Examiners requested that the Company provide documentation demonstrating that the Company's grievance procedures in existence during the experience period were properly handled in accordance with policy provisions and in compliance with applicable federal laws and regulations requiring a health carrier to comply with grievance procedures in accordance with the final regulations established by HHS, DOL, and Treasury. The Company identified a universe of 26 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 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

I. Grievance Records Maintenance

Examiners requested documentation demonstrating that the Company's grievance procedures were properly handled in accordance with federal laws and regulations requiring individual health insurance coverage to maintain records of all claims and notices associated with the internal claims and appeals process for the length of time specified in the final regulations established by HHS, DOL, and Treasury. 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 federal laws and regulations using the guidelines set forth in Chapter 20A, Grievance Procedures, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

J. First- and Second-Level Internal Appeals

Examiners requested that the Company identify all first- and second-level internal appeals received during the experience period. The Company identified a universe of 355 appeals. A random sample of 114 was selected for review. The following violations were noted:

3 Violations – 45 C.F.R. § 147.136(b) incorporating 29 C.F.R. § 2560.503-1

A plan or issuer must provide notice to individuals regarding internal claims and appeals and external review processes, in a culturally and linguistically appropriate manner, that complies with the requirements of federal laws and regulations, including a description of available internal appeals and external review processes. The Company failed to timely notify claimants of the plan's benefit determination in the three noted samples.

K. External Reviews

Examiners requested a list of all external reviews received during the experience period. The Company identified a universe of 91 reviews. A random sample of 79 was selected for review. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations noted above. No violations were noted.

XI. NETWORK ADEQUACY

Examiners requested documentation relating to network adequacy, including policies and procedures, network criteria and access, record keeping, filings, and provider contracts. 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 applicable standards found in 40 P.S. §§ 764a and 991.2111, 31 Pa. Code §§ 152.1 et seq. and 301.42, and 45 C.F.R. § 156.230.

A. Reasonable Criteria for Network

Examiners requested documentation demonstrating that the Company used reasonable criteria to maintain a network that was sufficient in number and types of providers to ensure that all services to covered persons would be accessible without unreasonable delay 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 the guidelines set forth in Chapter 20, Section I, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. 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. Examiners also requested that the Company demonstrate that it made 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 eight 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.

C. 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 six 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 20, Section I, Standards 3, 5, 6, and 7 of the *NAIC Market Regulation Handbook*. No violations were noted.

D. 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. The Company identified a universe of 14 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations noted above, specifically 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.

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 also made available, on a timely and reasonable basis, updates to its directory during the experience period. 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 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.

F. Accrediting Certification

Examiners requested a copy of the Company's HHS-recognized accrediting entity certification or a copy of the Company's network access plan for the experience period. The Company provided

five NCQA Accreditation Certificates for products offered in 2014 through 2017. In accordance with the requirements of the examination, the documentation was reviewed for compliance with applicable state and federal laws and regulations noted above, as well as 45 C.F.R. § 156.275. No violations were noted.

G. Provider Agreements

Examiners requested a copy of the various provider agreements in effect during the experience period. The Company identified a universe of eight documents. In accordance with the requirements of the examination, the documents were reviewed for compliance with applicable state and federal laws and regulations noted above. No violations were noted.

XII. PROVIDER CREDENTIALING

Examiners requested documentation relating to provider credentialing, including policies and procedures, credentialing programs, verification, and record keeping and monitoring. 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 applicable standards found in 40 P.S. § 991.2121, 28 Pa. Code § 9.761, and 45 C.F.R. § 156.275.

A. Credentialing and Recredentialing Program

Examiners requested documentation demonstrating that the Company established and maintained a program for credentialing and recredentialing in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of five documents and provided 28 additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination, all 33 documents were 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. Examiners also requested documentation demonstrating that the Company obtained, through a primary or secondary credentialing verification process, the information required by state laws and regulations applicable 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 and federal laws and regulations using the guidelines set forth in Chapter 20, Section J, Standards 2 and 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Verification

Examiners requested documentation demonstrating that the Company obtained primary or secondary verification of information required by state laws and regulations applicable during the experience period. The Company identified a universe of 14 documents and provided eight additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination, all 22 of the documents were 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 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 noted above, as well as 40 P.S. §§ 991.2117 and 1171.5, and 31 Pa. Code §§ 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 eight documents and provided five additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination, all 13 documents were 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 compliance 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 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, including policies and procedures for quality assessment, filings, reporting, communication, and certification. 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 applicable standards found in 28 Pa. Code Ch. 9, 42 U.S.C. § 18031, and 45 C.F.R. §§ 155.200(d) and 156.1105 et seq.

A. Quality Assessment Program

Examiners requested documentation demonstrating that the Company developed and maintained a quality assessment 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 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. Written Quality Assessment Program 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 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 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 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 K, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

D. Reporting of Problematic Providers

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 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 K, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

E. Quality Assessment and Quality Improvement Program Communication

Examiners requested documentation demonstrating that, during the experience period, the Company documented and communicated information about its quality assessment program and its quality improvement program to covered persons and providers. The Company identified a universe of 15 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 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 state and federal requirements 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 K, Standard 6 of the *NAIC Market Regulation Handbook*. No violations were noted.

G. Vendor 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. 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 K, Standard 7 of the *NAIC Market Regulation Handbook*. No violations were noted.

XIV. UTILIZATION REVIEW

Examiners requested documentation relating to utilization review, including policies and procedures for utilization review, reporting, operations, disclosure, timelines, and monitoring. 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 applicable standards found in 40 P.S. §§ 991.2136, 991.2151, and 991.2152; 28 Pa. Code Ch. 9, and accreditation 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 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 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 identified a universe of eight 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.

C. Utilization Review Program Operation

Examiners requested documentation demonstrating that the Company operated its utilization review program in accordance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of 17 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 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

D. Utilization Review Disclosure

Examiners requested documentation demonstrating that 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 10 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 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 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

F. Adverse Determination of Utilization Review

Examiners requested documentation demonstrating that the Company provided written notice of adverse determinations of standard utilization review 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 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 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 Review

Examiners requested documentation demonstrating that 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 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 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 organization complied with state 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 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. CLAIMS REVIEW

Examiners requested a list of all claims paid, denied, and partially paid, including a list of all pharmacy claims that were paid or rejected during the experience period, for the types of claims indicated below. The Company identified a universe of 9,250,764 claims. A random sample of claim files was requested, received, and reviewed for the following types of claims:

- A. Medical Claims
- B. Mammogram Claims
- C. Medical Foods Claims
- D. Autism Claims
- E. Emergency Services Claims
- F. Ambulance Claims
- G. Substance Use Disorder Claims
- H. Mental Health Claims
- I. Behavioral Health Claims
- J. HIV/AIDS Claims
- K. Opioid Claims
- L. Pharmacy Claims – Mental Health/Behavioral Health and Substance Use Disorder

In accordance with the requirements of the examination, all claim files were reviewed to ensure compliance with applicable state and federal laws and regulations, including applicable standards found in 40 P.S. §§ 991.2166 and 1171.5; 31 Pa. Code Ch. 146 and 154; 42 U.S.C. §§ 300gg-6, 300gg-13, and 18022; and 45 C.F.R. §§ 147.130, 147.150, and 156.110.

As noted in the claim review sections that follow, the Company identified numerous claims files as BlueCard claims, fully capitated claims, and CHIP or Medicare claims. Because these claims are processed in different ways, they are outside the scope of the examination. BlueCard is a national program that enables members of a Blue Cross and Blue Shield (BCBS) Plan to obtain health care services while traveling or living in another BCBS Plan's service area. Fully capitated claims are part of a payment arrangement with providers in which a set amount is paid for each enrolled person, per period of time, whether or not that person seeks care, i.e., the provider was paid in advance for having the member as a patient. Claims were, therefore, not processed for provider reimbursement.

Government programs, including Medicaid, CHIP, and Medicare are outside the scope of Insurance Department authority and outside the scope of this examination.

A. Medical Claims

Examiners requested lists of all medical claims paid, denied, and partially paid during the experience period. In accordance with the requirements of the examination, medical claim files were reviewed to ensure compliance with applicable state and federal laws and regulations. The random sample of medical claims included mammogram and autism spectrum disorder (ASD) claims, which were tested for compliance with all applicable state and federal laws, including those specific to mammograms (40 P.S. § 764c) and ASD (40 P.S. § 764h and Act 68) respectively. In addition, examiners requested identification of specific universes relating to mammogram claims and ASD claims, which were reviewed separately and discussed in subsections B and D below. Examiners found violations in all three sections.

Medical Paid Claims

Examiners requested a list of all medical claims paid during the experience period. The Company identified a universe of 5,799,436 paid medical claims. A random sample of 109 claim files was requested. Upon review, examiners determined that 22 files were BlueCard claims and 16 claims were fully capitated, which are outside of the scope of this examination; however, 21 of these claims were replaced with additional samples selected from the universe. In accordance with the requirements of the examination, 92 of 109 identified files were reviewed. The following violations were noted:

1 Violation – 40 P.S. § 991.2166(a)

A licensed insurer or managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

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 submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The noted clean claim was not paid within 45 days of receipt.

1 Violation – 42 U.S.C. § 300gg-13(a)(4) & 45 C.F.R. § 147.130(a)(1)(iv)

A health insurance issuer offering group or individual health insurance coverage shall, at a minimum, provide coverage for and shall not impose any cost-sharing requirements for, with respect to women, preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. The Company failed to provide coverage with no imposition of member liability for the noted claim.

Medical Denied Claims

Examiners requested a list of all medical claims denied during the experience period. The Company identified a universe of 756,473 denied medical claims. A random sample of 109 claims was requested. Upon review, examiners determined that 22 files were BlueCard claims and out of scope; however, these claims were replaced with additional samples selected from the universe. In accordance with the requirements of the examination, 109 files were reviewed. The following violations were noted:

3 Violations – 40 P.S. § 991.2166(a)

A licensed insurer or managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

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 submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the three noted claims within 45 days of receipt.

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

If a licensed insurer or a managed care plan fails to remit payment as required, 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 Company failed to pay the three noted claims timely and interest of \$2 or more remains unpaid.

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 the following act 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 three noted claims when the Company’s liability under the policy was reasonably clear.

Medical Partially-Paid Claims

Examiners requested a list of all medical claims partially paid during the experience period. The Company identified a universe of 308,878 partially-paid medical claims. A random sample of 109 claim files was requested and reviewed. Upon review, examiners determined that 17 files were BlueCard claims and 10 claims were fully capitated, which are outside the scope of this examination. Replacement samples were used for 19 of these claims and in accordance with the requirements of the examination, 101 of 109 identified files were reviewed. The following violations were noted:

5 Violations – 40 P.S. § 991.2166(a)

A licensed insurer or managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

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 submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the three noted claims within 45 days of receipt.

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

If a licensed insurer or a managed care plan fails to remit payment as required, 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 Company failed to pay the noted claim timely and interest of \$2 or more remains unpaid.

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 the following act 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 noted claim 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 an appointed designee. The files shall contain notes and work papers pertaining to the claim in detail so that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain complete records in the noted claim file.

B. Mammogram Claims

Examiners requested lists of all mammogram claims paid, denied, and partially paid during the experience period. In accordance with the requirements of the examination, mammogram claim files were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 764c, 991.2166, and 1171.5; 31 Pa. Code Ch. 146 and 154; 42 U.S.C. §§ 300gg-6, 300gg-13, and 18022; and 45 C.F.R. §§ 147.130 and 147.150. Examiners found violations in two of the three sections.

Mammogram Paid Claims

Examiners requested a list of all mammogram claims paid during the experience period. The Company identified a universe of 13,516 paid mammogram claims. A random sample of 109 claim files was requested and reviewed. Upon review, examiners determined that 11 files were BlueCard claims, which are outside the scope of this examination. In accordance with the requirements of the examination, 98 of 109 identified files were reviewed. The following violations were noted:

1 Violation – 40 P.S. § 991.2166(a)

A licensed insurer or managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

AND

40 P.S. § 1171.5(a)(10)(iii)

"Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

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 submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the noted claim within 45 days of receipt.

Mammogram Denied Claims

Examiners requested a list of all mammogram claims denied during the experience period. The Company identified a universe of 4,412 denied mammogram claims. A random sample of 108 claim files was requested. Upon review, examiners determined that six files were BlueCard claims, which are outside the scope of this examination. In accordance with the requirements of the examination, 102 of 108 identified files were reviewed. No violations were noted.

Mammogram Partially-Paid Claims

Examiners requested a list of all mammogram claims partially paid during the experience period. The Company identified a universe of 3,952 partially-paid mammogram claims. A random sample of 108 claim files was requested. Upon review, examiners determined that 17 files were BlueCard claims, which are outside the scope of the examination. In accordance with the requirements of the examination, 91 of 108 identified files were reviewed. The following violations were noted:

1 Violation – 40 P.S. § 991.2166(a)

A licensed insurer or managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

AND

40 P.S. § 1171.5(a)(10)(iii)

"Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Failing to adopt

and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

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 submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the noted claim within 45 days of receipt.

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 the following act 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 noted claim when the Company’s liability under the policy was reasonably clear.

C. Medical Foods Claims

Examiners requested lists of all medical foods claims paid, denied, and partially paid during the experience period. In accordance with the requirements of the examination, medical foods claim files were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 991.2166, 1171.5, and 3901 et seq.; 31 Pa. Code Ch. 146 and 154; 42 U.S.C. §§ 300gg-6, 300gg-13, and 18022; and 45 C.F.R. § 147.150. Examiners found violations in all three sections and noted the following concerns:

Concern 1: Several individuals required therapy for extended periods, and the untimely review of claims resulted in confusion and out-of-pocket costs that consumers should not have paid. In addition, it appears that providers may not have understood that these services required prior authorization. In some cases, it seemed lack of prior authorization may have resulted in claims denials or denied provider reimbursement for this benefit. Examiners recommend that the health

plan educate members, Company personnel, and providers regarding the requirements for accessing and utilizing the medical foods benefit.

Medical Foods Paid Claims

Examiners requested a list of medical foods claims paid during the experience period. The Company identified a universe of 2,015 paid medical food claims. A random sample of 107 medical foods claim files was requested. Upon review, examiners determined that 30 files were BlueCard claims which are outside the scope of this examination. In accordance with the requirements of the examination, 77 of 107 identified files were reviewed. The following violations were noted:

6 Violations – 40 P.S. § 991.2166(a)

A licensed insurer or managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

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 submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the six noted claims within 45 days of receipt.

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

If a licensed insurer or a managed care plan fails to remit payment as required, 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 Company failed to pay the two noted claims timely and interest of \$2 or more remains unpaid.

6 Violations – 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 the following act 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 perform a timely investigation of six claims that it would have reasonably paid in the ordinary course of business

6 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 the following act 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 failed to pay the six noted claims timely when the Company’s liability under the policy was reasonably clear.

2 Violations – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by an appointed designee. The files shall contain notes and work papers pertaining to the claim in detail so that pertinent events and the dates of the events can be reconstructed. The Company failed to provide the information needed to ensure the accurate claim processing for the two noted claim files.

Medical Foods Denied Claims

Examiners requested a list of medical foods claims denied during the experience period. The Company identified a universe of 841 denied medical foods claims. A random sample of 105 claim files was requested. Upon review, examiners determined that 18 files were BlueCard claims, which are outside the scope of this examination. In accordance with the requirements of the examination, 87 of 105 identified files were reviewed. The following violations were noted:

14 Violations – 40 P.S. § 991.2166(a)

A licensed insurer or managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

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 submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the 14 noted claims within 45 days of receipt.

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

If a licensed insurer or a managed care plan fails to remit payment as required, 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 Company failed to pay the 12 noted claims timely and interest of \$2 or more remains unpaid.

11 Violations – 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 the following act 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 perform a timely investigation of 11 claims that it would have reasonably paid in the ordinary course of business.

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 the following act 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 noted claim within a reasonable time after proof of loss for the claim listed.

13 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 the following act 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 failed to pay the 13 noted claims timely when the Company's liability under the policy was reasonably clear.

12 Violations – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by an appointed designee. The files shall contain notes and work papers pertaining to the claim in detail so that pertinent events and the dates of the events can be reconstructed. The Company failed to provide the information needed to ensure the accurate claim processing for the 12 noted claim files.

Medical Foods Partially-Paid Claims

Examiners requested a list of partially paid medical foods claims received during the experience period. The Company identified a universe of 170 partially-paid medical foods claims. A random sample of 76 claims was requested. Upon review, examiners determined that 11 files were BlueCard claims, which are outside the scope of this examination. In accordance with the requirements of the examination, 65 of 76 identified files were reviewed. The following violations were noted:

28 Violations – 40 P.S. § 991.2166(a)

A licensed insurer or managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

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 submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the 28 noted claims within 45 days of receipt.

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

If a licensed insurer or a managed care plan fails to remit payment as required, 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 Company failed to pay the 28 noted claims timely and interest of \$2 or more remains unpaid.

28 Violations – 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 the following act 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 perform a timely investigation of 28 claims that it would have reasonably paid in the ordinary course of business.

28 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 the following act 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 failed to pay the 28 noted claims timely when the Company’s liability under the policy was reasonably clear.

26 Violations – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by an appointed designee. The files shall contain notes and work papers pertaining to the claim in detail so that pertinent events and the dates of the events can be reconstructed. The Company failed to provide the information needed to ensure accurate claims processing for the 26 noted claim files.

D. Autism Claims

Examiners requested lists of all autism spectrum disorder (ASD) claims paid, denied, and partially paid during the experience period. In accordance with the requirements of the examination, ASD

claim files were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 764h, 991.2166, and 1171.5; 31 Pa. Code Ch. 146 and 154; 42 U.S.C. §§ 300gg-6, 300gg-13, and 18022; and 45 C.F.R. §§ 146.136 and 147.150. Examiners found violations in all three sections.

Autism Paid Claims

Examiners requested a list of all ASD claims paid during the experience period. The Company identified a universe of 10,707 paid ASD claims. A random sample of 109 claims was requested. Upon review, examiners determined that 17 claim files were BlueCard claims and two were fully-capitated claims, which are outside the scope of this examination. In accordance with the requirements of the examination, 90 of 109 identified files were reviewed. The following violations were noted:

2 Violations – 40 P.S. § 991.2166(a)

A licensed insurer or managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

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 submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the two noted claims within 45 days of receipt.

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

If a licensed insurer or a managed care plan fails to remit payment as required, 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 Company failed to pay the two noted claims timely and interest of \$2 or more remains unpaid.

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

AND

40 P.S. § 1171.5(a)(10)(i)

“Unfair methods of competition” and “unfair or deceptive acts or practices” in the business of insurance means the following act 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.

AND

42 U.S.C. §§ 300gg-6 & 18022(c)(1)(A) & (B)

The annual limitation on cost-sharing shall be equal to the amount defined in federal law and regulation. Any annual cost-sharing imposed must not exceed the limitations provided for in federal law and regulation. The Company failed to apply the member’s out-of-pocket expense for EHBs to the total maximum out-of-pocket accumulator, which may have resulted in these and other members paying more than the maximum allowable amount.

2 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 the following act 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 failed to pay the two noted claims timely when the Company’s liability under the policy was reasonably clear.

Autism Denied Claims

Examiners requested a list of all ASD claims that were denied during the experience period. The Company identified a universe of 2,287 denied ASD claims. A random sample of 108 denied claims was requested. Upon review, examiners determined that 15 files were BlueCard claims, which are outside the scope of this examination. In accordance with the requirements of the examination, 93 of 108 identified files were reviewed. The following violations were noted:

11 Violations – 40 P.S. § 764h(a)

Coverage is required for individuals under 21 years of age for the diagnostic assessment and treatment of ASD. The Company failed to provide required coverage for ASD claims in the 11 noted claim files.

17 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 the following act 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 failed to effectuate prompt settlements of claims when the Company’s liability under the policy had become reasonably clear; or the Company failed to effectuate prompt, fair and equitable settlements of claims. Further, the Company inconsistently balance billed the members for in-network services when the participating provider failed to obtain a prior authorization, or the prior authorization was denied by the Company when requested by the participating provider. Specifically, in some cases, the Company excluded coverage of the services performed by the type of provider or for the member’s diagnosis even with an approved prior authorization for the facility under which the participating provider was operating.

1 Violation – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by an appointed designee. The files shall contain notes and work papers pertaining to the claim in detail

so that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain complete records in the noted claim file.

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 noted claim within 30 days after notification of the claim and failed to provide timely 45-day status letters for the noted claim file.

Autism Partially-Paid Claims

Examiners requested a list of all ASD claims partially paid during the experience period. The Company identified a universe of 282 partially-paid ASD claims. A random sample of 82 claims was requested. Upon review, examiners determined that 28 files were BlueCard claims and one file was a fully-capitated claim, which are outside the scope of this examination. In accordance with the requirements of the examination, 53 of 82 identified files were reviewed. The following violations were noted:

1 Violation – 40 P.S. § 764h(a)

Coverage is required for individuals under 21 years of age for the diagnostic assessment and treatment of ASD. The Company failed to provide required coverage for ASD claims in the noted claim file.

2 Violations – 40 P.S. § 991.2166(a)

A licensed insurer or managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

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 submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the two noted claims within 45 days of receipt.

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

If a licensed insurer or a managed care plan fails to remit payment as required, 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 Company failed to pay the two noted claims timely and interest of \$2 or more remains unpaid.

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 the following act 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 denied the noted claim without conducting a reasonable investigation.

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 the following act 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.

E. Emergency Services Claims

Examiners requested lists of all emergency services claims paid, denied, and partially paid during the experience period. In accordance with the requirements of the examination, emergency services claim files were reviewed to ensure compliance with applicable state and federal laws and

regulations, including 40 P.S. §§ 991.2116, 991.2166, 1171.5, and 3042; 31 Pa. Code Ch. 146 and 154; 42 U.S.C. §§ 300gg-6 and 18022; and 45 C.F.R. §§ 147.138 and 147.150. Examiners found violations in all three sections.

Emergency Services Paid Claims

Examiners requested a list of all emergency services claims paid during the experience period. The Company identified a universe of 157,446 paid emergency services claims. A random sample of 109 claim files was requested. Upon review, examiners determined that 31 files were BlueCard claims, which are outside the scope of this examination. In accordance with the requirements of the examination, 78 of 109 identified files were reviewed. The following violation was noted:

1 Violation – 40 P.S. § 991.2166(a)

A licensed insurer or managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

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 submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the noted claim within 45 days of receipt.

Emergency Services Denied Claims

Examiners requested a list of all emergency services claims denied during the experience period. The Company identified a universe of 44,958 denied emergency services claims. A random sample of 109 claim files was requested. Upon review, examiners determined that 29 files were BlueCard

claims, which are outside the scope of this examination. In accordance with the requirements of the examination, 80 of 109 files were reviewed. The following violations were noted:

3 Violations – 40 P.S. §§ 991.2116 & 3042

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 or insurer. The managed care plan or insurer 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, both the presenting symptoms and the services provided shall be considered.

AND

42 U.S.C. §§ 300gg-19a(b) & 18022(b)(4)(E)(i) and (ii) & 45 C.F.R. § 147.138(b)

A group health plan or health insurance issuer offering group or individual health insurance shall cover emergency services without the need for any prior authorization, regardless of whether the furnishing health care provider is a participating provider, and the same cost-sharing requirement would apply as if such services were provided in-network, even if provided out-of-network. The Company failed to provide emergency benefits or timely payment of emergency benefits at the in-network level for the three noted claims.

3 Violations – 40 P.S. § 991.2166(a)

A licensed insurer or managed care plan shall pay clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

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 submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the three noted claims within 45 days of receipt.

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

If a licensed insurer or a managed care plan fails to remit payment as required, 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 Company failed to pay the three noted claims timely and interest of \$2 or more remains unpaid.

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 the following act 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 three noted claims when the Company’s liability under the policy was reasonably clear.

2 Violations – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by an appointed designee. The files shall contain notes and work papers pertaining to the claim in detail so that pertinent events and the dates of the events can be reconstructed. The Company failed to provide the information needed to ensure accurate claim processing for two noted claim files.

Emergency Services Partially-Paid Claims

Examiners requested lists of all emergency services claims partially paid during the experience period. The Company identified a universe of 21,644 partially-paid emergency services claims. A random sample of 109 claims was requested. Upon review, examiners determined that seven BlueCard claims and four CHIP or Medicare claims were provided, all of which are outside the

scope of this examination. In accordance with the requirements of the examination, 98 of 109 files were reviewed. The following violations were noted:

2 Violations – 40 P.S. §§ 991.2116 & 3042

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 or insurer. The managed care plan or insurer 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, both the presenting symptoms and the services provided shall be considered.

AND

42 U.S.C. §§ 300gg-19a(b) & 18022(b)(4)(E)(i) and (ii) & 45 C.F.R. § 147.138(b)

A group health plan or health insurance issuer offering group or individual health insurance shall cover emergency services without the need for any prior authorization, regardless of whether the furnishing health care provider is a participating provider, and the same cost-sharing requirement would apply as if such services were provided in-network, even if provided out-of-network. The Company failed to provide emergency benefits or timely payment of emergency benefits for the insureds where their policy and the law required provision thereof for two noted claims.

2 Violations – 40 P.S. § 991.2166(a)

A licensed insurer or managed care plan shall pay clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

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 submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the two noted claims within 45 days of receipt.

3 Violations – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by an appointed designee. The files shall contain notes and work papers pertaining to the claim in detail so that pertinent events and the dates of the events can be reconstructed. The Company failed to provide the information needed to ensure accurate claim processing for three noted claim files.

F. Ambulance Claims

Examiners requested lists of all ambulance claims paid, denied, and partially paid during the experience period. In accordance with the requirements of the examination, ambulance claim files were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 991.2116, 991.2166, 1171.5, and 3042; 31 Pa. Code Ch. 146 and 154; 42 U.S.C. §§ 300gg-6 and 18022; and 45 C.F.R. §§ 147.138 and 147.150. Examiners found violations in two of the three sections.

Ambulance Paid Claims

Examiners requested a list of all ambulance claims paid during the experience period. The Company identified a universe of 16,335 paid claims. A random sample of 109 claims was requested and reviewed. The following violations were noted:

4 Violations – 40 P.S. § 991.2166(a)

A licensed insurer or managed care plan shall pay clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

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 submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the four noted claims within 45 days of receipt.

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

If a licensed insurer or a managed care plan fails to remit payment as required, 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 Company failed to pay the two noted claims timely and interest of \$2 or more remains unpaid.

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 the following act 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 four noted claims when the Company’s liability under the policy was reasonably clear.

Ambulance Denied Claims

Examiners requested a list of all ambulance claims denied during the experience period. The Company identified a universe of 5,667 denied claims. A random sample of 109 claim files was requested. Upon review, examiners determined that 27 files were BlueCard claims, which are outside the scope of this examination. In accordance with the requirements of the examination, 82 of 109 identified files were reviewed. No violations were noted.

Ambulance Partially-Paid Claims

Examiners requested a list of all ambulance claims partially paid during the experience period. The Company identified a universe of 517 partially-paid claims. A random sample of 105 claim files was requested. Upon review, it was determined that 14 files were BlueCard claims which are

outside the scope of this examination. In accordance with the requirements of the examination, 91 of 105 identified files were reviewed. The following violations and concern were noted:

7 Violations – 40 P.S. § 991.2166(a)

A licensed insurer or managed care plan shall pay clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

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 submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the seven noted claims within 45 days of receipt.

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

If a licensed insurer or a managed care plan fails to remit payment as required, 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 Company failed to pay the seven noted claims timely and interest of \$2 or more remains unpaid.

37 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 the following act 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 37 noted claims when the Company’s liability under the policy was reasonably clear.

3 Violations – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by an appointed designee. The files shall contain notes and work papers pertaining to the claim in detail

so that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain complete records in the three noted claim files.

Concern: Prior authorization was sought and approved for 37 non-emergent ambulance claims; however, the Company failed to pay mileage in these claims. The Department recommends that the Company review prior authorization processes for non-emergency ambulance services to ensure proper payment of all lines in future claims.

G. Substance Use Disorder Claims

Examiners requested lists of all substance use disorder (SUD) claims paid, denied, and partially paid during the experience period. In accordance with the requirements of the examination, SUD 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., 991.2166, and 1171.5; 31 Pa. Code Ch. 146 and 154; 42 U.S.C. § 300gg-6, 300gg-13, and 18022; and 45 C.F.R. §§ 146.136, 147.150, and 156.125. Examiners found violations in all three sections.

Substance Use Disorder Paid Claims

Examiners requested a list of all SUD claims paid during the experience period. The Company identified a universe of 49,915 paid SUD claims. A random sample of 109 claims was requested. Upon review, examiners determined that 35 files were BlueCard claims, one file was not an SUD claim and one file was a CHIP claim, which are outside the scope of this examination. In accordance with the requirements of the examination, 72 of 109 identified files were reviewed. The following violations were noted:

1 Violation – 40 P.S. § 991.2166(a)

A licensed insurer or managed care plan shall pay clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

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 submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the noted claim within 45 days of receipt.

2 Violations – 40 P.S. § 1171.5(a)(1)(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.

AND

40 P.S. § 1171.5(a)(10)(i)

“Unfair methods of competition” and “unfair or deceptive acts or practices” in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practices shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.

AND

42 U.S.C. §§ 300gg-6 & 18022(c)(1)(A) & (B)

The annual limitation on cost-sharing shall be equal to the amount defined in federal law and regulation. Any annual cost-sharing imposed must not exceed the limitations provided for in federal law and regulation. The Company failed to apply individual members’ out-of-pocket expenses for EHBs to the individual level maximum out-of-pocket accumulator, which may have resulted in some members paying more than the maximum allowable amount specified in federal law or within the members’ Certificates of Coverage.

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 the following act 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 noted claim when the Company’s liability under the policy was reasonably clear.

Substance Use Disorder Denied Claims

Examiners requested a list of all SUD claims denied during the experience period. The Company identified a universe of 6,201 claims. A random sample of 109 claims was requested. Upon review, examiners determined that 39 files were BlueCard claims and one file was a CHIP claim, which are outside the scope of this examination. In accordance with the requirements of the examination, 69 of 109 identified files were reviewed. The following violations were noted:

17 Violations – 40 P.S. § 991.2166(a)

A licensed insurer or managed care plan shall pay clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

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 submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the 17 noted claims within 45 days of receipt.

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 mean 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 denied the noted claim without conducting a reasonable investigation.

16 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 the following act 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 16 noted claims when the Company’s liability under the policy was reasonably clear.

2 Violations – 40 P.S. § 1171.5(a)(1)(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.

AND

40 P.S. § 1171.5(a)(10)(i)

“Unfair methods of competition” and “unfair or deceptive acts or practices” in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practices shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.

AND

42 U.S.C. §§ 300gg-6 & 18022(c)(1)(A) & (B)

The annual limitation on cost-sharing shall be equal to the amount defined in federal law and regulation. Any annual cost-sharing imposed must not exceed the limitations provided for in federal law and regulation. The Company failed to apply individual members’ out-of-pocket

expenses for EHBs to the individual level maximum out-of-pocket accumulator, which may have resulted in some members paying more than the maximum allowable amount specified in federal law or within the members' Certificates of Coverage.

3 Violations – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by an appointed designee. The files shall contain notes and work papers pertaining to the claim in detail so that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain complete records in the three noted claim files.

Substance Use Disorder Partially-Paid Claims

Examiners requested a list of all SUD claims partially paid during the experience period. The Company identified a universe of 1,297 partially-paid SUD claims. A random sample of 107 claims was requested. Upon review, examiners determined that 80 files were BlueCard claims, which are outside the scope of this examination. In accordance with the requirements of the examination, 27 of 107 identified files were reviewed. The following violations were noted:

2 Violations – 40 P.S. § 991.2166(a)

A licensed insurer or managed care plan shall pay clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

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 submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the two noted claims within 45 days of receipt.

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

AND

40 P.S. § 1171.5(a)(10)(i)

“Unfair methods of competition” and “unfair or deceptive acts or practices” in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practices shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.

AND

42 U.S.C. §§ 300gg-6 & 18022(c)(1)(A) & (B)

The annual limitation on cost-sharing shall be equal to the amount defined in federal law and regulation. Any annual cost-sharing imposed must not exceed the limitations provided for in federal law and regulation. The Company failed to apply the individual member’s out-of-pocket expense for EHBs to the individual level maximum out-of-pocket accumulator, which may have resulted in this member paying more than the maximum allowable amount specified in federal law or within the member’s Certificate of Coverage.

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 the following act 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 two noted claims within a reasonable time after proof of loss.

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 two noted claims within 30 days after notification of the claims and failed to provide timely 45-day status letters for the two noted claim files.

H. Mental Health Claims

Examiners requested lists of all mental health claims paid, denied, and partially paid during the experience period. In accordance with the requirements of the examination, mental health claim files were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 908-11 et seq., 991.2166, and 1171.5; 31 Pa. Code Ch. 146 and 154; 42 U.S.C. §§ 300gg-6, 300gg-13, and 18022; and 45 C.F.R. §§ 146.136, 147.150, and 156.125. Examiners found violations in all three sections, including the following:

3 Violations – 40 P.S. §§ 908-11 et seq., 42 U.S.C. §§ 300gg-26 & 18022, & 45 C.F.R. § 146.136(c)(2)(i)

Licensed insurers are required to provide mental health and substance use disorder (SUD) benefits in parity with medical/surgical benefits. For quantitative treatment limitations (QTL), this means that a licensed insurer may not apply any QTL to mental health or SUD 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 proof of compliance for each plan type affected, for each classification of benefits, and for each type of QTL separately. In two plans, the financial requirement applied to the mental health/substance use disorder (MH/SUD) benefits did not apply to substantially all, i.e., at least two-thirds, of medical/surgical benefits as required in regulation. In one plan, the financial requirement applied to the MH/SUD benefits met the substantially all threshold but did not meet the predominant level threshold required in regulation.

Mental Health Paid Claims

Examiners requested a list of all mental health claims paid during the experience period. The Company identified a universe of 302,778 paid mental health claims. A random sample of 109 claims was requested. Upon review, examiners determined that 27 files were BlueCard claims, which are outside the scope of this examination. In accordance with the requirements of the examination, 82 of 109 identified files were reviewed. The following violations were noted:

2 Violations – 40 P.S. § 991.2166(a)

A licensed insurer or managed care plan shall pay clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

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 submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the two noted claims within 45 days of receipt.

2 Violations – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by an appointed designee. The files shall contain notes and work papers pertaining to the claim in detail so that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain complete records in the two noted claim files.

Mental Health Denied Claims

Examiners requested a list of all mental health claims denied during the experience period. The Company identified a universe of 32,231 denied mental health claims. A random sample of 109 claims was requested. Upon review, examiners determined that 31 files were BlueCard claims,

which are outside the scope of this examination. In accordance with the requirements of the examination, 78 of 109 identified files were reviewed. The following violations were noted:

2 Violations – 40 P.S. § 991.2166(a)

A licensed insurer or managed care plan shall pay clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

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 submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the two noted claims within 45 days of receipt.

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

If a licensed insurer or a managed care plan fails to remit payment as required, 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 Company failed to pay the noted claim timely and interest of \$2 or more remains unpaid.

1 Violation – 40 P.S. § 764g(c)(1)

Coverage is required for serious mental illness and must meet the minimum standards described in law, including at least 30 inpatient and 60 outpatient days annually. The Company failed to provide coverage for serious mental illness as required by law on the noted claim file.

2 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 the following act 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 two noted claims when the Company's liability under the policy was reasonably clear.

Mental Health Partially-Paid Claims

Examiners requested a list of all mental health claims partially paid during the experience period. The Company identified a universe of 6,092 partially-paid mental health claims. A random sample of 109 claims was requested. Upon review, examiners determined that 23 files were BlueCard claims, which are outside the scope of this examination. In accordance with the requirements of the examination, 86 of 109 identified files were reviewed. The following violations were noted:

5 Violations – 40 P.S. § 991.2166(a)

A licensed insurer or managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

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 submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the five noted claims within 45 days of receipt.

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

If a licensed insurer or a managed care plan fails to remit payment as required, 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 Company failed to pay the five noted claims timely and interest of \$2 or more remains unpaid.

5 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 the following act 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 five noted claims when the Company's liability under the policy was reasonably clear.

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

AND

40 P.S. § 1171.5(a)(10)(i)

“Unfair methods of competition” and “unfair or deceptive acts or practices” in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practices shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.

AND

42 U.S.C. §§ 300gg-6 & 18022(c)(1)(A) & (B)

The annual limitation on cost-sharing shall be equal to the amount defined in federal law and regulation. Any annual cost-sharing imposed must not exceed the limitations provided for in federal law and regulation. The Company failed to apply the individual member's out-of-pocket expense for EHBs to the individual level maximum out-of-pocket accumulator, which may have resulted in this member paying more than the maximum allowable amount specified in federal law or within the member's Certificate of Coverage.

1 Violation – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by an appointed designee. The files shall contain notes and work papers pertaining to the claim in detail

so that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain complete records in the noted claim file.

I. Behavioral Health Claims

Examiners requested lists of all behavioral health claims paid, denied, and partially paid during the experience period. In accordance with the requirements of the examination, behavioral health claim files were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 908-11 et seq., 991.2166, and 1171.5; 31 Pa. Code Ch. 146 and 154; 42 U.S.C. §§ 300gg-6, 300gg-13, and 18022; and 45 C.F.R. §§ 146.136, 147.150, and 156.125. Examiners found violations in all three sections.

Behavioral Health Paid Claims

Examiners requested a list of all behavioral health claims paid during the experience period. The Company identified a universe of 344,076 paid behavioral health claims. A random sample of 109 claims was requested. Upon review, examiners determined that 11 files were BlueCard claims and five were CHIP claims, which are outside the scope of this examination. In accordance with the requirements of the examination, 93 of the 109 identified files were reviewed. The following violations were noted:

2 Violations – 40 P.S. § 1171.5(a)(1)(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.

AND

40 P.S. § 1171.5(a)(10)(i)

“Unfair methods of competition” and “unfair or deceptive acts or practices” in the business of insurance means the following act if committed or performed with such frequency as to indicate a

business practices shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.

AND

42 U.S.C. §§ 300gg-6 & 18022(c)(1)(A) & (B)

The annual limitation on cost-sharing shall be equal to the amount defined in federal law and regulation. Any annual cost-sharing imposed must not exceed the limitations provided for in federal law and regulation. The Company failed to apply the individual members' out-of-pocket expenses for EHBs to the individual level maximum out-of-pocket accumulator, which may have resulted in some members paying more than the maximum allowable amount specified in federal law or within the members' Certificates of Coverage.

1 Violation – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by an appointed designee. The files shall contain notes and work papers pertaining to the claim in detail so that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain complete records in the noted claim file.

Behavioral Health Denied Claims

Examiners requested a list of all behavioral health claims denied during the experience period. The Company identified a universe of 36,707 denied behavioral health claims. A random sample of 109 claims was requested. Upon review, examiners determined that 24 files were BlueCard claims and two files were CHIP claims, all of which are outside the scope of this examination and were not reviewed. In accordance with the requirements of the examination, 83 of 109 identified files were reviewed. The following violations were noted:

11 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 the following act 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 11 noted claims when the Company's liability under the policy was reasonably clear.

10 Violations – 40 P.S. § 991.2166(a)

A licensed insurer or managed care plan shall pay clean claims submitted by a health care provider within 45 days of receipt of the clean claim.

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 submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the 10 noted claims within 45 days of receipt.

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

If a licensed insurer or a managed care plan fails to remit payment as required, 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 Company failed to pay the 10 noted claims timely and interest of \$2 or more remains unpaid.

2 Violations – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by an appointed designee. The files shall contain notes and work papers pertaining to the claim in detail so that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain complete records in the two noted claim files.

Behavioral Health Partially-Paid Claims

Examiners requested a list of all behavioral health claims partially paid during the experience period. The Company identified a universe of 7,145 partially-paid behavioral health claims. A random sample of 109 claims was requested. Upon review, examiners determined that 23 files

were BlueCard claims and three were CHIP claims, which are outside the scope of this examination. In accordance with the requirements of the examination, 83 of the 109 identified files were reviewed. The following violations were noted:

2 Violations – 40 P.S. § 991.2166(a)

A licensed insurer or managed care plan shall pay clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

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 submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the two noted claims within 45 days of receipt.

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

If a licensed insurer or a managed care plan fails to remit payment as required, 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 Company failed to pay the noted claim timely and interest of \$2 or more remains unpaid.

2 Violations – 40 P.S. § 1171.5(a)(1)(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.

AND

40 P.S. § 1171.5(a)(10)(i)

“Unfair methods of competition” and “unfair or deceptive acts or practices” in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practices shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.

AND

42 U.S.C. §§ 300gg-6 & 18022(c)(1)(A) & (B)

The annual limitation on cost-sharing shall be equal to the amount defined in federal law and regulation. Any annual cost-sharing imposed must not exceed the limitations provided for in federal law and regulation. The Company failed to apply individual members’ out-of-pocket expenses for EHBs to the individual level maximum out-of-pocket accumulator, which may have resulted in some members paying more than the maximum allowable amount specified in federal law or within the members’ Certificates of Coverage.

2 Violations – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by an appointed designee. The files shall contain notes and work papers pertaining to the claim in detail so that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain complete records in the two noted claim files.

J. HIV/AIDS Claims

Examiners requested lists of all HIV/AIDS claims paid, denied, and partially paid during the experience period. In accordance with the requirements of the examination, HIV/AIDS claim files were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 908-14, 991.2166, and 1171.5; 31 Pa. Code Ch. 146 and 154; 42 U.S.C. §§ 300gg-6 and 18022; and 45 C.F.R §§ 147.150 and 156.125. Examiners found violations in all three sections.

HIV/AIDS Paid Claims

Examiners requested a list of all HIV/AIDS claims paid during the experience period. The Company identified a universe of 7,567 paid HIV/AIDS claims. A random sample of 108 claims was requested. Upon review, examiners determined that 23 files were BlueCard claims, which are outside the scope of this examination. In accordance with the requirements of the examination, 85 of 108 identified files were reviewed. The following violations were noted:

1 Violation – 40 P.S. § 991.2166(a)

A licensed insurer or managed care plan shall pay clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

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 submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the noted claim within 45 days of receipt.

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

If a licensed insurer or a managed care plan fails to remit payment as required, 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 Company failed to pay the noted claim timely and interest of \$2 or more remains unpaid.

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 two noted claims within 30

days after notification of the claims and failed to provide timely 45-day status letters for the noted claim file.

HIV/AIDS Denied Claims

Examiners requested a list of all HIV/AIDS claims denied during the experience period. The Company identified a universe of 1,431 denied HIV/AIDS claims. A random sample of 105 claims was requested. Upon review, examiners determined that 27 files were BlueCard claims, which are outside the scope of this examination. In accordance with the requirements of the examination, 78 of 105 identified files were reviewed. The following violations were noted:

3 Violations – 40 P.S. § 991.2166(a)

A licensed insurer or managed care plan shall pay clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

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 submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the three noted claims within 45 days of receipt.

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 mean 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 four noted claims when the Company's liability under the policy was reasonably clear.

5 Violations – 42 U.S.C. § 18022(b)(1)(A), (H) and (I)

Essential health benefits shall include at least the following general categories and the items and services covered within the categories: ambulatory patient services, laboratory services, preventive and wellness services and chronic disease management. The Company failed to provide coverage for the assessment and treatment of HIV- and AIDS-related care for the five noted claims.

5 Violations – 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 the following act 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 denied the five noted claims without conducting a reasonable investigation.

4 Violations – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by an appointed designee. The files shall contain notes and work papers pertaining to the claim in detail so that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain complete records in the four noted claim files.

HIV/AIDS Partially-Paid Claims

Examiners requested a list of all HIV/AIDS claims partially paid during the experience period. The Company identified a universe of 540 partially-paid HIV/AIDS claims. A random sample of 83 claims was requested. Upon review, examiners determined that 17 files were BlueCard claims,

which are outside the scope of this examination. In accordance with the requirements of the examination, 66 of 83 identified files were reviewed. The following violations were noted:

3 Violations – 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 the following act 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 denied the three noted claims without conducting a reasonable investigation.

6 Violations – 40 P.S. § 991.2166(a)

A licensed insurer or managed care plan shall pay clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

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 submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the six noted claims within 45 days of receipt.

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

If a licensed insurer or a managed care plan fails to remit payment as required, 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 Company failed to pay the three noted claims timely and interest of \$2 or more remains unpaid.

2 Violations – 42 U.S.C. § 18022(b)(1)(A), (H) and (I)

Essential health benefits shall include at least the following general categories and the items and services covered within the categories: ambulatory patient services, laboratory services, preventive

and wellness services and chronic disease management. The Company failed to provide coverage for the assessment and treatment of HIV and AIDS related care for the two noted claims.

K. Opioid Addiction Claims

Examiners requested lists of all inpatient and outpatient opioid addiction treatment claims paid, denied, and partially paid during the experience period. In accordance with the requirements of the examination, opioid addiction 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., 991.2166, and 1171.5; 31 Pa. Code Ch. 146 and 154; 42 U.S.C. §§ 300gg-26 and 18022; and 45 C.F.R §§ 146.136, 147.150, 147.160, and 156.125. Examiners found violations in all three sections.

Opioid Addiction Paid Claims

Examiners requested a list of all inpatient and outpatient opioid addiction treatment claims paid during the experience period. The Company identified a universe of 36,898 paid opioid addiction treatment claims. A random sample of 109 claims was requested. Upon review, examiners determined that 46 files were BlueCard claims and two files were fully-capitated claims, which are outside the scope of this examination. In accordance with the requirements of the examination, 61 of 109 identified files were reviewed. The following violations were noted:

3 Violations – 40 P.S. § 991.2166(a)

A licensed insurer or managed care plan shall pay clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

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 submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the three noted claims within 45 days of receipt.

3 Violations – 40 P.S. § 1171.5(a)(1)(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.

AND

40 P.S. § 1171.5(a)(10)(i)

“Unfair methods of competition” and “unfair or deceptive acts or practices” in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practices shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.

AND

42 U.S.C. §§ 300gg-6 & 18022(c)(1)(A) & (B)

The annual limitation on cost-sharing shall be equal to the amount defined in federal law and regulation. Any annual cost-sharing imposed must not exceed the limitations provided for in federal law and regulation. The Company failed to apply individual members’ out-of-pocket expenses for EHBs to the individual level maximum out-of-pocket accumulator, which may have resulted in the members paying more than the maximum allowable amount specified in federal law or within the members’ Certificates of Coverage.

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 the following act 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 two noted claims within a reasonable time after proof of loss for the claims listed.

Opioid Addiction Denied Claims

Examiners requested a list of all inpatient and outpatient opioid addiction treatment claims denied during the experience period. The Company identified a universe of 10,443 denied inpatient and outpatient opioid addiction treatment claims. A random sample of 109 claims was requested. Upon review, examiners determined that 49 files were BlueCard claims, which are outside the scope of this examination. In accordance with the requirements of the examination, 60 of 109 identified files were reviewed. The following violations were noted:

1 Violation – 40 P.S. § 991.2166(a)

A licensed insurer or managed care plan shall pay clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

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 submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the noted claim within 45 days of receipt.

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 the following act 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 noted claim when the Company's liability under the policy was reasonably clear.

3 Violations – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by an appointed designee. The files shall contain notes and work papers pertaining to the claim in detail so that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain complete records in the three noted claim files.

Opioid Addiction Partially-Paid Claims

Examiners requested a list of all inpatient and outpatient opioid addiction treatment claims partially paid during the experience period. The Company identified a universe of 7,145 partially-paid opioid addiction treatment claims. A random sample of 109 claims was requested. Upon review, examiners determined that 89 files were BlueCard claims, which are outside the scope of this examination. In accordance with the requirements of the examination, 20 of 109 identified files were reviewed. The following violations were noted:

1 Violation – 40 P.S. § 991.2166(a)

A licensed insurer or managed care plan shall pay clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

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 submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the noted claim within 45 days of receipt.

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

If a licensed insurer or a managed care plan fails to remit payment as required, 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 Company failed to pay the noted claim timely and interest of \$2 or more remains unpaid.

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

AND

40 P.S. § 1171.5(a)(10)(i)

“Unfair methods of competition” and “unfair or deceptive acts or practices” in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practices shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.

AND

42 U.S.C. §§ 300gg-6 & 18022(c)(1)(A) & (B)

The annual limitation on cost-sharing shall be equal to the amount defined in federal law and regulation. Any annual cost-sharing imposed must not exceed the limitations provided for in federal law and regulation. The Company did not apply cost sharing as specified in the schedule of benefits for the noted claim.

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 the following act 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 denied the noted claim without conducting a reasonable investigation.

2 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 the following act 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 two noted claims when the Company’s liability under the policy was reasonably clear.

L. Pharmacy Claims

Examiners requested a list of all mental health/behavioral health and SUD pharmacy claims paid or rejected during the experience period. In accordance with the requirements of the examination, mental health/behavioral health and SUD pharmacy claim files were reviewed to ensure compliance with 40 P.S. §§ 908-1 et seq., 908-11 et seq., 991.2166, and 1171.5; 31 Pa. Code Ch. 146 and 154; 42 U.S.C. §§ 300gg-6, 300gg-13, and 18022; and 45 C.F.R. §§ 146.136, 147.150, and 156.125. Examiners found violations in two of the four sections.

Substance Use Disorder Paid Pharmacy Claims

Examiners requested a list of all paid SUD pharmacy claims from the experience period. The Company identified a universe of 62,629 paid SUD pharmacy claims. A random sample of 109 claim files was requested and reviewed to ensure compliance with applicable state and federal laws and regulations. No violations were noted.

Substance Use Disorder Rejected Pharmacy Claims

Examiners requested a list of all rejected SUD pharmacy claims from the experience period. The Company identified a universe of 28,397 rejected SUD pharmacy claims. A random sample of 109 claim files was requested and reviewed to ensure compliance with applicable state and federal laws and regulations. The following violations were noted:

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 the following act 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 process and pay the noted pharmacy claim when documentation supported its payment.

1 Violation – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by an appointed designee. The files shall contain notes and work papers pertaining to the claim in detail so that pertinent events and the dates of the events can be reconstructed. The Company failed to keep claim records accessible or the file was missing information for the noted claim.

Mental Health/Behavioral Health Paid Pharmacy Claims

Examiners requested a list of all paid mental health/behavioral health pharmacy claims from the experience period. The Company identified a universe of 892,348 paid mental health/behavioral health pharmacy claims. A random sample of 109 claim files was requested and reviewed to ensure compliance with applicable state and federal laws and regulations. No violations were noted.

Mental Health/Behavioral Health Rejected Pharmacy Claims

Examiners requested a list of all rejected mental health/behavioral health pharmacy claims from the experience period. The Company identified a universe of 303,748 rejected mental health/behavioral health pharmacy claims. A random sample of 109 claim files was requested and reviewed to ensure compliance with applicable state and federal laws and regulations. The following violations were noted:

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 the following act 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 process and pay the noted claim that it should have reasonably paid in the ordinary course of business.

1 Violation – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by an appointed designee. The files shall contain notes and work papers pertaining to the claim in detail so that pertinent events and the dates of the events can be reconstructed. The Company failed to keep claim records accessible or the file was missing information for the noted claim.

XVI. FORMULARY REVIEW

Examiners requested all pharmacy policies and procedures used during the experience period for processing mental health/behavioral health, SUD, and HIV/AIDS claims. Examiners also requested all formularies that covered the plans under review during the experience period. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with applicable standards found in state and federal laws and regulations 40 P.S. §§ 477a, 761, and 1171.5; 31 Pa. Code Ch. 146; 42 U.S.C. §§ 300gg-6 and 18022; 45 C.F.R. §§ 146.150, 147.150, 156.110, 156.122, 156.125, and 156.225, as well as those identified in each section.

A. Essential Health Benefit Drug Count Tool Results

Examiners requested documentation demonstrating Essential Health Benefit (EHB) Drug Count Tool results for the experience period. The Company identified a universe of 26 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.

B. Clinical Appropriateness Tool

Examiners requested documentation demonstrating Clinical Appropriateness Tool (CAT) results for the experience period, for the following conditions: diabetes mellitus, rheumatoid arthritis, bipolar affective disorder, schizophrenia, HIV/AIDS, HEP C, prostate cancer, breast cancer, and multiple sclerosis. 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. No violations were noted.

C. Formulary Outlier Review

Examiners requested documentation demonstrating the results of the Formulary Outlier Review Tool results, for the experience period, for diabetes mellitus, rheumatoid arthritis, bipolar affective disorder, schizophrenia, HIV/AIDS, HEP C, prostate cancer, breast cancer, and multiple sclerosis. 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. No violations were noted.

D. Mental Health/Substance Use Disorder and HIV/AIDS Drug Coverage

Examiners requested a list of drug benefits that covered MH/SUD and HIV/AIDS 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. No violations were noted.

E. Single Tablet Drug Regimens or Extended Release Products

Examiners requested a detailed summary of the Company pharmacy benefit coverage of single-tablet drug regimens or extended-release products in effect 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. No violations were noted.

F. Mental Health/Substance Use Disorder Pharmacy and Medical Claims Data

Examiners requested all MH/SUD pharmacy and medical claims data processed during the experience period. The Company identified a universe of 16 documents and provided one additional document in response to an examiner-issued information request. In accordance with the requirements of the examination, all 17 documents were reviewed to ensure compliance with applicable state and federal laws and regulations as noted above, as well as 40 P.S. §§ 908-1 et seq. and 908-11 et seq., and 45 C.F.R. § 146.136. No violations were noted.

G. Office Based Opioid Treatment and Opioid Treatment Program

Examiners requested medical policies in effect during the experience period for Office Based Opioid Treatment (OBOT) and Opioid Treatment Program (OTP) therapy. 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 as noted above, as well as 40 P.S. §§ 908-1 et seq. and 908-11 et seq., and 45 C.F.R. § 146.136. No violations were noted.

H. Office Based Opioid Treatment and Opioid Treatment Waiver Program

Examiners requested medical policies in effect during the experience period for OTP and OBOT waiver program physicians with a detailed summary of the counseling and/or psychotherapy

requirements. 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 as noted above, as well as 40 P.S. §§ 908-1 et seq. and 908-11 et seq., and 45 C.F.R. § 146.136. No violations were noted.

I. Urinalysis Criteria for MH/SUD Drugs

Examiners requested a copy of medical policies in effect during the experience period specific to the urinalysis criteria for all MH/SUD drugs. 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 as noted above, as well as 40 P.S. §§ 908-1 et seq. and 908-11 et seq., and 45 C.F.R. § 146.136. No violations were noted.

J. MH/SUD Inpatient Admission Criteria

Examiners requested medical policies that defined medical necessity or in-patient rehabilitation criteria for detoxification admission 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 as noted above, as well as 40 P.S. §§ 908-1 et seq. and 908-11 et seq., and 45 C.F.R. § 146.136. No violations were noted.

K. Pharmacy and Therapeutics Committees

Examiners requested a copy of meeting minutes regarding MH/SUD and HIV/AIDS coverage from the Pharmacy and Therapeutics Committee and/or notes pertaining to the drugs that fall under these diagnoses, as well as a summary of any changes made 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 as noted above, as well as 40 P.S. §§ 908-1 et seq. and 908-11 et seq., and 45 C.F.R. § 146.136. No violations were noted.

L. Utilization Management or Drug Utilization Committees

Examiners requested any written utilization management and/or drug utilization review committee notes that require financial or quality management, or patient life-saving concerns, as justification

for limitations placed on approval of medications for opioid dependence or MH/SUD drugs, in effect during the experience period. These include utilization-management techniques such as limits on dosages prescribed, Step Therapy or Prior Authorization, refill limits, or any other cost-containment methods used by the clinical staff for all HIV/AIDS drugs, as well as the certain SUD drugs. Examiners also requested the settings in which the drugs are dispensed; including other drugs for Medication Assisted Treatments (MAT) not specifically listed, along with any limits or benefits excluded based on medical necessity or medical appropriateness. The Company identified a universe of 11 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations as noted above, as well as 40 P.S. §§ 908-1 et seq. and 908-11 et seq., and 45 C.F.R. § 146.136. No violations were noted.

M. Medication Assisted Treatment Processes

Examiners requested documentation demonstrating all preauthorization and reauthorization processes specific to MAT for opioid medications during the experience period. The Company identified a universe of 15 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations as noted above, as well as 40 P.S. §§ 908-1 et seq. and 908-11 et seq., and 45 C.F.R. § 146.136. No violations were noted.

N. Utilization Review or Exclusions

Examiners requested documentation related to any utilization review or exclusions based on failure to complete a course of treatment 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 as noted above, as well as 40 P.S. §§ 908-1 et seq. and 908-11 et seq., and 45 C.F.R. § 146.136. No violations were noted.

O. Formulary Design – MH/SUD Drugs

Examiners requested documentation demonstrating formulary design for all MH/SUD drugs for each product sold during the experience period. 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 and federal laws and regulations as noted above, as well as 40 P.S. §§ 908-1 et seq. and 908-11 et seq., and 45 C.F.R. § 146.136. No violations were noted.

P. Policy Limits on MH/SUD

Examiners requested medical policies that may have imposed limits on MH/SUD treatment, such as physical examination, doctor shopping and privileged communication laws, and other requirements for MH/SUD in place during the experience period. The Company identified a universe of 38 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations as noted above, as well as 40 P.S. §§ 908-1 et seq. and 908-11 et seq., and 45 C.F.R. § 146.136. No violations were noted.

Q. Parity Assessment

Examiners requested a copy of the analyses conducted comparing medical/surgical policies to MH/SUD policies to assess parity for the experience period in 13 topic areas. The Company identified a universe of 12 documents and provided three additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination, all 15 documents were reviewed to ensure compliance with applicable state and federal laws and regulations as noted above, as well as 40 P.S. §§ 908-1 et seq. and 908-11 et seq., and 45 C.F.R. § 146.136. No violations were noted with respect to pharmacy limitations.

R. Pharmacy Benefit Management

Examiners requested documentation demonstrating internal or third-party pharmacy benefit management (PBM) policies that apply to MH/SUD treatment programs during the experience period. The Company identified a universe of 34 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations as noted above, as well as 40 P.S. §§ 908-1 et seq. and 908-11 et seq., and 45 C.F.R. § 146.136. No violations were noted.

S. Drug Information for MH/SUD Claims

Examiners requested analyses of policies and claims processing procedures relating to MH/SUD claims for all drugs in the following settings: in-patient and out-patient, OTP, mail order, and retail.

Examiners requested rationale for any denial based on the setting of the prescription. The Company identified a universe of four documents and provided one additional document in response to an examiner-issued information request. In accordance with the requirements of the examination, all five documents were reviewed to ensure compliance with applicable state and federal laws and regulations as noted above, as well as 40 P.S. §§ 908-1 et seq. and 908-11 et seq., and 45 C.F.R. § 146.136. No violations were noted.

T. Urine Testing Definition Requirements

Examiners requested documentation regarding SUD and Urine Testing Definition requirements, counseling sessions, and/or similar psychotherapy sessions. 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 as noted above, as well as 40 P.S. §§ 908-1 et seq. and 908-11 et seq., and 45 C.F.R. § 146.136. No violations were noted.

U. Medical and Clinical Policies

Examiners requested medical and/or clinical policies, applicable during the experience period, that applied to Opioid Dependence Therapy, Selective Serotonin Reuptake Inhibitors, Serotonin-Norepinephrine Reuptake Inhibitors, Antidepressants, Antipsychotics, and any other policies not requested that fall under the umbrella of MH/SUD. The Company identified a universe of 34 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations as noted above, as well as 40 P.S. §§ 908-1 et seq. and 908-11 et seq., and 45 C.F.R. § 146.136. No violations were noted.

V. MH/SUD Limits

Examiners requested documentation demonstrating that MH/SUD policy limits, annual or per episode day, or visit limits were compliant 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 as noted above, as well as 40 P.S. §§ 908-1 et seq. and 908-11 et seq., and 45 C.F.R. § 146.136. No violations were noted.

W. Medication Assistance Treatment Limits

Examiners requested documentation regarding lifetime limits on MAT for methadone and/or buprenorphine and if such limits apply to other medication outside of MH/SUD drugs during the examination 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 as noted above, as well as 40 P.S. §§ 908-1 et seq. and 908-11 et seq., and 45 C.F.R. § 146.136. No violations were noted.

X. Medication Limitations

Examiners requested written utilization management and/or drug utilization review committee notes that show financial, or quality management, or patient life-saving concerns, as justification for limitations placed on approval of medications, during the experience period, for opioid dependence or MH/SUD drugs. 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 as noted above, as well as 40 P.S. §§ 908-1 et seq. and 908-11 et seq., and 45 C.F.R. § 146.136. No violations were noted.

Y. HIV/AIDS Formulary Reviews

Examiners requested that the Company provide all HIV/AIDS formularies utilized during the experience period. The Company identified two formularies applicable to the experience period. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations as noted above. No violations were noted.

XVII. DATA INTEGRITY

As part of the examination, the Company was sent a preliminary examination packet in accordance with NAIC 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 its accuracy and completeness to determine compliance with the Insurance Department Act of 1921, Section 904(b) (40 P.S. §§ 323.1 et seq.). No violations were noted.

XVIII. RECOMMENDATIONS

The recommendations made below identify corrective measures the Department finds necessary as a result of the number, nature or severity of violations noted in this Examination Report.

1. The Company must review and revise internal control procedures, including its manual intervention in claims processing, to ensure compliance with 40 P.S. § 764h(a), which requires ASD coverage for covered individuals. The Company must ensure the identified clean claims are paid, and proof of such payment must be provided to the Department.
2. The Company must review and revise internal control procedures to ensure compliance with the mental health parity requirements included in 40 P.S. §§ 908-11 et seq., 42 U.S.C. §§ 300gg-26 and 18022, and 45 C.F.R. § 146.136(c)(2)(i). Specifically, the Company must evaluate QTL analyses and ensure that each QTL for mental health or SUD benefits in each classification is not more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. For the three plans noted in the report, the Company must perform this analysis and submit proof of compliance for each plan type affected, for each classification of benefits, and for each type of QTL separately. The Company must reprocess claims for all Pennsylvania members that may have been impacted to determine if restitution, including interest, is due. The Company must provide the Department with documentation that any restitution due to Pennsylvania consumers was paid accordingly.
3. The Company must comply with 40 P.S. §§ 991.2116 and 3042, 42 U.S.C. §§ 300gg-19a(b) & 18022(b)(4)(E)(i) and (ii), and 45 C.F.R. § 147.138(b) relative to emergency services coverage, and ensure violations noted in this Examination Report do not occur in the future. Further, the Department recommends that the Company review its EOBs and claims adjudication policies, procedures, and processes for needed improvements relating to emergency services and transport.
4. The Company must review and revise internal complaint processes to ensure compliance with 40 P.S. § 991.2141(b)(4). The Company must also include procedures to ensure compliance with 45 C.F.R. § 147.136(b), incorporating 29 C.F.R. § 2560.503-1, regarding timely appeal and grievance processing.

5. The Company must ensure that all clean claims are paid within 45 days of receipt as per 40 P.S. § 991.2166(a) and 31 Pa. Code § 154.18(a). The clean claims noted in this Examination Report that have not been paid must be paid and proof of such payment must be provided to the Department.
6. The Company must ensure all requirements are met related to interest payments as per 40 P.S. § 991.2166(b) and 31 Pa. Code § 154.18(c). Applicable interest amounts for unpaid claims noted in the Examination Report must be paid, and proof of such payment must be provided to the Insurance Department.
7. The Company must comply with 40 P.S. §§ 1171.5(a)(1)(i) and (a)(10)(i), as well as 42 U.S.C. §§ 300gg-6 and 18022(c)(1)(A) and (B), and ensure violations noted in this Examination Report relating to out-of-pocket expenses for Essential Health Benefits and cost-sharing requirements do not occur in the future. The Company must evaluate claims and member cost-sharing responsibilities and reprocess the maximum out-of-pocket accumulator calculations for all claims that may have been impacted from January 1, 2015 through December 31, 2018 to determine if restitution is due. The Company shall provide to the Department a list of all affected members, the amounts not applied to the accumulator, and proof of refunds as applicable.
8. The Company must implement procedures to ensure compliance with the Unfair Insurance Practices Act, including the following noted issues:
 - a. 40 P.S. § 1171.5(a)(10)(iii), the Company must implement reasonable standards to ensure the prompt investigation of claims;
 - b. 40 P.S. § 1171.5(a)(10)(iv), the Company must conduct a reasonable investigation based on all available information for claim processing;
 - c. 40 P.S. § 1171.5(a)(10)(v), the Company must affirm or deny coverage within 45 days after proof of loss for the claims is received;
 - d. Company must comply with 40 P.S. § 1171.5(a)(10)(vi) and ensure prompt, fair and equitable settlements are being provided to the claimants.
9. The Company must review and revise its internal controls to ensure that all records and documents are maintained in accordance with 31 Pa. Code § 146.3 relating to the maintenance of 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 Ch. 146, including sections 146.5 and 146.6, so that the violations relating to claim acknowledgement, status letters and acceptance or denials, as noted in this Examination Report, do not occur in the future.
11. The Company must review and implement procedures to comply with 42 U.S.C. § 300gg-13(a)(4) and 45 C.F.R. § 147.130(a)(1)(iv) and ensure that listed preventive screenings and services are provided without cost sharing. Cost sharing that was inappropriate paid as listed in this Examination Report must be refunded to the affected consumer, and proof of such payment must be provided to the Department.
12. The Company must review and revise internal control procedures to ensure compliance with coverage for Essential Health Benefits as described in 42 U.S.C. § 18022(b)(1)(A), (H), and (I) and ensure violations noted in this Examination Report do not occur in the future.
13. The Department acknowledges the Company's updated control procedures with respect to producer certification, and the Company must continue to review and revise internal control procedures as necessary to ensure compliance with the producer certification requirements of 45 C.F.R. § 155.220, so that violations relating to producer certification do not occur in the future.

XIX. COMPANY RESPONSE

Independence would like to thank the Pennsylvania Insurance Department for its time and effort in conducting this comprehensive Market Conduct Examination of certain Independence Health Group subsidiaries. We appreciate the professionalism of the examination team and their collaborative efforts in completing this review.

Independence would also like to take this opportunity to recognize the importance of this examination process. The examination and the subsequent recommendations help us to ensure that Independence and the entire health care system work to the benefit of our valued members.