COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT

MARKET CONDUCT EXAMINATION REPORT

OF

UPMC Health Coverage, Inc. and UPMC Health Options, Inc.

c/o UPMC Health System Group
600 Grant Street
Pittsburgh, PA 15219

As of: October 15, 2021
Issued: October 18, 2021

DIVISION OF HEALTH MARKET CONDUCT
OFFICE OF MARKET REGULATION

pennsylvania
INSURANCE DEPARTMENT

PENNSYLVANIA INSURANCE DEPARTMENT
EXAMINATION VERIFICATION

I, Penny Callihan, Market Conduct Examination Chief, Pennsylvania Insurance Department, certify that I was the Examiner-In-Charge of the Report of the Examination of UPMC Health Coverage, Inc. and UPMC Health Options, Inc., made as of 10/15/2021. The last date of examination file review was 08/30/2021 and the written Report of Examination was reviewed and accepted by David Buono, Acting Deputy Insurance Commissioner, on 10/18/2021.

I have reviewed the completed written Report of Examination and certify that the facts and figures recited herein are true and accurate, according to the records, documents, and other evidence obtained during the course of the examination.

Penny Callihan
(Examiner-in Charge)

Pennsylvania Insurance Department
(Name of Vendor/Department)

1209 Strawberry Square, Harrisburg, PA
(Address of Vendor/Department)

Penny Callihan
(Examiner in Charge Signature)

10/18/2021
(Date)

IN ORDER TO SATISFY 40 P.S. § 323.5(b), WHICH PROVIDES THAT NO LONGER THAN SIXTY (60) DAYS FROM THE COMPLETION OF THE EXAMINATION, THE EXAMINER IN CHARGE SHALL FILE WITH THE DEPARTMENT A VERIFIED WRITTEN REPORT OF EXAMINATION UNDER OATH.

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BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this __3rd___ day of _September, 2021, 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 David J. Buono Jr., Acting 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:
	:	
UPMC Health Coverage, Inc.	:	40 P.S. §§ 310.71(a); 310.71a(a); 323.3(a);
	:	323.4(b); 764c; 764h(a), (b); 908-1 et seq.; 908-
UPMC Health Options, Inc.	:	11 et seq.; 991.2116; 991.2141(a), (b)(3), (b)(4),
	:	(b)(5); 991.2166(a), (b); 1171.5(a)(1)(i),
600 Grant Street	:	1171.5(a)(10)(i), (iii), (v), (vi), (x), (xiv)
Pittsburgh, PA 15219	:	
	:	31 Pa. Code §§ 146.3; 146.4(a), (b); 146.6;
	:	146.7(a)(1); 146.7(c)(1); 154.18(a), (c)
	:	
	:	18 Pa.C.S. § 4117(k)(1)
	:	
	:	42 U.S.C. §§ 300gg-6(b); 300gg-19(a)(1)(c);
	:	300gg-26; 18022
	:	
	:	45 C.F.R. §§ 146.136(c)(2)(i); 146.136(c)(4)(i);
	:	147.136 incorporating 29 C.F.R. § 2560.503-1;
	:	156.130
	:	
	:	
Respondent	:	Docket No. MC21-10-009

CONSENT ORDER

And now, this 29th day of November, 2021, 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 UPMC Health System Group subsidiaries: UPMC Health Coverage, Inc., and UPMC Health Options, Inc., hereafter collectively referred to as "Respondent". Respondent maintains its address at 600 Grant Street, Pittsburgh, PA 15219.

(b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from January 1, 2015 through March 31, 2016.

(c) On October 18, 2021, 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 November 10, 2021.

(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) Violations of 40 P.S. §§ 310.71(a) and 310.71a(a), as contained in the Examination Report, are punishable by the following under 40 P.S. §§ 310.91:

(1) License revocation.

(2) Imposition of a penalty of not more than one thousand dollars ($1,000.00) for each violation.

(3) An order to cease and desist.

(4) Any other conditions as the commissioner deems appropriate.

(c) Violations of 40 P.S. §§ 764c, 764h(a), and 764h(b) ,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.

(d) Violations of 40 P.S. §§ 908-1 et seq. and 908-11 et. seq., as contained in the Examination Report, are punishable by the following under 40 P.S. § 908-15:

(1) License suspension, refusal to renew, or revocation.

(2) An order to cease and desist.

(3) Imposition of a penalty of not more than five thousand dollars ($5,000.00) for each violation.

(4) Imposition of a penalty of not more than ten thousand dollars ($10,000.00) for each willful violation.

(5) Provided that the total penalty imposed thereunder shall not exceed $500,000 in the aggregate during a single calendar year.

(e) Violations of 40 P.S. §§ 991.2116, 991.2141(a), 991.2141(b)(3), 991.2141(b)(4), 991.2141(b)(5), 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 action for 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.

(f) Violations of 40 P.S. §§ 1171.5(a)(1)(i), 1171.5(a)(10)(i), 1171.5(a)(10)(iii), 1171.5(a)(10)(v), 1171.5(a)(10)(vi), 1171.5(a)(10)(x), and 1171.5(a)(10)(xiv), 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.

(g) 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)(v), 1171.5(a)(10)(vi), 1171.5(a)(10)(x), and 1171.5(a)(10)(xiv), 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.

(h) Violations of 31 Pa. Code §§ 146.3, 146.4(a), 146.4(b), 146.6, 146.7(a)(1), and 146.7(c)(1), 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.

(i) In addition to any penalties imposed by the Commissioner for violations of 31 Pa. Code §§ 146.3, 146.4(a), 146.4(b), 146.6, and 146.7(c)(1), 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.

(j) 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 action for 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 activities described herein in the Findings of Fact, which incorporate the findings and conclusions contained in the Examination Report, and Conclusions of Law, insofar as the activities violate the laws of the Commonwealth of Pennsylvania.

(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 standards and processes sufficient to perform the comparative analyses necessary to determine if a covered plan or issuer is in compliance with the financial, quantitative treatment limitation and non-quantitative treatment limitation requirements specified in the final regulations of the Mental Health Parity and Addiction Equity Act. Respondent shall provide to the Department documentation sufficient to demonstrate a good faith effort to comply with those regulatory requirements.

(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 MOOP calculation processes and software implementation.

(e) Respondent shall pay two hundred fifty thousand dollars ($250,000) 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 April Phelps, 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: UPMC Health Coverage, Inc., Respondent

President / Vice President

Secretary / Treasurer

BY: UPMC Health Options, Inc., Respondent

President/Vice President

Secretary/Treasurer

COMMONWEALTH OF
PENNSYLVANIA
David J. Buono Jr.
Acting Deputy Insurance Commissioner

I. INTRODUCTION

The Market Conduct Examination was conducted on UPMC Health Coverage, Inc. and UPMC Health Options, Inc., hereafter collectively referred to as "Company," at the Company's offices located in Pittsburgh, Pennsylvania, in May 2017, June 2017, and February 2020. 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 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 an Examination Report may result in imposition of penalties. An 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 for 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 more specific 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

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

Lindsi Swartz, MBA, MCM
Market Conduct Examiner
PA Insurance Department

Michael Jones
Market Conduct Examiner
PA Insurance Department

Penny Callihan, MCM
Market Conduct Chief
PA Insurance Department

Nicole R. McClain, MCM
Market Conduct Examiner, II
PA Insurance Department

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

Frank Callihan, MCM
Market Conduct Examiner, II
PA Insurance Department

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

Irvin L. “Sam” Muszynski, JD, MCM
Contract Examiner

JoAnn Baldo, CPA, MCM
Contract Examiner

Lewis Bivona, CPA, AFE
Contract Examiner

II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted pursuant to the authority granted by Sections 903 and 904 (40 P.S. §§ 323.3 and 323.4) of the Insurance Department Act and covered the experience period of January 1, 2015 through March 31, 2016, unless otherwise noted. The purpose of the examination was to ensure compliance with Pennsylvania insurance laws and regulations, as well as 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 these statute and regulation sections are included in all reviews completed during the Examination, the Examination Report only notes when examiners found a violation of these sections in a particular sub-category.

III. COMPANY HISTORY

UPMC Health Plan, Inc.

UPMC Health Plan, Inc. was incorporated on March 14, 1994 and is 88.66% owned by UPMC Coverage Products, Inc. (other ownership is 1.62% by each of the following: UPMC, UPMC St. Margaret, UPMC Passavant, Magee Women's Hospital of UPMC, Children's Hospital of UPMC, Jefferson Regional Medical Center, The Washington Hospital), which is 100% owned by UPMC Holding Company, Inc., which is 100% owned by UPMC. UPMC Holding Company contains the following regulated entities: UPMC Health Plan, UPMC Health Benefits, UPMC Health Network, UPMC Health Coverage, UPMC Health Options, UPMC for You, UPMC Work Alliance, UPMC WorkPartners National, and Community Care Behavioral Health Organization.

February 1996 – Best Health Care of Western Pennsylvania (BHCWP) received approval of a Health Maintenance Organization (HMO) Certificate of Authority (COA) from the Pennsylvania Department of Health (DOH) and the Pennsylvania Insurance Department (PID). The approved service areas included Allegheny County and the sole product offering was a Medical Assistance Health Maintenance Organization (HMO). BHCWP finalized a contract with the Pennsylvania Department of Public Welfare (DPW) as a Medical Assistance managed care contractor.

January 1, 1997 – UPMC Health Plan, Inc. began operation of a Federal Employee Health Benefit (FEHB) plan, contracting with the Federal Office of Personnel Management.

July 1997 – BHCWP submitted a Health Maintenance Organization-Integrated Delivery System (HMO-IDS) agreement with Tri-State Health System (TSHS) to DOH to be the HMO physical health delivery network for commercial HMO and Point of Service (POS) products that the HMO was developing. DOH approved the agreement in July.

October 1997 – The corporate name of Best Health Care of Western Pennsylvania was changed to UPMC Health Plan, Inc., retaining "Best Health Care of Western Pennsylvania" as the name of its Medical Assistance product.

January 1, 1998 - UPMC Health Plan, Inc. went operational with the ASO/self-funded population.

July 1, 1998 – UPMC Health Plan, Inc. began operation of fully insured commercial Enhanced Access HMO and POS products.

July 1999 – UPMC Health Plan, Inc. began offering a medical-only Conversion HMO product.

January 2001 – UPMC for Life, the Medicare product name, became operational under the UPMC Health Plan COA. This was a Medicare+Choice HMO product.

2003 - UPMC Health Plan, Inc. changed the name of its Medical Assistance product (Best Health Care of Western Pennsylvania) to UPMC *for You*.

June 17, 2004 – UPMC Health Plan, Inc. transferred the UPMC for You Medical Assistance HMO product to UPMC for You, Inc.

July 8, 2004 – UPMC Health Plan, Inc. transferred the Commercial POS products to UPMC Health Network, Inc.

January 2006 – UPMC Health Plan, Inc. began to offer the UPMC for Life Specialty Plan (SNP) product.

August 1, 2006 - UPMC Health Plan, Inc. began to offer UPMC for Kids, the Children's Health Insurance Program (CHIP) product.

May 8, 2008 – UPMC Health Plan, Inc. received its COA as a licensed HMO in the State of Ohio to offer the Medicare Advantage HMO products.

June 1, 2008 – UPMC Health Plan, Inc. received its COA as a licensed HMO in the State of West Virginia to offer the Medicare Advantage HMO product.

January 1, 2009 – UPMC Health Plan, Inc. began to offer the Medicare Advantage HMO product in Ohio and West Virginia.

January 1, 2010 – UPMC Health Plan, Inc. began accepting members into the UPMC for Life Community Living product, for full dual eligible beneficiaries 60 years of age and older.

May 6, 2010 –CMS informed UPMC Health Plan, Inc. that UPMC for Life Community Living would be terminated effective June 30, 2010 and all current members transitioned to UPMC for Life Specialty Plan.

August 1, 2010 – UPMC Health Plan, Inc. began operation of UPMC for a Healthy You, an Adult Basic Product regulated by PID to provide health insurance for uninsured adult Pennsylvanians ages 19 to 64 delivered through contracted managed care plans.

September 16, 2011 – UPMC Health Plan, Inc. received CMS approval for UPMC for Life Options, a Medicare only Institutional SNP (I-SNP).

December 31, 2011 - UPMC Health Plan, Inc. Medicare Advantage Plans, and Contract H2169 discontinued for Ohio (Jefferson and Belmont counties) and West Virginia (counties of Brooke, Hancock, Marshall, Monongalia, Ohio, Preston, and Wetzel).

December 21, 2012 – UPMC Health Plan, Inc. received approval as a Private Review Agent/ Utilization Review entity from the Maryland Insurance Administration. This license was surrendered December 20, 2016.

May 19, 2014 – UPMC Health Plan, Inc. receive a Certification of Registration – Private Review Agent (PRA) (certificate number 14-PRA-190) from the State of Georgia Office of Insurance and Safety Fire Commissioner. This registration was withdrawn on July 13, 2016.

August 1, 2014 – Commercial HMO Off-Exchange-Only membership moved from UPMC Health Plan, Inc. to UPMC Health Coverage, Inc. with exception of Essential Silver plan.

January 1, 2016 - UPMC Health Plan, Inc. Non-ACA Compliant Conversion Plans and 2014 Off Exchange only Essential Silver plan were withdrawn.

July 27, 2018 - UPMC Health Plan, Inc. was granted a COA to transact business in the Commonwealth of Virginia.

November 1, 2018 – UPMC Health Plan, Inc. was granted a Certificate of Registration (Certificate Number P-18-05 (I)) to conduct business as a Private Review Agent (PRA) in the Commonwealth of Virginia.

November 16, 2018 – UPMC Health Plan, Inc. was granted a Certificate of Registration to conduct business as a Private Review Agent (PRA) in Maryland by the Maryland Insurance Administration.

December 31, 2018 - UPMC Health Plan, Inc. discontinued the UPMC for You Options (ISNP) product.

January 1, 2019 - UPMC for Kids Children's Health Insurance Program plan was moved from UPMC Health Plan, Inc. to Community Care.

January 22, 2019 - UPMC Health Plan, Inc. obtained a Non-profit Foreign Corporation certificate in Maryland from the State Department of Assessments and Taxation.

January 25, 2019 - UPMC Health Plan, Inc. was granted a COA as a Foreign Non-Profit Corporation to transact business in the state New Jersey by the New Jersey Department of the Treasury.

UPMC Health Coverage, Inc.

UPMC Health Coverage, Inc. was incorporated on May 15, 2013 and is 100% owned by UPMC Coverage Products, Inc., which is 100% owned by UPMC Holding Company, Inc., which is 100% owned by UPMC. UPMC Holding Company contains the following regulated entities: UPMC Health Plan, UPMC Health Benefits, UPMC Health Network, UPMC Health Coverage, UPMC Health Options, UPMC for You, UPMC Work Alliance, and Community Care Behavioral Health Organization.

April 28, 2014 – UPMC Health Coverage, Inc. received a Health Maintenance Organization (HMO) Certificate of Authority (COA) from the Pennsylvania Insurance Department (PID).

August 1, 2014 – Commercial Health Maintenance Organization (HMO) Off-Exchange-Only membership moved from UPMC Health Plan, Inc. to UPMC Health Coverage, Inc. with exception of Essential Silver plan.

July 1, 2018 - UPMC Health Coverage Inc., received its Certificate of Authority from Maryland's Department of Insurance on July 1, 2018 for the purpose of offering Commercial group products off Exchange only, Medicare Advantage HMO products (UPMC for Life) and Dual Special Needs Product (UPMC for Life DUAL).

UPMC Health Options, Inc.

UPMC Health Options, Inc. was incorporated on May 15, 2013 and is 100% owned by UPMC Health Network, Inc., which is 100% owned by UPMC Coverage Products, Inc., which is 100% owned by UPCM Holding Company, Inc., which is 100% owned by UPMC. UPMC Holding Company contains the following regulated entities: UPMC Health Plan, UPMC Health Benefits, UPMC Health Network, UPMC Health Coverage, UPMC Health Options, UPMC for You, UPMC Work Alliance, and Community Care Behavioral Health Organization.

December 30, 2013 – UPMC Health Options, Inc. received a Risk-Assuming PPO Certificate of Authority from the Pennsylvania Insurance Department (PID).

January 1, 2014 – Commercial membership moved from UPMC Health Network, Inc. to UPMC Health Options, Inc.

May 1, 2015 – UPMC Health Options, Inc. Conversion PPO withdrawn.

July 1, 2015- FEHB membership moved from UPMC Health Network, Inc. to UPMC Health Options, Inc.

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 audits conducted from 2013 through 2015. The examiners reviewed the audits to ensure they included those completed by an internal audit function within the Company or that they were conducted via a contracted vendor on behalf of the Company. The examiners reviewed documentation ensuring that all internal or external audits were current. The Company identified a universe of 41 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws. No violations were noted.

B. Information Technology Protection

Examiners requested documentation demonstrating that the Company had controls, safeguards, and procedures in place during the experience period for protecting the integrity of computer information. 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 noted above, as well as 31 Pa. Code Ch. 146a, 146b, and 146c. 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 that were reasonably calculated to detect, prosecute, and prevent fraudulent insurance acts for the experience period. The Company identified a universe of 48 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.

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

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 31 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. 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 three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 764a and 1551 et seq., 31 Pa. Code §§ 152 and 301, and 45 C.F.R. § 156.340. 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 nine 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.

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 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, including 40 P.S. §§ 764a and 1551 et seq., as well as 31 Pa. Code §§ 152.3 and 301.42. No violations were noted in the written records regarding operations and management; however, the following violations and concerns were noted with respect to Company operations and management based on responses and actions taken during the course of the examination:

Universe Violation – 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)

Licensed insurers are required to provide mental health and substance use disorder (MH/SUD) benefits in parity with medical/surgical benefits. For quantitative treatment limitations, this means that a licensed insurer may not apply any financial requirement (FR) or quantitative treatment limitation (QTL) to MH/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 FR/QTL separately. The Company imposed FRs/QTLs with respect to mental health benefits not in parity with medical/surgical benefits. Specifically, the Company failed to document its basis for defining benefits as MH/SUD or medical/surgical conditions, as required by the federal parity regulations, and that the standard whereby these benefits were assigned to benefit classifications or subclassifications was the same for MH/SUD and medical/surgical conditions. Further, the Company provided data that failed the substantially all or predominant level tests within certain specified classifications of benefits such that cost sharing was charged to consumers when it should not have been, or the level of cost sharing charged was too high for some plans.

Universe Violation – 40 P.S. §§ 908-11 et seq., 42 U.S.C. §§ 300gg-26 and 18022, and 45 C.F.R. § 146.136(c)(4)(i)

Licensed insurers are required to provide MH/SUD benefits in parity with medical/surgical benefits. For nonquantitative treatment limitations (NQTL), this means that a licensed insurer may not apply any NQTL in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying that limitation to MH/SUD benefits within that classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the classification. The Company imposed NQTLs with respect to MH/SUD benefits and was unable to provide adequate documentation demonstrating compliant parity analyses, despite numerous requests and guidance from examiners.

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.

AND

40 P.S. §1171.5 (a)(10)(xiv)

“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 promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

AND

31 Pa. Code § 146.4(a)

An insurer or agent may not fail to fully disclose to first-party claimants pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.

AND

31 Pa. Code § 146.4(b)

An insurer or agent may not fail to fully disclose to first-party claimants benefits, coverages or other provisions of an insurance policy or insurance contract when the benefits, coverages or other provisions are pertinent to a claim.

AND

31 Pa. Code § 146.7(a)(1)

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

The Company failed to provide clear information regarding claims denial reasons. Examiners noted inconsistencies, vagueness, and lack of clarity in EOBs and Explanations of Payments (EOPs) regarding claims processing. In many cases, examiners noted missing information related to claim denials and lack of disclosure of the specific provisions related to the denial of the claims. Examiners also identified the use of general denial codes that do not provide enough information to identify specific issues such that recipients can resolve or dispute denials effectively. In some cases, denial code "05" (not a covered benefit) appeared on EOBs when, in fact, a medical necessity determination had been made, which is not indicated in EOBs and provider remittance advice. A denial for lack of medical necessity has different ramifications than a denial for a non-covered service, including different appeal rights.

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.

AND

40 P.S. § 1171.5(a)(10)(x)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made.

AND

42 U.S.C. §§ 300gg-6(b) & 18022(c)(1), and 45 C.F.R. § 156.130

The Department was unable to determine if the Company accurately accumulated out-of-pocket costs toward the maximum-out-of-pocket limits (MOOP) in most cases, and in some cases, it was noted that member's out-of-pocket payments exceeded their MOOP limits. The Company indicated that the retroactive calculation of MOOP as of the processing date of a particular claim is a manual calculation process; however, when examiners attempted to calculate MOOP amounts based on information provided, the calculated totals did not match the information provided to consumers. Further, the Company referenced a data corruption issue that resulted in missing deductible and MOOP information on EOBs reconstructed for the purposes of this examination. The Company indicated it believes that the members' original EOBs displayed the appropriate information but has not provided documentation to demonstrate that the appropriate information was included on the original EOBs. Consumers cannot make informed health care decisions if they do not have accurate information regarding their out-of-pocket costs.

Concern 1: Examiners noted inconsistencies, vagueness, and lack of clarity in EOBs and EOPs regarding claims processing and denial reasons. Specifically, Autism claims denials involving procedure code H0046 included extreme variation in how the code was treated by the Company respecting payment or denial. Some claims for H0046 services were paid in full or at the contracted rate while other claims were denied as not a covered benefit or denied as a noncontracted code. Some noncontracted code denials included instructions to resubmit with a different CPT code while other noncontracted code denials did not include

instructions to resubmit. Further, the Company's use of denial code "05" (not a covered benefit) was sometimes used when the services were covered benefits, and therefore, presented an inaccurate denial reason. Even in cases where denial code "05" was used accurately, the Company did not include references to the pertinent policy provision, condition, or exclusion when appropriate. The Company also used denial code "97" (interim bill inclusive please resubmit) incorrectly, in that the code was sometimes used when the claims did not represent interim bills. This concern is identified in the following sections of the exam: Medical Denied Claims; Mammogram Denied Claims; Autism Paid, Denied, and Partially Paid Claims; and SUD Partially Paid Claims.

Concern 2: Examiners noted lack of clarity in Schedules of Benefits (SOB). For many benefit plans, member cost sharing responsibilities varied for MH/SUD outpatient services depending on the type of service. For these plans, SOB information related to applicable cost sharing for different types of outpatient MH/SUD services was unclear because the SOB information did not identify the specific MH/SUD services that were subject to copay versus those services that were subject to deductible and coinsurance. In addition, SOBs for large group plans did not specify that limits on physical, speech, and occupational therapy did not apply to Autism services. This issue was specifically identified in the Autism Paid Claims section; however, SOBs were designed similarly across plans. Notably, the Company detailed and provided an example of the changes that have been made to member plan documents in order to clarify these issues.

Concern 3: During the review of claims, Examiners noted numerous claims processing problems identified by the Company in response to unfair claims practices violations. The claims processing problems identified by the Company include claims that did not map correctly, resulting in claims failing to process according to the plan SOB, and claims that were denied or otherwise incorrectly processed due to manual intervention. One specific example of a processing problem identified by the Company was system programming that resulted in all claim lines being denied if the claims processing system and the utilization management system authorization dates did not match exactly. While the Company indicated this process has since changed and now matches authorization dates according to each claim line, recent complaints to the Department reflect that other claims processing

problems remain. The Company has stated that it will consult internally regarding these issues and will continue to work collaboratively with the Department to address any consumer complaints regarding Health Plan operations. This concern is identified in the following sections of the exam: Autism Paid and Denied Claims; and SUD Paid, Denied, and Partially Paid Claims.

Concern 4: During the initial review of sampled pharmacy claims through the Company's Pharmacy Benefit Manager (PBM), Express Scripts, Inc.(ESI), the examination team was notified of a two-year claim "lookback issue" where requested samples were not available for review within the claims system. This claim system limitation did not enable Examiners to review claim processing information for approximately 75% of the originally sampled claims. Notably, the Company has represented that it worked with the PBM in 2018 to increase the length of time that claims are maintained in the active system before being archived. The Department requests that the Company continue to monitor this process to minimize premature archiving of related data and documentation. This concern is identified in all Pharmacy Claims sections.

Concern 5: Regarding EOB processes, the Company indicated that it did not notify or communicate to the insured the availability of the EOB placed into the member's portal when there was no member liability or cost-sharing responsibility. In addition, the Company indicated that it did not issue EOBs to members for retroactive ineligibility denials since the individuals were no longer covered members. The Company has indicated that some of these issues have already been addressed or are in the process of being addressed, and it will continue to review the issue and work with the Department in addressing its concerns. This concern is identified in the following sections of the exam: Autism Paid and Denied Claims; Emergency Room Partially Paid and Denied Claims; Ambulance Paid and Partially Paid Claims; SUD Paid Claims; HIV/AIDS Paid, Denied, and Closed-without-payment Claims; Opioid Paid, Denied, and Partially Paid Claims; Mental Health Paid Claims; Mammogram Closed-without payment Claims, and Medical Foods Paid Claims.

Concern 6: 40 P.S. §§ 908-11 et seq., 42 U.S.C. §§ 300gg-26 and 18022, and 45 C.F.R. § 146.136(c)(2)(ii)(A) require that plans (or health insurance issuers) apply the same

standards to medical/surgical benefits and to MH/SUD benefits when determining which classification in which a particular benefit belongs. For example, if a plan treats home health care as an outpatient benefit, then any covered intensive outpatient MH/SUD services and partial hospitalization must be considered outpatient benefits as well. When initially asked about its classification of benefits, the Company indicated that it placed home health care in the outpatient benefits classification but placed mental health partial hospitalization services in the inpatient benefit classification during the examination experience period. The Company later indicated that its utilization management staff inadvertently mischaracterized those services as inpatient in their response to the Department (because the services required prior authorization) without realizing the significance of the inpatient designation in the context of comprehensive MHPAEA compliance analysis. The Company has indicated that this issue is being addressed.

Concern 7: The Company failed to perform timely eligibility determinations, which resulted in retroactive denials of claims. Based on claims reviews, examiners noted that eligibility redeterminations were made in spring of 2016 that affected claims processed in fall of 2015. Upon reprocessing the claims, the Company failed to provide notifications to members that the claims were adjusted to denials. In the absence of notifications to members for retroactive denials of the claims, the Explanations of Benefits (EOBs) reflecting claims payments were the final communications with the impacted members, leaving them to believe that the claims remained in a paid status. The Company has stated that it was not reasonably clear that they needed to send EOBs to non-members at the time; however, the Company has indicated that it has since modified its business practices to provide EOBs to members under these circumstances.

Concern 8: 29 C.F.R. §2560.503-1(g) requires that plan notifications of adverse benefit determinations include the specific reason or reasons for the adverse determination. Examiners noted that the Company's notifications of partially denied autism services included detailed narratives of improved member behaviors that were the basis of the Company's determinations to partially deny services; however, the notifications did not specifically identify the Company's evaluative standards for the behavior described in the narratives. As a result, the specific reason or reasons for the partial denials may not have

been clear to members and providers who were attempting to determine whether further appeal was warranted.

I. Response to Requests

Examiners requested documentation demonstrating that the Company understood that it was required to respond to requests from examiners in a timely manner. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code §§ 152.20 and 301.82. In addition to the review of policies and procedures, the Department analyzed the Company's timeliness of responses for items requested by the Department during the market conduct examination. One general data integrity violation, described later in this Examination Report, was noted for the Company's general failure to provide timely access to all information requested by the Department during the course of the examination. No other 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 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. 146a, 146b, and 146c. 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 three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 31 Pa. Code Ch. 146a, 146b, and 146c; 42 U.S.C. § 1320d-6; and 45 C.F.R. Part 164. 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 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 31 Pa. Code Ch. 146a, 146b, and 146c. 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. The Company identified a universe of three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code Ch. 146a, 146b, and 146c. No violations were noted.

N. Opt-Out Notices

Examiners requested documentation demonstrating that the Company disclosed information subject to an opt-out right, that the Company had policies and procedures in place so that non-public personal financial information would not be disclosed when a consumer who was not a customer had opted out, and that the Company provided opt-out notices to its customers and other affected consumers during the experience period. The Company identified a universe of two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code Ch. 146a, using the guidelines set forth in Chapters 16 and 20 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 two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code Ch. 146a. No violations were 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 three documents and supplied two additional documents in response to an examiner-issued information request. 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. 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 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 31 Pa. Code Ch. 146c. 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 Department were complete and accurate 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, including 40 P.S. § 1171.5(a)(5) and 31 Pa. Code Ch. 146. 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 one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code §§ 152.3 and 301.42. No violations were noted.

T. External Audits and Examinations

Examiners requested a list 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 five documents and supplied two additional documents in response to an examiner-issued information request. 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 2013 through 2015, as well as any Accident and Health related schedules or statements for 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. 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. 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 regulated entity's complaint register for the experience period. The Company identified a universe of three documents and supplied three additional documents in response to an examiner-issued information request. 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. 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 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. § 156.1010. 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 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. No violations were noted.

D. Complaint Response Time

Examiners requested documentation demonstrating 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 six documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulation. 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 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. 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 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. 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 three documents. In accordance with requirements of the examination, the documents were

reviewed to ensure compliance with applicable state and federal laws and regulations. No violations were noted.

H. Complaint Summaries

Examiners requested a description of the complaint reports and summaries prepared on a 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 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.

I. Pennsylvania Insurance Department Complaints

Examiners requested that the Company identify all Insurance Department complaints received during the experience period. The Company identified 33 Insurance Department complaints. 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 31 Pa. Code § 146.5. The following concerns were noted:

Concern 1: Examiner noted that in one complaint, the member's coverage was retroactively terminated due to her employer not paying premiums. The issue was ongoing for over four months between the employer and the account management of the Company without any communication being provided to the enrollees. In such scenarios, the Department expects that there will be appropriate communications to the employee members.

Concern 2: Examiners noted that in two complaint files, the members appealed their out-of-pocket costs for colonoscopies. Both members were under the age of 50 and had a family history of colon cancer. However, the members believed that the colonoscopies were preventive, and as a result, that they should not have out-of-pocket costs. Company communications with these members did not clearly identify the criteria that qualifies members for no-cost coverage under the federal preventive service guidelines for colorectal cancer screening. Also, one of the members was incorrectly told by the Company's customer service department that her colonoscopy would be covered at no cost to her. The

Department expects that the Company will provide accurate and clear communications to members regarding the criteria that qualifies members for no-cost coverage under the federal preventive service guidelines.

J. Consumer Complaints Received

Examiners requested that the Company identify all consumer complaints received during the experience period. The Company identified a universe of 4,214 Health Options and 193 Health Coverage consumer complaints. A random sample of 115 Health Options and 79 Health Coverage complaint files were requested. In accordance with the requirements of the examination, the complaints 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 violations and concern were noted:

8 Violations – 40 P.S. § 991.2141(a)

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 Company failed to offer a second-level internal complaint process to enrollees in the first level decision letters for the noted complaint files.

1 Violation – 40 P.S. § 991.2141(b)(3)

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 to include the allowance of written data or other information. The Company failed to send an acknowledgement letter informing the enrollee of their right to submit written data or other information for the noted claim file.

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 to include a review or 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 complaint in a timely manner for the noted claim file.

13 Violations – 40 P.S. § 991.2141(b)(5)

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 to include a written notification to the enrollee regarding the decision of the initial review committee within five business days of the decision. Notice shall include the basis for the decision and the procedure to file a request for a second level review of the decision of the initial review committee. The Company failed to communicate their decision to the enrollee in a timely manner for the 13 noted complaint files.

Concern: In some complaint files, the Company's notification to enrollees of the 15-day timely filing period for filing appeals to the Insurance Department was not easily identifiable for the enrollee . For Health Coverage plans, the notification of the timely filing period was included in the body of the decision letter, where it was easily identifiable by the enrollee. For Health Options plans, this notice was not included in the body of the letter; it was included with all appeal rights in an attachment to the letter. The Department expects that the Company will inform enrollees about the 15-day timely filing period for filing appeals to the Insurance Department in an easily identifiable manner for the enrollee.

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 1,867 active producers. A random sample of 114 active producers was selected for review. The records were compared to Department records of producers to verify appointments, terminations, and licensing, as well as the Federally-facilitated Marketplace Registration Status List. In accordance with the requirements of the examination, the records were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. § 310.71(f) and 45 C.F.R. § 155.220. The following violation and concern were noted:

1 Violation – 40 P.S. § 310.71(a)

An insurance producer shall not act on behalf of or as a representative of the insurer unless the insurance producer is appointed by the insurer. An insurance producer not acting as a representative of an insurer is not required to be appointed. Prior to the ACA, the Company's business was written out of UPMC Health Network. The business was transferred to UPMC Health Options in 2014. However, the appointments to UPMC Health Network were inadvertently not transferred to UPMC Health Options when the business was moved. As a result, one general violation is cited for the failure to transfer the appointments to UPMC Health Options.

Concern: Based on the Company responses and associated documentation on the status of multiple producers provided for review, the Company identified multiple issues, such as providing the examination team with duplicate producer contract records, non-producer data, inaccurate initial termination data, and misidentification of producers not appointed with Health Options or Health Coverage during the experience period. The Company indicated it is conducting staff training in an effort to avoid appointment oversights in the future. The Department also expects that the Company will initiate and maintain formal producer licensing oversight policies and procedures. The policies and procedures should include managerial oversight of producers, including internal auditing on a frequent basis to ensure producer appointments and registrations are maintained appropriately, as well to ensure producer appointment and registration compliance with departmental regulations. Specifically, if external databases do not archive producer history in a way that is accessible to the Company, the Company should maintain its own records and database in order to be able to access that history.

B. Terminated Producers

Examiners requested a list of all producers terminated during the experience period. The Company provided a list of 487 terminated producers and supplied 76 additional terminated producers in response to an examiner-issued information request. A sample of 86 terminated producers was requested. In accordance with the requirements of the examination, the files were reviewed to ensure compliance with standards set forth in 45 C.F.R. §155.220, 40 P.S. §310.71 et seq., and the files were compared to Departmental records of producers to verify appointments, terminations, and licensing. The following violations were noted:

2 Violations – 40 P.S. §310.71a(a)

An insurance producer shall not act on behalf of or as a representative of the insurer unless the insurance producer is appointed by the insurer. An insurance producer not acting as a representative of an insurer is not required to be appointed. An insurer that appoints an insurance producer shall file with the department a notice of appointment. Once appointed, an insurance producer shall remain appointed by an insurer until such time as the insurer

terminates the appointment in writing to the insurance producer or until the insurance producer's license is suspended, revoked or otherwise terminated. The Producers were not reported as terminated to the Department timely.

C. Account Balances

Examiners requested documentation showing that producer contracts' account balances were maintained 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 documents were reviewed to ensure compliance with applicable state and federal laws and regulations. No violations were noted.

D. Description of Agency System

Examiners requested a description of the type of agency system utilized by the Company during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

E. Licensing and Appointment Verification

Examiners requested documentation demonstrating how the Company verified that all business accepted from producers was written by individuals who were duly licensed and appointed to represent the Company during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code Ch. 39a. 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 Billing Practices

Examiners requested documentation describing requirements for premium collection and billing used 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.

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 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. 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 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. No violations were noted.

D. Assumption Reinsurance Agreements

Examiners requested documentation demonstrating that, whenever the Company transferred the obligation of its contracts to another regulated entity pursuant to an assumption reinsurance agreement during the experience period, the Company had sent the required notices to affected policyholders. The Company identified a universe of three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations. 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 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. 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 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. § 753(B)(8). 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 six documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. § 753(A)(4). No violations were noted.

H. Policyholders Services

Examiners requested documentation demonstrating that policyholder service was properly handled in accordance with policy provisions, and state and federal laws and regulations applicable during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations. 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 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. § 753(B)(8). 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 54 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. No violations were noted.

K. Cancelled Policies

Examiners requested a list of policies cancelled 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. 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 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. 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 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.

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 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. 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 five 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. The following concern was noted:

Concern: Examiners noted that, based on contract language, the Company did retain the right to audit producers to assure that inducements and kickbacks were not being made to procure business. The Company has indicated that no audits had been performed during the examination period related to producer conduct associated with potential illegal rebating, commission-cutting or inducements. The Department recommends that the Company schedule and conduct periodic audits to monitor producer conduct relative to illegal rebating, commission-cutting, and inducements.

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 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. §§ 477a, 761, and 1171.5(a)(7); and 45 C.F.R. §§ 146.121 and 147.110. 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 identified a universe of two policy and procedure documents and 347 policy forms. In accordance with the requirements of the examination, the documents and 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. 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 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 noted above, as well as 45 C.F.R. §§ 147.104 and 147.106. 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 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 42 U.S.C. § 300gg-4(a)(1) and 45 C.F.R. §§ 146.121 and 147.110. No violations were noted.

H. Cancellation Notices

Examiners requested documentation demonstrating that cancellation/nonrenewal, discontinuance, and declination notices complied with policy and contract provisions, Company guidelines, and state and federal laws and regulations applicable during the experience period. The Company identified a universe of 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 noted above, as well as 45 C.F.R. § 155.230. 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 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. 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 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 40 P.S. § 753. 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 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 40 P.S. § 764j and 29 U.S.C. §§ 1161 et seq. 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. 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 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 31 Pa. Code Ch. 146b. 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 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. §§ 146.111 and 147.108. 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 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. §§ 908-14 and 45 C.F.R. §§ 146.121 and 147.110. 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 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 40 P.S. §§ 1302.1 et seq., 42 U.S.C. 300gg-1, and 45 C.F.R. § 147.104. 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 federal laws and regulations, and in compliance with state laws and regulations applicable during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 45 C.F.R. § 147.104. 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 four 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. 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 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 42 U.S.C. § 300gg-14 and 45 C.F.R. § 147.120. 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 States Department of Health and Human Services (HHS), the United States Department of Labor (DOL), and the United States Department of the Treasury (Treasury). 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 noted above, as well as 45 C.F.R. § 147.106. 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 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 42 U.S.C. § 300gg-11 and 45 C.F.R. § 147.126. 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 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 42 U.S.C. § 300gg-13 and 45 C.F.R. § 147.130. No violations were noted.

W. 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 provided 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 45 C.F.R. § 147.128. 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 the claimants occurred within the required timeframe applicable during the experience period. The Company identified a universe of two documents and provided two additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination, the 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. No violations were noted.

B. Timely Investigations

Examiners requested documentation demonstrating that investigations were conducted timely during the experience period. The Company identified a universe of six 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. 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 two 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 42 156.1010. 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 six documents. Further, examiners requested documentation demonstrating that claims were handled in accordance with policy provisions, and state and federal laws and regulations applicable during the experience period. The Company identified a universe of 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 in the written documents; however, claims handling violations and concerns were identified; they are discussed in the Written Overview of Company Operations section, as well in several claims sections, of this Examination Report.

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 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. 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 two 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. 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 three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations. The following concern was noted:

Concern: The Company did not, during the experience period, have a formal policy relative to handling of denied and closed-without-payment claims. The Department expects that the Company will develop a policy and procedure that clearly outlines the manner in which denied and closed-without-payment claims are to be processed, consistent with Pennsylvania regulatory requirements and to ensure consistency.

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 two additional documents in response to an examiner-issued information request. 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.

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. No violations were noted.

J. Claims-Handling Practices

Examiners requested documentation demonstrating that claim files were handled in accordance with policy provisions, HIPAA, and state laws and regulations applicable during the experience period. The Company identified a universe of six documents and provided three additional documents in response to an examiner-issued information request. 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 with respect to written claims-handling practices.

K. Newborns' and Mothers' Protection Act

Examiners requested documentation demonstrating that the Company complied with the requirement of the federal Newborns' and Mothers' Health Protection Act of 1996 and the Pennsylvania Health Security Act. The Company identified a universe of 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. The following concern was noted:

Concern: Examiners noted that the certificates of coverage properly reflect compliance with the regulations for the Newborns' and Mothers' Health Protection Act. However, the language in the Company's claims processing policy did not match the certificates of coverage. The Department expects that the operating policy will be updated to reflect the certificate of coverage language so that the processing of claims is consistent with members' benefits.

L. Mental Health Parity and Addiction Equity Act

Examiners requested documentation demonstrating that the Company complied with the requirements of the federal Mental Health Parity and Addiction Equity Act of 2008 and the Pennsylvania Health Insurance Coverage Parity and Nondiscrimination Act. The Company identified a universe of three documents and provided numerous other documents in response to examiner-issued information requests. In accordance with the requirements of the examination, the 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. All findings with respect to mental health parity requirements are addressed in the Written Overview of Operations section of this examination report.

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

Examiners requested documentation demonstrating that group health plans complied with the requirements of the federal Women's Health and Cancer Rights Act of 1998 and corresponding state law during the experience period. The Company identified a universe of 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 noted above, as well as 40 P.S. §§ 764d and 1571, as well as 42 U.S.C. § 300gg-27. 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 17 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 § 89.93. 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. 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 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. 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 used to process grievances during the experience period, that were filed with the Department. 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. 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 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 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.

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 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. Voluntary Reviews 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 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. 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 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.

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

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 promulgated by HHS, DOL, and Treasury. The Company identified a universe of 15 documents and provided an additional four documents in response to an examiner-issued information request. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable federal laws and regulations. No violations were noted.

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 335 first- and second-level internal appeals. A random sample of 84 Health Options files and five Health Coverage files was requested. According to the requirements of the examination, the files were reviewed to ensure compliance with applicable state and federal laws and regulations. The following violations and concern were noted:

13 Violations – 42 U.S.C. § 300gg-19(a)(1)(c)

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan or issuer shall, at a minimum: have in effect an internal claims appeal process; provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance or ombudsman; and allow an enrollee to review their file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process. The Company failed to send an acknowledgement letter informing the enrollee of their right to submit written data or other information to be considered in making the decision or the letter was not sent in advance of the decision letter. The Department notes that the Company implemented processes in July 2017 to ensure that acknowledgment letters are sent in a timely manner for all grievance cases.

1 Violation - 29 C.F.R. § 2560.503-1(i)(2)(ii)

In the case of a pre-service claim, the plan or issuer shall notify the claimant of the plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. In the case of a group health plan that provides for one appeal of an adverse benefit determination, such notification shall be provided not later than 30 days after receipt by the plan of the claimant's request for review of an adverse benefit determination. In the case of a group health plan that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 15 days after receipt by the plan of the claimant's request for review of the adverse determination. The company failed to process the appeal timely.

1 Violation – 45 C.F.R. § 147.136(b)(2)(ii)(F)

A group health plan and a health insurance issuer offering group or individual health insurance coverage must implement an effective internal claims and appeals process that includes a provision for deemed exhaustion of the internal claims and appeals processes if the Company fails to strictly adhere to all the regulatory requirements. The process must then allow the claimant to initiate an external review. The Company did not strictly adhere to the provisions of the internal claims and appeals processes; the Company failed to hold a second level hearing.

1 Violation – 45 C.F.R. § 147.136(b)(3)(ii)(E)

A plan and issuer must provide notice to individuals, 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 provide notice that included the specific reason for the adverse benefit determination or reference to the particular plan provision.

5 Violations – 45 C.F.R. § 147.136(d)(2)(i)

A plan or issuer not subject to an applicable State external review process must provide an effective Federal external review process, which allows a claimant to file a request for an

external review with the plan or issuer if the request is filed within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. The Company did not provide opportunity for the claimants to file requests for an external review within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination.

Concern: The Company did not consistently make available oral language services on the acknowledgement letters for non-English speaking insureds aiding with filing claims and appeals according to 42 U.S.C.§300gg-19(b)(2) and 45 C.F.R. §§ 147.136(b)(2)(ii)(E) and 147.136(b)(3)(ii). The Department expects that the Company will add the non-English oral language services on all appeal communications to members moving forward.

K. External Appeals

Examiners requested that the Company identify all external appeals received during the experience period. The Company identified a universe of 13 external appeals. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations. The following violations were noted:

5 Violations – 45 C.F.R. § 147.136(d)(2)(ii)

Within five business days following the date of receipt of the external review request, the group health plan or health insurance issuer must complete a preliminary review of the request to determine whether: (1) The claimant is or was covered under the plan or coverage at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan or coverage at the time the health care item or service was provided; (2) The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the group health plan or health insurance coverage (e.g., worker classification or similar determination); (3) The claimant has exhausted the plan's or issuer's internal appeal process unless the claimant is not required to exhaust the internal

appeals process under paragraph (b)(1) of this section; and (4) The claimant has provided all the information and forms required to process an external review. Within one business day after completion of the preliminary review, the plan or issuer must issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and current contact information, including the phone number, for the Employee Benefits Security Administration. If the request is not complete, such notification must describe the information or materials needed to make the request complete and the plan or issuer must allow a claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later. The Company failed to complete its review within 5 days of receiving the external review request and failed to notify the enrollee within one day of the completion of the review in the five noted files. The Department notes that the Company implemented processes in October 2016 to ensure that cases are timely assigned and processed.

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 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.

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. The Company must make the access plans available: 1) on its business premises; 2) to regulators; and 3) to interested parties, absent proprietary information, upon request. The Company identified a universe of 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.

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 13 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.

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. 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 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. 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 identified a universe of two documents. In accordance with the examination, the

documents were 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 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. 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 re-credentialing in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of 19 documents and provided three additional documents in response to an examiner-issued information request. 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. 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 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. No violations were noted.

C. Verification

Examiners requested documentation demonstrating that the Company obtained primary or secondary verification of the information required by state laws and regulations applicable during the experience period. The Company identified a universe of seven documents and provided two additional documents in response to an examiner-issued information request. 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. 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 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 noted above, as well as 40 P.S. §§ 991.2117 and 1171.5, and 31 Pa. Code §§ 152.6 and 301.42. 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. 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. 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 24

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.

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

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 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. 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 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.

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 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. 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 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. 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 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.

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 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. No violations were noted.

XIII. 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; 31 Pa Code §152.2, 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 103 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. 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 18 documents and provided 43 additional documents in response to an examiner-issued information request. 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 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.

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

E. Timely Standard Utilization Review

Examiners requested documentation demonstrating that the Company made standard utilization review and benefit determinations in a timely manner as required by 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 and regulations. No violations were noted.

F. Adverse Determination of Utilization Review

Examiners requested documentation demonstrating that the Company provided written notice of adverse 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 and provided two additional documents in response to an examiner-issued information request. 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.

G. Expedited Utilization Review and Benefit Determinations

Examiners requested documentation demonstrating that the Company conducted expedited utilization review 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 six documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws. 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 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. No violations were noted.

I. Monitoring Utilization Review Entity

Examiners requested documentation demonstrating that the Company monitored the activities of each 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 20 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.

XIV. MEDICAL AND PHARMACY CLAIMS REVIEW

Examiners requested a list of all medical and pharmacy claims paid, denied, partially paid, and closed-without-payment during the experience period. The Company identified a universe of 2,175,470 medical 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. HIV/AIDS Claims
I. Opioid Addiction Claims
J. Mental and Behavioral Health Claims
K. Pharmacy Claims – Mental and Behavioral Health, Substance Use Disorder, HIV/AIDS, and Opioid

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.

The Company identified numerous plans in claims files as grandfathered or transitional relief plans. Grandfathered and transitional relief plans are outside of the scope of the examination. Issues related to grandfathered and transitional relief plans that were identified through the course of the examination will be addressed separately from this examination report.

The following general concern was noted in multiple sections of non-pharmacy claims:

Concern: The Company failed to provide in the claim file evidence of a reasonable explanation for delay in the processing of a claim within 45 days of notice or a previous status letter. The Department expects that the Company will modify system and operational processes to ensure all claim delays are communicated to insureds in a timely manner.

A. Medical Claims

Examiners requested lists of all medical claims paid, denied, partially paid, and closed-without-payment 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. Examiners found violations in all four sections.

Medical Paid Claims

Examiners requested a list of all medical claims paid during the experience period. The Company identified a universe of 1,048,575 paid medical claims. A random sample of 109 claim files was requested. In accordance with the requirements of the examination, the files were reviewed. The following violations were noted:

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

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made.

AND

31 Pa. Code § 146.4(a)

An insurer or agent may not fail to fully disclose to first-party claimants pertinent benefits, coverage or other provisions of an insurance policy or insurance contract under which a claim is presented. The Company failed to pay the claim in accordance with the member's coverage as described in the plan's Schedule of Benefits and failed to provide all necessary

information to demonstrate the manner in which the claim was paid. While the claim paid in error, it is noted that the claim processing error was to the member's benefit.

2 Violations - 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in the detail that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain complete claim files for the noted claims.

Medical Denied Claims

Examiners requested a list of all medical claims denied during the experience period. The Company identified a universe of 209,153 denied medical claims. A random sample of 109 claim files was requested. In accordance with the requirements of the examination, the files were reviewed. The following violations were noted:

6 Violations – 40 P.S. § 991.2166(a) & 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 for services provided within 45 days of receipt of the claim from the health care provider. The Company failed to pay the noted clean claims 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 failed to pay the noted claim when the Company's liability was reasonably clear.

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

"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 promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement. The Company failed to provide a reasonable explanation for denial of services otherwise appearing to be eligible for coverage.

Medical Partially Paid Claims

Examiners requested a list of all medical claims partially paid during the experience period. The Company identified a universe of 169,527 partially paid medical claims. A random sample of 109 claim files was requested. In accordance with the requirements of the examination, the files were reviewed. The following violations were noted:

1 Violation – 40 P.S. § 991.2166(a) & 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 for services provided 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.

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 failed to pay the noted claims when the Company's liability was reasonably clear. For one of the three claims, it is noted that when the claim paid, a claim processing error occurred but the error was to the member's benefit.

1 Violation – 31 Pa. Code § 146.3

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

Medical Closed-without-payment Claims

Examiners requested a list of all medical claims closed-without-payment during the experience period. The Company identified a universe of 52,387 medical claims that were closed-without-payment. A random sample of 109 claim files was requested. In accordance with the requirements of the examination, the files were reviewed. The following violations were noted:

1 Violation – 40 P.S. § 991.2166(a) & 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 for services provided 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.

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 claims when the Company's liability was reasonably clear.

B. Mammogram Claims

Examiners requested lists of all mammogram claims paid, denied, partially paid, and closed -without-payment 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; 18 Pa. C.S. § 4117; 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 four sections.

Mammogram Paid Claims

Examiners requested a list of all mammogram claims paid during the experience period. The Company identified a universe of 7,666 paid mammogram claims. A random sample of 108 claim files was requested. In accordance with the requirements of the examination, the files were reviewed. No violations were noted.

Mammogram Denied Claims

Examiners requested a list of all mammogram claims denied during the experience period. The Company identified a universe of 148 denied mammogram claims. A random sample of 76 claim files was requested. In accordance with the requirements of the examination, the files were reviewed. The following violations were noted:

2 Violations – 40 P.S. § 991.2166(a) & 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 for services provided within 45 days of receipt of the claim from the health care provider. The noted clean claims were not paid within 45 days of receipt.

Mammogram Partially Paid Claims

Examiners requested a list of all mammogram claims partially paid during the experience period. The Company identified a universe of 1,065 partially paid mammogram claims. A random sample of 105 claim files was requested. In accordance with the requirements of the examination, the files were reviewed. No violations were noted.

Mammogram Closed-without-payment Claims

Examiners requested a list of all mammogram claims closed-without-payment during the experience period. The Company identified a universe of 28 mammogram claims that were closed-without-payment. All 28 claim files were requested. In accordance with the requirements of the examination, the files were reviewed. The following violations and concerns were noted:

2 Violations – 40 P.S. § 764c

All group or individual health or sickness or accident insurance policies providing hospital or medical/surgical coverage shall also provide coverage for mammographic examinations. The minimum coverage required shall include all costs associated with a mammogram every year for women 40 years of age or older and with any mammogram based on a physician's recommendation for women under 40 years of age. The Company failed to provide coverage for mammographic examinations for the noted claims.

2 Violations – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in the detail that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain complete claim files for the noted claims.

Concern: Examiner noted that member eligibility files did not agree with the Company termination information, which could cause confusion for members and providers checking eligibility pre-service. The Department expects that group enrollment files will be reconciled with member eligibility files to assure information is accurate.

C. Medical Foods Claims

Examiners requested lists of all medical foods claims paid, denied, partially paid, and closed-without-payment 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 two of the four sections.

Medical Foods Paid Claims

Examiners requested a list of medical foods claims paid during the experience period. The Company identified a universe of 781 claims. A random sample of 83 claim files was requested. In accordance with the requirements of the examination, the files were reviewed. The following violation was noted:

1 Violation – 31 Pa. Code § 146.3

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

Medical Foods Denied Claims

Examiners requested a list of medical foods claims denied during the experience period. The Company identified a universe of 209 denied medical foods claims. A random sample of 76 claim files was requested. In accordance with the requirements of the examination, the files were reviewed. The following concern was noted:

Concern: Examiners noted that several sample files indicated individuals required therapy for extended periods, which was complicated by extended denial timeframes; since denial notifications were not timely, members and medical food providers were not aware that claims were denied due to lack of preauthorization requests. In addition, , it appears that medical food providers may not understand that these services require preauthorization, which in turn, jeopardizes member coverage and payment for said benefit. The Department expects that the Company will educate both members and providers regarding the requirements for utilizing the medical foods benefit.

Medical Foods Partially Paid Claims

Examiners requested a list of medical foods claims that were partially paid during the experience period. The Company identified a universe of 568 partially paid medical foods claims. A random sample of 83 claim files was requested. In accordance with the requirements of the examination, the files were reviewed. The following violation was noted:

1 Violation – 40 P.S. § 991.2166(a) & 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 for services provided within 45 days of receipt of the claim from the health care provider. The Company failed to pay the noted clean claim within 45 days of receipt.

Medical Foods Closed-without-Payment Claims

Examiners requested a list of medical foods claims that were closed-without-payment during the experience period. The Company identified a universe of 13 medical foods claims that were closed-without-payment. All 13 claim files were requested. In accordance with the requirements of the examination, the files were reviewed. The following violation was noted:

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 failed to pay the noted claim when the Company's liability was reasonably clear.

D. Autism Claims

Examiners requested lists of all autism spectrum disorder (ASD) claims paid, denied, partially paid, and closed-without-payment 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, 908-11 et seq., 991.2166, and 1171.5; 31 Pa. Code Ch. 146 and 154; 42 U.S.C. §§ 300gg-6, 300gg-13, 300gg-26, and 18022; 29 C.F.R. §2560.503-1(g); and 45 C.F.R. §§ 146.136, 147.150, 147.160, and 156.110. Examiners found violations in all four sections and noted the following concern:

Concern: For several claims, the Company failed to provide evidence that a reasonable explanation for the delay in the processing of a claim within 30 days of notice was provided to the claimant, as required under 31 Pa Code § 146.6. The Department expects that the Company will modify system and operational processes to ensure all claim delays are communicated to claimants in a timely matter.

Autism Paid Claims

Examiners requested a list of all ASD claims paid during the experience period. The Company identified a universe of 21,004 paid ASD claims. A random sample of 109 claim files was requested. In accordance with the requirements of the examination, the files were reviewed.

The following violations were noted:

4 Violations – 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)

Licensed insurers are required to provide mental health and substance use disorder benefits in parity with medical/surgical benefits. For quantitative treatment limitations (QTL), this means that a licensed insurer may not apply any financial requirement (FR) or QTL to mental health or substance use disorder (MH/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 the Company to provide proof of compliance for each plan type affected, each classification of benefits and for each type of QTL separately. The Company imposed FRs with respect to mental health benefits not in parity with medical/surgical

benefits. Specifically, the Company provided data that failed the substantially all or predominant level tests within certain specified classifications of benefits such that cost sharing was charged to consumers when it should not have been, or the level of cost sharing charged was too high.

5 Violations – 40 P.S. §§ 908-11 et seq., 42 U.S.C. §§ 300gg-26 and 18022, and 45 C.F.R. § 146.136(c)(4)(i)

Licensed insurers are required to provide MH/SUD benefits in parity with medical/surgical benefits. For nonquantitative treatment limitations (NQTL), this means that a licensed insurer may not apply any NQTL in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying that limitation to MH/SUD benefits within that classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the classification. The Company imposed a NQTL with respect to autism benefits in the Outpatient, All Other; In-network subclassification. Specifically, the Company limited the scope and duration of treatment for the members listed by partially denying requested hours of community-based wrap-around services (procedure code H2021). The Company has not demonstrated that the processes, strategies, evidentiary standards, or other factors used in applying the partial denials to the specified autism services were applied comparably and no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

1 Violation – 40 P.S. § 991.2166(a) & 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 for services provided within 45 days of receipt of the claim from the health care provider. The Company failed to pay the noted clean claim within 45 days of receipt.

4 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 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 process the noted claims according to the plans' Schedule of Benefits and issued member explanation of benefits and provider remittance advice that misrepresented the benefits of the member's policy. Further, plan Schedules of Benefits, Certificates of Coverage, and Autism Riders did not include language to indicate that rehabilitative/habilitative service limits do not apply to ASD services.

6 Violations – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in the detail that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain complete claim files for the noted claims.

10 Violations - 31 Pa. Code § 146.4(a)

An insurer or agent may not fail to fully disclose to first-party claimants pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.

AND

31 Pa. Code § 146.4(b)

An insurer or agent may not fail to fully disclose to first-party claimants benefits, coverages or other provisions of an insurance policy or insurance contract when the benefits, coverages or other provisions are pertinent to a claim. Plan Schedules of Benefits do not provide a clear indication of the outpatient services included in each of the two categories of outpatient behavioral health and substance abuse services identified in the Schedules of Benefits.

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

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

Autism Denied Claims

Examiners requested a list of all ASD claims that were denied during the experience period. The Company identified a universe of 4,724 denied autism claims. A random sample of 108 denied claims was requested. Upon review, examiners determined that 58 files were transitional relief or grandfathered plans, which are outside of the scope of the examination. In accordance with the requirements of the examination, the remaining 50 of 108 identified files were reviewed. The following violations were noted:

3 Violations – 40 P.S. § 764h(a)

A health insurance policy or government program covered under this section shall provide to covered individuals or recipients under twenty-one (21) years of age coverage for the diagnostic assessment of autism spectrum disorders and for the treatment of autism

spectrum disorders. The Company failed to pay the noted claims for autism spectrum disorder treatment due to claims processing errors.

1 Violation – 40 P.S. § 764h(b)

Coverage provided under this section by an insurer shall be subject to a maximum benefit of thirty-six thousand dollars ($36,000) per year but shall not be subject to any limits on the number of visits to an autism service provider for treatment of autism spectrum disorders. The Company placed coverage limits on the number of visits for the treatment of autism spectrum disorders during the experience period of the examination.

3 Violations – 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)

Licensed insurers are required to provide MH/SUD benefits in parity with medical/surgical benefits. For quantitative treatment limitations, this means that a licensed insurer may not apply any financial requirement (FR) or quantitative treatment limitation (QTL) to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant FR or QTL of that type applied to substantially all medical/surgical benefits in the same classification. Examiners requested the Company to provide proof of compliance for each plan type affected, each classification of benefits and for each type of QTL separately. The Company imposed QTLs with respect to mental health benefits not in parity with medical/surgical benefits. Specifically, it is noted that the Company did not demonstrate compliance with the substantially all or predominant level tests within the specified classifications of benefits.

3 Violations – 40 P.S. §§ 908-11 et seq., 42 U.S.C. §§ 300gg-26 and 18022, and 45 C.F.R. § 146.136(c)(4)(i)

Licensed insurers are required to provide MH/SUD benefits in parity with medical/surgical benefits. For nonquantitative treatment limitations (NQTL), this means that a licensed insurer may not apply any NQTL in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying that limitation to MH/SUD benefits within that classification are comparable to, and are applied no more stringently than, the

processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the classification. The Company imposed a nonquantitative treatment limitation (NQTL) with respect to autism benefits in the Outpatient, All Other; In-network subclassification. Specifically, the Company limited the scope and duration of treatment for the members listed by partially denying requested hours of community-based wrap-around services (procedure code H2021). The Company has not demonstrated that the processes, strategies, evidentiary standards, or other factors used in applying the partial denials to the specified autism services, were applied comparably and no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

3 Violations – 40 P.S. § 991.2166(a) & 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 for services provided within 45 days of receipt of the claim from the health care provider. The Company failed to pay the noted clean 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 noted clean claims timely and interest of $2 or more remains unpaid.

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 practice shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue. The member EOB misrepresented pertinent facts relating to the processing of the listed claims or misrepresented policy or contract provisions relating to coverage of services for the listed claims.

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

10 Violations - 40 P.S. § 1171.5(a)(10)(xiv)

"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 promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

AND

31 Pa. Code § 146.7(a)(1)

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer.

An insurer may not deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition, or exclusion is included in the denial. The Company failed to provide a reasonable explanation for denial of the noted claims, including the grounds of the specific policy provision, condition, or exclusion when such provision, condition, or exclusion was the basis of the denial.

Autism Partially Paid Claims

Examiners requested a list of all ASD claims partially paid during the experience period. The Company identified a universe of 307 partially paid ASD claims. A random sample of 76 claims was requested. Upon review, examiners determined that eight files were transitional relief or grandfathered plans, which are outside of the scope of the examination. In addition, 12 files were identified as medical claims not related to a primary diagnosis of autism. In accordance with the requirements of the examination, the remaining 56 of 76 identified files were reviewed. The following violations were noted:

3 Violations – 40 P.S. § 764h(a)

A health insurance policy or government program covered under this section shall provide to covered individuals or recipients under twenty-one (21) years of age coverage for the diagnostic assessment of autism spectrum disorders and for the treatment of autism spectrum disorders. The Company failed to pay the noted claims for autism spectrum disorder treatment due to claims processing errors.

10 Violations – 40 P.S. §§ 908-11 et seq., 42 U.S.C. §§ 300gg-26 and 18022, and 45 C.F.R. § 146.136(c)(4)(i)

Licensed insurers are required to provide MH/SUD benefits in parity with medical/surgical benefits. For nonquantitative treatment limitations (NQTL), this means that a licensed insurer may not apply any NQTL in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying that limitation to MH/SUD benefits within that classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in applying the limitation to medical/surgical benefits in the classification. The Company imposed an NQTL with

respect to autism benefits in the Outpatient benefits classifications. Specifically, the Company limited the scope and duration of treatment for the members listed by denying benefits for various services for the indicated procedure codes. The Company has not demonstrated, as written and in operation, that the processes, strategies, evidentiary standards, or other factors used in applying the denials to the specified autism services, were applied comparably and no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

6 Violations – 40 P.S. § 991.2166(a) & 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 for services provided within 45 days of receipt of the claim from the health care provider. The Company failed to pay the noted clean claims within 45 days of receipt.

6 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 noted clean claims timely and interest of $2 or more remains unpaid.

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 improperly denied the noted claims when the Company's liability under the policy was reasonably clear.

9 Violations - 40 P.S. § 1171.5(a)(10)(xiv)

"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 promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement. The Company failed to provide a reasonable explanation for denial of the noted claims.

1 Violation – 31 Pa. Code § 146.3

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

Autism Closed-without-payment Claims

Examiners requested a list of all ASD claims closed-without-payment during the experience period. The Company identified a universe of 181 closed-without-payment autism spectrum disorders claims. A random sample of 76 claims was requested. Upon review, examiners determined that 17 files were transitional relief or grandfathered plans, which are outside of the scope of the examination. In accordance with the requirements of the examination, the remaining 59 of 76 identified files were reviewed. The following violations were noted:

7 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.

AND

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.

AND

31 Pa. Code § 146.7(c)(1)

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

The Company failed to notify the claimant of additional time needed; due to Company processes, the Company failed to make a liability determination and failed to communicate to the claimant.

7 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 provide evidence that a

reasonable explanation for the delay in the processing/re-processing of the noted claims was sent to the claimant.

E. Emergency Services Claims

Examiners requested lists of all emergency services claims paid, denied, partially paid, and closed-without-payment 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 two of the four 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 277,517 paid emergency services claims. A random sample of 109 claim files was requested. In accordance with the requirements of the examination, the files were reviewed. No violations were noted.

Emergency Services Denied Claims

Examiners requested a list of all emergency services claims denied during the experience period. The Company identified a universe of 6,541 denied emergency services claims. A random sample of 108 claim files was requested. In accordance with the requirements of the examination, the files were reviewed. The following violations were noted:

5 Violations – 40 P.S. § 991.2116

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

emergency services, a managed care plan shall consider both the presenting symptoms and the services provided.

AND

42 U.S.C. § 18022(b)(4)(E)(i) and (ii)

Coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network. The Company failed to provide emergency benefits for the insureds where their policy and the law required provision thereof for the noted claims.

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 6,576 partially paid emergency services claims. A random sample of 108 claim files was requested. In accordance with the requirements of the examination, the files were reviewed. The following violations and concern were noted:

16 Violations – 31 Pa. Code §146.4(a)

An insurer or agent may not fail to fully disclose the first-party claimant's pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented. The Company failed to fully disclose the first-party claimant's pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented. The EOB failed to provide all necessary information to demonstrate the manner in which the noted claims were paid.

11 Violations - 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 pay the noted claims in accordance with the member's coverage as described in the plan's Schedule of Benefits.

Concern: The Company indicated in summary responses to this claim section for multiple claims that EOBs incorrectly reflected member liability based on additional review. The Department expects that the Company will implement additional internal claim processing oversight and audit frequency to ensure all claims are processed properly and all EOBs consistently and correctly indicate and communicate member liability.

Emergency Services Closed-without-payment Claims

Examiners requested a list of all emergency services claims closed-without-payment during the experience period. The Company identified a universe of 5,594 emergency services claims closed-without-payment. A random sample of 108 claim files was requested. In accordance with the requirements of the examination, the files were reviewed. No violations were noted.

F. Ambulance Claims

Examiners requested lists of all ambulance claims paid, denied, partially paid, and closed-without-payment during the experience period. In accordance with the requirements of the examination, ambulance claim files were reviewed to ensure compliance 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 noted violations in three of the four sections.

Ambulance Paid Claims

Examiners requested a list of all ambulance claims paid during the experience period. The Company identified a universe of 12,590 paid ambulance claims. A random sample of 109 claim files was requested. In accordance with the requirements of the examination, the files were reviewed. The following violation was noted:

1 Violation – 40 P.S. § 991.2166(a) & 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 for services provided within 45 days of receipt of the claim from the health care provider. The Company failed to pay the noted clean claim within 45 days of receipt.

Ambulance Denied Claims

Examiners requested a list of all ambulance claims denied during the experience period. The Company identified a universe of 1,349 denied ambulance claims. A random sample of 105 claim files was requested. In accordance with the requirements of the examination, the files were reviewed. The following violations and concern were noted:

1 Violation – 31 Pa. Code § 146.3

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

Ambulance Partially Paid Claims

Examiners requested a list of all ambulance claims partially paid during the experience period. The Company identified a universe of 251 partially paid ambulance claims. A random sample of 76 claim files was requested. In accordance with the requirements of the examination, the files were reviewed. The following violations and concern were noted:

3 Violations – 40 P.S. § 991.2166(a) & 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 for services provided within 45 days of receipt of the claim from the health care provider. The Company failed to pay the noted clean claims within 45 days of receipt.

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 noted claims when the Company's liability was reasonably clear.

Concern: EOBs reflected unpaid amounts for duplicate ambulance services as member liability. The Company indicated that member liability is correct because non-par providers can balance bill members. Since the services were already paid for by the Plan, the Department notes that it is misleading to display the services as unpaid and resulting in the member's liability. For purposes of accuracy and clarity, the Department expects that the EOB will indicate that the services were denied as being previously paid by the Plan and the member liability is $0.

Ambulance Closed-without-payment Claims

Examiners requested a list of all ambulance claims that were closed-without-payment during the experience period. The Company identified a universe of 428 ambulance claims that were closed-without-payment. A random sample of 82 claim files was requested. In accordance with the requirements of the examination, the files were reviewed. No violations were noted.

G. Substance Use Disorder Claims

Examiners requested lists of all substance use disorder (SUD) claims paid, denied, partially paid, and closed-without-payment 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 18 Pa. C.S. § 4117(k)(1), 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 noted violations in all four 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 26,000 paid SUD claims. A random sample of 109 claims was requested. In accordance with the requirements of the examination, the files were reviewed. The following violations and concern were noted:

1 Violation – 18 Pa. C.S. § 4117(k)(1)

All applications for insurance and all claim forms shall contain or have attached thereto the following notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. The Company failed to provide the required fraud warning notice on the out-of-network claim form.

2 Violations – 40 P.S. § 991.2166(a) & 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 for services provided within 45 days of receipt of the claim from the health care provider. The Company failed to pay the noted clean claims within 45 days of receipt.

14 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 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 process the noted claims according to the plans' Schedules of Benefits and issued member EOBs and provider remittance advice that misrepresented the benefits of the member's policy.

1 Violation – 31 Pa. Code § 146.3

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

Substance Use Disorder Denied Claims

Examiners requested a list of all SUD claims denied during the experience period. The Company identified a universe of 1,802 claims. A random sample of 105 claims was requested. Upon review, examiners determined that 37 files were transitional relief or grandfathered plans, which are outside of the scope of the examination. In accordance with the requirements of the examination, 68 of 105 identified files were reviewed. The following violations and concerns were noted:

14 Violations – 40 P.S. §§ 908-1 et seq.

Licensed insurers are required to provide coverage for benefits for alcohol or other drug abuse and dependency. The certification and referral from the licensed physician controls both the nature and duration of the treatment. The Company failed to pay the noted claims for substance use disorder treatment due to claims processing errors.

1 Violation - 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)

Licensed insurers are required to provide mental health and substance use disorder (MH/SUD) benefits in parity with medical/surgical benefits. For quantitative treatment limitations (QTL), this means that a licensed insurer may not apply any financial requirement (FR) or QTL to MH/SUD benefits in any classification that is more restrictive than the predominant FR or QTL of that type applied to substantially all medical/surgical benefits in the same classification. Examiners requested the Company to provide proof of compliance for each plan type affected, each classification of benefits and for each type of QTL separately. The Company imposed FRs with respect to substance use disorder benefits not in parity with medical/surgical benefits. Specifically, it is noted that the Company did not demonstrate compliance with the substantially all or predominant level tests within the specified classifications of benefits.

24 Violations – 40 P.S. § 991.2166(a) & 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 for services provided within 45 days of receipt of the claim from the health care provider. The Company failed to pay the noted clean claims within 45 days of receipt.

24 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 noted clean claims timely and interest of $2 or more remains unpaid.

14 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 practice shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue. The members' EOBs misrepresented pertinent facts relating to claims processing, or misrepresented policy or contract provisions relating to coverage of services for the noted claims.

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

Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies. The Company processed claims out of date order resulting in denial of the original claim submissions as duplicate claims. The Company also failed to pay the correct amounts for the noted claims.

18 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 within a reasonable time for the noted claims.

19 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 noted claims when the Company's liability under the policy was clear.

20 Violations - 40 P.S. § 1171.5(a)(10)(xiv)

"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 promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement. The Company failed to provide a reasonable explanation that clearly outlined the reason for denials in the noted claims.

Concern: The Department has concerns relating to the handling of provider disputes (i.e., claims submitted by providers on behalf of members). The provider manual and provider dispute procedures provided by the Company do not delineate the specific information that providers must submit to the Company when acting on behalf of a member or how to demonstrate that they have member consent to submit an appeal on the member's behalf. The standards provided by the Company do not outline that if the provider fails to submit written member authorization, the dispute will be treated as an administrative appeal and not a member appeal. The Department expects that the Company will modify the provider dispute procedures to clarify the information required for the provider to submit a complaint or appeal on behalf of the member.

Substance Use Disorder Partially Paid Claims

Examiners requested a list of all SUD partially paid claims received during the experience period. The Company identified a universe of 434 partially paid substance use disorder claims. A random sample of 82 claims was requested. Upon review, examiners determined that 38 files were transitional relief or grandfathered plans, which are outside of the scope of the examination. In accordance with the requirements of the examination, the remaining 44 of 82 identified files were reviewed. The following violations were noted:

1 Violation – 40 P.S. §§ 908-1 et seq.

Licensed insurers are required to provide coverage for benefits for alcohol or other drug abuse and dependency. The certification and referral from the licensed physician controls both the nature and duration of the treatment. The Company failed to pay the noted claim for substance use disorder treatment due to claims processing errors. **1 Violation – 40 P.S. § 991.2166(a) & 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 for services provided within 45 days of receipt of the claim from the health care provider. The Company failed to pay the noted clean claim 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. The member EOB misrepresented pertinent facts relating to the processing of the listed claims or misrepresented policy or contract provisions relating to coverage of services for the listed claims.

2 Violations – 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(b) & 18022(c)(1), and 45 C.F.R. § 156.130

The annual limitation on cost sharing shall not exceed the dollar amounts as defined in federal law and regulation for self-only and family coverage. The Company failed to attribute out-of-pocket costs to the enrollee's out-of-pocket maximum in the noted claim files.

18 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.

AND

31 Pa. Code § 146.7(a)(1)

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

the denial. The Company failed to affirm or deny coverage within a reasonable time for the noted claims.

6 Violations - 40 P.S. § 1171.5(a)(10)(xiv)

"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 promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement. The Company failed to provide a reasonable explanation for denial of the noted claims.

Substance Use Disorder Closed-without-Payment Claims

Examiners requested a list of all SUD claims closed-without-payment during the experience period. The Company identified a universe of 610 substance use disorder claims closed-without-payment. A random sample of 83 claims was requested. Upon review, examiners determined that 18 files were transitional relief plans, which are outside of the scope of the examination. In accordance with the requirements of the examination, the remaining 65 of 83 identified files were reviewed. The following violations were noted:

8 Violations - 40 P.S. §§ 908-11 et seq., 42 U.S.C. §§ 300gg-26 and 18022, and 45 C.F.R. § 146.136(c)(4)(i)

Licensed insurers are required to provide MH/SUD benefits in parity with medical/surgical benefits. For NQTL, this means that a licensed insurer may not apply any NQTL in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying that limitation to MH/SUD benefits within that classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in applying the limitation to medical/surgical benefits in the classification. The Company imposed NQTLs with respect to SUD benefits in various benefit classifications; specifically, the Company applied prior authorization requirements. The Company has not demonstrated that the processes, strategies, evidentiary standards, or

other factors used in applying prior authorization to SUD benefits were applied comparably and no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the same classifications.

H. HIV/AIDS Claims

Examiners requested lists of all HIV/AIDS claims paid, denied, partially paid, and closed-without-payment 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 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 two of the four 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 1,859 paid HIV/AIDS claims. A random sample of 105 claim files was requested. In accordance with the requirements of the examination, the files were reviewed. The following violations were noted:

2 Violations – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in the detail that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain complete claim files for the noted claims.

HIV/AIDS Denied Claims

Examiners requested a list of all HIV/AIDS claims denied during the experience period. The Company identified a universe of 75 denied HIV/AIDS claims. All 75 claim files were requested. In accordance with the requirements of the examination, the files were reviewed. No violations were noted.

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 43 partially paid HIV/AIDS claims. All 43 claim files were requested. In accordance with the requirements of the examination, the files were reviewed. No violations were noted.

HIV/AIDS Closed-without-Payment Claims

Examiners requested a list of all HIV/AIDS claims that were closed-without-payment during the experience period. The Company identified a universe of 49 HIV/AIDS claims closed-without-payment. All 49 claim files were requested. In accordance with the requirements of the examination, the files were reviewed. The following violation was noted:

1 Violation – 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 for services provided within 45 days of receipt of the claim from the health care provider. The Company failed to pay the noted clean claim within 45 days of receipt.

I. Opioid Addiction Claims

Examiners requested lists of all inpatient and outpatient opioid addiction treatment claims paid, denied, partially paid, and closed-without-payment during the experience period. In accordance with the requirements of the examination, opioid treatment 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-26 and 18022; and 45 C.F.R §§ 146.136, 147.150, 147.160, and 156.125. Examiners found violations in all four 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 32,656 paid opioid

claims. A random sample of 109 claim files was requested. In accordance with the requirements of the examination, the files were reviewed. The following violations were noted:

1 Violation – 40 P.S. § 991.2166(a) & 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 for services provided within 45 days of receipt of the claim from the health care provider. The Company failed to pay the noted clean claim within 45 days of receipt.

5 Violations – 40 P.S. § 1171.5(a)(10)(x)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means the following act if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made.

AND

31 Pa. Code § 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in the detail that pertinent events and the dates of the events can be reconstructed.

AND

31 Pa. Code § 146.4(a)

An insurer or agent may not fail to fully disclose to first-party claimants' pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented. The Company failed to pay claims in accordance with the member's

coverage as described in the plan's Schedule of Benefits and failed to provide all necessary information to demonstrate the manner in which the claim was paid in the noted claim files.

3 Violations – 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)

Licensed insurers are required to provide mental health and substance use disorder (MH/SUD) benefits in parity with medical/surgical benefits. For quantitative treatment limitations (QTL), this means that a licensed insurer may not apply any financial requirement (FR) or QTL to MH/SUD benefits in any classification that is more restrictive than the predominant FR or QTL of that type applied to substantially all medical/surgical benefits in the same classification. Examiners requested the Company to provide proof of compliance for each plan type affected, each classification of benefits and for each type of QTL separately. The Company imposed FRs with respect to mental health benefits not in parity with medical/surgical benefits. Specifically, the Company provided data that failed the substantially all or predominant level tests within certain specified classifications of benefits such that cost sharing was charged to consumers when it should not have been, or the level of cost sharing charged was too high.

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 6,171 opioid denied claims. A random sample of 108 claim files was requested. In accordance with the requirements of the examination, the files were reviewed. The following violations and concern were noted:

1 Violation – 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)

Licensed insurers are required to provide mental health and substance use disorder (MH/SUD) benefits in parity with medical/surgical benefits. For quantitative treatment limitations (QTL), this means that a licensed insurer may not apply any financial requirement (FR) or QTL to MH/SUD benefits in any classification that is more restrictive

than the predominant FR or QTL of that type applied to substantially all medical/surgical benefits in the same classification. Examiners requested the Company to provide proof of compliance for each plan type affected, each classification of benefits and for each type of QTL separately. The Company imposed FRs with respect to mental health benefits not in parity with medical/surgical benefits. Specifically, the Company provided data that failed the substantially all or predominant level tests within certain specified classifications of benefits such that cost sharing was charged to consumers when it should not have been, or the level of cost sharing charged was too high.

1 Violation – 31 Pa. Code § 146.3

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

Concern: The Company stated that Schedules of Benefits include covered services and in-network and out-of-network financial cost associated with those covered services. In the case of claims for providers under Special Investigation Unit (SIU) reviews, the member's expectation of payment of services based on the Schedule of Benefits was not realized, as additional restrictions were placed on the providers for claims submissions. For example, when a member expected a 20% cost share for an out of network provider service, the member was responsible for 100% of charges because the provider did not adhere to the additional claim submission requirements. The Department expects that the Company will reach out to the members utilizing providers under review and advise that there is a risk of increased member financial responsibility if they continue to utilize that specific provider.

Opioid Addiction Partially Paid Claims

Examiners requested a list of all inpatient and outpatient opioid addiction treatment claims partially paid claims during the experience period. The Company identified a universe of 2,068 opioid partially paid claims. A random sample of 107 claim files was requested. In

accordance with the requirements of the examination, the files were reviewed. The following violations were noted:

1 Violation – 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)

Licensed insurers are required to provide MH/SUD benefits in parity with medical/surgical benefits. For quantitative treatment limitations (QTL), this means that a licensed insurer may not apply any financial requirement (FR) or QTL to MH/SUD benefits in any classification that is more restrictive than the predominant FR or QTL of that type applied to substantially all medical/surgical benefits in the same classification. Examiners requested the Company to provide proof of compliance for each plan type affected, each classification of benefits and for each type of QTL separately. The Company imposed FRs with respect to mental health benefits not in parity with medical/surgical benefits. Specifically, the Company provided data that failed the substantially all or predominant level tests within certain specified classifications of benefits such that cost sharing was charged to consumers when it should not have been, or the level of cost sharing charged was too high.

5 Violations – 40 P.S. § 991.2166(a) & 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 for services provided within 45 days of receipt of the claim from the health care provider. The Company failed to pay the noted clean claims within 45 days of receipt.

6 Violations – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in the detail that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain complete claim files for the noted claims.

Opioid Addiction Closed-without-Payment Claims

Examiners requested a list of all inpatient and outpatient opioid addiction treatment claims closed without-payment during the experience period. The Company identified a universe of 1,128 opioid claims closed-without-payment. A random sample of 105 claims was requested. In accordance with the requirements of the examination, the files were reviewed. The following violations were noted:

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 failed to pay the noted claims when the Company's liability was reasonably clear.

J. Mental Health Claims

Examiners requested lists of all mental health claims paid, denied, partially paid, and closed-without-payment during the experience period. In accordance with the requirements of the examination, mental health claim files were reviewed to ensure compliance with 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 three of the four sections.

Mental Health Paid Claims

Examiners requested a list of all mental health claims paid during the experience period. The Company identified a universe of 251,394 paid mental health claims. A random sample of 109 claim files was requested. The following violations were noted:

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

31 Pa. Code § 146.4(a)

An insurer or agent may not fail to fully disclose the first-party claimant's pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.

AND

31 Pa. Code § 146.4(b)

An insurer or agent may not fail to fully disclose the first-party claimant's benefits, coverages or other provisions of an insurance policy or insurance contract when the benefits, coverages or other provisions are pertinent to a claim. The Company failed to process the claim according to the plan's Schedule of Benefits and issued member explanation of benefits and provider remittance advice that misrepresented the benefits of the member's policy.

Mental Health Denied Claims

Examiners requested a list of all mental health claims denied during the experience period. The Company identified a universe of 8,635 claims. A random sample of 108 claim files was requested. In accordance with the requirements of the examination, the files were reviewed. No violations were noted.

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 1,428 mental and behavioral health claims partially paid. A random sample of 109 claim files was requested. In accordance with the requirements of the examination, the files were reviewed. The following violations were noted:

2 Violations – 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)

Licensed insurers are required to provide MH/SUD benefits in parity with medical/surgical benefits. For quantitative treatment limitations (QTL), this means that a licensed insurer may not apply any financial requirement (FR) or QTL to MH/SUD benefits in any classification that is more restrictive than the predominant FR or QTL of that type applied to substantially all medical/surgical benefits in the same classification. Examiners requested the Company to provide proof of compliance for each plan type affected, each classification of benefits and for each type of QTL separately. The Company imposed FRs with respect to mental health benefits not in parity with medical/surgical benefits. Specifically, the Company provided data that failed the substantially all or predominant level tests within certain specified classifications of benefits such that cost sharing was charged to consumers when it should not have been, or the level of cost sharing charged was too high.

2 Violations – 40 P.S. § 991.2166(a) & 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 for services provided

within 45 days of receipt of the claim from the health care provider. The Company failed to pay the noted clean claims within 45 days of receipt.

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 failed to pay the noted claims when the company's liability was reasonably clear.

Mental Health Closed-without-payment Claims

Examiners requested a list of all mental and behavioral health claims closed-without payment during the experience period. The Company identified a universe of 4,420 closed-without-payment claims. A random sample of 108 claim files was requested and reviewed. The following violations were noted:

8 Violations – 40 P.S. § 1171.5(a)(10)(xiv)

"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 promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement. The Company failed to provide reasonable explanations for denials on the following claims.

K. Pharmacy Claims

Examiners requested that the Company identify all SUD, mental health/behavioral health, HIV/AIDS, and Opioid pharmacy claims paid or rejected during the experience period. In accordance with the requirements of the examination, SUD, mental health/behavioral health, HIV/AIDS, and Opioid pharmacy claim files were reviewed to ensure compliance

with applicable state and federal 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 two of the eight sections.

Substance Use Disorder Paid Pharmacy Claims

Examiners requested a list of all SUD pharmacy drug claims paid during the experience period. The Company identified a universe 16,214 paid SUD pharmacy claims. An initial sample of 109 paid claims was requested based on the universe provided for the experience period. Upon learning that only 2,341 claims were available due to a two-year look back constraint associated with vendor data, examiners requested a second, random sample of 108 paid SUD pharmacy claims based on the reduced universe. In accordance with the requirements of the examination, the files were reviewed. Sample files in this revised population cover service dates between 2/5/16 and 3/31/16. No violations were noted.

Substance Use Disorder Rejected Pharmacy Claims

Examiners requested a list of all SUD pharmacy claims rejected during the experience period. The Company identified a universe of 103,061 SUD pharmacy claims rejected during the experience period. An initial random sample of 109 rejected claims was created based on the universe provided for the experience period. Upon learning that only 2,482 claims were available due to a two-year look back constraint associated with vendor data, examiners requested a revised sample of 108 rejected claims. In accordance with the requirements of the examination, the files were reviewed. Sample files in this revised population cover service dates between 1/15/16 and 3/31/16. No violations were noted.

Mental Health/Behavior Health Paid Pharmacy Claims

Examiners requested a list of all mental health/behavioral health pharmacy claims paid during the experience period. The Company identified a universe of 540,012 paid mental health/behavioral health pharmacy claims. An initial random sample of 109 paid claims was created based on the universe provided for the experience period. An additional revised sample of 109 paid claims, based on a reduced universe of 79,087 claims, was

requested, due to a two year look back constraint associated with vendor Express Scripts, Inc. data and associated claim file accessibility. In accordance with the requirements of the examination, the files were reviewed. Sample files in this revised population cover service dates between 2/5/16 and 3/31/16. No violations were noted.

Mental Health/Behavioral Health Rejected Pharmacy Claims

Examiners requested a list of all mental health/behavioral health pharmacy claims rejected during the experience period. The Company identified a universe of 103,061 rejected mental health/behavioral health pharmacy claims during the experience period. An initial random sample of 109 rejected claims was created based on the universe provided for the experience period. Upon learning that only 14,726 claims were available due to a two-year look back constraint associated with vendor data, examiners requested a second random sample of 109 rejected claims, based on the reduced universe. In accordance with the requirements of the examination, the files were reviewed. Sample files in this revised universe cover service dates between 1/15/16 and 3/31/16. No violations were noted.

HIV/AIDS Paid Pharmacy Claims

Examiners requested a list of all HIV/AIDS pharmacy claims paid during the experience period. The Company identified a universe of 3,488 paid HIV/AIDS pharmacy claims. An initial random sample of 108 paid claims was created based on the universe provided for the experience period. An additional revised sample of 105 paid claims, based on a reduced universe of 510 claims, was requested due to a two-year look back constraint associated with vendor Express Scripts, Inc. data and associated claim file accessibility. In accordance with the requirements of the examination, the files were reviewed. Sample files in this revised population cover service dates between 2/5/16 and 3/31/16. The following concern was noted:

Concern: For claim sample number 50, member materials stated that the member was responsible for three $500 copays for a 90-day supply of the brand-name specialty drug, Truvada, when purchased in a retail setting. However, the member was charged only two copays because UPMC-owned pharmacies charge two copays for a 90- day supply instead

of the standard retail cost share of three copays for a 90-day supply. The Company acknowledged that the practice of UPMC-owned pharmacies charging two copays for a 90-day supply is not discussed in member materials. The Department expects that the Company will update member materials to provide clear and complete information to members about their cost sharing responsibilities, including any differences in cost sharing responsibilities for UPMC owned pharmacies versus non-UPMC owned pharmacies.

HIV/AIDS Rejected Pharmacy Claims

Examiners requested a list of all HIV/AIDS pharmacy claims rejected during the experience period. The Company identified a universe of 618 rejected HIV/AIDS claims during the experience period. An initial random sample of 105 rejected claims was requested based on the universe provided for the experience period. Upon learning that only 117 claims were available due to a two-year look back constraint associated with vendor data, examiners requested a revised random sample of 76 rejected claims, based on a reduced universe. Of the revised sample, five were not available for review by examiners due to the examiners' inability to access sampled claims using Company provided claim data, thus an additional five claims were provided as replacements. Sample files in this revised population cover service dates between 1/15/16 and 3/31/16. In accordance with the requirements of the examination, the files were reviewed. No violations were noted.

Opioid Paid Pharmacy Claims

Examiners requested a list of all opioid pharmacy claims paid during the experience period. The Company identified a universe of 15,872 paid opioid pharmacy claims. A random sample of 108 paid claims was requested based on the universe provided for the experience period. Upon learning that only 2,285 claims were available due to a two-year look back constraint associated with vendor data, examiners requested a second, random sample of 108 paid claims, based on a reduced universe. Sample files in this revised population cover service dates between 2/5/16 and 3/31/16. In accordance with the requirements of the examination, the files were reviewed. The following violation was noted:

Concern: For claim sample number 60, the claim was not processed according to the plan Schedule of Benefits. While the claim processing error resulted in the member paying less out of pocket, the Department remains concerned that the claim confusingly did not process according to the Schedule of Benefits. The Department expects that the Company will take necessary steps to ensure accurate processing of pharmacy claims.

Opioid Rejected Pharmacy Claims

Examiners requested a list of all Opioid pharmacy claims rejected during the experience period. The Company identified a universe of 15,008 opioid pharmacy claims rejected during the experience period. An initial random sample of 108 rejected claims was requested based on the universe provided for the experience period. Upon learning that only 2,472 claims were available due to a two-year look back constraint associated with vendor data, examiners requested and reviewed a second random sample of 108 rejected claims. In accordance with the requirements of the examination, the files were reviewed. Sample files in this revised population cover service dates between 1/15/16 and 3/31/16. No violations were noted.

XV. 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, including 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 175 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, Hepatitis C, prostate cancer, breast cancer, and multiple sclerosis. 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.

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, Hepatitis C, prostate cancer, breast cancer, and multiple sclerosis. 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.

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 51 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 of Extended Release Products

Examiners requested a detailed summary of the Company pharmacy benefit coverage of single-tablet drug regimens versus multi-tab regimens 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. 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 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.

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 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 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. The following concern was noted:

Concern: The Company failed to provide methadone through an outpatient setting both under medical (physician office and clinics) and pharmacy setting for SUD while it was available through the pharmacy benefit for pain. This creates additional barriers for patients to receive treatment for SUD. The Company has indicated that this benefit limitation has been modified such that methadone is now covered for treatment of SUD in the outpatient setting effective January 1, 2018.

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 six documents and provided an additional six documents in response to an examiner-issued information request. 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 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 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 inpatient rehabilitation criteria for detoxification admission 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 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. The following concern was noted:

Concern: When providers prescribed less than a 30-day supply of SUD drugs for each drug fill, members were charged the same co-pay amount for the lesser quantity as they would have been charged for one 30-day supply. This created a financial barrier to SUD drugs by charging members multiple co-pays each month. The Department expects the Company to develop communication procedures to inform providers and patients of the impact of this practice on member co-pays or out of pocket expenses.

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 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.

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 listed 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

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 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 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.

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 ten documents. 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. The following concern was noted:

Concern: The Company failed to provide methadone through an outpatient setting both under medical (physician office and clinics) and pharmacy setting for SUD while it was available through the pharmacy benefit for pain. This creates additional barriers for patients

to receive treatment for SUD. The Company has indicated that this benefit limitation has been modified such that methadone is now covered for treatment of SUD in the outpatient setting effective January 1, 2018.

P. 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. 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.

Q. MH/SUD Treatment Programs Policies

Examiners requested documentation demonstrating policies that applied to MH/SUD treatment programs 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 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.

R. 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: inpatient and outpatient, OTP, mail order, and retail. Examiners requested rationale for any denial based on the setting of the prescription. 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 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. The following concern was noted:

Concern: The Company indicated that the setting of prescriptions is not captured in denial data because the setting used to dispense the medication is not always known at the time of

the coverage review and does not impact the decision of a drug's clinical appropriateness. The Department expects that the Company will update operational coverage review policies and associated databases to include all setting information so that denial information based on setting can be captured.

S. 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 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 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. 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 53 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. The following concern was noted:

Concern: Upon initial review, the coverage policy language for Vyvanse (lisdexamfetamine), appeared to indicate that the burden is on the patient to provide the needed information for coverage. Upon further investigation, the Company clarified that the responsibility is on the provider to present the needed documentation for coverage. The Department expects that the Company will ensure that all prior authorization policy language clearly indicate if the patient is responsible, or the provider is responsible, for providing needed information in order for coverage determinations to be made by the Company.

U. 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 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 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. 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 two documents. 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.

W. Prior Authorization Criteria for MH/SUD Drugs

Examiners requested documentation demonstrating prior authorization criteria for MH/SUD drugs. The Company identified a universe of 44 documents. 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 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 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. Formulary Underwriting Review

Examiners requested all formularies utilized by the Company during the experience period. The Company identified a universe of one document and provided 13 additional documents in response to examiner-issued requests. 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; however, pharmacist reviewers and Company pharmacists were unable within the examination to address drug categorization and drug classification discrepancies. During the post-examination period, reviewer and Company pharmacists will continue their analyses, and will be addressed through appropriate and agreed-upon steps.

XVI. 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.). Several data integrity issues were found during the examination. The data integrity issues from each review are identified below:

Medical Paid, Denied, and Partially Paid Claims; Mammogram Paid and Closed-without-Payment Claims; Medical Foods Paid, Denied, and Partially Paid Claims; ASD Paid and Denied Claims; Emergency Room Paid, Denied, Partially Paid, and Closed-without-Payment Claims; Ambulance Paid, Denied, and Closed-without-Payment Claims; SUD Denied Claims; HIV/AIDS Paid, Denied, Partially Paid, and Closed-without-Payment Claims; Opioid Paid, Denied, Partially Paid, and Closed-without-Payment Claims; Mental and Behavioral Health Partially Paid Claims

Situation: During claims review in the noted claims sections, examiners found that the Company failed to maintain and provide evidence that the Company acknowledged receipt of paper claims within 10 days, as required in 31 Pa. Code § 146.5(a).

Finding: The Company did not fully comply with 31 Pa. Code § 146.5(a), which requires that every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. While the Company did not provide evidence that paper claims were acknowledged within 10 working days, the Department notes that the Company did acknowledge claims that were submitted electronically.

ASD Paid and Partially Paid Claims; Mental and Behavioral Health Paid Claims

Situation: During claims review, examiners found EOBs that were missing deductible and MOOP information. The Company indicated that a data corruption issue resulted in missing deductible and MOOP information on EOBs reconstructed for the purposes of this examination. The Company failed to keep documentation to ascertain compliance.

Finding: While the Company believes that members' original EOBs displayed the appropriate information, the Company has not provided documentation to demonstrate that appropriate and accurate information was included on the original EOBs.

The following violation was noted:

1 Violation – 40 P.S. § 323.3(a) and 323.4(b)

Every company or person subject to examination must keep all books, records, accounts, papers, documents, and any and all computer or other recording relating to the property, assets, business, and affairs such that examiners may ascertain whether the company or person has complied with the laws being examined. The company or person from whom information is sought must provide examiners timely, convenient, and free access to all such documentation. The Company failed to exercise sufficient due diligence to ensure compliance with the noted sections of the Insurance Department Act of 1921.

XVII. 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), 40 P.S. § 764h(b), and 40 P.S. § 908-1 et. seq., which requires ASD and SUD 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 and SUD parity compliance requirements of 40 908-11 et seq.; 42 U.S.C. § 300gg-26; and 45 C.F.R. § 146.136. This includes the following noted issues:
    a. The Company must evaluate its basis for defining and classifying benefits and ensure that the same standards are applied to medical/surgical benefits and to mental health and SUD benefits in determining the classification or applicable sub-classification in which a benefit belongs.
    b. 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 plans noted in the Final Exit Summaries and this Examination Report, as well as other plans identified by the Company, 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 during the exam period 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.

c. The Company must evaluate NQTL analyses and ensure that for each NQTL for mental health or SUD benefits in each classification, the processes, strategies, evidentiary standards, or other factors used in applying that limitation to mental health or SUD benefits within that classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in applying the limitation to medical/surgical benefits in the classification. This includes, inter alia, scope and duration of treatment for ASD, mental health, SUD, and Special Investigation Unit investigations relating to opioid addiction treatment.

d. The Company must ensure that parity analyses are documented to demonstrate that QTLs and NQTLs imposed with respect to mental health and SUD benefits were determined to be compliant with parity requirements prior to selling the policies.

3. 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)(1)(i) and 1171.5(a)(10)(i), the Company must accurately represent the benefits, advantages, conditions or terms of insurance policies, as well as pertinent facts or policy or contract provisions relating to coverages at issue, in member documents, including Schedules of Benefits and Explanations of Benefits;

b. 40 P.S. § 1171.5(a)(10)(iii), the Company must implement reasonable standards to ensure the prompt investigation of claims;

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. 40 P.S. § 1171.5(a)(10)(vi), the Company must ensure prompt, fair and equitable settlements are being provided to the claimants;

e. 40 P.S. § 1171.5(a)(10)(x), the Company must provide an explanation of benefits that properly represents the activity of the claim;

f. 40 P.S. § 1171.5(a)(10)(xiv), the Company must provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for the denial of a claim or for the offer of a compromise settlement.

4. The Company must review and revise internal control procedures to ensure compliance with the claims handling requirements of 31 Pa. Code Ch. 146, so that the concerns and violations relating to complete files, claims acknowledgements, status letters, acceptance or denials, and denial reasons, as noted in this Examination Report, do not occur in the future. For example:
    a. With respect to 31 Pa. Code § 146.4(a), the Company must fully disclose benefits, coverages, or other provisions of insurance policies under which a claim is presented;
    b. With respect to 31 Pa. Code § 146.4(b), the Company must fully disclose benefits, coverages, or other provisions of insurance policies when the benefits, coverages or other provisions are pertinent to a claim;
    c. With respect to 31 Pa. Code § 146.5(a), the Company must acknowledge the receipt of notice of a claim within 10 working days;
    d. With respect to 31 Pa. Code § 146.6, the Company must ensure claimants receive a reasonable and timely written explanation for delay if claims investigations cannot be completed within 30 days of notification of the claim;
    e. With respect to 31 Pa. Code § 146.7(a)(1), the Company must ensure claimants are advised of the acceptance or denial of a claim within 15 working days after receipt, and for denials based on a specific policy provision, condition, or exclusion, reference to the policy provision, condition or exclusion must be included in the denial. The Department expects the Company to establish guidelines to ensure the use of clear and proper denial codes, as well as consistency in denial code usage. The Department also expects that all EOBs and EOPs include sufficient clarity in descriptions and codes for insureds/providers to understand the claims processing that occurred and reasons for denials. The Company has stated

that it will continue to review this issue and work with the Department in addressing the Department's concerns.

f. With respect to 31 Pa. Code § 146.7(c)(1) If the Company needs more time to determine whether a first-party claim should be accepted or denied, the Company must notify the first-party claimant within 15 working days after receipt of the claim, giving the reasons more time is needed. The Company must ensure claimants are provided timely status letters in such cases.

5. 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(b) & 18022(c)(1), and 45 C.F.R. § 156.130, 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 noted SUD claims that may have been impacted to determine if restitution is due. The Company must provide the Department with documentation to demonstrate that any restitution due to Pennsylvania consumers was paid accordingly. The Company must take corrective action to enhance MOOP calculation processes and confirm accuracy through reporting over a two-year period. This corrective action should involve development of a software implementation to ensure accumulator amounts are accurate and reportable both in real time and retrospective time periods upon demand. Accumulator information should be available in members' online portals for review and mailed to members who do not have internet access.

6. 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). Those clean claims that have not been paid as noted in this Examination Report must be paid, and proof of such payment must be provided to the Department.

7. 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.

8. The Company must review and revise internal complaint processes to ensure compliance with 40 P.S. § 991.2141. The Company must include procedures to ensure compliance with 45 C.F.R. § 147.136, incorporating 29 C.F.R. § 2560.503-1 , including internal review processes and timely appeal and grievance processing.
9. 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. The Company must ensure the identified clean claims are paid, and proof of such payment must be provided to the Department.
10. The Company must develop and implement internal control procedures to ensure compliance with the producer appointment and termination requirements of 40 P.S. §§ 310.1 et seq.
11. The Company must review and implement procedures to comply with 18 Pa. C.S. § 4117(k)(1) to provide the required fraud warning notice on claim forms.
12. The Company must review and revise its internal controls to ensure that all records and documents are maintained in accordance with 40 P.S. §§ 323.3 and 323.4 so that the violation noted in this Examination Report does not occur in the future. These procedures must also ensure compliance with 31 Pa. Code § 146.3 relating to the maintenance of complete claim files and documentation.
13. The Department expects that the Company will modify its SOBs to provide sufficient detail to allow consumers to fully understand their benefit coverage and cost sharing responsibilities.
14. The Department expects that the Company will review its claim system programming and manual claim processing procedures, and implement system modifications, training for claims analysts/examiners, and any other necessary corrective measures to prevent claims processing errors.
15. The Department expects that the Company will communicate the availability of all EOBs to members regardless of member liability or cost sharing associated with a claim. Further, to the extent that EOBs are consumer tools, the Department recommends that the Company update EOB processes and policies to fully inform all consumers, regardless of eligibility status, of all determinations made during

claim processing when mass adjustments or eligibility issues dictate non-payment, modification of claim processing status, or provider ability to bill.

16. The Department expects that the Company will augment its adverse benefit determination letters to ensure clarity of reason or reasons for denied services and the specific criteria on which the adverse benefit determination was based.

XVIII. COMPANY RESPONSE

UPMC LIFE CHANGING MEDICINE

UPMC Health Plan
US Steel Tower
600 Grant Street, 55th Floor
Pittsburgh, PA 15219
412-434-1200

November 8, 2021

Penny Callihan
Health Market Conduct Division Chief
Office of Market Regulation
Bureau of Market Actions
Pennsylvania Insurance Department
1321 Strawberry Square
Harrisburg, PA 17120

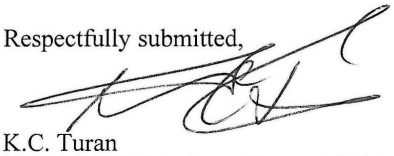
Dear Ms. Callihan:

Please accept this letter as the response of UPMC Health Coverage, Inc. and UPMC Health Options, Inc. (together "UPMC Health Plan") to the findings and recommendations of the Department's Market Conduct Examination.

We would like to thank you and your staff for the collaborative manner in which this Examination was conducted, and for the continuous feedback provided by your team throughout the course of the Examination. We hope it goes without saying that UPMC Health Plan at all times shared, and continues to share, the Department's goals – specifically, that our members receive the full spectrum of benefits to which they are entitled, as well as the high quality of service they deserve. We routinely evaluate existing policies, procedures and operations, and we endeavor to expeditiously make changes or enhancements that may be necessary to achieve these goals. When issues are identified, we are committed to taking the necessary steps to correct them. Our response to this Examination will be no different, as we will swiftly address the recommendations made by the examiners.

Thank you, again, for your ongoing efforts, and we look forward to continuing to work with the Department to make affordable, high-quality coverage options available to consumers.

Respectfully submitted,



K.C. Turan
SVP, Chief Risk, Compliance & Ethics Officer
UPMC Insurance Services