



**COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT**

MARKET CONDUCT
EXAMINATION REPORT

OF

**Aetna Health Inc., (a Pennsylvania Corporation)
Aetna Health Insurance Company
Aetna Life Insurance Company
Aetna HealthAssurance Pennsylvania, Inc.**

151 Farmington Avenue
Hartford, CT 06156

As of: October 21, 2025
Issued: November 20, 2025

**Division of Health Market Conduct
Office of Market Regulation**



PENNSYLVANIA INSURANCE DEPARTMENT
EXAMINATION VERIFICATION

I, Penny Callihan, Market Conduct Examiner 2 from
(Name of Examiner) (Title of Examiner)

Pennsylvania Insurance Department certify that I was the Examiner-In-Charge of the Report of
(Name of Vendor/Department)

Examination of Aetna Health Inc., PA Corp.; Aetna Health Insurance Company; Aetna Life Insurance
Company, and Aetna HealthAssurance Pennsylvania, Inc. made as of 10/21/2025

The last date of examination file review was 09/22/2025 and the written Report
(Date)

of Examination was reviewed and accepted by Joseph Handline
(Chief of Market Conduct Examiner)

on 10/24/2025
(Date)

I have reviewed the completed written Report of Examination and certify that the facts and figures recited
therein 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 17120
(Address of Vendor/Department)

Penny Callihan
(Examiner in Charge Signature)

11/04/2025
(Date)

IN ORDER TO SATISFY SECTION 40 P.S. § 323.5(b), THAT PROVIDES FOR 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 _July__, 2023, 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., 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.



Michael Humphreys
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
Aetna Health Inc., (a Pennsylvania corporation)	:	40 P.S. §§ 323.3(a); 323.4(b); 908-11 et seq.; 991.2166(a), (b); 1171.5(a)(1)(i); 1171.5(a)(10)(i), (v), (vi)
Aetna Health Insurance Company	:	
	:	31 Pa. Code §§ 146.3; 146.4(a), (b); 146.6;
Aetna Life Insurance Company	:	146.7(c)(1); 154.18(a), (c)
	:	
Aetna HealthAssurance Pennsylvania, Inc.	:	42 U.S.C. §§ 300gg-6(b); 300gg-19; 300gg-26; 18022
	:	
	:	45 C.F.R. §§ 146.136(c)(2)(i); 146.136(c)(4)(i); 147.136 incorporating 29 C.F.R. §
151 Farmington Avenue	:	2560.503-1; 156.130
	:	
Hartford, CT 06156	:	
	:	
Respondent	:	Docket No. MC25-12-009
	:	

CONSENT ORDER

And now, this 20th day of January, 2026, 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 Aetna and its subsidiaries: Aetna Health Inc., (a Pennsylvania corporation), Aetna Health Insurance Company, Aetna Life Insurance Company, and Aetna Health Assurance Pennsylvania, Inc., hereafter collectively referred to as “Respondent.” Respondent maintains its address at 151 Farmington Avenue, Hartford, CT 06156.
- (b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from October 1, 2021 through December 31, 2022.
- (c) On November 20, 2025, the Insurance Department issued a Market Conduct Examination Report to Respondent (“Examination Report”).
- (d) Respondent did not provide a response to the Examination Report to the Insurance Department.

- (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 accordance 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. §§ 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.
- (c) Violations of 40 P.S. §§ 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.

(d) Violations of 40 P.S. §§ 1171.5(a)(1)(i), 1171.5(a)(10)(i), 1171.5(a)(10)(v), 1171.5(a)(10)(vi), as contained in the Examination Report, are punishable by the following under 40 P.S. § 1171.9:

- (1) An order to cease and desist.
- (2) License suspension or revocation.

(e) 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)(v), 1171.5(a)(10)(vi), as contained in the Examination Report, the Commissioner may, under 40 P.S. §§ 1171.10 and 1171.11, file an action in which the Commonwealth Court may impose the following civil penalties:

- (1) An injunction.
- (2) For each method of competition, act or practice which the company knew or should have known was in violation of the law, a penalty of not more than five thousand dollars (\$5,000.00) for each violation but not to exceed an aggregate penalty of fifty thousand dollars (\$50,000) in any six-month period.
- (3) For each method of competition, act or practice which the company did not know nor reasonably should have known was in violation of the law, a penalty of not more than one thousand dollars (\$1,000.00) for each

violation but not to exceed an aggregate penalty of ten thousand dollars (\$10,000) in any six-month period.

(f) 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, 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 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 and 1171.11, file an action in which the Commonwealth Court may impose the following civil penalties:

- (1) An injunction.
- (2) For each method of competition, act or practice which the company knew or should have known was in violation of the law, a penalty of not more than five thousand dollars (\$5,000.00) for each violation but not to exceed an aggregate penalty of fifty thousand dollars (\$50,000) in any six-month period.
- (3) For each method of competition, act or practice which the company did not know nor reasonably should have known was in violation of the law, a penalty of not more than one thousand dollars (\$1,000.00) for each violation but not to exceed an aggregate penalty of ten thousand dollars (\$10,000) in any six-month period.

(h) 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 accordance 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 share the Examination Report and this Order with each of its directors and submit affidavits executed by each of its directors, stating under oath that they have received a copy of the Examination Report and this Order. Such affidavits 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.

- (d) Respondent shall report on a quarterly basis, beginning thirty (30) 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. All reporting shall be completed within 12 months from the date of this Order.
 - (e) Respondent shall pay a total penalty of Five Hundred Fifty Thousand Dollars (\$550,000) to the Commonwealth of Pennsylvania in settlement of the violations identified in the Examination Report. The penalty shall be proportioned as follows: Three Hundred Thirty Thousand Dollars (\$330,000) on behalf of Aetna Life Insurance Company, One Hundred Ten Thousand Dollars (\$110,000) on behalf of Aetna HealthAssurance Pennsylvania, Inc., Eighty-Two Thousand Five Hundred Dollars (\$82,500) on behalf of Aetna Health Inc. PA Corp, and Twenty-Seven Thousand Five Hundred Dollars (\$27,500) on behalf of Aetna Health Insurance Company.
 - (f) Payment of this matter shall be made by check payable to the “Commonwealth of Pennsylvania.” Payment should be directed to the attention of Hem Mahat, Pennsylvania Insurance Department, 1326 Strawberry Square, Harrisburg, PA 17120. Payment must be made no later than thirty (30) days after the date this order is executed.
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: Aetna Health Inc., (a Pennsylvania corporation), Respondent



Edward C. Lee
Vice President & Secretary

BY: Aetna Health Insurance Company,
Respondent



Edward C. Lee
Vice President & Secretary

BY: Aetna Life Insurance Company, Respondent



Edward C. Lee
Vice President & Secretary

BY: Aetna HealthAssurance Pennsylvania, Inc.,
Respondent



Edward C. Lee
Vice President & Secretary



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

I. INTRODUCTION

The Market Conduct Examination (Examination) was conducted on Aetna Health Inc., PA Corp; Aetna Health Insurance Company; Aetna Life Insurance Company; and Aetna HealthAssurance Pennsylvania, Inc., hereafter collectively referred to as “Company,” 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 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 or claim 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:

Joseph Handline, MCM
Chief, Health Market Conduct Division
Co-Examiner-in Charge
Pennsylvania Insurance Department

Penny Callihan, MCM
Co-Examiner-in-Charge
Pennsylvania Insurance Department

Holly Lehman, MCM
Co-Examiner-in-Charge
Pennsylvania Insurance Department

Holly Blanchard, AIE, FLMI, INS, ACP, CCP, MCM
Contract Supervisory Insurance Examiner

Cynthia Fitzgerald, AIRC, ACS, AIAA, CICSR, CFE(Fraud)
CIE, MCM, PAHM, ITP
Contract Examiner-In-Charge

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

Rashanda Lloyd, MCM
Market Conduct Examiner
Pennsylvania Insurance Department

Ellis Savage, MCM
Market Conduct Examiner
Pennsylvania Insurance Department

Steven Veronikis, MCM
Market Conduct Examiner
Pennsylvania Insurance Department

Alayna Badeau, MCM
Contract Examiner

Lawrence J Cohen, PharmD, BCPP, FASHP, FCCP, FCP, FNAP
Contract Clinical Subject Matter Expert

Ben Darnell
Contract Examiner

Cara Phillips
Contract Examiner

II. SCOPE OF EXAMINATION

The Examination was conducted pursuant to the authority granted by Sections 903 and 904 (40 P.S. §§ 323.3 and 323.4) of the Insurance Department Act and covered the experience period of October 1, 2021, through December 31, 2022, 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 specific emphasis of the Examination was laws and regulations for which violations and concerns were cited in the previously conducted comprehensive Affordable Care Act (ACA) examination.

The Examination focused on the Company's policies, procedures, and processes in the following areas: Operations and Management, Claims, Pharmacy Formulary, Network Adequacy, Provider Credentialing, 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 statutory and regulatory 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

Aetna Health Inc. (PA) (“AHI-PA”), formerly United States Health Care Systems of Pennsylvania, Inc. d.b.a. Aetna U.S. Healthcare, is a corporation domiciled in the State of Pennsylvania. AHI-PA was incorporated on May 7, 1981, and is a wholly-owned subsidiary of Aetna Health Holdings, LLC, whose immediate parent is Aetna Inc. (“Aetna”). Effective November 28, 2018, AHI-PA became part of the insurance holding company system currently controlled by CVS Health Corporation (“CVS Health”) as a result of a merger transaction between Aetna and a subsidiary of CVS Pharmacy, Inc., which is a direct subsidiary of CVS Health.

AHI-PA is licensed to conduct business as a Health Maintenance Organization in 24 states. AHI-PA’s legal home office address and its principal executive office address is 1425 Union Meeting Road, Blue Bell, PA 19422. AHI-PA is overseen by a Board of Directors and principal officers include: President, Vice-President, Vice-President/Secretary, Vice-President/Treasurer, Principal Financial Officer/ Controller, Assistant Controllers (3), and Senior Investment Officer.

Aetna Health Insurance Company (“AHIC”) (fka Corporate Health Insurance Company) is a corporation domiciled in the State of Pennsylvania. AHIC was originally incorporated in Minnesota on July 8, 1938, as Omaha Financial Life Insurance Company and reincorporated in Pennsylvania on July 18, 1997. AHIC is a wholly owned subsidiary of Aetna Inc. (“Aetna”). AHIC is licensed to do business as a Life, Accident and Life Insurer. AHIC also writes the out-of-network portion of the Quality Point of Service product for certain HMO’s, stop-loss reinsurance for certain HMO’s and Medicare-Supplement business. Effective November 28, 2018, AHIC became part of the insurance holding company system currently controlled by CVS Health as a result of a merger transaction between Aetna and a subsidiary of CVS Pharmacy, Inc., which is a direct subsidiary of CVS Health. AHIC’s legal home office address and its principal executive office address is 1425 Union Meeting Road, Blue Bell, PA 19422. AHIC is overseen by a Board of Directors and principal officers include: President, Vice-President/Secretary, Vice-President/Treasurer, Principal Financial Officer/Controller, and Assistant Controllers (4).

Aetna Life Insurance Company (“ALIC”) was organized in June 1853 and became a member of the insurance holding company system then controlled by Aetna Inc., a Pennsylvania corporation (“Aetna”), in 1967. ALIC is a wholly owned, direct subsidiary of Aetna. Effective November 28, 2018, ALIC became part of the insurance holding company system currently controlled by CVS

Health Corporation (“CVS Health”) as a result of a merger transaction between Aetna and a subsidiary of CVS Pharmacy, Inc., which is a direct subsidiary of CVS Health. ALIC is licensed as a life and accident and health company in all 50 states including the District of Columbia, Guam, Northern Mariana Islands, Puerto Rico, and Virgin Islands.

Aetna HealthAssurance Pennsylvania, Inc. (“AHAP”) is a corporation domiciled in Pennsylvania. AHAP was incorporated on June 3, 2015, and is a wholly-owned subsidiary of Aetna Health Holdings, LLC (“AHH”), whose immediate parent is Aetna. AHAP is licensed to do business as a Risk Assuming Preferred Provider Organization in the State of Pennsylvania. AHAP’s legal home office address and its principal executive office address is 1425 Union Meeting Road, Blue Bell, PA 19422. Effective November 28, 2018, AHAP became part of the insurance holding company system currently controlled by CVS Health as a result of a merger transaction between Aetna and a subsidiary of CVS Pharmacy, Inc., which is a direct subsidiary of CVS Health. AHAP is overseen by a Board of Directors and principal officers include: President/CEO, Vice-President/Secretary, Vice-President/Treasurer, Principal Financial Officer/Controller, Assistant Controllers (3), and Senior Investment Officer.

IV. COMPANY OPERATIONS AND MANAGEMENT

Examiners requested documentation relating to company operational and compliance procedures. The procedures were reviewed to assure best practices and compliance with applicable laws and regulations. Documents requested dealt with company management and governance, and monitoring business functions and contracted-entities. Unless noted, all documents identified in each universe by the Company were requested, received, and reviewed by the examiners. When 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. 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 193 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.

B. 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 46 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.

C. 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 during 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 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. No violations were noted in the policy and procedure documents 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:

1 General Violation - 40 P.S. § 1171.5(a)(1)(i)

“Unfair methods of competition” and “unfair or deceptive acts or practices” in the business of insurance means making, publishing, issuing or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which misrepresents the benefits, advantages, conditions or terms of any insurance policy.

AND

40 P.S. § 1171.5(a)(10)(i)

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

AND

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. Schedules of Benefits (SOBs) for most plans state that certain services, including Autism services, are “covered based on the type of service and where it is received”. This language does not provide members with a clear indication of any applicable coverage parameters or the cost sharing associated with the services. Further, examiners were unable to determine if claims for these services were paid according to members’ coverage in some cases since the SOBs do not include this information. This issue is identified as a general violation in the Company Operations section of the report because it was noted across several claim sections.

CONCERN: Examiners noted in many claim sections that the Company issued Explanations of Benefits (EOBs) and provider remittance that failed to fully disclose to claimants a description of specific services for processed claims. Since EOBs state “Medical Services” for the description of service for these claims, the EOBs do not provide enough information for members to determine whether claims were processed according to their benefit coverage.

D. 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 two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code §§ 152.20 and 301.82. In addition to the review of policies and procedures, the Department analyzed the Company’s timeliness, completeness, and accuracy 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.

E. 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 69 documents. In accordance with the requirements of the Examination, the documents were reviewed to determine if the Company had corrected instances of non-compliance identified in the past. No violations were noted.

V. 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. When 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 one document 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 laws and regulations noted above, specifically 31 Pa. Code § 146.5. 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 one document and supplied one additional document 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, 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 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. 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 and supplied an additional seven 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. The following violations were noted:

Universe Violation - 31 Pa Code § 146.6

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

AND

31 Pa Code § 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the claim, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the initial notification and every 45 days thereafter, send to the claimant a letter setting forth reasons additional time is needed for investigation and state when a decision on the claim may be expected. The Company failed to send claimants notifications setting forth reasons additional time was needed when claims investigations could not be completed within 30 days after notification of the claims. The Department notes that, while claim investigation delay letters were not sent during the examination experience period, the Company has indicated the issue was corrected for all claim system platforms by November 29, 2023.

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. No violations were noted.

F. Newborns' and Mothers' Health Protection Act of 1996

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 two documents and supplied an additional five 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, as well as 40 P.S. §§ 1581 through 1584, and 42 U.S.C. § 300gg-25. No violations were noted.

VI. 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. When 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, 28 Pa. Code § 9.679, 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 five 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.

B. Access Plan Filed

Examiners requested documentation demonstrating that the Company filed an access plan for each managed care plan offered in Pennsylvania and filed updates whenever it made a material change to an existing managed care plan during the experience period. Examiners also requested documentation demonstrating that access plans were made available: 1) on the Company's business premises; 2) to regulators; and 3) to interested parties, absent proprietary information, upon request. 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.

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

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, 7 days per week within its network and provided coverage for emergency services outside of its network. 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. § 991.2116, 31 Pa. Code §§ 152.15 and 301.62(c), and 45 C.F.R. § 147.138. No violations were noted.

E. Written Agreements with Providers

Examiners requested documentation demonstrating that executed written agreements between the Company and each participating provider were in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of three documents. In accordance with the requirements of the Examination, the documents were reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

F. Intermediary Contracts

Examiners requested documentation demonstrating that the Company's contracts with intermediaries were 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 laws and regulations. No violations were noted.

G. Participating Provider Arrangements

Examiners requested documentation demonstrating that the Company's arrangements with participating providers complied 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 laws and regulations. No violations were noted.

H. 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 two documents and supplied 31 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. Accrediting Certification

Examiners requested documentation demonstrating that the Company received 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 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.

J. Provider Agreements

Examiners requested sample copies of the various provider agreements in effect during the experience period, including agreements with pharmacy benefit managers, behavioral health claims administrators, mental health parity actuarial vendors, etc. The Company identified a universe of three documents. In accordance with the requirements of the Examination, the documents were reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

VII. 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. When 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 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.

B. Accrediting Verification

Examiners requested documentation demonstrating that the Company verified the credentials of health care professionals before entering into a contract with the health care professionals during the experience period. The Company identified a universe of 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.

C. Primary or Secondary Verification Process

Examiners requested documentation demonstrating that the Company obtained, through either a primary or secondary credentialing verification process, the information required by state and federal laws and regulations applicable during the experience period. The Company identified a universe of two documents. In accordance with the requirements of the Examination, the

documents were reviewed to ensure compliance with applicable state 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 changes in the status of any information that is required to be verified by the Company. 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.

E. Provider Opportunity to Review

Examiners requested documentation demonstrating that the Company afforded health care professionals the opportunity to review and correct information submitted in support of that health care professional's credentialing verification. 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.

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. The Company identified a universe of two documents and supplied four 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.

VIII. 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. When 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 applicable state and federal laws and regulations. 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.

B. Annual Report

Examiners requested documentation demonstrating that the Company filed an annual summary report of its utilization review activities and maintained records of all benefit requests, claims, and notices associated with utilization review and benefit determinations in accordance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of eight documents and supplied seven 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 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.

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, 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 seven 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.

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 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.

F. Adverse Determination of Utilization Review

Examiners requested documentation demonstrating that the Company provided written notice of any adverse standard utilization review determinations in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe 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. Expedited Utilization Review and Benefit Determination

Examiners requested documentation demonstrating that the Company conducted expedited utilization review and benefit determinations in a timely manner and in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of 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.

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 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.

I. Monitoring Utilization Review Entity

Examiners requested documentation demonstrating that the Company monitored the activities of the utilization review organization or entity with which the Company contracted and ensured that the organization complied with state and federal laws and regulations applicable during the experience period. The Company identified a universe of 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.

IX. MEDICAL CLAIMS REVIEW

Examiners requested a list of all medical (i.e., non-pharmacy) paid, denied, and case rate claims during the experience period for the claim categories listed below. The Company identified a universe of 392,250 medical claims. A random sample of claim files was requested, received, and reviewed for the following types of claims:

- A. Autism Claims
- B. Emergency Services Claims
- C. Medical Foods Claims
- D. Emergent Ambulance Claims
- E. Emergency Services Claims
- F. Mental Health Claims
- G. Newborn Claims
- H. Opioid Treatment Claims
- I. Substance Use Disorder Claims

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 following general concerns were noted in many sections of claims:

CONCERN: Examiners noted in many claim sections that the Company issued Explanations of Benefits (EOBs) and provider remittance that failed to fully disclose to claimants a description of specific services for processed claims. Since the EOBs state “Medical Services” for the description of service for these claims, the EOBs do not provide enough information for members to determine whether claims were processed according to their benefit coverage.

A. Autism Claims

Examiners requested lists of all paid, denied, and case rate autism spectrum disorder (ASD) claims for 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 three sections.

Autism Paid Claims

Examiners requested a list of all ASD claims paid during the experience period. The Company identified a universe of 9,494 paid ASD claims. In accordance with the requirements of the Examination, a random sample of 114 files was reviewed. The following violations were noted:

22 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 mental health and substance use disorder (MH/SUD) benefits in parity with medical/surgical (M/S) benefits. For nonquantitative treatment limitations (NQTLs), this means that a licensed insurer may not apply any NQTL in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying that limitation to MH/SUD benefits within that classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the classification. The Company imposed an NQTL with respect to autism benefits in the Outpatient, Other benefit subclassification. Specifically, the Company limited the scope and duration of treatment for the noted claims by partially denying benefits for Applied Behavior Analysis (ABA) services. The Company did not demonstrate, as written and in operation, that the processes, strategies, evidentiary standards, or other factors used in applying these limitations 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 limitations with respect to medical/surgical benefits in the classification.

66 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 NQTLs, this means that a licensed insurer may not apply any NQTL in any classification unless the processes, strategies, evidentiary standards, or other factors used in

applying that limitation to MH/SUD benefits within that classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the classification. The Company imposed an NQTL with respect to autism benefits in the Outpatient, Other benefit subclassification. Specifically, the Company limited the scope and duration of treatment for the noted claims by requiring prior authorization for Applied Behavior Analysis (ABA) services. The Company did not demonstrate, as written and in operation, that the processes, strategies, evidentiary standards, or other factors used in applying these requirements 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 limitations with respect to medical/surgical benefits in the classification.

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

“Unfair methods of competition” and “unfair or deceptive acts or practices” in the business of insurance means making, publishing, issuing, or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which misrepresents the benefits, advantages, conditions or terms of any insurance policy.

AND

40 P.S. § 1171.5(a)(10)(i)

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

AND

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. The Company failed to fully disclose member cost sharing responsibilities for ASD services in plan Schedules of Benefits (SOBs).

3 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 §146.6

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.

31 Pa. Code § 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the claim, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the initial notification and every 45 days thereafter, send to the claimant a letter setting forth 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 noted claims within 30 days after notification of the claims and did not provide written explanation for the delay.

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

7 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 detail so that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain complete claim files for the noted claims.

114 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 detail so that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain complete claim files for the noted claims; specifically, SOBs do not include sufficient details of member cost sharing information to allow examiners to determine whether the claims were paid based on the members’ coverage in the plans.

CONCERN: The Company failed to provide an IEP for the school services which were provided in a classroom setting that resulted in fewer hours of ABA services approved than were requested. It is unclear in the Utilization Management notes if the company is applying school-based services appropriately.

Autism Denied Claims

Examiners requested a list of all ASD claims that were denied during the experience period. The Company identified a universe of 3,185 denied autism claims. In accordance with the requirements of the Examination, a random sample of 107 files was reviewed. 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 practice shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue. The Company misrepresented policy benefits on the Explanation of Benefits (EOB).

107 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.

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. The Company failed to fully disclose member cost sharing responsibilities for ASD services in plan Schedules of Benefits (SOBs).

5 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 § 146.6

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.

AND

31 Pa Code § 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the claim, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the initial notification and every 45 days thereafter, send to the claimant a letter setting forth 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 noted claims within 30 days after notification of the claims and did not provide written explanation for the delay.

7 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 original claim submission for the noted claims.

7 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 detail so that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain complete claim files for the noted claims.

Autism Case Rate Claims

Examiners requested a list of all ASD case rate claims for the experience period. The Company identified a universe of 9 case rate autism claims. In accordance with the requirements of the Examination, a random sample of 3 files was reviewed. The following violations were noted:

3 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 detail so that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain complete claim files for the noted claims.

B. Emergency Services Claims

Examiners requested lists of all paid, denied, and case rate emergency services claims for 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 three sections.

Emergency Services Paid Claims

Examiners requested a list of all emergency services claims paid during the experience period. The Company identified a universe of 53,993 paid emergency services claims. In accordance with the requirements of the Examination, a random sample of 114 files was 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 38,409 denied emergency services claims. In accordance with the requirements of the Examination, a random sample of 109 files was reviewed. The following violations were noted:

35 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 § 146.6

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.

AND

31 Pa Code § 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the claim, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the initial notification and every 45 days thereafter, send to the claimant a letter setting forth 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 noted claims within 30 days after notification of the claim and did not provide written explanation for the delay.

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 original claim submission for the noted claims.

3 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 detail so that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain complete claim files for the noted claims.

Emergency Services Case Rate Claims

Examiners requested lists of all emergency services case rate claims for the experience period. The Company identified a universe of 63,181 case rate emergency services claims. In accordance with the requirements of the Examination, a random sample of 114 files was reviewed. The following violations were noted:

5 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 § 146.6

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.

AND

31 Pa Code § 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the claim, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the initial notification and every 45 days thereafter, send to the claimant a letter setting forth 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 noted claims within 30 days after notification of the claim and did not provide written explanation for the delay.

C. Emergency Ambulance Claims

Examiners requested lists of all paid, denied, and case rate emergency ambulance claims for the experience period. In accordance with the requirements of the Examination, emergency 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 all three sections.

Emergency Ambulance Paid Claims

Examiners requested a list of all emergency ambulance claims paid during the experience period. The Company identified a universe of 2,360 paid emergency ambulance claims. In accordance with the requirements of the Examination, a random sample of 107 files was reviewed. The following violations were noted:

1 Violation - 40 P.S. § 991.2116(a)

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 Company denied the original claim and first reprocessed claim for lack of precertification, but the Company is not permitted to require precertification on emergency services.

4 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. § 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 claim timely and interest of \$2 or more remains unpaid.

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

“Unfair methods of competition” and “unfair or deceptive acts or practices” in the business of insurance means making, publishing, issuing or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which misrepresents the benefits, advantages, conditions or terms of any insurance policy.

AND

40 P.S. § 1171.5(a)(10)(i)

“Unfair methods of competition” and “unfair or deceptive acts or practices” in the business of insurance means the following act if committed or performed with such frequency as to indicate a business 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 claim according to the plan SOBs and issued member EOB and provider remittance advice that misrepresented the benefits of the member’s policy.

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

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 all out-of-pocket costs to the member’s out-of-pocket maximum accumulator for the noted claim file.

5 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 §146.6

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 a reasonable explanation for the delay in the processing.

AND

31 Pa. Code § 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the claim, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the initial notification and every 45 days thereafter, send to the claimant a letter setting forth 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 noted claims within 30 days after notification of the claims and did not provide written explanation for the delay.

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.

Emergency Ambulance Denied Claims

Examiners requested a list of all emergency ambulance claims denied during the experience period. The Company identified a universe of 556 denied emergency ambulance claims. In accordance with the requirements of the Examination, a random sample of 82 files was reviewed.

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 § 146.6

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.

AND

31 Pa Code § 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the claim, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the initial notification and every 45 days thereafter, send to the claimant a letter setting forth 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 noted claims within 30 days after notification of the claims and did not provide written explanation for the delay.

7 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 original claim submissions of the noted claims when the Company’s liability under the policy was reasonably clear.

4 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.

Emergency Ambulance Case Rate Claims

Examiners requested a list of all emergency ambulance case rate claims for the experience period. The Company identified a universe of 19 case rate emergency ambulance claims. In accordance

with the requirements of the Examination, a random sample of 11 files was reviewed. The following violations were noted:

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.

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. The EOBs for the noted claims do not accurately represent the amounts billed as provided on the claim processing details.

11 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.

D. Substance Use Disorder Claims

Examiners requested lists of all paid, denied, and case rate substance use disorder (SUD) claims for 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 three sections.

Substance Use Disorder Paid Claims

Examiners requested a list of all SUD claims paid during the experience period. The Company identified a universe of 8,203 paid SUD claims. In accordance with the requirements of the Examination, a random sample of 109 files was reviewed. The following violations were noted:

6 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 § 146.6

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.

AND

31 Pa Code § 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the claim, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the initial notification and every 45 days thereafter, send to the claimant a letter setting forth 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 noted claims within 30 days after notification of the claims and did not provide written explanation for the delay.

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 2,112 denied substance use disorder claims. In accordance with the requirements of the Examination, a random sample of 108 files was reviewed. The following violations were noted:

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

If a licensed insurer or a managed care plan fails to remit payment as required, interest at 10% per annum shall be added to the amount owed on the clean claim, and 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.

21 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 § 146.6

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.

AND

31 Pa Code § 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the claim, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the initial notification and every 45 days thereafter, send to the claimant a letter setting forth 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 noted claims within 30 days after notification of the claims and did not provide written explanation for the delay.

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 original claim submission for the noted claims.

8 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.

Substance Use Disorder Case Rate Claims

Examiners requested a list of all SUD case rate claims for the experience period. The Company identified a universe of 946 case rate substance use disorder claims. In accordance with the requirements of the Examination, a random sample of 81 files was reviewed. The following violations were noted:

10 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 § 146.6

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.

AND

31 Pa Code § 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the claim, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the initial notification and every 45 days thereafter, send to the claimant a letter setting forth 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 noted claims within 30 days after notification of the claims and did not provide written explanation for the delay.

E. Mental Health Claims

Examiners requested lists of all paid, denied, and case rate mental health claims for 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 two of the three 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 163,768 paid mental health claims. In accordance with the requirements of the Examination, a random sample of 109 files was reviewed. No violations were noted.

Mental Health Denied Claims

Examiners requested a list of all mental health claims denied during the experience period. The Company identified a universe of 18,505 denied mental health claims. In accordance with the

requirements of the Examination, a random sample of 109 files was reviewed. The following violations were noted:

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 original claim submission for 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.

17 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.

AND

31 Pa Code § 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the claim, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the initial notification and every 45 days thereafter, send to the claimant a letter setting forth 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 noted claims within 30 days after notification of the claims and did not provide written explanation for the delay.

Mental Health Case Rate Claims

Examiners requested a list of all mental health case rate claims for the experience period. The Company identified a universe of 1,926 case rate mental health claims. In accordance with the requirements of the Examination, a random sample of 88 files was 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.

3 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 § 146.6

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.

AND

31 Pa Code § 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the claim, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the initial notification and every 45 days thereafter, send to the claimant a letter setting forth 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 noted claims within 30 days after notification of the claims and did not provide written explanation for the delay.

F. Opioid Addiction Treatment Claims

Examiners requested lists of all inpatient and outpatient opioid addiction treatment claims paid, denied, and partially paid during the experience period. In accordance with the requirements of the Examination, opioid addiction 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 three sections.

Opioid Addiction Treatment 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 4,594 paid opioid addiction treatment claims. In accordance with the requirements of the Examination, a random sample of 108 files was 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)(4)(i)

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

imposed an NQTL with respect to opioid addiction treatment benefits in the Inpatient benefit classification. Specifically, the Company limited the scope and duration of treatment for the noted claims by requiring prior authorization for inpatient opioid addiction treatment services. The Company did not demonstrate, as written and in operation, that the processes, strategies, evidentiary standards, or other factors used in applying these requirements to the specified inpatient opioid addiction treatment services, were applied comparably and no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitations with respect to medical/surgical benefits in the classification.

5 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 Treatment 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 919 denied opioid addiction treatment claims. In accordance with the requirements of the Examination, a random sample of 107 files was 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.

21 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 § 146.6

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.

AND

31 Pa Code § 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the claim, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the initial notification and every 45 days thereafter, send to the claimant a letter setting forth 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 noted claims within 30 days after notification of the claims and did not provide written explanation for the delay.

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

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

7 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 Treatment Case Rate Claims

Examiners requested a list of all inpatient and outpatient opioid addiction treatment case rate claims for the experience period. The Company identified a universe of 74 case rate opioid addiction treatment claims. In accordance with the requirements of the Examination, a random sample of 36 files was reviewed. The following violations were noted:

6 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.

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. The Company failed to process the noted claims according to the plan SOBs and issued member EOBs and provider remittance advice that misrepresented the benefits of the members' policies.

7 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.

G. Newborn Claims

Examiners requested lists of all newborn paid, denied, and case rate claims for the experience period. In accordance with the requirements of the Examination, newborn claim files were reviewed to ensure compliance with 40 P.S. §§ 771 et seq., 991.2166, and 1171.5; 31 Pa. Code § 89.205, Ch. 146 and 154; 42 U.S.C. §§ 300gg-6, 300gg-25, and 18022; and 45 C.F.R §§ 147.150 and 156.125. Examiners found violations in all three sections.

Newborn Paid Claims

Examiners requested a list of all newborn claims paid during the experience period. The Company identified a universe of 10,386 paid newborn claims. In accordance with the requirements of the Examination, a random sample of 109 files was reviewed. The following violations were noted:

3 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 § 146.6

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.

AND

31 Pa Code § 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the claim, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the initial notification and every 45 days thereafter, send to the claimant a letter setting forth 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 noted claims within 30 days after notification of the claims and did not provide written explanation for the delay.

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.

Newborn Denied Claims

Examiners requested a list of all newborn claims denied during the experience period. The Company identified a universe of 5,372 denied newborn claims. In accordance with the

requirements of the Examination, a random sample of 108 files was reviewed. The following violations were noted:

34 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 § 146.6

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.

AND

31 Pa Code § 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the claim, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the initial notification and every 45 days thereafter, send to the claimant a letter setting forth 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 noted claims within 30 days after notification of the claims and did not provide written explanation for the delay.

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 original claim submission for the noted claims.

9 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.

Newborn Case Rate Claims

Examiners requested a newborn case rate claims for the experience period. The Company identified a universe of 4,239 case rate newborn claims. In accordance with the requirements of the Examination, a random sample of 110 files was reviewed. The following violations 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.

X. FORMULARY REVIEW

Examiners requested all pharmacy policies and procedures used during the experience period for processing 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 67 documents and supplied 60 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. Request for Exception Process

Examiners requested documentation demonstrating that the health plan had procedures in place to allow an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan. The Company identified a universe of four documents and supplied nine 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. 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 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.

D. 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 22 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. 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 18 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. 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 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.

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

H. 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 one document. In accordance with the requirements of the Examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations as noted above, as well as 40 P.S. §§ 908-1 et seq. and 908-11 et seq., and 45 C.F.R. § 146.136. No violations were noted.

I. MH/SUD Inpatient Admission Criteria

Examiners requested medical policies that defined medical necessity criteria for services relating to MH/SUD during the experience period. The Company identified a universe of one document. In accordance with the requirements of the Examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations as noted above, as well as 40 P.S. §§ 908-1 et seq. and 908-11 et seq., and 45 C.F.R. § 146.136. No violations were noted.

J. Admissions and Readmissions for MH/SUD Services

Examiners requested the medical policy that defines the number of admissions and readmissions for MH/SUD that the Company's medical policy allows for each company and product within the experience period. The Company identified a universe of one document and supplied eight 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 as noted above, as well as 40 P.S. §§ 908-1 et seq. and 908-11 et seq., and 45 C.F.R. § 146.136. No violations were noted.

K. Pharmacy and Therapeutics Committees

Examiners requested a copy of meeting minutes regarding MH/SUD and HIV/AIDS coverage from the Pharmacy and Therapeutics Committee and/or notes pertaining to the drugs that fall under these diagnoses, as well as a summary of any changes made during the experience period. The Company identified a universe of four documents. In accordance with the requirements of the Examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations as noted above, as well as 40 P.S. §§ 908-1 et seq. and 908-11 et seq., and 45 C.F.R. § 146.136. No violations were noted.

L. Medication Assisted Treatment Processes

Examiners requested documentation about the settings in which Medication Assisted Treatment (MAT) for opioid medications were dispensed during the experience period. The Company identified a universe of eight documents. In accordance with the requirements of the Examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations as noted above, as well as 40 P.S. §§ 908-1 et seq. and 908-11 et seq., and 45 C.F.R. § 146.136. No violations were noted.

M. Preauthorizations and Reauthorizations for MAT Drugs

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

N. Utilization Reviews or Exclusions

Examiners requested utilization reviews or exclusions based on failure to complete a course of treatment during the experience period. The Company identified a universe of one document and supplied six 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 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. Medical Policies Posing Limits to MH/SUD

Examiners requested any medical policies that may pose limits to MH/SUD such as: physical examination, doctor shopping and privileged communication laws, tamper resistant prescription forms, and urine test requirements for MH/SUD during the experience period. The Company identified a universe of one document. In accordance with the requirements of the Examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations as noted above, as well as 40 P.S. §§ 908-1 et seq. and 908-11 et seq., and 45 C.F.R. § 146.136. No violations were noted.

P. Third-Party PBM Policies

Examiners requested internal or third-party pharmacy benefit management (PBM) policies that applied to mental health and substance use disorder treatment programs during the experience period. The Company identified a universe of one document and supplied eight 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 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.

XI. MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)

Examiners requested documentation relating to the Mental Health Parity and Addiction Equity Act during the experience period, including policies and procedures, NQTL comparative analyses, and Financial Requirement/Quantitative Treatment Limitation (FR/QTL) testing. Unless noted, all documents identified in the universe by the Company were requested, received, and reviewed by the examiners. When 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. §§ 908-11 et seq., 42 U.S.C. § 300gg-26, 45 C.F.R. § 146.136, and 45 C.F.R. § 147.136, incorporating 29 C.F.R. §2560.503-1(g).

A. Financial Requirements/Quantitative Treatment Limitations

Examiners requested documentation that the Company complied with FR/QTL mental health parity requirements found in state and federal laws and regulations applicable during the experience period. The Company identified a universe of 3,315 plans across small group, large group and student health for policy years 2021 & 2022. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 908-11 et seq.; 42 U.S.C. § 300gg-26; and 45 C.F.R. § 146.136, using the guidelines set forth in Chapter 24, Section G, Standard 3 of the NAIC Market Regulation Handbook. The following violations were noted:

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 MH/SUD benefits in parity with M/S benefits. For FRs and QTLs, this means that a licensed insurer may not apply any FR or 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 M/S benefits in the same classification. While the Company performed FR/QTL testing for the exam experience period, the Company's FR/QTL testing submitted in response to the data call did not exclude expected claim dollar amounts for all MH/SUD benefits from the substantially all and predominant test calculations; specifically, the

Company did not exclude claim dollar amounts for all services that may be prescribed for both M/S and MH/SUD conditions. Subsequently, the Company submitted several versions of FR/QTL testing templates for 14 sample plans based on the Department's requests for clarification and exclusion of all MH/SUD claim dollar amounts from the testing calculations. 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, the level of cost sharing charged was too high, and/or visit limits were applied when they should not have been.

B. Nonquantitative Treatment Limitations

Examiners requested documentation demonstrating that the Company complied with NQTL mental health parity requirements found in state and federal laws and regulations applicable during the experience period. The Company was also specifically required to submit MHPAEA comparative analyses for NQTLs for the experience period. The Company identified a universe of nine documents and supplied 20 additional documents and 45 sample files in response to examiner-issued information requests. The Department also considered limitations noted during claims review. 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:

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 NQTLs, this means that a licensed insurer may not apply any NQTL in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying that limitation to MH/SUD benefits within that classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in applying the limitation to medical/surgical benefits in the classification. The Company imposed NQTLs with respect to MH and SUD benefits, but the comparative analyses provided for these NQTLs is insufficient to demonstrate parity compliance. Specifically, the Company has not demonstrated, as written and in operation, that the processes, strategies, evidentiary standards, or other factors used in applying the following limitations to MH/SUD services, were applied

comparably and no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitations with respect to medical/surgical benefits in the classifications where they were applied as follows:

The Company imposed prior authorization (also known as precertification), concurrent review, and retrospective review on MH/SUD benefits in the inpatient (in-network and out-of-network) benefit classifications; the outpatient, other (in-network and out-of-network) benefit subclassifications; and the outpatient, office out-of-network subclassification.

The Company applied medical necessity criteria to Applied Behavior Analysis (ABA) services for autism in the outpatient, other (in-network and out-of-network) subclassifications, that do not appear to align with generally accepted standards of care. The Company's application of its medical necessity criteria for ABA services resulted in partial denials of ABA services. In some cases, the peer-to-peer review process with providers resulted in providers withdrawing their initial requests for ABA services and submitting requests for fewer hours of ABA services. The Department notes, however, that the Company voluntarily agreed to remove the following requirements from their ABA medical necessity guide:

The engagement or commitment from parent(s) or guardian(s) to participate in treatment for outpatient services (including ABA).

The involvement of, or referrals to, appropriate health care, community or supplemental resources for outpatient treatment (including ABA).

NQTLs cannot be applied to MH/SUD benefits unless comparative analyses demonstrate parity compliance. Since the comparative analyses for these NQTLs do not demonstrate parity compliance, they should not have been imposed.

XII. 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 Section 904(b) of the Insurance Department Act of 1921 (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:

Untimely Responses to Information Requests

Situation: For some Information Requests (IRs), extension requests and/or finalized responses were not submitted on a timely basis.

Finding 1: The Company requested an extension for response to IR #019 on 07/25/2023, which was one day after the original due date of 07/24/2023.

Finding 2: IR #023 was issued on 07/20/2023 with an initial due date of 07/25/2023; information that was fully responsive to the request was not submitted until 10/01/2023.

Finding 3: IR #s 14, 15, 17, 18, 20, 21, and 22 were issued to the Company to request files for sample claims, beginning on 07/06/2023, with the first group of claims due on 07/17/2023. The Company requested additional time and was granted an initial extension to 07/20/2023, as well as a subsequent extension to 08/04/2023. On 08/03/2024, the Company advised the Department they would not be able to submit all requested samples by the 2nd extension date of 08/04/2023 and proposed that all sample claims could be provided by 10/01/2023. The Department advised the Company that the proposed date of 10/01/2023 was unacceptable and counter-proposed that the Company either provide the requested sample claims by 08/31/2023 or provided immediate system access and training for examiner review of claims. The Company then agreed to the 08/31/2023 due date.

Incomplete or Inaccurate Responses to Information Request

Situation: In IR #025, examiners requested that the Company provide all related and identified corresponding fee schedules related to Case Rate claims.

Finding: The Company's initial response to IR #025 failed to include all related and identified fee schedules. In some cases, the necessary fee schedule information was later provided, but in other cases, the necessary information was not provided. In addition, some claims identified as case rate claims were later determined to be claims submitted by non-participating providers, and therefore, were not case rate claims.

Exam Sections G.1, G.2, G.11, G.16, and G.18 - Claims

Situation: During the review of claim samples, incomplete or inaccurate information was noted.

Finding 1: For some sample claims, the Company submitted incorrect documents for the specific claims or failed to provide documents such as EOBs, EPPs (Explanations of Provider Payments), or utilization management documentation.

Finding 2: Some sample claims were for plans underwritten in other states and therefore out-of-scope.

Coordination of Benefits (COB)

Situation: The Department cited violations related to the Company's COB process in many claim sections. The claim sample documentation provided by the Company appeared to indicate that there was no other coverage for these members, but the Company was requesting information from the members regarding other coverage and denying claims when they did not provide the requested information. The Company disagreed with the Department's findings but failed to provide any documentation to support its position when responding to Department Initial Summaries.

Finding: Despite the Department's guidance regarding exam process related to supporting documentation, the Company failed to provide documentation supporting its position regarding COB for 69 sample claims until the Company submitted its response to the draft exam report. Upon review of the additional documentation, the Department still required additional clarification or

documentation for some sample claims. Failure to provide the necessary documentation and detailed explanations earlier in the exam process resulted in a significant extension of the review process at the conclusion of the exam.

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.

XIII. 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 to ensure compliance with the mental health and SUD parity compliance requirements of 40 P.S. §§ 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 MH/SUD benefits are provided in every benefit classification in which M/S benefits are provided.
 - b. The Company must ensure that for benefits that may be prescribed for both M/S conditions and MH/SUD conditions [Diagnostic & Laboratory Services, Emergency Room Services, Emergency Ambulance (Air and Land), Non-Emergency Ambulance (Air and Land), Habilitative & Rehabilitative Services (Occupational Therapy, Physical Therapy, and Speech Therapy), Home Health Care, Nutritional Counseling & Support, Primary Care Physician Office Visits, Specialist Physician Office Visits, Preventive Services, and Urgent Care], only expected claim payments for the benefits that are for M/S conditions are included in the FR/QTL calculations for the substantially all and predominant level tests.
 - c. The Company must evaluate FR/QTL analyses and ensure that each FR/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 MHPAEA FR/QTL Exit Summary 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 FR/QTL separately. The Company must reprocess claims for all Pennsylvania members that may have been impacted from January 1, 2021 to present to determine if restitution, including interest, is due. The Company must provide the Department with documentation that any restitution due to Pennsylvania consumers has been paid accordingly.

- d. 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 opioid addiction treatment.
 - e. 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.
2. 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)(v), the Company must affirm or deny coverage within a reasonable time after claims are received.
 - c. 40 P.S. § 1171.5(a)(10)(vi), the Company must ensure prompt, fair and equitable settlements are being provided to the claimants; for any claims improperly denied, as identified in Claim section Exit Summaries and this Examination Report, the Company must ensure the identified clean claims are paid, and proof of such payment must be provided to the Department.
3. 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 § 146.6, 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.
 - d. 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.
4. 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.
5. 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 Department.
6. 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.
7. The Company must review and revise internal control procedures to ensure compliance with 42 U.S.C. § 300gg-19 and 45 C.F.R. § 147.136 incorporating 29 C.F.R. § 2560.503-1, relating to content of adverse benefit determinations. Specifically, the Department expects that the Company will augment its adverse benefit determination letters for ABA services

to ensure clarity of reason or reasons for denied services and the specific criteria on which the adverse benefit determination was based.

8. 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. The Company has indicated that modifications to SOBs are well underway and that the revised SOBs have been submitted to the Department as part of the form review process. The Company shall submit the revised SOBs to the Department's Health Market Conduct team as part of post-examination reporting.

XIV. COMPANY RESPONSE