COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT

MARKET CONDUCT EXAMINATION REPORT

OF

UnitedHealthcare Insurance Company

c/o UnitedHealth Group
185 Asylum St, CT039-020A
Hartford, CT 06103

As of: August 8, 2019
Issued: October 3, 2019

HEALTH MARKET CONDUCT BUREAU

VERIFICATION

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

Sean Connolly, Examiner-in-Charge

Sworn to and Subscribed Before me

This 2nd Day of May, 2019

SAWYER D. THOMPSON
NOTARY PUBLIC
PITT COUNTY, NC
My Commission Expires: 09/26/2022

Notary Public

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BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

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

Jessica K. Altman
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
UNITED HEALTHCARE INSURANCE COMPANY	:	40 P.S. §§ 323.3(a); 323.4(b); 764c; 764g; 764h; 908-1 et seq.; 908-11 et seq.; 991.2116; 991.2141(b), (c); 991.2142(a); 991.2166(a), (b); 1171.5(a)(10)(i), (iii), (iv), (v), (vi), (x), (xiv); 3042
185 Asylum Street Hartford, CT 06103-0450	:	
	:	31 Pa. Code §§ 146.3; 146.4(b); 146.5(a), (b); 146.6; 146.7(a), (c); 154.17(e), (f); 154.18(a), (c)
	:	
	:	18 Pa.C.S. § 4117(k)(1)
	:	
	:	42 U.S.C. §§ 300gg-6(b); 300gg-13(a)(4); 300gg-19(a); 300gg-19a(b); 300gg-26; 18022(b), (c)
	:	
	:	45 C.F.R. §§ 146.136(c)(2)(i); 146.136(c)(4)(i); 147.130(a)(1)(iv); 147.136 incorporating 29 C.F.R. § 2560.503-1; 147.138(b); 156.125; 156.130
	:	
Respondent	:	Docket No. MC18-07-010

CONSENT ORDER

And now, this 3rd day of October, 2019, 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) Respondent is United Healthcare Insurance Company, and maintains its address at 185 Asylum Street, Hartford, CT 06103-0450.

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

(c) On August 8, 2019, the Insurance Department issued a Market Conduct Examination Report to Respondent ("Examination Report").

(d) Respondent provided to the Insurance Department a response to the Examination Report on September 9, 2019.

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

CONCLUSIONS OF LAW

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

(a) Respondent is subject to the jurisdiction of the Pennsylvania Insurance Department.

(b) Violations of Sections 40 P.S. §§ 764c, 764g, and 764h, as contained in the Examination Report, are punishable by the following under 40 P.S. § 763:

(1) License revocation.

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

(c) Violations of 40 P.S. §§ 991.2116, 991.2141(b)(3), 991.2141(b)(4), 991.2141(b)(5), 991.2141(c)(1), 991.2142(a), 991.2166(a) and 991.2166(b), as

contained in the Examination Report, are punishable by the following under 40 P.S. § 991.2182:

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

(2) An injunction to prohibit any activity that violates the act.

(3) An order temporarily prohibiting respondent from enrolling new members.

(4) A requirement to develop and adhere to a plan of correction.

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

(1) An order to cease and desist.

(2) License suspension or revocation.

(e) In addition to any penalties imposed by the Commissioner for violations of 40 P.S. §§ 1171.5(a)(10)(i), 1171.5(a)(10)(iii), 1171.5(a)(10)(iv), 1171.5(a)(10)(v), 1171.5(a)(10)(vi), 1171.5(a)(10)(x), and 1171.5(a)(10)(xiv), as contained in the Examination Report, the Commissioner may, under 40 P.S. §§ 1171.10, 1171.11, file an action in which the Commonwealth Court may impose the following civil penalties:

(1) An injunction.

(2) For each method of competition, act or practice which the company knew or should have known was in violation of the law, a penalty of not more

than five thousand dollars ($5,000.00) for each violation but not to exceed an aggregate penalty of fifty thousand dollars ($50,000) in any six-month period.

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

(f) Violations of 31 Pa. Code §§ 146.3, 146.4(b), 146.5, 146.5(a), 146.5(b), 146.6, 146.7(a)(1) and 146.7(c)(1), as contained in the Examination Report, are punishable by the following under 40 P.S. §1171.9:

(1) An order to cease and desist.

(2) License suspension or revocation.

(g) In addition to any penalties imposed by the Commissioner for violations of 31 Pa. Code §§ 146.3, 146.4(b), 146.5(a), 146.5(b), 146.6, 146.7(a)(1) and 146.7(c)(1), as contained in the Examination Report, the Commissioner may, under 40 P.S. §§1171.10 1171.11, file an action in which the Commonwealth Court may impose the following civil penalties:

(1) An injunction.

(2) For each method of competition, act or practice which the company knew or should have known was in violation of the law, a penalty of not more than five thousand dollars ($5,000.00) for each violation but not to exceed

an aggregate penalty of fifty thousand dollars ($50,000) in any six-month period.

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

(h) Violations of 31 Pa. Code §§ 154.17(e), 154.17(f), 154.18(a), and 154.18(c), as contained in the Examination Report, are punishable by the following under 40 P.S. § 991.2182:

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

(2) An injunction to prohibit any activity that violates the act.

(3) An order temporarily prohibiting respondent from enrolling new members.

(4) A requirement to develop and adhere to a plan of correction.

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

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

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

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

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

ORDER

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

(a) Respondent shall cease and desist from engaging in the activities described herein in the Findings of Fact, which incorporate the findings and conclusions contained in the Examination Report, and Conclusions of Law, insofar as the activities violate the laws of the Commonwealth of Pennsylvania.

(b) Respondent shall file an affidavit stating under oath that it will provide each of its directors, at its next scheduled directors meeting, a copy of the adopted Examination Report and any related Orders. Such affidavit shall be submitted within 30 days of the date of this Order.

(c) Respondent shall comply with all recommendations contained in the Examination Report. This shall include adoption and implementation of standards and processes sufficient to perform the comparative analyses necessary to determine if a covered plan or issuer is in compliance with the financial, quantitative treatment limitation and non-quantitative treatment limitation requirements specified in the final regulations of the Mental Health Parity and Addiction Equity Act.

Respondent shall provide to the Department documentation sufficient to demonstrate a good faith effort to comply with those regulatory requirements.

(d) Respondent shall conduct an Education and Outreach Campaign ("Campaign") to invest in the betterment of care for Pennsylvania policyholders who may need mental health and substance use disorder benefits. The following parameters shall be met:

(1) Total expenditures shall be not less than $800,000;

(2) The campaign's duration shall be for at least two years following the date of this Order;

(3) The focus shall be on Pennsylvania policyholders/members, Pennsylvania clients/employers and producers, and Pennsylvania community outreach;

(4) At least 50% of the expenditures shall be on activities directed to policyholders/members, clients/employers and producers, with quarterly reporting to the Department;

(5) The balance of the Campaign expenditures shall be spent on community outreach activities; however, anticipated expenditures on community outreach activities shall be submitted to the Department for approval and must be approved before actual expenditures may be credited to the Campaign.

(6) All expenditures shall be with the goal of informing members of, and assuring that members are provided, the mental health and substance use disorder benefits and protections to which they are entitled under law.

(e) Respondent shall report on a quarterly basis, beginning ninety (90) days after the date of this Order, all restitution paid as a result of the reprocessing of those claims as identified in the Examination Report. Each quarterly report shall also include a summary of the current status of the Education Outreach Campaign.

(f) Respondent shall pay one million dollars ($1,000,000) to the Commonwealth of Pennsylvania in settlement of the violations contained in the Examination Report.

(g) Payment of this matter shall be made by check payable to the Commonwealth of Pennsylvania. Payment should be directed to Crystal Welsh, Bureau of Market Regulation, 1209 Strawberry Square, Harrisburg, PA 17120. Payment must be made no later than 30 days after the date of this Order.

(h) To determine Respondent's compliance with the full and timely implementation of all recommendations ("Recommendations") in the Examination Report, the Department may conduct a re-examination of Respondent, beginning no earlier than twenty-four (24) months from the date of this Order. The experience period for the re-examination will commence no earlier than twelve (12) months from the date of this Order.

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

Insurance Department may enforce the provisions of this Order in an administrative action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

7. Alternatively, in the event the Insurance Department finds that there has been a breach of any of the provisions of this Order that Respondent has not remedied after being afforded a reasonable opportunity to do so, the Insurance Department may declare this Order to be null and void and, thereupon, reopen the entire matter for appropriate action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

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

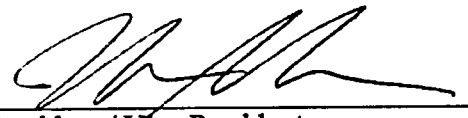
9. Respondent hereby expressly waives any relevant statute of limitations and application of the doctrine of laches for purposes of any enforcement of this Order.

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

11. This Order shall be final upon execution by the Insurance Department. Only the Insurance Commissioner or a duly authorized delegee is authorized to bind

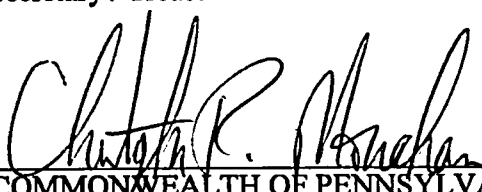
the Insurance Department with respect to the settlement of the alleged violations of law contained herein, and this Consent Order is not effective until executed by the Insurance Commissioner or a duly authorized delegee.

BY: UNITED HEALTHCARE INSURANCE COMPANY, Respondent



President / Vice President

Secretary / Treasurer

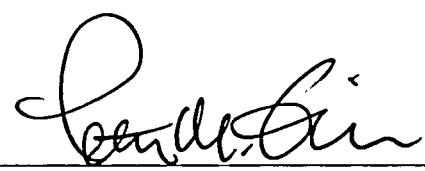


COMMONWEALTH OF PENNSYLVANIA
Christopher R. Monahan
Deputy Insurance Commissioner

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: UNITED HEALTHCARE INSURANCE COMPANY, Respondent

President / Vice President



Secretary / Treasurer

COMMONWEALTH OF PENNSYLVANIA
Christopher R. Monahan
Deputy Insurance Commissioner

I. INTRODUCTION

The Market Conduct Examination was conducted on UnitedHealthcare Insurance Company, hereafter collectively referred to as "Company," at the Company's offices located in Shelton, Connecticut, March 13, 2017, through March 17, 2017. Subsequent and follow-up reviews were conducted in the offices of the Pennsylvania Insurance Department (the Department) and off-site locations.

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

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

Throughout the course of the examination, Company officials were provided status memoranda or summaries, which reference specific policy numbers with citations to each section of law violated. Additional information was requested to clarify apparent violations. Multiple conference calls, status meetings, and an exit conference were conducted with Company officials to discuss the

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

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

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

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

Donna Fleischauer
Market Conduct Division Chief
Pennsylvania Insurance Department

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

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

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

Lindsi Swartz, MBA
Market Conduct Examiner
PA Insurance Department

Michael Jones
Market Conduct Examiner
PA Insurance Department

Penny Callihan
Market Conduct Examiner
PA Insurance Department

JoAnn Baldo, CPA, MCM
Contract Examiner

Lewis Bivona, CPA, AFE
Contract Examiner

Joseph Barrett
Market Conduct Examiner
PA Insurance Department

Frank Callihan
Market Conduct Examiner
PA Insurance Department

Gary Jones
Market Conduct Examiner
PA Insurance Department

Nicole McClain
Market Conduct Examiner
PA Insurance Department

Ryan Sellers
Market Conduct Examiner
PA Insurance Department

II. SCOPE OF EXAMINATION

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

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

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

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

III. COMPANY HISTORY

UnitedHealthcare Insurance Company is an insurance company within UnitedHealth Group. Subsidiary insurance companies operate as single state marketing arms in Illinois, New York and Ohio. The company represents the merged, former health insurance operation of MetLife and Travelers - known as the MetraHealth Insurance Company – and United Health and Life Insurance Company, the predecessor insurance operations of UnitedHealth Group, as more fully described below.

UnitedHealthcare Insurance Company ("UnitedHealthcare") was originally incorporated in Illinois as The Travelers Insurance Company of Illinois in 1972. The name was changed to The MetraHealth Insurance Company during 1994, at which time it was also redomesticated to Connecticut.

On January 3, 1995, Travelers and MetLife each contributed assets associated with their group medical insurance and managed care businesses to The MetraHealth Companies, Inc. (the company's then direct parent) or its subsidiaries. Travelers and MetLife also contributed to MetraHealth all of the capital stock of their wholly owned subsidiaries, including The MetraHealth Insurance Company, constituting their group medical insurance and managed care businesses.

On October 2, 1995, 100% of The MetraHealth Companies Inc. was purchased by UnitedHealthcare Corporation.

In May 1996, the MetraHealth Companies, Inc. and MetraHealth Pharmacy Management, Inc. were merged with and into The MetraHealth Insurance Company with the company as the survivor.

Due to the considered overlap of The MetraHealth Insurance Company's state licenses with those of UnitedHealthcare's original insurance subsidiary, United Health and Life Insurance Company, a Minnesota insurance company, the companies were merged effective January 1, 1997. At the same time, the surviving entity, The MetraHealth Insurance Company, was renamed UnitedHealthcare Insurance Company.

UnitedHealthcare is licensed to write life and group accident and health business in the District of Columbia, the U.S. Virgin Islands, Puerto Rico, Guam, and all states except New York.

UnitedHealthcare provides Medicare supplement and other supplemental coverage to members of the AARP, and other senior insureds, administrative services only (ASO) and stop loss coverage to regional and national large employer accounts, and also small case and middle market segments (groups defined by up to 50 and 5,000 employees, respectively). Two thirds of the middle market business and virtually all of the small case segment is insured business.

In March of 2000, UnitedHealthcare Insurance Company's direct parent, UnitedHealthcare Corporation changed its name to UnitedHealth Group Incorporated ("UnitedHealth Group").

In June 2000, UnitedHealth Group contributed all the shares of UnitedHealthcare Insurance Company to its wholly owned subsidiary UnitedHealthcare Services, Inc, who in turn contributed all the issued and outstanding shares of UnitedHealthcare Insurance Company to its wholly owned subsidiary, Unimerica, Inc., a Delaware corporation. As of June 30, 2000, UnitedHealthcare Insurance Company became a direct wholly owned subsidiary of Unimerica, Inc.

On March 31, 2004, Unimerica, Inc. changed its name to UHIC Holdings, Inc.

On June 24, 2005, UHIC became licensed in the Commonwealth of the Mariana Islands and in November, 2005 it became licensed in American Samoa.

In 2008 UHIC amended its name from United HealthCare Insurance Company to UnitedHealthcare Insurance Company.

In addition to the medical business, UnitedHealthcare is starting to develop and market life, dental, stop loss, vision and other insured and self-insured plans.

United Healthcare Insurance Company was first licensed to do business in Pennsylvania on October 26, 1994. The most recent certificate of authority is dated April 1, 2019.

IV. COMPANY OPERATIONS AND MANAGEMENT

Examiners requested documentation relating to internal audit and compliance procedures. The audits and procedures were reviewed to assure best practices and compliance with applicable laws and regulations. Documents requested dealt with information technology protection, anti-fraud policies and procedures, disaster recovery plans, monitoring business functions, record retention policies and procedures, company management and governance, privacy protections and notices, and standards for handling non-public personal information. Unless noted, all documents identified in each universe by the Company were requested, received, and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with applicable standards found in 40 P.S. §§ 764a and 1551 et seq., and 31 Pa. Code Ch. 152 and 301.

A. Audits Conducted

Examiners requested a list of all audits conducted from 2013 through 2015. The examiners reviewed the audits to ensure they included those completed by an internal audit function within the Company or conducted via a contracted vendor on behalf of the Company. The examiners reviewed documentation ensuring that all internal or external audits were up-to-date. The Company identified a universe of five documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, using the guidelines set forth in Chapter 16, Section A, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Information Technology Protection

Examiners requested documentation demonstrating that the Company had controls, safeguards, and procedures in place during the experience period for protecting the integrity of computer information. The Company identified a universe of two documents and supplied 16 additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination, all 18 documents were reviewed to

ensure compliance with applicable state laws and regulations noted above, as well as 31 Pa. Code Ch. 146a, 146b, and 146c, using the guidelines set forth in Chapter 16, Section A, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Anti-fraud Procedures

Examiners requested anti-fraud procedures and annual reports demonstrating that the Company had anti-fraud initiatives in place that were reasonably calculated to detect, prosecute, and prevent fraudulent insurance acts for the experience period. The Company identified a universe of two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, using the guidelines set forth in Chapter 16, Section A, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

D. Disaster Recovery Plan

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

E. Third-Party Agreements

Examiners requested copies of contracts between the Company and any third-party entities, including managing general agents, general agents, third-party administrators, and vendors, conducting activities on behalf of the Company during the experience period. The Company identified a universe of 33 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 45 C.F.R. § 156.340, using the guidelines set forth in Chapter 16, Section A, Standard 5 of the *NAIC Market Regulation Handbook*. No violations were noted.

F. Contracted-Entity Activity Monitoring

Examiners requested documentation demonstrating that the Company adequately monitored the activities of entities that contractually assumed a business function or acted on behalf of the Company during the experience period. The Company identified a universe of one document and supplied 27 additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination all 28 documents were reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 45 C.F.R. § 156.340, using the guidelines set forth in Chapters 16, Section A, Standard 6 of the *NAIC Market Regulation Handbook*. The following concern was noted:

Concern: The Company failed to adequately monitor the activities of an entity that contractually assumed a business function or acted on behalf of the Company.

G. Record Retention

Examiners requested copies of the record retention policies and procedures for assurance that Company records were adequate, accessible, consistent and orderly, and complied with state retention requirements for the experience period. The Company identified a universe of two documents and supplied one additional document in response to an examiner-issued information request. In accordance with the requirements of the examination, all three documents were reviewed to ensure compliance with applicable state laws and regulations, using the guidelines set forth in Chapter 16, Section A, Standard 7 of the *NAIC Market Regulation Handbook*. No violations were noted.

H. Written Overview of Operations

Examiners requested a written overview of the Company's operations including management structure, type of carrier, states where the Company is licensed, and the major lines of business the Company had written for the experience period, including information if a regional office handled any portion of the Pennsylvania business. The request included current organizational charts outlining the structure of Pennsylvania operations with respect to management, marketing, customer service, complaints, underwriting and claims, and identifying any specialty operations conducted separately. The Company identified a

universe of three documents and supplied 16 additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination, all 19 documents were reviewed to ensure compliance with applicable state laws and regulations noted above, specifically 31 Pa. Code §§ 152.3 and 301.42, using the guidelines set forth in Chapter 16, Section A, Standard 8 of the *NAIC Market Regulation Handbook*. No violations were noted in the written records regarding operations and management; however, the following violations were noted with respect to Company operations and management based on responses and actions taken during the course of the examination:

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

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

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

Licensed insurers are required to provide MH/SUD benefits in parity with medical/surgical benefits. For nonquantitative treatment limitations (NQTL), this means that a licensed insurer may not apply any NQTL in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying that limitation to 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 nonquantitative treatment limitations with respect to mental health and SUD benefits and was unable to provide adequate documentation demonstrating compliant parity analyses, despite numerous requests and guidance from examiners. It was noted that the Company limited the scope and duration of treatment for certain mental health and SUD claims in a manner that was applied more stringently than medical/surgical benefits within the classification.

I. Response to Requests

Examiners requested documentation demonstrating that the Company recognized it was required to respond to requests from the examiners in a timely manner. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state laws and regulations noted above, specifically 31 Pa. Code §§ 152.3 and 301.42, using the guidelines set forth in Chapter 16, Section A, Standard 9 of the *NAIC Market Regulation Handbook*. No violations were noted. In addition to the review of policies and procedures, the Department analyzed the Company's timeliness of responses for items requested by the Department during the market conduct examination. One general data integrity violation, described later in this Examination Report, was noted for the Company's general failure to provide timely access to all requests made by the Department during the course of the examination.

J. Privacy Policies and Procedures

Examiners requested documentation demonstrating that the Company assured that the collection, use, and disclosure of information gathered in connection with insurance transactions was performed in a manner that minimized any improper intrusion into the privacy of applicants and policyholders during the experience period. The Company identified a universe of three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations noted above, as well as 31 Pa. Code Ch. 146a, 146b, and 146c, using the

guidelines set forth in Chapter 16, Section A, Standard 10 of the *NAIC Market Regulation Handbook*. No violations were noted.

K. Insurance Information Security

Examiners requested documentation demonstrating that the Company had developed and implemented written policies, standards, and procedures for the management of insurance information for the experience period. The Company identified a universe of three documents and supplied 21 additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination, all 24 documents were reviewed to ensure compliance with applicable state laws and regulations noted above, as well as 31 Pa. Code Ch. 146a, 146b, and 146c, using the guidelines set forth in Chapter 16, Section A, Standard 11 of the *NAIC Market Regulation Handbook*. No violations were noted.

L. Security Protection of Non-Public Information

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

M. Privacy Notices

Examiners requested documentation demonstrating that the Company provided privacy notices to its customers and, if applicable, to its consumers who are not customers regarding treatment of non-public personal financial information. The Company identified a universe of three documents and supplied 23 additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination, all 26 documents were reviewed to ensure compliance with applicable state laws and regulations noted above, as well as 31 Pa. Code Ch. 146a, 146b, and 146c, using the guidelines set forth

in Chapter 16, Section A, Standard 13 of the *NAIC Market Regulation Handbook*. No violations were noted.

N. Opt-Out Notices

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

O. Non-Public Personal Financial Information

Examiners requested documentation demonstrating that the Company's collection, use, and disclosure of non-public personal financial information were in compliance with policy provisions, and state and federal laws and regulations applicable during the experience period. The Company identified a universe of three documents and supplied 21 additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination, all 24 documents were reviewed to ensure compliance with applicable state laws and regulations noted above, as well as 31 Pa. Code Ch. 146a, using the guidelines set forth in Chapter 16, Section A, Standard 15 of the *NAIC Market Regulation Handbook*. No violations were noted.

P. Non-Public Personal Health Information Disclosure

Examiners requested documentation that the Company had policies and procedures in place so that non-public personal health information would not be disclosed, except as permitted by law, unless a customer or a consumer who was not a customer had authorized the disclosure in the experience period. The Company identified a universe of three documents and supplied 21 additional documents in response to an examiner-issued information

request. In accordance with the requirements of the examination, all 24 documents were reviewed to ensure compliance with applicable state laws and regulations noted above, as well as 31 Pa. Code Ch. 146a and 146b, using the guidelines set forth in Chapter 16, Section A, Standard 16 of the *NAIC Market Regulation Handbook*. No violations were noted.

Q. Written Information Security Program

Examiners requested documentation demonstrating that the Company implemented a comprehensive written information security program for the protection of non-public customer information for the experience period**.** The Company identified a universe of five documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations noted above, as well as 31 Pa. Code Ch. 146c, using the guidelines set forth in Chapter 16, Section A, Standard 17 of the *NAIC Market Regulation Handbook*. No violations were noted.

R. Data Submission to Regulator

Examiners requested documentation demonstrating that the Company's data that was required to be reported to the Department were complete and accurate for the experience period. The Company identified a universe of three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations noted above, as well as 40 P.S. § 1171.5(a)(5) and 31 Pa. Code Ch. 146, using the guidelines set forth in Chapter 16, Section A, Standard 18 of the *NAIC Market Regulation Handbook*. Examiners also analyzed the Company's timeliness and completeness of responses to items requested by the Department. As noted above, one general data integrity violation was noted for the Company's failure to submit complete responses in a timely manner and failure to provide timely access to data and documentation for all requests made by the Department during the course of the examination. No additional violations were noted.

S. Management of Compliance Division

Examiners requested a description of the management structure of the Company as it relates to Major Medical Health insurance subject to consumer protection provisions of the Affordable Care Act, including the management structure that handles compliance issues

and mental health parity requirements, during the experience period. The Company identified a universe of three documents (organizational charts) describing the management structure of the Company as it relates to compliance issues. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code §§ 152.3 and 301.42. No violations were noted.

T. External Audits and Examinations

Examiners requested a list of all examination fines, penalties and recommendations from any state for the last five years, as well as copies of all Financial and Market Conduct Examination reports issued during the last five years. The Company identified a universe of 12 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations. One noted data integrity violation is discussed in the data integrity violation section of this Examination Report.

U. Annual Statements

Examiners requested copies of the annual statements for 2013 through 2015, as well as any Accident and Health related schedules or statements for the experience period. The Company identified a universe of 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.

V. CONSUMER COMPLAINTS

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

A. Complaint Handling

Examiners requested documentation demonstrating that all complaints were recorded in the required format on the regulated entity's complaint register for the experience period. The Company identified a universe of two documents and supplied 22 additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination, all 24 documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 16, Section B, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted**.**

B. Complaint Handling Procedures

Examiners requested documents relating to complaint handling and for communicating complaint handling procedures to policyholders. The Company identified a universe of four documents and supplied 12 additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination, all 16 documents were reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 45 C.F.R. § 156.1010, using the guidelines set forth in Chapter 16, Section B, Standard 2 of the *NAIC Market Regulation Handbook*. The following violation and concern were noted:

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

The complaint process shall consist of an initial review to include a review of the complaint, which shall be completed within 30 days of receipt of the complaint. The Company failed to review the noted complaint within 30 days of receipt of the complaint.

Concern: The Company response to the request for information regarding social media complaints and appeals states that the Company is not treating social media complaints as a complaint or appeal because "there is no expressed request to reconsider a decision." The Company defined a complaint, as, "where non-plan decision review requests (concerning, for example, health plan operations or management) are tracked, reviewed and responded to per PA requirements." No request for reconsideration needs to be expressed to be considered a complaint; therefore, examiners recommended that the Company track the social media comments that meet the definition of complaint "any written communication that expresses dissatisfaction with a specific person or entity subject to regulation under the state's insurance laws." In response, the Company provided additional documentation noting the tracking of social media complaints and appeals. Based on all of the documentation received, the Department remains concerned that the handling of social media complaints could be inconsistent and recommends that the Company update the policies or procedures for the handling of such complaints to ensure consistency.

C. Complaint Resolution

Examiners requested documentation demonstrating that the Company took adequate steps to finalize and resolve complaints in accordance with contract language, and state and federal laws and regulations applicable during the experience period. The Company identified a universe of two documents and supplied six additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination, all eight documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 16, Section B, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted**.**

D. Complaint Response Time

Examiners requested documentation that the timeframe within which the Company responded to complaints, including social media complaints, during the experience period was in accordance with applicable state and federal laws and regulations. The Company identified a universe of five documents and supplied 34 additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination, all 39 documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 16, Section B, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

E. Complaint Disposal

Examiners requested documentation demonstrating that the Company took adequate steps to finalize and dispose of complaints in accordance with policy provisions, and state and federal laws and regulations applicable during the experience period. The Company identified a universe of two documents and supplied one additional document in response to an examiner-issued information request. In accordance with the requirements of the examination, all three documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 16, Section B, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

F. Listing of Complaints

Examiners requested a listing of all complaints filed with the Company during the experience period. The list included complaints received from the Department, as well as complaints made directly to the Company on behalf of Pennsylvania consumers. The Company identified a universe of six documents and supplied two additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination, all eight documents were reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

G. Complaint Listing Number

Examiners requested the original files and complaint registry for all complaints if there were fewer than 50 complaints on the listing. The Company identified a universe of 405 complaints during the experience period. The documentation and review of these complaints was conducted under a separate section of the examination. The documents were reviewed to ensure compliance with applicable state laws and regulations. No violations were noted with respect to the Company providing files.

H. Definition of Complaint

Examiners requested documentation regarding complaint handling policies, including the Company's definition of what constitutes a complaint. The Company identified a universe of four documents and supplied an additional six documents in response to examiner-issued information requests. In accordance with requirements of the examination, all 10 documents were reviewed to ensure compliance with applicable state and federal laws and regulations, specifically 40 P.S. § 991.2102. No violations were noted.

I. Complaint Summaries

The Company was asked to describe complaint reports and summaries prepared on a recurring basis and identify the recipients of those reports. The Company was also asked to provide an example of each report and/or summary document. The Company identified a universe of five documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations. No violations were noted.

J. Pennsylvania Insurance Department Complaints

Examiners requested that the Company identify all Insurance Department complaints received during the experience period. The Company identified 33 Insurance Department complaints. The documents were reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 31 Pa. Code § 146.5. In addition to a data integrity violation, discussed later in the Examination Report, the following violations were noted:

10 Violations – 31 Pa. Code § 146.5(b)

Every insurer, upon receipt of an inquiry from the Department respecting a claim shall, within 15 working days of receipt of the inquiry, furnish the Department with an adequate response to the inquiry. The Company failed to respond to the Department in a timely manner for the 10 noted claim files.

1 Violation – 45 C.F.R. § 147.136, incorporating 29 C.F.R. § 2560.503-1

A plan and issuer must provide notice to individuals, in a culturally and linguistically appropriate manner, that complies with the requirements of federal laws and regulations, including a description of available internal appeals and external review processes. The Company failed to include the appropriate appeals language in the first-level determination letter for the noted complaint file.

K. Consumer Complaints Received

Examiners requested that the Company identify all consumer complaints received during the experience period. The Company identified a universe of 318 consumer complaints and the examiners selected a random sample of 84 documents for review. The documents were reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 31 Pa. Code §§ 146.5 and 154.1. In addition to a data integrity violation discussed below, the following violations were noted:

3 Violations – 40 P.S. § 991.2141(b)(3)

A managed care plan shall establish and maintain an internal complaint process with two levels of review by which an enrollee shall be able to file a complaint regarding a participating health care provider or the coverage, operations or management policies of the managed care plan. The complaint process shall consist of an initial review to include the allowance of written data or other information. The Company failed to send an acknowledgement letter informing the enrollee of their right to submit written data or other information to be considered in making the decision or the letter was not sent in advance of the decision letter for the three noted complaint files.

1 Violation – 40 P.S. § 991.2141(b)(5)

A managed care plan shall establish and maintain an internal complaint process with two levels of review by which an enrollee shall be able to file a complaint regarding a participating health care provider or the coverage, operations, or management policies of the managed care plan. The complaint process shall consist of an initial review to include a written notification to the enrollee regarding the decision of the initial review committee within five business days of the decision. Notice shall include the basis for the decision and the procedure to file a request for a second-level review of the decision of the initial review committee. The Company failed to communicate a decision on all matters included in the complaint for the noted complaint file.

4 Violations – 40 P.S. § 991.2141(c)(1)

A managed care plan shall establish and maintain an internal complaint process with two levels of review by which an enrollee shall be able to file a complaint regarding a participating health care provider or the coverage, operations or management policies of the managed care plan. The complaint process shall include a second-level review that includes a review of the decision of the initial review committee by a second-level review committee consisting of three or more individuals who did not participate in the initial review. At least one-third of the second-level review committee shall not be employed by the managed care plan. The Company failed to review the decision of the initial review by a second-level review committee consisting of three or more individuals who did not participate in the initial review and one of which is not an employee of the managed care plan for the four noted complaint files.

4 Violations – 40 P.S. § 991.2142(a)

An enrollee shall have 15 days from receipt of the notice of a decision from the second-level review committee to appeal the decision to the Department of Health or the Insurance Department, as appropriate. The Company failed to inform enrollees of the 15-day timely filing period for filing an appeal in the four noted complaint files.

2 Violations – 31 Pa. Code § 154.17(e)

Managed care plans shall complete the initial level of review of an enrollee complaint within 30 days of receipt of the complaint. The plan shall notify the enrollee in writing of plan's decision following the initial review within five business days of the decision. The notification shall include the basis for the decision and the procedure to file a request for a second-level review of the decision of the initial review committee. The Company failed to respond to the enrollee in a timely manner in the two noted complaint files.

1 Violation – 31 Pa. Code § 154.17(f)

Managed care plans shall complete the second level of review of an enrollee complaint within 45 days of receipt of the enrollee's request for review. The enrollee has the right to appear before the second-level review committee. The plan shall notify the enrollee in writing within five business days of the rendering of a decision by the second-level complaint review committee, including the basis for the decision and the procedure to file a request for a second-level review of the decision of the initial review committee. The Company failed to provide the enrollee adequate notification of their right to appear before the second-level review committee for the noted complaint file.

L. First-Level Internal Appeals

Examiners requested that the Company identify all first-level internal appeals received during the experience period. The Company identified 339 first-level internal appeals and examiners selected a random sample of 84 documents for review. The documents were reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 31 Pa. Code §§ 146.5 and 154.17. The following violations and concerns were noted:

2 Violations – 31 Pa. Code § 146.3

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

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

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan shall have an internal claims appeal process, provide notice to enrollees in a culturally and linguistically appropriate manner of available internal and external appeals processes, provide notice of the availability of consumer assistance, and allow an enrollee to review their file, present evidence and testimony as part of the appeals process, and receive continued coverage pending the outcome of the appeals process. The Company failed to send in advance of the decision letter an acknowledgement letter informing enrollees of their rights regarding submitting additional information to be considered in the Company's decision-making process in the 12 noted complaint files.

19 Violations – 45 C.F.R. § 147.136, incorporating 29 C.F.R. § 2560.503-1

In the case of group health plans and health insurance issuers, the claimant shall be notified of the benefit determination on review within a reasonable amount of time. The Company failed to process appeals pursuant to defined timelines in the noted complaint files.

VI. PRODUCER LICENSING

Examiners requested documentation relating to producer licensing, including policies and procedures regarding systems, record-keeping, and verification. Unless noted, all documents identified in the universe by the Company were requested, received, and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with applicable standards found in 40 P.S. §§ 310.1 et seq.

A. Active Producers

Examiners requested a list of all producers active during the experience period. The Company identified a universe of 2,781 active producers during the experience period. A random sample of 125 active producers was selected for review. The records were compared to Department records of producers to verify appointments, terminations, and licensing, as well as the Federally-facilitated Marketplace Registration Status List. In accordance with the requirements of the examination, the records were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. § 310.71(f) and 45 C.F.R. § 155.220, using the guidelines set forth in Chapter 16, Section D, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Terminated Producers

Examiners requested a list of all producers terminated during the experience period. The Company identified a universe of 342 terminated producers. A random sample of 94 terminated producers was selected for review. In accordance with the requirements of the examination, appointments, terminations, and licensing records were reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 45 C.F.R. § 155.220, using the guidelines set forth in Chapter 16, Section D, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Account Balances

Examiners requested documentation showing that producer contracts' account balances were maintained in accordance with producer contracts for the experience period. The Company identified a universe of one document. The producer and agency contract agreements and commission schedules were reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section D, Standard 6 of the *NAIC Market Regulation Handbook*. No violations were noted.

D. Description of Agency System

Examiners requested a description of the type of agency system utilized by the Company during the experience period. The Company identified a universe of one document with a description of how their agency system operates with regard to agent activity. The document was reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

E. Licensing and Appointment Verification

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

VII. POLICYHOLDER SERVICES

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

A. Collection Billing Practices

Examiners requested policies and procedures used for collection/billing practices describing requirements for issuance of notices with required advance notice. The Company identified a universe of five documents and supplied four additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination, all nine documents were reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section E, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Timely Policy Issuance and Insured-Requested Cancellations

Examiners requested documentation describing requirements for timely policy issuance, insured-requested cancellations, and all correspondence directed to the Company 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, all seven documents were reviewed to ensure compliance with applicable state laws and regulations, using the guidelines set forth in

Chapter 16, Section E, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Correspondence Received by the Company

Examiners requested documentation describing the requirements for timely and responsive answers by appropriate Company departments to all correspondence directed to the Company during the experience period. The Company identified a universe of five documents and supplied 22 additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination, all 27 documents were reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section E, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

D. Assumption Reinsurance Agreements

Examiners requested documentation demonstrating that, whenever the Company transferred the obligation of its contracts to another regulated entity pursuant to an assumption reinsurance agreement during the experience period, the Company had sent the required notices to affected policyholders. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state laws and regulations, using the guidelines set forth in Chapter 16, Section E, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

E. Policies with Service-Related Transactions

Examiners requested a list of service-related transactions, including policy addition requests, dropped policy transactions, and individual ID change transactions, that occurred during the experience period. The Company identified a universe of three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section E, Standard 5 of the *NAIC Market Regulation Handbook*. No violations were noted.

F. Premium Refunds

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

G. Reinstatement

Examiners requested documentation demonstrating how the Company monitored and assured that reinstatement was applied consistently and in accordance with policy provisions and state laws and regulations applicable during the experience period. The Company identified a universe of five documents and supplied 20 additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination, all 25 documents were reviewed to ensure compliance with applicable state laws and regulations noted above, as well as 40 P.S. § 753(A)(4), using the guidelines set forth in Chapter 20, Section E, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

H. Unearned Premium and Refunds

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

I. Premium and Billing Notices

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

J. Cancelled Policies

Examiners requested a list of cancelled policies that occurred during the experience period. The Company identified a universe of two documents, which showed that 311 policies were cancelled for non-payment during the experience period. In accordance with the requirements of the examination, the policies were reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 45 C.F.R. § 155.430, using guidelines set forth in Chapter 16, Section E, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

K. Cancelled Policy Refunds

Examiners requested a list of refunds resulting from cancelled policies that occurred during the experience period. The Company identified a universe of one document, which indicated that 151 policies were cancelled and required a refund during the experience period. In accordance with the requirements of the examination, the policies were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 16, Section E, Standard 5 of the *NAIC Market Regulation Handbook*. No violations were noted.

L. Policy Reinstatements

Examiners requested a list of policy reinstatements requested during the experience period. The Company identified a universe of two documents, which indicated that 338 policies were reinstated. In accordance with the requirements of the examination, the policies were

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

VIII. UNDERWRITING AND RATING

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

A. Rating Schedules

Examiners requested rating schedules for major medical health individual, small group, and large group plans subject to consumer protection provisions of the Affordable Care Act effective during the experience period. The Company identified a universe of six documents. The Company reported that they did not perform large group rating during this period. In accordance with the requirements of the examination, the rating schedules were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 16, Section F, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Mandated Disclosures

Examiners requested documentation demonstrating how the Company assured that all mandated disclosures were issued in accordance with state and federal laws and regulations applicable during the experience period. The Company provided a list of 39 policy form informational documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 16, Section F, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Prohibition of Illegal Rebating

Examiners requested documentation demonstrating how the Company assured that it did not permit illegal rebating, commission-cutting, or inducements during the experience period. The Company identified a universe of eight documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations noted above, as well as 40 P.S. §§ 310.45, 310.46, and 471, using the guidelines set forth in Chapter 16, Section F, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

D. Underwriting Practices

Examiners requested documentation demonstrating that the Company's underwriting practices were not unfairly discriminatory and that the Company adhered to state and federal laws and regulations applicable during the experience period. Examiners also reviewed Company guidelines relating to selection of risks. The Company identified a universe of one document. In accordance with the requirements of the examination, the document provided, as well as other materials provided throughout the Underwriting and Rating review process, were reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 40 P.S. §§ 477a, 761, and 1171.5(a)(7); and 45 C.F.R. §§ 146.121 and 147.110, using the guidelines set forth in Chapter 16, Section F, Standard 4, and Chapter 20, Section F, Standard 7 of the *NAIC Market Regulation Handbook*. No violations were noted.

E. Form Filing

Examiners requested documentation establishing the Company's processes to assure that all forms, including policies, contracts, riders, amendments, endorsement forms, and certificates, were filed with the Department for the experience period. The Company provided 13 forms—four small group policy forms, four large group policy forms, and five combination plans along with certificates of coverage for each category. In accordance with the requirements of the examination, all 13 policy forms were reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 31 Pa. Code §§ 152.3 and 301.42, using the guidelines set forth in Chapter 16, Section F, Standard 5 of the *NAIC Market Regulation Handbook*. No violations were noted.

F. Issue and Renewal

Examiners requested documentation demonstrating that policies, contracts, riders, amendments, and endorsements were issued or renewed accurately, timely, and completely during the experience period. The Company identified a universe of two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 45 C.F.R. §§ 147.104 and 147.106, using the guidelines set forth in Chapter 16, Section F, Standard 6 of the *NAIC Market Regulation Handbook*. No violations were noted.

G. Policy Rejections and Declinations

Examiners requested documentation demonstrating the Company's rejections and declinations during the experience period were not unfairly discriminatory. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 42 U.S.C. § 300gg-4(a)(1) and 45 C.F.R. §§ 146.121 and 147.110, using the guidelines set forth in Chapter 16, Section F, Standard 7 of the *NAIC Market Regulation Handbook*. No violations were noted.

H. Cancellation Notices

Examiners requested documentation demonstrating that cancellation/nonrenewal, discontinuance, and declination notices complied with policy and contract provisions, Company guidelines, and state and federal laws and regulations applicable during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 45 C.F.R. § 155.230, using the guidelines set forth in Chapter 16, Section F, Standard 8, and Chapter 20, Section F, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

I. Rescissions

Examiners requested documentation demonstrating that rescissions were not made for non-material misrepresentation during the experience period. The Company identified a universe of three

documents. Examiners further requested documentation demonstrating that the Company did not retrospectively rescind coverage unless the individual (or a person seeking coverage on behalf of the individual) performed an act, practice or omission that constituted fraud, or made an intentional misrepresentation of material fact during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 45 C.F.R. § 147.128, using the guidelines set forth in Chapter 16, Section F, Standard 9, and Chapter 20A, Rescissions, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted**.**

J. Information on Policy Forms

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

K. COBRA and Mini-COBRA

Examiners requested documentation demonstrating that the Company complied with the provisions of COBRA and/or continuation of benefits procedures contained in policy forms, and state and federal laws and regulations applicable during the experience period. The Company identified a universe of 16 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 40 P.S. § 764j and 29 U.S.C §§ 1161 et seq., using the guidelines set forth in Chapter 20, Section F, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

L. Genetic Information Nondiscrimination Act Compliance

Examiners requested documentation demonstrating that the Company complied with the Genetic Information Nondiscrimination Act of 2008 and Pennsylvania law. The Company identified a universe of two documents. In accordance with the requirements of the examination, the documents

were reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 40 P.S. §§ 908-11 et seq., and 45 C.F.R. §§ 146.121 and 146.122, using the guidelines set forth in Chapter 20, Section F, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

M. Health Information Protection

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

N. Pre-existing Conditions

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

O. Coverage Discrimination Based on Health Status

Examiners requested documentation demonstrating that the Company did not improperly deny coverage or discriminate based on health status in the group market or against eligible individuals in the individual market in conflict with the requirements of state and federal laws and regulations applicable during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 40 P.S.

§§ 908-11 et seq., and 45 C.F.R. §§ 146.121 and 147.110, using the guidelines set forth in Chapter 20, Section F, Standard 7 of the *NAIC Market Regulation Handbook*. No violations were noted.

P. Compliance with Guaranteed Issuance

Examiners requested documentation demonstrating that the Company issued coverage that complied with guaranteed-issue requirements of state and federal laws and regulations applicable during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 40 P.S. §§ 1302.1 et seq., 42 U.S.C. 300gg-1, and 45 C.F.R. § 147.104, using the guidelines set forth in Chapter 20, Section F, Standards 8 and 9, and Chapter 20A, Guaranteed Availability of Coverage, Standards 1 and 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

Q. Individual Portability

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

R. Clinical Trials

Examiners requested documentation demonstrating that the Company did not deny or restrict coverage for qualified individuals, as defined in state and federal laws and regulations, who participated in approved clinical trials during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with state and federal laws and regulations noted above, as well as 42 U.S.C. § 300gg-8, using the guidelines set forth in Chapter 20A, Coverage for Individuals Participating in Approved Clinical Trials, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

S. Dependent Coverage

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

T. Group Health Plan Renewability

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

U. Lifetime Limits

Examiners requested documentation demonstrating that the Company did not establish lifetime or annual limits on the dollar amount of essential health benefits (EHBs) for any individual, in accordance with final regulations established by HHS, DOL, and Treasury during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the provided document, as well as other documents requested during the Underwriting and Rating review process, were reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 42 U.S.C. § 300gg-11 and 45 C.F.R. § 147.126, using the guidelines set forth in Chapter 20A, Lifetime/Annual Benefits Limits, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

V. Cost-Sharing Requirements

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

W. Mental Health Parity and Addiction Equity Act Compliance

Examiners requested documentation demonstrating that the Company complied with state law and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which prohibits health insurance issuers that provide mental health or SUD benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits during the experience period. The Company identified a universe of six documents. In accordance with the requirements of the examination, the documents, as well as other documents requested during the Underwriting and Rating review process, were reviewed to ensure compliance with applicable state and federal laws and regulations noted above, as well as 40 P.S. §§ 908-1 et seq. and 908-11 et seq., 42 U.S.C. § 300gg-26, and 45 C.F.R. § 146.136. No violations were noted with respect to underwriting and rating practices.

X. 30-Day Notice

Examiners requested documentation demonstrating that, before coverage was rescinded during the experience period, the Company provided at least 30 days' advance written notice to each plan enrollee (or, in the individual market, primary subscriber) who would be affected. The Company identified a universe of six documents. In accordance with the requirements of the examination, the provided documents, as well as documents requested during the Underwriting and Rating review process, were reviewed to ensure compliance with applicable state and federal laws and regulations

noted above, as well as 45 C.F.R. § 147.128, using the guidelines set forth in Chapter 20A, Rescissions, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

IX. CLAIMS PROCEDURES

Examiners requested documentation relating to claims procedures, including policies and procedures for claims handling, record keeping, dispositions, and timelines. Unless noted, all documents identified in the universe by the Company were requested, received, and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with applicable standards found in 40 P.S. § 1171.5 and 31 Pa. Code Ch. 146.

A. Claimant Contact

Examiners requested documentation demonstrating that the initial contact with the claimant occurred within the required timeframe applicable during the experience period. The Company identified a universe of 84 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations noted above, specifically 31 Pa. Code § 146.5, as well as 45 C.F.R. § 155.230, using the guidelines set forth in Chapter 16, Section G, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Timely Investigations

Examiners requested documentation demonstrating that investigations were conducted timely during the experience period. The Company identified a universe of 84 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations noted above, as well as 45 C.F.R. §§ 147.136 and 156.1010, using the guidelines set forth in Chapter 16, Section G, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Timely Claims Resolution

Examiners requested documentation demonstrating that claims were resolved in a timely manner during the experience period. The Company identified a universe of 84 documents. In accordance with the requirements of the examination, the documents were reviewed to

ensure compliance with applicable state laws and regulations noted above, as well as 45 C.F.R. §§ 147.136 and 156.1010, using the guidelines set forth in Chapter 16, Section G, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

D. Claims Handling

Examiners requested a brief description of how claims were handled during the experience period, from the date received through closure, including timeliness requirements. The Company identified a universe of two documents. 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 84 documents. In accordance with the requirements of the examination, all 86 documents were reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section G, Standard 6, and Chapter 20, Section G, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

E. Claims Forms

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

F. Claim Reserves

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

G. Denied and Closed-without-Payment Claims

Examiners requested documentation demonstrating that denied and closed-without-payment claims were handled in accordance with policy provisions and state laws and regulations applicable during the experience period. The Company identified a universe of 12 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section G, Standard 9 of the *NAIC Market Regulation Handbook*. No violations were noted.

H. Cancelled Benefit Checks

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

I. Claims Closing Practices

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

J. Claims Handling Practices

Examiners requested documentation demonstrating that claim files were handled in accordance with policy provisions and state laws and regulations applicable during the experience period. The Company identified a universe of seven documents. In accordance

with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 20, Section G, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

K. Newborns' and Mothers' Protection Act

Examiners requested documentation demonstrating that the Company complied with the 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. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations noted above, as well as 40 P.S. §§ 1581 through 1584, and 42 U.S.C. § 300gg-25, using the guidelines set forth in Chapter 20, Section G, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

L. Mental Health Parity and Addiction Equity Act

Examiners requested documentation demonstrating that the Company complied with the requirements of the federal Mental Health Parity and Addiction Equity Act of 2008 and the Pennsylvania Health Insurance Coverage Parity and Nondiscrimination Act. The Company identified a universe of three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations noted above and 40 P.S. §§ 908-1 et seq. and 908-11 et seq., as well as 42 U.S.C. § 300gg-26, and 45 C.F.R § 146.136, using the guidelines set forth in Chapter 20, Section G, Standard 3 of the *NAIC Market Regulation Handbook*. Numerous violations were noted; however, violations and concerns relating to the processing and payment of mental health and SUD claims have been addressed in other sections of this Examination Report.

Concern: It is recommended that the Company revise its policies and Certificates of Coverage to ensure that it is clear to members that Mental Health Parity requirements apply to services provided for autism spectrum disorders (ASD).

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

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

N. Group Coverage Replacements

Examiners requested documentation demonstrating that the Company complied with state laws and regulations for group coverage replacements applicable during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state laws and regulations noted above, as well as 31 Pa. Code § 89.93, using the guidelines set forth in Chapter 20, Section G, Standard 5 of the *NAIC Market Regulation Handbook*. No violations were noted.

X. GRIEVANCES

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

A. Grievances

Examiners requested documentation demonstrating that the Company treated as a grievance any written complaint, or any oral complaint that involved an urgent care request, submitted by or on behalf of a covered person regarding: 1) the availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; 2) claims payment, handling or reimbursement for health care services; or 3) matters pertaining to the contractual relationship between a covered person and the health carrier during the experience period. The Company identified a universe of 29 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using guidelines set forth in Chapter 20, Section H, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Grievance Procedures

Examiners requested documentation demonstrating that the Company documented, maintained, and reported grievances, and established and maintained grievance procedures in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of 17 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance

with applicable state and federal laws and regulations using guidelines set forth in Chapter 20, Section H, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Grievance Procedure Disclosure

Examiners requested documentation demonstrating how the Company implemented grievance procedures and how these procedures were disclosed to covered persons in compliance with state and federal laws and regulations applicable during the experience period. Examiners requested copies of files showing the Company's grievance procedures, including all forms used to process grievances during the experience period, that were filed with the Department. The Company identified a universe of one document and supplied 10 additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination, all 11 documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section H, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

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

Examiners requested documentation demonstrating that the Company had procedures for and conducted first-level reviews of grievances involving adverse benefit determinations in compliance with state and federal laws and regulations applicable during the experience period. 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, all eight documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section H, Standard 4, and Chapter 20A, Grievance Procedures, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

E. Grievance Reviews Not Involving Adverse Determination

Examiners requested documentation demonstrating that the Company had procedures for and conducted standard reviews of grievances not involving adverse benefit determinations in compliance with state and federal laws and regulations applicable during the experience

period. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section H, Standard 5 of the *NAIC Market Regulation Handbook*. No violations were noted.

F. Second-Level Reviews of Grievances

Examiners requested documentation demonstrating that the Company had procedures for second-level reviews of grievances, and that the Company conducted voluntary reviews of grievances in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of seven documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws using the guidelines set forth in Chapter 20, Section H, Standard 6 of the *NAIC Market Regulation Handbook*. No violations were noted.

G. Expedited Review of Grievances

Examiners requested documentation demonstrating that the Company had procedures for and conducted expedited reviews of grievances involving adverse determinations in compliance with state and federal laws and regulations 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, all three documents were reviewed to ensure compliance with applicable state and federal laws using guidelines set forth in Chapter 20, Section H, Standard 7, and Chapter 20A, Grievance Procedures, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

H. Grievance Procedures Comply with Federal Law

Examiners requested documentation demonstrating that the Company's grievance procedures were properly handled in accordance with policy provisions and federal laws and regulations applicable during the experience period. The Company identified a universe of two documents and supplied two additional documents in response to an examiner-issued

information request. In accordance with the requirements of the examination, all four documents were reviewed to ensure compliance with applicable federal laws and regulations using guidelines set forth in Chapter 20, Section H, Standard 7, and Chapter 20A, Grievance Procedures, Standard 2. No violations were noted.

I. Grievance Records Maintenance

Examiners requested documentation demonstrating that the Company's grievance procedures were properly handled in accordance with federal laws and regulations requiring individual health insurance coverage to maintain records of all claims and notices associated with the internal claims and appeals process for the length of time specified in the final regulations established by HHS, DOL, and Treasury. The Company identified a universe of five documents and supplied three additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination, all eight documents were reviewed to ensure compliance with applicable federal laws and regulations using guidelines set forth in Chapter 20A, Grievance Procedures, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

J. Compliance with Federal Requirements for Grievance Handling

Examiners requested documentation demonstrating that the Company's grievance procedures were properly handled in accordance with federal laws and regulations requiring the Company to comply with grievance procedures requirements, in accordance with final regulations established by HHS, DOL, and Treasury. 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, all three documents were reviewed to ensure compliance with applicable federal laws using guidelines set forth in Chapter 20A, Grievance Procedures, Standard 2 of the *NAIC Market Regulation Handbook.* No violations were noted.

XI. NETWORK ADEQUACY

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

A. Reasonable Criteria for Network

Examiners requested documentation demonstrating that the Company used reasonable criteria to maintain a network that was sufficient in number and types of providers to ensure that all services to covered persons would be accessible without unreasonable delay during the experience period. The Company identified a universe of three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using guidelines set forth in Chapter 20, Section I, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Access Plan Filed

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

C. Contract Forms Filed

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

D. Access to Emergency Services

Examiners requested documentation demonstrating that, during the experience period, the Company ensured covered persons had access to emergency services 24 hours per day, seven days per week within its network and provided coverage for emergency services outside of its network. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations noted above, specifically 31 Pa. Code §§ 152.15 and 301.62(c), and 45 C.F.R. § 147.138, using the guidelines set forth in Chapter 20, Section I, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

E. Provider Directory

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

F. Accrediting Certification

Examiners requested a copy of the Company's HHS-recognized accrediting entity certification or a copy of the Company's network access plan for the experience period. The Company provided documentation of its network access plan that lists how documentation and providers who participate in its network were handled during the experience period. In accordance with the examination, the documentation was reviewed for compliance with applicable state and federal laws and regulations noted above, as well as 45 C.F.R. § 156.275. No violations were noted.

XII. PROVIDER CREDENTIALING

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

A. Credentialing and Recredentialing Program

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

B. Accrediting Verification

Examiners requested documentation demonstrating that the Company verified the credentials of health care professionals before entering into a contract with the health care professionals during the experience period. Examiners also requested documentation demonstrating that the Company obtained, through a primary or secondary credentialing verification process, the information required by state laws and regulations applicable during the experience period. The Company identified a universe of two documents and supplied five additional documents in response to an examiner-issued information request. In accordance with the requirements of the examination, all seven documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the

guidelines set forth in Chapter 20, Section J, Standards 2 and 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Primary Verification

Examiners requested documentation demonstrating that the Company obtained primary or secondary verification of information required by state laws and regulations applicable during the experience period. The Company identified a universe of two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section J, Standards 3 and 5 of the *NAIC Market Regulation Handbook*. No violations were noted.

D. Provider Notification of Changes in Status

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

E. Provider Opportunity to Review

Examiners requested documentation demonstrating that the Company provided to health care professionals the opportunity to review and correct information submitted in support of their credentialing verification for the experience period. The Company identified a universe of two documents. In accordance with the requirements of the examination, the provided documents, as well as five additional documents provided during the Provider Credentialing review process, were reviewed to ensure compliance with applicable state and

federal laws and regulations using the guidelines set forth in Chapter 20, Section J, Standard 7 of the *NAIC Market Regulation Handbook*. No violations were noted.

F. Contractor Credentialing Monitoring

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

XIII. QUALITY ASSESSMENT AND IMPROVEMENT

Examiners requested documentation relating to quality assessment and improvement, including policies and procedures for quality assessment, filings, reporting, communication, and certification. Unless noted, all documents identified in the universe by the Company were requested, received, and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with applicable standards found in 28 Pa. Code Ch. 9, 42 U.S.C. § 18031 and 45 C.F.R. §§ 155.200(d) and 156.1105 et seq.

A. Quality Assessment

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

B. Quality Assessment Filing

Examiners requested documentation demonstrating that the Company filed a written description of the quality assessment program in the prescribed format, which included a signed certification by a corporate officer of the Company that the filing met federal requirements applicable during the experience period. The Company identified a universe of two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section K, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Quality Improvement Program

Examiners requested documentation demonstrating that the Company developed and maintained a quality improvement program in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of five documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section K, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

D. Reports to Appropriate Licensing Authority

Examiners requested documentation demonstrating that the Company reported to the appropriate licensing authority any persistent pattern of problematic care provided by a provider that was sufficient to cause the Company to terminate or suspend contractual arrangements with the provider during the experience period. The Company identified a universe of five documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section K, Standard 4 of *the NAIC Market Regulation Handbook*. No violations were noted.

E. Quality Assessment Program Communication

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

F. Annual Certification of Program

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

G. Quality Assessment and Improvement Entity Monitoring

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

XIV. UTILIZATION REVIEW

Examiners requested documentation relating to utilization review, including policies and procedures for utilization review, reporting, operations, disclosure, timelines, and monitoring. Unless noted, all documents identified in the universe by the Company were requested, received, and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with applicable standards found in 40 P.S. §§ 991.2136, 991.2151, and 991.2152; 28 Pa. Code Ch. 9, and accreditation standards found at 45 C.F.R. § 156.275.

A. Utilization Review Program

Examiners requested documentation demonstrating that the Company established and maintained a utilization review program in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of nine documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section L, Standard 1 of the *NAIC Market Regulation Handbook*. The following concern was noted:

Concern: The examiners reviewed the Approval and Certification Notices Policy provided by the Company. The language used may have the potential to be misleading as the statute specifies a clear requirement to "Provide all decisions in writing to include the basis and clinical rationale for the decision." The Company's insert of the policy appears to indicate that certification/approval should be provided in writing only when it is not the standard practice. It is recommended that the language of the policy be modified to make clear all certifications/approvals are to be provided in writing per Pennsylvania statute.

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

C. 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 27 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section L, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

D. Utilization Review Disclosure

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

E. Timely Standard Utilization Review

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

F. Adverse Determination of Utilization Review

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

G. Expedited Utilization Review and Benefit Determinations

Examiners requested documentation demonstrating that the Company conducted expedited utilization review 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 two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section L, Standard 6 of the *NAIC Market Regulation Handbook*. No violations were noted.

H. Emergency Services Utilization Review

Examiners requested documentation demonstrating that the Company conducted utilization reviews or made benefit determinations for emergency services in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20A, Utilization Review, Standard 4 of the *NAIC Market Regulation Handbook*. The following concern was noted:

Concern: The handbook response provided indicates that "UCS" does not conduct utilization review for treatment of emergency services. The Company did not define "UCS" in its response and did not appropriately respond to examiner requests for information related to the existence of policies or procedures. The Company is encouraged to clearly define all acronyms and provide greater detail based on information requested when responding to all examination inquiries.

I. Monitoring Utilization Review Entity

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

XV. MEDICAL AND PHARMACY CLAIMS REVIEW

Examiners requested a list of all medical and pharmacy claims paid, denied, partially paid, and closed without payment during the experience period. The Company identified a universe of 980,877 medical claims. A random sample of claim files was requested, received, and reviewed for the following types of claims:

A. Medical Claims
B. Mammogram Claims
C. Medical Foods Claims
D. Autism Claims
E. Emergency Services Claims
F. Ambulance Claims
G. Substance Use Disorder Claims
H. Mental Health Claims
I. Pharmacy Claims – Mental Health and Substance Use Disorder Claims and Medical Foods 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.

During the claims review process, examiners found numerous instances in which the Company mailed out explanations of benefits (EOBs) that misrepresented the activity of the associated claim. In some cases, the Company's adjudication process resulted in premature issuance of member EOBs, which inaccurately reflected the final outcome of claims adjudication and incorrect cost-sharing accumulators. Because this may have caused confusion for members, the Company is encouraged to review its EOBs and claims adjudication policies, procedures, and processes for possible improvements.

For all claims in which the Company incorrectly denied all or part of the claim, or in other circumstances leading to overpayment by a consumer, such as problems with accumulator calculations, the Company shall provide proof of payment, including interest if applicable.

A. Medical Claims

Examiners requested lists of all medical claims paid, denied, partially paid, and closed without payment during the experience period. In accordance with the requirements of the examination, medical claim files were reviewed to ensure compliance with applicable state and federal laws and regulations. The random sample of medical claims included mammogram and ASD claims, which were tested for compliance with all applicable state and federal laws, including those specific to mammograms (40 P.S. § 764c) and ASD (40 P.S. § 764h and Act 68) as appropriate. In addition, examiners requested identification of specific universes relating to mammogram claims and autism claims, which were reviewed separately and discussed in subsections B and D below. Examiners found violations in three of the four sections. No violations were found in the paid claims section.

Medical Paid Claims

Examiners requested a list of all medical claims paid during the experience period. The Company identified a universe of 601,028 paid medical claims. A random sample of 109 paid medical claim files was requested and reviewed. No violations were noted.

Medical Denied Claims

Examiners requested a list of all medical claims denied during the experience period. The Company identified a universe of 83,615 denied medical claims. A random sample of 109 claims was requested. Upon review, it was determined that six files were not provided. In accordance with the requirements of the examination, the remaining 103 files were reviewed. The following violations were noted:

1 Violation – 40 P.S. § 764c

Coverage for mammographic examinations, at a minimum, shall include all costs associated with a mammogram every year for women 40 years of age or older and with any mammogram based on a physician's recommendation for women under 40 years of age.

AND

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

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum, provide coverage for and shall not impose any cost-sharing requirements for, with respect to women, preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. The Company failed to provide coverage for mammography, or digital breast tomosynthesis, for the noted claim file**.**

1 Violation – 40 P.S. § 764h(a)

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

10 Violations – 40 P.S. § 991.2166(a)

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

AND

31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the 10 noted claims within 45 days of receipt.

40 P.S. § 1171.5(a)(10)(iii)

"Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. (iii)

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

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

"Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (v) 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. Affirming or denying services did not occur in a reasonable time although proof of loss appeared to have been established in the eight noted claim files.

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

"Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (vi) 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's liability was reasonably clear, but claims were not paid or were not paid in a prompt manner in the eight noted claim files.

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

"Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (xiv) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement. A reasonable explanation for services was not provided for the three noted claim files.

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

8 Violations – 31 Pa. Code § 146.6

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

Medical Partially-Paid Claims

Examiners requested a list of all medical claims partially paid during the experience period. The Company identified a universe of 56,607 partially-paid medical claims. A random sample of 109 claim files was requested and reviewed. The following violations were noted:

2 Violations – 40 P.S. § 991.2166(a)

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

AND

31 Pa Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the two noted claims within 45 days of receipt.

AND

40 P.S. § 1171.5(a)(10)(iii)

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

2 Violations – 31 Pa. Code § 146.6

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

2 Violations – 40 P.S. § 764c

Coverage for mammographic examinations, at a minimum, shall include all costs associated with a mammogram every year for women 40 years of age or older and with any mammogram based on a physician's recommendation for women under 40 years of age.

AND

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

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum, provide coverage for and shall not impose any cost-sharing requirements for, with respect to women, preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. The Company failed to provide coverage for mammography, or digital breast tomosynthesis, for the two noted claim files.

Medical Closed-without-payment Claims

Examiners requested a list of all medical claims closed without payment during the experience period. The Company identified a universe of 25,577 medical claims that were closed without payment. A random sample of 109 claims was requested and reviewed. The following violations were noted:

17 Violations – 40 P.S. § 991.2166(a)

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

AND

31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the 17 noted claims within 45 days of receipt.

AND

40 P.S. § 1171.5(a)(10)(iii)

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

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

“Unfair Methods of Competition” and “Unfair or Deceptive Acts or Practices” in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. (iv) Refusing to pay claims without conducting a reasonable investigation based upon all available

information. The Company denied claims without conducting a reasonable investigation as the noted members had active coverage on the date of service for the listed claim. The Company noted as a reason for the denial or delay that the requested additional information from the member and/or providers was not received. No proof of the Company's request for information was contained in the eight noted claims files and the received information does not appear to have been evaluated.

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

"Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (v) 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. Affirming or denying services did not occur in a reasonable time although proof of loss appeared to have been established in the noted claim file.

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

"Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (vi) 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's liability was reasonably clear, but claims were not paid or were not paid in a prompt manner in the four noted claim files.

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

If a licensed insurer or a managed care plan fails to remit payment as required, interest at 10% per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The Company failed to pay the 14 noted claims timely and interest of $2 or more remains unpaid.

10 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 records in the 10 noted claim files. Specifically, examiners noted that authorizations, referrals and other expected correspondence were not maintained in the 10 noted claim files sufficient to evaluate the Company's claims adjudication process.

17 Violations – 31 Pa. Code § 146.5(a)

Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice. The Company failed to acknowledge submitted claims within 10 working days in the 17 noted claim files.

24 Violations – 31 Pa. Code § 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to complete the investigation of the claim within 30 days after notification of the claim and to provide timely 45-day status letters for the 24 noted claim files.

B. Mammogram Claims

Examiners requested lists of all mammogram claims paid, denied, partially paid, and closed without payment during the experience period. In accordance with the requirements of the examination, mammogram claim files were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 764c, 991.2166, and 1171.5; 31 Pa. Code Ch. 146 and 154; 18 Pa. C.S. § 4117; 42 U.S.C. §§ 300gg-6, 300gg-13, and 18022; and 45 C.F.R. §§ 147.130 and

147.150. Examiners found violations in three of the four sections. No violations were found in the paid claims section.

Mammogram Paid Claims

Examiners requested a list of all mammogram claims paid during the experience period. The Company identified a universe of 6,946 mammogram paid claims. A random sample of 109 claim files was requested and reviewed. No violations were noted.

Mammogram Denied Claims

Examiners requested a list of all mammogram claims denied during the experience period. The Company identified a universe of 1,283 mammogram denied claims. A random sample of 107 claim files was requested and reviewed. The following violations were noted:

7 Violations – 40 P.S. § 764c

Coverage for mammographic examinations, at a minimum, shall include all costs associated with a mammogram every year for women 40 years of age or older and with any mammogram based on a physician's recommendation for women under 40 years of age.

AND

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

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum, provide coverage for and shall not impose any cost-sharing requirements for, with respect to women, preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. The Company denied coverage for mammography, or digital breast tomosynthesis, for the seven noted claim files.

1 Violation – 40 P.S. § 991.2166(a)

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

AND

31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the noted claim within 45 days of receipt.

AND

40 P.S. § 1171.5(a)(10)(iii)

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

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: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (vi) 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’s liability was reasonably clear, but claims were not paid or were not paid in a prompt manner in the seven noted claim files.

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

“Unfair Methods of Competition” and “Unfair or Deceptive Acts or Practices” in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (xiv) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation

to the facts or applicable law for denial of a claim or for the offer of a compromise settlement. A reasonable explanation for services was not provided for the noted claim file.

Mammogram Partially-Paid Claims

Examiners requested a list of all mammogram claims partially paid during the experience period. The Company identified a universe of 799 partially-paid mammogram claims. A random sample of 105 claim files was requested and reviewed. The following violations were noted:

2 Violations – 40 P.S. § 991.2166(a)

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

AND

31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the two noted claims within 45 days of receipt.

AND

40 P.S. § 1171.5(a)(10)(iii)

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

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

“Unfair Methods of Competition” and “Unfair or Deceptive Acts or Practices” in the business of insurance means: Any of the following acts if committed or performed with such frequency as to

indicate a business practice shall constitute unfair claim settlement or compromise practices: (xiv) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement. A reasonable explanation for services was not provided for the noted claim file.

1 Violation – 31 Pa. Code § 146.6

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

Mammogram Closed-without-payment Claims

Examiners requested a list of all mammogram claims closed without payment during the experience period. The Company identified a universe of seven closed mammogram claims. All seven files were requested and reviewed. The following violations were noted:

1 Violation - 40 P.S. § 1171.5(a)(10)(iii)

"Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. (iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies. The Company failed to affirm or deny coverage of claims within a reasonable time for the noted claim file.

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

“Unfair Methods of Competition” and “Unfair or Deceptive Acts or Practices” in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (xiv) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation

to the facts or applicable law for denial of a claim or for the offer of a compromise settlement. A reasonable explanation for services was not provided for the noted claim file.

3 Violations – 31 Pa. Code § 146.6

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

C. Medical Foods Claims

Examiners requested lists of all medical foods claims paid, denied, partially paid, and closed without payment during the experience period. In accordance with the requirements of the examination, medical foods claim files were reviewed to ensure compliance with 40 P.S. §§ 991.2166, 1171.5, and 3901 et seq.; 31 Pa. Code Ch. 146 and 154; 18 Pa. C.S. § 4117; 42 U.S.C. §§ 300gg-6, 300gg-13, and 18022; and 45 C.F.R. § 147.150. Examiners found violations in two of the four sections.

Medical Foods Paid Claims

Examiners requested a list of medical foods claims paid during the experience period. The Company identified a universe of 34 claims. All 34 claims were requested and reviewed. No violations were noted.

Medical Foods Denied Claims

Examiners requested a list of medical foods claims denied during the experience period. The Company identified a universe of 172 medical foods provider-submitted, denied claims. A random sample of 76 claims was requested and reviewed. The following violations were noted:

4 Violations – 40 P.S. § 991.2166(a)

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

AND

31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the four noted claims within 45 days of receipt.

40 P.S. § 1171.5(a)(10)(iii)

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

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: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.

AND

40 P.S. § 1171.5(a)(10)(xiv)

"Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (xiv) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation

to the facts or applicable law for denial of a claim or for the offer of a compromise settlement. The Company has committed or performed the above acts with such frequency as to indicate a business practice which constitutes unfair claim settlement practices in the noted files. The five noted claim files did not contain a denial or Explanations of Benefits (EOBs).

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

"Unfair Methods of Competition "and "Unfair or Deceptive Acts or Practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (x) Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made. The Company did not include an EOB that properly represented the activity of the claim after sending a letter requesting information to the subscriber. An EOB or a denial is needed to clearly explain the adjudication process in the noted claim file.

Medical Foods Partially-Paid Claims

Examiners requested a list of partially-paid medical foods claims received during the experience period. The Company identified a universe of 87 partially-paid medical foods claims. A random sample of 76 claims was requested and reviewed. No violations were noted.

Medical Foods Closed-without-payment Claims

Examiners requested a list of closed-without-payment medical foods claims received during the experience period. The Company identified a universe of 28 medical foods closed-without-payment claims, which were requested and reviewed. The following violations were noted:

1 Violation – 40 P.S. § 991.2166(a)

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

AND

31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the noted claim within 45 days of receipt.

AND

40 P.S. § 1171.5(a)(10)(iii)

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

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

If a licensed insurer or a managed care plan fails to remit payment as required, interest at 10% per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The Company failed to pay the noted claim timely and interest of $2 or more remains unpaid.

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

“Unfair Methods of Competition” and “Unfair or Deceptive Acts or Practices” in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (v) 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. Affirming or denying services did not occur in a reasonable time although proof of loss appeared to have been established in the two noted claim files.

D. Autism Claims

Examiners requested lists of all ASD claims paid, denied, partially paid, and closed without payment during the experience period. In accordance with the requirements of the examination, ASD claim files were reviewed to ensure compliance with 40 P.S. §§ 764h, 991.2166, and 1171.5; 31 Pa. Code Ch. 146 and 154; 18 Pa. C.S. § 4117; 42 U.S.C. §§ 300gg-6, 300gg-13, and 18022; and 45 C.F.R. §§ 146.136 and 147.150. Examiners found violations in all four sections and noted the following concerns:

Concern 1: The Company failed to provide a clear EOB to the members that defined the services performed. The EOB stated "special medical" or "medical service" in the procedure description location, which does not define with sufficient specificity the actual service performed.

Concern 2: The Company mailed out EOBs that misrepresented the activity of the claim. Some members received EOBs showing 100% cost-sharing responsibility when the claim was paid by other insurance and/or the member already received an EOB showing no cost-sharing responsibility.

Autism Paid Claims

Examiners requested a list of all ASD claims paid during the experience period. The Company identified a universe of 4,094 paid ASD claims. A random sample of 108 claims was requested and reviewed. The following violations and concern were noted:

1 Violation – 40 P.S. § 991.2166(a)

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

AND

31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the two noted claims within 45 days of receipt.

AND

40 P.S. § 1171.5(a)(10)(iii)

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

1 Violation – 31 Pa. Code § 146.5(a)

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

1 Violation – 31 Pa. Code § 146.6

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

12 Violations – 40 P.S. § 1171.5(a)(10)(i)

“Unfair methods of competition” and “unfair or deceptive acts or practices” in the business of insurance means, misrepresenting pertinent facts or policy or contract provisions, if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices.

AND

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

The annual limitation on cost sharing shall not exceed the dollar amounts as defined in federal law and regulation for self-only and family coverage. The Company failed to attribute out-of-pocket costs to the enrollee's out-of-pocket maximum as directed by federal law in the 12 noted claim files.

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

"Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (v) 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. Affirming or denying services did not occur in a reasonable time although proof of loss appeared to have been established in the noted claim file.

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

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

Autism Denied Claims

Examiners requested a list of all ASD claims that were denied during the experience period. The Company identified a universe of 1,840 denied autism claims. A random sample of 107 denied claims was requested and reviewed. The following violations and concern were noted:

6 Violations – 40 P.S. § 764h(a)

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

24 Violations – 40 P.S. § 991.2166(a)

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

AND

31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the 24 noted claims within 45 days of receipt.

AND

40 P.S. § 1171.5(a)(10)(iii)

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

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

If a licensed insurer or a managed care plan fails to remit payment as required, interest at 10% per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The Company failed to pay the 12 noted claims timely and interest of $2 or more remains unpaid.

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

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means, misrepresenting pertinent facts or policy or contract provisions, if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices.

AND

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

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

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

"Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (v) 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. Affirming or denying services did not occur in a reasonable time although proof of loss appeared to have been established in the four noted claim files.

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

"Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (vi) 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's liability was reasonably clear, but claims were not paid or were not paid in a prompt manner in the 13 noted claim files.

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

1 Violation – 31 Pa. Code § 146.5(a)

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

12 Violations – 31 Pa. Code § 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to complete the investigation of the claim within 30 days after notification of the claim and failed to provide timely 45-day status letters for the 12 noted claim files.

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

All applications for insurance and all claim forms shall contain or have attached thereto the following notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to

criminal and civil penalties. The Company failed to provide the required fraud warning notice on claim forms.

Autism Partially-Paid Claims

Examiners requested a list of all ASD claims partially paid during the experience period. The Company identified a universe of 301 partially-paid ASD claims. A random sample of 82 claims was requested and reviewed. The following violations and concern were noted:

1 Violation – 40 P.S. § 764h(a)

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

19 Violations – 40 P.S. § 991.2166(a)

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

AND

31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the 19 noted claims within 45 days of receipt.

AND

40 P.S. § 1171.5(a)(10)(iii)

"Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. (iii)

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

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

If a licensed insurer or a managed care plan fails to remit payment as required, interest at 10% per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The Company failed to pay the four noted claims timely and interest of $2 or more remains unpaid.

1 Violation – 31 Pa. Code § 146.6

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

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

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means, misrepresenting pertinent facts or policy or contract provisions, if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices.

AND

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

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

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

"Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (v) 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. Affirming or denying services did not occur in a reasonable time although proof of loss appeared to have been established in the four noted claim files.

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

"Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (vi) 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's liability was reasonably clear, but claims were not paid or were not paid in a prompt manner in the 16 noted claim files.

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

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

Autism Closed-without-payment Claims

Examiners requested a list of all ASD claims closed without payment during the experience period. The Company identified a universe of 567 ASD claims closed without payment. A random sample of 105 claims was requested and reviewed. The following violations and concern were noted:

6 Violations – 40 P.S. § 764h(a)

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

18 Violations – 40 P.S. § 991.2166(a)

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

AND

31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the 18 noted claims within 45 days of receipt.

AND

40 P.S. § 1171.5(a)(10)(iii)

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

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

If a licensed insurer or a managed care plan fails to remit payment as required, interest at 10% per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The Company failed to pay the six noted claims timely and interest of $2 or more remains unpaid.

1 Violation - 40 P.S. § 1171.5(a)(10)(iv)

"Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. (iv) Refusing to pay claims without conducting a reasonable investigation based upon all available information. The Company denied claims without conducting a reasonable investigation as the noted members had active coverage on the date of service for the listed claim. The Company noted as a reason for the denial or delay that the requested additional information from the member and/or providers was not received. The Company denied claims without conducting a reasonable investigation as the noted members had active coverage on the date of service for the listed claim. The Company noted as a reason for the denial or delay that the requested additional information from the member and/or providers was not received. No proof of the Company's request for information was contained in the noted claim file.

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

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

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

2 Violations – 31 Pa. Code § 146.5(a)

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

58 Violations – 31 Pa. Code § 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to complete the investigation of the claim within 30 days after notification of the claim and failed to provide timely 45-day status letters for the58 noted claim files.

4 Violations – 31 Pa. Code § 146.7(a)(1)

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition, or exclusion is included in the denial. The Company failed to provide and/or include the grounds of a specific policy provision, condition, or exclusion in written denial letters for the four noted claim files.

E. Emergency Services Claims

Examiners requested lists of all emergency services claims paid, denied, partially paid, and closed without payment during the experience period. In accordance with the requirements of the examination, emergency services claim files were reviewed to ensure compliance with 40 P.S. §§ 991.2116, 991.2166, 1171.5, and 3042; 31 Pa. Code Ch. 146 and 154; 18 Pa. C. S. § 4117; 42 U.S.C. §§ 300gg-6 and 18022; and 45 C.F.R. §§ 147.138 and 147.150. Examiners found no violations.

Emergency Services Paid Claims

Examiners requested a list of all emergency services claims paid during the experience period. The Company identified a universe of 13,144 paid emergency services claims. A random sample of 109 claim files was requested and 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 791 denied emergency services claims. A random sample of 105 claim files was requested and reviewed. No violations were noted.

Emergency Services Partially-Paid Claims

Examiners requested lists of all emergency services claims partially paid during the experience period. The Company identified a universe of 484 partially-paid emergency services claims. A random sample of 83 claim files was requested and reviewed. No violations were noted.

Emergency Services Closed-without-payment Claims

Examiners requested a list of all emergency services claims closed without payment during the experience period. The Company identified a universe of 2,040 emergency services claims closed without payment. A random sample of 108 claim files was requested and reviewed. No violations were noted.

F. Ambulance Claims

Examiners requested lists of all ambulance claims paid, denied, partially paid, and closed without payment during the experience period. In accordance with the requirements of the examination, ambulance claim files were reviewed to ensure compliance with 40 P.S. §§ 991.2116, 991.2166, 1171.5, and 3042; 31 Pa. Code Ch. 146 and 154; 18 Pa. C. S. § 4117; 42 U.S.C. §§ 300gg-6 and 18022; and 45 C.F.R. §§ 147.138 and 147.150. Examiners found violations in each of the four sections and noted the following concerns:

Concern 1: Examiners noted that the Company had acknowledged in 13 of the 17 sample files that the Company's adjudication process resulted in the premature issuance of member EOBs, which failed to provide an accurate reflection of the final outcome of the claims' adjudications and could have resulted in confusion for the members.

Concern 2: The Department offers the following guidance with regard to re-adjudication of ambulance transport claims after quality assurance review: To initiate refund proceedings from one claimant and/or provider and not another under like or similar circumstances may be considered a violation under the Unfair Insurance Practices Act. While not identified as a violation for purposes of this examination, the Department will be following up on this practice.

Concern 3: The Company appears to place emphasis on balance billing for emergency ambulance transport by providing instructions as part of the Explanation of Payment (EOP), which are issued to non-participating billing providers. It is also recognized that as part of the EOP there is some guidance to the billing providers to not balance bill its members, particularly for emergency services. The concern lies with the lack of the ability by the Company to confirm that balance billing for emergency services is in fact not occurring. The Company is encouraged to implement greater controls designed to ensure that its members are not unfairly balance billed especially when the consumer has little or no ability to choose a participating emergency provider.

Ambulance Paid Claims

Examiners requested a list of all ambulance claims paid during the experience period. The Company identified a universe of 1,486 claims paid. A random sample of 107 claims was requested and reviewed. The following violations and concerns were noted:

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

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

AND

42 U.S.C. § 300gg-19a(b) & 45 C.F.R. § 147.138(b)

A group health plan or health insurance issuer offering group or individual health insurance shall cover emergency services without the need for any prior authorization, regardless of whether the furnishing health care provider is a participating provider, and the same cost-sharing requirement would apply as if such services were provided in-network, even if provided out-of-network. The Company failed to pay all reasonably necessary costs associated with the emergency services provided during the period of the emergency in the two noted claim files.

5 Violations – 40 P.S. § 991.2166(a)

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

AND

31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the five noted claims within 45 days of receipt.

AND

40 P.S. § 1171.5(a)(10)(iii)

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

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

If a licensed insurer or a managed care plan fails to remit payment as required, interest at 10% per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The Company failed to pay the four noted claims timely and interest of $2 or more remains unpaid.

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

“Unfair Methods of Competition” and “Unfair or Deceptive Acts or Practices” in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative. The Company failed to affirm or deny coverage of the claim within a reasonable time after proof of loss for the two noted claim files.

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: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (vi) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear. The Company improperly denied the two noted claim files when the company's liability under the policy was reasonably clear. The Company later paid the overdue claims even though new information was not presented, indicating coverage was available and appropriate when the claims originally denied.

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 records in the three noted claim files.

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

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

Ambulance Denied Claims

Examiners requested a list of all ambulance claims denied during the experience period. The Company identified a universe of 351 denied claims. A random sample of 82 claim files was requested and reviewed. The following violations and concerns were noted:

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

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

AND

42 U.S.C. § 300gg-19a(b) & 45 C.F.R. § 147.138(b)

A group health plan or health insurance issuer offering group or individual health insurance shall cover emergency services without the need for any prior authorization, regardless of whether the furnishing health care provider is a participating provider, and the same cost-sharing requirement would apply as if such services were provided in-network, even if provided out-of-network. The Company failed to pay all reasonably necessary costs associated with the emergency services provided during the period of the emergency in the three noted claim files.

5 Violations – 40 P.S. § 991.2166(a)

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

AND

31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the five noted claims within 45 days of receipt.

AND

40 P.S. § 1171.5(a)(10)(iii)

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

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

If a licensed insurer or a managed care plan fails to remit payment as required, interest at 10% per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The Company failed to pay the two noted claims timely and interest of $2 or more remains unpaid.

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

“Unfair Methods of Competition” and “Unfair or Deceptive Acts or Practices” in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. (iv) Refusing to pay claims without conducting a reasonable investigation based upon all available information. The Company denied claims without conducting a reasonable investigation as the noted members had active coverage on the date of service for the listed claim. The Company noted as a reason for the denial or delay that the requested additional information from the member and/or providers was not received. No proof of the Company’s request for information was contained in the four noted claims files.

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

“Unfair Methods of Competition” and “Unfair or Deceptive Acts or Practices” in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. (v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative. The Company failed

to affirm or deny coverage of the four noted claims within a reasonable time after proof of loss for the claims listed.

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

"Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. (vi) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear. The Company improperly denied the five noted claims when the Company's liability under the policy was reasonably clear. The Company later paid the claims even though new information was not presented.

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

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

Ambulance Partially-Paid Claims

Examiners requested a list of all partially-paid ambulance claims received during the experience period. The Company identified a universe of 115 claims. A random sample of 76 claim files was requested and reviewed. The following violations and concerns were noted:

1 Violation – 40 P.S. §§ 991.2116 & 3042

If an enrollee seeks emergency services and the emergency health care provider determines that emergency services are necessary, the emergency health care provider shall initiate necessary intervention to evaluate and, if necessary, stabilize the condition of the enrollee without seeking or receiving authorization from the managed care plan or insurer. The managed care plan or insurer

shall pay all reasonably necessary costs associated with the emergency services provided during the period of the emergency. When processing a reimbursement claim for emergency services, both the presenting symptoms and the services provided shall be considered.

AND

42 U.S.C. § 300gg-19a(b) & 45 C.F.R. § 147.138(b)

A group health plan or health insurance issuer offering group or individual health insurance shall cover emergency services without the need for any prior authorization, regardless of whether the furnishing health care provider is a participating provider, and the same cost-sharing requirement would apply as if such services were provided in-network, even if provided out-of-network. The Company failed to pay all reasonably necessary costs associated with the emergency services provided during the period of the emergency in the noted claim file.

6 Violations – 40 P.S. § 991.2166(a)

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

AND

31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the six noted claims within 45 days of receipt.

AND

40 P.S. § 1171.5(a)(10)(iii)

"Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. (iii)

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

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

If a licensed insurer or a managed care plan fails to remit payment as required, interest at 10% per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The Company failed to pay the noted claim timely and interest of $2 or more remains unpaid**.**

6 Violations – 31 Pa. Code § 146.6

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

Ambulance Closed-without-payment Claims

Examiners requested a list of all closed-without-payment ambulance claims received during the experience period. The Company identified a universe of 132 closed-without-payment ambulance claims. A random sample of 76 claim files was requested. During the review, it was determined that four files were found to be duplicates, thus a total of 72 claims were reviewed. In addition to a data integrity violation noted later in the Examination Report, the following violations were noted:

8 Violations – 40 P.S. § 991.2166(a)

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

AND

31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the eight noted claims within 45 days of receipt.

AND

40 P.S. § 1171.5(a)(10)(iii)

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

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

If a licensed insurer or a managed care plan fails to remit payment as required, interest at 10% per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The Company failed to pay the two noted claims timely and interest of $2 or more remains unpaid.

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

“Unfair Methods of Competition” and “Unfair or Deceptive Acts or Practices” in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claims settlement or compromise practices. (vi) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company’s liability has become reasonably clear. The Company failed to pay or deny correctly the noted claims. The claims which indicated that the Company’s liability was reasonably clear by being clean were not paid within 45 days in the five noted files.

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

19 Violations – 31 Pa. Code § 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to provide timely 45-day status letters for the 19 noted claim files.

G. Substance Use Disorder Claims

Examiners requested lists of all substance use disorder (SUD) claims paid, denied, partially paid, and closed without payment during the experience period. In accordance with the requirements of the examination, SUD claim files were reviewed to ensure compliance with 40 P.S. §§ 908-1 et seq., 908-11 et seq., 991.2166, and 1171.5; 31 Pa. Code Ch. 146 and 154; 18 Pa. C.S. § 4117; 42 U.S.C. § 300gg-6, 300gg-13, and 18022; and 45 C.F.R. §§ 146.136, 147.150, and 156.125. Examiners found violations in each of the four sections and noted the following concern:

Concern 1: The Company failed to provide to members a clear EOB that defined the services performed. The EOBs state "special medical," "medical service," or "laboratory services" in the procedure description location, which does not define with sufficient specificity the actual services performed. With regard to "laboratory services," the EOBs are particularly unclear when numerous laboratory services are performed on the same date of service.

Substance Use Disorder Paid Claims

Examiners requested a list of all SUD claims paid during the experience period. The Company identified a universe of 39,507 paid SUD claims. A random sample of 115 claims was requested; however, only three SUD paid claims provided by the Company included SUD diagnoses, resulting

in only three claims for review by examiners. The files were reviewed, and the following violations were noted:

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

As noted in the Company Operations and Management section of this Examination Report, licensed insurers are required to provide SUD benefits in parity with medical/surgical benefits. For quantitative treatment limitations (QTL), this means that the Company may not apply any QTL or financial requirement to mental health and SUD services that is more restrictive than those QTLs or financial requirements applied to substantially all of the medical/surgical services in the same classification. The Company imposed a QTL with respect to SUD benefits and failed to demonstrate compliance with the substantially all or predominant level tests described in regulation within the specified classification of benefits in the noted claim file.

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

As noted in the Company Operations and Management section of this Examination Report, licensed insurers are required to provide SUD benefits in parity with medical/surgical benefits. For nonquantitative treatment limitations (NQTL), this means that a licensed insurer may not apply any NQTL in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying that limitation to 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 SUD benefits and limited the scope and duration of treatment for the noted claim in a manner that was applied more stringently than medical/surgical benefits within the classification.

2 Violations – 40 P.S. § 991.2166(a)

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

AND

31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the two noted claims within 45 days of receipt.

AND

40 P.S. § 1171.5(a)(10)(iii)

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

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

“Unfair Methods of Competition” and “Unfair or Deceptive Acts or Practices” in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (vi) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company’s liability under the policy has become reasonably clear. The Company improperly denied the noted claim when the Company’s liability under the policy was reasonably clear. The Company later paid the claim even though new information was not presented.

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

1 Violation – 31 Pa. Code § 146.5(a)

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

1 Violation – 31 Pa. Code § 146.6

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

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

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the 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 claim within 30 days after notification of the claim and status letters were not mailed out every 45 days thereafter in the noted claim file.

Substance Use Disorder Denied Claims

Examiners requested a list of all SUD claims denied during the experience period. The Company identified a universe of 7,325 claims. A random sample of 109 claims was requested; however, only 31 of 109 claims provided by the Company included SUD diagnoses. An additional random

sample of 13 SUD denied claims was requested; however, only four of those 13 claims included SUD diagnoses. A total of 35 claims were reviewed and the following violations and concerns were noted:

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

Licensed insurers are required to provide coverage for benefits for alcohol or other drug abuse and dependency. The certification and referral from the licensed physician controls both the nature and duration of the treatment. The Company failed to provide coverage for SUD benefits in the two noted claim files.

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

As noted in the Company Operations and Management section of this Examination Report, licensed insurers are required to provide SUD benefits in parity with medical/surgical benefits. For quantitative treatment limitations (QTL), this means that the Company may not apply any QTL or financial requirement to mental health and SUD services that is more restrictive than those applied to substantially all of the medical/surgical services in the same classification. The Company imposed a QTL with respect to SUD benefits, but the Company failed to demonstrate compliance with the substantially all or predominant level tests described in regulation within the specified classification of benefits in the three noted claim files.

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

As noted in the Company Operations and Management section of this Examination Report, licensed insurers are required to provide SUD benefits in parity with medical/surgical benefits. For NQTL, this means that a licensed insurer may not apply any NQTL in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying that limitation to 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 SUD benefits in a manner that was applied more stringently than medical/surgical benefits within the classification for the 27 noted claim files.

1 Violation – 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, misrepresenting pertinent facts or policy or contract provisions, if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices.

AND

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

The annual limitation on cost sharing shall not exceed the dollar amounts as defined in federal law and regulation for self-only and family coverage. The Company failed to attribute out-of-pocket costs to the enrollee's out-of-pocket maximum as directed by federal law in the 12 noted claim files.

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

"Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurances means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. (iv) Refusing to pay claims without conducting a reasonable investigation based upon all available information. The Company denied claims without conducting a reasonable investigation as the noted members had active coverage on the date of service for the listed claim. The Company noted as a reason for the denial or delay that the requested additional information from the member and/or providers was not received. No proof of the Company's request for information was contained in the noted claim file.

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

"Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. (v) 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. The Company failed to affirm or deny coverage of the claims within a reasonable time after proof of loss for the two noted claims.

13 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 records in the 13 noted claim files.

2 Violations – 31 Pa. Code § 146.4(b)

An insurer or agent may not fail to fully disclose to first-party claimants the benefits, coverages or other provisions of an insurance policy or insurance contract when the benefits, coverages or other provisions are pertinent to a claim. The Company mailed an EOB that misrepresented pertinent facts relating to the claim for the two noted claim files.

Substance Use Disorder Partially-Paid Claims

Examiners requested a list of all SUD partially-paid claims received during the experience period. The Company identified a universe of 2,240 SUD partially-paid claims. A random sample of 108 claims was requested; however, only 22 claims included SUD diagnoses. An additional random sample of 15 SUD partially-paid claims was requested, and only four of those 15 contained SUD diagnoses. As a result, a total of 26 claims were reviewed and the following violations were noted:

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

As noted in the Company Operations and Management section of this Examination Report, licensed insurers are required to provide SUD benefits in parity with medical/surgical benefits. For quantitative treatment limitations (QTL), this means that the Company may not apply any QTL or financial requirement to mental health and SUD services that is more restrictive than those applied to substantially all of the medical/surgical services in the same classification. The Company imposed a QTL with respect to SUD benefits and failed to demonstrate compliance with the substantially all or predominant level tests described in regulation within the specified classification of benefits in the noted claim file.

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

As noted in the Company Operations and Management section of this Examination Report, licensed insurers are required to provide 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 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 SUD benefits. It was noted that the Company limited the scope and duration of treatment for the SUD claims in a manner that was applied more stringently than medical/surgical benefits within the classification for the five noted claim files.

2 Violations – 31 Pa. Code § 146.4(b)

An insurer or agent may not fail to fully disclose to first-party claimants, benefits, coverages or other provisions of an insurance policy or insurance contract when the benefits, coverages or other provisions are pertinent to a claim. The Company mailed out EOBs that misrepresented pertinent facts relating to the two noted claim files.

1 Violation – 45 C.F.R. § 156.125

An issuer does provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's health conditions. The Company's exclusion of Methadone treatment as maintenance appeared discriminatory to individuals who have an SUD, and the Company failed to sufficiently justify the exclusion of Methadone for SUD when it was a covered health service for pain management.

Substance Use Disorder Closed-Without-Payment Claims

Examiners requested a list of all SUD claims closed without payment during the experience period. The Company identified a universe of 1,308 closed-without-payment SUD claims. A random sample of 107 claims was requested; however, only 37 of claims included SUD diagnoses. An additional random sample of 15 SUD closed-without-payment claims was requested; however, only

eight of those claims included SUD diagnoses. As a result, a total of 45 claims were reviewed and the following violations and concerns were noted:

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

Licensed insurers are required to provide coverage for benefits for alcohol or other drug abuse and dependency. The certification and referral from the licensed physician controls both the nature and duration of the treatment. The Company failed to provide coverage for SUD benefits in the two noted claim files.

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

As noted in the Company Operations and Management section of this Examination Report, licensed insurers are required to provide SUD benefits in parity with medical/surgical benefits. For quantitative treatment limitations (QTL), this means that the Company may not apply any QTL or financial requirement to mental health and SUD services that is more restrictive than those applied to substantially all of the medical/surgical services in the same classification. The Company imposed a QTL with respect to SUD benefits and failed to demonstrate compliance with the substantially all or predominant level tests described in the regulation within the specified classification of benefits in the noted claim file.

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

As noted in the Company Operations and Management section of this Examination Report, licensed insurers are required to provide 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 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 SUD benefits in a manner that was applied more stringently than medical/surgical benefits within the classification for the 53 noted claim files.

4 Violations – 40 P.S. § 991.2166(a)

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

AND

31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the four noted claims within 45 days of receipt.

AND

40 P.S. § 1171.5(a)(10)(iii)

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

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

“Unfair Methods of Competition” and “Unfair or Deceptive Acts or Practices” in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. (v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the Company or its representative. The Company failed to affirm or deny coverage of the claim within a reasonable time after proof of loss for the four noted claims.

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

"Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. (vi) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear. The Company improperly denied the three noted claims and later paid the claims even though new information was not presented.

22 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 records in the 22 noted claim files.

1 Violation – 31 Pa. Code § 146.4(b)

An insurer or agent may not fail to fully disclose to first-party claimants the benefits, coverages or other provisions of an insurance policy or insurance contract when the benefits, coverages or other provisions are pertinent to a claim. The Company mailed an EOB that misrepresented pertinent facts relating to the claim for the noted claim file.

H. Mental Health Claims

Examiners requested lists of all Mental Health claims paid, denied, partially paid, and closed without payment during the experience period. In accordance with the requirements of the examination, mental health claim files were reviewed to ensure compliance with 40 P.S. §§ 908-11 et seq., 991.2166, and 1171.5; 31 Pa. Code Ch. 146 and 154; 18 Pa. C.S. § 4117; 42 U.S.C. §§ 300gg-6, 300gg-13, and 18022; and 45 C.F.R. §§ 146.136, 147.150, and 156.125. Examiners found violations in each of the four sections.

Mental Health Paid Claims

Examiners requested a list of all mental health claims paid during the experience period. The Company identified a universe of 10,301 paid mental health claims. A random sample of 109 claims was requested; however, only 80 of the 109 mental health paid claims provided by the Company included mental health diagnoses. As a result, 80 files were reviewed, and the following violations were noted:

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

As noted in the Company Operations and Management section of this Examination Report, licensed insurers are required to provide SUD benefits in parity with medical/surgical benefits. For QTL, this means that the Company may not apply any QTL or financial requirement to mental health and SUD services that is more restrictive than those applied to substantially all of the medical/surgical services in the same classification. The Company imposed a QTL with respect to mental health benefits, but the Company failed to demonstrate compliance with the substantially all or predominant level tests described in regulation within the specified classification of benefits in the 50 noted claim files.

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

As noted in the Company Operations and Management section of this Examination Report, licensed insurers are required to provide mental health 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 mental health 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 mental health benefits that limited the scope and duration of treatment in a manner that was applied more stringently than medical/surgical benefits within the classification in the two noted claim files.

1 Violation – 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, misrepresenting pertinent facts or policy or contract provisions, if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices.

AND

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

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

Mental Health Denied Claims

Examiners requested a list of all mental health claims denied during the experience period. The Company identified a universe of 1,308 denied mental health claims. A random sample of 108 claims was requested; however, only 41 of the 108 denied mental health claims provided by the Company included mental health diagnoses. As a result, a total of 41 claims were reviewed and the following violations and concerns were noted:

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

"Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. (iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies. The prompt investigation of a claim is considered prompt when the claims are correctly paid or denied in 45 days or less. Prompt investigation could not be established in the noted claim file.

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

"Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.

AND

40 P.S. § 1171.5(a)(10)(xiv)

"Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: (xiv) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

The Company failed to provide information regarding disposition of the claim within a reasonable amount of time.

Mental Health Partially-Paid Claims

Examiners requested a list of all mental health claims partially paid during the experience period. The Company identified a universe of 792 partially-paid mental health claims. A random sample of 105 claims was requested. During the review, it was determined that 33 files contained an ASD diagnosis code, which were excluded from review. In accordance with the requirements of the examination, the 72 remaining files were reviewed, and the following violations were noted:

13 Violations – 40 P.S. § 991.2166(a)

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

AND

31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the 13 noted claims within 45 days of receipt.

AND

40 P.S. § 1171.5(a)(10)(iii)

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

10 Violations – 31 Pa. Code § 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to provide timely 45-day status letters for the 10 noted claim files.

Mental Health Closed-without-payment Claims

Examiners requested a list of all mental health claims closed without payment during the experience period. The Company identified a universe of 684 mental health claims closed without payment. A random sample of 105 claims was requested. During the review, it was determined that 62 files contained an ASD diagnosis code, which were excluded from review. The remaining 43 files were reviewed, and the following violations were noted:

5 Violations – 40 P.S. § 764g(c)(1)

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

10 Violations – 40 P.S. § 991.2166(a)

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

AND

31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim submitted by a health care provider within 45 days of receipt of the claim from the health care provider. The Company failed to pay the ten noted claims within 45 days of receipt.

AND

40 P.S. § 1171.5(a)(10)(iii)

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

6 Violations – 40 P.S. § 1171.5(a)(10)(iv)

“Unfair Methods of Competition” and “Unfair or Deceptive Acts or Practices” in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. (iv) Refusing to pay claims without conducting a reasonable investigation based upon all available

information. It appears that an unfair claim settlement occurred by requesting information that was already available in the six noted claim files.

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

9 Violations – 31 Pa. Code § 146.6

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

I. Pharmacy Claims

Examiners requested that the Company identify all mental health, SUD, and medical foods pharmacy claims rejected (denied) during the experience period. In accordance with the requirements of the examination, mental health, SUD, and medical foods pharmacy claim files were reviewed to ensure compliance with 40 P.S. §§ 908-1 et seq., 908-11 et seq., 991.2166, and 1171.5; 31 Pa. Code Ch. 146 and 154; 18 Pa. C.S. § 4117; 42 U.S.C. §§ 300gg-6, 300gg-13, and 18022; and 45 C.F.R. §§ 146.136, 147.150, and 156.125. A concern was noted in one of the four sections.

Substance Use Disorder Rejected Pharmacy Claims

Examiners requested that the Company identify all rejected claims for SUD pharmacy drugs. These claims were in outpatient retail settings or mail order settings only. The Company identified a universe of 8,811 rejected SUD pharmacy claims. A random sample of 109 claims was requested and reviewed. The following concern was noted:

Concern: Failure to provide outpatient in or out-of-network medication treatment (methadone under the Opioid Treatment Program or OTP) for SUD, when similar treatments for medical surgical benefits are available for outpatient in/out of network for pain. There is no validation that methadone is being provided in an opioid treatment program, and therefore no indication that the company provides methadone for SUD. This creates additional barriers for patients to receive treatment for SUD, where methadone is preferred and/or the sole option for some patients.

Mental and Behavioral Health Rejected Pharmacy Claims

Examiners requested all rejected claims for mental and behavioral health pharmacy drugs. These claims were for outpatient retail setting or mail order settings only. The Company identified a universe of 104,196 mental and behavioral health pharmacy claims rejected during the experience period. A random sample of 109 claim files was requested and reviewed to ensure compliance with applicable state and federal laws and regulations. No violations were noted.

Medical Foods Rejected Pharmacy Claims

Examiners requested a list of all pharmacy medical foods rejected claims during the experience period. The Company identified a universe of 1,100 medical foods rejected pharmacy claims during the experience period. A random sample of 107 claim files was requested. In review of the first 20 claims sampled, no violations were noted, and the balance of the claim sample reviews were discontinued.

XVI. FORMULARY REVIEW

Examiners requested that the Company identify all pharmacy policies and procedures used during the experience period for mental health and SUD, Human Immunodeficiency Virus, Acquired Immunodeficiency Syndrome (HIV/AIDS) and major depressive disorder. 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 as identified in each section.

A. Mental Health and Substance Use Disorder Pharmacy Policies and Procedures

Examiners requested all pharmacy policies and procedures used during the experience period for mental health and SUD requirements and non-discrimination requirements. The Company identified 63 pharmacy policy and procedure documents. In accordance with the requirements of the examination, the files were reviewed to ensure compliance with 40 P.S. §§ 908-1 et seq., 908-11 et seq., and 1171.5; 31 Pa. Code Ch. 146; 42 U.S.C. §§ 300gg-6 and 18022; and 45 C.F.R. §§ 146.136, 147.150, and 156.125. The following concern was noted:

Concern: Based on documentation provided by the Company, it is clear there was a prior authorization requirement for buprenorphine and the preferred buprenorphine/naloxone product, Zubsolv, during the experience period. The practice of establishing prior authorizations potentially creates a barrier for treatment. It is noted that the Company removed the prior authorization requirement for buprenorphine and Zubsolv effective 3/1/2017. It is recommended that the Company continue to review the use of medical management techniques such as prior authorizations moving forward to reduce potential barriers for patients to receive necessary medications for the treatment of SUD.

B. HIV/AIDS Pharmacy Policies and Procedures

Examiners requested all pharmacy policies and procedures used during the experience period for HIV/AIDS requirements and non-discrimination requirements. The Company identified a universe of 63 documents. In accordance with the requirements of the

examination, the files were reviewed to ensure compliance with 40 P.S. § 1171.5, 31 Pa. Code Ch. 146, 42 U.S.C. §§ 300gg-6 and 18022; and 45 C.F.R. §§ 147.150 and 156.125. No violations were noted.

C. Major Depressive Disorder Pharmacy Policy and Procedures

Examiners requested all pharmacy policies and procedures used during the experience period for major depressive disorder requirements and non-discrimination requirements. The Company identified 63 pharmacy policy and procedure documents. In accordance with the requirements of the examination, the files were reviewed to ensure compliance with 40 P.S. §§ 908-11 et seq. and 1171.5, 31 Pa. Code Ch. 146, 42 U.S.C. §§ 300gg-6 and 18022, and 45 C.F.R. §§ 146.136,147.150, and 156.125. No violations were noted.

D. Formulary Underwriting Review – Mental and Behavioral Health

Examiners requested all mental and behavioral health formularies utilized during the experience period. The Company identified two formularies. In accordance with the requirements of the examination, the formularies were reviewed to ensure compliance with 40 P.S. §§ 477a, 761, 908-11 et seq., and 1171.5; 42 U.S.C. §§ 300gg-6 and 18022; and 45 C.F.R. §§ 146.136, 147.150, and 156.125. No violations were noted.

E. Formulary Underwriting Review – HIV/AIDS

Examiners requested all HIV/AIDS formularies utilized during the experience period. The Company identified two formularies. In accordance with the requirements of the examination, the formularies were reviewed to ensure compliance with 40 P.S. §§ 477a, 761, and 1171.5; 42 U.S.C. §§ 300gg-6 and 18022; and 45 C.F.R. §§ 146.150 and 156.125. No violations were noted.

XVII. DATA INTEGRITY

As part of the examination, the Company was sent a preliminary examination packet in accordance with NAIC uniformity standards. The purpose of the packet was to provide certain basic examination information, identify preliminary requirements, and to provide specific requirements for requested data call information. Once the Company provided all requested information and data contained within the data call, the Department reviewed and validated the data to ensure its accuracy and completeness to determine compliance with the Insurance Department Act of 1921, Section 904(b) (40 P.S. § 323.1 et seq.). Several data integrity issues were found during the examination. The data integrity issues from each review are identified below:

Company Operations and Management Fines

Situation: As examiners reviewed the complete list of "fines, penalties, and recommendations from any state in the last five years," it was noted that the Company failed to include a fine that was assessed by the Pennsylvania Insurance Department on January 8, 2016.

Finding: The Company failed to report a fine that had been assessed. The Company subsequently addressed the data integrity issue involving the lack of reporting of the fine and penalty from Pennsylvania; however, that does not change the fact it was not originally reported.

Consumer Complaints

Situation: Examiners requested that the Company identify all Pennsylvania Insurance Department Complaints received during the experience period. The Company failed to keep documentation to ascertain compliance.

Finding: The noted claim file did not include a complete file including letters to verify compliance.

Medical Denied Claims

Situation: Examiners requested a list of all medical claims denied during the experience period. A random sample of 109 claims was requested. Upon review, the examiners determined six files were not provided.

Finding: Only 103 claims, of a sample size of 109, were reviewed because the Company failed to provide six of the files requested.

Medical Closed-without-payment Claims

Situation: As the examiners reviewed the medical claims closed-without-payment, it was noted that 44 samples were not claims closed-without-payment.

Finding: 44 of the 109 claims closed-without-payment provided were not properly identified.

Autism Closed-without-payment Claims

Situation: Examiners requested a list of all ASD claims closed without payment. It was noted that six of the claims identified as 'closed without payment' were partially-paid claims.

Finding: Six of the 105 closed-without-payment claims requested were not properly identified.

Ambulance Closed-without-payment Claims

Situation: Examiners requested a list of all closed-without-payment ambulance claims received during the experience period. A random sample of 76 claim files was requested. During the review, it was noted that four of the 76 claims closed-without-payment were duplicates.

Finding: Four of the 76 ambulance claims closed-without-payment were duplicates.

Mental Health Paid Claims

Situation: Examiners requested a list of all mental health claims paid during the experience period. A random sample of 109 claims was requested. Only 80 of the 109 claims included a mental health diagnosis. Two of the 80 claims provided were denied claims.

Finding: 29 of the 109 mental health paid claims provided did not include mental health diagnosis. Two of the claims provided were denied claims rather than paid claims. These claims were improperly identified.

The following violation was noted:

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

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

XVIII. RECOMMENDATIONS

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

1. The Company must review and revise internal complaint review processes to complete the initial review within 30 days of the receipt of the complaint as per 40 P.S. § 991.2141(b)(4).

2. The Company must ensure that all clean claims are paid within 45 days of receipt as per 40 P.S. § 991.2166(a), 40 P.S. § 1171.5(a)(10)(iii), 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.

   The analyses and corrections listed in Recommendations 1 and 2 above include compliance with 40 P.S. § 764h, i.e., the Company must ensure diagnostic assessment of ASD and treatment of ASD coverage for covered individuals under 21 years of age, and identified clean claims must be paid, and proof of such payment must be provided to the Department.

3. The Company must ensure all requirements are met related to interest payments as per 40 P.S. § 991.2166(b) and 31 Pa. Code § 154.18(c). Applicable interest amounts for unpaid claims noted in the Examination Report must be paid, and proof of such payment must be provided to the Insurance Department.

4. The Company must comply with 31 Pa. Code § 154.17 and ensure the violations noted in this Examination Report relating to complaint handling and notifications do not occur in the future.

5. The Company must review and revise internal complaint processes to ensure compliance with 40 P.S. § 991.2141. The Company must include procedures to ensure compliance with 45 C.F.R. § 147.136(b) relating to internal review processes,

as well as compliance with 45 C.F.R. § 147.136(a) and (e), incorporating 29 C.F.R. § 2560.503-l regarding timely appeal and grievance processing.

6. The Company must comply with 40 P.S. § 991.2142 and 42 U.S.C. § 300gg-19(a)(1)(c), and ensure violations noted in this Examination Report relating to complaint appeal processing and acknowledgement notifications do not occur in the future.

7. 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 violations relating to claim acknowledgement, status letters and acceptance or denials, as noted in this Examination Report, do not occur in the future. For example:

    a. With respect to 31 Pa. Code § 146.5(a), the Company must acknowledge the receipt of notice of a claim within 10 working days;
    b. With respect to 31 Pa. Code § 146.5(b), the Company must ensure timely response to Department inquiries regarding claims;
    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, the Company must ensure claimants are advised of the acceptance or denial of a claim within 15 working days after receipt. If the insurer 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.

8. The Company must implement procedures to ensure compliance with the Unfair Insurance Practices Act, including the following noted issues:

a. 40 P.S. § 1171.5(a)(10)(iii), the Company must implement reasonable standards to ensure the prompt investigation of claims;
b. 40 P.S. § 1171.5(a)(10)(iv), the Company must conduct a reasonable investigation based on all available information for claim processing;
c. 40 P.S. § 1171.5(a)(10)(v), the Company must affirm or deny coverage within 45 days after proof of loss for the claims is received;
d. Company must comply with 40 P.S. § 1171.5(a)(10)(vi) and ensure prompt, fair and equitable settlements are being provided to the claimants;
e. 40 P.S. § 1171.5(a)(10)(x), the Company must provide an explanation of benefits that properly represents the activity of the claim after sending a letter requesting information to the subscriber;
f. 40 P.S. § 1171.5(a)(10)(xiv), the Company must provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for the denial of a claim or for the offer of a compromise settlement.

9. The Company must review and implement procedures to comply with 40 P.S. § 764c to ensure proper coverage of mammograms from properly licensed service providers. As part of this provision, the Company must comply with 42 U.SC. § 300gg-13 and 45 C.F.R. § 147.130 and ensure that listed preventive screenings and services, including mammograms as specified there and in 40 P.S. § 764c, are provided without cost-sharing requirements.

10. The Company must comply with 40 P.S. §§ 991.2116 and 3042, 42 U.S.C. § 300gg-19a(b), and 45 C.F.R. § 147.138(b) relative to emergency services coverage and ensure violations noted in this Examination Report do not occur in the future. Further, the Department recommends that the Company review its EOBs and claims adjudication policies, procedures, and processes for needed improvements relating to emergency services and transport.

11. 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. §§ 764g, 908-1 et seq., and 908-11 et seq.; 42 U.S.C. § 300gg-26; and 45 C.F.R. § 146.136. This includes the following noted issues:

a. Quantitative Treatment Limitations. As noted in the Company Operations and Management section of this Examination Report, the Company must evaluate QTL analyses and ensure that each QTL for mental health or SUD benefits in each classification is not more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. In addition, for the period specified below, the Company must perform this analysis and submit proof of compliance for each plan type affected, for each classification of benefits, and for each type of QTL separately. The Company must reprocess claims for all Pennsylvania members that may have been impacted to determine if restitution, including interest, is due. The Company must provide the Department with documentation that any restitution due to Pennsylvania consumers was paid accordingly. The Company shall provide a list of all affected Pennsylvania members, the amounts of refunds due including interest, and proof of refund, as applicable. Due to the systemic nature of this violation, the universe for restitution recalculation is expanded beyond the experience period of the examination to January 1, 2015 through December 31, 2018.

b. Nonquantitative Treatment Limitations. As noted in the Company Operations and Management section of this Examination Report, 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 mental health and SUD benefits and SUD laboratory claims documentation requirements.

12. The Company must comply with 40 P.S. § 1171.5(a)(10)(i), as well as 42 U.S.C. §§ 300gg-6 and 18022, and 45 C.F.R. § 156.130, and ensure violations noted in this Examination Report relating to out-of-pocket expenses for Essential Health Benefits and cost-sharing requirements do not occur in the future. The Company must evaluate claims and member cost-sharing responsibilities and reprocess the maximum out-of-pocket accumulator calculations for all autism claims that may have been impacted to determine if restitution is due. The Company must provide the Department with documentation to demonstrate that any restitution due to Pennsylvania consumers was paid accordingly. Due to the systemic nature of this violation, the universe for restitution recalculation is expanded beyond the experience period of the examination to January 1, 2014 through December 31, 2018.

13. The Company must review and implement procedures to comply with 18 Pa. C.S. § 4117(k)(1) to provide the required fraud warning notice on claim forms.

14. 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.

XIX. COMPANY RESPONSE

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VIA ShareFile

September 9, 2019

Katie Dzurec
Senior Advisor to the Commissioner
Health Market Conduct Bureau
Pennsylvania Insurance Department
1209 Strawberry Square
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Re: UnitedHealthcare Insurance Company - Response to Examination Report
Examination Warrant Number: 16-M33-014

Dear Ms. Dzurec:

This letter is in response to the Recommendations in the Pennsylvania Insurance Department's ("Department") Market Conduct Examination Report of UnitedHealthcare Insurance Company ("UnitedHealthcare") dated August 8, 2019 for the examination period of January 1, 2015 through March 31, 2016.

We would like to thank the Department for its professionalism and considerations throughout the examination process. UnitedHealthcare acknowledges the importance of the market conduct examination process as it strives to make the health care system work better for our members.

UnitedHealthcare is pleased to note that the Department's Examiner's found no violations in the areas of Company Operations and Management including Privacy Policies and Procedures, Network Adequacy, Grievance Procedures, Claim Processing Procedures, Provider Credentialing, Pharmacy, Formulary, Provider Directory, Quality Assessment and Improvement, Producer Licensing, Policy Holder Services, Utilization Review Operations, Mental Health and Substance Use Disorder Pharmacy Policies and Procedures, Underwriting and Rating, Claims Procedures and Emergency Service Claims.

We respectfully offer the following comments to the Examiner's Recommendations:

Recommendation 1:

The Company must review and revise internal complaint review processes to complete the initial review within 30 days of the receipt of the complaint as per 40 P.S. §991.2141(b)(4).

Company Response:

The Company will review and where necessary revise its procedures to ensure that initial internal complaint review processes are completed within 30 days of the receipt of a complaint as required by 40 P.S. §991.2141(b)(4)

Recommendation 2:

The Company must ensure that all clean claims are paid within 45 days of receipt as per 40 P.S. §991.2166(a), 40P.S. § 1171.5(a)(10)(iii), 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. The analyses and corrections listed in Recommendations 1 and 2 above include compliance with 40 P.S.§ 764h, i.e., the Company must ensure diagnostic assessment of ASD and treatment of ASD coverage for covered individuals under 21 years of age, and identified clean claims must be paid, and proof of such payment must be provided to the Department.

Company Response:

The Company will review its procedures to ensure that all clean claims including autism spectrum disorders (ASD) diagnostic and treatment claims are paid within 45 days of receipt as required by 40 P.S. §991.2166(a), 40 P.S. §1171.5(a)(10)(iii), and 31 Pa. Code § 154.18(a). Proof of payment of unpaid clean claims identified during the examination process will be provided to the Department.

Recommendation 3:

The Company must ensure all requirements are met related to interest payments as per 40 P.S. §991.2166(b) and 31 Pa. Code §154.18(c). Applicable interest amounts for unpaid claims noted in the Examination Report must be paid, and proof of such payment must be provided to the Insurance Department.

Company Response:

The Company will ensure that applicable interest is paid to any unpaid claims identified in the Examination Report as required by 40 P.S. §991.2166(b) and 31 Pa. Code §154.18(c). Proof of payment will be provided to the Department.

Recommendation 4:

The Company must comply with 31 Pa. Code §154.17 and ensure the violations noted in this Examination Report relating to complaint handling and notifications do not occur in the future.

Company Response:

The Examiners noted 1 violation related to not completing review of a complaint within 30 days of receipt. The Company will take appropriate action(s) to ensure this does not occur in the future. In regards to social media complaints the Examiners identified a concern as to how the Company was handling social media complaints and appeals. The Company provided the Examiners with documentation setting out Company procedures for tracking social media complaints and appeals. In light of the Department's concern, the Company will review and modify as appropriate its procedures for social media complaints and appeals to ensure consistency in handling and processing.

Recommendation 5:

The Company must review and where appropriate revise internal complaint processes to ensure compliance with 40 P.S. §991.2141. The Company must include procedures to ensure compliance with 45 C.F.R. §147.136(b) relating to internal review processes, as well as compliance with 45 C.F.R. §147.136(a) and (e), incorporating 29 C.F.R. §2560.503-l regarding timely appeal and grievance processing.

Company Response:

The Company will review and where appropriate revise internal complaint processes to ensure compliance with 40 P.S. §991.2141. The Company will also review its procedures to ensure compliance with 45 C.F.R. §147.136(b) relating to internal review processes, compliance with 45 C.F.R. §147.136(a) and (e) and 29 C.F.R. §2560.503-l. regarding timely appeal and grievance processing.

Recommendation 6:

The Company must comply with 40 P.S. §991.2142 and 42 U.S.C. §300gg-19(a)(1)(c), and ensure violations noted in this Examination Report relating to complaint appeal processing and acknowledgement notifications do not occur in the future.

Company Response:

The Company will review and where appropriate revise complaint processes to ensure compliance with 40 P.S. §991.2142 and 42 U.S.C. §300gg-19(a)(1)(c) complaint appeal processing and acknowledgement notifications.

Recommendation 7:

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 violations relating to claim acknowledgement, status letters and acceptance or denials, as noted in this Examination Report, do not occur in the future. For example: a) With respect to 31 Pa. Code §146.5(a), the Company must acknowledge the receipt of notice of a claim within 10 working days; b) With respect to 31 Pa. Code §146.5(b), the Company must ensure timely response to Department inquiries regarding claims; 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; and d) With respect to 31 Pa. Code §146.7, the Company must ensure claimants are advised of the acceptance or denial of a claim within 15 working days after receipt. If the insurer 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.

Company Response:

The Company will review and where appropriate revise internal control procedures to ensure compliance with the claims handling requirements of 31 Pa. Code Ch. 146.

Recommendation 8:

The Company must implement procedures to ensure compliance with the Unfair Insurance Practices Act, including the following: a)40 P.S. §1171.5(a)(10)(iii), the Company must implement reasonable standards to ensure the prompt investigation of claims; b)40 P.S. § 1171.5(a)(10)(iv), the Company must conduct a reasonable investigation based on all available information for claim processing; c)40 P.S. §1171.5(a)(10)(v), the Company must affirm or deny coverage within 45 days after proof of loss for the claims is received; d) Company must comply with 40 P.S. §1171.5(a)(10)(vi) and ensure prompt, fair and equitable settlements are being provided to the claimants; e) 40 P.S. §1171.5(a)(10)(x), the Company must provide an explanation of benefits that properly represents the activity of the claim after sending a letter requesting information to the subscriber; f) 40 P.S. §1171.5(a)(10)(xiv), the Company must provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for the denial of a claim or for the offer of a compromise settlement.

Company Response:

The Company will review and where necessary modify its processes to ensure compliance with requirements of the Pennsylvania Unfair Insurance Practices Act.

Recommendation 9:

The Company must review and implement procedures to comply with 40 P.S. §764c to ensure proper coverage of mammograms from properly licensed service providers. As part of this provision, the Company must comply with 42 U.SC. §300gg-13 and 45 C.F.R. § 147.130 and ensure that listed preventive screenings and services, including mammograms as specified there and in 40 P.S. §764c, are provided without cost-sharing requirements.

Company Response:

The Company will review its procedures to ensure compliance with mammogram coverage requirements of 40 P.S. §764c. Additionally, the Company will review it procedures to ensure compliance with 42 U.SC. §300gg-13 and 45 C.F.R. §147.130 and that the listed preventive screenings and services, including mammograms referenced in 40 P.S. §764c are provided without cost-sharing requirements.

Recommendation 10:

The Company must comply with 40 P.S. §§991.2116 and 3042, 42 U.S.C. §300gg-19a(b), and 45 C.F.R. §147.138(b) relative to emergency services coverage and ensure violations noted in this Examination Report do not occur in the future. Further, the Department recommends that the Company review its EOBs and claims adjudication policies, procedures, and processes for needed improvements relating to emergency services and transport.

Company Response:

The Company will review its processes to ensure compliance with 40 P.S. §§991.2116 and 3042, 42 U.S.C. §300gg-19a(b), and 45 C.F.R. §147.138(b) relative to emergency service coverage. Additionally, the Company will further review its EOBs and claims adjudication policies, procedures, and processes to identify opportunities for improvements related to emergency and ambulance services.

Recommendation 11:

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. §§764g, 908-1 et seq., and 908-11 et seq.; 42 U.S.C. §300gg-26; and 45 C.F.R. §146.136. This includes the following noted issues:

a. Quantitative Treatment Limitations. As noted in the Company Operations and Management section of this Examination Report, the Company must evaluate QTL analyses and ensure that each QTL for mental health or SUD benefits in each classification is not more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. In addition, for the period specified below, the Company must perform this analysis and submit proof of compliance for each plan type affected, for each classification of benefits, and for each type of QTL separately. The Company must reprocess claims for all Pennsylvania members that may have been impacted to determine if restitution, including interest, is due. The Company must provide the Department with documentation that any restitution due to

Pennsylvania consumers was paid accordingly. The Company shall provide a list of all affected Pennsylvania members, the amounts of refunds due including interest, and proof of refund, as applicable. Due to the systemic nature of this violation, the universe for restitution recalculation is expanded beyond the experience period of the examination to January 1, 2015 through December 31, 2018.

b. Nonquantitative Treatment Limitations. As noted in the Company Operations and Management section of this Examination Report, 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 mental health and SUD benefits and SUD laboratory claims documentation requirements.

Company Response:

While the Company believes its current QTL and NQTL processes are fully compliant, the Company was not able to produce all contemporaneous documentation to satisfy the Examiners inquiry for the period under review. The Company will continue its review and where necessary revise internal control procedures to ensure compliance with the mental health and SUD parity compliance requirements of 40 P.S. §§764g, 908-1 et seq., and 908-11 et seq.; 42 U.S.C. §300gg-26; and 45 C.F.R. §146.136.

Quantitative Treatment Limitations. The Company respectfully disagrees on the point of noncompliance with respect to MH/SUD quantitative treatment limits. As noted in our March 29, 2019 response to the Department, it was determined for plan design years 2014 and 2015 data input into the MHP QTL Model did not match the issued Certificates of Coverage. Performed retesting of these small and large plans for 2016, 2017 and 2018 passed testing without reoccurrence of this issue.

The Company will continue evaluating QTL analyses to ensure that each QTL for mental health or SUD benefits in each classification is not more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. In addition, for the period specified below, the Company will perform an analysis and submit proof to the Department of compliance for each plan type affected, for each classification of benefits, and for each type of QTL separately. The Company will reprocess claims for all Pennsylvania members that may have been impacted to determine if restitution, including interest, is due. For the period of January 1, 2015 through December 31, 2018, the Company will provide the Department with documentation that any restitution due to Pennsylvania consumers was paid accordingly. The Company will provide the Department with a list of all affected Pennsylvania members, the amounts of refunds due including interest, and proof of refund.

Nonquantitative Treatment Limitations. The Company will continue to evaluate and analyze NQTLs to 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 each classification are comparable to, and are applied no more stringently than, the processes, strategies,

evidentiary standards or other factors utilized in applying the limitation to medical/surgical benefits in the classification. This review will include improvements to the process to document the analysis of NQTLs related to Prior Authorizations for mental health and SUD benefits and SUD laboratory claims.

Recommendation 12:

The Company must comply with 40 P.S. §1171.5(a)(10)(i), as well as 42 U.S.C. §§300gg-6 and 18022, and 45 C.F.R. §156.130, and ensure violations noted in this Examination Report relating to out-of-pocket expenses for Essential Health Benefits and cost-sharing requirements do not occur in the future. The Company must evaluate claims and member cost-sharing responsibilities and reprocess the maximum out-of-pocket accumulator calculations for all autism claims that may have been impacted to determine if restitution is due. The Company must provide the Department with documentation to demonstrate that any restitution due to Pennsylvania consumers was paid accordingly. Due to the systemic nature of this violation, the universe for restitution recalculation is expanded beyond the experience period of the examination to January 1, 2014 through December 31, 2018.

Company Response:

The Company will review its processes to ensure compliance with 40 P.S. §1171.5(a)(10)(i), as well as 42 U.S.C. §§300gg-6 and 18022, and 45 C.F.R. §156.130 Essential Health Benefits and cost-sharing requirements. The Company will evaluate claims and member cost-sharing responsibilities for the period of January 1, 2014 - December 31, 2018 and where appropriate reprocess the maximum out-of-pocket accumulator calculations for autism claims that may have been impacted. The Company will provide the Department with documentation to demonstrate that any restitution due to Pennsylvania consumers was paid accordingly.

Recommendation 13:

The Company must review and implement procedures to comply with 18 Pa. C.S. § 4117(k)(1) to provide the required fraud warning notice on claim forms.

Company Response:

The Company will review and where appropriate supplement procedures to ensure compliance with the fraud warning notice requirements of 18 Pa. C.S. §4117(k)(1).

Recommendation 14:

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.

Company Response:

> The Company believes it is substantially in compliance with claim file documentation requirements, however, the Company will further review internal controls to ensure that all Company records and documents are maintained in accordance with 40 P.S. §§323.3 and 323.4 and that claim files and related documentation are complete as required by 31 Pa. Code §146.3.

UnitedHealthcare has established processes and procedures in place. Company operations and claims processing procedures are in compliance with applicable State and Federal laws and regulations. As we have discussed with the Department, the violations identified in the Examination Report were not willful or intentional. UnitedHealthcare welcomes the opportunity to further review our processes and procedures with the goal of refining them and to otherwise ensure we have addressed the recommendations in the Examination Report.

In conclusion, we again thank the Department for its professionalism and the opportunity to respond to the Examination Report. We look forward to working with the Department to bring the examination process to conclusion.

Please let us know if there are any follow-up questions or if further discussions would be helpful.

Sincerely,

Carrie Birmingham
Regulatory Affairs Analyst