THE COMMONWEALTH OF MASSACHUSETTS

OFFICE OF CONSUMER AFFAIRS AND BUSINESS REGULATION

DIVISION OF INSURANCE

Report on the Limited Scope Market Conduct Examination of

Blue Cross Blue Shield of Massachusetts HMO Blue, Inc.
Blue Cross and Blue Shield of Massachusetts, Inc.

Boston, Massachusetts

For the Period January 1, 2022, through December 31, 2022

NAIC COMPANY CODES: 12219 AND 53228

EMPLOYER ID NUMBERS: 04-3362283 AND 04-1045815

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COMMISSIONER

December 8, 2025

The Honorable Michael T. Caljouw
Commissioner of Insurance
Commonwealth of Massachusetts
Division of Insurance
One Federal Street, Suite 700
Boston, Massachusetts 02110-2012

Dear Commissioner Caljouw:

Pursuant to your instructions and in accordance with Massachusetts General Laws, Chapter 175, Section 4, the Massachusetts Division of Insurance ("Division") has performed a limited-scope market conduct examination ("Continuum of Regulatory Options/Interrogatory") of the market conduct affairs of **Blue Cross Blue Shield of Massachusetts HMO Blue, Inc. and Blue Cross and Blue Shield of Massachusetts, Inc.** ("Companies" or "BCBSMA"). The examination included but was not limited to the company's 2022 calendar year health insurance business in Massachusetts.

The Companies home office:

101 Huntington Avenue, Suite 1300
Boston, MA, USA 02199

The following report thereon is respectfully submitted.

ACRONYMS

Acute Treatment Services ("ATS")
American Society of Addition Medicine (“ASAM”)
Behavioral Health (“BH”)
Better Business Bureau (“BBB”)
Blue Cross Blue Shield of Massachusetts (“BCBSMA” or “Blue Cross”)
Consolidated Appropriations Act (“CAA”)
INS Regulatory Insurance Services, Inc. ("INS")
Massachusetts Attorney General’s Office (“AGO”)
Massachusetts Division of Insurance (“Division”)
Market Conduct Annual Statement (“MCAS”)
Market Regulation Handbook ("MRH” or “the Handbook")
Medical/Surgical (“M/S”)
Mental Health (“MH”)
NAIC Company Codes (“Cocodes”)
National Association of Insurance Commissioners ("NAIC")
Non-Quantitative Treatment Limitation (“NQTL”)
Obstetrics and Gynecology (“OB-GYN”)
Office of Patient Protection (“OPP”)
Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”)
Pharmacy Benefit Managers (“PBMs”)
Quantitative Treatment Limitation (“QTL”)
Quantity vs Time (“QvT”)
Substance Use Disorder (“SUD”)
System for Electronic Rate Form Filing (“SERFF”)
Third-Party Administrators (“TPAs”)
United States of America (“USA”)

BACKGROUND

On or about July 2023, the Massachusetts Division of Insurance (“Division") commenced a behavioral health parity compliance market conduct examination, pursuant to section 8K of Chapter 26 of the Massachusetts General Laws as amended by Chapter 177 of the Acts of 2022 (An Act Addressing Barriers to Care for Mental Health), section 4 of Chapter 175, section 10 of Chapter 176G and all other applicable statutes. Following the legislative mandate, the limited scope examination focused primarily but not exclusively on compliance with the applicable provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MPHAEA"), as amended, any federal guidance or regulations relevant to the act, including 45 CFR Part 146.136, 45 CFR Part 147.136, 45 CFR Part 147.160 and 45 CFR Part 156.115(a) (3), and applicable state mental health parity laws, including, but not limited to, section 47B of Chapter 175, section 8A of Chapter 176A, section 4A of Chapter 176B and sections 4, 4B and 4M of Chapter 176G.

The examination included an Interrogatory as provided under the Continuum of Regulatory Options ("Continuum") for market conduct examinations. The Continuum focused the examination on high-level aggregate data requests for areas such as utilization review, including prior authorization data, concurrent review, retrospective review, denials of authorization, step-therapy, network admission standards/reimbursement rates, network adequacy, geographic restrictions, complaint/grievance data, information verifying compliance with MPHEA, and denials of payment and coverage. In addition, the examiners reviewed the Market Conduct Annual Statement (“MCAS”), National Association of Insurance Commissioners (“NAIC”) financial filings, and Massachusetts health binder filings within the System for

Electronic Rate and Form Filing (“SERFF”). In addition, for those companies that received a report from the Massachusetts Attorney General’s Office (“AGO”) in 2020, the examiners conducted an evaluation of the Company responses.

INS Regulatory Insurance Services, Inc. ("INS"), a consultant qualified to perform market analysis and market conduct examinations under the management and general direction of the Division, conducted the limited scope examination described in the preceding paragraphs.

SCOPE OF EXAMINATION

The examination was initiated with an interrogatory, one of the options outlined in the Continuum of Options section of the NAIC Market Regulation Handbook (“MRH” or “the Handbook”). The interrogatory focused on MHPAEA compliance in key areas, including utilization review, step therapy, network admission standards, network adequacy, denials of payment and coverage, quantitative treatment limitations, and the policies and procedures used to monitor compliance within the companies and with third-party administrators and vendors. Additionally, the interrogatory inquired about the methods employed to ensure the accuracy of the 2022 Health MCAS filed by the companies. The examiners used sources, including the companies responses, the MCAS filing, and existing reports within the Division, to assess the accuracy and completeness of company-reported data.

EXAMINATION APPROACH

The examination employed the guidance and standards in the 2022 Handbook, the examination standards of the Division, the Commonwealth of Massachusetts' insurance laws, regulations, bulletins, and applicable federal laws and regulations. Examiners performed all procedures under the supervision of the Division's market conduct examination staff.

The Handbook provides guidance on optional processes and procedures for use during the examination and includes an approach designed to detect potential areas of non-compliance. The methodology outlined in the Handbook identifies key practices and controls used to operate the business and to meet essential business objectives, including measures designed to ensure compliance with applicable MHPAEA state and federal laws and regulations.

All unacceptable or non-compliant practices may not have been discovered or noted in this report. Failure to identify improper or non-compliant business practices does not constitute acceptance of such practices. The Companies shall report to the Division on any such corrective actions taken.

Interested parties can review all Massachusetts laws, regulations, and bulletins cited in this report on the Division's website at http://www.mass.gov/doi.

EXECUTIVE SUMMARY

This summary provides a high-level overview of the examination results, while the remainder of the text summarizes all observations, conclusions, recommendations, and corrective actions required as a result of the examination.

Required Company Corrective Action

Policies and Procedures Related to Claim Denials

Corrective Action: The Companies should clarify their internal documentation to indicate that the 30-day timeline for responding to appeals begins on the day the appeal is received, including when that receipt is on a non-business day. The Companies must review their website pages regarding appeals and grievances to ensure that all various grievance processes included in Massachusetts General Laws c. 176O §13 are clearly outlined for consumers. The website should be updated to include the ability for consumers to file a grievance in person, by mail or by telephone. The Companies must submit a report to the Division's Market Conduct Section on or before February 12, 2026, indicating the internal grievance procedures have been documented and implemented correctly both within internal documentation and on the Companies website. This internal grievance procedure finding is part of the Companies general compliance and not related explicitly to mental health parity.

Corrective Action: The Companies should review the Cotiviti claim denial workflow documents to ensure that a more stringent business practice is not occurring by making mental health providers provide additional clinical evidence when other claims denials do not require that same level of proof. The Companies must submit a report to the Division's Market Conduct Section on or before February 12, 2026, detailing their findings on the Cotiviti workflow documentation review.

I. COMPLAINTS/GRIEVANCES

Closed Consumer Complaints

The interrogatory requested a summary log of all closed consumer complaints submitted by consumers directly to the Companies from January 1, 2022, through December 31, 2022. This log included any closed complaints submitted to the Division, the Massachusetts Office of the Attorney General ("AGO"), the Better Business Bureau ("BBB"), MyPatientsRights.org, and the Office of Patient Protection ("OPP").

Examination Procedures Performed: INS reviewed the complaint summary log for MHPAEA compliance and identified complaints and grievances related to potential network adequacy insufficiencies. INS also inquired whether there were processes and procedures in place with third-party administrators to ensure all complaints were correctly reported. Further, INS:

a) reviewed the Companies complaints and grievance registers to identify if there was a lack of in-network providers,
b) reviewed the Companies complaint and grievance register to identify if there were sufficient in-network providers for M/S, MH, and SUD,
c) reviewed the Companies complaint/grievance registers to detect any identifiable trends for out-of-network denials,
d) reviewed the Companies complaint/grievance registers to identify any trends related to consumers having to pay out-of-network rates due to a lack of in-network providers,
e) inquired if there were policies and procedures in place for any third-party administrators (especially those handling MH/SUD) to report complaints/grievances to the Companies, and
f) reviewed to determine the final number of complaints and identify those that were of potential concern.

Examination Conclusions: BCBSMA received 594 complaints, of which 68 were related to behavioral health. Of these, 12 behavioral health complaints were of potential concern. Eleven (11) indicated an insufficient network of mental health professionals (6 of those 11 were related to Applied Behavioral Analysis (ABA)/Autism), and one was a result of delays in processing mental health claims. The six ABA/Autism claims were resolved after the Division of Insurance became involved. The Company indicated that all the ABA therapy claims originated from a single provider who had recently left the network. Based on the review of the complaint/grievance summary log, the Company's complaint and grievance procedures meet Massachusetts statutory and regulatory requirements.

There were 594 consumer complaints, and 12 were of potential concern.

Closed Provider Complaints/Grievances

The interrogatory requested a summary log of all closed provider complaints submitted by consumers directly to the companies from January 1, 2022, through December 31, 2022. This log included any closed complaints submitted to the Division, the AGO, the BBB, MyPatientsRights.org, and the OPP.

Examination Procedures Performed: INS reviewed the summary log for MHPAEA compliance and identified any complaints/grievances related to potential network adequacy insufficiencies. In addition, INS inquired whether there were processes and procedures in place with third-party administrators to ensure all complaints were correctly reported. Further, INS:

a) reviewed the Companies' complaint/grievance registers to identify whether there were sufficient in-network providers.

b) reviewed the Companies complaint/grievance registers to identify whether there was a lack of in-network providers for M/S, MH, and SUD.
c) reviewed the Companies complaint/grievance registers to identify whether there were trends for out-of-network denials.
d) reviewed the Companies complaint/grievance registers to identify trends related to consumers having to pay out-of-network rates due to a lack of in-network providers.
e) inquired if there were policies and procedures in place for any third-party administrators (especially those handling MH/SUD) to report complaints/grievances to the Companies, and
f) reviewed to determine the final number of complaints and identify those of potential concern.

Examination Conclusions: The Companies have implemented revised policies and procedures to ensure that all provider complaints are tracked and submitted to the insurance company. The provider *disputes guide* appears to provide mechanisms that allow members and providers to complain and further allow multiple claims to be submitted as part of a single dispute. Based on the review of the complaint/grievance summary log, the Companies complaint/grievance procedures meet Massachusetts statutory and regulatory requirements.

There was one (1) provider complaint, and the examiners did not have enough information to evaluate whether it was of potential concern.

II. MARKET CONDUCT ANNUAL STATEMENT

Companies with $50,000 or more in yearly premium sales in certain lines of business must file the MCAS report annually. The companies were asked to verify the accuracy of their MCAS data or, if they had not filed MCAS, to supply the information contained in the MCAS to the examiners. The examiners verified with the Companies that they attested to the accuracy of the data.

Examination Procedures Performed: INS reviewed the MCAS fields related to prior authorizations (pharmacy and excluding pharmacy), and external review data for both in-exchange and out-of-exchange. Further, INS:

a) developed statewide averages for each field for both in-exchange and out-of-exchange,
b) reviewed all prior authorization denials for non-pharmacy and pharmacy, and compared the state data to the statewide medians and averages,
c) reviewed the percentage of MH/SUD prior authorization denials to see if they were higher than M/S prior authorization denials,
d) reviewed the consumer-requested external reviews (excluding pharmacy) that were overturned, and,
e) verified that addendums were filed about the accuracy of the MCAS data.

Examination Conclusions: The examiners noted that there were no in-exchange prior authorizations for pharmacy only, and there were also no in-exchange consumers who requested external reviews for both Companies. BCBSMA should continue to verify the accuracy of the MCAS filing data. Based on the review of the MCAS data, the Companies MCAS filing meets Massachusetts statutory and regulatory requirements.

III. DENIAL OF PAYMENT AND COVERAGE

Third-Party Administrator Claims Processing

The Companies supplied the names of the internal and external third-party administrators ("TPAs") involved in claims processing. For this review, the request focused on any TPAs directly involved in claims processing, including those administrators who accept, deny, or otherwise adjudicate the claims. For example, the request might include pharmacy benefit managers ("PBMs"), administrators that process M/S and MH/SUD claims, and administrators that may process international claims. The list of requested TPAs should include those processing M/S claims, as well as those involved in MH/SUD claims processing. The examiners reviewed the response to identify which providers are used and for what purpose.

Examination Procedures Performed: INS reviewed the third-party entities involved with claims processing. Further, INS identified whether:

a) M/S claims are processed through a different vendor than those processing claims for MH/SUD,
b) a vendor (within the Companies group or an outside vendor) is used for pharmacy claims, and
c) whether a PBM is utilized.

Examination Conclusions: The Companies provided a list of third-party entities involved in claim determinations and identified the type of claims that each third-party processes. However, the Companies did not provide information regarding Cotiviti until the second inquiry regarding claim denials. Cotiviti is a third-party vendor that conducts post-payment reviews and appeals directly impacting providers. It was also noted that the Companies provided another vendor, ClaimsXten (CXT) that edits claims: although they are not directly involved in claims processing, their edits could result in claim denials. In addition, the examiners found references to NASCO. According to research, NASCO adjudicates claims for Blue Cross and Blue Shield of Massachusetts.

Examination Recommendation: The Companies should be transparent about utilizing vendors for post-claim auditing and include all third-party administrators, including internal and external vendors, in subsequent requests for entities involved in claims determinations.

Policies and Procedures Related to Claim Denials

Examination Procedures Performed: INS reviewed the third-party policies and procedures for claim denials. Further, INS also identified whether:

a) the Companies have adequate processes and procedures for claims processing,
b) if the Companies write in multiple jurisdictions, the policies and procedures for claims denials must include information about state-specific requirements,
c) the state-specific addendums have been reviewed to determine if all addendums are up to date with any recent bulletins, statutes, regulations, or related recent amendments or revisions, and
d) the information provided was adequate to determine if the individual at the Companies making the denial decision is experienced in the area they are reviewing. Ideally, the individual should be board-certified in the area being reviewed (e.g., psychologist/board-certified, behavior analyst-doctoral, and/or a psychologist with clinical experience).

Examination Conclusions: The Companies submitted 35 documents outlining their denial process including a provider dispute document, 35 claim denial workflows, and three (3) denial codes with descriptions for M/S, MH and SUD claims.

The examiners observed that the internal appeal document did not clarify the start date for internal appeals. The examiners noted that the website page for filing an internal appeal/grievance did not include options to file in person, by mail, by telephone or by electronic means. The website only provides a form but does not include the phone number for appeals. The Companies should ensure that all components of Massachusetts General Laws c. 176O §13 are properly implemented in both internal processes and procedures and external documentation (such as a member's Explanation of Benefits (EOB), company website, etc.)

The examiners also observed that there were manual workarounds related to MRI contrast injections, dated references to ICD-9 billing codes (from 2015), documentation for suspending most claims (especially those with multiple medical services), and notes about overriding the system.

There were two Cotiviti documents provided, one that appears to address MH and SUD denial codes and workflows and another that appears to address M/S denial codes and workflows. The MH and SUD workflow document explicitly requires the provider to file an appeal along with clinical documentation in order to have a further review of the claim denial. The other document that appears to address M/S denial codes, allows providers to request further review without additional clinical review documentation. The M/S claim denial the workflow document allows for adjusting, drafting a replacement claim, or recommending to the provider to consider an appeal, if necessary.

The examiners found that the Companies have updated some of the workflows to include recent changes to legislation, such as allowing supervised providers to be covered under the umbrella of a licensed clinic or licensed mental health facility.

Corrective Action: The Companies should clarify its internal documentation to indicate that the 30-day timeline for responding to appeals begins on the day the appeal is received, including when that receipt is on a non-business day. The Companies must review their website pages regarding appeals and grievances to ensure that all various grievance processes included in Massachusetts General Laws c. 176O §13 are clearly outlined for consumers. The website should be updated to include the ability for consumers to file a grievance in person, by mail or by telephone. The Companies must submit a report to the Division's Market Conduct Section on or before February 12, 2026, indicating the internal grievance procedures have been documented and implemented correctly both within internal documentation and on the Companies website. This internal grievance procedure finding is part of the company's general compliance and not related explicitly to mental health parity.

The Companies should review the Cotiviti claim denial workflow documents to ensure that a more stringent business practice is not occurring by making mental health providers provide additional clinical evidence when other claims denials do not require that same level of proof. The Companies must submit a report to the Division's Market Conduct Section on or before February 12, 2026, detailing their findings on the Cotiviti workflow documentation review.

M/S, MH and SUD Claims Received, Paid, Denied (in part or in whole)

Examination Procedures Performed: The Companies provided the claims received, paid, denied in part, and denied in whole, separated by M/S, MH, and SUD. The examiner totaled the data and created statewide averages and medians to determine if companies were outside of the statewide thresholds; however, accommodations were made to exclude entities that did not meet minimum thresholds. Further, INS identified whether:

a) the claims paid were less than statewide averages and medians,
b) the percentage of total denials was over the statewide averages and medians,
c) the denials for M/S claims were higher than statewide averages and medians,
d) the denials for M/H claims were higher than statewide averages and medians,
e) the denials for SUD claims were higher than statewide averages and medians, and
f) the denials of MH and SUD claims were higher than M/S claim denials.

Examination Conclusions: As reported, the Companies' combined data resulted in a higher percentage of claim denials for all claims combined than the statewide average for those companies subject to MHPAEA. The details on the supplemental report did provide further insight into these SUD denials with 1,586 incomplete claims, 714 coding errors and 1,085 duplicate claims, however, *the examiners are more concerned with the 7,017 claims denied for the category of "other administrative denials." Similarly, there were 18,626 mental health claim denials for the category of "other administrative denials.*" The Companies did provide the reasons for other administrative denials for MH/SUD by company, however, there was no indicator for which company represented which data set (spreadsheet). Some of the most common reasons for the MH/SUD other administrative denials include:

1. Benefits are not available because it was submitted after the claim filing time limit,
2. Separate benefits are not available because the procedure was included with another procedure,
3. Separate benefits are not available for this service because it is included in the overall care given to you by your health care provider,
4. There is no separate reimbursement for this procedure,
5. Separate benefits or additional coverage is not available,
6. Benefits cannot be determined at this time because the procedure code provided does not meet national billing standards,
7. Consideration cannot be given for this service until we receive complete provider information,
8. Consideration for this claim cannot be given until medical records have been obtained and reviewed from your medical provider, and
9. Benefits are not valid without a valid primary care provider identified (HMO only.)

The Companies were not asked to provide the most common reasons for M/S claim denials but should be prepared to do so in future examinations.

Observation: Based on the review, the examiners recommend that the Companies be prepared to provide the most common other administrative denial reasons for M/S in future requests.

IV. NETWORK ADEQUACY

The Companies were asked to supply processes and procedures to demonstrate their compliance with the state and federal requirements for network adequacy. The Companies were also asked to provide a listing of their MHPAEA plans. The examiners selected a plan from the Companies list and performed a search on their website, searching for an Obstetrics and Gynecology ("OB-GYN") provider and a MH or SUD provider.

Policies and Procedures Compliance with Federal Requirements on Provider Data Accuracy

Examination Procedures Performed: INS reviewed the Companies' policies and procedures to determine if the BCBSMA complied with federal requirements on provider data accuracy. The purpose of the INS review was:

a) to ensure the Companies had documented policies and procedures,
b) to ensure compliance with the No Surprises Act (42 USCS § 300gg-115) for all provider types and
c) to confirm that the accuracy of provider data is reviewed every 90 days.

Examination Conclusions: BCBSMA provided policies and procedures for behavioral health providers and health facilities regarding provider directory accuracy. The Companies also provided a supplemental document with a workflow, verifying the process for M/S providers and health facilities, but not an official policy and procedures document.

BCBSMA contracts with a vendor who collects practitioner demographic data and attestations from their credentialed medical, mental health, substance use, and dental professional network of providers. "Following state and federal regulations and BCBS Association, all contracted providers must attest to the accuracy and completeness of Directory data once every 90 days and again on 120 days for providers who have not responded. BCBSMA also posts provider notifications on the Provider Portal every 90-days." The vendor utilized by the Companies for both credentialing and provider data accuracy does require attestations from all providers every 120 days. If the vendor's data indicates the data is incorrect, the application requires the provider/facility take action to make corrections. In addition, the Companies also conduct their own internal verification process monthly to confirm data accuracy. Initially BCBSMA provided only the audit of MH/SUD providers but subsequently provided the data for medical/surgical providers.

The documentation provided by BCBSMA includes timelines for removing providers from the directory/website in certain situations, allowing 120 days in some cases for a provider to confirm accuracy. BCBSMA provided a recent audit of the M/S provider data accuracy.

Based on the review of the data provided by BCBSMA, they meet federal and Massachusetts statutory and regulatory requirements regarding provider data accuracy.

Observation: Based on the review, the examiners recommend that the Companies be prepared to provide an official document in the future that outlines the processes and procedures used by the Companies for audits and any vendors assisting with provider data accuracy.

List of Massachusetts Plans Subject to Mental Health Parity in 2022

Examination Procedures Performed: INS reviewed the Companies' response to verify that the list of plans subject to the mental health parity requirement in 2022 was provided to the Division. Further, INS reviewed the Companies' response to verify:

a) the Companies responded to the question, and
b) the list provided matches the 2022 SERFF Filing Binder (if applicable).

Examination Conclusions: Based on the review of the plans supplied by the Companies, the response is sufficient and accurate.

Basic Web Searches

Examination Procedures Performed:
The examiners selected a plan from the Companies' list and performed a search on the BCBSMA's website for an OB-GYN provider and a MH or SUD provider. Further, INS:

a) conducted a basic search without a login to find an OB-GYN within the plan's service area,
b) conducted a basic search without a login to find an MH/SUD provider,
c) confirmed that the name of the plan displayed on the website was consistent with the Companies name provided, and
d) reported challenges encountered in the search to the Companies.

Examination Conclusions: There were no concerns identified based on the review of the BCBSMA website.

V. NETWORK ADMISSION STANDARDS

The Companies supplied the network admission standards, reimbursement rates, and policies, and the number of network admissions during the examination period of review.

Network Admission Standards Policies/Procedures Data Submitted

Examination Procedures Performed: INS reviewed the network admission standards, reimbursement rates, and policies, and the number of network admissions during the examination period of review to determine if ample processes and procedures were in place. Further, INS considered:

a) if any additional barriers exist that make it harder for MH/SUD providers to become a member of the network,
b) if the Companies are using a TPA or another vendor for MH/SUD. If the Companies have processes in place for the vendor to follow rather than relying solely on the vendor to determine what network admission standards will apply,
c) if there are differences between MH/SUD and M/S admission processes, evaluate the differences to ensure they do not result in more stringent or have extra requirements for MH/SUD applicants. (For example, what are the liability insurance requirements for M/S versus MH/SUD?)

Examination Conclusions: BCBSMA supplied documentation regarding professional credentialing and recredentialing requirements for M/S, MH and SUD providers.

Observations: During the review, the examiners identified that all behavioral health providers are required to have 24-hour coverage by a Blue Cross credentialed behavioral health practitioner. However, from the medical/surgical area, only four types of practitioners require supervision from a Blue Cross-credentialed practitioner for medical/surgical providers.

Subsequent Company Action: BCBSMA responded to the inquiry that the coverage arrangements were removed from the application effective April 8, 2025.

Reimbursement Rate Policies

Examination Procedures Performed: INS reviewed the reimbursement rate policies and procedures. Further, INS reviewed the reimbursement rate policies to:

a) ensure the rate policies were complete and detailed,
b) verify whether a third-party or internal entity handles the reimbursement rate policies, and
c) verify the reimbursement procedures/methods are not more stringent for MH/SUD than for M/S providers. (Additional software, etc.)

Examination Conclusions: BCBSMA provided a document titled "Professional Credentialing and Recredentialing Requirements." The document stated that Blue Cross Blue Shield of Massachusetts ("Blue Cross") credentials all primary care providers ("PCPs"), specialty care physicians ("SCPs"), oral and maxillofacial surgeons, and licensed clinicians (together, "Practitioners") who have applied for enrollment in their networks and who have met all contractual requirements. Once the credentialing process is complete, the Companies execute an Agreement and send a welcome letter that includes the effective date of network participation and confirms the networks in which the provider is participating.

The Companies further explained the process for provider reimbursement. BCBSMA maintains a methodology for reimbursement and rate setting for in-network inpatient, outpatient, and emergency care medical/surgical and mental health/substance use disorder benefits. Based upon provider types (i.e., practitioner or facility), a reasonable base (i.e., floor) rate is established by the plan for prospective network providers. Providers may accept these rates or request negotiations, which, based upon market dynamics, may influence the base rate values for final contracts between the provider and the plan. No physician specialties are categorically provided with reduced rates for either mental health/substance use disorder or medical/surgical.

BCBSMA recognizes that parity requirements do not require a plan to pay identical reimbursement rates to providers across provider types/specialties, but rather that the methodology for developing and applying reimbursement rates under the plan must be comparable. The plan's rate methodologies are intended to create stability within the network, reduce provider abrasion, and ensure member access to healthcare and coverage affordability. Reimbursement rates are proprietary, confidential, and are not disclosed due to the competitive disadvantage that could occur for the plan in the market.

The Companies further elaborated that they regularly review the company conversion factor and compare it to the Medicare conversion factor and for the majority of the providers the rate is higher.

Based on the review of the reimbursement rate policies, the Companies reimbursement procedures meet Massachusetts statutory and regulatory requirements as the factors, sources, and evidentiary standards are the same and no more stringent for MH/SUD providers than for M/S providers.

Number of Network Admissions During the Period (M/S, MH and SUD)

Examination Procedures Performed: INS reviewed the network admissions for the examination period. Further, INS reviewed the data to ensure:

a) the information was separated into M/S and MH/SUD,
b) the information included facilities for M/S and MH/SUD,
c) the reasons for denial were included, and
d) the percentage of denials for MH/SUD was similar to those for M/S.

Examination Conclusions: BCBSMA initially provided a list of admissions to the network. It was noted that 30% of M/S applicants and 36% of MH/SUD providers were ineligible for credentialing. Of the total

applicants, 31% of M/S applicants were not accepted into the network, while 37% of the MH/SUD applicants were not accepted into the network.

BCBSMA explained that the term "ineligible for credentialing review" may describe a situation ("case") where the application is incomplete and therefore could not be reviewed by the Credentialing and Peer Review department for acceptance into the network. BCBSMA also explained that one applicant could have multiple applications pending due to entry errors made while submitting the application. The Companies elaborated that MH/SUD providers are more likely to be individual providers without practice support or access to health system credential support functions, so they may need assistance and additional follow-up. BCBSMA further reported that MH/SUD and M/S have the same acceptance rates, with MH/SUD 1% higher than M/S.

Based on the review of the network admissions, the Companies network admissions meet Massachusetts statutory and regulatory requirements.

VI. POLICY AND PROCEDURES FOR COMPLIANCE WITH MHPAEA

Examination Procedures Performed: The Companies supplied policies, procedures, and documentation to show the implementation of MHPAEA compliance. Further, INS reviewed the data to:

a) ensure the Companies have policies and procedures for ensuring compliance with MHPAEA,
b) ensure the Companies monitor/audit vendors for compliance, and
c) ensure the Companies have an organized compliance plan for MHPAEA oversight.

Examination Conclusions: BCBSMA submitted policies/procedures and documentation related to the Analysis of Concurrent/Retrospective Review (58 pages), Analysis of Geographic Restrictions, Analysis of Network Admission Reimbursement Rates, Analysis of Prior Authorization Retrospective Review, Supplemental Information for BCBSMA NQTL Docs 2022, and CVS NQTL Comparative Analysis Summary for BCBSMA 2023 Custom Formulary. The documentation also included references specifically to the state of Massachusetts. Based on the review, the Companies meet Massachusetts statutory and regulatory requirements regarding policies and procedures for compliance with MHPAEA.

VII. QUANTITATIVE TREATMENT LIMITATIONS

The Companies must demonstrate that QTL testing was conducted with indicators for pass/fail.

Examination Procedures Performed: The examiners reviewed the data to determine if the QTL testing was complete. Further, INS reviewed the data to:

a) ensure the Companies provided testing results (pass/fail),
b) verify if the Companies reported fail in any one or multiple categories,
c) verify if the QTL analysis included the substantially all testing,
d) verify if the QTL analysis includes predominant testing, and
e) verify if the Companies demonstrated that the substantially all testing (2/3 threshold) was completed before the predominant testing.

Examination Conclusions: The examiners reviewed the QTL analysis documentation provided by the Companies. The examiners noted that in the review of the QTL medications, there were quantity limits on certain opioid treatment and smoking cessation medications. BCBSMA responded that "quantity limits

(QLs) establish a maximum quantity of certain medications that will be covered over a specified time period. Limits are expressed in terms of Maximum Daily Dose (MDD) which limits the medication to a specified quantity per day (e.g., 1 tablet per day), Quantity vs Time ("QvT") which limits the medication to a quantity dispensed per time period (e.g., 8 tablets per 30 days), Max per Fill which specifies the maximum number of units allowed per fill, and Max per Calendar Year which limits the maximum number of days allowed per calendar year (e.g., 168 day supply per calendar year)." The Companies did respond that these medications are covered based on the quantity limits, and depending on the plan, members may be eligible to obtain a 30-day, 60-day, or even 90-day prescription, depending upon how the medication is filled (e.g., mail order, retail pharmacy, etc.). The examiners requested a review of the more detailed analysis, which showed how they arrived at the determination that all the plans passed. The examiners also requested the documentation include whether the substantially all testing was conducted prior to the predominant testing. The Companies provided screenshots of the analysis, so it appears that all the testing was conducted; however, a more detailed review may be recommended during a future examination. Based on the review, the Companies meet Massachusetts statutory and regulatory requirements regarding QTL testing.

VIII. STEP THERAPY

The Companies submitted the step-therapy requirements, the number of step-therapy requests and how many were approved, denied in part, or denied in whole.

List of M/S, MH/SUD and Pharmacy Benefits Requiring Step-Therapy

Examination Procedures Performed: The examiners reviewed the data to determine if the step-therapy or fail first requirements distinguished between M/S, MH/SUD, and pharmacy. Further, INS reviewed the data to:

a) ensure the Companies provided step-therapy documentation,
b) verify the Companies provided step-therapy for both M/S and MH/SUD,
c) identify if any MH/SUD medications should not require step-therapy (e.g., smoking cessation), and
d) determine if all medications within a particular class of MH/SUD medications, including generic versions, require step therapy.

Examination Conclusions:
BCBSMA does not have step therapy requirements for non-medication services. The policies related to non-medication services are designed to ensure that the member is receiving the appropriate level of care for their individual clinical needs. Step therapy requirements are put in place when there is more than one medication that has been established to be clinically effective to treat a particular condition, and one of those treatments is more cost effective. The initial documentation provided did not include what steps or medications were necessary before allowing a patient to use a drug (usually a brand name) on the list. The Companies did provide several examples that included the details of what medications are required to try before moving to the next option. Generally, this requires a patient to try at least one option first, before being approved for the next level, some medications require 2 steps and others 3 steps. There is also a caveat that in most cases the patient must use at least one of the first options or any of the step 2 medications within the previous 130 days. Based on the review of the step therapy documentation, the company meets Massachusetts statutory and regulatory requirements regarding step therapy.

Number of Step-Therapy Requests, Approved, Denied (in part or in whole)

Examination Procedures Performed: The examiners reviewed the data to determine the number of approved, partially denied, or fully denied step-therapy requests that were completed during the examination period. Further, INS reviewed the data to:

a) determine statewide averages and medians for approvals, partial denials, and whole denials,
b) determine if the Companies had higher averages and medians than the statewide averages, and
c) identify if the number/percentages of denials and partial denials are higher for MH and SUD as compared to M/S.

Examination Conclusions: BCBSMA did supply the three numbers for pharmacy step therapy, approvals, denials, and total requests. Based on the review of the number of step-therapy requests approved, denied (in part or in whole), the Companies comply with Massachusetts statutory and regulatory requirements.

Observations: BCBSMA should be able to distinguish data between the two companies in future requests.

IX. UTILIZATION REVIEW

The Companies were requested to provide the TPAs for MH/SUD, the medical necessity guidelines criteria, and the sources for those guidelines. In addition, the Companies were requested to provide the M/S, M/H, and SUD requests separated by approved, denied in part, and denied in whole, further classified by prior authorization, concurrent review, and retrospective review.

Third-Party Administrators and Medical Necessity Claim Determinations

Examination Procedures Performed: The examiners reviewed the list of third-party administrators provided by the Companies. Further, INS reviewed the data to verify if:

a) the list included all TPAs and the role they play in determining medical necessity (type of claims, etc.),
b) the address was provided for the TPA vendor, and
c) whether the TPA is affiliated with the Companies or group.

Examination Conclusions: BCBSMA reported that they do not carve out the management of behavioral health benefits to a third-party entity. However, they do engage with third-party contractors who specialize in the review of certain medical services. BCBSMA provided two entities providing independent claim/benefit determinations. The Companies also provided the addresses of the company and indicated that neither entity is affiliated with the BCBSMA. The examiners conducted further research and discovered that Blue Benefit Administrators of Massachusetts appears to be an affiliated subsidiary that may be involved in determining medical necessity. Blue Benefit Administrators is utilized only for self-funded employer groups. Based on the review of the third-party administrators involved in medical necessity documentation, the Companies meet Massachusetts statutory and regulatory requirements.

Medical Necessity Guidelines

Examination Procedures Performed: The examiners reviewed the utilization review medical necessity guidelines. Further, INS reviewed the data to:

a) verify that the M/S medical necessity guideline criteria were supplied,
b) verify that the MH/SUD medical necessity guideline criteria were supplied, and

c) review the medical necessity guidelines to determine if medical necessity criteria for MH/SUD are comparable to, or less strict than, those for medical/surgical care.

Examination Conclusions: BCBSMA did provide links to entities conducting medical necessity guidelines criteria and the entity that conducts utilization management for chiropractic services. The Companies also supplied a link to the medical necessity guidelines utilized by another vendor who conducts utilization management for High Tech Radiology, Sleep Medicine, Medical Oncology, Radiation Oncology and Genetic Testing. BCBSMA also provided the medical necessity guidelines for all other services other than the contracted utilization management vendors. Based on the review of the medical necessity guidelines, the Companies' medical necessity guidelines meet Massachusetts statutory and regulatory requirements.

Sources for Medical Necessity Guidelines

Examination Procedures Performed: The examiners reviewed the sources used for determining medical necessity guidelines. Further, INS reviewed the data to:

a) verify the list of sources used by the Companies in the development of the criteria for M/S was provided,
b) verify the list of sources used by the Companies in the development of criteria for MH/SUD was provided,
c) verify that the sources for M/S medical necessity criteria are consistent with scientifically based guidelines of national medical or healthcare coverage organizations or governmental agencies,
d) verify that the sources for MH/SUD medical necessity criteria are consistent with scientifically based guidelines of national medical or healthcare coverage organizations or governmental agencies, and
e) determine if the Companies modified the medical necessity criteria used by a third-party to be in line with company objectives.

Examination Conclusions: BCBSMA provided a list of sources used for medical necessity criteria. BCBSMA also supplied a list of National Medical professional organizations, a list of evidence-based evaluations by consensus panels/Technology Evaluation bodies, and a list of criteria from regional professional associations including many Massachusetts based associations.

BCBSMA did not state whether they modify criteria used from a third-party source, but they did mention using Blue Cross Blue Shield Association Medical Policy Committee review, the Blue Cross and Blue Shield Association Technology Evaluation Center as well as in-house review of the relevant scientific literature.

Based on the review of the sources for medical necessity guidelines, the sources used to determine medical necessity guidelines for M/S, MH, and SUD meet Massachusetts statutory and regulatory requirements.

Prior Authorization, Concurrent Review, and Retrospective Review

Note: Not all health insurance companies are required to perform concurrent and retrospective reviews in every instance. For example, a concurrent review typically focuses on treatments that are currently in progress. If a patient's treatment has been concluded or if the review is not pertinent to the ongoing care, a concurrent review may not be necessary. However, it should be noted that Massachusetts regulations do include requirements for concurrent review, primarily within the workers' compensation system and for health insurance carriers, to ensure the appropriateness and medical necessity of ongoing treatment, as outlined in Massachusetts General Laws, Chapter 176O, Section 12. Similarly, retrospective reviews may not be necessary in situations where the company has made an effort to verify concurrent reviews by

analyzing documentation and coding before claims are submitted, thereby ensuring accuracy.

Examination Procedures Performed: The examiners reviewed the approved, partially denied, and whole denials for prior authorization, concurrent reviews, and retrospective reviews, divided into M/S, MH, and SUD. Further, INS reviewed the data to:

a) develop averages and medians for M/S, MH, and SUD prior authorization, concurrent reviews, and retrospective reviews,
b) verify the Companies supplied the prior authorization data for M/S, MH, and SUD,
c) verify the prior authorization approvals, denials, and partial denials are in line with statewide averages,
d) review the prior authorizations and determine if the percentage of denials (partial and whole) is higher for MH or SUD than M/S,
e) review the prior authorizations and determine if the percentage of denials (partial and whole) is higher for both MH and SUD combined than it is for M/S,
f) verify that the Companies supplied the concurrent review data for M/S, MH, and SUD,
g) verify the concurrent review approvals, denials and partial denials are in line with statewide averages,
h) evaluate the concurrent review numbers provided by the Companies and determine if the percentage of denials (partial and whole) is higher for MH or SUD than M/S,
i) assess the concurrent review data and determine if the percentage of denials (partial and whole) is higher for both MH and SUD combined than it is for M/S,
j) verify that the Companies supplied the retrospective review data for M/S, MH, and SUD,
k) verify that the retrospective review approvals, denials, and partial denials are in line with statewide averages,
l) assess the retrospective review data and determine if the percentage of denials (partial and whole) is higher for MH or SUD than M/S,
m) assess the retrospective review data and determine if the percentage of denials (partial and whole) is higher for both MH and SUD combined than it is for M/S.

Examination Conclusions: The Companies provided prior authorizations, concurrent reviews, and retrospective reviews that were approved, denied in whole, or denied in part for M/S, MH, and SUD. The Companies were able to separate the data based on the unique NAIC Company Codes ("Cocodes.") Based on the review of the data, BCBSMA meets the Massachusetts statutory and regulatory requirements for prior authorizations, concurrent reviews, and retrospective reviews.

XI. Massachusetts Attorney General Status Update Regarding the 2020 Examination

The examiners requested documentation and explanations to verify that the Companies complied with the Massachusetts Attorney General's 2020 examination. The documentation submitted to the Attorney General report was reviewed for accuracy and completeness. The examiners also requested additional information as part of the review. The recommendations from the AGO's report included details in the areas of network adequacy and utilization review.

Network Adequacy

Examination Conclusions: BCBSMA reported having made extensive changes to ensure data accuracy in the provider directories. Several projects were completed, including outreach and validation of locations. BCBSMA is utilizing a vendor to send reminders every 90 days to Health Care Professionals to verify and update their directory information. This includes name, address, phone numbers, specialties, medical groups, hospital affiliations, gender, board certification, spoken languages, network status, whether they are accepting new patients, and if they offer telemedicine.

A suppression policy has been implemented to suppress a provider after 180 days of no response per the Consolidated Appropriations Act ("CAA") requirements. This policy includes verifying practice locations and where the provider accepts appointments. As of April 2020, BCBSMA implemented a procedure to conduct outreach every 90 days and has been repeating this process monthly. The process included outreach to all providers regardless of whether they had more than three locations. This meets the expectation of removing locations where the provider does not practice.

BCBSMA provided an entire printed provider directory and a current link to it. The date of the printed directory was accurate. The examiners were able to verify that there was a phone number and a link for consumers to report inaccurate provider information. BCBSMA also provided details on how consumers could view outpatient services.

The response from BCBSMA indicates the providers identified for the audit, those audits that were completed, and those audits that required additional research. In addition, the documentation indicated those providers that did not respond, and the providers that were suppressed. The same is true for the facilities; however, it was noted that no facilities were suppressed. BCBSMA confirmed that no MH/SUD facilities were suppressed during the examination timeframe. The Companies supplied the most recent revisions for the 2022 data year, which were updated on November 23, 2022.

The Companies provided an example of the printed provider directory (PDF) for each plan, which includes details for healthcare professionals, hospitals, and facilities other than hospitals.

Based on the data reviewed, BCBSMA appears to be in compliance with the Attorney General's examination related to network adequacy.

Utilization Review

BCBSMA responded that, for an admission to a hospital or other covered health care facility that is certified or licensed by the Massachusetts Department of Public Health, coverage is provided for medically necessary acute treatment services and clinical stabilization services for up to a total of 14 days without prior approval, as long as the health care facility notifies BCBSMA timely.

The initial treatment plan should be provided to BCBSMA within 48 hours of admission. Concurrent review may start on or after day seven of a member's admission, but no denials are issued until after the first 14 days. As of July 2019, BCBSMA updated its policy to ensure that it applies to out-of-network and/or out-of-state providers for members with an out-of-network benefit.

BCBSMA acknowledged that the AGO's letter alleged that BCBSMA's previous policy was "unfairly denying or impeding certain Members' coverage for Acute Treatment Services ("ATS") and Clinical

Stabilization Services ("CSS") received from out-of-state providers", however the letter also stipulates that the AOD did not "constitute evidence of any liability, fault or wrongdoing by BCBSMA."

Based on the data reviewed, BCBSMA appears to be in compliance with the Attorney General's examination related to utilization review.

SUMMARY

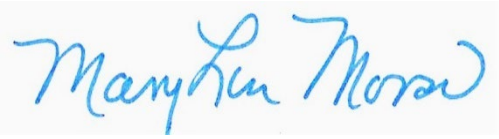
Based upon the procedures performed in this examination, INS has reviewed the Companies responses to the interrogatory which included utilization review, prior authorization data, concurrent review, retrospective review, denials of authorization, step-therapy, network admission standards/reimbursement rates, network adequacy, complaint/grievance data, information verifying compliance with MHPAEA, and denials of payment and coverage, as set forth in the 2022 Handbook, the examination standards of the Division, and the Commonwealth of Massachusetts insurance laws, regulations, and bulletins.

ACKNOWLEDGEMENT

This acknowledgment is to certify that the undersigned is duly qualified and, in conjunction with INS, applied certain agreed-upon procedures to the Companies' corporate records for the Division to perform a comprehensive market conduct examination of the BCBSMA.

The undersigned's participation in this comprehensive market conduct examination as the Examiner-In-Charge encompassed responsibility for the coordination and direction of the examination performed, which was in accordance with, and substantially complied with, those standards established by the NAIC and the Handbook. In addition, this participation consisted of involvement in the planning (development, supervision, and review of agreed-upon procedures), communication, and status reporting throughout the examination, administration, and preparation of the examination report.

The Division acknowledges the cooperation and assistance extended to all examiners by the officers and employees of the Companies during the comprehensive market conduct examination.



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Commonwealth of Massachusetts
Division of Insurance
Boston, Massachusetts

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The INS Companies
Market Regulation Division
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Market Regulation Division
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