THE COMMONWEALTH OF MASSACHUSETTS

OFFICE OF CONSUMER AFFAIRS AND BUSINESS REGULATION

DIVISION OF INSURANCE

Report on the Limited Scope Market Conduct Examination of

Boston Medical Center Health Plan, Inc.

Charlestown, MA

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

NAIC COMPANY CODE: 13203

EMPLOYER ID NUMBER: 04-3373331

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MICHAEL T. CALJOUW
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 **Boston Medical Center Health Plan, Inc.** ("Company"). The examination included, but was not limited to, the Company's 2022 calendar year health insurance business in Massachusetts.

The Company's home office:

100 City Square, Suite 200
Charlestown, MA 02129

The following report thereon is respectfully submitted.

ACRONYMS

American Society of Addiction Medicine (“ASAM”)
Beacon Health Options (“Beacon”)
Behavioral Health (“BH”)
Better Business Bureau (“BBB”)
Boston Medical Center Health Plan, Inc. (“BMC” or “Company”)
Carelon Behavioral Health (“Carelon”)
Centers for Medicare and Medicaid (“CMS”)
Council for Affordable Quality Healthcare, Inc. (“CAQH”)
HealthCare Administrative Solutions Inc. (“HCAS”)
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”)
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”)
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 Company 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 Company. The examiners used sources, including the Company 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 Company 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.

COMPANY BRAND CLARIFICATION

The Boston Medical Center Health Plan, Inc., also known as Boston Medical Center ("BMC") HealthNet Plan, was rebranded to do business as WellSense Health Plan ("WellSense"). The name change officially occurred in May 2022 to reflect the health plan's growth beyond Boston and its statewide reach. WellSense is offered in two states, Massachusetts and New Hampshire. References for WellSense Massachusetts differentiate it from WellSense New Hampshire. The underlying insurer retains the name of Boston Medical Center Health Plan, Inc.

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 Actions

Closed Provider Complaints/Grievances

Examination Conclusions: The Company received 15 complaints submitted by providers in 2022, 12 of which were related to mental health and substance use disorders. The complaints cite problems the provider has experienced with the Company's handling of billing, as well as concerns with other providers or facilities regarding the quality of care, including the appropriateness of treatment, and allegations of patient abuse or neglect while the patient was in treatment. Moreover, the Company received a fraudulent claim from a provider for services not rendered. Based on the review of the complaint and grievance policies and procedures, the Company's complaint and grievance procedures meet Massachusetts statutory and regulatory requirements. There were no complaints of concern from MH/SUD.

In addition to the provider's complaints, there were 7,608 WellSense Provider Appeals. The Company did not separate the number of appeals by category (M/S, MH, and SUD) as requested in the interrogatory question; therefore, the examiners were unable to assess how the appeal decisions impacted each category. In addition, a significantly high percentage of the provider appeals were decided in favor of the Company rather than the provider.

The initial data supplied by the Company did not include a final resolution on 61 appeals, as these were pending at the time the data was supplied. Subsequently those appeals were finalized, and the decisions included 20 dismissals, 19 overturned, and 22 of the appeals were upheld in favor of the Company.

Corrective Actions: The Company must begin tracking provider complaints and appeals by category (M/S, MH, and SUD), thereby allowing the complaint and appeal decisions for M/S, MH, and SUD to be compared for parity. The Company must submit documentation to the Division's Market Conduct Section on or before February 12, 2026, detailing the formal procedures in place for tracking provider complaints.

Policies and Procedures Related to Claim Denials

Examination Conclusions: The Company submitted documentation for Carelon Behavioral Health ("Carelon"), WellSense, Delta Dental, and Northwood. Carelon, formerly Beacon Health Options, manages claims for MH/SUD and is not a subsidiary of the Company. The Company provided M/S claim data from WellSense which is a Boston Medical subsidiary. Delta Dental is not a subsidiary that manages dental claims while Northwood, another non-subsidiary manages durable medical equipment, prosthetics, orthotics, and medical supply claims. The documentation includes references to federal regulations; however, much of the documentation did not include state-specific claims processing requirements regarding behavioral health claims processing, such as M.G.L. c. 176G and bulletin 2024-02.

Subsequent Company Actions: The Company stated that they are in the process of insourcing all BH work and that they will continue to update all claims processing documentation to include state-specific behavioral health statutes, regulations, and bulletins.

The Company will be updating the section as needed in the WellSense Health Plan Provider Manual related to Urgent Preservice Authorization Determinations to clarify that the initial adverse determination timelines meet statutory requirements. This observation is not a violation; the updated language provides further clarification of the existing language within the manual.

The Company confirmed that claims processing documents and plan benefit system configurations do not have lifetime or annual limits on mental health services

The Company explained that claims processed by Northwood will be marked as pending if one line of the claim is placed on hold. The Company also clarified that the system requires the entire claim to be finalized with all lines completed before the claim can be paid. The Company stated that most claims with a pending status are cleared for processing within 30 days, however, the Company clarified that consumers do not incur a delay in obtaining their durable medical equipment, even if the claim has a pending status. .

Corrective Actions: The Company must:

- continue to update the Company's new in-house BH claim processing documentation, and the WellSense Health Plan Provider Manual, which include state-specific behavioral health statutes, regulations, and bulletins, and
- submit documentation to the Division's Market Conduct Section on or before February 12, 2026, demonstrating the behavioral health claims procedures have all been updated.

Reimbursement Rate Policies

Examination Conclusions: The Company response did not provide an overview of reimbursement rates for MH or SUD providers. There were no rates or criteria provided to indicate that reimbursement rates are in line with CMS, MassHealth, or other established reimbursement rates that are publicly available for comparison.

Subsequent Company Action: The Company states in their follow-up response that they have developed an "Internal Provider Contract Review and Approval Policy," which describes their reimbursement and benchmark methodology for M/S and BH providers, but no such document was uploaded for review. The Company also said the WellSense Mental Health Parity Oversight Committee reviews and monitors business operations including reimbursement rate procedures/documents, and the committee affirms that the process is not more cumbersome for MH and SUD than they are for M/S, but no documentation was provided.

Corrective Actions:

- The Company must provide the formal policy and procedure ("Internal Provider Contract Review and Approval Policy") regarding reimbursement that details rate reimbursements and clarifies if there are any differences between reimbursement rates for medical/surgical and behavioral health providers. The Company must submit documentation to the Division's Market Conduct Section on or before February 12, 2026, detailing the formal policy and procedures for provider reimbursements, clarifying if there are any differences between reimbursement rates for medical/surgical and behavioral health providers.

I. COMPLAINTS/GRIEVANCES

Closed Consumer Complaints

The interrogatory requested a summary log of all closed consumer complaints submitted by consumers directly to the Company 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 Company's complaints and grievance registers to identify if there was a lack of in-network providers,
b) reviewed the Company's complaint and grievance register to identify if there were sufficient in-network providers for M/S, MH, and SUD,
c) reviewed the Company's complaint/grievance registers to detect any identifiable trends for out-of-network denials,
d) reviewed the Company's 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 Company, and
f) reviewed to determine the final number of complaints and identify those that were of potential concern.

Examination Conclusions: The Company reported 75 consumer complaints for 2022, and of those, five (5) were related to mental health/substance use disorders. Most of the complaints fell into one of the following categories: administrative complaints against the plan, clinical quality of care (QOC) complaints against providers, or administrative complaints against providers.

Of the 75 consumer complaints, there were seven (7) consumer complaints and five (5) administrative complaints filed with WellSense against its plans and providers. These complaints include issues such as incorrect processing of claims through the hospital causing denials, unexpected deductible charges, difficulty finding a new in-network PCP, claims incorrectly applied, and providers failing to inform the insured that they are no longer participating in the plan. The two (2) complaints submitted to WellSense Massachusetts allege difficulty in finding outpatient mental health treatment through the company's provider directory. Complainants report reaching out to several providers listed online and being told that these providers were either not accepting new patients or only doing the initial intake.

Based on the review of the complaint/grievance summary log, the Company's complaint and grievance procedures comply with Massachusetts' statutory and regulatory requirements.

Subsequent Company Actions: The Company reviewed the mental health and substance use disorder providers in the state to verify the accuracy of their information and availability on the Company's website, to ensure that consumers can access the available providers covered under their plan. In addition, the Company stated that it continues to review and update its provider data accuracy weekly and has contractually obligated Carelon to uphold these same standards.

Closed Provider Complaints/Grievances

The interrogatory requested a summary log of all closed provider complaints submitted by consumers directly to the Company 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 that all complaints were correctly reported. Further, INS:

a) reviewed the Company's complaint/grievance registers to identify whether there were sufficient in-network providers.
b) reviewed the Company's complaint/grievance registers to identify whether there was a lack of in-network providers for M/S, MH, and SUD.
c) reviewed the Company's complaint/grievance registers to identify whether there were trends for out-of-network denials.
d) reviewed the Company's 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 Company, and
f) reviewed to determine the final number of complaints and identify those of potential concern.

Examination Conclusions: The Company received 15 complaints submitted by providers in 2022, 12 of which were related to mental health/substance use disorders. The complaints cite problems the provider has experienced with the Company's handling of billing, as well as concerns with other providers or facilities regarding the quality of care, including the appropriateness of treatment, allegations of patient abuse or neglect while the patient was in treatment. Moreover, the Company received a fraudulent claim from a provider for services not rendered. Based on the review of the complaint/grievance policies and procedures, the Company's complaint and grievance procedures meet Massachusetts statutory and regulatory requirements. There were no provider complaints of concern from MH/SUD providers.

In addition to the provider's complaints, there were 7,608 WellSense Provider Appeals. The Company did not separate the number of appeals by category (M/S, MH, and SUD) as requested in the interrogatory question; therefore, the examiners were unable to assess how the appeal decisions impacted each category. In addition, a significantly high percentage of the provider appeals were decided in favor of the Company as opposed to the provider.

The initial data supplied by the Company did not include a final resolution on 61 appeals, and the Company explained that these were appeals that had not been finalized at the time the data was supplied. Subsequently those appeals were finalized, and the decisions included 20 dismissals, 19 overturned, and 22 of the appeals were upheld in favor of the Company.

Corrective Actions:

- The Company must begin tracking provider complaints and appeals by category (M/S, MH, and SUD), thereby allowing the complaint and appeal decisions for M/S, MH, and SUD to be compared for parity. The Company must submit documentation to the Division's Market Conduct Section on or before February 12, 2026, detailing the formal procedures in place for tracking provider complaints.

II. MARKET CONDUCT ANNUAL STATEMENT

Companies with $50,000 or more in annual premium sales in certain lines of business are required to 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 Company 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 Company submitted the MCAS data; however, they did not provide the attestation for the 2022 MCAS filing data. It was noted that the number of prior authorizations requested did not match the number of approved and denied requests for out-of-exchange lines (103, 104, and 105). Similarly, the number of prior authorization requests for behavioral health did not equal the number of approved and denied requests. The Company's prior authorizations denied for in-exchange were higher than the statewide average. The Company's prior authorizations for out-of-exchange pharmacy were denied at a higher rate than the statewide average, and the in-exchange pharmacy authorizations, including out-of-network pharmacies, were denied at a higher rate than the statewide average. The in-network pharmacy authorizations were also denied at a slightly higher rate than the statewide average.

Subsequent Company Actions: The Company filed its 2022 report, including their attestation for the health line of business with the NAIC, and the examiners were able to access it within MCAS. The Company also supplied corrected numbers for prior authorizations.

The Company provided a supplemental document listing non-formulary medications, non-preferred medications, and those requiring prior authorizations. Many medications on this list appear to be brand-name pharmaceuticals, but they may also have generic options. Providers might benefit from a list of alternative medications within the same class to prescribe to patients, potentially reducing pharmaceutical denials.

The Company reviewed the prior authorization denials for pharmacy for both in-exchange and out-of-exchange to determine common reasons for denials. The results of that analysis determined that the medications that were consistently denied fell into three categories: non-formulary medications, non-preferred medications, and step-therapy medications.

III. DENIAL OF PAYMENT AND COVERAGE

Third-Party Administrator Claims Processing

The Company 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 Company group or an outside vendor) is used for pharmacy claims, and
c) whether a PBM is utilized.

Examination Conclusions: The Company provided a list of vendors but did not fully explain which type of claims processing each vendor conducted. In their initial response, the Company provided the vendor names and which entity was designated to conduct mental health claim handling. The Company also supplied Delta Dental who processes all dental claims.

Subsequent Company Actions: The Company responded that Carelon Behavioral Health (formerly Beacon Health Options) will no longer conduct MH/SUD claims processing as of January 1, 2026, and that the vendor will be replaced with in-house claims processing.

The Company provided a list of third-party entities involved in claim determinations. The information included a description of the type of claims that each third-party processes, as well as the name of the third party, the business address, a brief description of the services they provide, and whether they are affiliated with the Company or Group.

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 Company has adequate processes and procedures for claims processing,
b) if the Company writes 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 Company 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., a psychologist/board-certified, behavior analyst with a doctoral degree, and/or a psychologist with clinical experience).

Examination Conclusions: The Company submitted documentation for Carelon Behavioral Health ("Carelon"), WellSense, Delta Dental, and Northwood. Carelon, formerly Beacon Health Options,

manages claims for MH/SUD and is not a subsidiary of the Company. The Company provided M/S claim data from WellSense which is a Boston Medical subsidiary. Delta Dental is not a subsidiary that manages dental claims while Northwood, another non-subsidiary manages durable medical equipment, prosthetics, orthotics, and medical supply claims. The documentation includes references to federal regulations; however, much of the documentation did not include state-specific claims processing requirements regarding behavioral health claims processing, such as M.G.L. c. 176G and bulletin 2024-02.

Subsequent Company Actions: The Company stated that they are in the process of insourcing all BH work and that they will continue to update all claims processing documentation to include state-specific behavioral health statutes, regulations, and bulletins.

The Company will be updating the section as needed in the WellSense Health Plan Provider Manual related to Urgent Preservice Authorization Determinations to clarify that the initial adverse determination timelines meet statutory requirements. This observation is not a violation; the updated language provides further clarification of the existing language within the manual.

The Company confirmed that claims processing documents and plan benefit system configurations do not have lifetime or annual limits on mental health services

The Company explained that claims processed by Northwood will be marked as pending if one line of the claim is placed on hold. The Company also clarified that the system requires the entire claim to be finalized with all lines completed before the claim can be paid. The Company stated that most claims with a pending status are cleared for processing within 30 days, however, the Company clarified that consumers do not incur a delay in obtaining their durable medical equipment, even if the claim has a pending status.

Corrective Actions: The Company must:

- continue to update the Company's new in-house BH claim processing documentation, and the WellSense Health Plan Provider Manual, which include state-specific behavioral health statutes, regulations, and bulletins, and
- submit documentation to the Division's Market Conduct Section on or before February 12, 2026, demonstrating the behavioral health claims procedures have all been updated.

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

Examination Procedures Performed: The Company 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: The Company initially provided data for claims received, paid, and denied, but did not report any partial claim denials.

The initial data provided for MH claim denials placed the Company above the statewide average for all companies subject to MHPAEA. Although the Company's denial rate for SUD claims was below the statewide average, there was a significant number of SUD claim denials, and the Company had the third-highest number of SUD denials in the state. The Company evaluated their denial rates and indicated that the most common reason for denial was member ineligibility, followed by untimely filings and no authorization.

Subsequent Company Action: The Company provided updated data on claims received, paid, and denied. Even with the updated figures, the percentage of complete and partial denials remains higher for MH/SUD than for M/S. The company reviewed its denial rates and found that the most common reason for denial was member ineligibility, followed by untimely filings and lack of authorization. The data also showed that MH/SUD denials, billing errors, and duplicate claims were higher than those for M/S.

In a follow-up conference with the Company, they provided an explanation of the ongoing efforts to ensure claim accuracy. Providers have access to educational materials for appropriate billing practices which includes the following efforts: (i) providers new to the network receive a welcome packet with helpful resources to assist with claims and billing; (ii) the Company provides the opportunity for onsite or recorded orientations to educate providers and assist with claims and billing questions, including targeting training for certain provider types; (iii) providers receive ongoing updates and reminders through the Company's quarterly provider newsletter: and (iv) providers may contact the Company with questions via phone, email or its provider relations consultant. In connection with this update, the Company provided supporting documentation, including a sample welcome letter, copies of a targeted training for behavioral health providers joining the network effective January 1, 2026, and an excerpted section from the most recent newsletter on behavioral health claims submission updates. The Company stated that it will continue to offer flexible opportunities to providers to ensure comprehensive billing and claims education is met across its network.

Based on the initial information provided by the Company and subsequent information, the Company meets with Massachusetts' and federal statutory requirements.

IV. NETWORK ADEQUACY

The Company was asked to supply processes and procedures to demonstrate their compliance with the state and Federal requirements for network adequacy. The Company was also asked to provide a listing of its MHPAEA plans. The examiners selected a plan from the Company's list. They performed a search on the Company 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 Company's policies and procedures to determine if the Company complied with Federal requirements on provider data accuracy. The purpose of the INS review was:

a) to ensure the Company 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: The Company provided its 2021 policy for the provider directory. The policy stated that "providers may submit changes at any time to the Provider Enrollment Department. Requests are verified with the provider, and the appropriate systems and provider directory are updated. The Provider Enrollment staff validates the submitted information and enters the information within 7 days from the receipt date." The documentation provided by the Company did not include a reference to provider directory audits; however, it did mention, "Provider Directory Outreach MM/YR."

Carelon utilizes CAQH (Council for Affordable Quality Healthcare, Inc.), an independent entity that provides a database for the collection of provider data. CAQH allows providers to complete credentialing and directory information in one place and share it with multiple health plans. The 2021 policy for the provider directory also stated, "providers will be given 30 days to respond to the Plan's request to review its data. Non-responders will be put on a corrective action plan and may be terminated."

Based on the additional information provided by the Company, the Company meets network adequacy state and federal standards.

Subsequent Company Actions: The Company revised its procedures to include a timeline of 2 days (instead of 7 days) for corrections and updates coming directly from a provider/facility in compliance with 42 U.S. Code § 300gg-115(a)(2)(C) Protecting patients and improving the accuracy of provider directory information, M.G.L. c. 176O § 28 and 211 CMR § 52.15.18. The Company also provided the most current policies and procedures related to provider directory audits of all providers/facilities, including M/S, MH, and SUD. The information indicated which audits are completed every 90 days to verify compliance with 42 U.S. Code § 300gg-115. The information also provides more details on the Company's procedures about the corrective action plan that is implemented for providers that do not respond to the Company's inquiries regarding provider data accuracy.

List of Massachusetts Plans Subject to Mental Health Parity in 2022

Examination Procedures Performed: INS reviewed the Company's 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 Company's response to verify:

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

Examination Conclusions: The initial response did not include the full name of the plan, the name of the plan as it appears on the printed provider directory, the name of the plan as it appears on a consumer's health insurance card, or the name of the plan as it appears when conducting searches of the online provider directory.

Based on the additional information provided by the Company, the Company meets the expectations for the list of plans in 2022.

Subsequent Company Actions: The Company provided the full name of the plan, the name of the plan as it appears on the printed provider directory, the name of the plan as it appears on a consumer's health insurance card, and the name of the plan as it appears when conducting searches of the online provider directory.

Basic Web Searches

Examination Procedures Performed:
The examiners selected a plan from the Company's list and performed a search on the Company website searching 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 plans 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 Company name provided, and
d) reported challenges encountered in the search to the Company.

Examination Conclusions: The examiners conducted web searches for a provider for a substance use disorder professional with the Carelon Behavioral Health Plan and an OB-GYN with the Boston Medical Center Health Plan Network. The examiners initially encountered challenges finding an OB-GYN provider. This is because there appeared to be two sites, one for regular physicians and another for behavioral health providers. Based on the review of the information provided and the recent updates to the company website, the Company meets state standards for conducting basic web searches.

Based on the additional information provided by the Company, the Company meets the expectations for basic web searches for M/S and MH/SUD providers.

Subsequent Company Actions: The Company provided a copy of an insured medical card, which includes the Company's website and phone numbers for members to call for assistance and a separate phone number for finding providers. The Company updated its website, which included more intuitive search options for consumers to select their plan and search for providers. The updated website does include a drop-down for nineteen languages for members to select from, allowing consumers to conduct provider searches, details, and filtering options in their own language. There are filtering options available, including features like accepting new patients, gender specific information, and languages spoken as search features. The initial pages of the website were significantly improved to include broad categories, and the open text search field was not removed but minimized in its importance for provider searching. The system does still offer the ability to search for a specific provider by name or by area. Consumers will have improved searching because there is less reliance on an open text field, minimizing the likelihood of typographical errors. The main company website contains a link directly to Carelon Behavioral Health website if that provider type is selected.

V. NETWORK ADMISSION STANDARDS

The Company 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 Company is using a TPA or another vendor for MH/SUD. If the Company has 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: The Company submitted three documents related to network admission standards. The submitted documentation mentioned processes and procedures to ensure compliance with federal and state requirements; however, there were no details in the document regarding reviewing providers by their specialty. To confirm a comprehensive network, each specialty and service should be evaluated to include whether the provider is accepting new patients, and whether the availability of on-site and online appointment options should be included.

Subsequent Company Actions: The Company submitted additional documents for Carelon Behavioral Health listing geographical standards for time and distance; however, these standards do not specify the ratio of patients to providers, nor do they include the type of county (e.g., large metro, metro, micro, rural, or extreme access considerations). Even if there are two providers within a 60-mile/60-minute radius for behavioral health, that does not guarantee they will have availability. Also, the wait times within the document state that the wait times will not exceed 14 calendar days for non-emergency behavioral health services, and the federal standard is 10 days.

It should be noted that the Company also provided documentation for WellSense, which acknowledged the use of enrollment data, providers not accepting new patients, and geographic location (time/distance) of providers for maintaining network adequacy. Additional documentation was also provided by the Company related to M/S providers, including primary care, specialty, and high-volume specialists. The supplemental information related to M/S providers details the member ratios for providers. The documentation also mentions an annual evaluation to validate the effectiveness of the established standards and compare them to the actual performance for network adequacy.

In a follow-up conference with the Company, it confirmed that it currently utilizes the Council for Affordable Quality HealthCare ("CAQH") for its M/S provider network admissions. The Company further referenced its Provider Manual which outlines the four-step process to become credentialed and enrolled in the Company's network, including the following steps: (i) completion of the HealthCare Administrative Solutions Inc. ("HCAS") enrollment form; (ii) completion of the Company's Provider Data form; (iii) ensuring that the CAQH application is completed, that the applicant has a current attestation, and that permission to access each CAQH account has been granted; and (iv) submission of the completed forms to the Company via email, fax or mail. The Company confirmed that upon its insourcing of the management of behavioral health services, effective January 1, 2026, all MH/SUD network provider admissions will be incorporated into its current CAQH process for network admissions.

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: The Company response did not provide an overview of reimbursement rates for MH or SUD providers. There were no rates or criteria provided to indicate that reimbursement rates are in line with CMS, MassHealth, or other established reimbursement rates that are publicly available for comparison.

Subsequent Company Action: The Company states in their follow-up response that they have developed an "Internal Provider Contract Review and Approval Policy," which describes their reimbursement and benchmark methodology for M/S and BH providers, but no such document was uploaded for review. The Company also said the WellSense Mental Health Parity Oversight Committee reviews and monitors business operations including reimbursement rate procedures/documents, and the committee affirms that the process is not more cumbersome for MH and SUD than they are for M/S, but no documentation was provided.

Corrective Actions:

- The Company must provide the formal policy and procedure ("Internal Provider Contract Review and Approval Policy") regarding reimbursement that details rate reimbursements and clarifies if there are any differences between reimbursement rates for medical/surgical and behavioral health providers. The Company must submit documentation to the Division's Market Conduct Section on or before February 12, 2026, detailing the formal policy and procedures for provider reimbursements, clarifying if there are any differences between reimbursement rates for medical/surgical and behavioral health 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: The Company submitted two documents related to network admission standards: an M/S list of approved providers and a provider onboarding spreadsheet for Carelon concerning MH/SUD providers. The lists provided by the Company included only those applicants that were approved. The lists did not include denied determinations, nor did they provide the reasons for approvals and denials. Based on the review of the original and subsequent company action data, the Company is in compliance with state network admission standards.

Subsequent Company Actions: The Company provided an explanation that no new contracts (M/S) were denied access to the network for WellSense, as they have an open network, and providers meeting the credentialing criteria are permitted to join the network. Carelon Behavioral Health (MH/SUD) had one network admission denial in the initial submission.

VI. POLICY AND PROCEDURES FOR COMPLIANCE WITH MHPAEA

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

a) ensure the Company has policies and procedures for ensuring compliance with MHPAEA,
b) ensure the Company monitors/audits vendors for compliance, and
c) ensure the Company has an organized compliance plan for MHPAEA oversight.

Examination Conclusions: The Company submitted thirteen (13) documents. One document related to appropriate professional policies stated, "The Plan fully or partially delegates management of behavioral health services, durable medical equipment, prosthetics, orthotics, medical supplies, pharmacy services, high-end radiology services, and non-emergent medical transportation (only for NH benefit reviews). Each vendor has its own appropriate professional policy, which has been approved as part of delegation oversight." In another document from Carelon regarding compliance, specifically related to behavioral health, the report said, "As a managed behavioral health organization... does not establish the benefit coverage plan designs for its contracted client plans. As a result, the client plans have responsibility for the financial testing and actuarial certification relating to QTLs applicable to MH/SUD benefits to ensure they meet MHPAEA's standards and are no more restrictive than the predominant financial requirements and QTLs applied to substantially all medical and surgical benefits." According to the documentation submitted by the Company, Carelon Behavioral Health (Carelon) establishes policies for compliance but does not assume responsibility for ensuring adherence to MHPAEA standards.

The Company provided their policies, procedures and documentation that demonstrating their implementation of MHPAEA.

Company Subsequent Actions: The Company provided additional information stating that WellSense and Carelon have medical management committees conducting routine oversight, both organizations are accredited by the National Committee for Quality Assurance (NCQA). The provided information also stated that WellSense, through its Clinical Vendor Oversight Committee, conducts an annual review of each vendor that performs delegated management for Plan Members. This annual audit includes a review of policies and procedures, verifying that the Company applies them consistently. The Company also affirmed that it has an internal Mental Health Parity Oversight Committee with representatives from both WellSense and Carelon, as well as other business areas, which confirms compliance with MHPAEA requirements annually.

VII. QUANTITATIVE TREATMENT LIMITATIONS

The Company 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 Company provided testing results (pass/fail),
b) verify if the Company 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 Company demonstrated that the substantially all testing (2/3 threshold) was completed before the predominant testing.

Examination Conclusions: The Company provided the QTL financial requirements for thirteen group policies. The financial requirements were broken down by the required six criteria for QTL predominant testing, including inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency, and prescription drugs. No information was provided on whether substantially all testing had been conducted before the predominant testing, nor indication of pass or fail; however, there was an indicator of "Y" for compliant, "Met," and "Meet Basic," so the examiners are assuming they are positive outcomes. Based on the review of the original and supplemental information, the Company is in compliance with QTL analysis testing.

Subsequent Company Actions: The Company provided an explanation verifying whether the substantially all testing is conducted prior to the predominant testing.

VIII. STEP THERAPY

The Company 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 Company provided step-therapy documentation,
b) verify the Company 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: The documentation for processes and procedures did not contain documentation indicating that patients and providers can request exceptions, and that insurance providers must respond to these requests within three business days (or 24 hours in emergencies). The Company's document provided prescription drugs that utilize step therapy but did not include the data broken out by categories to distinguish between M/S and MH/SUD medications. It was noted that two of the medications for opioid withdrawal, including Buprenorphine Hydrochloride and Buprenorphine-Naloxone were listed as requiring step therapy under the MH/SUD category. It was also noted that the opioid analgesic Methadone HCL was listed as requiring step therapy under the M/S category. The documentation did not include a list of medical policies or prescription drugs that include criteria for failed first-line treatment.

Based on the initial documentation and the additional documentation provided by the Company they are in compliance with state step-therapy requirements.

Subsequent Company Actions: The Company provided updated documentation related to the step therapy protocol, including the ability to seek an exception in compliance with M.G.L. c. 176O, § 12A and M.G.L. c. 118E, § 51A. The Company also provided a list of medications or medical treatments that require a fail-

first option. The details within the documents include the medication or previous treatment required before the option becomes accessible.

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 Company 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: The Company did not initially provide the total number of step-therapy request determinations or the total number of step-therapy requests approved, denied in part, or denied in whole. However, after a request from the examiners, the Company submitted data for questions 23 and 24 related to step-therapy determinations.

The examiners analyzed the initial and subsequent information submitted by the Company and determined that the percentage of paid and denied claims was consistent with statewide averages. No medication was denied under all circumstances; however, it was noted that the majority of the denied medicines were brand name, aligning with the fail-first documentation provided by the Company.

Based on the supplemental information provided, the Company meets with state standards for step therapy.

IX. UTILIZATION REVIEW

The Company were requested to provide the TPAs for MH/SUD, the medical necessity guidelines criteria, and the sources for those guidelines. In addition, the Company was 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 Company. 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 Company or group.

Examination Conclusions: The Company did not provide a list of all third-party entities involved in MH/SUD or M/S benefit determinations, nor did it specify the type of claims they oversee. No list included the name of the third party, the business address, a brief description of the services they provide, and whether they are affiliated with the Company.

Subsequent Company Actions: The Company provided a list of all third-party entities involved in MH/SUD or M/S benefit determinations and the types of claims they oversee. The list included the name of the third

party, the business address, a brief description of the services they provide, and whether they are affiliated with the Company or Group.

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: The Company initially provided links to entities conducting medical necessity guidelines criteria for both M/S and MH/SUD. The links direct users to the Company's website and then to another document archiving site. There are folders for pharmacy, clinical, and medical policies. The Company also provided a list of resources reviewed when developing and reviewing clinical criteria. There was a document for eviCore and two for Northwood. No document specific to Beacon Health Options ("Beacon") related to MH/SUD medical necessity guidelines existed. The Company did not indicate whether they modify any of the medical necessity criteria used by a contracted third-party source.

Based on the supplemental information provided, the Company meets state standards for medical necessity guidelines.

Subsequent Company Actions: The Company provided the medical necessity guidelines used by Beacon for MH/SUD in the Commonwealth of Massachusetts. Beacon medical necessity criteria are reviewed and updated at least annually to ensure that they reflect the latest developments in serving individuals with behavioral health diagnoses. Beacon's Corporate Medical Management Committee (CMMC) adopts, reviews, revises, and approves Medical Necessity Criteria per client and regulatory requirements.

The Company explained that WellSense reviews the medical necessity criteria utilized by its partner clinical suppliers. WellSense also reviews the criteria developed by other organizations and utilized by the Plan (e.g., InterQual® criteria). WellSense does not modify any of the medical necessity criteria from outside sources, but the Plan will recommend revisions to these clinical review criteria if the guidelines are not in compliance with a state mandate. When these medical necessity criteria are not revised by the third-party vendor or other entity that has developed the criteria, the Plan will develop and implement internal clinical review criteria to manage the service (rather than utilize the clinical criteria from the outside source) to ensure compliance with a state mandate.

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 that the list of sources used by the Company in the development of the criteria for M/S was provided,
b) verify that the list of sources used by the Company 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 Company modified the medical necessity criteria used by a third party to be in line with Company objectives.

Examination Conclusions: The Company did not initially provide the medical necessity guidelines used by Carelon for MH/SUD. However, based on the additional information provided, the Company meets state standards for the sources used in medical necessity guidelines.

Subsequent Company Actions: The Company provided the medical necessity guidelines (67 pages) used by Carelon for MH/SUD. The sources for medical necessity include nationally recognized sources such as the Centers for Medicare and Medicaid (CMS), the American Society of Addiction Medicine (ASAM), and InterQual Behavioral Health.

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 Company 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 Company 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 Company 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 company 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, and
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 Company provided all the requested information. No unusual trends or patterns were identified in the data provided by the Company. There are no recommendations for M/S, MH, and SUD prior authorization, concurrent review, and retrospective reviews.

SUMMARY

Based upon the procedures performed in this examination, INS has reviewed the Company 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

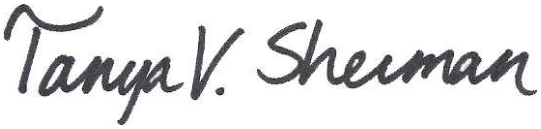
This acknowledgment is to certify that the undersigned is duly qualified and, in conjunction with INS, applied certain agreed-upon procedures to the Company's corporate records for the Division to perform a comprehensive market conduct examination of the Company.

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 Company during the comprehensive market conduct examination.

Commonwealth of Massachusetts
Division of Insurance
Boston, Massachusetts

The INS Companies
Market Regulation Division
Dallas, Texas



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