THE COMMONWEALTH OF MASSACHUSETTS

OFFICE OF CONSUMER AFFAIRS AND BUSINESS REGULATION

DIVISION OF INSURANCE

Report on the Limited Scope Market Conduct Examination of

Cigna Health and Life Insurance Company

Tampa, FL

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

NAIC COMPANY CODE: 67369

EMPLOYER ID NUMBER: 59-1031071

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COMMONWEALTH OF MASSACHUSETTS
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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 **Cigna Health and Life Insurance Company** ("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:

900 Cottage Grove Road
Bloomfield, Connecticut 06002

The following report thereon is respectfully submitted.

ACRONYMS

American Specialty Health (“ASH”)
American Specialty Health Group Inc. (“ASH Group”)
American Society of Addiction Medicine (“ASAM”)
Behavioral Health (“BH”)
Better Business Bureau (“BBB”)
Cigna Health and Life Insurance Company (“CHLIC” or the “Company”)
Evernorth Behavioral Health (“EBH”)
eviCore Healthcare MSI, LLC (“eviCore”)
INS Regulatory Insurance Services, Inc. ("INS")
Licensed Marriage and Family Therapists (“LMFT”)
Licensed Mental Health Counselor (“LMHC”)
Massachusetts Attorney General’s Office (“AGO”)
Massachusetts Division of Insurance (“Division”)
Market Conduct Annual Statement (“MCAS”)
Market Regulation Handbook ("MRH” or “the Handbook")
MCG Health (“MCG”)
Medical/Surgical (“M/S”)
Mental Health (“MH”)
National Association of Insurance Commissioners ("NAIC")
National Clinical Mental Health Counseling Examination (“NCMHCE”)
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”)
Pharmacy and Therapeutics (“P&T”) committee
Quantitative Treatment Limitation (“QTL”)
Return on Investment (“ROI”)
Substance Use Disorder (“SUD”)
System for Electronic Rate Form Filing (“SERFF”)
Third-Party Administrators (“TPAs”)
United States of America (“USA”)
Utilization Management (“UM”)

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.

COMPANY BRAND CLARIFICATION

Cigna is a global health services organization, while CareLink is a specific Cigna plan or network that provides access to a network of doctors and hospitals. CareLink plans typically offer access to both local Cigna Open Access Plus providers and, in certain regions like Massachusetts and Rhode Island, a different participating network. In Massachusetts, Cigna Health and Life Insurance Company ("CHLIC") utilizes CareLink. CareLink is a strategic alliance that combines Tufts Health Plan's provider network in Massachusetts and Rhode Island with Cigna's strong national OAP provider network. The Company leverages the Tufts provider network for medical services. However, for mental health and substance use disorders, the Company employs its Evernorth Behavioral Health provider network. Cigna's alliance with Tufts ended 12/31/2024.

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.

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.

CORRECTIVE ACTIONS

Network Admission Standards Policies/Procedures Data Submitted

Examination Conclusions: The Company did not provide the policies and procedures for identifying the network admission standards but indicated the vendor would provide those standards. The examiners reviewed the standards listed on the Cigna website at: Medical Network Credentialing | Cigna Healthcare for M/S and also Evernorth Provider - Resources - Credentialing for MH/SUD. Both application processes appear to be very similar, with proof of certification, professional liability insurance, and state-specific requirements. There is one difference, and that is the amount of time it takes to process the application. For M/S the Company website says, "once we receive the application packet, we'll start the credentialing process. This typically takes 45 to 60 days to complete." For the MH/SUD application process, including providers and facilities, the Evernorth website states, "…the entire process to join the Evernorth Behavioral Health network can take up to 90 days to complete."

The additional information provided by the Company did identify some state-specific credentialing requirements, especially those for the timeline related to credentialing in Massachusetts. While some licensure requirements in Massachusetts align with national standards for Licensed Mental Health Counselors ("LMHCs"), the state has more specific and rigorous requirements in certain areas. There was no state specific detail regarding qualifications for mental health practitioners. The Commonwealth does require that all LMHC licensees hold a qualified master's degree, have accrued 3,360 hours of post-master's supervised clinical experience and pass the National Clinical Mental Health Counseling Examination ("NCMHCE"). Similarly, Massachusetts requires clinical membership in the American Association for Marriage and Family Therapy and 3,360 hours of post-master's experience for Licensed Marriage and Family Therapists ("LMFTs").

The examiners did note differences between the credentialing procedures for BH and those for M/S. It does appear that the credentialing procedures and re-credentialing procedures are similar, however there are some differences. There are also two additional sections to the credentialing document for BH, including provisional credentialing (which is not allowed for the M/S side) and an additional section for requirements for practitioner participation where the Credentialing Committee reviews criteria at least

annually and may alter the exceptions to the criteria. The BH credentialing procedures and additional requirements specifically mention procedures on what to do if a BH provider is rejected or terminated from the network. The additional requirements also discuss the provider's right to review information and correct any erroneous information. Further there are procedures for providers to obtain a status update on their application for BH, but not for M/S providers.

The M/S credentialing procedures mention that a practitioner (provider) who is leaving a delegated credentialing arrangement and establishing a direct contract with Cigna must undergo initial credentialing within 6 months prior to the termination date from the delegate if the delegate does not provide a copy of the practitioner's credentialing file. If the delegate provides a copy of the practitioner's credentialing file, the practitioner may be recredentialed three years from delegates last credentialing date.

Corrective Actions:

- The Company should update their behavioral health licensing and credentialing documentation to include Massachusetts' state specific standards, especially when considering utilizing providers from other states for independent clinical practice in neighboring states and/or telehealth services. The specific statute references include Massachusetts General Laws Chapter 112, Sections 163–172 and associated administrative code (262 CMR).

Subsequent Company Actions: The Company acknowledges the discrepancy on the website, and they have reviewed the website content. Please note that the quoted 90-day timeline for MH/SUD applications includes time in which Evernorth Behavioral Health ("EBH") and the provider may be collaborating to complete missing/inaccurate portions of the submitted application, as well as negotiating contract terms. The Company explained that the time referenced for medical credentialing cites the time for credentialing only, and the behavioral cites the entire contracting process, inclusive of contract language & rate negotiations as well as credentialing time. The Company confirms that these timelines are accurate and will not be updating websites at this time. The state regulation 211 CMR, § 52.09 – Credentialing, states that carriers shall complete credentialing of 95% of Health Care Professionals' initial clean and complete credentialing applications within 60 days of receipt; however, more time is allowed for re-credentialing applications and those with a delay to be notified within 75 days.

The Company is updating the behavioral health licensing and credentialing documentation as required by February 12, 2026.

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 30 consumer complaints received in 2022, and of those, seven (7) were related to mental health and substance use disorders. The seven complaints related to mental health and substance use disorders allege incorrect provider billing, double billing by the clinic, prescription dosage changes, member waiting on a psych evaluation from the facility, inappropriate care while detoxing, and the member was told that the provider was contracted, but the facility advised them that they were not.

The Company provided 30 complaints, 11 of which did not include final dispositions.

Subsequent Company Actions: The Company provided the complaint dispositions for the 11 executive complaints. The majority of the dispositions resulted in claims being paid/processed.

Closed Provider Complaints/Grievances

The interrogatory requested a summary log of all closed provider complaints consumers submitted 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 or 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 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 reported five (5) MH/SUD provider complaints for 2022, and of those, one (1) was related to mental health and substance use disorders, while the remaining four (4) are related to issues with Evernorth Behavioral Health ("EBH") (Evernorth is the third-party administrator that coordinates behavioral health services for the Company.) The five (5) provider complaints allege difficulty using EBH's website, to the point that providers avoid Cigna/Evernorth patients because they don't want to deal with the website. In addition, these complaints indicate dissatisfaction with the providers' inability to send appeals via email. The complaints also cited frustration with the situation where Evernorth requires the appeal to include a formal cover sheet. Still, when the providers attempt to retrieve the required cover, the access site is down, making it challenging to meet Evernoth's requirement. Of the five (5) MH/SUD provider-initiated complaints, three (3) were of potential concern.

The Company reviewed its provider portals/processes for both M/S and MH/SUD. They explained that the portal is identical for all Cigna customers, regardless of the provider's specialty type. Appeals must be mailed or faxed. A cover sheet is not required, but it is encouraged. The Company also provided more information regarding three complaints. One complaint related to the providers' inability to access their patients on the Company's website, and the Company confirmed that their information can be viewed in their portal following two-factor authentication.

Subsequent Company Actions: One complaint related to the inability to submit claims through Availity, the Company confirmed that they do not offer a free option for M/S or MH/SUD providers to submit claims through Availity, however providers can submit claims through Availity for a cost or they can select other options that are free. The complaint in reference was for an initial claim, not an appeal.

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 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 an MCAS attestation for data accuracy and completeness. The Company did not report on any individual or small group business for either on-exchange or off-exchange for 2022. The Companies' primary health business in 2022 is primarily large group comprehensive and large group/individual grandfathered plans. The Company also has premiums for the Other Health[1] business, but that data was not collected in 2022. No areas of concern were identified in this initial review of the data.

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 information for two third-party administrators contracted to process claims and their affiliations. Their response did not include Evernorth. Evernorth is considered a TPA that performs claim determinations for behavioral health claims and should be included in this list. The Company subsequently provided an updated list of Third-Party Administrators that included Evernorth Behavioral Health, Inc. They explained that EBH provides utilization management and claims processing for behavioral health services.

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,

[1] The Market Conduct Annual Statement line of other health was collected starting 2023 and includes: Individual, Association and Employer Group limited health plans such as accident only, accidental death and dismemberment, specified disease, hospital/other indemnity, and hospital/surgical/medical expense.

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., psychologist/board-certified, behavior analyst-doctoral, and/or a psychologist with clinical experience).

Examination Conclusions: The Company did not initially provide the policies and procedures for M/S and MH/SUD claim denial. The Company does not have any policies and procedures pertaining to general claims processing; rather, they have a comprehensive manual with guidance for each type of claims processing situation. For example, there is a section for behavioral health authorizations, one for behavioral health customer administrative appeals, and one for behavioral health claims processed through Proclaim (a company that provides specialized billing and administrative assistance to mental health professionals). If the claim is denied, it can reference the specific section to address concerns for adjustments, duplicate claims, or appeals processing for that type of claim, etc.

The Company provided the following sections from their claims processing manual, which included specifics for adjusting a claim, procedures for specific vendors, prior authorization documentations for vendors, how to conduct administrative appeals by vendor, general administrative appeals, and processes for suspending administrative denials.

The three vendors at the time of the examination included EviCore, American Specialty Health ("ASH"), and Evernorth.

The Company also supplied guidelines, which included Massachusetts-specific mandates for behavioral health.

Based on the review of the data provided by the Company, the policies and procedures for denials meet Massachusetts' statutory and regulatory requirements.

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 Conclusion: The Company provided the requested denial information. Although the Company was not an outlier compared to other companies writing in the state, the examiners did note that the claim denials for M/S were 7.5%, for MH, they were 5.08% and for SUD, they were higher at 12.22%.

The examiners requested additional information from the Company regarding the SUD claims. They asked the Company to verify the accuracy of the data and report to the Division if the higher percentage of claim denials for SUD included duplicate or incomplete claims.

The examiners did not have any remaining concerns after reviewing the additional claims data and related information that the Company supplied.

Subsequent Company Action: The Company responded that the bulk of the SUD denials were for procedure code H0020 (Methadone treatment). When billing for a service like H0020, you must include the patient's specific diagnosis code (e.g., opioid use disorder) from the ICD-10-CM classification system. This procedure is only covered when billed with diagnosis codes F11.2XX (Opioid dependence); otherwise, it's an administrative denial (plan exclusion).

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 their MHPAEA plans. The examiners selected a plan from the Company's list and 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 relies on a partnership with another plan for its M/S provider network and network adequacy compliance. The Company did not submit written policies and procedures for Network Adequacy; instead, the Company referred the examiners to the Tufts Health Plan in response to the question. For the Behavioral Health plan, the Company submitted policies and procedures for updating the MH/SUD provider directory. However, the two versions of the policy (one dated 06/14/2022 and the other 08/09/2022) did not specify the frequency of the audits, only the random sampling that was conducted. The documentation also contained specifics for California and for Georgia, but not details related to the Commonwealth of Massachusetts. There was a note within the policy and procedures documents referencing state-specific statutes that can be found by going to iComply and clicking the View Common Bulletins hyperlink. There was also no mention of M/H or SUD facilities, only providers.

The Company demonstrated compliance with verifying provider data every 90 days for large group plans, as it is a requirement mandated by the "No Surprises Act." Maintaining accurate provider directories and updating them regularly, requiring verification at least every 90 days, ensures the information is current and reliable for consumers.

Observation: The examiners did not see any M/H or SUD facilities included in the audits. The examiners did see the Company definition in their Consolidated Appropriations Act- Medical Provider Data

Validation policy, their definition of a provider is as follows: "Provider" means a licensed Health Care Professional ("HCP"), Facility (i.e., Hospital, Rehab Facility, Skilled Nursing Facility, etc.) or Ancillary Provider (i.e., Ambulatory Surgery Center, etc.). It was unclear in the data provided by the Company whether facilities were included in the audits. The Company should ensure, in future requests for audits, that facilities are included.

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: 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 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: No concerns were noted in the two basic searches conducted.

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, and

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 did not provide the policies and procedures for identifying the network admission standards but indicated the vendor would provide those standards. The examiners reviewed the standards listed on the Cigna website at: Medical Network Credentialing | Cigna Healthcare for M/S and also Evernorth Provider - Resources - Credentialing for MH/SUD. Both application processes appear to be very similar, with proof of certification, professional liability insurance, and state-specific requirements. There is one difference, and that is the amount of time it takes to process the application. For M/S the Company website says, "once we receive the application packet, we'll start the credentialing process. This typically takes 45 to 60 days to complete." For the MH/SUD application process, including providers and facilities, the Evernorth website states, "…the entire process to join the Evernorth Behavioral Health network can take up to 90 days to complete."

The additional information provided by the Company did identify some state-specific credentialing requirements, especially those for the timeline related to credentialing in Massachusetts. While some licensure requirements in Massachusetts align with national standards for Licensed Mental Health Counselors ("LMHCs"), the state has more specific and rigorous requirements in certain areas. There was no state specific detail regarding qualifications for mental health practitioners. The Commonwealth does require that all LMHCs licensees hold a qualified master's degree, have accrued 3,360 hours of post-master's supervised clinical experience and pass the National Clinical Mental Health Counseling Examination ("NCMHCE"). Similarly, Massachusetts requires clinical membership in the American Association for Marriage and Family Therapy and 3,360 hours of post-master's experience for Licensed Marriage and Family Therapists ("LMFTs").

The examiners did note differences between the credentialing procedures for BH and those for M/S. It does appear that the credentialing procedures and re-credentialing procedures are similar, however there are some differences. There are also two additional sections to the credentialing document for BH, including provisional credentialing (which is not allowed for the M/S side) and an additional section for requirements for practitioner participation where the Credentialing Committee reviews criteria at least annually and may alter the exceptions to the criteria. The BH credentialing procedures and additional requirements specifically mention procedures on what to do if a BH provider is rejected or terminated from the network. The additional requirements also discuss the provider's right to review information and correct any erroneous information. Further there are procedures for providers to obtain a status update on their application for BH, but not for M/S providers.

The M/S credentialing procedures mention that a practitioner (provider) who is leaving a delegated credentialing arrangement and establishing a direct contract with Cigna must undergo initial credentialing within 6 month prior to the termination date from the delegate if the delegate does not provide a copy of the practitioner's credentialing file. If the delegate provides a copy of the practitioner's credentialing file, the practitioner may be recredentialed three years from delegates last credentialing date.

Corrective Actions:

- The Company should update their behavioral health licensing and credentialing documentation to include Massachusetts' state specific standards, especially when considering utilizing providers from other states for independent clinical practice in neighboring states and/or telehealth services. The specific statute references include Massachusetts General Laws Chapter 112, Sections 163–172 and associated administrative code (262 CMR).

- The Company should explain why the BH credentialing process contains information emphasizing issues with providers getting rejected/terminated from the network, the ability to correct erroneous information and timelines on obtaining information about the status of their applications.
- The Company should explain why a M/S provider leaving an existing credentialing arrangement could lose their status for three years if they don't get the credentialing documentation to the Company 6 month prior to the departure from that previous arrangement.

Subsequent Company Actions: The Company acknowledges discrepancy on the website, and they reviewed the website content. Please note that the quoted 90-day timeline for MH/SUD applications includes time in which Evernorth Behavioral Health ("EBH") and the provider may be collaborating to complete missing/inaccurate portions of the submitted application as well as negotiating contract terms. The Company explained that the time referenced for medical credentialing cites the time for credentialing only and behavioral cites the entire contracting process, inclusive of contract language & rate negotiations as well as credentialing time. The Company confirms that these timelines are accurate and will not be updating websites at this time. The state regulation 211 CMR, § 52.09 – Credentialing, states that carriers shall complete credentialing of 95% of Health Care Professionals' initial clean and complete credentialing applications within 60 days of receipt, however, more time is allowed for re-credentialing applications and those with a delay to be notified within 75 days.

The Company is updating the behavioral health licensing and credentialing documentation as required by February 12, 2026.

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 provided only a high-level overview that lacked detail about how provider reimbursement rates are determined. The Company should create a formal policy and procedure for reviewing the reimbursement rate calculations from their local vendor, CareLink, to ensure that rate reimbursements for their CareLink's M/S providers (Tufts) align with Cigna's national OAP network and Evernorth's behavioral health providers. No further action is needed for this review, but the Company should be prepared to provide similar data for Evernorth in future examinations.

Observation: The Company should consider the development of a formal process and procedures document regarding reimbursement rate policies for providers. Cigna's alliance with Tufts ended 12/31/2024. Cigna currently contracts directly with providers and national vendors to achieve network adequacy.

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 provided the MH/SUD admission requests only. The examiners reviewed the data submitted by the M/S partner CareLink, which utilizes the Tufts' Health Plan provider network. For the Evernorth Behavioral Health network (MH/SUD): There was a total of 2,332 MH/SUD individual provider applicants, and of those, 169 (7.2%) of the applications were declined or discontinued, 76 (3.2%) were invalid applications, and 2,063 providers with approved contracts (88.4%). However, it should be noted that there were an additional 24 providers (1%) that were missing from the 2,332 applications that were either contracted, declined/discontinued or had an invalid application. In 2022, 65 Clinics and 13 facility applications were submitted. Of the 78 applications submitted by facilities and clinics, 36 (46%) were denied or discontinued, 35 (45%) were approved or completed, and 7 remained in a temporary status or qualifying or in process.

The examiners requested that the Company confirm that only the M/S providers are contracted with CareLink (also known as Tuft's Network Plan and Point32Health) and that no MH/SUD providers are used outside of the Evernorth Behavioral Health network. They should explain why 100% of all provider credentialing requests for the M/S vendor are approved, while only 90% of MH/SUD providers and 45% of clinics or facilities are approved. The request also asked why the credentialing process for MH/SUD should not be considered more stringent than that used for M/S. The Company should provide a reason for the 24 applications that were neither approved nor declined or marked invalid. The Company confirmed that no MH/SUD providers are utilized outside of the Evernorth Behavioral Health network.

The Company confirmed that the reports submitted for medical versus behavioral originally contained different parameters. The medical report only includes providers that were submitted to and reviewed by Credentialing, a unit within Cigna. The behavioral report included all providers who had submitted a request to join the network but may have discontinued the process before being submitted to credentialing (i.e., submitted an incomplete application and did not complete, did not agree to contract terms, provider requested discontinuance prior to credentialing, or was non-responsive). The Company's Behavioral unit has revised the report to align with the medical parameters and included only those that were submitted to credentialing for review. Only one behavioral provider was denied by Credentialing in 2022, reflecting a 99.9% approval rate. The Company provided a spreadsheet with 1,759 providers (counseling, nurse practitioners, psychology, and social work). Of the 1,759 providers reported, 1,758 were approved and one was denied.

The credentialing process for MH/SUD and M/S is similar and involves the same procedures and review factors, as outlined in policies HM-NET-016 (MH/SUD) and CR-01 (M/S). After reviewing the originally submitted approval data, it was determined that the M/S report only included providers who were submitted to and reviewed by Credentialing. The MH/SUD report included all providers who requested to join the network but may have discontinued the process before being submitted to credentialing (for example, submitting an incomplete application, failing to complete the process, not agreeing to contract terms, requesting discontinuance prior to credentialing, or being non-responsive). The MH/SUD report has been adjusted and submitted herewith to align with the same parameters as M/S.

The results now show 100% approval of M/S providers and 99.9% (with one denial) of MH/SUD providers, indicating that the MH/SUD process is no more stringent.

The 24 applications were those that were in a temporary status or qualifying process, i.e., "in process" at the time of review.

Based on the review, the company meets Massachusetts statutory and regulatory requirements regarding network admissions for the examination period.

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 a detailed side-by-side comparative analysis of non-quantitative treatment limitations ("NQTLs"), distinguishing between M/S and MH/SUD benefits. This document includes utilization management for both inpatient and outpatient services, as well as prescription drug coverage.

The Company supplied the responsibilities, qualifications, and preferred skill sets for those individuals who are involved in the peer-to-peer review process, including the Medical Director (Medical Principle) and Medical Officer for behavioral health providers. The Company also confirmed that the peer reviewers for MH/SUD possess the same level of training and experience as the licensed mental health professionals. Behavioral Health psychiatrists who are used in the peer-to-peer process are trained on substance use disorders. The P&T committee must include one practicing physician who is an expert in mental health conditions.

The Company provided the vendors performing utilization management. Cigna Health Management, Inc., an affiliate of CHLIC performs utilization reviews for most medical/surgical ("M/S") benefits. A separate entity, eviCore, reviews certain M/S services for Cigna, American Specialty Health, reviews physical therapy and occupational therapy on behalf of CHLIC, along with both national and regional vendors that perform Utilization Management ("UM.") All entities adhere to Cigna's policies and procedures when performing utilization reviews, and all the data provided includes utilization reviews of certain M/S services.

UM Coverage determinations of MH/SUD services are made in accordance with evidence-based treatment guidelines by physician peer reviewers licensed in the same or similar specialty area as the treating provider. Cigna uses MCG Health ("MCG"), part of the Hearst Health network, provides unbiased clinical guidance that gives healthcare organizations confidence in their patient-centered care decisions. for non-SUD primary diagnosis of behavioral health level of care, and Cigna uses American Society of Addiction Medicine ("ASAM") criteria for coverage guidance in utilization review level of care of SUD services.

The examiners noted that the cost of performing a review and the Return on Investment ("ROI") numbers reported on the NQTL document were quite dated, and the Company did update the document to more current standards in their subsequent actions.

The Company explained the process that occurs when the mental health professional and the peer reviewer disagree, including the appeal process. The Company stated that the provider or facility has the right to

seek an informal reconsideration of an adverse pre-service or concurrent care determination from a Massachusetts-licensed clinical peer reviewer or by a clinical peer review designated by a Massachusetts-licensed clinical peer review. If the Massachusetts-licensed clinical peer reviewer is not available for the reconsideration review within one (1) business day of the request. After completing the peer-to-peer review with the rendering provider, the Cigna Medical Director approves or denies the requested service based on all the clinical information provided. All reconsideration and appeal options are available if a case results in a denial, just as they are available for denials issued for an M/S request

The examiners noted that some of the data referenced in the comparative analysis included references to ROI calculations using data from 2019, 2020 and part of 2021. The Company stated that the ROI calculation has been updated since the examination period. To ensure consistent application of the ROI requirement for Prior Authorization to Outpatient: All Other Services for MH/SUD and M/S, Cigna reviewed the codes, services, and related ROIs. Based on this review, EBH removed prior authorization for intensive outpatient on 05/02/22 and for the partial level of care on 01/01/25.

Subsequent Company Actions: The examiners could not initially determine whether the Company responded to the request for the number of peer-to-peer reviewers for MH/SUD in the Commonwealth of Massachusetts. The Company provided supplemental information that there are three peer-to-peer reviewers for MH/SUD in the Commonwealth of Massachusetts and included applicable job descriptions. Additionally, Cigna stated that Massachusetts does not require a same-state license, so all total, there are 22 peer-to-peer reviewers available to conduct MH/SUD reviews or appeals.

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 did not offer individual health policies in Massachusetts during the review period of the examination. Similarly, the Company did not offer small group policies in Massachusetts during the review period. The Company did provide the QTL Testing for Large Group and the top five group policies. As there was no QLT testing because Cigna does not have any individual or small group policies, the examiners had very limited data to review; The Company, however, did provide a QLT testing document for the large group testing. The Company confirmed that the substantially all testing was conducted prior to the predominant testing.

Cigna does not apply any type of Quantitative Treatment Limitations (QTLs) such as age, day, visit or dollar limits to any services when rendered to treat an MH/SUD diagnosis. This includes both traditionally MH/SUD services (e.g., counseling, residential treatment, etc.) and standard medical services (e.g., PT/ST/OT). Since no QTLs are applied to services provided to treat an MH/SUD diagnosis, testing is not required. None of the plans is Grandfathered. All plans include MH/SUD benefits.

The Company explained why the QTL testing did not include details regarding benefit limits. Cigna tests the outpatient benefits in two ways as allowed by the federal regulations: (1) combined (not sub-classified); and (2) sub-classified. Only if a plan's MH/SUD cost sharing does not pass testing under the "combined" test do we then look at the sub-classified testing to determine if the plan's outpatient MH/SUD cost sharing passes testing.

The documentation contains separate tabs for each of the four required classifications and two sub-classifications of benefits as allowed by federal law. Each tab shows the test results for the predominant and substantially all testing for each classification/sub-classification of benefits. At the bottom of each tab is a smaller chart that summarizes the findings and compares the "minimally compliant" cost share to the actual MH/SUD cost share to be applied under the plan for that classification/sub-classification of benefits.

Observation: The Company should consider using the QTL workbook that identifies each covered service, classification, and allows the company/examiners to easily reference the certificate of coverage and schedule of benefits by page number.[2]

Subsequent Company Actions: Cigna will consider using the state's template for the next submission.

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 Company provided three lists for MH/SUD, and they appear to include only MH with little to no notes for SUD. The examiners reviewed the data to determine if there were any addiction treatment drugs in the formulary. They did not see any opioid treatment medications such as Methadone, Buprenorphine, or Naltrexone listed. There were no smoking cessation medications such as Nicotrol, nicotine gum/patches/lozenges, Bupropion (Zyban/Wellbutrin), or Varenicline (Chantix). The lists also did not include any alcohol treatment medications such as Naltrexone (Revia, Vivitrol), Acamprosate (Campral), and Disulfiram (Antabuse). The one exception listed was Wellbutrin.

The Company confirmed that the existing plans cover SUD medications. The formulary lists provided only included medications requiring step therapy. The Company stated that they do not have any SUD

[2] qtl-template.xlsx

medications that require step therapy.

The Company provided an exhibit titled: "Ex.17_Step Therapy How do I answer as criteria question asking about Prior Drug Therapy" which lists several states, including Massachusetts. Essentially, the instructions are that if a step therapy request is received for Massachusetts, the frontline agent adds a note to the request informing the clinical team that they cannot apply step therapy if there is indication that the patient is stable on the drug in compliance with Massachusetts General Law c. 176O § 12A. The Company explained that this statutory requirement is unique and is not a standard step therapy approval reason, so it is not covered in the clinical policies. Instead, a separate manual process has been instituted. This also applies in situations where switching a patient's medication would likely cause an adverse reaction in or physical or mental harm to the insured.

Based on the review, the Company meets Massachusetts statutory and regulatory requirements regarding step-therapy.

Observation: The Company should consider an automated workflow to replace this manual process with step therapy requests for Massachusetts consumers.

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: Based on the information provided by the Company, overall, they had a 92% approval rating for step therapy with an 8% denial rate. Broken down further by category, denials for M/S were 7.7% and MH/SUD denials were 8.1%. Although the MH/SUD step therapy denials were higher, they were within a 1% variance from M/S. No concerns were identified.

IX. UTILIZATION REVIEW

The Company was 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: Based on the review of the third-party administrators and medical necessity claim determinations, the Company provided information for American Specialty Health Group Inc. ("ASH Group") and eviCore Healthcare MSI, LLC ("eviCore"). The response did not include Evernorth Behavioral Health, Inc., a part of Evernorth Health Services, which handles the behavioral health benefit determinations for Cigna.

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 responded with three hyperlinks to the three vendors' medical necessity guidelines.

The medical necessity guidelines are similar and generally include information from an individual's medical records. This could include things such as virtual or in-person clinical evaluations, which include detailed history and physical examinations since the onset or change in symptoms. Other items that could be necessary to establish medical necessity include lab studies, imaging, pathology reports, procedure reports, and reports from other providers involved in the treatment of the relevant condition. The Company also provided its Healthcare Medical Assessment and Coverage Process for Determination of Medical Necessity Coverage Criteria Recommendations, effective 7/01/03 and approved on 12/10/24. On page 5 of that document, the Company describes its medical necessity criteria needed for medical, surgical, diagnostic, psychiatric, substance abuse, or other health care technologies, supplies, treatments, procedures, or devices to be medically necessary.
Based on the review of the data provided, the Company meets federal and Massachusetts statutory and regulatory requirements regarding medical necessity criteria.

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 Company in the development of the criteria for M/S was provided,
b) verify 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 indicate which sources of data were used for determining medical necessity, but rather generic sources such as major national and international associations, physicians, literature, etc. The website for EBH did include specific references to medical necessity criteria; however, the documentation specifically referenced the state of California. The Company indicated that they can and may modify any medical necessity criteria used by contracted third-party sources (eviCore).

For Massachusetts, per HM-CLN-040 Utilization Management Guidelines Used For Utilization Management Decisions, the Company uses MCG for mental health disorders, unless prohibited by law, Cigna Coverage policies when appropriate, and ASAM criteria for substance use disorder medical necessity coverage determinations, unless prohibited by state law.

The Company provided their policy for determining medical necessity coverage criteria. The following medical necessity criteria were reported within the policy. Typically, Cigna considers medical, surgical, diagnostic, psychiatric, substance abuse or other healthcare technologies, supplies, treatments, procedures, or devices to be medically necessary if the following criteria are met:

- required to diagnose or treat an illness, injury, disease, or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site, and duration;
- not primarily for the convenience of the patient, physician, or other health professional;
- not more costly than an alternative service(s), medication(s), or supply(ies) that is at least as likely to produce equivalent therapeutic or diagnostic results with the same safety profile as to the prevention, evaluation, diagnosis, or treatment of the member's sickness, injury, condition, disease, or its symptoms; and
- rendered in the least intensive setting that is appropriate for the delivery of the services, supplies, or medications. Where applicable, the Medical Director or Review Organization may compare the cost-effectiveness of alternative services, supplies, medications, or settings when determining the least intensive setting.

Subsequent Company Actions: The Company explained that their medical necessity guideline document lists California because, at this time, California is the only state that has a deviation from Cigna's standards. If/when another state enacts medical necessity criteria that vary from Cigna's standard, they will be reflected in that section.

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 had averages higher than the statewide averages for the percentage of denials for all M/S requests, including prior authorization, concurrent reviews, and retrospective reviews. The MH requests for prior authorization, concurrent review, and retrospective reviews were lower than those for M/S and SUD. One percentage seemed high for SUD; however, it was because there were so few retrospective review requests for SUD, so having one denial skewed the numbers. Overall, there are no areas of concern. There are no recommendations to M/S, MH, and SUD prior authorization, concurrent review, and retrospective reviews.

SUMMARY

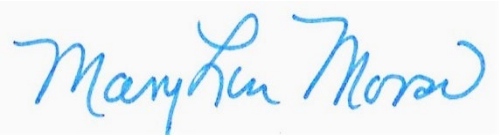
Based upon the procedures performed in this examination, INS has reviewed the Company responses to the interrogatory which included utilization review, prior authorization data, concurrent review, retrospective review, denials of authorization, step-therapy, network admission standards/reimbursement 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.



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