THE COMMONWEALTH OF MASSACHUSETTS

OFFICE OF CONSUMER AFFAIRS AND BUSINESS REGULATION

DIVISION OF INSURANCE

Report on the Limited Scope Market Conduct Examination of

ConnectiCare Of Massachusetts, Inc.

Farmington, CT

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

NAIC COMPANY CODE: 95299

EMPLOYER ID NUMBER: 06-1576788

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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 **ConnectiCare of Massachusetts, Inc.** ("ConnectiCare" or "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:

175 Scott Swamp Road
Farmington, CT 06032

The following report thereon is respectfully submitted.

ACRONYMS

Better Business Bureau ("BBB")
Behavioral Health ("BH")
ConnectiCare of Massachusetts, Inc. ("ConnectiCare" or "Company")
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's 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 HISTORY AND STATUS IN MASSACHUSETTS

ConnectiCare is an issuer in the small group health insurance market in Massachusetts. ConnectiCare will be exiting the Massachusetts insurance market and does not anticipate having any Massachusetts members as of November 30, 2025.

EXECUTIVE SUMMARY

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

Required Company Corrective Action:

The report includes observations and general recommendations, but there are no corrective actions. The Company is exiting the Massachusetts health insurance market and will not have any Massachusetts members after November 30, 2025.

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: Typically, INS reviews the complaint summary log for MHPAEA compliance and identifies any complaints and grievances related to potential network adequacy insufficiencies. INS also inquires whether there were processes and procedures in place with third-party administrators to ensure all complaints were correctly reported. Further, INS:

a) reviews the Company's complaints and grievance registers to identify if there was a lack of in-network providers,
b) reviews the Company's complaint and grievance register to identify if there were sufficient in-network providers for M/S, MH, and SUD,
c) reviews the Company's complaint/grievance registers to detect any identifiable trends for out-of-network denials,
d) reviews 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) inquires 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) reviews to determine the final number of complaints and identify those that were of potential concern.

As the Company did not have consumer complaints during the examination period, the above procedures were minimized to only verifying policies and procedures.

Examination Conclusions: The Company received no complaints from consumers during the examination review period. The Company does have policies and procedures in place to ensure that complaints are captured and reported. 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 0 total consumer complaints, and 0 were of potential concern.

Observations: The Company should consider reviewing policies and procedures for vendors processing claims/complaints (Optum Behavioral Health, HealthPlex, Express Scripts, EyeMed, and Cognizant Technology Services) to ensure consumer complaints are being properly routed to the Company

Closed Provider Complaints/Grievances

The interrogatory requested a summary log of all closed provider complaints submitted 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: Typically, INS reviews the summary log for MHPAEA compliance and identifies any complaints/grievances related to potential network adequacy insufficiencies. In addition, INS inquires whether there were processes and procedures in place with third-party administrators to

ensure all complaints were correctly reported. Further, INS:

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

As the Company did not have consumer complaints during the examination period, the above procedures were minimized to only verifying policies and procedures.

Examination Conclusions: The Company had zero reported provider complaints during the examination review period. The Company has policies and procedures in place to ensure that provider complaints are captured and reported. Based on the review of the complaint/grievance policies and procedures, the Company's complaint/grievance procedures meet Massachusetts' statutory and regulatory requirements.

There were 0 provider complaints, and 0 were of potential concern.

Observations: The Company should consider reviewing policies and procedures for vendors processing claims/complaints (Optum Behavioral Health, HealthPlex, Express Scripts, EyeMed, and Cognizant Technology Services) to ensure provider complaints are being properly routed to the Company,

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 addenda were filed about the accuracy of the MCAS data.

Examination Conclusions: The Company confirmed that the MCAS data is accurate. The Company did not report any information for in-exchange prior authorizations. From a total of 79 out-of-exchange prior authorizations (Prospective Utilization Review Requests), excluding Pharmacy requests reported, 64 or

81% were approved and 15 or 19% were denied. Of the 14 out-of-exchange prior authorizations (Prospective Utilization Review Requests), pharmacy-only requests, 3, or 21%, were denied. The Company did not report any prior authorization pharmacy-only requests approved. Based on the review of the MCAS data, the Company meets Massachusetts' statutory and regulatory requirements.

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's response regarding five (5) third-party entities involved in claim determinations and the types of claims they process was sufficient. Optum Behavioral Health provided claims administration, payment, credentialing, customer service, grievances, utilization, case management, and complaints for the Company's behavioral health claims and utilization management. This response was complete and sufficient.

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

Examination Conclusions: The Company provided three (3) documents from Optum providing instructions related to the processing of inpatient, partial, intensive outpatient and residential treatment claims, processing claims with accommodating or individual authorization, and ER services.
The documentation submitted by the Company did not include any state-specific requirements for the

Commonwealth of Massachusetts. For example, the Commonwealth has specific requirements regarding coordination of clinically appropriate behavioral health services (Mass. General Laws c. 6A § 16P) and the requirement that autism treatment for fully funded plans is subject to ARICA. There was, however, a reference in the section entitled SMI containing a hyperlink to a document, Severe Mental Illness and Biologically Based Mental Illness, which includes state special processing mandates.

The examiners did find in the *OBH Facets All Facility Treatment_Redacted* document, it mentions having to pend and override the system over fifteen times.

Observation: Based on the review, the examiners recommend that the Company confirm that all vendors (especially those operating in multiple states), provide detailed documentation that includes a section on state-specific requirements for denials. The Company should consider updating their claim processing system to rely less on manual overrides to maintain accuracy, efficiency and reduce potential consumer harm.

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 outliers. 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 provided data for claims received, paid, and denied. The denial percentages were the highest for the Company's substance use disorders (SUD), with 71.60% of their claims denied in whole. The Company did have small numbers for both MH and SUD claims, which could skew the results with higher percentages, however, the denials for SUD were significant compared to the claims paid.

Observations: Based on the review of the claims received, paid, and denied, the Company should evaluate why the percentage of claim denials for SUD are significantly higher than MH and M/S claims to ensure they are in compliance with MHPAEA. The Company should also reevaluate the efficiency in manual processing of claims.

IV. NETWORK ADEQUACY

The Companies were asked to supply processes and procedures to demonstrate their compliance with 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's TPA, Optum, provided their network adequacy processes. Network adequacy in Massachusetts must comply with the 211 CMR 52.12 statutory mandate. This mandate requires plans to offer adequate numbers and types of providers. This allows the carrier to self-report and devise a corrective action plan if they are not meeting the network adequacy standards. Based on the review, the Company and its TPA Optum meet network adequacy standards for Massachusetts

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 Company, 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 identified based on the review of the Company's website.

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.
c) if the Company has processes in place for its vendor to follow rather than relying solely on the vendor to determine what network admission standards will apply, and
d) 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: ConnectiCare utilizes United Behavioral Health (UBH) as their TPA for all behavioral health services, including provider credentialing. United Behavioral Health's Credentialing Plan 2022-2023 reported that they conduct ongoing monitoring of participating clinicians' licenses, practices, and services. The Credentialing department reviews state and federal reports within thirty days of their release to identify Participating Clinicians or Participating Organizational Providers who have received OIG sanctions on Medicare or Medicaid participation, GSA debarments, CMS Preclusion List, or any other sanctions against their license or certification. If the Credentialing Department staff member identifies a professional license that is not valid, an OIG sanction on Medicare or Medicaid participation, a sanction on the CMS Preclusion List, GSA debarment, or any other sanction against a license or certification, action shall be taken as outlined in the pertinent Agreement.

Optum's network provider management, credentialing, and recredentialing policy in Massachusetts explained the process utilized for the credentialing/recredentialing of clinicians. Massachusetts clinicians may choose to opt-out or opt-in to the network(s) of their choice. Optum will notify applicants of an incomplete application within twenty business days of receiving it. They will process clean, complete 95% initial credentialing applications for all provider types within 60 days of receiving the application. Providers are recredentialed every 36 months. They complete 95% of clean and complete recredentialing applications within 120 days of receipt. This process complies with 211 CMR, § 52.09 – Credentialing.
Based on the review of network admission standards, the Company meets Massachusetts' statutory requirements.

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's response included general information about rates, for standard physician fee schedules documents from Optum for behavioral health provider fee schedules, and analysis documents comparing both medical and behavioral health fee schedules.
Within the Optum documentation, there was one outlining services in Massachusetts, New Hampshire, Connecticut, and Maine. This document explained that in 2022, there were five (5) fee schedule groupings. These ranged from the lower-cost geographies, based on the CMS national physician fee schedule rates

(fee schedules in these areas of the country had rates that were approximately 5% below the national fee schedule rates), to the highest cost geographies (fee schedules in these areas of the country had rates that were approximately 15% below the national fee schedule rates). Further, the Optum document states, "Set the rates for non-physician providers. Once the base fee schedule rates for physicians set forth above are set, these are then adjusted for individual provider types/licensure levels as follows:

- 85% of the physician fee schedule payment amount (e.g., psychologists and nurse practitioners)
- 75% of the physician fee schedule payment amount (e.g., social workers, master's level mental health counselors.)"

ConnectiCare provides its provider partners with detailed reimbursement policies and billing guidelines through its website. Providers must adhere to these rules, which are frequently updated, to ensure proper claims payment and avoid denied or recouped claims.

Observations: The Company must review the reimbursement rates for behavioral health provided by Optum. Paying behavioral health providers, a lower percentage of the physician fee schedule (e.g., 75% or 85%) may violate the Mental Health Parity and Addiction Equity Act ("MHPAEA"). MHPAEA requires plans to ensure their non-quantitative treatment limitations (NQTLs), such as provider reimbursement rates and network composition, are applied comparably to both mental health/substance use disorder ("MH/SUD") and medical/surgical ("M/S") benefits. A tiered reimbursement structure that consistently pays MH/SUD providers with a lower percentage of the physician rate than their M/S counterparts could be perceived as a discriminatory practice. In addition, the Company may want to inquire why reimbursement rates for BH providers are based on national physician fee schedules rather than a regional fee schedule rate that reflects local market conditions, including cost of living and provider supply.

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 a spreadsheet that listed 1,554 individual practitioners (social workers, nurses, psychologists, physicians, master level counselors, marriage and family therapists, and alcohol and drug counselors) and eight (8) mental health and substance use facilities that submitted determinations in 2022. The Company provided a list of 1,562 determinations made in the 2022 data year. All determinations were approved, with no denials reported. From a total of 1,562 determinations made in 2022, 1,401 were reported for mental health and 158 were reported for substance use. The Company did not provide any medical/surgical determinations made in 2022.

Observations: The Company should be prepared to provide medical/surgical determinations for future examinations. It is also recommended that the Company include whether these determinations were denied and/or approved. Reviewing network admissions and denials for M/S, MH, and SUD allows the Company to keep a pulse on provider data, ensure regulatory compliance, and identify systemic issues that could hinder providers/facilities from applying.

VI. POLICY AND PROCEDURES FOR COMPLIANCE WITH MHPAEA

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

a) ensure the 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 provided three separate documents that included policies detailing non-retaliation and non-intimidation measures, mental health parity compliance, and procedures for resolving compliance issues and accessing the hotline.

According to the Company response, two individuals are responsible for attesting to MHPAEA compliance, including the Chief Compliance Officer and the Chief Executive Officer. The Company also stated that they conduct Mental Health Parity ("MHP") awareness training for all newly hired employees. Additionally, the Company provides training and annual education for all employees, directors, and other governing body members, agents, and other representatives engaged in functions subject to compliance with MHP.

Based on the information provided by the Company, they have policies and procedures in place to comply with Massachusetts' statutory requirements for MHPAEA compliance.

VII. QUANTITATIVE TREATMENT LIMITATIONS

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

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

a) ensure the 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 testing results for four of its plans. The testing was broken down by covered services, inpatient, out-patient, in-network, out-of-network, and emergency services. Within the testing results, the Company indicated whether the threshold was met and if the predominant level was met.

The comparative analysis template used by the Company contains all of the covered services; however, it was noted that for some of the plans, none of the MH/SUD services had red boxes with no dollar amounts in the column for the expected claim dollar amount for each Medical/Surgical benefit. The other remaining tabs contain no mention of MH/SUD. The template explicitly states that, for QTL testing, only the list of expected claim dollar amounts for medical/surgical benefits is necessary.

Based on the review of the QTL documentation supplied by the Company, the Company meets state and

federal QTL analysis requirements as it uses the preferred worksheet template.

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 a document listing the step-therapy medications for M/S MH and SUD. The documentation includes an explanation of the treatment options required first to progress to the next level of treatment.

Based on the review of the document provided by the Company, they meet Massachusetts' requirements for step therapy.

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

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

a) determine statewide averages and medians for approvals, partial denials, and whole denials,
b) determine if the 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 supply the requested information for step-therapy approvals, partial denials, and whole denials. There was one step-therapy request determination during 2022 for medical surgical cases and 10 prescription drug requests: five were approved through utilization reviews and five were denied through utilization reviews. There were no step-therapy requests for MH/SUD.

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: The Company identified five entities that provide benefit determinations and the types of claims they oversee. The first entity conducts claims administration and payment, along with a call center, benefit configuration, IT and other support services for medical and pharmaceutical claims. The second entity provides claims administration and payment, as well as customer service and utilization management for pharmaceutical claims. The third entity handles claims administration and payment, plus credentialing, customer service, and the management of grievances and complaints for vision claims. The fourth entity conducts claims administration and payment, as well as credentialing, customer service, utilization management, grievance management, and complaint management for dental claims. The fifth entity provides claims administration and payment, along with credentialing, customer service, grievance management, case management, and complaint management for behavioral health claims and related utilization management.

Based on the review of the third-party administrators and medical necessity claim determinations, the Company provided a sufficient response.

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 reported that the sources used developing medical necessity criteria used for M/S or MH/SUD appropriate treatment determinations include published peer review literature, clinical practice guidelines, specialty society position papers, consensus documents from professional medical organizations, and external specialty-matched peer reviewers.

Clinical guidelines that outline medical necessity criteria are developed internally using the sources reported above and are not modified from third-party sources.

Optum utilizes written criteria that are consistent with NCQA and URAC requirements and applicable State and Federal regulations. Optum uses scientifically based clinical evidence to evaluate behavioral health treatments, technologies, or services for Optum behavioral health members. The Hierarchy of Clinical Evidence is used to determine which health services are safe, effective, and potentially eligible for benefit coverage.

Based on the review of the documentation provided by the Company, they meet Massachusetts and federal requirements for medical necessity.

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: Based on the review of the sources for medical necessity guidelines, the Company's medical necessity guidelines for M/S, MH, and SUD meet Massachusetts' statutory and regulatory requirements.

Prior Authorization, Concurrent Review, and Retrospective Review

Note: Not all health insurance companies are required to perform concurrent and retrospective reviews in every instance. For example, a concurrent review typically focuses on treatments that are currently in progress. If a patient's treatment has concluded or the review is not pertinent to 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 reported a total of 25 medical/surgical requests, of which 23 were approved, and two were denied in whole prior authorization. There were two SUD requests, and both requests were approved. There were no MH requests reported.

There are no concerns noted with the information reported by the Company for prior authorization, concurrent review and retrospective reviews.

SUMMARY

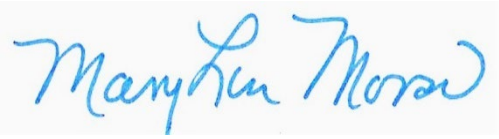
Based upon the procedures performed in this examination, INS has reviewed the Company's responses to the interrogatory which included utilization review, prior authorization data, concurrent review, retrospective review, denials of authorization, step-therapy, network admission standards/reimbursement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