THE COMMONWEALTH OF MASSACHUSETTS

OFFICE OF CONSUMER AFFAIRS AND BUSINESS REGULATION

DIVISION OF INSURANCE

Report on the Limited Scope Market Conduct Examination of

Health New England, Inc.

Springfield, MA

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

NAIC COMPANY CODE: 95673

EMPLOYER ID NUMBER: 04-2864973

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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 **Health New England, Inc.** ("Company"). The examination included but was not limited to the Company's 2022 calendar year health insurance business in Massachusetts.

The Company's home office:

One Monarch Place, Suite 1500
Springfield, MA 01144

The following report thereon is respectfully submitted.

ACRONYMS

Behavioral Health (“BH”)
Better Business Bureau (“BBB”)
Health New England (“HNE”)
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”)
System for Electronic Filing (“SERFF”)
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.

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.

Required Company Corrective Action

Market Conduct Annual Statement

Examination Conclusions: The Company did not file the MCAS data for 2022 for small group, individual, or catastrophic plans, despite its premiums being well above the required $50,000 threshold and therefore meeting the filing requirement for the MCAS reporting.

Corrective Actions: The Company must file the report going forward, starting with the 2025 MCAS filing.

Reimbursement Rate Policies

Examination Conclusions: The Company's response did not include policies and procedures. The Company must develop an official reimbursement policy that includes written procedures detailing reimbursement rate determinations. The policy should state rate reimbursements and clarify if there are any differences between reimbursement rates for medical/surgical, mental health, and substance use providers.

Subsequent Company Actions: The Company reported that it develops its commercial base reimbursement rates by analyzing applicable market rates and relying upon the site of service-adjusted percentage of Medicare RVU fee schedules. The Company has started to establish an official reimbursement policy that includes written procedures detailing reimbursement rate determinations. The policy should state rate reimbursements and clarify if there are any differences between reimbursement rates for medical/surgical, mental health, and substance use providers.

Corrective Action: The Company has not yet implemented the official reimbursement policy. Once the policy has been implemented, please submit the implemented document to the Division's Market Conduct Section on or before 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 161 complaints, six (6) of which were related to mental health and substance use disorders. The examiners found 16, or 9.9% of complaints that were of concern, including potential ACA violations, inaccurate provider/facility data, improper billing as out-of-network for providers, denials for FDA-approved equipment, denials for telehealth mental health care, other mental health care (in-person), and one complaint claiming potential fraud and abuse related to the Behavioral Health Network ("BHN").

Of the 161 total consumer complaints, 16 were of potential concern; the examiners requested additional information outlining the final resolution for the 16 complaints. In addition, the examiners recommended the Company include more details on future resolutions in the complaint log.

Subsequent Company Actions: The Company provided a spreadsheet reporting a more detailed explanation of the complaint resolutions for the 16 noted complaints of concern.

Based on the Company response, there are no concerns with closed consumer complaints.

Closed Provider Complaints/Grievances

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

Examination Procedures Performed: INS reviewed the summary log for MHPAEA compliance and identified any complaints/grievances related to potential network adequacy insufficiencies. In addition,

INS inquired whether there were processes and procedures in place with third-party administrators to ensure 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 had zero reported provider complaints during the examination review period. The Company must implement written policies and procedures requiring third party vendors to track and submit all complaints to the Company. The Company must submit documentation to the Division showing that this process is routinely monitored for compliance.

Subsequent Company Actions: The Company submitted a response indicating that within the company complaints and appeals process, the Company can record who has filed the complaint/appeal and one of the options is a provider. However, the Company explained that all complaints/appeals that are recorded are on behalf of members. Further the Company clarified that if a provider complaint is received, it would be routed not by a member, but as a provider dispute.

The Company also clarified that third party vendors that are delegated to report complaints and appeals are required to submit them timely to HNE.

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 examiners identified two areas of concern after reviewing the MCAS data.

The first concern identified by the examiners is that the Company did not file the MCAS data for 2022 for small group, individual, or catastrophic plans, even though its premiums are well above the required $50,000 threshold and therefore meet the filing requirement for the MCAS reporting. However, the Company initially supplied equivalent MCAS data directly to the examiners and subsequently provided additional data after receiving an extension from the Division.

The second area of concern is that the Company had higher percentages of MH and SUD denials than M/S denials. They also had a high percentage of denied prior authorizations for pharmacy only, and external reviews overturned. These percentages could be skewed because the total numbers are small, inflating the percentage values.

Subsequent Company Action for Concern 1: The Company misconstrued communication with the Division as exempting the Company from the requirement of filing the annual MCAS report. The Company responded to the examiners' request by supplying equivalent MCAS data for 2022, as well as additional data, directly to the examiners and the Division.

Corrective Action for Concern 1: The Company must file the annual report starting with the 2025 MCAS filing.

Subsequent Company Action and Discussion for Concern 2: The Company explained that the raw numbers for prior authorization denials for MH and SUD appear to result in higher percentage rates. However, upon closer examination, the higher percentages were due to the total pool of reviews for MH/SUD services being much smaller than for medical/surgical services. HNE will continue to monitor this area for compliance.

The Company also noted a clerical error in the reporting of the total number of prior authorizations (paid and denied) for in-exchange prior authorizations. They provided the updated numbers, and the numbers reconciled.

Corrective Action for Concern 2: No further action is necessary.

III. DENIAL OF PAYMENT AND COVERAGE

Third-Party Administrator Claims Processing

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

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

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

Examination Conclusions: The Company provided a list of all third-party entities involved in claim determinations and identified the type of claims that each third-party processes. 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 reported that it routinely monitors its vendors' claim denial process as detailed in its policy, Oversight of Delegated Clinical Entities. The policy states that, at least semiannually, delegated clinical entities will submit reports demonstrating compliance with all Utilization Management ("UM") requirements, including but not limited to decision timeliness, denial notices, and the appeals process. The policy also reports that clinical guidelines developed and implemented by the Company's delegated entities are reviewed at least annually by HNE licensed community providers, the Clinical Care Advisory Committee (medical criteria), or the Behavioral Health Advisory Committee (MH/SUD) to ensure these guidelines adhere to generally accepted standards of medical and clinical practice based on objective and credible scientific evidence published in peer-reviewed medical literature.

Health New England Inc. reported that medical necessity reviews for MH/SUD and/or M/S are conducted according to their Physician Reviewers and Other Appropriate Reviewers policy. The Company provided their Physician Reviewers and Other Appropriate Reviewers policy, which explains that, annually, the Manager of UM and the Manager of Behavioral Health verify the roster of Clinical Services Integration ("CSI") licensed staff and external reviewers by checking the Board of Registration in Medicine website, the Professional Licensing Board website, and any other relevant board website to ensure reviewers hold current, unrestricted licenses. The policy states that behavioral health clinical denials must be reviewed by a physician who is an appropriate BH reviewer.

The Company stated that, for denials, any item or service, whether MH/SUD or M/S, is reviewed according to the Utilization Management decisions policy. This policy outlines the types of requests and decisions, as well as the timeframe and notification requirements during the review process. However, the policy does not include any specific provisions related to MH/SUD.

Subsequent Company Action:
Although the Company complies with the appropriate specialist reviewer requirement the messaging is contradictory because the *Utilization Management Decisions* document states, "All adverse Organization

Determinations based on medical necessity or appropriateness will be made by *a person licensed in the appropriate specialty related to such health service* and, where applicable, by a provider in the same licensure category as the ordering provider." However, the *Physician Reviewers and Other Appropriate Reviewers* policy states, "For Behavioral Health (BH) services, a *physician*, who is an appropriate BH reviewer, must review any clinical denial." The Company clarified that in this case, the "physician" for behavioral health services would be a specialist in that field, such as a psychiatrist.

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

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

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

Examination Conclusions: The Company provided data for claims received, paid, and denied. The partial and whole denials for MH were not higher than the M/S. The partial and whole denials for SUD were higher than MH, but neither was higher than the M/S. The Company should continue to monitor the claim denials. Overall, the Company had the second lowest percentage of claims paid and the second highest percentage of claim denials for all M/S, MH and SUD claims. The variance from statewide averages and medians for claim denials was between 4% and 5%. Although the data did not indicate any trends or patterns this year, the Company may want to continue to monitor the denials to ensure that MH and SUD claim denials are not disproportionate to M/S.

Subsequent Company Actions: The Company acknowledges this recommendation.

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's 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 subsidiary vendor for much of the network adequacy compliance. However, there are two internal departments, the Provider Enrollment Department and New England Credentialing Associates, that also conduct regular reviews to verify the data. The Company did not submit written policies and procedures for Network Adequacy; only an overall summary was provided. The Company mentioned the process includes providers and hospitals but did not confirm whether facilities were reviewed for accuracy. The Company should verify if provider facilities are evaluated as part of the provider and hospital directory audit.

Based on the subsequent Company response, they meet the state and federal requirements for ensuring provider data accuracy.

Subsequent Company Actions: The Company reported that facilities are included in audits of a significantly valid sample of directory data that is performed by the Provider Data Management Department.

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 requirements in 2022 was provided to the Division. Further, INS reviewed the Company's response to verify:

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

Examination Conclusions: The Company's response was sufficient; however, there could be confusion for consumers because their membership cards say HMO, the printed provider directory says HMO-POS Fully Funded, and when searching online, the member will have to select the HMO Network and Connector (HMO Fully Funded) option. Please explain whether the two HMO networks all utilize the same providers, and whether there is any difference in providers from the HMO Network and the Connector (HMO Fully Funded).

Based on the Company's subsequent response there are no concerns regarding the plans supplied by the Company for the examination period of review.

Subsequent Company Actions: The Company responded that the HMO Network and the Connector HMO Fully Funded Network utilize the same provider network.

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: There is some concern that consumers may not necessarily know the difference between the HMO Network or Connector (HMO Fully Funded), as both plans are considered HMO Fully Funded plans. There may also be some confusion about the difference between the local providers, the national providers in the extended network, and Multiplan's PHCS Providers. Please explain the difference between the Health New England PPO Network, and the regional providers within MA vs the Multiplan's PHCS Providers. Consider providing tooltip or screen tip with a description for the following options for the online provider search website – HNW PPO Network, Regional Providers with MA and Multiplan's PHCS Providers. These descriptions could help members or potential members to know the difference between the plan options.

Subsequent Company Actions: The Company explained that the base in-plan provider network is the same for the Health New England PPO Network, and the regional providers within MA vs the Multiplan's PHCS Providers. HNE is contracted with Multiplan's PHCS for providers inside New England, but outside of the HNE Service Area. HNE also contracts with United HealthCare for providers outside New England and those providers would be considered in-plan. The member cost share for providers participating in HNE, Multiplan PHCS and United Healthcare Provider Networks would be processed at the in-plan level of benefits.
The Company also acknowledged the recommendation to consider providing a tooltip or screen tip with a description for the following options for the online provider search website- HNW PPO Network, Regional Providers with MA and Multiplan's PHCS Providers.

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 have processes in place for the vendor to follow rather than relying solely on the vendor to determine what network admission standards will apply,
c) if there are differences between MH/SUD and M/S admission processes, evaluate the differences to ensure they do not result in more stringent or have extra requirements for MH/SUD applicants. (For example, what are the liability insurance requirements for M/S versus MH/SUD?)

Examination Conclusions: The Company did not provide the policies and procedures for identifying the network admission standards. A provider must first complete the one-page Letter of Interest Form to initiate the credentialing process. This step applies to most provider types, except for durable medical

equipment, telehealth-only providers, Medicaid/MassHealth Behavioral Health providers, and chiropractors. In addition to the Letter of Interest, the examiners identified a second form but could not determine if the form was still utilized. There also may be a provider enrollment form that must be completed before the user can log into CAQH to continue to completion. It is uncertain whether there is a different application for MH/SUD providers or if they all use the same process. The Company must provide policies and procedures identifying network admission standards. It is also recommended that providers have more information on the steps necessary to start and complete the process, so they know what they need to submit before they start the application process.

The Company is utilizing CAQH for the network admission standards process which is in line with Massachusetts requirements. This software ensures that the admission process is completed appropriately for each respective provider type. Based on the Company response and the follow-up response, the Company meets state requirements for network admission policies and procedures.
Subsequent Company Actions: The Company provided its Standard Operating Procedure for Provider Selection, Recruitment, and Retention, effective on 5/31/12 and last reviewed on 3/14/25. The procedure explained that to maintain a sufficient provider network, provider contracting utilizes geo-access mapping. They also conduct periodic monitoring of member complaints about access, and annual access and availability surveys are conducted, and the results are reviewed. If access issues are identified, provider contracting reaches out to specific providers in an attempt to contract with these providers to ensure that its network allows sufficient access to covered services.

The Company acknowledged the recommendation to ensure providers have more information on the steps necessary to start and complete the process, so they know what to submit before beginning the application process.

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 did not include policies and procedures. The Company must develop an official reimbursement policy that includes written procedures detailing reimbursement rate determinations. The policy should state rate reimbursements and clarify if there are any differences between reimbursement rates for medical/surgical, mental health, and substance use providers.

Subsequent Company Actions: The Company reported that it develops its commercial base reimbursement rates by analyzing applicable market rates and relying upon the site of service-adjusted percentage of Medicare RVU fee schedules. The Company has started to establish an official reimbursement policy that includes written procedures detailing reimbursement rate determinations. The policy should state rate reimbursements and clarify if there are any differences between reimbursement rates for medical/surgical, mental health, and substance use providers.

Corrective Action: The Company has not yet implemented the official reimbursement policy. Once the policy has been implemented, please submit the implemented document to the Division's Market Conduct Section on or before February 12, 2026.

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 document listing all the applicants for admission in 2022. The document did not include any indication of whether the applicant was seeking admission for the mental health or substance use disorder specialties; however, it did include the designations/certifications for the applicants.

The Company should continue to monitor the network admission standards and confirm with network adequacy analysis that enough providers are available for M/S, MH and SUD.

Subsequent Company Actions: The Company also acknowledges the recommendation to continue to monitor the network admission standards and confirm with network adequacy analysis that enough providers are available for M/S, M/H and SUD.

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 did not include the policies and procedures. The Company stated that Health New England's Legal Department is responsible for MHPAEA Compliance oversight. The Company must have formal policies and procedures outlining the details surrounding its internal assessments and all compliance projects, including state and federal requirements. They should explain whether the legal department coordinates with all the other departments regarding MHPAEA compliance.

The Company reported that, per the Division of Insurance's guidance and the Mental Health Parity and Addiction Equity Act ("MHPAEA"), Health New England conducts a yearly review to ensure compliance with federal and state parity laws and regulations. This review entails monitoring the updated regulatory guidance and meeting with key stakeholders of parity sections to maintain updated forms and documentation. HNE has completed an NQTL Comparative Analysis, which is reviewed yearly. HNE effectively manages all compliance projects, including state and federal requirements. Notwithstanding, HNE acknowledges this recommendation. HNE's legal department coordinates with other internal

departmental stakeholders to ensure compliance with MHPAEA.

Subsequent Company Action: The Company submits comparative analysis and conducts annual reviews to ensure compliance with federal and state parity laws and regulations. The Company recently established formal written policies and procedures outlining the details surrounding its internal assessments and all compliance projects, including state and federal requirements. The new policies and procedures were implemented on 10/01/2025.

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 supply the QTL testing results. The Company must provide its annual QTL testing results as required under MHPAEA and the Affordable Care Act. This analysis should include the details for substantially all testing prior to the predominant testing and indicate whether the plan passed or failed.

Subsequent Company Actions: The Company reported that it submits annually its Mental Health Parity Compliance and Certification as requested by the Division. This filing demonstrates that they have reviewed their administrative and other practices in accordance with the provisions of the federal and Massachusetts Mental Health Parity Certification pursuant to Section 254 of Chapter 224 of the Acts of 2012, as amended by Chapter 110 of the Acts of 2017.

Observation: Although the Company did previously provide the Mental Health Parity Compliance and Certification to the Division's Health Unit. The Company failed to submit similar information to the examiners. The Company did not provide QTL analysis for 2022, which should have included an indicator whether the substantially all testing was conducted prior to the predominant testing and a pass/fail indication. The Company must be able to provide all requested documentation in future market conduct examinations whether or not it has been routinely submitted to the Division.

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 26 medications used to treat MH/SUD conditions. One exception was a drug used to treat dementia/Alzheimer's disease, Donepezil Hydrochloride tablets, also known by the brand name Aricept, which could fall under both MH/SUD and M/S categories. It is unclear whether the Company only sent a list of medications for MH/SUD or if this list also included medications requiring step-therapy for M/S. They should also supply details on medications or treatments that require a fail-first or step-therapy approach. The details should specify which medication, or previous treatment must be attempted before the step-therapy option is accessible.

The Company provided guidelines for step therapy exceptions in compliance with M.G.L. c. 176O, § 12A and M.G.L. c. 118E, § 51A. The Company provided its policy titled Health New England's Guideline for Step Therapy Exception, effective 4/01/24 and revised on 5/13/25. The policy reported, "If the member's provider believes it is medically necessary for the member to use a product in place of trying a first-line product, they can request a Step Therapy Exception from Health New England. Health New England will review the exception request and make a determination." The policy includes a list of medical necessities and explains that a caveat applies if the provider requests the exception for an off-label or experimental use.

Subsequent Company Action: The Company submitted the medications or medical treatments that require a fail-first or step-therapy approach. The documentation included which medication or previous treatment is necessary before accessing the option.

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 percentage of step-therapy denials is slightly above statewide ratios.

Observation: The Company should continue to monitor step-therapy requests and implement a system that allows requests to be identified by type - M/S, MH, or 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 response was sufficient; however, the responses to subsequent questions indicated that an additional entity, Carelon Behavioral Health, may be used for utilization management. The Company should verify whether Carelon Behavioral Health should have been included in the list of vendors conducting benefit determinations and if confirmed, include them in subsequent requests.

Subsequent Company Actions: Carelon Behavioral Health manages benefits for the four outpatient behavioral health services for children and adolescents' services established in Massachusetts. In providing these services, Carelon is required to follow Health New England's policy and procedures as well as its own internal policy and procedures. HNE will include Carelon Behavioral Health in subsequent requests.

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 did supply the medical necessity criteria for Carelon, the behavioral health provider. The Company did not submit medical necessity guidelines nor a link to the guidelines for M/S; however, they did submit a paragraph explaining their overall process. The Company must develop written formal policy and procedure documents containing medical necessity guidelines for M/S, MH, and SUD. (It is important to note if there are any differences in the criteria among the three categories.)

The Company provided their *Medical Necessity and Experimental and Investigational- Medical Policy* revised on 1/15/25. The policy describes their standards for determining what is medically necessary, what is not medically necessary, and their definition of experimental and investigational. The Company reported that they do not delegate the decision of whether to impose a medical necessity review on any service to any third-party source. The Company's policy regarding *Oversight of Delegated Clinical Entities* outlines the delegation oversight process for third-party sources. This policy applies to all services, including all

medical/surgical services and all MH/SUD services, where utilization management is delegated to a third-party source. Notwithstanding, the Company acknowledges this recommendation.

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 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 was above statewide averages for MH denials/partial denials of prior authorizations, concurrent review, and retrospective reviews. There were no reported prior authorizations for SUD. The Company was above statewide averages for whole and partial denials for concurrent reviews for SUD. The Company was below statewide averages for M/S denials/partial denials for prior authorizations, concurrent review and retrospective reviews.

In addition, the examiners noted in their review of the Company website that there are a significant number of Behavioral Health forms. There were 28 behavioral health forms, primarily for requests for treatment and prior authorization.
The Company must review the prior authorization, concurrent review, and retrospective review processes and procedures for MH and SUD and determine why the denials are much higher than those for M/S.

They should also consider simplifying both the behavioral health and medical-surgical prior authorization process or streamlining it so fewer forms are needed–some forms can be revised to cover more options using a checkbox-type or similar format.

Subsequent Company Actions: The Company attributes this to the fact that a substantial volume of MH/SUD services are not subject to medical necessity reviews, neither HNE, nor in the Commonwealth of Massachusetts. The Company will continue to monitor to ensure compliance with the Massachusetts regulations regarding utilization review of covered benefits, including the use of standardized forms. The Company will consider the recommendation to simplify the requests for treatment and prior authorization forms.

SUMMARY

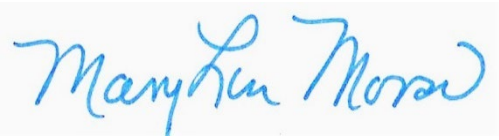
Based upon the procedures performed in this examination, INS has reviewed the Company responses to the interrogatory which included utilization review, prior authorization data, concurrent review, retrospective review, denials of authorization, step-therapy, network admission standards/reimbursement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

ACKNOWLEDGEMENT

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

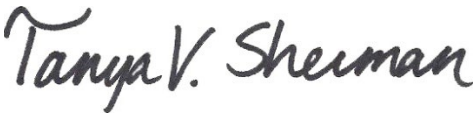
The undersigned's participation in this comprehensive market conduct examination as the Examiner-In-Charge encompassed responsibility for the coordination and direction of the examination performed, which was in accordance with, and substantially complied with, those standards established by the NAIC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

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



Commonwealth of Massachusetts
Division of Insurance
Boston, Massachusetts

The INS Companies
Market Regulation Division
Dallas, Texas



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