THE COMMONWEALTH OF MASSACHUSETTS

OFFICE OF CONSUMER AFFAIRS AND BUSINESS REGULATION

DIVISION OF INSURANCE

Report on the Limited Scope Market Conduct Examination of

UnitedHealthcare Insurance Company

Hartford, CT

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

NAIC COMPANY CODE: 79413

EMPLOYER ID NUMBER: 36-2739571

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COMMISSIONER

May 14, 2026

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 **UnitedHealthcare Insurance Company** ("Company"). The examination included but was not limited to the Company's 2022 calendar year health insurance business in Massachusetts.

The Company's home office:

185 ASYLUM STREET
HARTFORD, CT, USA 06103-3408

The following report thereon is respectfully submitted.

ACRONYMS

Applied Behavioral Analysis ("ABA")
American Society of Addiction Medicine ("ASAM")
The Better Business Bureau ("BBB")
Behavioral Health ("BH")
Centers for Medicare & Medicaid Services ("CMS")
Central Escalation Unit ("CEU")
Child and Adolescent Level of Care/Service Intensity Utilization System ("CALOCUS-CASII")
Council for Affordable Quality Healthcare, Inc. ("CAQH")
Early Childhood Service Intensity Instrument ("ECSII")
INS Regulatory Insurance Services, Inc. ("INS")
Level of Care Utilization System ("LOCUS")
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")
National Committee for Quality Assurance Managed Care Organization ("NCQA")
Non-Quantitative Treatment Limitation ("NQTL")
Obstetrics and Gynecology ("OB-GYN")
Office of Patient Protection ("OPP")
Optum Behavioral Health ("OBH")
Out-of-Pocket ("OOP")
Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA")
Pharmacy Benefit Managers ("PBMs")
Prescription Drug List ("PDL")
Quantitative Treatment Limitation ("QTL")
Substance Use Disorder ("SUD")
System for Electronic Rate Form Filing ("SERFF")
Third-Party Administrators ("TPAs")
United States of America ("USA")

BACKGROUND

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

The examination included an Interrogatory as provided under the Continuum of Regulatory Options ("Continuum") for market conduct examinations. The Continuum focused the examination on high-level aggregate data requests for areas such as utilization review, including prior authorization data, concurrent review, retrospective review, denials of authorization, step-therapy, network admission standards/ reimbursement rates, network adequacy, geographic restrictions, complaint/grievance data, information verifying compliance with MPHEA, and denials of payment and coverage. In addition, the examiners reviewed the Market Conduct Annual Statement ("MCAS"), National Association of Insurance Commissioners ("NAIC") financial filings, and Massachusetts health binder filings within the System for Electronic Rate and Form Filing ("SERFF"). In addition, for those companies that received a report from the Massachusetts Attorney General's Office ("AGO") in 2020, the examiners conducted an evaluation of the Company responses.

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

SCOPE OF EXAMINATION

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

EXAMINATION APPROACH

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

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

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

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

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:

Closed Consumer Complaints

Examination Conclusions: The Company received 1,104 consumer complaints during the examination review period from three different sources and provided the following documents to the examiners: Division of Insurance ("DOI") complaints, administrative member complaints/appeals, and the member complaint log from the Central Escalation Unit ("CEU"). There were a total of 97 consumer complaints/appeals related to MH/SUD.

There were 27 member complaints submitted from the DOI, of those, only two (2) were related to MH/SUD, and both were overturned upon review.

There were 73 administrative member complaints/appeals: sixty-three (63) member appeals and 10 member complaints. Among these, 46 involved mental health issues and one (1) substance abuse. Of the 47 MH/SUD complaints and appeals, the reasons included: claims payment (22), lack of information (10), medical necessity criteria not met (9) , inaccurate information given by UBH (2), inaccurate provider referral/information given by UBH (1), adverse benefit determination (1), excluded service (1), and non-QOC Breach of patient confidentiality (1). Of those same 47 MH/SUD complaints/appeals, the dispositions for the complaints include 24 upheld, 14 overturned, two (2) partially overturned, five (5) unsubstantiated, and two (2) substantiated.

There were 1,004 member complaints, of which 48 were related to MH/SUD. The Company has policies and procedures in place to ensure that complaints from internal/external vendors are captured and reported. Of the 48 consumer complaints related to mental health/substance abuse, 29 were related to disputes of drugs that require clinical coverage reviews, seven (7) were related to disputes concerning application of co-payment, deductible, maximum or Out-of-Pocket ("OOP"), five (5) were related to disputes of excluded medication or new prescription drug product not added to the Prescription Drug List ("PDL"). Four (4) were related to disputes regarding the authorization process. Two (2) involved disputes of ancillary charges, such as the dollar difference between brand and generic charged in addition to copay. One (1) was related to disputes of quantity limits. Of the 48 complaints, 25 resulted in the Company's position being overturned, while 23 resulted in the Company's position being upheld. The examiners noted that of the 48 MH/SUD complaints 34 were related to prescription drugs, with 21 of these overturned. Additionally, nine complaints involved disputes concerning a case or claim flagged for audit review, but none of those were related to MH/SUD.

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

Corrective Action:
The Company must:

- Provide the details of the 34 member complaints related to the pharmacy benefits, including why the specific drug in each complaint either required a clinical coverage review prior to use, or was excluded from coverage, along with an explanation for the disposition of the complaint.
- Explain what the basis was for overturning the 16 administrative member complaints/appeals and the 25 member complaints. For example, was additional information provided or was an internal Company error causing the initial denial.

Please provide a response to the above request to the Division on or before March 1, 2026.

Subsequent Company Action: The Company provided the information requested for the member complaints and explained that the basis for overturning the administrative member complaints/appeals was due to new information received with the complaint submission.

Closed Provider Complaints/Grievances

Examination Conclusions: The Company had 112 provider complaints during the examination review period from three different sources Division complaints, administrative member complaints/appeals and the member complaint log from the Central Escalation Unit ("CEU"). There were five DOI/AG complaints, none of them were MH/SUD related and three of the five were overturned. There was a total of 102 provider dispute complaints related to MH/SUD, three were unknown. There were two CEU reported provider complaints, neither of which were related to MH/SUD. The Company did not provide all closed provider complaints submitted during the examination period rather they only provided closed Behavioral Health provider complaints/appeals submitted.

Of the 102 provider disputes 90 were related to mental health and 12 were related to substance abuse. Of those, 65 cite lack of information, 24 cite claims payments, eight (8) cite lack of precertification, three (3) cite medical necessity criteria not met, one (1) cites appeals review process, and one (1) cites excluded services. The resolutions include upheld (50), overturned (45), partial overturned (6), and unsubstantiated (1). Approximately 50% of the provider's disputes are upheld and the other 50% are overturned.

Observation: The Company should be prepared to comply with the Division's request and provide all the provider's complaints, including M/S, to regulators and examiners in the future.

Corrective Action:
The Company must

- explain what is meant by "lack of information" as the reason for the complaint and why there are so many complaints for MH/SUD that cite either lack of information (65) or lack of precertification (8),
- explain if the information requirements for MH/SUD claims require the member's mental health history for processing,
- explain if the process for processing MH/SUD provider complaints has changed recently,
- explain whether more historic patient information is being requested for MH/SUD for precertification, prior authorization or post claim reviews than for M/S claims processing, and
- explain what triggers an appeal for MH/SUD claims.

Please provide responses to the above requests to the Division on or before March 1, 2026.

Subsequent Company Action: The Company stated that "lack of information" refers to claims for which the plan requested additional documentation or information from the provider in order to complete the claim review. They stated that the member's mental health history is not required for processing

claims, and that there have been no changes made in how MH/SUD provider complaints are handled. They also stated that a claims appeal is triggered when a provider, member, or authorized member representative submits a request to review the adjudication of a claim.

Market Conduct Annual Statement

Examination Conclusions: The Company submitted a confirmation of the accuracy of the MCAS data. The Company tested the MCAS data against their internal financial statement, which had a few minor variances, most likely related to the timing of claims, with less than a 1 % variance that was unexplained.

The examiner reviewed the MCAS data and identified the Company as an outlier for in-exchange prior authorization denials, which was the highest in the state. However, the total number of in-exchange authorizations was very small, skewing the percentage values. The Company was also identified as an outlier for out-of-exchange prior authorizations for pharmacy-only requests, with 60% of these requests denied. The Company was also identified as an outlier for out-of-exchange customer-requested appeals on final adverse determinations that were overturned by an external review organization. However, the number of initial requests was four (4) and three (3) of those were overturned, resulting in a high percentage of 75%. Still, the low volume of cases skews the overall results.

Corrective Action:

- The Company must provide a detailed analysis of the top 5 reasons, including the number of denials for each reason, for pharmacy prior authorizations denials for out-of-exchange.

Please provide a response to the above request to the Division on or before March 1, 2026.

Subsequent Company Action: The Company provided the analysis requested and no further information is required.

Policies and Procedures Related to Claim Denials

Examination Conclusions: According to the information provided by the Company, three (3) third-party entities are involved in claims handling. All three of the entities are affiliated with the Company. The TPAs include OptumRx, Inc. (Pharmacy), United Behavioral Health (Behavioral) and United HealthCare Services, Inc. (Medical/Surgical). There were two documents related to Optum, three related to United Behavioral Health, and none related to United HealthCare Services, Inc.

The documentation from Optum included a claims procedures section of a manual and a workflow document for pharmacy prescriptions. The manual contains detailed information on claim processing, data about formularies, pharmacy payments, member appeal rights, and how certain medications, such as contraceptives and opioids, may be processed differently. It also provided hyperlinks to external documents like Medicare Opioid guidance, but it did not include state-specific details.

The documentation for United Behavioral Health included claims processing details for facility services, physician review and emergency and crisis services.

The emergency and crisis service document contained references to state-specific processing instructions for Maryland and New York.

The physician review document provides guidance to ensure that the billing codes being submitted are by behavioral health providers who are authorized to bill those codes. The document is 48 pages that were

very detailed and include instructions for denying and processing claims. There are sections for particular types of claims, such as Applied Behavioral Analysis ("ABA"). It also includes a state-specific exception section for plans situated in Colorado related to annual mental health evaluations. Massachusetts has a similar law, the Mental Health ABC Act (Chapter 177 of the Acts of 2022). There is reference within the document about processing plans situated in Massachusetts related to behavioral health codes for children and adolescents. It contains references and a hyperlink to the *OBH UNET Pre-Existing Conditions* document.

Corrective Action:
The Company must:

- supply the claim processes and procedures for United HealthCare Services, Inc.
- add an exception for Massachusetts for the annual mental health wellness examination in the *OBH UNET Physician Review Document* in compliance with An Act addressing barriers to care for mental health (Chapter 177 of the Acts of 2022), and
- explain why there are references to a pre-existing conditions document on the payment screen for behavioral health (page 35).

Please provide the claim processes and procedures for United HealthCare Services, Inc., the *updated OBH UNET Physician Review Document* and an explanation for the pre-existing conditions document to the Division on or before March 1, 2026.

Subsequent Company Action: The Company provided the requested claims processes and procedures. The MA Wellness Exam mandate is included in the current *OBH UNET Physician Review Document* and the current job aid has since been revised and no longer references pre-existing conditions.

Observations: The Company should also consider adding a reference to the opioid section of the Optum manual for claims procedures about the Massachusetts state-specific law, Chapter 94C, Section 19D.

Subsequent Company Response: The Company stated that the information has been discussed and communicated via an Optum Perk blog that is available to all Optum Members and Providers.

Policies and Procedures Compliance with Federal Requirements on Provider Data Accuracy

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

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

Examination Conclusions: The Company provided two documents. The first, titled the *Data Consolidated Appropriations Act Provider Directory Verification and Suppression* document, explains that the verification process offers two options: providers can verify their data via Provider Express or through a second option for data verification through authoritative sources including but not limited to the Council for Affordable Quality Healthcare, Inc. ("CAQH"). The document includes the fields that providers verify, such as basic information about the practice location, appointment phone number, group names, specialties and digital contact information. The document also states that data verification must occur every 90 days, and individuals who have not confirmed their data within the last 180 days will be suspended.

The second document was identical to the first, with minor edits regarding the review and approval history of the document. No documents were provided on the process for handling medical/surgical or facility data accuracy.

Corrective Action:

- The Company must provide formal documentation showing compliance with the No Surprises Act for providers and facilities other than behavioral health.

Please provide a response to the above request to the Division on or before March 1, 2026.

Subsequent Company Action: The Company provided formal documentation demonstrating that it ensures compliance with the No Surprises Act (NSA) requirements for all applicable providers and facilities, beyond behavioral health.

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 provided a 31-page document on UHC credentialing. The document outlines credentialing, recredentialing, eligibility criteria, requirements for credentialing, the appeal process, and ongoing monitoring for providers and facilities. It also details the credentialing process when networks merge.

The Company provided an addendum referencing state and federal regulatory credentialing. The first document referenced 180 days in multiple places; however, the addendum did contain a section specific to Massachusetts, including references to compliance with 211 CMR 52.09 and the appropriate timelines outlined in that regulation. The addendum also includes references for complying with NCQA accreditation standards, as well as using the initial credentialing application used in the Commonwealth of Massachusetts.

The Company also provided separate documentation related to credentialing for behavioral health providers and facilities, much of which is similar to the requirements for M/S providers and facilities. Both the M/S and the BH credentialing documents require applicants to have general/comprehensive liability insurance, as well as errors and omissions (malpractice) insurance, for at least the "per Occurrence" and aggregate limits established by UnitedHealth Group's Provider Guidelines. It is defined in the UBH credentialing document as professional liability insurance coverage, including limits of $1/$3 million for physician Clinicians and $1/$1 million for other Clinicians, or limits as specified by applicable state law. The details for UnitedHealthcare credentialing did not include dollar amounts.

Corrective Actions:

- The Company must confirm that the liability and errors and omissions insurance required for MH/SUD is similar to and not more stringent than that required for M/S providers.
- The Company must explain why the credentialing requirements for MH/SUD providers include an exclusion for providers who are not enrolled in Medicare.

  CMS does not require all behavioral health providers to contract with Medicare, but it does require them to enroll to receive payment for services to Medicare beneficiaries. While Medicare Advantage ("MA") plans must contract with a network of behavioral health providers to ensure patient access, individual providers can choose not to enroll, enter private "opt-out" agreements, or be paid by other insurance[1]. It is recommended that the Company update the section about Medicare participation exclusions within their *UBH Credentialing Plan 2022* to clarify that the provider does not have to be contracted with Medicare, but Medicare Advantage plans must contract with the network if it has not already been updated.

Please provide confirmation of the required insurance for M/S providers and an explanation about the exclusion of credentialing for MH/SUD providers that are not enrolled in Medicare to the Division on or before March 1, 2026.

Subsequent Company Action: The Company confirmed that the liability and errors and omissions insurance required for MH/SUD is similar to and not more stringent than that required for M/S providers and that the credentialing plan is utilized by all lines of business.

Observations:
The Company should consider adding additional requirements to the Massachusetts addendum related to 130 CMR 403.405 (Provider Eligibility: In-state Home Health Agencies).

Subsequent Company Response: The Company stated that the regulation 130 CMR 403.405 pertains exclusively to MassHealth (Medicaid) participation and does not apply to fully insured commercial insurance providers.

Reimbursement Rate Policies

Examination Conclusions: Optum (United Behavioral Health) provided two documents titled "*Annual Update of Base Rate Fee Schedules for Covered Health Services in MA, NH, CT, ME",* dated July 2021 and July 2022. This policy defines the process by which Optum Behavioral Health annually reviews and updates its base fee schedule reimbursement rates for Optum's network of contracted behavioral health providers. Fee schedules are based on their geography as reflected by the relationship between the Centers for Medicare & Medicaid Services ("CMS") national physician fee schedule rates for the year and geography. There are five fee schedules ranging from 5% below the national fee schedule rates to 15% above the national fee schedules for the higher cost geographies. 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)

[1] Frequently Asked Questions about Billing Medicare for Behavioral Health Integration (BHI) Services

75% of the physician fee schedule payment amount (e.g., social workers, master's level mental health counselors)

The Company did not provide the reimbursement rate policies for M/S providers.

Corrective Actions:

The Company must

- explain why Optum reimbursement rates for BH providers are based on national physician fee schedules and not a regional fee schedule rate that reflects local market conditions, including cost of living and provider supply, rather than a purely national rate,
- explain why behavioral health providers (psychologists, nurse practitioners, social workers, master's level mental health counselors) are reimbursed at either 75% or 85% of the physician fee schedules, and reimbursement rates are not based on the specific providers fee schedule type,
- explain whether M/S non-physician practitioners are also reimbursed at 75% or 85% of the physician fee schedules,
- explain why reimbursing behavioral health providers at 75% or 85% of physician fee schedules would not be considered a mental health parity violation,
- explain whether the fee schedules for behavioral health providers have changed since 2022,
- provide M/S reimbursement rate policies when requested in the future, and
- provide a detailed explanation of whether reimbursement rate policies for MH/SUD differ from M/S rate reimbursements and how and why they differ.

Please provide responses for the rate reimbursement questions above to the Division on or before March 1, 2026.

Subsequent Company Action: The Company provided explanations for the corrective actions listed above and no further actions are required.

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 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.

Examination Conclusions: The Company received 1,104 consumer complaints during the examination review period from three different sources and provided the following documents to the examiners: Division of Insurance ("DOI") complaints, administrative member complaints/appeals, and the member complaint log from the Central Escalation Unit ("CEU"). There were a total of 97 consumer complaints/appeals related to MH/SUD.

There were 27 member complaints submitted from the DOI, of those, only two (2) were related to MH/SUD, and both were overturned upon review.

There were 73 administrative member complaints/appeals: sixty-three (63) member appeals and 10 member complaints. Among these, 46 involved mental health issues and one (1) substance abuse. Of the 47 MH/SUD complaints and appeals, the reasons included: claims payment (22), lack of information (10), nine (9) medical necessity criteria not met, inaccurate information given by UBH (2), inaccurate provider referral/information given by UBH (1), adverse benefit determination (1), one (1) excluded service , and non-QOC Breach of patient confidentiality (1). Of those same 47 MH/SUD complaints/appeals, the dispositions for the complaints include 24 upheld, 14 overturned, two (2) partially overturned, five (5) unsubstantiated, and two (2) substantiated.

There were 1,004 member complaints, of which 48 were related to MH/SUD. The Company has policies and procedures in place to ensure that complaints from internal/external vendors are captured and reported. Of the 48 consumer complaints related to mental health/substance abuse, 29 were related to disputes of drugs that require clinical coverage reviews, seven (7) were related to disputes concerning application of co-payment, deductible, maximum or Out-of-Pocket ("OOP"), five (5) were related to disputes of excluded medication or new prescription drug product not added to the Prescription Drug List ("PDL"). Four (4) were related to disputes regarding the authorization process. Two (2) involved disputes of ancillary charges, such as the dollar difference between brand and generic charged in addition to copay. One (1) was related to disputes of quantity limits. Of the 48 complaints, 25 resulted in the Company's position being overturned, while 23 resulted in the Company's position being upheld. The examiners noted that of the 48 MH/SUD complaints 34 were related to prescription drugs, with 21 of these overturned. Additionally, nine complaints involved disputes concerning a case or claim flagged for audit review, but none of those were related to MH/SUD.

There were two complaints of concern, both were member complaints, one related to Optum denying several of their claims for outpatient mental health treatment from an out-of-network provider and the other was related to unpaid claims for a specific provider. Both complaints were submitted to the Company by the Division, and both were overturned.

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

Corrective Action:
The Company must:

- Provide the detail of the 34 member complaints related to the pharmacy benefits, including why the specific drugs in each complaint either required a clinical coverage review prior to use, or were excluded from coverage, along with an explanation for the disposition of the complaint.
- Explain what the basis was for overturning the 16 administrative member complaints/appeals and the 25 member complaints. For example, was additional information provided or was an internal Company error causing the initial denial.

Please provide a response to the above request to the Division on or before March 1, 2026.

Closed Provider Complaints/Grievances

The interrogatory requested a summary log of all closed provider complaints submitted by providers 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: 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.

Examination Conclusions: The Company had 112 provider complaints during the examination review period from three different documents, Division complaints, administrative member complaints/appeals and the member complaint log from the Central Escalation Unit ("CEU"). There were five DOI/AG complaints, none of them were MH/SUD related and three of the five were overturned. There were a total of 102 provider dispute complaints related to MH/SUD, three were unknown. There were 2 CEU reported provider complaints, neither of which were related to MH/SUD. The Company only provided BH closed provider complaints/appeals.

Of the 102 provider disputes 90 were related to mental health and 12 were related to substance abuse. Of those, 65 cite lack of information, 24 cite claims payments, eight (8) cite lack of precertification, three (3) cite medical necessity criteria not met, one (1) cite appeals review process, and one (1) cites excluded services. The resolutions include upheld (50), overturned (45), partial overturned (6), and unsubstantiated (1). Approximately 50% of the provider's disputes are upheld and the other 50% are overturned.

Observation: The Company should be prepared to provide all the provider's complaints, including M/S, to regulators and examiners when this information is requested in the future.

Corrective Action:
The Company must

- explain what is meant by "lack of information" as the reason for the complaint and why there are so many complaints for MH/SUD that cite either lack of information (65) or lack of precertification (8),
- explain if the information requirements for MH/SUD claims require the member's mental health history for processing,
- explain if the process for processing MH/SUD provider complaints has changed recently,
- explain whether more historic patient information is being requested for MH/SUD for precertification, prior authorization or post claim reviews than for M/S claims processing, and
- explain what triggers an appeal for MH/SUD claims.

Please provide responses to the above requests to the Division on or before March 1, 2026.

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.

The examiners reviewed the 2022 Health Market Conduct Annual Statement (MCAS) Filing data. The data fields from the MCAS Health Blank are related to prior authorizations (Pharmacy and Excluding Pharmacy) and the external review data for both in-exchange and out-of-exchange. The results are listed in the chart below.

Examination Conclusions: The Company submitted a confirmation of the accuracy of the MCAS data. The Company tested the MCAS data against their internal financial statement, which had a few minor variances, most likely related to the timing of claims, with less than a 1 % variance that was unexplained.

The examiner reviewed the MCAS data and identified the Company as an outlier for in-exchange prior authorization denials, which was the highest in the state. However, the total number of in-exchange authorizations was very small, skewing the percentage values. The Company was also identified as an outlier for out-of-exchange prior authorizations for pharmacy-only requests, with 60% of these requests denied. The Company was also identified as an outlier for out-of-exchange customer-requested appeals on

final adverse determinations that were overturned by an external review organization. However, the number of initial requests was four (4) and three (3) of those were overturned, resulting in a high percentage of 75%. Still, the low volume of cases skews the overall results.

Corrective Action:

- The Company must provide a detailed analysis of the top 5 reasons, including the number of denials for each reason, for pharmacy prior authorizations denials for out-of-exchange.

Please provide a response to the above request to the Division on or before March 1, 2026.

III. DENIAL OF PAYMENT AND COVERAGE

Third-Party Administrator Claims Processing

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

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

a) M/S claims are processed through a different vendor than those processing claims for MH/SUD,
b) a vendor (within the 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: According to the information provided by the Company, three (3) third-party entities are involved in claims handling. All three of the entities are affiliated with the Company. The TPAs include OptumRx, Inc. (Pharmacy), United Behavioral Health (Behavioral) and United HealthCare Services, Inc. (Medical/Surgical). There were two documents related to Optum, three related to United Behavioral Health, and none related to United HealthCare Services, Inc.

The documentation from Optum included a claims procedures section of a manual and a workflow document for pharmacy prescriptions. The manual contains detailed information on claim processing, data about formularies, pharmacy payments, member appeal rights, and how certain medications, such as contraceptives and opioids, may be processed differently. It also provided hyperlinks to external documents like Medicare Opioid guidance, but it did not include state-specific details.

The documentation for United Behavioral Health included claims processing details for facility services, physician review and emergency and crisis services.

The emergency and crisis service document contained references to state-specific processing instructions for Maryland and New York.

The physician review document provides guidance to ensure that the billing codes being submitted are by behavioral health providers who are authorized to bill those codes. The document is 48 pages that were very detailed and include instructions for denying and processing claims. There are sections for particular types of claims, such as Applied Behavioral Analysis ("ABA"). It also includes a state-specific exception section for plans situated in Colorado related to annual mental health evaluations. Massachusetts has a similar law, the Mental Health ABC Act (Chapter 177 of the Acts of 2022). There is reference within the document about processing plans situated in Massachusetts related to behavioral health codes for children and adolescents. It contains references and a hyperlink to the *OBH UNET Pre-Existing Conditions* document.

Corrective Action:
The Company must:

- supply the claim processes and procedures for United HealthCare Services, Inc.
- add an exception for Massachusetts for the annual mental health wellness examination in the *OBH UNET Physician Review Document* in compliance with An Act addressing barriers to care for mental health (Chapter 177 of the Acts of 2022), and
- explain why there are references to a pre-existing conditions document on the payment screen for behavioral health (page 35).

Please provide the claim processes and procedures for United HealthCare Services, Inc., the *updated OBH UNET Physician Review Document* and an explanation for the pre-existing conditions document to the Division on or before March 1, 2026.

Observations: The Company should also consider adding a reference to the opioid section of the Optum manual for claims procedures about the Massachusetts state-specific law, Chapter 94C Section 19D.

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 Company was in line with statewide averages for all claims denied and M/S.

IV. NETWORK ADEQUACY

The companies were asked to supply processes and procedures to demonstrate their compliance with the state and federal requirements for network adequacy. The companies were also asked to provide a listing of their MHPAEA plans. The examiners selected a plan from the 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:

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

Examination Conclusions: The Company provided two documents. The first, titled the *Data Consolidated Appropriations Act Provider Directory Verification and Suppression* document, explains that the verification process offers two options: providers can verify their data via Provider Express or through a second option for data verification through authoritative sources including but not limited to the Council for Affordable Quality Healthcare, Inc. ("CAQH"). The document includes the fields that providers verify, such as basic information about the practice location, appointment phone number, group names, specialties and digital contact information. The document also states that data verification must occur every 90 days, and individuals who have not confirmed their data within the last 180 days will be suspended.

The second document was identical to the first, with minor edits regarding the review and approval history of the document. No documents were provided on the process for handling medical/surgical or facility data accuracy.

Corrective Action:

- The Company must provide formal documentation showing compliance with the No Surprises Act for providers and facilities other than behavioral health.

Please provide the documentation showing compliance with the No Surprises Act for providers and facilities other than behavioral health to the Division on or before March 1, 2026.

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. There are fifteen different plans in the Commonwealth of Massachusetts.

Basic Web Searches

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

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

Examination Conclusions: The examiners searched for a substance use disorder professional and an OB-GYN on the Company website using the Choice Plus plan for zip code 01301. The option to search for substance use disorder returned a list of options, including options such as day treatment, medication-assisted treatment in a physician's office, outpatient, substance abuse experts, and substance use disorder treatment residential.

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. If the Company has processes in place for the vendor to follow rather than relying solely on the vendor to determine what network admission standards will apply, and

c) if there are differences between MH/SUD and M/S admission processes, evaluate the differences to ensure they do not result in more stringent or have extra requirements for MH/SUD applicants. (For example, what are the liability insurance requirements for M/S versus MH/SUD?)

Examination Conclusions: The Company provided a 31-page document on UHC credentialing. The document outlines credentialing, recredentialing, eligibility criteria, requirements for credentialing, the appeal process, and ongoing monitoring for providers and facilities. It also details the credentialing process when networks merge.

The Company provided an addendum referencing state and federal regulatory credentialing. The first document referenced 180 days in multiple places; however, the addendum did contain a section specific to Massachusetts, including references to compliance with 211 CMR 52.09 and the appropriate timelines outlined in that regulation. The addendum also includes references for complying with NCQA accreditation standards, as well as using the initial credentialing application used in the Commonwealth of Massachusetts.

The Company also provided separate documentation related to credentialing for behavioral health providers and facilities, much of which is similar to the requirements for M/S providers and facilities. Both the M/S and the BH credentialing documents require applicants to have general/comprehensive liability insurance, as well as errors and omissions (malpractice) insurance, for at least the "per Occurrence" and aggregate limits established by UnitedHealth Group's Provider Guidelines. It is defined in the UBH credentialing document as professional liability insurance coverage, including limits of $1/$3 million for physician Clinicians and $1/$1 million for other Clinicians, or limits as specified by applicable state law. The details for UnitedHealthcare credentialing did not include dollar amounts.

Corrective Actions:

- The Company must confirm that the liability and errors and omissions insurance required for MH/SUD is similar to and not more stringent than that required for M/S providers.
- The Company must explain why the credentialing requirements for MH/SUD providers include an exclusion for providers who are not enrolled in Medicare.

Please provide confirmation of the required insurance for M/S providers and an explanation about the exclusion of credentialing for MH/SUD providers that are not enrolled in Medicare to the Division on or before March 1, 2026.

CMS does not require all behavioral health providers to contract with Medicare, but it does require them to enroll to receive payment for services to Medicare beneficiaries. While Medicare Advantage (MA) plans must contract with a network of behavioral health providers to ensure patient access, individual providers can choose not to enroll, enter private "opt-out" agreements, or be paid by other insurance[2]. It is recommended that the Company update the section about Medicare participation exclusions within their *UBH Credentialing Plan 2022* to clarify that the provider does not have to be contracted with Medicare, but Medicare Advantage plans must contract with the network if it has not already been updated.

Observations:

The Company should consider adding additional requirements to the Massachusetts addendum related to 130 CMR 403.405 (Provider Eligibility: In-state Home Health Agencies).

[2] Frequently Asked Questions about Billing Medicare for Behavioral Health Integration (BHI) Services

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: Optum (United Behavioral Health) provided two documents titled "*Annual Update of Base Rate Fee Schedules for Covered Health Services in MA, NH, CT, ME",* dated July 2021 and July 2022. This policy defines the process by which Optum Behavioral Health annually reviews and updates its base fee schedule reimbursement rates for Optum's network of contracted behavioral health providers. Fee schedules are based on their geography as reflected by the relationship between the Centers for Medicare & Medicaid Services ("CMS") national physician fee schedule rates for the year and geography. There are five fee schedules ranging from 5% below the national fee schedule rates to 15% above the national fee schedules for the higher cost geographies. 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)

The Company did not provide the reimbursement rate policies for M/S providers. Without the M/S documentation, the examiners were unable to verify compliance with MHPAEA.

Corrective Actions:

The Company must

- explain why Optum reimbursement rates for BH providers are based on national physician fee schedules and not a regional fee schedule rate that reflects local market conditions, including cost of living and provider supply, rather than a purely national rate,
- explain why behavioral health providers (psychologists, nurse practitioners, social workers, master's level mental health counselors) are reimbursed at either 75% or 85% of the physician fee schedules, and reimbursement rates are not based on the specific providers fee schedule type,
- explain whether non-physician practitioners are also reimbursed at 75% or 85% of the M/S physician fee schedules,
- explain why reimbursing behavioral health providers at 75% or 85% of physician fee schedules would not be considered a mental health parity violation,
- explain whether the fee schedules for behavioral health providers have changed since 2022,
- provide M/S reimbursement rate policies when requested in the future, and
- provide a detailed explanation of whether reimbursement rate policies for MH/SUD differ from M/S rate reimbursements and how and why they differ.

Please provide responses to the rate reimbursement questions above to the Division on or before March

1, 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 list of admissions to the network. Of the total 4,759 applicants, 67.18% (3,197) were M/S applicants, while 32.82% (1,562) of the applicants were MH/SUD. Among the 1,562 MH/SUD applicants, 1,400 were MH providers, 154 were SUD providers, four (4) were MH facilities, and four (4) were SUD facilities. All MH/SUD providers and facilities were approved. Of the 3,197 M/S provider applications, five (5), or 0.16% were denied.

Based on the review of the network admissions, the Company's network admissions meet the Massachusetts statutory and regulatory requirements.

VI. POLICY AND PROCEDURES FOR COMPLIANCE WITH MHPAEA

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

a) ensure the 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 a mental health parity program description, which was developed on April 1, 2021, and became effective as of May 10, 2021. The document includes details about the scope of the mental health parity program, who is responsible, the resources allocated, and the governance structure. In addition, the documentation includes references to Non-Quantitative Treatment Limitations, guidance on responses to requests for mental health parity analysis, mental health parity education and training, quality and compliance monitoring, evaluation and reports, and an annual workplan to ensure Non-Quantitative Treatment Limitations ("NQTL") MH parity.

Additional documentation provided by the Company included the process for conducting NQTL analysis, which included the following benefit classifications, INN Inpatient, OON Inpatient, INN Outpatient - Office Visits, INN Outpatient - All Other Outpatient services, OON Outpatient, Emergency Care, and Prescription Drugs, in accordance with the federal regulations and sub-regulatory guidance. The NQTL documented analyses identify the factors that trigger each NQTL (Step 1), as well as the sources and evidentiary standards for each factor (Steps 2 and 3). Each NQTL analysis also provides detailed comparative analysis both "as written" and "in operation" (Step 4), and findings and conclusions (Step 5). Please note that the Comparative Analyses were not provided nor reviewed.

Based on the documentation provided by the Company, it appears they have policies and procedures in place to ensure compliance with MHPAEA; however, MHPAEA compliance testing was not performed

to conclude MHPAEA compliance. The compliance plan includes UHC and involves working with Optum Behavioral Health ("OBH") as UHC's behavioral health delegate.

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 many plans, including individual, small group, and large group FR/QTL compliance testing templates. The templates used appear to be the most current at the time; however, there are newer FR/QTL compliance testing templates that contain additional information for columns F and G related to citations in the form of page numbers and sections in both the Certificate of Coverage and Schedule of Benefits, where the services included in each line of the listed Covered Services can be found. Newer versions of the template also include details for column H, defining NQTLs specific to the covered service, such as prior authorization and step therapy.

Observation: The Company did provide QTL testing templates that appear to be complete and met the attributes, a through e, listed above. The Company may want to consider using one of the more updated FR/QTL compliance testing templates for future analysis. Further analysis of the QTL and NQTL process is recommended to determine the accuracy and completeness of the process.

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 supplied a list of step therapy drugs for Massachusetts from October 5, 2023. The document included 158 medications requiring step therapy. Only four of the step

therapy medications were for MH/SUD. All four of the MH/SUD medications requiring step therapy were brand-name products, and none of them are available in generic form. For these four medications, members would have to try one to three lower-cost, step-one medications before being approved for the brand-name medication. The two anti-depression medications require attempts at three generics, but the other two brand-name medications used for antipsychotic treatment or to treat Schizophrenia require only one prior attempt at a generic medication. None of these medications were for opioid usage, SUD, or smoking cessation products.

Based on the information supplied by the Company, they comply with the Massachusetts statutory and regulatory requirements for step therapy. The comparative analysis would be needed to determine compliance with MHPAEA.

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 had one of the highest step therapy denial rates in the state. Of the 1,567 step-therapy requests 53.48% or 838 were approved and 46.53% or 729 were denied. Of the 1,567 step therapy requests, 1,458 were M/S and 109 were MH/SUD. There were 762 approved M/S step therapy requests and 76 approved MH/SUD requests. There were 696 (44.4%) M/S and 33 (2%) MH/SUD step therapy denials.

Observation:
The Company should continue to monitor the step-therapy denials to identify any trends or medications that providers consistently request without attempting to obtain lower-tiered generic options.

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 provided a list of seven third-party vendors that assist with medical necessity claim determinations. Only one (1), EviCore Healthcare, is not affiliated with the Company. The remaining six (6) are affiliated. OptumRx, Inc. acts as the Pharmacy Benefit Manager (PBM) that manage, and conducts claims administration for pharmacy and utilization review. OptumHealth Care Solutions, LLC conducts utilization management. OptumInsight, Inc. conducts claims analytics and recovery, as well as retrospective fraud, waste and abuse. OrthoNet Holdings, Inc. conducts utilization review and utilization management. United Behavioral Health conducts utilization management and claims administration for behavioral health, whereas Unite HealthCare Services, Inc. conducts claims administration, medical management, including utilization review and utilization management for medical/surgical claims.

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 provided the document and links to the clinical criteria and guidelines for medical necessity. However, there is not enough information to determine if the medical necessity criteria for MH/SUD services are comparable to and no more stringent than the criteria for M/S services.

There are no concerns with the information provided by the Company related to medical necessity guidelines.

Sources for Medical Necessity Guidelines

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

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

Examination Conclusions: The Company provided documentation for the sources used to develop medical necessity criteria. Both M/S and MH/SUD use externally developed, evidence-based medical necessity

criteria (e.g., InterQual for M/S and American Society of Addiction Medicine ("ASAM"), Level of Care Utilization System ("LOCUS"), Child and Adolescent Level of Care/Service Intensity Utilization System ("CALOCUS-CASII"), and Early Childhood Service Intensity Instrument ("ECSII") for MH/SUD), as well as internally developed evidence-based medical necessity criteria (e.g., clinical policies) when making medical necessity coverage determinations. Additional sources that may be used for the clinical criteria would include scientifically based clinical evidence, peer-reviewed literature, and results from the *Hierarchy of Clinical Evidence,* such as using well-designed controlled clinical trials. Clinical criteria and guidelines vary depending on the service. For example, adult mental health inpatient services would utilize LOCUS guidelines, whereas inpatient substance use treatment would use ASAM Criteria. ASAM is the only criterion MH/SUD uses to make SUD medical necessity coverage determinations, unless otherwise mandated by state law or contract.

The Company does not modify the criteria provided by third-party sources.

Based on the review of the information provided by the Company, the sources used for determining medical necessity comply with the Massachusetts 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 supplied all the requested data, including prior authorizations, concurrent reviews, and retrospective reviews for M/S, MH, and SUD. Eighty-five and ½ percent (85.5%) of M/S prior authorizations were approved, as were 96.5% of M/H and 98.6% of SUD prior authorizations. Eighty-eight and a half (88.5%) of M/S concurrent reviews were approved, as were 100% of MH and 100% of concurrent reviews. Sixty-five and a half percent (65.5%) of M/S retrospective reviews were approved, 98% of MH, and 94% of SUD retrospective reviews were approved.

There were no concerns noted with the data provided by the company for prior authorization, concurrent reviews, and retrospective reviews. Note, data analysis was performed and no utilization management files were reviewed.

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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Commonwealth of Massachusetts
Division of Insurance
Boston, Massachusetts

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The INS Companies
Market Regulation Division
Philadelphia, Pennsylvania

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Market Regulation Division
Philadelphia, Pennsylvania