THE COMMONWEALTH OF MASSACHUSETTS

OFFICE OF CONSUMER AFFAIRS AND BUSINESS REGULATION

DIVISION OF INSURANCE

Report on the Limited Scope Market Conduct Examination of

United States Fire Insurance Company

Eatontown, NJ

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

NAIC COMPANY CODE: 21113

EMPLOYER ID NUMBER: 13-5459190

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December 8, 2025

The Honorable Michael T. Caljouw
Commissioner of Insurance
Commonwealth of Massachusetts
Division of Insurance
One Federal Street, Suite 700
Boston, Massachusetts 02110-2012

Dear Commissioner Caljouw:

Pursuant to your instructions and in accordance with Massachusetts General Laws, Chapter 175, Section 4, the Massachusetts Division of Insurance ("Division") has performed a limited-scope market conduct examination ("Continuum of Regulatory Options/Interrogatory") of the market conduct affairs of **United States Fire 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:

5 Christopher Way, 2nd Floor I
Eatontown, NJ 07724

The following report thereon is respectfully submitted.

ACRONYMS

The Better Business Bureau ("BBB")
Behavioral Health ("BH")
Crum and Forster ("C&F")
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")
Milliman Care Guidelines ("MCG")
National Association of Insurance Commissioners ("NAIC")
National Committee for Quality Assurance ("NCQA")
Non-Quantitative Treatment Limitation ("NQTL")
Obstetrics and Gynecology ("OB-GYN")
Office of Patient Protection ("OPP")
Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA")
Pharmacy Benefit Managers ("PBMs")
Quantitative Treatment Limitation ("QTL")
Substance Use Disorder ("SUD")
System for Electronic Rate Form Filing ("SERFF")
Third-Party Administrators ("TPAs")
United States of America ("USA")

BACKGROUND

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

The examination included an Interrogatory as provided under the Continuum of Regulatory Options ("Continuum") for market conduct examinations. The Continuum focused the examination on high-level aggregate data requests for areas such as utilization review, including prior authorization data, concurrent review, retrospective review, denials of authorization, step-therapy, network admission standards/ reimbursement rates, network adequacy, geographic restrictions, complaint/grievance data, information verifying compliance with MPHEA, and denials of payment and coverage. In addition, the examiners reviewed the Market Conduct Annual Statement ("MCAS"), National Association of Insurance Commissioners ("NAIC") financial filings, and Massachusetts health binder filings within the System for

Electronic Rate and Form Filing ("SERFF"). In addition, for those companies that received a report from the Massachusetts Attorney General's Office ("AGO") in 2020, the examiners conducted an evaluation of the Company responses.

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

SCOPE OF EXAMINATION

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

EXAMINATION APPROACH

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

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

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

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

COMPANY INFORMATION AND BUSINESS

The parent company of United States Fire Insurance Company is Fairfax Financial Holdings Limited, through its wholly owned subsidiary, Crum & Forster Holdings Corporation. United States Fire Insurance Company is one of the companies within the Crum & Forster group, which is in turn owned by the global organization, Fairfax Financial Holdings.

The United States Fire Insurance Company offers a product in Massachusetts that complies with state

MHPAEA laws. The product is an accident and health policy that is not technically a student health policy, but rather a blanket accident and sickness policy issued to prep schools. A US Fire Insurance Company's blanket accident and health policy can be structured to cover students, teachers, and administrators; however, coverage depends entirely on the specific terms of the policy purchased by the educational institution. The plan uses utilization management and a network of providers. The number of individuals covered is small, which could significantly impact the percentage values of claims and denials, potentially skewing the results.

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:

Policies and Procedures Related to Claim Denials

Examination Conclusions: The Company explained that their claims administrator utilizes the filled and approved policy language when reviewing any claims on their behalf. All claims are adjudicated based upon the plan terms, conditions and limitations found within the filed policy. Any large claims are forwarded to a second resource at the administrator for review and to ensure compliance with policy language. They did not provide their claims administrator's policies/procedures for claims processing including claim denials.

The Company stated that the parent Company, Crum and Forster, conducts random claim audits periodically and issues an annual questionnaire to all administrators at the beginning of each year to review business practices, ensure adherence to contractual obligations, and verify compliance with applicable state insurance laws.

Corrective Actions: The Company must provide its policies and procedures for claim denials. Please submit the policies and procedures for claims handling to the Division by February 12, 2026.

Basic Web Searches

Examination Conclusions: The Company does not have a website in the US Fire Insurance Company name. They explained that they utilize the Cigna Healthcare provider network in Massachusetts. The examiners attempted to search for an OB-GYN provider and a mental health counselor but were unsure which plan to select from the Cigna Find a Provider search located at the Cigna Health Care Provider Directory.

Corrective Actions: The Company must explain which plan a member should select to find providers in Massachusetts for an OB-GYN and a mental health counselor. The Company must specify whether the plan name for searching the Cigna website is listed on the card that members receive, or if not, how the member knows which plan to select without logging in.

Please submit the plan details for members to find a provider on the Cigna website and any additional information that will assist the member in finding providers to the Division on or before February 12, 2026.

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 link to www.changehealthcare.com operated by Optum. They utilize InterQual an evidence-based clinical decision support solution for payers, providers and government agencies who want to help ensure clinically appropriate medical-utilization decisions. The examiners were unable to see specific medical necessity criteria without filling out a request form.

Corrective Actions: The Company must provide their medical necessity criteria for M/S and MH/SUD. Please submit the medical necessity criteria to the Division 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: Typically, INS reviews the complaint summary log for MHPAEA compliance and identified complaints and grievances related to potential network adequacy insufficiencies. INS also inquires whether there were processes and procedures in place with third-party administrators to ensure all complaints were correctly reported. Further, INS:

a) reviews the Company's complaints and grievance registers to identify if there was a lack of in-network providers,
b) reviews the Company's complaint and grievance register to identify if there were sufficient in-network providers for M/S, MH, and SUD,
c) reviews the Company's complaint/grievance registers to detect any identifiable trends for out-of-network denials,
d) reviews the Company's complaint/grievance registers to identify any trends related to consumers having to pay out-of-network rates due to a lack of in-network providers,
e) inquires if there were policies and procedures in place for any third-party administrators (especially those handling MH/SUD) to report complaints/grievances to the Company, and
f) reviews to determine the final number of complaints and identify those that were of potential concern.

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

Examination Conclusions: The Company had no consumer complaints during the examination review period. The Company did not provide their policies and procedures in place to ensure that complaints from internal/external vendors are captured and reported.

Subsequent Company Actions: The Company provided their policies and procedures for complaint handling.

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 identified 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: No closed provider complaints were directly submitted by providers to the Company from January 1, 2022, through December 31, 2022, for the blanket accident and sickness coverage in Massachusetts.

II. MARKET CONDUCT ANNUAL STATEMENT

Companies with $50,000 or more in yearly premium sales in certain lines of business must file the MCAS report annually. The companies were asked to verify the accuracy of their MCAS data or, if they had not filed MCAS, to supply the information contained in the MCAS to the examiners. The examiners verified with the Company that they attested to the accuracy of the data.

Examination Procedures Performed: INS reviewed the MCAS fields related to prior authorizations (pharmacy and excluding pharmacy), and external review data for both in-exchange and out-of-exchange. Further, INS:

a) developed statewide averages for each field for both in-exchange and out-of-exchange,
b) reviewed all prior authorization denials for non-pharmacy and pharmacy and compared the state data to the statewide medians and averages,
c) reviewed the percentage of MH/SUD prior authorization denials to see if they were higher than M/S prior authorization denials,
d) reviewed the consumer-requested external reviews (excluding pharmacy) that were overturned, and,
e) verified that addenda were filed about the accuracy of the MCAS data.

Examination Conclusions: The Company provided MCAS data for out-of-exchange prior authorizations only. There were four prior authorizations (prospective utilization review requests), excluding pharmacy for mental health benefits, behavioral health benefits, and substance use disorders; all four were approved. They also reported two prior authorization (prospective utilization review requests) pharmacy-only requests, and both requests were approved.

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 third-party entities involved in claim determinations for the reporting period. HealthSmart processes the accident & sickness claims; Cigna is the PPO network that provides cost containment services; Express Script is the Prescription Benefit Manager that processes cost containment services; and Zelis works with HealthSmart in validating Payment Integrity Solution that includes claims editing, hospital bill review, out of network claim pricing, and support for the recent NSA payment guidelines for emergency services.

Policies and Procedures Related to Claim Denials

Examination Procedures Performed: INS reviewed the third-party policies and procedures for claim denials. Further, INS also identified whether:

a) the Company has adequate processes and procedures for claims processing,
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 explained that its claims administrator utilizes the filled and approved policy language when reviewing any claims on its behalf. All claims are adjudicated based on the plan's terms, conditions, and limitations found within the filed policy. Any large claims are forwarded to a second resource at the administrator for review and to ensure compliance with policy language. The Company did not provide its claims administrator's policies/procedures for claims processing, including claim denials.

The Company stated that the parent Company, Crum and Forster, conducts random claim audits periodically and an annual questionnaire to all administrators at the beginning of each year to review

business practices, adherence to contractual obligations, and to verify compliance with applicable state insurance laws.

Corrective Action: The Company must provide its policies and procedures for claim denials. Please submit the policies and procedures for claims handling to the Division by February 12, 2026.

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 on claims received, paid, and denied. The overall percentage of claims denied was 31.04%, compared to the statewide average of 12.49%. The percentage of M/S claims denied was 59.44% versus the statewide average of 15.37%. The percentage of Mental Health claims denied was 17.78%, compared to the statewide average of 8.03%. There were no substance use disorder claims during the review period. It is important to note that the total number of claims is very low, which may skew the percentage figures. The Company only issues accident and sickness policies for prep schools in the Commonwealth. The total claims for the year were only 441.

Observation: The Company should continue to monitor the number of M/S and MH claims denied. Overall, the Company had the highest percentage of claims denials for M/S and MH claims.

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 provided Cigna's network adequacy procedures. They

confirmed that Cigna confirms with providers and delegated entities every 90 days. The delegated entities and providers must review and confirm that the directory content information Cigna has is accurate. Providers will be suppressed from the directories if directory content information cannot be verified after four 90-day cycles.

Evernorth is the health services segment of The Cigna Group, providing behavioral health services for Cigna Healthcare members. Evernorth has delegated the responsibility for performing credentialing and re-credentialing functions following the National Committee for Quality Assurance ("NCQA") and state requirements. Evernorth performs oversight of all Delegated Entities.

Based on the review of the Company's practices related to network adequacy, the examiners have determined that the Company complies with the Massachusetts and federal requirements governing the accuracy of provider data.

List of Massachusetts Plans Subject to Mental Health Parity in 2022

Examination Procedures Performed: INS reviewed the Company's response to verify that the list of plans subject to the mental health parity requirement in 2022 was provided to the Division. Further, INS reviewed the Company's response to verify:

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

Examination Conclusions: The Company provided a list of 21 schools and academies covered under the plan for 2022. Based on the review of the plans supplied by the Company, the response is sufficient and accurate.

Basic Web Searches

Examination Procedures Performed:
The examiners selected a plan from the Company's list and performed a search on the Company's 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 Company does not have a website in the US Fire Insurance Company name. They explained that they utilize the Cigna Healthcare provider network in Massachusetts. The examiners attempted to search for an OB-GYN provider and a mental health counselor but were unsure which plan to select from the Cigna Find a Provider search located at the Cigna Health Care Provider Directory.

Corrective Actions: The Company must explain which plan a member should select to find providers in Massachusetts for an OB-GYN and a mental health counselor. The Company must specify whether the plan name for searching the Cigna website is listed on the card that members receive, or if not, how the member knows which plan to select without logging in.

Please submit the plan details for members to find a provider on the Cigna website and any additional information that will assist the member in finding providers to the Division on or before February 12, 2026.

The available plan options from the Cigna website include:

Network, Network POS
- Massachusetts
- Seamless – New England

Local Plus
- LocalPlus

OAP
- Open Acess Plus, OA plus, Choice Fund AO Plus

PPO
- PPO, Choice Fund PPO

V. NETWORK ADMISSION STANDARDS

The Company supplied the network admission standards, reimbursement rates and policies, and the number of network admissions during the examination period of review.

Network Admission Standards Policies/Procedures Data Submitted

Examination Procedures Performed: INS reviewed the network admission standards, reimbursement rates and policies, and the number of network admissions during the examination period of review to determine if ample processes and procedures were in place. Further, INS considered:

a) if any additional barriers exist that make it harder for MH/SUD providers to become a member of the network,
b) if the Company is using a TPA or another vendor for MH/SUD. If the Company has processes in place for the vendor to follow rather than relying solely on the vendor to determine what network admission standards will apply,
c) if there are differences between MH/SUD and M/S admission processes, evaluate the differences to ensure they do not result in more stringent or have extra requirements for MH/SUD applicants. (For example, what are the liability insurance requirements for M/S versus MH/SUD?)

Examination Conclusions: United States Fire Insurance Company utilizes the Cigna Healthcare provider network in Massachusetts. Cigna reported that they admit providers (all types) to Cigna's participating provider network(s) when they have agreed to all terms of their agreement, signed the agreement, and met all required credentialing criteria. Cigna provided their credentialing and recredentialing policies for practitioners, facilities, and healthcare facilities and programs, as well as the provider directory content and maintenance. Based on the review of the network admission standards, the Company's network admission standards meet the Massachusetts statutory and regulatory requirements.

Reimbursement Rate Policies

Examination Procedures Performed: INS reviewed the reimbursement rate policies and procedures. Further, INS reviewed the reimbursement rate policies to:

a) ensure the rate policies were complete and detailed,

b) verify whether a third-party or internal entity handles the reimbursement rate policies, and
c) verify the reimbursement procedures/methods are not more stringent for MH/SUD than for M/S providers. (Additional software, etc.)

Examination Conclusions: The Company provided their rating methodology protocol for healthcare and behavioral health, prepared in October 2023 by Cigna. Cigna uses standard Medicare Resource Based Relative Value Scale ("RBRVS"), a CMS created reimbursement methodology to reimburse providers for members covered under the Medicare program and as a baseline for commercial reimbursement rates. Cigna's RBRVS methodology calculates the allowable fee for a covered service. The Company reported the factors considered in the negotiation (geographic market, type of provider, supply of provider type and/or specialty, network adequacy, and Medicare reimbursement rates). The Company wrote that these factors are considered in every negotiation but may be weighted differently on a case-by-case basis. For clarification, there is no standard weight according to factor, weighting depends upon the facts and circumstances presented in each negotiation.

The Company should be prepared to provide examples of calculations on future exams and if requested by the Division of Insurance.

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 their request for network admissions during the examination period. There were 4,293 individuals (2,583 Med/Surg and 1,710 Mental Health) and 32 facilities (23 Med/Surg and 9 BH). All individuals and facilities were approved with the exception of one (1) individual that was denied due to a license issue. 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: Crum and Forster ("C&F") provided their *Claims Oversight Procedures* dated October 2023. They explain that the C&F claims team requires the TPA administrators to investigate, pay, settle or deny all claims in accordance with the terms of applicable policy, applicable laws and any claim guidelines provided to the administrators from time to time. Any claims falling outside the administrator's authority ideally would require approval from C&Fs claims team following the C&Fs referral submission process which specifies the operational guidelines, point of contact, and the claim file specifications along with the requisite documents. There are no recommendations.

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 only offers the coverage to large groups (prep schools), therefore the questions pertaining to small group and individual policies are not applicable. Regarding large group plans, no plans are issued in Massachusetts with mental health benefits included in the policy that contain quantitative limits.

Observation: The Company should be prepared in the future to provide evidence upon request that QTL testing was conducted and that the substantially all and predominant testing was conducted in the proper order.

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 explained that step edits are only reviewed as part of the prior authorization process for this program. Prior authorizations are required for specialty drugs and medications that cost more than $5,000. There were two medications reviewed in 2022. Both medications were approved.

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 reported a total of two (2) step-therapy request determinations during the period and both requests were approved.

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 stated that the only third-party entity involved in MH/SUD or M/S benefit determinations for the accident & sickness plan is HealthSmart. 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:

d) verify that the M/S medical necessity guideline criteria were supplied,
e) verify that the MH/SUD medical necessity guideline criteria were supplied, and
f) 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 link to www.changehealthcare.com operated by Optum. They utilize InterQual, an evidence-based clinical decision support solution for payers, providers, and government agencies that want to help ensure clinically appropriate medical-utilization decisions. The examiners were unable to see specific medical necessity criteria without completing a request form.

Corrective Action: The Company must provide their medical necessity criteria for M/S and MH/SUD. Please submit the medical necessity criteria to the Division on or before February 12, 2026.

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 reported that InterQual criteria is being used and that there are no modifications to the criteria used. Their TPA, HealthSmart, does not utilize any third-party vendors. The TPA has its own internal clinical team responsible for determining medical necessity on any claims. The examiners were able to find that HealthSmart uses medical policies and clinical utilization management ("UM") guidelines to determine medical necessity, often through its subsidiary HealthLink. The examiners were also able to find a HealthSmart Provider Manual[1] online that might contain more information regarding missing procedures. Within the manual, there was a reference to "Review Guidelines will be conducted in accordance with the following National Database: Healthcare Screening Criteria for Utilization Management, Geographic Annualized Volume - Milliman Care Guidelines."

Corrective Action: The Company must confirm whether the Milliman Care Guidelines ("MCG") are the only source for determining the medical necessity guidelines and whether MCG includes scientific guidelines for determining medical necessity for behavioral health.

Prior Authorization, Concurrent Review, and Retrospective Review

Note: Not all health insurance companies are required to perform concurrent and retrospective reviews in every instance. For example, a concurrent review typically focuses on treatments that are currently in progress. If a patient's treatment has been concluded or if the review is not pertinent to the ongoing care, a concurrent review may not be necessary. However, it should be noted that Massachusetts regulations do include requirements for concurrent review, primarily within the workers' compensation system and for health insurance carriers, to ensure the appropriateness and medical necessity of ongoing treatment, as outlined in Massachusetts General Laws, Chapter 176O, Section 12. Similarly, retrospective reviews may not be necessary in situations where the Company has made an effort to verify concurrent reviews by analyzing documentation and coding before claims are submitted, thereby ensuring accuracy.

Examination Procedures Performed: The examiners reviewed the approved, partially denied, and whole denials for prior authorization, concurrent reviews, and retrospective reviews, divided into M/S, MH, and SUD. Further, INS reviewed the data to:

a) develop averages and medians for M/S, MH, and SUD prior authorization, concurrent reviews, and retrospective reviews,

[1] hs-provider-manual_0323.pdf

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,
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 only four (4) M/S total requests for retrospective review, all four requests were approved. There are no recommendations.

SUMMARY

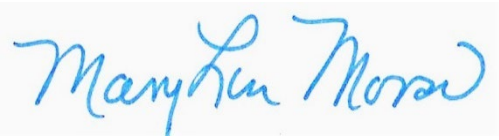
Based upon the procedures performed in this examination, INS has reviewed the Company's responses to the interrogatory which included utilization review, prior authorization data, concurrent review, retrospective review, denials of authorization, step-therapy, network admission standards/reimbursement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