THE COMMONWEALTH OF MASSACHUSETTS

OFFICE OF CONSUMER AFFAIRS AND BUSINESS REGULATION

DIVISION OF INSURANCE

Report on the Limited Scope Market Conduct Examination of

Wellfleet Insurance Company

Fort Wayne, IN

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

NAIC COMPANY CODE: 32280

EMPLOYER ID NUMBER: 95-4077789

TABLE OF CONTENTS

COMMONWEALTH OF MASSACHUSETTS
Office of Consumer Affairs and Business Regulation
DIVISION OF INSURANCE
One Federal Street, Suite 700 • Boston, MA 02110
(617) 521-7794 • (877) 563-4467 • www.mass.gov/doi

MAURA T. HEALEY
GOVERNOR

KIMBERLEY DRISCOLL
LIEUTENANT GOVERNOR

ERIC PALEY
SECRETARY

LAYLA R. D'EMILIA
UNDERSECRETARY

MICHAEL T. CALJOUW
COMMISSIONER

December 8, 2025

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

Dear Commissioner Caljouw:

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

5814 Reed Road
Fort Wayne, IN, USA 46835-3568

The following report thereon is respectfully submitted.

ACRONYMS

American Society of Addiction Medicine ("ASAM")
American Specialty Health ("ASH")
The Better Business Bureau ("BBB")
Behavioral Health ("BH")
INS Regulatory Insurance Services, Inc. ("INS")
Massachusetts Attorney General's Office ("AGO")
Massachusetts Division of Insurance ("Division")
Market Conduct Annual Statement ("MCAS")
Market Regulation Handbook ("MRH" or "the Handbook")
Medical/Surgical ("M/S")
Mental Health ("MH")
National Association of Insurance Commissioners ("NAIC")
National Committee for Quality Assurance ("NCQA")
National Comprehensive Cancer Network ("NCCN")
Network Quality and Performance ("NQ&P")
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")
World Professional Association for Transgender Health ("WPATH")

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:

There were no corrective actions reported for the Company.

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 its policies and procedures in place to ensure that complaints from internal/external vendors are captured and reported.

Subsequent Company Actions: The Company provided its policies and procedures for complaint handling, including the process to obtain consumer complaints from vendors such as Cigna.

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.

Additionally, 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 received three (3) complaints submitted by providers in 2022, one (1) of which was related to mental health/substance use disorders. The complaints allege denial of claims. The complaint dispositions include maintained denial (2) and substantiated (1).

There were a total of three (3) consumer complaints, and zero (0) were of potential concern.

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 is below the $50,000 threshold; therefore, they do not have to file MCAS data.

III. DENIAL OF PAYMENT AND COVERAGE

Third-Party Administrator Claims Processing

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

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

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

Examination Conclusions: The Company provided a list of third-party entities (all unaffiliated) involved in claim determinations for the reporting period. Zelis Claims Integrity, Inc. reviews claims for proper coding and accuracy, including all in-network and out-of-network claims. Express Scripts, Inc. provides adjudication of prescription claims at the point of sale.

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 they contract with Cigna to perform certain utilization management reviews, such as precertification, in accordance with the requirements set forth in the member's plan documents. Moreover, Wellfleet issues claim denials pursuant to the benefits and exclusions set forth in the member's plan documents and in accordance with Wellfleet's payment guidelines. They provided their payment guidelines and pharmacy policies and procedures related to claim denials (in part or in whole).

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 percentage of all claims paid was 78.93%. The percentage of M/S claims denied in whole was 19.36% as compared to the statewide average of 15.07%. The total percentage of M/S denials was 23.37% as compared to the statewide average of 19.38%. There were 8 MH claims denied in part and 12 MH claims denied in whole, for an overall denial rate significantly lower than statewide averages. There were no SUD claims denied.

Observations: Overall, the Company had the third lowest percentage of claims paid and the second highest percentage of claim denials for M/S claims. The Company should continue to monitor the claim denials to ensure that M/S claim denials are not disproportionate to MH and SUD 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 every 90 days Cigna confirms that providers and delegated entities have reviewed and confirmed that the directory content information provided by Cigna is accurate. Providers will be suppressed from the directories if directory content information cannot be verified after four 90-day cycles. Cigna has a Network Quality and Performance ("NQ&P") internal group that receives provider responses and follows up on outreach efforts.

Based on the review of the Company's practices related to network adequacy, the examiners have determined that the Company complies with state 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 has six student health plans subject to MHPAEA. Based on the review of the plans supplied by the Company, the response is sufficient and accurate.

Basic Web Searches

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

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

Examination Conclusions: The examiners had difficulty locating both behavioral health providers and OB-GYNs.

The examiners searched for providers by utilizing the link provided by the Company for the school landing page. https://www.studentinsurance.com/
The examiners were able to select their plan from the list and then proceed to search for an OB-GYN and a mental health counselor.

For the mental health counselor, there is a link once the user has selected "find health professionals" that allows a member to click CareConnect: Talk to a Mental Health Counselor 24/7 & Find Wellbeing Resources. The links allows members to contact CareConnect (call, email, text or ask an expert), to call using a 1-888 number, and to Access care using the same phone number.

There is also a hyperlink to Cigna PPO Electronic Provider Network Directory.
The examiners searched for an OB-GYN for zip code 02138.
The Cigna website then requires members to select a plan.

Subsequent Company Actions: The Company provided the instructions on how members can search for providers within the Cigna website. The Company provided a mock student health card demonstrating which Cigna plan must be selected to retrieve the correct list of providers. The Company also provided screenshot images on how a member can locate a behavioral health provider through their plan.

Observation: The Division appreciates the details provided by the Company of navigating the websites for the student health plans and are pleased to know that there is also a downloadable application for students to use, as well as navigating the online 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 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: Wellfleet 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 have 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. The Cigna documentation includes a section for Massachusetts, which includes the procedures to follow the National Committee for Quality Assurance ("NCQA") standards for credentialing and recredentialing. In addition, the examiners were able to see references about using the uniform credentialing application.

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. Cigna uses the 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 examinations when 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 M/S and 1,710 Mental Health) and 32 facilities (23 M/S and 9 BH). All individuals and facilities were approved except for one (1) individual who 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 Company supplied policies, procedures, and documentation to show the implementation of MHPAEA compliance. Further, INS reviewed the data to:

a) ensure the Company has policies and procedures for ensuring compliance with MHPAEA,
b) ensure the Company monitors/audits vendors for compliance and,
c) ensure the Company has an organized compliance plan for MHPAEA oversight.

Examination Conclusions: The Company provided their processes for applying Non-Quantitative Treatment Limitations (NQTLs) regarding medical/surgical (MS), mental health (MH), and substance use disorder (SUD) benefits, as issued by Student Health Insurance Plans. These processes include determining medical necessity, prior authorizations, concurrent reviews, retrospective reviews, provider access credentialing and reimbursement, prescription drug classification (such as factors and sources that influence formulary design, prior authorizations, and quantity limits), and step therapy.

Based on the review, the Company meets the Massachusetts statutory and regulatory requirements regarding compliance with MHPAEA.

VII. QUANTITATIVE TREATMENT LIMITATIONS

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

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

a) ensure the Company provided testing results (pass/fail),
b) verify if the Company reported fail in any one or multiple categories,
c) verify if the QTL analysis included the substantially all testing,
d) verify if the QTL analysis includes predominant testing, and
e) verify if the Company demonstrated that the substantially all testing (2/3 threshold) was completed before the predominant testing.

Examination Conclusions: It is important to note that Wellfleet does not issue small group policies in Massachusetts. The Company provided their QTL testing for Cambridge College (Graduate and Undergraduate), Eastern Nazarene College, MGH, Our Lady of Elms, and Pine Manor. The testing included the substantially all and predominant testing for inpatient in-network and out-of-network, outpatient in-network and out-of-network, option-patient (in office, out of office, and other), and emergency. The Company is using the updated comparative analysis form.

Based on the review, the Company meets the Massachusetts statutory and regulatory requirements regarding compliance with QTL testing.

VIII. STEP THERAPY

The Company submitted the step-therapy requirements, the number of step-therapy requests, and the number 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 reported that only pharmacy benefits require step-therapy or fail first. They provided 2,344 medications for M/S and 255 medications for mental health. The MH/SUD medications listed for step-therapy include prescriptions that are either controlled substances or are brand name medications that require attempts at one or more generic options first.

Based on the review of the M/S, MH/SUD, and pharmacy benefits requiring step-therapy, the Company meets the Massachusetts statutory and regulatory requirements.

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: For Step Therapy, the Company reported a total of 58 M/S claims, with 53 approved and five (5) denied. Of these, 22 were Mental Health claims, with 21 approved and one (1) denied. There were no requests for SUD medications, and no submissions for concurrent or retrospective review under the pharmacy benefit.

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 hyperlinks to the utilization review organizations used for determining medical necessity for both M/S and MH/SUD. Wellfleet delegates its non-pharmacy utilization management to Cigna and conducts reviews only for Gender-affirming procedures for all members in-house at Wellfleet. The Cigna site includes guidelines from the following sources: EviCore, American Specialty Health ("ASH"), MCG Guidelines (Commercial), WellMed Healthcare, National Comprehensive Cancer Network ("NCCN") drugs and biologics, and Wolters Kluwer Clinical Drug Information Lexi-Drugs. In addition, the Cigna website also features a list of state-specific guidelines, including those for Massachusetts.

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 two (2) entities that were involved in MH/SUD or M/S

benefit determinations for the reporting period. The first entity, Cigna Healthcare, oversees claims and benefit determinations for M/S and MH/SUD. The second entity, RemedyOne, provides consultations for claims and benefit determinations for M/S, MH/SUD, and prescription drugs.

Based on the review of the medical necessity guidelines, the Company's medical necessity guidelines meet the Massachusetts statutory and regulatory requirements.

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 their behavioral health guidelines, Cigna's medical necessity guidelines, the American Society of Addiction Medicine ("ASAM") criteria, World Professional Association for Transgender Health ("WPATH"). Based on the review of the sources for medical necessity guidelines, the Company's medical necessity guidelines for M/S, MH, and SUD meet Massachusetts statutory and regulatory requirements.

Subsequent Company Action: The Company explained that they do not modify medical necessity criteria from any of the third-party administrator's medical necessity guidelines to be in line with Company objectives. Wellfleet delegates its non-pharmacy medical necessity reviews to Cigna and its pharmacy medical necessity reviews to RemedyOne, without modification.

Observation: The Company should consider conducting routine audits on their TPAs, if they are not already doing so. These audits could confirm whether the TPA is following the plan's rules for items such as modifying medical necessity criteria.

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,
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 40 prior authorization requests for the period of review. From a total of 66 M/S claims, 40 M/S prior authorization requests were approved, and 26 prior authorization requests were denied in whole. The percentage of prior authorizations denied in whole reported for the Company's M/S business was 39.39%, as compared to a statewide average of 15.22%. The Company had no MH or SUD claims, and there was no data related to concurrent review and retrospective reviews.

Observation: The Company should continue to monitor the denied M/S prior authorizations. The examiners understand that the percentage may be slightly skewed due to the lower number of prior authorizations reported.

SUMMARY

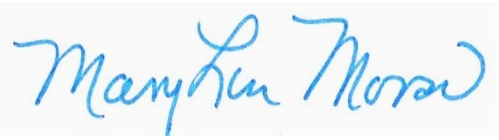
Based upon the procedures performed in this examination, INS has reviewed the Company's responses to the interrogatory which included utilization review, prior authorization data, concurrent review, retrospective review, denials of authorization, step-therapy, network admission standards/reimbursement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



Commonwealth of Massachusetts
Division of Insurance
Boston, Massachusetts

The INS Companies
Market Regulation Division
Dallas, Texas

The INS Companies
Market Regulation Division
Dallas, Texas