



**pennsylvania**  
INSURANCE DEPARTMENT

**COMMONWEALTH OF PENNSYLVANIA  
INSURANCE DEPARTMENT**

**MARKET CONDUCT  
EXAMINATION REPORT**

**OF**


**FIRST PRIORITY LIFE INSURANCE  
COMPANY AND  
HMO OF NORTHEASTERN  
PENNSYLVANIA, INC. d/b/a FIRST  
PRIORITY HEALTH  
INSURANCE COMPANY  
c/o Highmark, PITTSBURGH, PA**

**As of: December 26, 2017  
Issued: February 8, 2018**

**BUREAU OF MARKET ACTIONS  
LIFE AND HEALTH DIVISION**


## Verification

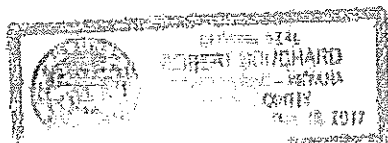
Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. §4903 (relating to false swearing).

  
Heather Harley, Examiner in Charge

**Sworn to and Subscribed Before me**

This 28 Day of November, 2017

  
\_\_\_\_\_  
Notary Public



# **Hospital Service Association of Northeastern Pennsylvania**

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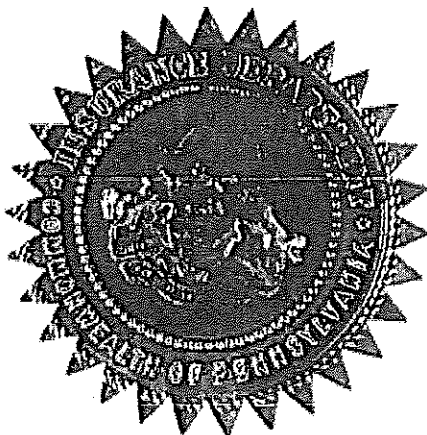
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BEFORE THE INSURANCE COMMISSIONER  
OF THE  
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 22<sup>nd</sup> day of August, 2017, in accordance with Section 905(c) of the Pennsylvania Insurance Department Act, Act of May 17, 1921, P.L. 789, as amended, P.S. § 323.5, I hereby designate Christopher R. Monahan, Deputy Insurance Commissioner, to consider and review all documents relating to the market conduct examination of any company and person who is the subject of a market conduct examination and to have all powers set forth in said statute including the power to enter an Order based on the review of said documents. This designation of authority shall continue in effect until otherwise terminated by a later Order of the Insurance Commissioner.



Jessica K. Altman  
Jessica K. Altman  
Acting Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER  
OF THE  
COMMONWEALTH OF PENNSYLVANIA

IN RE:	:	VIOLATIONS:
	:	
FIRST PRIORITY LIFE INSURANCE	:	40 P.S. §310.71a(a)
COMPANY, INC.	:	
	:	40 P.S. §323.4
and	:	
	:	40 P.S. §764c
HMO OF NORTHEASTERN	:	
PENNSYLVANIA, INC.	:	40 P.S. §764g(c)(1)
D/B/A FIRST PRIORITY HEALTH	:	
	:	40 P.S. §764h(a)
C/O Highmark	:	
120 Fifth Avenue, Suite 3128	:	40 P.S. §§908-2 <u>et seq.</u>
Pittsburgh, PA 15222	:	
	:	40 P.S. §§908-11 <u>et seq.</u>
	:	
	:	40 P.S. §991.2141(b)(4), (c)(3)
	:	
	:	40 P.S. §991.2166(a), (b)
	:	
	:	40 P.S. §1171.5(a)(10)(i)
	:	
	:	40 P.S. §1171.5(a)(10)(v)
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	:	
	:	31 Pa. Code §§146.3, 146.5(a), 146.6
	:	146.7(c)(1)
	:	
	:	31 Pa. Code §§154.18(a), (c), (d)
	:	
	:	45 C.F.R. §§146.136(c)(4), 147.160
	:	
	:	45 C.F.R. §156.115(a)(1)&(5)
	:	
	:	45 C.F.R. §147.136(b)
	:	
	:	42 U.S.C. §300gg-6



: 42 U.S.C. §18022(b)(1)(B)(E)(G)  
:  
: 42 U.S.C. §18022(c)(1)  
:  
:  
:  
Respondent. : Docket No. MC17-12-001

### CONSENT ORDER

AND NOW, this                      day of                      , 2018, this Order is hereby  
issued by the Insurance Department of the Commonwealth of Pennsylvania pursuant  
to the statutes cited above and in disposition of the matter captioned above.

1. Respondent hereby admits and acknowledges that it has received proper notice  
of its rights to a formal administrative hearing pursuant to the Administrative Agency  
Law, 2 Pa.C.S. §101, et seq., or other applicable law.

2. Respondent hereby waives all rights to a formal administrative hearing in this  
matter, and agrees that this Consent Order shall have the full force and effect of an  
order duly entered in accordance with the adjudicatory procedures set forth in the  
Administrative Agency Law, supra, or other applicable law.

### FINDINGS OF FACT

3. The Insurance Department finds true and correct each of the following

**Findings of Fact:**

- (a) Respondent is First Priority Life Insurance Company, Inc. and HMO of Northeastern Pennsylvania, Inc. d/b/a First Priority Health, collectively c/o Highmark Inc., and maintains its address at 120 Fifth Avenue, Suite 3128, Pittsburgh, PA 15222.
- (b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from January 1, 2015 to March 31, 2016.
- (c) On December 26, 2017, the Insurance Department issued a Market Conduct Examination Report to Respondent.
- (d) A response to the Examination Report was provided by Respondent on January 25, 2018.
- (e) The Examination Report notes violations of the following:

- i. 40 P.S. §310.71a(a), requiring that an insurer which terminates an appointment notify the Department in writing, within 30 days following the effective date of the termination.
- ii. 40 P.S. §323.4, requiring every company or person from whom information is sought by the Department, including its officers, directors and agents, to provide to the examiners timely, convenient and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the company being examined.
- iii. 40 P.S. §764c, requiring policies providing hospital or medical/surgical coverage to provide coverage for mammographic examinations, including 2-D and 3-D imaging.
- iv. 40 P.S. §764g(c)(1), requiring large group health insurance policies to provide coverage for serious mental illnesses that meet minimum standards that include at least 30 inpatient and 60 outpatient days annually.
- v. 40 P.S. §764h(a), requiring large group health insurance policies to provide coverage for the diagnostic assessment of and treatment of autism spectrum disorders for covered individuals under twenty-one (21) years of age.

- vi. 40 P.S. §§908-2 et seq., requiring group health insurance policies to provide coverage of inpatient detoxification, nonhospital residential and outpatient services for alcohol or other substance use and dependency, with a certification and referral by a licensed physician or psychologist controlling both the nature and duration of treatment to the extent of the mandate.
- vii. 40 P.S. §908-11 et seq., requiring health insurers to comply with, inter alia, the federal Mental Health Parity and Addiction Equity Act of 2008 (42 U.S.C. §300gg-26).
- viii. 40 P.S. §991.2141(b)(4), requiring a managed care plan to have a complaint process in which the initial review of a complaint is completed within (30) days of receipt of the complaint.
- ix. 40 P.S. §991.2141(c)(3), requiring a managed care plan to have a complaint process in which the second level review of a complaint is completed within 45 days of receipt of a request for such review.
- x. 40 P.S. §991.2166(a), requiring a licensed insurer or managed care plan to pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim.

- xi. 40 P.S. §991.2166(b), requiring, if a licensed insurer or managed care plan fails to remit the payment as provided under subsection (a), payment of interest at ten per centum (10%) per annum to be added to the amount owed on the clean claim, with interest calculated beginning the day after the required payment date and ending on the date the claim is paid.
- xii. 40 P.S. §1171.5(a)(10)(i), prohibiting misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue, if committed or performed with such frequency as to indicate a business practice in claims settlement practices.
- xiii. 40 P.S. §1171.5(a)(10)(v), requiring an insurer to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the insurer or its representative, if committed or performed with such frequency as to indicate a business practice in claims settlement practices.
- xiv. 40 P.S. §1171.5(a)(10)(vi), prohibiting the failure to attempt in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear, if committed or performed with such frequency as to indicate a business practice in claims settlement practices.

- xv. 31 Pa. Code §146.3, requiring an insurer's claim files to be subject to examination by the Commissioner or by her appointed designees, with the files containing notes and work papers pertaining to the claim in sufficient detail that pertinent events and the dates of the events can be reconstructed.
- xvi. 31 Pa. Code §146.5(a), requiring an insurer, upon receiving notification of a claim, to acknowledge the receipt of such notice within ten working days, unless payment is made within such period; and if an acknowledgement is made by means other than writing, to make an appropriate dated notation of such acknowledgment in the claim file of the insurer.
- xvii. 31 Pa. Code §146.6, requiring an insurer, if an investigation cannot be completed within thirty (30) days, and if it is not completed, then every forty-five (45) days thereafter, to provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected.
- xviii. 31 Pa. Code §146.7(c)(1), requiring an insurer, if it cannot make a determination of acceptance or denial of a first-party claim within 15 days of receipt of a properly executed proof of loss, to notify the first-party claimant within 15 working days after receipt of the proof of loss giving the reasons more time is needed.

- xix. 31 Pa. Code §154.18(a), requiring a licensed insurer or managed care plan to pay a clean claim and the uncontested portions of a contested claim submitted by a health care provider for services within 45 days of the licensed insurer's or managed care plan's receipt of the claim from the health care provider, where the claim is submitted under a health insurance policy.
- xx. 31 Pa. Code §154.18(c), requiring that interest due to a health care provider on a clean claim be calculated and paid by the licensed insurer or managed care plan to the health care provider, with the interest added to the amount owed on the clean claim and paid within 30 days of the payment of the claim.
- xxi. 31 Pa. Code §154.18(d), specifying that claims paid by a licensed insurer or managed care plan are considered clean claims and are subject to the interest provisions of the act, and requiring that if a paid claim is re-adjudicated by the licensed insurer or managed care plan, a new 45-day period for the prompt payment provision begins again at the time additional information prompting the readjudication is provided to the plan, with the prompt payment requirements applying to additional moneys owed or paid to the health care provider and to the uncontested portion of a contested claim.

- xxii. 42 U.S.C. §300gg-6, relating to comprehensive health care coverage, requiring individual and small group market health insurers to ensure that such coverage includes the essential health benefits package and requiring limitations on annual cost-sharing for group health plans.
- xxiii. 42 U.S.C. 18022(b)(1)(B),(E),(G), the essential health benefit (EHB) provision of the Affordable Care Act, requiring coverage of certain general categories and items and services in those categories, including emergency services, mental health and substance use disorder services including behavioral health treatment, and rehabilitative and habilitative services and devices;
- xxiv. 42 U.S.C. §18022(c)(1), the essential health benefits (EHB) provision of the Affordable Care Act, requiring that the cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage may not exceed specified dollar amounts.
- xxv. 45 C.F.R. §146.136(c)(4), requiring that group health insurance policies may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the coverage, as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the



processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

xxvi. 45 C.F.R. §147.136(b), requiring that a health insurance issuer offering health insurance coverage must comply with all the specified requirements of the internal claims and appeals process; and incorporating 29 C.F.R. §2560.503-1(i)(2)(ii), which requires (a) in the case of a pre-service claim, notification to the claimant of the plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances, (b) in the case of a group health plan that provides for one appeal of an adverse benefit determination, such notification to be provided not later than 30 days after receipt by the plan of the claimant's request for review of an adverse benefit determination, and (c) in the case of a group health plan that provides for two appeals of an adverse benefit determination, such notification to be provided, with respect to any one of the two appeals, not later than 15 days after receipt by the plan of the claimant's request for review of the adverse benefit determination.

xxvii. 45 C.F.R. §147.160, requiring that health insurance coverage offered by a health insurance issuer in the individual market must comply with 45 C.F.R. §146.136 in the same manner and to the same extent as the provision applies to health insurance coverage offered in connection with a large group policy.

xxviii. 45 C.F.R §156.115(a)(1) and (5), specifying that provision of essential health benefits (EHB) means that a health plan provides benefits that are substantially equal to the EHB-benchmark plan including, with respect to habilitative services and devices, health care services and devices that help a person keep, learn, or improve skills and functioning for daily living, and that are not subject limits on coverage that are less favorable than any such limits imposed on coverage of rehabilitative services and devices.

#### CONCLUSIONS OF LAW

4. In accord with the above Findings of Fact and applicable provisions of law, the Insurance Department makes the following Conclusions of Law:

- (a) Respondent is subject to the jurisdiction of the Pennsylvania Insurance Department.
- (b) Respondent's violations of 40 P.S. §310.71a(a) are punishable by the following, under 40 P.S. §310.91:
  - (1) Suspension, revocation or refusal to issue the certificate of qualification or license.
  - (2) Imposition of a civil penalty not to exceed five thousand dollars (\$5,000.00) for every violation of the Act.

- (3) An order to cease and desist.
  - (4) Any other conditions as the Commissioner deems appropriate.
- (c) Respondent's violations of Sections 40 P.S. §§764c, 764g(c)(1) and 764h(a) are punishable by the following under 40 P.S. §763:
- (1) License revocation.
  - (2) Imposition of a penalty of not more than one thousand dollars (\$1,000.00) for each violation.
- (d) Respondent's violations of 40 P.S. §§991.2141(b)(4), 991.2141(c)(3), 991.2166(a) and 991.2166(b) are punishable by the following under 40 P.S. §991.2182:
- (1) Imposition of a penalty of not more than five thousand dollars (\$5,000.00) for each violation.
  - (2) An injunction to prohibit any activity that violates the act.
  - (3) An order temporarily prohibiting respondent from enrolling new members.
  - (4) A requirement to develop and adhere to a plan of correction.
- (e) Respondent's violations of 40 P.S. §§1171.5(a)(10)(i), 1171.5(a)(10)(v) and 1171.5(a)(10)(vi) are punishable by the following under 40 P.S. §1171.9:
- (1) An order to cease and desist.
  - (2) License suspension or revocation.

(f) In addition to any penalties imposed by the Commissioner for Respondent's violations of 40 P.S. §§1171.5(a)(10)(i), 1171.5(a)(10)(v) and 1171.5(a)(10)(vi), the Commissioner may, under 40 P.S. §§1171.10, 1171.11, file an action in which the Commonwealth Court may impose the following civil penalties:

- (1) An injunction.
- (2) For each method of competition, act or practice which the company knew or should have known was in violation of the law, a penalty of not more than five thousand dollars (\$5,000.00) for each violation but not to exceed an aggregate penalty of fifty thousand dollars (\$50,000) in any six month period.
- (3) For each method of competition, act or practice which the company did not know nor reasonably should have known was in violation of the law, a penalty of not more than one thousand dollars (\$1,000.00) for each violation but not to exceed an aggregate penalty of ten thousand dollars (\$10,000) in any six month period.

(g) Respondent's violations of 31 Pa. Code §§146.3, 146.5(a), 146.6 and 146.7(c)(1) are punishable by the following under 40 P.S. §1171.9:

- (1) An order to cease and desist.
- (2) License suspension or revocation.

- (i) In addition to any penalties imposed by the Commissioner for Respondent's violations of 31 Pa. Code §§146.3, 146.5(a), 146.6 and 146.7(c)(1), the Commissioner may, under 40 P.S. §§1171.10, 1171.11 file an action in which the Commonwealth Court may impose the following civil penalties:
- (1) An injunction.
  - (2) For each method of competition, act or practice which the company knew or should have known was in violation of the law, a penalty of not more than five thousand dollars (\$5,000.00) for each violation but not to exceed an aggregate penalty of fifty thousand dollars (\$50,000) in any six month period.
  - (3) For each method of competition, act or practice which the company did not know nor reasonably should have known was in violation of the law, a penalty of not more than one thousand dollars (\$1,000.00) for each violation but not to exceed an aggregate penalty of ten thousand dollars (\$10,000) in any six month period.
- (h) Respondent's violations of 31 Pa. Code §154.18(a),(c) and (d) are punishable by the following under 40 P.S. §991.2182:
- (1) Imposition of a penalty of not more than five thousand dollars (\$5,000.00) for each violation.
  - (2) An injunction to prohibit any activity that violates the act.

- (3) An order temporarily prohibiting respondent from enrolling new members.
- (4) A requirement to develop and adhere to a plan of correction.

ORDER

5. In accord with the above Findings of Fact and Conclusions of Law, the Insurance Department orders and Respondent consents to the following:

- (a) Respondent shall cease and desist from engaging in the prohibited activities described herein in the Findings of Fact and Conclusions of Law.
- (b) Respondent shall file an affidavit stating under oath that it will provide each of its directors, at the next scheduled directors meeting, a copy of the adopted Report and related Orders. Such affidavit shall be submitted within thirty (30) days of the date of this Order.
- (c) Respondent shall comply with all recommendations contained in the attached Report.
- (d) Respondent shall pay Ninety Thousand Dollars (\$90,000.00) to the Commonwealth of Pennsylvania in settlement of the violations pertaining to

the prompt payment of claims, the retention of records, drug and alcohol abuse coverage and Pennsylvania's requirement for compliance with the Federal Mental Health Parity and Addiction Equity Act.

- (e) Payment of this matter shall be made by check payable to the Commonwealth of Pennsylvania. Payment should be directed to April Phelps, Bureau of Market Actions, 1227 Strawberry Square, Harrisburg, Pennsylvania 17120. Payment must be made no later than thirty (30) days after the date of this Order.

6. In the event the Insurance Department finds that there has been a breach of any of the provisions of this Order, based upon the Findings of Fact and Conclusions of Law contained herein may pursue any and all legal remedies available, including but not limited to the following: The Insurance Department may enforce the provisions of this Order in the Commonwealth Court of Pennsylvania or in any other court of law or equity having jurisdiction; or the Department may enforce the provisions of this Order in an administrative action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

7. Alternatively, in the event the Insurance Department finds that there has been a breach of any of the provisions of this Order, the Department may declare this Order to be null and void and, thereupon, reopen the entire matter for appropriate action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

8. In any such enforcement proceeding, Respondent may contest whether a breach of the provisions of this Order has occurred but may not contest the Findings of Fact and Conclusions of Law contained herein.

9. Respondent hereby expressly waives any relevant statute of limitations and application of the doctrine of laches for purposes of any enforcement of this Order.

10. This Order constitutes the entire agreement of the parties with respect to the matters referred to herein, and it may not be amended or modified except by an amended order signed by all the parties hereto.

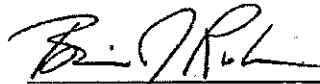
11. This Order shall be final upon execution by the Insurance Department. Only the Insurance Commissioner or a duly authorized delegate is authorized to bind the Insurance Department with respect to the settlement of the alleged violations of law



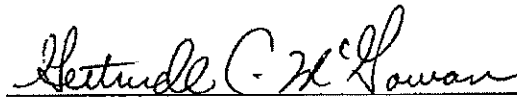
contained herein, and this Consent Order is not effective until executed by the  
Insurance Commissioner or a duly authorized delegee.

BY:

FIRST PRIORITY LIFE INSURANCE  
COMPANY, INC.  
Respondent

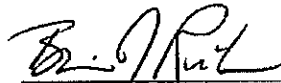


\_\_\_\_\_  
President / Vice President



\_\_\_\_\_  
Secretary / Treasurer

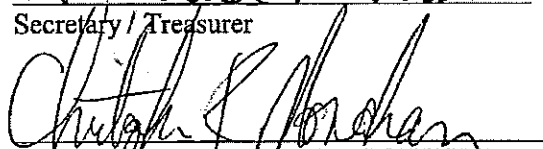
HMO OF NORTHEASTERN  
PENNSYLVANIA, INC. D/B/A FIRST  
PRIORITY HEALTH,  
Respondent



\_\_\_\_\_  
President / Vice President



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Secretary / Treasurer



COMMONWEALTH OF PENNSYLVANIA  
Christopher R. Monahan  
Deputy Insurance Commissioner

## ***I. INTRODUCTION***

The Market Conduct Examination was conducted on Hospital Service Association of Northeastern Pennsylvania, d/b/a Blue Cross of Northeastern Pennsylvania (BCNEPA), and its wholly-owned subsidiaries First Priority Life Insurance Company, Inc. (FPLIC) and HMO of Northeastern Pennsylvania, Inc., d/b/a First Priority Health (FPH), hereafter collectively referred to as "Company," at the Company's offices located in Wilkes-Barre, Pennsylvania and Pittsburgh, Pennsylvania September 19, 2016, through September 26, 2016; July 11, 2016 through July 15, 2016; September 19 through September 21, 2016; October 17 through October 19, 2016; December 5, 2016 through December 8, 2016; and January 30, 2017 through February 2, 2017. Subsequent and follow-up reviews were conducted in the offices of the Pennsylvania Insurance Department and off-site locations.

Pennsylvania Market Conduct Examination Reports generally note only those items to which the Department, after review, takes exception due to a violation; however, this report includes practices, procedures and sample claim files both with and without exceptions. A violation is any instance of Company activity that does not comply with an insurance statute or regulation. Violations contained in the Report may result in imposition of penalties. The Examination Report may include management recommendations addressing areas of concern noted by the Department, but for which no statutory violation was identified. This enables Company management to review these areas of concern in order to determine the potential impact upon Company operations or future compliance.

It is also noted that certain areas subject to examination are and will continue to be the focus of ongoing compliance emphasis by the Department. These areas reflect developments in complex areas of health insurance regulation at both the national and state

levels, such as, for example, discrimination in formulary design and parity for non-quantitative treatment limitations in mental health and substance use disorder coverage. The Department anticipates providing more specific guidance to the industry with respect to these areas, and also appreciates and anticipates the continued cooperation of the Company in providing coverage consistent with the laws and regulations governing these complex areas.

Throughout the course of the examination, Company officials were provided status memoranda, which referenced specific policy numbers with citation to each section of law violated. Additional information was requested to clarify apparent violations. An exit conference was conducted with Company officials to discuss the various types of violations identified during the examination and review written summaries provided on the violations found.

The courtesy and cooperation extended by the Officers and employees of the Company during the course of the examination is acknowledged.

The following examiners participated in the Examination and in the preparation of this Report.

Donna Fleischauer  
Market Conduct Division Chief  
Pennsylvania Insurance Department

Heather Harley, AMCM, FLMI, HIA, MHP, DIA, LTCP, ACIP  
Examiner-in-Charge

Gary Boose  
Market Conduct Examiner  
Pennsylvania Insurance Department

Lindsi Swartz  
Market Conduct Examiner  
Pennsylvania Insurance Department

Sean Connolly  
Contract Examiner

Ralph Romano  
Contract Examiner

## **II. SCOPE OF EXAMINATION**

The Market Conduct Examination was conducted pursuant to the authority granted by Sections 903 and 904 (40 P.S. §§323.3 and 323.4) of the Insurance Department Act and covered the experience period of January 1, 2015, through March 31, 2016, unless otherwise noted. The purpose of the examination was to ensure compliance with Pennsylvania insurance laws and regulations.

The examination focused on the Company's policies and procedures in areas such as: Operations and Management, Complaints, Producer Licensing, Policyholder Services, Underwriting and Rating, Claims, Grievances, Network Adequacy, Provider Credentialing, Quality Assessment and Improvement, and Utilization Review.

The Company was requested to identify the universe of files for each segment of the review. Based on the universe sizes identified, random sampling was utilized to select the files reviewed for this examination.

During the course of the examination, for control purposes, some of the review segments identified in this Report may have been broken down into various sub-categories by line of insurance or Company administration. These specific sub-categories, if not reflected individually in the Report, are included and grouped within the respective general categories of the Examination Report.

Within the duration of the market conduct examination, the Company provided the examiners with multiple positive process improvements relative to the transition of the Company's claim handling from BCNEPA's system to Highmark Inc.'s enhanced claim system administration, policies and procedures, management structure, compliance oversight, and corporate governance. Highmark Inc. added valuable resources, tools and advanced technologies to enhance the products and services offered to members.

One example of improved member services is the revision of the Explanation of Benefits (EOBs) statements. As a result, the policyholders received clearer information on the statements. The examiners also noted that the consumer complaint, appeal and grievance process was greatly improved by Highmark's record keeping documentation and improved tools.

Highmark Inc.'s size and scale will provide a positive impact to operate efficiently, comply with governmental requirements, and improve the overall customer service experience.

### **III. COMPANY HISTORY AND LICENSING**

#### **HMO of Northeastern Pennsylvania, Inc. d/b/a First Priority Health**

HMO of Northeastern Pennsylvania, Inc. d/b/a First Priority Health (FPH) was incorporated in the Commonwealth of Pennsylvania on May 5, 1986, as a wholly-owned subsidiary of Hospital Service Association of Northeastern Pennsylvania, d/b/a Blue Cross of Northeastern Pennsylvania (BCNEPA). Effective October 31, 1986, FPH was issued a Pennsylvania Certificate of Authority as a non-profit health maintenance organization under the provisions of the Health Maintenance Organization Act, Act of December 29, 1972, P.L. 1701, No. 364 (40 P.S. §§1551 et seq.). The Company commenced business on January 1, 1987, and was federally qualified on June 30, 1987. FPH filed for and received approval of the fictitious name First Priority Health, effective August 22, 1995. At that time, FPH began doing business as First Priority Health.

On April 29, 2005, BCNEPA sold a 40% minority interest of FPH to Highmark Inc. FPH provides a basic managed care product, BlueCare HMO, an open access HMO plan, BlueCare HMO Plus, and an HMO Individual Conversion product.

On or about June 1, 2015, BCNEPA sold a 100% majority interest of FPH to Highmark Inc.

#### **First Priority Life Insurance Company, Inc.**

First Priority Life Insurance Company, Inc. (FPLIC) was incorporated on July 15, 1997, under the name of Eastern American Life Insurance Company, Inc., as a wholly-owned subsidiary of Hospital Service Association of Northeastern Pennsylvania, d/b/a Blue Cross of Northeastern Pennsylvania (BCNEPA). FPLIC was primarily formed to market and administer a non-gatekeeper preferred provider organization product to be marketed as First Point. On December 30, 1997, FPLIC filed an amendment to its

Articles of Incorporation to change its name to First Priority Life Insurance Company, Inc.

Effective August 18, 1998, FPLIC was issued a Certificate of Authority to issue policies and otherwise transact the business of insurance in the Commonwealth of Pennsylvania under Section 202, subdivision (a), Paragraphs (1) Life and Annuities, and (2) Accident and Health, of the Act of May 17, 1921, as amended, (40 P.S. § 382) in accordance with its Charter and the Laws of the Commonwealth of Pennsylvania.

On April 29, 2005, BCNEPA sold a 40% minority interest of FPLIC to Highmark Inc.

FPLIC commenced business selling a Preferred Provider Organization (PPO) product, BlueCare Qualified High Deductible, on November 6, 2006. FPLIC is currently selling both group and individual PPO products and commenced selling an Exclusive Provider Organization (EPO) product in 2008.

On or about June 1, 2015, BCNEPA sold a 100% majority interest of FPLIC to Highmark Inc.



#### **IV. COMPANY OPERATIONS AND MANAGEMENT**

The Company was requested to provide copies of its internal audit and compliance procedures. The audits and procedures were reviewed to assure best practices. Documents requested dealt with information technology protection, anti-fraud policies and procedures, disaster recovery plans, monitoring business functions, record retention policies and procedures, company management and governance, privacy protections and notices, and standards for handling non-public personal information. Unless noted, all documents identified in the universe by the Company were requested, received and reviewed by the examiners.

##### **A. Policies and Procedures for Information Technology Protection**

The Company was requested to provide copies of policies and procedures or other documentation demonstrating that the Company has controls, safeguards and procedures for protecting the integrity of computer information in accordance with Standard #2 for the examination period of January 1, 2015 through March 31, 2016. The Company provided nine documents which were reviewed to ensure compliance with the standards set forth in Chapters 16 and 20 of the NAIC Market Regulation Handbook, CMS, CCIIO regulations and 31 Pa. Code §§152.20, 301.82. No violations were noted.

##### **B. Anti-Fraud Procedures**

The Company provided anti-fraud procedures demonstrating that the Company has antifraud initiatives in place that are reasonably calculated to detect, prosecute and prevent fraudulent insurance acts. The policies and procedures were reviewed to assure best practices.

##### **C. Third Party Agreements**

The Company was requested to provide copies of contracts with any third party entity, including managing general agents, general agents, third-party administrators and vendors

conducting activities on behalf of the insurer during the examination period. The Company provided 24 documents which were reviewed by the examiners. No violations were noted.

#### **D. Record Retention**

The Company provided record retention policies and procedures demonstrating the general requirement for retention of records is seven years from execution of the record, unless otherwise specified in the Guidelines issued pursuant to the Act (41 Pa. B. 5849). The policies and procedures were reviewed to ensure compliance with the Insurance Company Law and Sections 903 and 904 of the Act (40 P.S. §§323.3 and 323.4), which require the Company to maintain records in a manner as the Department may require to readily verify compliance with laws and to provide timely, convenient and free access to all records. Consumer Complaints and Producer Licensing (including log of complaints and correspondence with state or federal regulators) shall be retained for seven years and failure to maintain a complete record of all complaints received during the preceding four years is a violation. Record storage sites should have appropriate security systems and have adequate protection from loss or damage by fire or other hazards. An electronic record must accurately reflect the record as it was first generated. Recordkeeping systems must be archival in nature and include safeguards that provide reasonable assurances against tampering, alteration or degradation of records. Paperless systems must have the capability to reproduce records in hard copy or other medium acceptable to the Department that is as legible as the original document and that includes all information in the original record, including signatures, notations and approval stamps. Sufficient visual terminals must be available to provide Department examiners with ready access to data during the course of an examination.

**4 Concerns:** There are four concerns in the Consumer Complaints section for failure to match the complaint departmental record retention procedures to the corporate record retention years.

#### **E. Privacy policies and procedures**

The Company was requested to provide documentation that the Company has policies and procedures in place so that non-public personal health information will not be disclosed, except as permitted by law, unless a customer or a consumer who is not a customer, has authorized the disclosure. The Company's Privacy Office was organized and provided the requested information. The privacy information to consumers was well-written and easily understood. No violations were noted.

#### **F. Security protection of non-public customer information**

The Company was requested to provide policies and procedures or other documentation demonstrating that the Company implemented a comprehensive written information security program for the protection of nonpublic customer information for the experience period of January 1, 2015, through March 31, 2016. No violations were noted.

#### **G. Data submission to regulator policies and procedures**

The Company was requested to provide policies and procedures, or other documentation, demonstrating that the Company's data that is required to be reported to the Pennsylvania Insurance Department is complete and accurate during the experience period of January 1, 2015, through March 31, 2016. No violations were noted.

#### **H. Management of Compliance Division**

The Company was requested to describe the management structure of the Company as it relates to Major Medical Health insurance, including the management structure that handles compliance issues. The Company identified a universe of two documents describing the management structure of the Company as it relates to compliance issues which were requested and reviewed by the examiners. In accordance with the requirements of the exam, the Company provided a satisfactory description of the Company's management structure as related to compliance issues. No violations were noted.

## **V. CONSUMER COMPLAINTS**

### **A. Complaint Handling**

The Company was requested to provide all consumer complaints and copies of consumer complaint logs for the experience period. The Company identified a universe of 14 documents, and also provided a complaint log. No violations were noted.

### **B. Complaint Handling Procedures**

The Company was requested to provide policies and procedures or other documentation demonstrating the Company has adequate complaint handling procedures in place and communicates such procedures to policyholders. The Company identified a universe of 14 documents which was requested, received and reviewed. No violations were noted.

### **C. Complaint Resolution**

The Company was requested to provide policies and procedure or other documentation demonstrating that the Company takes adequate steps to finalize and dispose of complaints in accordance with applicable statutes, rules and regulations and contract language. No violations were noted.

### **D. Complaint Response Time**

The Company was requested to provide policies and procedures or other documentation demonstrating that the timeframe within which the Company responds to complaints is in accordance with applicable statutes, rules and regulations. No violations were noted.

### **E. Complaint Disposal**

The Company was requested to provide policies and procedures or other documentation demonstrating that the Company takes adequate steps to finalize and dispose of complaints in accordance with The Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010 (together the Affordable Care Act or ACA), the

Health Insurance Portability and Accountability Act of 1996 (HIPAA), and applicable state laws and regulations. The Company provided 14 documents which were reviewed. No violations were noted.

#### **F. The Definition of a Complaint**

The Company was requested to provide policies, procedures and guidelines for complaint handling, including the Company's definition of what constitutes a complaint. The company provided one document which was reviewed. No violations were noted.

#### **G. Complaint Summaries**

The Company was requested to provide a description and copies of the complaint reports and summaries prepared on a regularly recurring basis by the Company and identify recipients of the reports, as well as provide examples of each report and/or summary document. The Company provided three documents which were reviewed. No violations were noted.

#### **H. Consumer Complaints**

The Company identified 1,531 consumer complaints received during the experience period. Of the 1,531 complaints identified, 136 complaints were forwarded from the Pennsylvania Insurance Department. The Pennsylvania Insurance Department's list of written consumer complaints forwarded to the Company during the experience period was compared to the Company's complaint log. The following violation and concerns were noted:

##### **1 Violation - 40 P.S. §991.2141(b)(4)**

The complaint process shall consist of an initial review to include a review of the complaint which shall be completed with (30) days of receipt of the complaint. The Company failed to review the complaint within 30 days of receipt of the complaint.

**Concern 1:** The Company may not acknowledge receipt of a complaint in a timely fashion in some instances. Examiners noted that the Company's acknowledgement letters may be drafted and mailed anywhere from one to fifteen business days after receipt of a complaint from the member or member's representative.

**Concern 2:** The Company does not use clear and effective language in its acknowledgment and decision letters regarding members contacting the Pennsylvania Insurance Department for assistance with complaints, the complaint process and/or follow-up after a denial.

### **I. First Level Internal Appeals**

The Company was requested to identify all first level internal appeals received during the experience period. The Company identified 1,610 first level internal appeals received during the experience period. The examiners selected a random sample of 119 first level internal appeals. Of those 119 first level appeal files received and reviewed, 24 were grievances and 95 were complaints. The following violations and concerns were noted:

#### **1 Violation—45 C.F.R. §147.136(b), incorporating 29 C.F.R. §2560.503-1(i)(2)(ii)**

In the case of a pre-service claim, the plan administrator shall notify the claimant of the plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. In the case of a group health plan that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals not later than 15 days after receipt by the plan of the claimant's request for review of the adverse determination. The Company failed to provide a decision regarding a pre-service adverse benefit determination within 15 days for a plan with two appeal review levels.

**1 Violation- 40 P.S. §991.2141(b)(4)**

The Complaint process shall consist of an initial review to include a review of the complaint which shall be completed within 30 days of receipt of the complaint. The Company failed to review the complaint within 30 days of receipt of the complaint.

**Concern 1:** The Company did not acknowledge receipt of complaints in a timely fashion in some instances. Examiners noted that the Company's acknowledgement letters may be drafted and mailed anywhere from one to 15 business days after the receipt of a complaint from the member or member's representative. The Company will be monitoring the acknowledgement letters on an on-going basis to ensure the requirements are met.

**Concern 2:** The Company does not use clear and effective language in its acknowledgement and decision letters regarding members contacting the Pennsylvania Insurance Department for assistance with complaints, the complaint process and/or follow-up after a denial.

**J. All Internal Second Level and External Appeals**

The Company was requested to identify all internal second level and external (grievance) appeals received during the experience period. The Company identified 33 internal second level and external appeals total received during the experience period. All 33 internal second level and external grievance appeal files were requested, received and reviewed. Nine of the appeals were internal second level appeal and 24 were external grievance appeals. Of the nine internal second level appeals, three were grievances and six were complaints. The following violations and concerns were noted:

**2 Violations – 31 Pa. Code §146.3**

File and record documentation. The claim files of the insurer shall be subject to examination by the Commissioner or by her appointed designees. The files shall contain notes and work papers pertaining to the claim in such detail that pertinent events and the

dates of the events can be reconstructed. The Company failed to maintain two complete claim files when it failed to include the Independent Review Organization (IRO) contact information in the acknowledgement letter and/or subsequent mailings with the member during the external review process. The member is afforded the right to receive the IRO's contact information immediately. This information should have been included in one of the first letters to the member in the external grievance review process; thus, the company failed to maintain a complete complaint file.

**1 Violation – 40 P.S. §991.2141(c)(3)**

The complaint process shall include a second level review that shall be completed within 45 days of receipt of a request for such review. The Company failed to complete the second level review within 45 days of receipt of a request for such a review.

**Concern 1:** The Company may not acknowledge receipt of a complaint in a timely fashion in some instances. The examiners noted that the Company's acknowledgement letters may be drafted and mailed anywhere from one to fifteen business days after receipt of a complaint. The Company has begun monitoring acknowledgement letters.

**Concern 2:** The Company does not use clear and effective language in its acknowledgement and decision letters regarding members contacting the Pennsylvania Insurance Department for assistance with complaints, the complaint process and/or follow up after a denial.

**Concern 3:** The Examiners noted that in all three internal second level grievances the first level denial was overturned before a hearing so a decision letter was never issued or the member withdrew the grievance prior to the hearing after speaking to the Company. One sample file did not include a written decision on the withdrawn grievance, only verbal communication was provided.



## **VI. PRODUCER LICENSING**

The Company was requested to provide a list of all producers active during the experience period. The Company provided a list of 1,308 active producers. A sample of 45 terminated producers was selected, received and reviewed. The records were compared to departmental records of producers to verify appointments, terminations and licensing. Records were also compared to the Federally-facilitated Marketplace Registration Status List in order to verify compliance with 45 C.F.R. §155.220. The following violations were noted:

### **5 Violations – 40 P.S. §310.71a**

(a) Termination. An insurer which terminates an appointment pursuant to section 671-A(d) shall notify the department in writing on a form approved by the department, or through an electronic process approved by the department, within 30 days following the effective date of the termination.

(b) Reason for termination. If the reason for the termination was a violation of this act or if the insurer had knowledge that the licensee was found to have engaged in any activity prohibited by this act, the insurer shall inform the department in the notification.

Five producers were listed as terminated by the Company but not reported as terminated to the Department. Department records indicate an active status.

<b>Producer Last Name</b>	<b>Producer First Name</b>
GRANTEED	JOSEPH
LOSCIG	ANTHONY
MUMMERT	BROOKE
RIZZO	CHRISTINE
SCHWENTNER	SUSAN

The Company was also requested to provide policies and procedures requiring that a producer's contract account balances are in accordance with the producer's contract. The Examiners reviewed the producer, agency and commission schedules. In addition, the Company provided a description of the agency system as of pre-merger and post-merger. No violations were noted.

## **VII. POLICYHOLDER SERVICES**

The Company was requested to provide copies of policies and procedures used for the collection/billing practices that described requirements for issuances of notices with required advance notice. The Company identified a universe of eight documents and all documents were received and reviewed. The policies and procedures were reviewed to ensure compliance with the standards set forth in Chapter 16 and 20 of the NAIC Market Regulation Handbook, CMS CCIIO Regulations and Guidance, and 31 Pa. Code §§152.20, 301.82. No violations were noted.

### **A. Timely Issuance**

The Company was requested to provide copies of policies and procedures or other documentation describing requirements for timely policy issuance, insured requested cancellations, and all correspondence directed to the Company. The Company provided 15 documents which were reviewed in accordance with Chapters 16 and 20 of the NAIC Market Regulation Handbook, CMS CCIIO Regulations and Guidance, and 31 Pa. Code §§152.20, 301.82. No violations were noted.

### **B. Department Correspondence**

The Company was requested to provide policies and procedures describing the requirements for timely and responsive answers by appropriate departments to all correspondence directed to the Company. The documents were reviewed in accordance with Chapters 16 and 20 of the NAIC Market Regulation Handbook, CMS CCIIO Regulations and Guidance, and 31 Pa. Code §§152.20, 301.82. No violations were noted.

### **C. Assumption Reinsurance Agreements**

The Company was requested to provide policies and procedures to demonstrate that, when the Company transfers the obligation of its contracts to another regulated entity pursuant to an assumption reinsurance agreement, the regulated entity has sent required notices to

affected policyholders. The Company provided 11 documents which were reviewed in accordance with the NAIC Market Regulation Handbook, CMS CCHIO Regulations and Guidance, and 31 Pa. Code §§152.20, 301.82. No violations were noted.

#### **D. Reinstatement**

The Company was requested to provide copies of policies and procedures or other documentation demonstrating how the Company monitors and assures that reinstatement is applied consistently and in accordance with policy provisions. The Company provided 6 documents which were reviewed in accordance with Chapters 16 and 20 of the NAIC Market Regulation Handbook, CMS CCHIO Regulations and Guidance, and 31 Pa. Code §§152.20, 301.82. No violations were noted.

#### **E. Unearned Premium and Refunds**

The Company was requested to provide copies of policies and procedures or other documentation demonstrating how unearned premium calculation refunds are handled. The Company identified a universe of nine documents which were requested and received. In accordance with the requirements of the exam, the policies and procedures were reviewed to ensure compliance with the standards set forth in Chapters 16 and 20 of the NAIC Market Regulation Handbook, CMS CCHIO Regulations and Guidance, and 31 Pa. Code §§152.20, 301.82. No violations were noted.

#### **F. Premium and Billing Notices**

The Company was requested to provide a sample of premium and billing notices used during the examination period. The Company provided 17 documents which were reviewed in accordance with Chapter 16 and 20 of the NAIC Market Regulation Handbook, CMS CCHIO Regulations and Guidance, and 31 Pa. Code §§152.20, 301.82. The Examiners noted that the Company's Policyholder Services policies and procedures were easily accessed by Examiners. No violations were noted.

### **VIII. UNDERWRITING AND RATING**

The Company was requested to provide the ACA Major Medical Health Individual, Small Group and Large Group rating schedules effective during the experience period. The Company identified a universe of four documents which were requested, received and reviewed. In accordance with the requirements of the exam, the material submitted by the Company were reviewed to ensure underwriting and rating guidelines were in place and being followed in a uniform and consistent manner, and that no underwriting practices or procedures were in place that could be considered discriminatory in nature, or specifically prohibited by statute or regulation. No violations were noted.

#### **A. Mandated Disclosures**

The Company was requested to provide policies and procedures or other documentation demonstrating how the Company assures that all mandated disclosures are in accordance with statutes, rules and regulations. The Company provided a list of 61 forms and form copies. The documents were reviewed in accordance with the Insurance Department Act, Section 903, 40 P.S. §323.3(a). No violations were noted.

#### **B. Prohibition of Illegal Rebating**

The Company was requested to provide policies and procedures demonstrating how the Company assures that it does not permit illegal rebating, commission cutting or inducements. The Company provided two documents which were reviewed in accordance with Standard 3 Underwriting and Rating, Chapter 16 of the NAIC Market Regulation Handbook and 40 P.S. §323.3. No violations were noted.

#### **C. Underwriting Practices**

The Company was requested to provide policies and procedures or other documentation demonstrating that the Company's underwriting practices are not

unfairly discriminatory and that the Company adheres to applicable statutes, rules and regulations, and regulated entity guidelines in the selection of risks. The Company provided two documents which were reviewed in accordance with the NAIC Market Regulation and the Insurance Department Act. No violations were noted.

#### **D. Form Filing**

The Company was requested to provide policies and procedures establishing the Company's processes to assure that all forms, including policies, contracts, riders, amendments, endorsement forms and certificates are filed with the Pennsylvania Insurance Department. The Company provided a list of 61 forms and copies which included: 36 FPH/FPLIC Small Group Products, six HMO FPH/FPLIC Large Group Products and 19 FPH/FPLIC Individual Products. All 61 documents were reviewed to ensure compliance with the standards set forth in Chapters 16 of the NAIC Market Regulation Handbook. No violations were noted.

#### **E. Renewals**

The Company was requested to provide policies and procedures or other documents demonstrating that policies, contracts, riders, amendments and endorsements are issued or renewed accurately, timely and completely. The Company provided one document which was reviewed in accordance with the NAIC Market Regulation Handbook and the Insurance Department Act. No violations were noted.

#### **F. Policy Rejections**

The Company was requested to provide policies and procedures or other documentation demonstrating the Company's rejections and declinations are not unfairly discriminatory. The Company provided one document which was reviewed. No violations were noted.

### **G. Cancellations**

The Company was requested to provide policies and procedures documenting that cancellation/nonrenewal, discontinuance and declination notices comply with the policy and contract provisions, state laws and the Company's guidelines. The Company provided eight documents which were reviewed in accordance with Standard 8 Underwriting and Rating and Chapter 16 of the NAIC Market Regulation Handbook. No violations were noted.

### **H. Rescissions**

The Company was requested to provide policies and procedures demonstrating that rescissions are not made for non-material misrepresentation. The Company provided one document which was reviewed in accordance with Standard nine Underwriting and Rating and Chapter 16 of the NAIC Market Regulation Handbook and the Insurance Department Act. No violations were noted.

### **I. Cancellation Practices**

The Company was requested to provide policies and procedures or other documentation demonstrating that cancellation practices comply with policy provisions, HIPAA and state laws. The Company provided two documents which were reviewed in accordance with the Chapter 20 of the NAIC Market Regulation Handbook, to assure that cancellation practices comply with policy provisions, HIPAA and 40 P.S. §323.3. No violations were noted.

### **J. Complete and Accurate Information on Policy Forms**

The Company was requested to provide policies and procedures or other documents, in order to demonstrate that pertinent information on applications that form a part of the policy are complete and accurate. The Company provided one document which was reviewed in accordance with Standard 2 Underwriting and Rating, Chapter 20 of

the NAIC Market Regulation Handbook and 40 P.S. §323.3. No violations were noted.

#### **K. COBRA**

The Company was requested to provide policies and procedures or other documentation demonstrating that the Company complies with the provisions of COBRA and/or continuation of benefits procedures contained in policy forms, statutes, rules and regulations. The Company provided one document which was reviewed in accordance with Standard 3 Underwriting and Rating, Chapter 20 of the NAIC Market Regulation Handbook and 40 P.S. §323.3(a). No violations were noted.

#### **L. Genetic Information Nondiscrimination Act Compliance**

The Company was requested to provide policies and procedures or other documentation demonstrating that the Company complies with the Genetic Information Nondiscrimination Act of 2008 and Pennsylvania law (40 P.S. §§908-11 et seq.) The Company provided one document which was reviewed in accordance with Standard 4, Underwriting and Rating, Chapter 20 of the NAIC Market Regulation Handbook and 40 P.S. §323.3(a). No violations were noted.

#### **M. Health Information Protection**

The Company was requested to provide policies and procedures demonstrating that the Company complies with proper use and protection of health information in accordance with statutes, rules and regulations. The Company provided one document which was reviewed in accordance with Standard 5 Underwriting and Rating, Chapter 20 of the NAIC Market Regulation Handbook and 40 P.S. §323.3(a). No violations were noted.

#### **N. Pre-existing Conditions**

The Company was requested to provide documentation that the Company complies with the provision of HIPAA and state laws regarding limits on the use of pre-existing



exclusions. The Company provided one document which was reviewed in accordance with Standard 6 Underwriting and Rating, Chapter 20 of the NAIC Market Regulation Handbook. No violations were noted.

#### **O. Coverage Discrimination based on Health Status**

The Company was requested to provide documentation demonstrating that the Company does not improperly deny coverage or discriminate based on health status in the group market or against eligible individuals in the individual market in conflict with the requirements of HIPAA or state law. The Company provided one document which was reviewed in accordance with Standard 7 Underwriting and Rating, Chapter 20 of the NAIC Market Regulation Handbook and 40 P.S. §323.3. No violations were noted.

#### **P. Compliance with Guaranteed Issuance**

The Company was requested to provide policies and procedures or other documentation demonstrating that the Company's coverages comply with the guaranteed-issue requirements of HIPAA and state laws for groups. The Company provided one document which was reviewed in accordance with Standard 8 Underwriting and Rating, Chapter 20 of the NAIC Market Regulation Handbook and 40 P.S. §323.3. No violations were noted.

#### **Q. Individual**

The Company was requested to provide policies and procedures demonstrating that when the Company is issuing individual insurance coverage to eligible individuals, the enrollees are entitled to portability under the provisions of the ACA and HIPAA and in compliance with applicable statutes, rules and regulations. The Company provided one document which was reviewed in accordance with Standard 9 Underwriting and Rating, Chapter 20 of the NAIC Market Regulation Handbook and 40 P.S. §323.3. No

violations were noted.

#### **R. Clinical Trials**

The Company was requested to provide policies and procedures or other documentation, in order to demonstrate that the Company does not deny coverage or restrict coverage for qualified individuals who participate in approved clinical trials, as defined in applicable statutes, rules and regulations. The Company provided one document which was reviewed in accordance with Standard 1 Coverage for Individuals Participating in Approved Clinical Trials, Chapter 20 A of the NAIC Market Regulation Handbook and 40 P.S. §323.3. No violations were noted.

#### **S. Dependent Coverage**

The Company was requested to provide policies and procedures or other documentation in order to demonstrate that the Company makes available dependent coverage for children until attainment of 26 years of age, when providing or offering group or individual health insurance coverage. The Company provided one document which was reviewed in accordance with Standard 1 Extension of Dependent Coverage, Chapter 20A of the NAIC Market Regulation and 40 P.S. §323.3. No violations were noted.

#### **T. Individual Health Plans**

The Company was requested to provide policies and procedures demonstrating that the Company, when offering individual market health insurance coverage, shall issue any applicable health benefit plan to any eligible individual who: 1) applies for the plan; 2) agrees to make the required premium payments; and 3) agrees to satisfy the other reasonable provisions of the health benefit plan that are not inconsistent with the final regulations promulgated under the ACA by the U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL) and the U.S. Department of the

Treasury (Treasury). The Company provided one document which was reviewed in accordance with Standard 1 Guaranteed Availability of Coverage Chapter 20 A of the NAIC Market Regulation Handbook and 40 P.S. §323.3. No violations were noted.

#### **U. Small Group Health Insurance Coverage**

The Company was requested to provide policies and procedures demonstrating that the Company, when providing a group health plan or offering small group market health insurance coverage, shall issue any applicable health benefit plan to any eligible small group employer that: 1) applies for the plan; 2) agrees to make the required premium payments; and 3) agrees to satisfy the other reasonable provisions of the health benefit plan that not inconsistent with the final regulations promulgated under the ACA by DOL, HHS, and Treasury. The Company provided one document which was reviewed in accordance with Standard 2 Guaranteed Availability of Coverage, Chapter 20A of the NAIC Market Regulation Handbook and 40 P.S. § 323.3 (a). No violations were noted.

#### **V. Group Health Plan Renewability**

The Company was requested to provide policies and procedures or other documentation demonstrating that the Company, when providing a group health plan or offering individual market health insurance coverage, shall renew or continue in force the coverage at the option of the policyholder, subject to final regulations promulgated under the ACA by DOL, HHS, and Treasury. The Company provided one document which was reviewed in accordance with Standard 1 Guaranteed Renewability of Coverage, Chapter 20A of the NAIC Market Regulation Handbook and 40 P.S. §323.3 (a). No violations were noted.

#### **W. Small Employer Renewability**

The Company was requested to provide documentation demonstrating that the

Company, when providing a group health plan or offering small group market health insurance coverage, shall renew or continue in force the coverage at the option of the small employer subject to final regulations promulgated under the ACA by DOL, HHS, and Treasury. The Company provided one document which was reviewed in accordance with Standard 2 Guaranteed Renewability of Coverage, Chapter 20A of the NAIC Market Regulation Handbook and 40 P.S. §323.3 (a). No violations were noted.

#### **X. Lifetime Limits**

The Company was requested to provide documentation demonstrating that the Company does not establish lifetime or annual limits on the dollar amount of essential health benefits for any individual in accordance with the final regulations promulgated under the ACA by DOL, HHS, and Treasury. The Company provided one document which was reviewed in accordance with Standard 1 Lifetime/Annual Benefits Limits, Chapter 20 A of the NAIC Market Regulation Handbook and 40 P.S. §323.3 (a). No violations were noted.

#### **Y. Pre-existing Condition for applicants under age 19 years**

The Company was requested to provide policies and procedures or other documentation demonstrating that the Company does not deny coverage to applicants or proposed insured under the age of 19 years pursuant to the provisions of any preexisting condition exclusion or preexisting condition limitation. The Company provided one document which was reviewed in accordance with Standard 1, Prohibitions on Pre-Existing Exclusions for Individuals under 19 years of age, Chapter 20A of the Market Regulation Handbook and 40 P.S. § 323.3 (a). No violations were noted.

## **Z. Marketing Materials Enrollment Language**

The Company was requested to provide policies and procedures or other documentation in order to demonstrate that the Company's group health plans do not contain policy language, enrollment materials, or marketing and sales materials that directly or indirectly suggest that individuals under the age of 19 with a pre-existing condition cannot enroll in coverage or receive benefits under a group health or individual health insurance policy. The Company provided one document which was reviewed in accordance with Standard 3, Prohibitions on Pre-Existing Conditions Exclusions for Individuals under 19 years of age, Chapter 20A of the NAIC Market Regulation Handbook and 40 P.S. §323.3 (a). No violations were noted.

## **AA. Cost Sharing Requirements**

The Company was requested to provide policies and procedures or other documentation demonstrating that the Company does not impose cost sharing requirements upon preventative services, as defined in, and in accordance with, final regulations promulgated under the ACA by DOL, HHS, and Treasury. The Company provided one document and it was reviewed in accordance with Standard 1, Preventative Services, Chapter 20A of the NAIC Market Regulation Handbook and 40 P.S. §323.3 (a). No violations were noted.

## **BB. Coverage Rescinded**

The Company was requested to provide policies and procedures demonstrating that the Company does not retrospectively rescind an individual's or group's coverage (including family coverage in which the individual is included) unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact. The Company provided one document and it was reviewed in accordance with

Standard 1 Rescissions, Chapter 20A of the NAIC Market Regulation Handbook and 40 P.S. §323.3(a). No violations were noted.

#### **CC. 30 Day Notice**

The Company was requested to provide documentation which showed that, before coverage may rescinded, the Company provides at least 30 days' advance written notice to each plan enrollee (or, in the individual market, primary subscriber) who would be affected. The Company provided one document and it was reviewed in accordance with Standard 2 Rescissions, Chapter 20A of the NAIC Market Regulation Handbook and 40 P.S. §323.3 (a). No violations were noted.

## **IX. CLAIMS PROCEDURES**

### **A. Claimant Contact**

The Company was requested to provide documentation demonstrating that the initial contact with the claimant occurs within the required timeframe. The Company provided six documents which were reviewed in accordance with Chapter 16 (Section G, Standard #1) of the NAIC Market Regulation Handbook and 31 Pa. Code §§146.1 to 146.10. No violations were noted.

### **B. Timely Investigations**

The Company was requested to provide policies, procedures or other documentation to demonstrate that investigations are conducted timely. The Company identified nine documents which were reviewed in accordance with Chapters 16 and 20 of the NAIC Market Regulation Handbook, CMS CCIIO Regulations and Guidance, and 31 Pa. Code §§152.20, 301.82. No violations were noted.

### **C. Claims Resolved in a Timely Manner**

The Company was requested to provide policies and procedures demonstrating that claims are resolved in a timely manner and to provide the Company's claim handling procedures during the experience period. The Company provided one document which was reviewed in accordance with Chapters 16 and 20 of the NAIC Market Regulation Handbook, CMS CCIIO Regulations and Guidance, and 31 Pa. Code §§152.20, 301.82. No violations were noted.

### **D. Claims Handling**

The Company was requested to provide a brief description of how claims are handled from the date received through closure. The Company identified one document which was reviewed in accordance with standards set forth in Chapters 16 and 20 of the NAIC Market Regulation Handbook, CMS CCIIO Regulation and Guidance, and 31 Pa. Code §§152.20,

301.82. No violations were noted.

#### **E. Claim Forms**

The Company was requested to provide policies and procedures and other documents demonstrating the Company's claim forms are appropriate for the type of product. The Company provided three documents which were reviewed in accordance with Chapter 16, Section G and Standard #5 of the NAIC Market Regulation Handbook and 31 Pa. Code §§146.1 to 146.10. No violations were noted.

#### **F. Denied and Closed-without-Payment Claims**

The Company was requested to provide copies of policies and procedures or other documentation demonstrating how denied and closed-without-payment claims are handled in accordance with policy provisions. The Company identified 14 documents which were reviewed in accordance with Chapters 16 and 20 of the NAIC Market Regulation Handbook and 31 Pa. Code §§152.20, 301.82. No violations were noted.

#### **G. Cancelled Benefit Checks**

The Company was requested to provide policies and procedures demonstrating how cancelled benefit checks and drafts reflect appropriate claims handling practices. Five documents were received and reviewed in accordance with Chapters 16 and 20 of the NAIC Market Regulation Handbook, CMS CCHIO Regulations and Guidance, and 31 Pa. Code §§152.20, 301.82. No violations were noted.

#### **H. Claims Handling Practices**

The Company was requested to provide policies and procedures in order to demonstrate how claim handling practices do not, by offering substantially less than is due under the policy during the experience period, compel claimants to institute litigation to recover amounts due under policies in cases of clear liability and coverage. One document was reviewed in accordance with Chapters 16 and 20 of the Market Regulation Handbook, CMS CCHIO Regulation and Guidance, and 31 Pa. Code §§152.20, 301.82. No violations



were noted.

### **I. HIPAA Claims Handling Practices**

The Company was requested to provide policies demonstrating that claim files are handled in accordance with policy provisions, HIPAA and state laws during the experience period. The Company provided six documents which were reviewed in accordance with Chapter 16 and 20 of the NAIC Market Regulation handbook, CMS CCIIO Regulations and Guidance, and 31 Pa. Code §§152.20, 301.82. No violations were noted.

### **J. Newborns' and Mother's Health Protection Act**

The Company was requested to provide policies and procedures demonstrating that the Company complies with the requirement of the federal Newborns' and Mothers' Health Protection Act of 1996 and the Pennsylvania Health Security Act (40 P.S. §§1581-1584). The Company provided five documents which were reviewed in accordance with Chapters 16 and 20 of the NAIC Market Regulation Handbook, CMS CCIIO Regulations and Guidance, and 31 Pa. Code §§152.20, 301.82. No violations were noted.

### **K. Compliance with Mental Health Parity and Addiction Equity Act**

The Company was requested to provide policies and procedures or other documentation that the group health plan(s) complies with the requirements of the federal Mental Health Parity and Addiction Equity Act of 2008 (45 U.S.C. §300gg-26) and the Pennsylvania Health Insurance Coverage Parity and Nondiscrimination Act (40 P.S. §§908-11 et seq.) (together, MHPAEA). The Company provided 15 documents which were reviewed in accordance with 31 Pa. Code §§152.20, 301.82. No violations were noted; however, the following concerns were noted:

**Concern 1:** In determining compliance with MHPAEA, the Department requested the Company to provide all policies and procedures that demonstrate compliance. It is a concern that the Company responded with the following: "*all mandated requirements are*

*programmed directly into the OSCAR and FACETS systems for appropriate claim adjudication,”* which does not demonstrate compliance. Additional information provided only addresses compliance with the quantitative treatment limitation requirements but did not mention the processes, strategies, evidentiary standards or other factors used to apply nonquantitative treatment limitations pursuant to the requirements under MHPAEA.

**Concern 2:** The Company’s system platform, FACETS, specifies that the healthcare reform (HCR) out-of-pocket maximums do not include pharmacy member liabilities for the following large group plans: HMOB Bluecare HMO Basic, BHMO Plan year- Bluecare HMO and Plus Bluecare HMO Plus. If a plan covers pharmacy benefits, the member’s out-of-pocket expense shall be included in the maximum-out-of-pocket accumulator for the benefit period.

**Concern 3:** The Company’s system platform, FACETS, specifies that outpatient mental health care services are not included in the coinsurance maximum for the following large group plan: Plus Bluecare HMO Plus. If a plan covers outpatient mental health benefits, the member’s out-of-pocket expense for in-network services shall be included in the maximum-out-of-pocket accumulator for the benefit period.

#### **L. Women’s Health and Cancer Rights Act of 1998**

The Company was requested to provide policies demonstrating that group health plans comply with the requirements of the federal Women’s Health and Cancer Rights Act of 1998 and the corresponding state law (40 P.S. §764d). The Company provided eight documents which were reviewed in accordance with Chapters 16 and 20 of the NAIC Market Regulation Handbook, CMS CCIIO Regulations and Guidance, and 31 Pa. Code §152.20. No violations were noted.

#### **M. Group Coverage Replacements**

The Company was requested to provide documentation demonstrating that the Company

complies with applicable statutes, rules and regulations for group coverage replacement during the experience period. The Company provided 10 documents which were reviewed in accordance with Chapters 16 and 20 of the NAIC Market Regulation Handbook, CMS CCHIO Regulations and Guidance, 31 Pa. Code §§152.20, 301.82. No violations were noted.

#### **N. Proper Claim Handling**

The Company was requested to provide policies and procedures demonstrating that claims are properly handled in accordance with policy provisions, state laws and applicable statutes, including the ACA and HIPAA rules and regulations. The Company identified a universe of four documents and 10 additional documents were provided in response to an information request. The 14 documents were reviewed in accordance with Chapters 16 and 20 of the NAIC Market Regulation Handbook, CMS CCHIO Regulations and Guidance, 31 Pa. Code §§152.20, 301.82. No violations were noted.

#### **O. Denied and Closed-Without-Payment Claims**

The Company was requested to provide policies and procedures demonstrating that denied and closed-without-payment claims are handled in accordance with policy provisions, state law and applicable statutes. The Company provided 10 documents which were reviewed in accordance with Chapters 16 and 20 of the NAIC Market Regulation Handbook, CMS CCHIO Regulations and Guidance, and 31 Pa. Code §§152.20, 301.82. No violations were noted.

## **X. COMPLAINTS AND GRIEVANCES**

Examiners requested that the Company provide policies and procedures or other documentation demonstrating that the Company properly treats as a complaint or grievance any written complaint, or any oral complaint that involves an urgent care request, submitted by or on behalf of a covered person regarding: 1) the availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; 2) claims payment, handling or reimbursement for health care services; or 3) matters pertaining to the contractual relationship between a covered person and the health carrier. The Company provided 12 documents which were reviewed in accordance with the requirements of the Exam. The policies and procedures were reviewed to ensure compliance with the standards set forth in the NAIC Market Regulation Handbook, 40 P.S. § 991.2141, 40 P.S. § 991.2142, 40 P.S. § 991.2143, 40 P.S. § 1171.1 et seq., 31 Pa. Code § 154, 31 Pa. Code §§ 146.1 to 146.9, and 45 C.F.R. § 147.136. No violations were noted.

### **A. Complaint and Grievance Procedures**

The Company was requested to provide policies and procedures or other documents demonstrating that the Company maintains, documents and reports complaint and grievance procedures in compliance with applicable statutes. The Company provided 17 documents which were reviewed in accordance with Chapter 20, Section H and Standard #2 of the NAIC Market Regulation Handbook, 40 P.S. § 991.2141, 40 P.S. § 991.2142, 40 P.S. § 991.2143, 31 Pa. Code § 154.13, Pa. Code §§ 146.1 - 146.9 and 45 C.F.R. § 147.136. No violations were noted.

### **B. Complaint and Grievance Procedures Disclosure**

The Company was requested to demonstrate how the Company has implemented complaint and grievance procedures and how this information has been disclosed to covered persons. The Company was also requested to provide copies of files showing the Company's

complaint and grievance procedures, including all forms filed with the Insurance Department that were used to process grievances. The Company provided 31 documents which were reviewed in accordance with Chapter 20, Section H and Standard #3 of the NAIC Market Regulation Handbook, 40 P.S. §991.2141, 40 P.S. §991.2142, 40 P.S. §1171.1 et seq., 31 Pa. Code §154.13, Pa. Code §§146.1 to 146.9 and 45 C.F.R. §147.136. No violations were noted.

### **C. Complaint and Grievance Review**

The Company was requested to provide policies and procedures demonstrating the Company has procedures for and conducts first level reviews of grievances involving an adverse determination in compliance with applicable statutes, rules and regulations. The Company provided 14 documents which were reviewed in accordance with Chapter 20, Section H and Standard #4 of the NAIC Market Regulation Handbook, 40 P.S. §991.2141, 40 P.S. §991.2142, 40 P.S. §1171.1 et seq., 31 Pa. Code §154.31, Pa. Code §§146.1 to 146.9 and 45 C.F.R. §147.136. No violations were noted.

The Company was also requested to provide policies demonstrating the Company has procedures for and conducts standard reviews of grievances not involving an adverse determination in compliance with applicable statutes and regulations. The Company provided one document, and the Company responded to an Information Request and produced nine more documents for review. In total, the Company provided 10 documents which were reviewed. No violations were noted.

### **D. Voluntary Reviews of Complaints and Grievances**

The Company was requested to provide policies or other documentation demonstrating the Company has procedures for voluntary reviews of complaints and grievances and conducts voluntary reviews of complaints and grievances in compliance with applicable statutes and regulations. The Company initially provided one document for review. The examiners issued an Information Request requesting additional information. The Company provided

seven additional documents in response to the Information Request. In total, the Company provided eight documents which were reviewed in accordance with Chapter 20, Section H and Standard #6 of the NAIC Market Regulation Handbook, 40 P.S. §991.2141, 40 P.S. §991.2142, 40 P.S. §1171.1 et seq., 31 Pa. Code §154.13, Pa. Code §§146.1 - 146.9 and 45 C.F.R. §147.136. No violations were noted.

#### **E. Expedited Grievance Review**

The Company was requested to provide policies and procedures demonstrating the Company has procedures for and conducts expedited reviews of grievances involving an adverse determination in compliance with applicable statutes and regulations. The Company provided seven documents which were reviewed in accordance with Chapter 20, Section H and Standard # 7 of the NAIC Market Regulation Handbook, 40 P.S. §1171.1 et seq., 31 Pa. Code §154.13, Pa Code §§146.1 to 146.9 and 45 C.F.R. §147.136. No violations were noted.

#### **F. Complaint and Grievance Procedures comply with the ACA and HIPAA**

The Company was requested to provide policies and procedures demonstrating that the Company's complaint and grievance procedures are properly handled in accordance with policy provisions, state law, the ACA and HIPAA. The Company identified a universe of 14 documents which were requested, received and reviewed to ensure compliance with the standards set forth in Chapter 20, Section H and Standard #8 of the NAIC Market Regulation Handbook, 40 P.S. §991.2141, 40 P.S. §991.2142, 40 P.S. §1171.1 et seq., 31 Pa. Code §154.13, Pa. Code §§146.1 to 146.9 and 45 C.F.R. §147.136. No violations were noted.

The Company was also requested to provide policies and procedures or other documentation demonstrating that the Company's grievance procedures are properly handled in accordance with federal laws requiring a health carrier to conduct first-level reviews of grievances involving an adverse determination in accordance with the final

regulations promulgated under the ACA by HHS, DOL and Treasury. The Company identified a universe of 14 documents which were requested, received and reviewed. In accordance with the requirements of the exam, the policies were reviewed to ensure compliance with the standard set forth in Chapter 20A and Standard #3 of the NAIC Market Regulation Handbook and 45 C.F.R. §145.136. No violations were noted.

#### **G. First Level Appeals**

The Company was requested to identify all first level internal appeals received during the experience period. The Company identified 1,610 first level internal appeals received during the experience period and a random sample of 119 first level internal appeal files were requested, received and reviewed. The following violations and concerns were noted:

##### **1 Violation – 45 C.F.R. §147.136(b), incorporating 29 C.F.R. §1450.402- (i)(2)(ii)**

In the case of a pre-service claim, the plan administrator shall notify the claimant, in accordance with paragraph (j) of this section, of the plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. In the case of a group health plan that provides for one appeal of an adverse benefit determination, such notification shall be provided not later than 30 days after receipt by the plan of the claimant's request for review of an adverse benefit determination. In the case of a group health plan that provides for two appeals of an adverse determination, such notification shall be provided, with respect to any one of such two appeals, not later than 15 days after receipt by the plan of the claimant's request for review of the adverse determination. The Company failed to provide a decision regarding a pre-service adverse benefit determination within 15 days for a plan with two appeal review levels.

##### **1 Violation – 40 P.S. §991.2141(b)(4)**

The complaint process shall consist of an initial review to include a review of the complaint which shall be completed within (30) days of receipt of the complaint. The Company failed to review the complaint within 30 days of receipt of the complaint.

**Concern 1:** The Company may not acknowledge receipt of a complaint in a timely fashion in some instances. Examiners noted that the Company's acknowledgement letters may be drafted and mailed anywhere from one to fifteen business days after receipt of a complaint from the member or member's representative.

**Concern 2:** The Company does not use clear and effective language in its acknowledgment and decision letters regarding members contacting the Pennsylvania Insurance Department for assistance with complaints, the complaint process and/or follow-up after a denial.

#### **H. Second Level Appeals and External Grievances**

The Company was requested to identify all internal second level and external (grievance) appeals received during the experience period. The Company identified 33 internal second level and external appeals. Nine of the appeals were internal second level appeals, and 24 were external grievance appeals. Of the nine internal second level appeals, three were grievances and six were complaints. All 33 internal second level and external grievance appeal files were requested, received and reviewed. The following violation and concerns were noted:

##### **1 Violation – 40 P.S. §991.2141(c)(3)**

The complaint process shall include a second level review that shall be completed within forty-five (45) days of receipt of a request for such review. The Company failed to complete the second level review within forty-five (45) days of receipt of a request for such review.

**Concern 1:** The Company may not acknowledge receipt of a complaint in a timely fashion in some instances. Examiners noted that the Company's acknowledgement letters may be drafted and mailed anywhere from one to fifteen business days after receipt of a complaint from the member or member's representative.



**Concern 2:** The Company does not use clear and effective language in its acknowledgment and decision letters regarding members contacting the Pennsylvania Insurance Department for assistance with complaints, the complaint process and/or follow-up after a denial.

**Concern 3:** Examiners noted that in all three internal second level grievances the first level denial was overturned before a hearing, so a decision letter was never issued or the member withdrew his or her grievance prior to the hearing after speaking to the Company. One sample did not have a written response from the Company.

## **XI. NETWORK ADEQUACY**

The Company was requested to provide policies and procedures or other documentation demonstrating (1) that the health carrier files an access plan with the insurance commissioner for each managed care plan that the carrier offers in the state, and files updates whenever it makes a material change to an existing managed care plan, and (2) that the carrier makes the access plans available on its business premises, to regulators, and to interested parties, absent proprietary information, upon request. The Company provided a statement about provider networks, two provider directories, and links to the BCNEPA and Highmark provider directories, in response to the request, which were reviewed in accordance with Standard 2 Underwriting and Rating, Chapter 20 of the NAIC Market Regulation Handbook and Insurance Department Act, Section 903 (40 P.S. §323.3). No violations were noted.

The Company was requested to provide policies and procedures or other documentation demonstrating that the health carrier files with the Department all required contract forms and any material changes to a contract proposed for use with its participating providers and intermediaries. The Company identified a universe of 11 documents which was requested, received, and reviewed. In accordance with the requirements of the exam, the documentation was reviewed to ensure compliance with the standards set forth in Chapter 20, Section I, and Standard #3 of the *NAIC Market Regulation Handbook*. No violations were noted.

### **Access to Emergency Services**

The Company was requested to provide policies and procedures or other documentation demonstrating that during the experience period the health carrier ensured covered persons had access to emergency services 24 hours per day, 7 days per week within its network and provides coverage for emergency services outside of its network, pursuant

to 40 P.S. §§991.2101 et seq., 28 Pa. Code Ch. 9, and 31 Pa. Code Ch. 152, 154 and 301. The Company identified a universe of 6 documents which were requested, received and reviewed. No violations were noted.

#### **A. Written Agreements with Providers**

The Company was requested to provide policies, procedures or other documentation demonstrating that the Company executes with each participating provider written agreements that are in compliance with applicable statutes, rules and regulations. The Company provided 11 documents which were reviewed. No violations were noted.

#### **B. Accrediting Certification**

The Company was requested to provide a copy of its HHS-recognized accrediting entity certification. The Company provided a National Committee for Quality Assurance certificate of accreditation. The certificate was reviewed in accordance with Chapter 20 of the NAIC Market Regulation Handbook, CMS CCIIO Regulations and Guidance, and 31 Pa. Code §§152.20, 301.82. No violations were noted.

#### **C. Contracts with Intermediaries**

The Company was requested to provide policies and procedures or other documentation demonstrating that the health carrier's contracts with intermediaries are in compliance with applicable statutes, rules and regulations. The Company provided eight documents which were reviewed in accordance with Chapters 16 and 20 of the NAIC Market Regulation Handbook, CMS CCIIO Regulations and Guidance, and Pa. Code §§152.20, 301.82. No violations were noted.

#### **D. Participating Provider Arrangements**

The Company was requested to provide policies and procedures or documentation demonstrating that the Company's arrangement with participating providers comply with applicable statutes, rules and regulations. The Company provided 11 documents which

were reviewed in accordance with Chapter 20, Section 1 and Standard #7 of the NAIC Market Regulation Handbook. No violations were noted.

#### **E. Provider Directory**

The Company was requested to provide policies and procedures demonstrating that the health carrier provides at enrollment a provider directory that lists all providers who participate in its network and that it provides updates to its directory during the experience period. The Company provided one document which was reviewed. No violations were noted.

#### **F. Provider Credentialing**

The Company was requested to provide policies and procedures or documentation demonstrating that the Company establishes and maintains a program for credentialing and re-credentialing in compliance with applicable statutes, rules and regulations. The Company provided eight documents which were reviewed. No violations were noted.

#### **G. Provider Agreements**

The Company was requested to provide sample copies of the various provider agreement in effect during the experience period. The Company provided 11 documents which were reviewed. No violations were noted.

## **XII. PROVIDER CREDENTIALING**

The Company was requested to provide policies demonstrating that the Company establishes and maintains a program for credentialing and re-credentialing in compliance with applicable statutes, rules and regulation. The Company provided eight documents which were reviewed to ensure compliance with the standards set forth in Chapter 20, Section J and Standard #1 of the NAIC Market Regulation Handbook. No violations were noted.

### **A. Credentialing Verification**

The Company was requested to provide policies and procedure demonstration that the Company verified the credentials of a health care professional before entering into a contract with that health care professional during the experience period. The Company provided one document which was reviewed in accordance with the standards set forth in Chapters 16 and 20 of the NAIC Market Regulation Handbook and 31 Pa. Code §§152.20, 301.82. No violations were noted.

### **B. Healthcare Professional Credentialing Verification Model Act**

The Company was requested to provide policies demonstrating that the Company obtains primary or secondary verification of the information required by 28 Pa. Code Ch. 9. The Company provided seven documents which were reviewed in accordance with the requirements set forth in Chapters 16 and 20 of the NAIC Market Regulation Handbook and 31 Pa. Code §§152.20, 301.82. No violations were noted.

The Company was also requested to provide policies and procedures demonstrating the Company obtains every three years primary verification of the information required by 28 Pa. Code Ch. 9. The Company identified a universe of four documents and the documents were reviewed to ensure compliance with the standard set forth in Chapter 20, Section J and Standard #5 of the NAIC Market Regulation Handbook. No violations were noted.

### **C. Provider Status Changes**

The Company was requested to provide policies and procedures demonstrating that the Company requires all participating providers to notify the health carrier's designated individual of changes in the status of any information that is to be required to be verified by the health carrier. The Company identified a universe of two documents which were reviewed for compliance with the standards set forth in Chapters 16 and 20 of the NAIC Market Regulation Handbook and 31 Pa. Code §§152.20, 301.82. No violations were noted.

### **D. Provider Credentialing Verification Correction**

The Company was requested to provide policies and procedures demonstrating that the Company requires a health care professional the opportunity to review and correct information submitted in support of that health care professional's credentialing verification. The Company identified a universe of seven documents. The documents were reviewed in accordance with the standards set forth in Chapters 16 and 20 of the NAIC Market Regulation Handbook, CMS CCHIO Regulations and Guidance and 31 Pa. Code §§152.20, 301.82. No violations were noted.

### **E. Contractor Credentialing Monitoring**

The Company was requested to provide policies and procedures demonstrating that it monitors the activities of any entity with which it contracts to perform credentialing functions. The Company identified a universe of three documents which was reviewed by the examiners to ensure compliance with the standards set forth in 28 Pa. Code §9.761 et seq. (Provider Credentialing), with reference to the Health Care Professional Credentialing Verification Model Act (#70). No violations were noted.

### **XIII. QUALITY ASSESSMENT AND IMPROVEMENT**

#### **A. Quality Assessment Program**

The Company was requested to provide policies and procedures or other documentation demonstrating that the Company develops and maintains a quality assessment program in compliance with applicable statutes, rules and regulations. The Company demonstrated improved quality policies and procedures upon the acquisition to Highmark ownership. No violations were noted.

#### **B. Quality Improvement Program**

The Company was requested to provide policies and procedures or other documentation demonstrating the Company develops and maintains a quality improvement program in compliance with applicable statutes, rules and regulations. The Company provided one document which was reviewed in accordance with Chapter 20, Section K and Standard #3 of the NAIC Market Regulation Handbook. No violations were noted.

#### **C. Reports to Appropriate Licensing Authority**

The Company was requested to provide policies and procedures demonstrating that the Company reports to the appropriate licensing authority any persistent pattern of problematic care provided by a provider that is sufficient to cause the health carrier to terminate or suspend contractual arrangements with the provider. The Company provided one document which was reviewed in accordance with the NAIC Market Regulation Handbook, with reference to the Health Care Professional Quality Assessment and Improvement Model Act (#71) Section 5, and applicable rules, statutes and regulations. No violations were noted.

#### **D. Quality Assessment Program Communication**

The Company was requested to provide documentation that the Company communicates information about its quality assessment program and its quality improvement program to covered persons and providers. One document was received and reviewed by the examiners to ensure compliance with the standard set forth in Chapter 20, Section K and Standard #5 of the NAIC Market Regulation Handbook. No violations were noted.

#### **E. Annual Certification of Program**

The Company was requested to provide policies and procedures demonstrating the Company annually certifies to the Insurance Commissioner that its quality assessment and quality improvement program, along with the materials provided to providers and consumers, meets applicable statutes, rules and regulations. The Company provided one document which was reviewed for compliance in accordance with Chapter 20, Section K and Standard #6 of the Market Regulation Handbook. No violations were noted.

#### **F. Quality Assessment and Improvement Entity Monitoring**

The Company was requested to provide policies and procedures demonstrating that the Company monitors the activities of the entity with which it contracts to perform quality assessment or quality improvement function and ensures that the requirements of the applicable state laws and regulations are met, with reference to the Quality Assessment and Improvement Model Act (#71). The Company provided one document which was reviewed in accordance with Chapter 20, Section K and Standard #7 of the NAIC Market Regulation Handbook. No violations were noted.



#### **XIV. UTILIZATION REVIEW**

##### **A. Utilization Review Program**

The Company was requested to provide policies and procedures demonstrating that the Company establishes and maintains a utilization review program in compliance with applicable statutes, rules and regulations. The Company provided two documents which were reviewed in accordance with the NAIC Market Regulation Handbook, Standard 1, and with reference to the Utilization Review and Benefit Determination Model Act (#73), Sections 5, 7 and 12. No violations were noted.

##### **B. Annual Report to Department**

The Company was requested to provide policies and procedures or other documentation demonstrating the Company files with the Insurance Department an annual summary report of its utilization review and benefit determinations in accordance with applicable state statutes, rules and regulations. The Company provided four documents which were reviewed in accordance with 31 Pa. Code §§152.20, 301.82. No violations were noted.

##### **C. Utilization Review Program Operation**

The Company was requested to provide policies and procedures demonstrating the Company operates its utilization review program in accordance with applicable state statutes, rules and regulations. The Company provided 27 documents which were reviewed in accordance with Chapter 20, Section L, Standard #2 of the NAIC Market Regulations Handbook and 40 P.S. §991.2152. No violations were noted.

##### **D. Utilization Review Disclosure**

The Company was requested to provide policies and procedures demonstrating the Company discloses information about its utilization review and benefit determination procedures to covered persons or authorized representatives. The Company provided seven documents which were reviewed in accordance with Chapter 20, Section L, Standard

#3 of the NAIC Market Regulation Handbook and 40 P.S. §991.2152. No violations were noted.

#### **E. Timely Standard Utilization Review**

The Company was requested to provide policies and procedures demonstrating the Company makes standard utilization review and benefit determinations in a timely manner as required by applicable state statutes, rules and regulations, as well as applicable provisions of HIPAA. The Company provided two documents which were reviewed in accordance with Standard 4 of the NAIC Market Regulation Handbook, with reference to the Utilization Review and Benefit Determination Model Act (#73) Section 9, and applicable state law and regulations. No violations were noted.

#### **F. Adverse Determination of Utilization Review**

The Company was requested to provide policies and procedures demonstrating the Company provides written notice of an adverse determination of standard utilization review and benefit determinations in compliance with applicable statutes, rules and regulations. The Company provided eight documents which were reviewed in accordance with Chapter 20, Section L and Standard #5 of the NAIC Market Regulation Handbook, and 40 P.S. §991.2152. No violations were noted.

#### **G. Expedited Utilization Review and Benefit Determinations**

The Company was requested to provide policies and procedures demonstrating that the Company conducts expedited utilization review and benefit determinations in a timely manner and in compliance with applicable statutes, rules and regulations. The Company provided two documents which were reviewed in accordance with Chapter 20, Section L, and Standard #7 of the NAIC Market Regulation Handbook and 40 P.S. §991.2152. No violations were noted.

#### **H. Emergency Services Utilization Reviews**

The Company was requested to provide policies and procedures demonstrating the Company conducts utilization reviews and makes benefit determinations for emergency services in compliance with applicable statutes, rules and regulations. The Company provided two documents which were reviewed in accordance with 31 Pa. Code §§152.20, 301.82. No violations were noted.

#### **I. Monitoring Utilization Review Entity**

The Company was requested to provide policies and procedures demonstrating the Company monitors the activities of the utilization review organization or entity with which the carrier contracts and ensures that the contracting organization complies with 40 P.S. §§991.2101 et seq., 28 Pa. Code Ch. 9, and 31 Pa. Code Ch. 152, 154 and 301. The Company provided two documents which were reviewed in accordance with Standard #7, NAIC Market Regulation Handbook. No violations were noted.

## **XV. MEDICAL AND PHARMACY CLAIMS REVIEW**

The Company was requested to provide a list of all medical and pharmacy claims paid during the experience period. The Company identified a universe of 121,447 medical claims received under the FACETS claims administration platform during the January 1, 2015 through December 31, 2015, experience period. The Company identified a universe of 35,740 medical claims received under the OSCAR claims administration platform during the January 1, 2016 through March 31, 2016, experience period. A random sample was requested, received and reviewed for each of the sections listed below:

1. General Medical Claims
2. Medical Food Claims
3. Emergency Services Claims
4. Mammogram Claims
5. Autism Claims
6. Dental Anesthesia Claims
7. Substance Use Disorder Claims
8. Mental Health Claims
9. Ambulance Claims
10. Pharmacy Claims – Mental Health and Substance Use Disorder

### **A. General Medical Claims**

The Company was requested to provide lists of all medical paid, partially paid and denied claims during the experience period. There were two claims administration platforms used during the period, named FACETS and OSCAR, which doubled the claim review into six separate sections. The examiners found no violations within five of the six sections.

#### **Medical Paid Claims - FACETS**

The Company was requested to provide a list of all medical claims paid during the experience period. The Company identified a universe of 121,447 medical claims paid under the FACETS claims administration platform. A random sample of 109 claim files was requested, received and reviewed to ensure compliance with 31 Pa. Code §§152.20, 301.82. No violations were noted.

#### **Medical Paid Claims - OSCAR**

The Company was requested to provide a list of medical claims paid during the experience period and the Company identified a universe of 35,740 OSCAR system claims. A random sample of 109 claims was requested, received and reviewed to ensure compliance with 31 Pa. Code §§152.20, 301.82. No violations were noted.

#### **Medical Partially Paid Claims - FACETS**

The Company was requested to provide a list of all medical claims partially paid during the experience period. The Company identified a universe of 9,060 medical claims partially paid under the FACETS claims administration platform. A random sample of 109 claim files was requested, received and reviewed to ensure compliance with 31 Pa. Code §§152.20, 301.82. The following violations were noted:

#### **1 Violation - 31 Pa. Code §146.3**

The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the

claim in enough detail such that pertinent events and the dates of the events can be reconstructed. The claim file was missing sufficient information.

**5 Violations - 40 P.S. §991.2166(a)**

A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim. The claims were not paid within 45 days of receipt of the clean claim.

**5 Violations - 40 P.S. §991.2166(b)**

If a licensed insurer or a Managed Care Plan fails to remit payment as provided under subsection (a), interest at ten per centum (10%) per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer or managed care plan shall not be required to pay any interest calculated to be less than \$2. The interest due of \$2 or more was not paid.

**31 Pa. Code §154.18(c)**

Interest due to a health care provider on a clean claim shall be calculated and paid by the licensed insurer or managed care plan to the health care provider and shall be added to the amount owed on the clean claim. The interest shall be paid within 30 days of the payment of the claim. The interest payment due of \$2 or more was not paid within 30 days of the claim payment.

**1 Violation - 40 P.S. §1171.5(a)(10)(v)**

(a) "Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices" in the business of insurance means: (10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices:

(v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss

statements have been completed and communicated to the company or its representative. The claim was not denied within a reasonable time after proof of loss was communicated to the Company.

#### **Medical Partially Paid Claims - OSCAR**

The Company was requested to provide a list of medical claims partially paid during the experience period. The Company identified a universe of 9,697,477 medical claims partially paid under the OSCAR claims administration platform. A random sample of 109 partially paid claims was requested, received and reviewed to ensure compliance with 31 Pa. Code §§152.20, 301.82. No violations were noted.

#### **Medical Denied Claims - FACETS**

The Company was requested to provide a list of all medical claims denied during the experience period. The Company identified a universe of 12,508 medical claims denied under the FACETS claims administration platform. A random sample of 109 medical denied claims was requested, received and reviewed to ensure compliance with 31 Pa. Code §146 and 40 P.S. §1171.5. No violations were noted.

#### **Medical Denied Claims - OSCAR**

The Company was requested to provide a list of all medical claims denied during the experience period. The Company identified a universe of 1,691,239 medical claims denied under the OSCAR claims administration platform. A random sample of 109 denied claims were requested, received and reviewed to ensure compliance with 31 Pa. Code §§152.20, 301.82. No violations were noted.

### **B. Medical Food Claims**

The Company was requested to provide lists of all medical food claims for paid, partially paid and denied claims during the experience period. Two claims administration platforms were used during the period, named FACETS and OSCAR, which doubled the claim

review into six separate sections. The examiners found no violations within five of the six sections.

#### **Medical Foods Paid Claims – OSCAR**

The Company was requested to provide a list of claims received during the experience period. The Company identified a universe of 248 medical foods provider-submitted claims under the OSCAR claims administration platform. A random sample of 82 medical foods provider-submitted claims were requested, received and reviewed. Of the 82 medical foods provider-submitted claims reviewed, 1 claim was not a medical food claim. In accordance with the requirements of the exam, the files were reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. The files were also reviewed for compliance with the Affordable Care Act, 42 U.S.C. §18022 (essential health benefits), and 45 C.F.R Subch. B Parts 146, 147, and 156. The provider-submitted claim files were reviewed for compliance with 40 P.S. §991.2166 (prompt payment of claims). No violations were noted.

#### **Medical Foods Paid Claims – FACETS**

The Company was requested to provide a list of paid claims received during the experience period. No medical foods paid claims were identified under the FACETS claims administration platform. No violations were noted.

#### **Medical Foods Partially Paid Claims - OSCAR**

The Company was requested to provide a list of claims received during the experience period. The Company identified a universe of 176 medical foods partially paid provider submitted claims through OSCAR claims administration system. A random sample of 76 claims were requested, received and reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. The files were also reviewed for compliance with the Affordable Care Act, 42 U.S.C. §18022 (essential health benefits), and 45 C.F.R Subch. B Parts 146,



147 and 156. The provider-submitted claim files were reviewed for compliance with 40 P.S. §991.2166 (prompt payment of claims). The following violations were noted:

**1 Violation - 40 P.S. §991.2166(a)**

A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim. The clean claim was not paid within 45 days of receipt.

**1 Violation - 40 P.S. §991.2166(b)**

If a licensed insurer or a managed care plan fails to remit the payment as provided under subsection (A), interest at ten per centum (10%) per annum shall be added to the amount owed on the clean claim. Interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer shall not be required to pay any interest calculated to be less than \$2 dollars. The interest due of \$2 or more was not paid as required.

**Medical Foods Partially Paid Claims – FACETS**

The Company was requested to provide a list of partially paid claims received during the experience period. The Company identified a universe of seven medical foods partially paid claims under the FACETS claims administration platform. All seven medical foods partially paid claims were requested, received and reviewed to ensure compliance with 40 P.S. §991.2166 (prompt payment of claims). No violations were noted.

**Medical Foods Denied Claims - OSCAR**

The Company was requested to provide a list of claims received during the exam experience period. The Company identified a universe of 82 medical foods denied submitted claims under the OSCAR claims administration platform. A random sample of 82 medical foods denied claims were requested and reviewed to ensure compliance with

31 Pa. Code Ch. 146 and 40 P.S. §1171.5, the Affordable Care Act, 42 U.S.C. §18022 (essential health benefits), and 45 C.F.R. Subch. B Parts 146, 147 and 156, and 40 P.S. §991.2166 (prompt payment of claims). No violations were noted.

#### **Medical Foods Denied Claims – FACETS**

The Company was requested to provide a list of claims received during the experience period. The Company identified a universe of 13 medical foods denied claims under the FACETS claims administration platform. All 13 medical foods denied claims were requested, received and reviewed to ensure compliance with 40 P.S. §991.2166 (prompt payment of claims). No violations were noted.

#### **C. Emergency Services Claims**

The Company was requested to provide lists of all Emergency Services claims for paid, partially paid and denied claims during the experience period. There were two claims administration platforms used during the period, named FACETS and OSCAR, which doubled the claim review into six separate sections. The examiners found 14 violations in the six Emergency Services sections.

#### **Emergency Services Paid Claims - FACETS**

The Company was requested to provide a list of emergency services claims paid during the experience period. The Company identified a universe of 14 emergency services claims paid under the FACETS claims administration platform, which were requested, received and reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. The files were also reviewed for compliance with the Affordable Care Act, 42 U.S.C. §18022 (essential health benefits), and 45 C.F.R Subch. B Parts 146, 147, and 156. The provider-submitted claim files were reviewed for compliance with 40 P.S. §991.2166 (prompt payment of claims). No violations were noted.

### **Emergency Services Paid Claims - OSCAR**

The Company was requested to provide a list of emergency services claims paid during the experience period. The Company identified a universe of 3,557 emergency service claims under the OSCAR claims administration platform and a random sample of 108 claims which was requested, received and reviewed. Of the 108 sample files, 59 were provider-submitted and 49 were subscriber-submitted claims. In accordance with the requirements of the exam, the files were reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. The files were also reviewed for compliance with the Affordable Care Act, 42 U.S.C. §18022 (essential health benefits), and 45 C.F.R Subch. B Parts 146, 147, and 156. The provider-submitted claim files were reviewed for compliance with 40 P.S. §991.2166 (prompt payment of claims). The following violations were noted:

#### **1 Violation 31. Pa. Code §146.5**

Every insurer, upon receiving notification of a claim, shall, within 10 working days acknowledge the receipt of the notice unless payment is made within the period of time. The Company failed to provide proof they acknowledged the noted claim within 10 working days.

#### **4 Violations 40 P.S. §991.2166(a)**

A licensed insurer or managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim. The four noted claims were not paid within 45 days of receipt of the clean claim.

### **Emergency Services Partially Paid Claims - FACETS**

The Company was requested to provide a list of emergency services claims partially paid during the experience period. The Company identified a universe of 56 emergency services claims partially paid under the FACETS claims administration platform which was requested, received and reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. The files were also reviewed for compliance with the Affordable Care Act,

42 U.S.C. §18022 (essential health benefits), and 45 C.F.R Subch. B Parts 146, 147, and 156. The provider submitted claim files were reviewed for compliance with 40 P.S. §991.2166 (prompt payment of claims). The following violations were noted:

**3 Violations – 40 P.S. §991.2166(a)**

A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim. The three claims noted were not paid within 45 days of receipt of the clean claim.

**3 Violations – 40 P.S. §991.2166(b)**

If a licensed insurer or a managed care plan fails to remit payment as provided under subsection (a), interest at ten per centum (10%) per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer or managed care plan shall not be required to pay any interest calculated to be less than \$2. The interest due of \$2 or more on the three claims was not paid.

**Emergency Services Partially Paid Claims - OSCAR**

The Company was requested to provide a list of emergency services claims partially paid during the experience period. The Company identified a universe of 49,090 emergency services claims partially paid under the OSCAR claims administration platform. A random sample of 109 claims was requested, received and reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. The files were also reviewed for compliance with the Affordable Care Act, 42 U.S.C. §18022 (essential health benefits), and 45 C.F.R Subch. B Parts 146, 147, and 156. The provider submitted claim files were reviewed for compliance with 40 P.S. §991.2166 (prompt payment of claims). The following violations were noted:

## **2 Violations – 40 P.S. §991.2166(a)**

A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim. The two claims noted were not paid within 45 days of receipt of the clean claim.

### **Emergency Services Denied Claims - FACETS**

The Company was requested to provide a list of all claims denied during the experience period. The Company identified a universe of 2,137 emergency services claims denied under the FACETS claims administration platform. A random sample of 108 denied claims was requested, received and reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. The files were also reviewed for compliance with the Affordable Care Act, 42 U.S.C. §18022 (essential health benefits), and 45 C.F.R Subch. B Parts 146, 147, and 156. The provider-submitted claim files were reviewed for compliance with 40 P.S. §991.2166 (prompt payment of claims). No violations were noted.

### **Emergency Services Denied Claims - OSCAR**

The Company was requested to provide a list of all emergency services denied claims during the experience period. The Company identified a universe of 10,856 emergency services claims denied under the OSCAR claims administration platform. A random sample of 109 denied claims was requested, received and reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. The files were also reviewed for compliance with the Affordable Care Act, 42 U.S.C. §18022 (essential health benefits), and 45 C.F.R Subch. B Parts 146, 147, and 156. The provider submitted claim files were reviewed for compliance with 40 P.S. §991.2166 (prompt payment of claims). The following violation was noted:

## **1 Violation – 40 P.S. §991.2166(a)**

A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim. The claim noted was not paid

within 45 days of receipt of the clean claim.

#### **D. Mammogram Claims**

The Company was requested to provide lists of all mammogram claims for paid, partially paid and denied claims during the experience period. Two claims administration platforms were used during the period, named FACETS and OSCAR, which doubled the claim review into six separate sections. The examiners found no violations within two of the six sections.

##### **Mammogram Paid Claims - FACETS**

The Company was requested to provide a list of mammogram claims paid during the experience period. The Company identified a universe of four mammogram claims paid under the FACETS claims administration platform. All four claims were requested, received and reviewed to ensure compliance with 31 Pa. Code §§152.20, 301.82 and 40 P.S. §764c. No violations were noted.

##### **Mammogram Paid Claims - OSCAR**

The Company was requested to provide a list of mammogram claims paid during the experience period. The Company identified a universe of 63,207 mammogram claims paid under the OSCAR claims administration platform. A random sample of 109 paid claims was requested, received and reviewed to ensure compliance with 31 Pa. Code §§152.20, 301.82 and 40 P.S. §764c. The following violations were noted:

##### **3 Violations – 31 Pa. Code §154.18(a)**

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim under subsection (d) submitted by a health care provider for services, within 45 days of the licensed insurer's or managed care plan's receipt of the claim from the health care provider. The three noted claims submitted by the health care

provider for services were not paid within 45 days of the licensed insurer's or managed care plan's receipt of the claim from the health care provider.

### **3 Violations – 31 Pa. Code §154.18(d)**

Claims paid by a licensed insurer or managed care plan are considered clean claims and are subject to the interest provisions of the act. If a paid claim is re-adjudicated by the licensed insurer or managed care plan, a new 45-day period for the prompt payment provision begins again at the time additional information prompting the re-adjudication is provided to the plan. The three noted claims were not paid within a 45-day period.

### **Mammogram Partially Paid Claims - FACETS**

The Company was requested to provide a list of mammogram claims partially paid during the experience period. The Company identified a universe of 1,149 mammogram claims partially paid under the FACETS claims administration platform. A random sample of 107 claims were requested, received and reviewed to ensure compliance with 31 Pa. Code §§152.20, 301.82 and 40 P.S. §764c. The following violation was noted:

### **1 Violation – 40 P.S. §991.2166(a)**

A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim. The claim noted was not paid within 45 days of receipt of the clean claim.

### **Mammogram Partially Paid Claims - OSCAR**

The Company was requested to provide a list of mammogram claims partially paid during the experience period. The Company identified a universe of 6,514 mammogram claims partially paid under the OSCAR claims administration platform. A random sample of 109 partially paid claims was requested, received and reviewed to ensure compliance with 31 Pa. Code §§152.20, 301.82 and 40 P.S. §764c. The following violations were noted:

**12 Violations – 31 Pa. Code §154.18(a)**

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim under subsection (d) submitted by a health care provider for services, within 45 days of the licensed insurer's or managed care plan's receipt of the claim from the health care provider. The 12 claims noted were not paid within 45 days of the licensed insurer's or managed care plan's receipt of the claim.

**12 Violations – 31 Pa. Code §154.18(d)**

Claims paid by licensed insurers or managed care plans are considered clean claims and are subject to the interest provisions of the act. If a paid claim is re-adjudicated by the licensed insurer or managed care plan, a new 45-day period for the prompt payment provisions begins again at the time additional information prompting the re-adjudication is provided to the plan. The 12 noted claims were not paid within a 45-day period.

**12 Violations – 40 P.S. §991.2166(a)**

A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim. The 12 noted clean claims were not paid within 45 days of receipt.

**1 Violation – 40 P.S. §1171.5(a)(10)(v)**

Unfair methods of competition and unfair or deceptive acts or practices are defined as:

(a) "Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means: (10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. (v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative. The Company failed to affirm or deny coverage of the noted claim within a reasonable time after proof of loss.



### **Mammogram Denied Claim - FACETS**

The Company was requested to provide a list of all mammogram denied claims during the period. The Company identified a universe of 117 mammogram claims denied under the FACETS claims administration platform. A random sample of 76 denied claims was requested, received and reviewed to ensure compliance with 31 Pa. Code §§152.20, 301.82 and 40 P.S. §764c. No violations were noted.

### **Mammogram Denied Claims - OSCAR**

The Company was requested to provide a list of mammogram claims denied during the experience period. The Company identified a universe of 2,679 mammogram claims denied under the OSCAR claims administration platform. A random sample of 108 denied claims were requested, received and reviewed to ensure compliance with 31 Pa. Code §§152.20, 301.82 and 40 P.S. §764c. The following violations were noted:

#### **1 Violation – 40 P.S. §991.2166(a)**

A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim. After re-adjustment, the denial was reversed; the noted clean claim was not paid within 45 days of receipt.

#### **9 Violations – 40 P.S. §1171.5(a)(10)(v)**

Unfair methods of competition and unfair or deceptive acts or practices are defined as:

(a) "Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices.... Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative. The Company failed to affirm or deny coverage of the 9 noted claims within a reasonable time after proof of loss for the claims listed.

### **1 Violation-40 P.S. §764c**

Policies providing hospital or medical/surgical coverage must also provide coverage mammographic examinations, whether 2-D or 3-D. The Company failed to provide coverage for 3-D mammography or digital breast tomosynthesis for the noted claim.

### **E. Autism Claims**

The Company was requested to provide lists of all autism claims for paid, partially paid and denied claims during the experience period. Two claims administration platforms used during the period, named FACETS and OSCAR, which doubled the claim review into six separate sections.

#### **Autism Spectrum Disorders Paid Claims - OSCAR**

The Company was requested to provide a list of all autism spectrum disorders claims paid during the experience period. The Company identified a universe of 7,639 autism claims paid under the OSCAR claims administration platform. A random sample of 109 paid claims was requested, received and reviewed. Of the 109 paid claims reviewed, 13 claims were not autism claims. The remaining files were reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. The files were also reviewed for compliance with the Affordable Care Act, 42 U.S.C. §18022 (essential health benefits), and 45 C.F.R Subch. B Parts 146, 147, and 156. No violations were noted.

#### **Autism Spectrum Disorders Paid Claims – FACETS**

The Company was requested to provide a list of all autism spectrum disorder claims paid during the experience period. The Company identified a universe of 2,273 autism claims paid under the FACETS claims administration platform. A random sample of 108 paid claims was requested, received and reviewed to ensure compliance with 31 Pa. Code Ch. 146, 40 P.S. §1171.5, Act 62, 40 P.S. §764h and 45 C.F.R. Subch. B Parts 146 and 147. No violations were noted.

### **Autism Spectrum Disorders Partially Paid Claims - OSCAR**

The Company was requested to provide a list of all autism spectrum disorders claims partially paid during the experience period. The Company identified a universe of 2,108 autism claims partially paid under the OSCAR claims administration platforms. A random sample of 108 partially paid claims was requested, received and reviewed. Of the 108 partially paid claims reviewed, 19 claims were not autism claims. The remaining files were reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. The files were also reviewed for compliance with the Affordable Care Act, 42 U.S.C. §18022 (essential health benefits), and 45 C.F.R. Subch. B Parts 146, 147, and 156. The following violations were noted:

#### **9 Violations – 40 P.S. §991.2166(a)**

A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim. The nine clean claims noted were not paid within 45 days of receipt.

#### **2 Violations – 31 Pa Code §154.18(c)**

Interest due to a health care provider on a clean claim shall be calculated and paid by the licensed insurer or managed care plan to the health care provider and shall be added to the amount owed on the clean claim. The interest shall be paid within 30 days of the payment of the claim. The interest payments due of \$2 or more on the two claims noted were not paid within 30 days of the claim payment.

#### **2 Violations – 40 P.S. §991.2166(b)**

If a licensed insurer or a managed care plan fails to remit the payment as provided under subsection (a), interest at 10% per annum shall be added to the amount owed on the clean claim. Interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer shall not be required to pay any interest calculated to be less than \$2. The interest due of \$2 or more on the two claims

noted was not paid as required.

#### **Autism Spectrum Disorders Partially Paid Claims - FACETS**

The Company was requested to provide a list of all autism spectrum disorder claims partially paid and the Company identified a universe of 37 claims. A random sample of 37 partially paid claims were requested, received and reviewed. Of the files received, 10 files were not autism claims. The other remaining files were reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5, Act 62, 40 P.S. §764h and 45 C.F.R. Subch. B Parts 146 and 147. No violations were noted.

#### **Autism Spectrum Disorders Denied Claims - OSCAR**

The Company was requested to provide a list of all autism spectrum disorders claims denied. The Company identified a universe of 2,367 autism claims denied under the OSCAR claims administration program. A random sample of 108 denied claims was requested, received and reviewed. Of the 108 denied claims reviewed, 32 were not autism claims. The remaining files were reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. The files were also reviewed for compliance with the Affordable Care Act, 42 U.S.C. §18022 (essential health benefits), and 45 C.F.R. Subch. B Parts 146, 147, and 156. No violations were noted.

#### **Autism Spectrum Disorders Denied Claims - FACETS**

The Company was requested to provide a list of all autism spectrum disorders claims denied during the experience period. The Company identified a universe of 553 autism claims denied under the FACETS claims administration platform. A random sample of 105 denied claims was requested, received and reviewed. Of the 105 denied claims reviewed, two claims were not autism claims the remaining files were reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. The files were also reviewed for compliance with Act 62, 40 P.S. §764h and 45 C.F.R Subch. B Parts 146 and 147. No violations were noted.

## **F. Dental Anesthesia Claims**

The Company was requested to provide lists of all dental anesthesia claims for paid, partially paid and denied claims during the experience period. There were two claims administration platforms used during the period, named FACETS and OSCAR, which doubled the claim review into six separate sections. The examiners found no violations to all six sections.

### **Dental Anesthesia Paid Claims- OSCAR**

The Company was requested to provide a list of dental anesthesia paid claims received during the experience period. The Company identified a universe of 30,891 dental anesthesia paid provider submitted claims under the OSCAR claims administration platforms. A random sample of 109 claims was requested, received and reviewed to ensure compliance with 40 P.S. §991.2166 (prompt payment of claims). The files were also reviewed for compliance with the Affordable Care Act, 42 U.S.C. §18022 (essential health benefits), and 45 C.F.R. Subch. B Parts 146, 147, and 156. No violations were noted.

### **Dental Anesthesia Paid Claims- FACETS**

The Company was requested to provide a list of dental anesthesia paid claims received during the experience period. The Company identified a universe of 865 dental anesthesia paid provider submitted claims under the FACETS claims administration platforms. A random sample of 105 claims was requested, received and reviewed to ensure compliance with 40 P.S. §991.2166 (prompt payment of claims). The files were also reviewed for compliance with the Affordable Care Act, 42 U.S.C. §18022 (essential health benefits), and 45 C.F.R. Subch. B Parts 146 and 147. No violations were noted.

### **Dental Anesthesia Partially Paid Claims-OSCAR**

The Company was requested to provide a list of dental anesthesia partially paid claims received during the experience period. The Company identified a universe of 16,424 dental anesthesia partially paid provider submitted claims under the OSCAR claims

administration platform. A random sample of 109 claims was requested, received and reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. The files were also reviewed for compliance with the Affordable Care Act, 42 U.S.C. §18022 (essential health benefits), and 45 C.F.R Subch. B Parts 146 and 147. The provider-submitted claim files were reviewed for compliance with 40 P.S. §991.2166 (prompt payment of claims). No violations were noted.

#### **Dental Anesthesia Partially Paid Claims- FACETS**

The Company was requested to provide a list of dental anesthesia partially paid claims received during the experience period. The Company identified a universe of 470 dental anesthesia partially paid provider submitted claims under the FACETS claims administration platforms. A random sample of 83 claims was requested, received and reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. The files were also reviewed for compliance with the Affordable Care Act, 42 U.S.C. §18022 (essential health benefits), and 45 C.F.R Subch. B Parts 146 and 147. The provider-submitted claim files were reviewed for compliance with 40 P.S. §991.2166 (prompt payment of claims). No violations were noted.

#### **Dental Anesthesia Denied Claims-OSCAR**

The Company was requested to provide a list of dental anesthesia denied claims received during the experience period. The Company identified a universe of 5,914 dental anesthesia claims denied provider submitted claims under the OSCAR claims administration platform. A random sample of 109 claims was requested, received and reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. The files were also reviewed for compliance with the Affordable Care Act, 42 U.S.C. §18022 (essential health benefits), and 45 C.F.R Subch. B Parts 146 and 147. The provider-submitted claim files were reviewed for compliance with 40 P.S. §991.2166 (prompt payment of claims). No violations were noted.

### **Dental Anesthesia Denied Claims-FACETS**

The Company was requested to provide a list of dental anesthesia denied claims received during the experience period. The Company identified a universe of 502 dental anesthesia claims denied provider submitted claims under the FACETS claims administration platforms. A random sample of 105 claims was requested, received and reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. The files were also reviewed for compliance with the Affordable Care Act, 42 U.S.C. §18022 (essential health benefits), and 45 C.F.R Subch. B Parts 146 and 147. The provider-submitted claim files were reviewed for compliance with 40 P.S. §991.2166 (prompt payment of claims). No violations were noted.

### **G. Substance Use Disorder Claims**

The Company was requested to provide lists of all substance use disorder claims for paid, partially paid and denied claims during the experience period. There were two claims administration platforms used during the period, named FACETS and OSCAR, which doubled the claim review into six separate sections. The examiners found violations within five of the six sections.

### **Substance Use Disorder Paid Claims - OSCAR**

The Company was requested to provide a list of all substance use claims paid during the experience period. The Company identified a universe of 73,434 substance use disorder claims paid within the OSCAR claims administration platform. A random sample of 109 claims was requested, received and reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. Additionally, the files were reviewed for compliance with 40 P.S. §§908-1 et seq. and 40 P.S. §§908-11 et seq.; the Affordable Care Act; the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. §300gg-26; and 45 C.F.R Subch. B Parts 146 and 147. The following violations were noted:

### **6 Violations – 31 Pa. Code §146.3**

File and record documentation. The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in enough detail such that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain a complete file for the six claims noted.

### **Substance Use Disorder Paid Claims - FACETS**

The Company was requested to provide a list of all substance use claims paid during the experience period. The Company identified a universe of 952 substance use disorder claims denied within the FACETS claims administration platform. A random sample of 105 paid claims was requested, received and reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. Additionally, the files were reviewed for compliance with 40 P.S. §§908-1 et seq. and 40 P.S. §§908-11 et seq.; the Affordable Care Act; the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. §300gg-26; and 45 C.F.R Subch. B Parts 146 and 147. The following violations and concern were noted:

### **7 Violations – 31 Pa. Code §146.3**

File and record documentation. The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in enough detail such that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain a complete claim file for the seven claims noted.

**Concern:** Some services required a prior authorization (PA) and those services were paid. However, out of due diligence, the examiners were interested in looking through the utilization management (UM) and case management (CM) notes for the prior authorizations, and UM and CM notes were missing from the claim file. The examiners did not cite missing notes as violations in these PA claims files because the claims were



paid; however, all UM and CM notes for PAs must always be part of the claim file.

### **Substance Use Disorder Partially Paid Claims - OSCAR**

The Company was requested to provide a list of all substance use claims partially paid during the experience period. The Company identified a universe of 37,159 substance use disorder claims partially paid within the OSCAR claims administration platform. A random sample of 109 partially paid claims was requested, received and reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. Additionally, the files were reviewed for compliance with 40 P.S. §§908-1 et seq. and 40 P.S. §§908-11 et seq.; the Affordable Care Act; the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. §300gg-26; and 45 C.F.R Subch. B Parts 146 and 147. The following violations and concerns were noted:

#### **2 Violations – 31 Pa. Code §154.18(a)**

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim under subsection (d) submitted by a health care provider for services , within 45 days of the licensed insurer's or managed care plan's receipt of the claim from the health care provider. The two noted claims submitted by the health care provider for services were not paid within 45 days of the licensed insurer's or managed care plan's receipt of the claim from the health care provider.

#### **2 Violations – 40 P.S. §991.2166(a)**

A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim. The two noted claims were not paid within 45 days of receipt.

#### **1 Violation – 40 P.S. §991.2166(b)**

If a licensed insurer or a managed care plan fails to remit the payment as provided under subsection (a), interest at 10% per annum shall be added to the amount owed on the clean

claim. Interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer or managed care plan shall not be required to pay any interest calculated to be less than \$2. The Company failed to pay interest due of \$2 or more for the one claim noted.

**1 Violation – 40 P.S. §1171.5(a)(10)(v)**

Unfair methods of competition and unfair or deceptive acts or practices are defined as:

(a) "Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means: (10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. (v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.

The Company failed to affirm or deny coverage of the claim within a reasonable time after proof of loss for the claim noted.

**4 Violations – 40 P.S. §§ 908-11 et seq., 45 C.F.R. § 146.136(c)(4) and 45 C.F.R. §147.160**

Licensed insurers are required to provide mental health and substance use disorder benefits in parity with medical/surgical benefits. For non-quantitative treatment limitations (NQTL), this means that a licensed insurer may not apply any NQTL in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying that limitation to MH/SUD benefits within that classification are “comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the classification.”

The Company imposed a non-quantitative treatment limitation with respect to mental health and substance use disorder benefits not in parity with medical/surgical benefits. It was noted that the Company is limiting the scope and duration of treatment for the claims listed in a manner that is applied more stringently than medical/surgical benefits within the

classification in the four claims noted.

#### **4 Violations – 31 Pa. Code §146.3**

File and record documentation. The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in enough detail such that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain a complete claim file for the four claims noted.

#### **4 Violations – 40 P.S. §908-2 et seq.**

Licensed insurers are required to provide, in group policies, inpatient detoxification, nonhospital residential and outpatient services for alcohol or other substance use and dependency. A certification and referral by a licensed physician or psychologist controls both the nature and duration of treatment to the extent of the mandate.

The Company failed to provide coverage for mandated substance use disorder benefits for the four claims noted.

**Concern:** When the examiners were onsite in December 2016 and January 2017, the Company stated that it did not have any procedure codes related to dispensing methadone, despite examiners repeatedly asking about this topic. While reviewing substance use disorder claims, examiners noted that, in fact, there is a procedure code associated with methadone administration. The code, H0020, has the description “Alcohol and/or Other Drug Abuse Services; Methadone Administration and/or Service (provision of the drug by a licensed program)”. The examiners noted the Company provided additional information regarding covering methadone for commercial insurance products beginning on January 1, 2018.

### **Substance Use Disorder Partially Paid Claims - FACETS**

The Company was requested to provide a list of all substance use claims partially paid during the experience period. The Company identified a universe of 154 substance use disorder claims partially paid within the FACETS claims administration platform. A random sample of 75 partially paid claims was requested, received and reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. Additionally, the files were reviewed for compliance with 40 P.S. §§908-1 et seq. and 40 P.S. §§908-11 et seq.; the Affordable Care Act; the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. §300gg-26; and 45 C.F.R Subch. B Parts 146 and 147. The following concern was noted:

**Concern:** The Company failed to provide a clear explanation of benefits to the members. The explanation of benefits contained revenue codes that were not defined and the service definitions were not clear.

### **Substance Use Disorder Denied Claims - OSCAR**

The Company was requested to provide a list of all substance use claims denied during the experience period. The Company identified a universe of 25,131 substance use disorder claims denied within the OSCAR claims administration platform. A random sample of 109 denied claims was requested, received and reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. Additionally, the files were reviewed for compliance with 40 P.S. §§908-1 et seq. and 40 P.S. §§908-11 et seq.; the Affordable Care Act; the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. §300gg-26; and 45 C.F.R Subch. B Parts 146 and 147. The following violations were noted:

#### **2 Violations – 40 P.S. §§ 908-11 et seq., 45 C.F.R. § 146.136(c)(4) and 45 C.F.R. §147.160**

Licensed insurers are required to provide mental health and substance use disorder benefits in parity with medical/surgical benefits. For non-quantitative treatment limitations

(NQTL), this means that a licensed insurer may not apply any NQTL in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying that limitation to MH/SUD benefits within that classification are "comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the classification."

The Company imposed a non-quantitative treatment limitation with respect to mental health and substance use disorder benefits not in parity with medical/surgical benefits. It was noted that the Company is limiting the scope and duration of treatment for the claims listed in a manner that is applied more stringently than medical/surgical benefits within the classification in the two claims noted.

#### **4 Violations – 40 P.S. §908-2 et seq.**

Licensed insurers are required to provide, in group policies, inpatient detoxification, nonhospital residential and outpatient services for alcohol or other substance use and dependency. A certification and referral by a licensed physician or psychologist controls both the nature and duration of treatment to the extent of the mandate. The Company failed to provide coverage for mandated substance use disorder benefits for the four claims noted.

#### **2 Violations – 40 P.S. §1171.5(a)(10)(v)**

Unfair methods of competition and unfair or deceptive acts or practices are defined as:

(a) "Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means: (10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. (v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative. The Company failed to affirm or deny coverage within a reasonable time after proof of loss was received for the two claims noted.

### **9 Violations – 31 Pa. Code §146.3**

File and record documentation. The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in enough detail such that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain a complete claim file for the nine claims noted.

### **Substance Use Disorder Denied Claims - FACETS**

The Company was requested to provide a list of all substance use claims denied during the experience period. The Company identified a universe of 653 substance use disorder claims denied within the FACETS claims administration platform. A random sample of 105 denied claims was requested, received and reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. Additionally, the files were reviewed for compliance with 40 P.S. §§908-1 et seq. and 40 P.S. §§908-11 et seq.; the Affordable Care Act; the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. §300gg-26; and 45 C.F.R. Subch. B Parts 146 and 147. The following violations and concern were noted:

### **2 Violations – 40 P.S. §§ 908-11 et seq., 45 C.F.R. § 146.136(c)(4) and 45 C.F.R. §147.160**

Licensed insurers are required to provide mental health and substance use disorder benefits in parity with medical/surgical benefits. For non-quantitative treatment limitations (NQTL), this means that a licensed insurer may not apply any NQTL in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying that limitation to MH/SUD benefits within that classification are “comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the classification.” The Company imposed a non-quantitative treatment limitation with respect to mental health and substance use disorder benefits not in parity with medical/surgical benefits. It was noted that the Company is limiting the scope and duration of treatment for the claims

listed in a manner that is applied more stringently than medical/surgical benefits within the classification in the two claims noted.

## **2 Violations – 31 Pa. Code §146.3**

File and record documentation. The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in enough detail such that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain a complete claim file for the two claims noted.

**Concern:** The Company failed to provide a clear explanation of benefits to the members. The explanation of benefits contained revenue codes that were not defined and the service definitions were not clear.

## **H. Mental Health Claims**

The Company was requested to provide lists of all Mental Health claims for paid, partially paid and denied claims during the experience period. There were two claims administration platforms used during the period, named FACETS and OSCAR, which doubled the claim review into six separate sections. The examiners found no violations within one of the six sections.

### **Mental Health Paid Claims - OSCAR**

The Company was requested to provide a list of all mental health claims paid during the experience period. The Company identified a universe of 255,139 mental health claims paid under the OSCAR claims administration platform. A random sample of 109 files was requested, received and reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. Additionally, the files were reviewed for compliance with 40 P.S. §§908-1 et seq. and 40 P.S. §§908-11 et seq.; the Affordable Care Act; 42 U.S.C. §18022 (essential health benefits); the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C.

§300gg-26; and 45 C.F.R Subch. B Parts 146, 147, and 156. The following violations were noted:

**11 Violations – 40 P.S. §§ 908-11 et seq., 45 C.F.R. § 146.136(c)(4) and 45 C.F.R. §147.160**

Licensed insurers are required to provide mental health and substance use disorder benefits in parity with medical/surgical benefits. For quantitative treatment limitations, this means that a licensed insurer may not apply any quantitative treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. The Company imposed a quantitative treatment limitation with respect to mental health and substance use disorder benefits not in parity with medical/surgical benefits.

It was noted that the Company has not demonstrated compliance with the substantially all or predominant level tests within the specified classifications of benefits. The Company was requested to provide proof of compliance for each plan type affected, each classification of benefits and for each type of quantitative treatment limitation separately.

**2 Violations 31 Pa. Code §146.3**

The claim files of the insurer shall be subject to examination by the Commissioner or his appointed designees. The files shall contain notes and work papers pertaining to the claim in enough detail such that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain a complete claim file for the two noted claims.

**1 Violation 31 Pa. Code §154.18(a)**

Licensed insurer and managed care plans shall pay clean claims and the uncontested portions of a contested claim under subsection (d) submitted by a health care provider for services, within 45 days of the licensed insurer's or managed care plan's receipt of the claim from the health care provider. The noted claim was not paid within 45 days of the



licensed insurer's or managed care plan's receipt of the claim.

### **Mental Health Paid Claims - FACETS**

The Company was requested to provide a list of all mental health claims paid during the experience period. The Company identified a universe of 8,879 mental health claims paid under the FACETS claims administration platform. A random sample of 109 paid claims was requested, received and reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. Additionally, the files were reviewed for compliance with 40 P.S. §§908-1 et seq. and 40 P.S. §§908-11 et seq.; the Affordable Care Act, including 42 U.S.C. §300gg-6 and 42 U.S.C. §18022 (essential health benefits); the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. §300gg-26; and 45 C.F.R Subch. B Parts 146, 147, and 156. The following violation and concerns were noted:

#### **1 Violation – 31 Pa. Code §146.3**

File and record documentation. The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in enough detail such that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain a complete claim file for the one claim noted.

**Concern 1:** The Company's system platform FACETS specifies that the healthcare reform (HCR)-out-of-pocket maximums do not include pharmacy member liabilities for the following large group plans: HMOB Bluecare HMO Basic, BHMO Plan year- Bluecare HMO and Plus Bluecare HMO Plus. If a plan has coverage of pharmacy benefits, the member's out-of-pocket expense shall be included in the maximum-out-of-pocket accumulator for the benefit period.

**Concern 2:** The Company's system platform FACETS specified that outpatient mental health care services are not included in the coinsurance maximum for the following large

group plan: Plus Bluecare HMO Plus. If a plan has coverage of outpatient mental health benefits, the member's out-of-pocket expense for in-network services shall be included in the maximum-out-of-pocket accumulator for the benefit period.

**Concern 3:** The Company failed to provide a clear explanation of benefits to the members. The explanation of benefits contained revenue codes that were not defined and the service definitions were unclear.

### **Mental Health Partially Paid Claims - OSCAR**

The Company was requested to provide a list of all mental health claims partially paid during the experience period. The Company identified a universe of 74,376 mental health claims partially paid under the OSCAR claims administration platform. A random sample of 109 partially paid claims was requested, received and reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. Additionally, the files were reviewed for compliance with 40 P.S. §§908-1 et seq. and 40 P.S. §§908-11 et seq.; the Affordable Care Act, including 42 U.S.C. §300gg-6 and 42 U.S.C. §18022 (essential health benefits); the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. §300gg-26; and 45 C.F.R Subch. B Parts 146, 147, and 156. The following violations were noted:

#### **1 Violation – 42 U.S.C. §18022(b)(1)(B)(E)&(G)**

Essential health benefits requirements. Essential health benefits. In general, subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories: (B) Emergency Services; (E) Mental Health and substance use disorder services, including behavioral health treatment and (H) Laboratory Services. The Company failed to provide the essential health benefits package of mental health/SUD/behavioral health treatment, emergency services and laboratory services for the claim noted.

### **3 Violations – 31 Pa. Code §146.3**

File and record documentation. The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in enough detail such that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain a complete claim file for the claims noted.

### **6 Violations – 31 Pa. Code §154.18(a)**

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of contested claim under subsection (d) submitted by a health care provider for services, within 45 days of the licensed insurer's or managed care plan's receipt of the claim from the health care provider. The six claims submitted by the health care provider for services were not paid within 45 days of the licensed insurer's or managed care plan's receipt of the claim from the health care provider.

### **1 Violation – 40 P.S. §908-2 et seq.**

Licensed insurers are required to provide, in group policies, inpatient detoxification, nonhospital residential and outpatient services for alcohol or other substance use and dependency. A certification and referral by a licensed physician or psychologist controls both the nature and duration of treatment to the extent of the mandate. The Company failed to properly provide coverage for substance use disorder benefits for the claim noted.

### **7 Violations – 40 P.S. §991.2166(a)**

A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim. The seven clean claims noted were not paid within 45 days of receipt.

### **3 Violations – 40 P.S. §991.2166(b)**

If a licensed insurer or a managed care plan fails to remit the payment as provided under subsection (a), interest at ten per centum (10%) per annum shall be added to the amount owed on the clean claim. Interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer or managed care plan shall not be required to pay any interest calculated to be less than \$2. The Company failed to pay interest due of \$2 or more for the three claims noted.

### **Mental Health Partially Paid Claims - FACETS**

The Company was requested to provide a list of all mental health claims partially paid during the experience period. The Company identified a universe of 618 mental health claims partially paid under the FACETS claims administration platform. A random sample of 105 partially paid claims was requested, received and reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. Additionally, the files were reviewed for compliance with 40 P.S. §§908-1 et seq. and 40 P.S. §§908-11 et seq.; the Affordable Care Act, including 42 U.S.C. §300gg-6 and 42 U.S.C. §18022 (essential health benefits); the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. §300gg-26; and 45 C.F.R Subch. B Parts 146, 147, and 156. The following violations and concerns were noted:

### **13 Violations – 31 Pa. Code §146.3**

File and record documentation. The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in enough detail such that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain a complete claim file for the 13 claims noted.

### **2 Violations – 40 P.S. §764h (a)**

Autism spectrum disorders coverage. A health insurance policy or government program covered under this section shall provide to covered individuals or recipients under twenty-

one (21) years of age coverage for the diagnostic assessment of autism spectrum disorders and for the treatment of autism spectrum disorders. The Company failed to provide coverage for the assessment and treatment of Autism Spectrum Disorders for the two claims noted. Specifically, procedure 92507 is considered a mandated benefit under Act 62 and reflects services for the diagnostic assessment and treatment of Autism Spectrum Disorders. (Note that while the Autism Spectrum Disorder diagnosis is not defined by the Company as a mental health condition, it was identified in these claims that had both diagnoses.)

**Concern 1:** The Company's system platform FACETS specifies that the healthcare reform (HCR)-out-of-pocket maximums do not include pharmacy member liabilities for the following large group plans: HMOB Bluecare HMO Basic, BHMO Plan year- Bluecare HMO and Plus Bluecare HMO Plus. If a plan has coverage of pharmacy benefits, the member's out-of-pocket expense shall be included in the maximum-out-of-pocket accumulator for the benefit period.

**Concern 2:** The Company's system platform FACETS specified that outpatient mental health care services are not included in the coinsurance maximum for the following large group plan: Plus Bluecare HMO Plus. If a plan has coverage of outpatient mental health benefits, the member's out-of-pocket expense for in-network services shall be included in the maximum-out-of-pocket accumulator for the benefit period.

**Concern 3:** The Company failed to provide a clear explanation of benefits to the members. The explanation of benefits contained revenue codes that were not defined and the service definitions were unclear.

#### **Mental Health Denied Claims - OSCAR**

The Company was requested to provide a list of all mental health claims denied during the experience period. The Company identified a universe of 34,280 mental health claims

denied under the OSCAR claims administration platform. A random sample of 109 denied claims was requested, received and reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. Additionally, the files were reviewed for compliance with 40 P.S. §§908-1 et seq. and 40 P.S. §§908-11 et seq.; the Affordable Care Act, including 42 U.S.C. §300gg-6 and 42 U.S.C. §18022 (essential health benefits); the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. §300gg-26; and 45 C.F.R Subch. B Parts 146, 147, and 156. The following violations were noted:

**1 Violation – 40 P.S. §§908-11 et seq., 45 C.F.R. § 146.136(c)(4) and 45 C.F.R. §147.160**

Licensed insurers are required to provide mental health and substance use disorder benefits in parity with medical/surgical benefits. For non-quantitative treatment limitations (NQTL), this means that a licensed insurer may not apply any NQTL in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying that limitation to MH/SUD benefits within that classification are “comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the classification.”

The Company imposed a nonquantitative treatment limitation with respect to mental health and substance use disorder benefits not in parity with medical/surgical benefits. The Company is limiting the scope and duration of treatment for the claims listed in a manner that was applied more stringently than medical/surgical benefits within the classification in the claim file noted.

**2 Violations – 45 C.F.R §156.115(a)(1)&(5)**

Provision of essential health benefits (EHB) means that a health plan provides benefits that are substantially equal to the EHB-benchmark plan including, with respect to habilitative services and devices, health care services and devices that help a person keep, learn, or improve skills and functioning for daily living, and that are not subject limits on coverage that are less favorable than any such limits imposed on coverage of rehabilitative services and devices. The Company failed to provide coverage that was substantially equal to the

EHB-benchmark plan, by including limitations for habilitative speech-language pathology that excludes benefits for pre-speech deficiencies, which is less favorable than any such limit imposed on coverage of rehabilitative services and devices, for the two claims noted.

## **2 Violations – 31 Pa. Code §146.3**

File and record documentation. The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in enough detail such that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain a complete claim file for the two claims noted.

## **Mental Health Denied Claims - FACETS**

The Company was requested to provide a list of all mental health claims denied during the experience period. The Company identified a universe of 2,670 mental health claims denied under the FACETS claims administration platform. A random sample of 108 denied claims was requested, received and reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. Additionally, the files were reviewed for compliance with 40 P.S. §§908-1 et seq. and 40 P.S. §§908-11 et seq.; the Affordable Care Act, including 42 U.S.C. §300gg-6 and 42 U.S.C. §18022 (essential health benefits); the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. §300gg-26; and 45 C.F.R Subch. B Parts 146, 147, and 156. The following violations and concerns were noted:

## **5 Violations – 40 P.S. §§908-11 et seq., 45 C.F.R. §146.136(c)(4) and 45 C.F.R. §147.160**

Licensed insurers are required to provide mental health and substance use disorder benefits in parity with medical/surgical benefits. For non-quantitative treatment limitations (NQTL), this means that a licensed insurer may not apply any NQTL in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying that limitation to MH/SUD benefits within that classification are “comparable to, and are

applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the classification.”

The Company imposed a nonquantitative treatment limitation with respect to mental health and substance use disorder benefits not in parity with medical/surgical benefits. The Company is limiting the scope and duration of treatment for the five noted claims in a manner that was applied more stringently than medical/surgical benefits within the classification.

**1 Violation – 40 P.S. §764g(c)(1)**

Health insurance policies covered under this section shall provide coverage for serious mental illnesses that meet at a minimum the following standards: (1) coverage for serious mental illnesses shall include at least 30 inpatient and 60 outpatient days annually. The Company failed to provide coverage for outpatient mental health services for the claim noted.

**1 Violation – 40 P.S. §908-2 et seq.**

Licensed insurers are required to provide, in group policies, inpatient detoxification, nonhospital residential and outpatient services for alcohol or other substance use and dependency. A certification and referral by a licensed physician or psychologist controls both the nature and duration of treatment to the extent of the mandate. The Company failed to provide coverage for substance use disorder benefits for the claim noted. Additionally, the certification and referral by a licensed physician or psychologist controls both the nature and duration of treatment and limitations cannot be applied.

**7 Violations – 31 Pa. Code § 146.3**

File and record documentation. The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in enough detail such that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain a



complete claim file for the seven claims noted.

**Concern 1:** The Company's system platform FACETS specifies that the healthcare reform (HCR)-out-of-pocket maximums do not include pharmacy member liabilities for the following large group plans: HMOB Bluecare HMO Basic, BHMO Plan year- Bluecare HMO and Plus Bluecare HMO Plus. If a plan has coverage of pharmacy benefits, the member's out-of-pocket expense shall be included in the maximum-out-of-pocket accumulator for the benefit period.

**Concern 2:** The Company's system platform FACETS specified that outpatient mental health care services are not included in the coinsurance maximum for the following large group plan: Plus Bluecare HMO Plus. If a plan has coverage of outpatient mental health benefits, the member's out-of-pocket expense for in-network services shall be included in the maximum-out-of-pocket accumulator for the benefit period.

### **I. Ambulance Claims**

The Company was requested to identify all ambulance claims received during the experience period that were paid, partially paid and denied. The examiners reviewed the information for two separate systems and noted violations based on the system review. The Company provided additional documentation up through the third quarter of 2017 to explain the violations. This additional documentation was helpful to the examiners for the removal of violations based on correct denials due to automobile and workers' compensation insurance coverages. There were a total of 10 violations noted in the OSCAR system and six violations noted in the FACETS system.

#### **Ambulance Paid Claims - OSCAR**

The Company was requested to provide a list of all ambulance claims paid during the experience period. The Company identified 1,727 OSCAR ambulance claims received

during the experience period. A random sample of 107 files was requested, received and reviewed applicable statutes. The following violations were noted:

**1 Violation - 31 Pa. Code §146.5(a)**

Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insured, and dated. Failure to acknowledge pertinent communications- The Company failed to acknowledge paper claims within the required 10 working days and did not include an appropriately dated notation of acknowledgment in one of the claim noted.

**Ambulance Paid Claims -FACETS**

The Company was requested to identify all ambulance claims received during the experience period that were paid during the experience period. The Company identified a universe of 231 FACETS ambulance claims received under the FACETS claims administration platform. A random sample of 82 paid claims was requested, received and reviewed to ensure compliance with all applicable statute. The following violations were noted:

**2 Violations - 40 P.S. §1171.5(a)(10)(vi)**

Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claims settlement or compromise practices. (vi) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability has become reasonably clear. The Company's system error resulted in unfair and inequitable settlement of out-of-network (OON) provider claims by paying OON providers with a reason code of "Exceeds Scheduled Rate and other incorrect claims handling."

### **Ambulance Partially Paid Claims - OSCAR**

The Company was requested to provide a list of all ambulance claims partially paid during the experience period. The Company identified 1,209 OSCAR ambulance claims. A random sample of 107 files was requested, received and reviewed. During the review, it was determined that 24 of the 107 files were duplicates of other files. Research showed that removing duplicates from the entire population left only 217 files in the population, which requires a sample size of 76. The duplicated files were removed and the last 7 files in the sample were deleted from the 83 files remaining to make a complete, correct sample of 76 claim files partially paid during the experience period. The 76 claims were reviewed to ensure compliance with all applicable statutes. The following violations were noted:

#### **1 Violation - 31 Pa. Code §146.5(a)**

Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insured, and dated. The Company failed to acknowledge the noted claim within the required 10 working days and did not include an appropriate notation of acknowledgment.

#### **1 Violation - 40 P.S. § 1171.5(a)(10)(vi)**

Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claims settlement or compromise practices. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability has become reasonably clear. The Company failed to acknowledge paper claims within the required 10 working days and did not include an appropriate notation of acknowledgments in the claim files noted.

### **Ambulance Partially Paid Claims – FACETS**

The Company was requested to identify all partially paid ambulance claims during the experience period. The Company identified a universe of nine claims. All nine claims were requested, received and reviewed. Upon review, the examiners determined there were, in fact, only four claims and the remaining five identified were lines included in the first four. In accordance with the requirements of the examination, the four claims were reviewed to ensure compliance with the applicable statutes. No violations were noted.

### **Ambulance Denied Claims - OSCAR**

The Company was requested to identify all ambulance claims denied during the experience period. The Company identified 1,727 OSCAR ambulance claims denied during the experience period. A random sample of 107 was requested, received and reviewed to ensure compliance with applicable statutes. The following violations were noted:

#### **5 Violations – 31 Pa. Code §146.5(a)**

Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insured, and dated. The Company failed to acknowledge paper claims within the required 10 working days and did not include appropriately dated notations of acknowledgments in the claim files noted.

#### **1 Violation - 31 Pa. Code §146.6**

Every insurer shall complete the investigation of the claim within 30 days after notification of the claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and then every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to send a

written explanation of the reason for delay at the end of 30 days and every 45 days thereafter until completed.

#### **1 Violation - 31 Pa. Code §146.7(c)(1)**

The following provisions govern acceptance or denial of a claim where additional time is needed to make a determination: If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the proof of loss giving the reasons more time is needed. The Company failed to send a written explanation within 15 working days after receipt giving the reason more time was needed.

#### **Ambulance Denied Claims - FACETS**

The Company was requested to identify all ambulance claims received during the experience period that were denied. The Company identified a universe of 147 FACETS ambulance claims. A random sample of 76 claims was requested, received and reviewed to ensure compliance with applicable statutes. The following violations were noted:

#### **4 Violations - 40 P.S. §1171.5(a)(10)(vi)**

Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claims settlement or compromise practices. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability has become reasonably clear. The Company incorrectly denied the four claims noted.

#### **J. Pharmacy Claims – Mental Health and Substance Use Disorder**

The Company was requested to identify all mental health and substance use disorder (MH/SUD) pharmacy claims received during the experience period that were paid, partially paid and denied. The examiners reviewed the information for two separate

systems and noted violations based on the system review. The Company provided additional documentation up through the third quarter of 2017 to explain the violations. This additional documentation and explanations were helpful to the examiners for the removal of some violations. The remaining violations are summarized in the sections below.

### **Pharmacy MH/SUD Paid Claims - OSCAR**

The Company was requested to provide a list of all mental health/substance use disorder pharmacy claims paid during the experience period. The Company identified a universe of 861 MH/SUD pharmacy claims paid under the Express Scripts, Inc., EDW, 4UM [utilization management] and OSCAR/INSINQ platforms. A random sample of 105 claims was requested, received and reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. Additionally, the files were reviewed for compliance with 40 P.S. §§908-1 et seq. and 40 P.S. §§908-11 et seq.; the Affordable Care Act, including 42 U.S.C. §300gg-6 and 42 U.S.C. §18022 (essential health benefits); the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. §300gg-26; and 45 C.F.R Subch. B Parts 146, 147, and 156. The following violations were noted:

### **3 Violations – 40 P.S. §1171.5(a)(10)(i)**

Unfair methods of competition and unfair or deceptive acts or practices defined. (a) “Unfair methods of competition” and “unfair or deceptive acts or practices” in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.

AND

#### **42 U.S.C. § 18022(c)(1) and 42 U.S.C. § 300gg-6**

The annual limitation on cost-sharing shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of title 26 for self-only and family coverage, respectively, increased by an amount equal to the product of that amount and the premium adjustment percentage determined in accordance with statute for the calendar year. The Company failed to apply the member's out-of-pocket expense for EHBs to the total maximum out-of-pocket accumulator, which may have resulted in some members paying more than the maximum allowable amount as specified in the ACA. Upon notification of these violations within the market conduct examination in the second quarter of 2017, the Company correctly applied the noted out-of-pocket expense for EHBs to the accumulator and provided proof of refunds to the impacted consumers.

#### **Pharmacy MH/SUD Paid Claims - FACETS**

The Company was requested to provide a list of all MH/SUD claims paid during the experience period. The Company identified a universe of 10,068 MH/SUD pharmacy claims paid within the Express Scripts, Inc. eService Delivery ("ESD"), Sanovia (legacy utilization management system) and the FACETS claims administration/adjudication platform. A random sample of 109 paid claims was requested, received and reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. Additionally, the files were reviewed for compliance with 40 P.S. §§908-1 et seq. and 40 P.S. §§908-11 et seq.; the Affordable Care Act; 42 U.S.C. §18022 (essential health benefits); the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. §300gg-26; and 45 C.F.R Subch. B Parts 146, 147, and 156. No violations were noted.

#### **Pharmacy MH/SUD Partially Paid Claims - OSCAR**

The Company was requested to provide a list of all MH/SUD pharmacy claims partially paid during the experience period. The Company identified a universe of 7,371 MH/SUD pharmacy claims partially paid within the Express Scripts, Inc. eService Delivery ("ESD"), Electronic Data Warehouse ("EDW"), 4UM (utilization management system) and the

OSCAR claims administration/adjudication platform. A random sample of 109 partially paid claims was requested, received and reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. Additionally, the files were reviewed for compliance with 40 P.S. §§908-1 et seq. and 40 P.S. §§908-11 et seq.; the Affordable Care Act; 42 U.S.C. §18022 (essential health benefits); the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. §300gg-26; and 45 C.F.R Subch. B Parts 146, 147, and 156. The following violation was noted:

**1 Violation – 31 Pa. Code § 146.3**

File and record documentation. The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in enough detail such that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain a complete claim file for the noted claim.

**Pharmacy MH/SUD Partially Paid Claims - FACETS**

The Company was requested to provide a list of all MH/SUD pharmacy claims partially paid during the experience period. The Company identified a universe of 97,257 MH/SUD pharmacy claims partially paid under the Express Scripts, Inc., Sanovia [utilization management] and FACETS platforms. A random sample of 109 partially paid claims was requested, received and reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. Additionally, the files were reviewed for compliance with 40 P.S. §§908-1 et seq. and 40 P.S. §§908-11 et seq.; the Affordable Care Act, including 42 U.S.C. §300gg-6 and 42 U.S.C. §18022 (essential health benefits); the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. §300gg-26; and 45 C.F.R Subch. B Parts 146, 147, and 156. The following violations and concern were noted:

**1 Violation 42 U.S.C. § 300gg-6**

Cost sharing under group health plans- A group health plan shall ensure that any annual



cost-sharing imposed under the plan does not exceed the limitation provided for under paragraph (1) of section 18022(c) of this title. The Company failed to apply the member's out-of-pocket expense for the policy and the member accumulated more than the threshold amounts for coordinated referred services and in network services that applied an out-of-pocket expense.

### **5 Violations – 31 Pa. Code § 146.3**

**File and record documentation.** The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in enough detail such that pertinent events and the dates of the events can be reconstructed. The Company failed to maintain a complete claim file for the 5 claims noted.

**Concern:** Under 40 P.S. §§ 908-11 et seq., 45 C.F.R. §146.136(c)(4) and 45 C.F.R. §147.160, licensed insurers are required to provide mental health and substance use disorder benefits in parity with medical/surgical benefits. For non-quantitative treatment limitations (NQTL), this means that a licensed insurer may not apply any NQTL in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying that limitation to MH/SUD benefits within that classification are “comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the classification.” The Company imposed a nonquantitative treatment limitation with respect to substance use disorder that was not clearly in parity with the NQTL imposed with respect to medical/surgical benefits. Specifically, there is a concern that the process of developing the standards used by the Company for its prior authorization requirements for mental health/substance use disorder treatments (e.g., a buprenorphine/naloxone combination) was not in parity with the process of developing the standards used by the Company for its prior authorization requirements for medical/surgical treatments.

### **Pharmacy MH/SUD Denied Claims - OSCAR**

The Company was requested to identify all true reject claims for MH/SUD pharmacy drugs. These claims were for outpatient retail setting or mail order settings only. The Company identified 3,401 MH/SUD pharmacy claims during the experience period. A random sample of 109 denied claims was requested, received and reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. Additionally, the files were reviewed for compliance with 40 P.S. §§908-1 et seq. and 40 P.S. §§908-11 et seq.; the Affordable Care Act, including 42 U.S.C. §300gg-6 and 42 U.S.C. §18022 (essential health benefits); the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. §300gg-26; and 45 C.F.R Subch. B Parts 146, 147, and 156. No violations were noted.

### **Pharmacy MH/SUD Denied Claims - FACETS**

The Company was requested to identify all true reject claims for MH/SUD pharmacy drugs. These claims were for outpatient retail setting or mail order settings only. The Company identified 8,948 MH/SUD pharmacy claims used during the experience period. A random sample of 109 files was requested, received and reviewed to ensure compliance with 31 Pa. Code Ch. 146 and 40 P.S. §1171.5. Additionally, the files were reviewed for compliance with 40 P.S. §§908-1 et seq. and 40 P.S. §§908-11 et seq.; the Affordable Care Act, including 42 U.S.C. §300gg-6 and 42 U.S.C. §18022 (essential health benefits); the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. §300gg-26; and 45 C.F.R Subch. B Parts 146, 147, and 156. The following concerns were noted:

**Concern 1:** Under 45 C.F.R. § 146.136(c)(4) and 45 C.F.R. §147.160, licensed insurers are required to provide mental health and substance use disorder benefits in parity with medical/surgical benefits. For non-quantitative treatment limitations (NQTL), this means that a licensed insurer may not apply any NQTL in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying that limitation to MH/SUD benefits within that classification are “comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in

applying the limitation to medical/surgical benefits in the classification.” The Company imposed a nonquantitative treatment limitation with respect to substance use disorder that was not clearly in parity with the NQTL imposed with respect to medical/surgical benefits. Specifically, there is a concern that the process of developing the standards used by the Company for its prior authorization requirements for mental health/substance use disorder treatments (e.g., a buprenorphine/naloxone combination) was not in parity with the process of developing the standards used by the Company for its prior authorization requirements for medical/surgical treatments.

**Concern 2:** The combination of factors, which include the Drug Utilization Review (DUR) messages, requiring prior authorization for buprenorphine and buprenorphine/naloxone products used only for SUD, the urinalysis medical policy on drugs used SUD, lack of ID numbers, in the claims, all indicate that the Company effectively neither provides methadone for SUD treatment, nor provides buprenorphine (with or without naloxone) under the OBOT programs.

## **XVI. HIV/AIDS DRUGS**

The Company was requested to identify all pharmacy policies and procedures used during the experience period for Special Drugs specific to HIV/AIDS diagnosis conditions. The Company identified 10 HIV/AIDS pharmacy policies and procedures used during the experience period. The Company identified 3 policy benefit design documents used during the experience period. The 10 Pharmacy Policies and procedures were requested, received and reviewed to ensure compliance with all applicable statutes. The following concern was noted:

**Concern for the 1/1/2016 to 3/31/2016 Experience Period:** The examiners have concerns regarding the practices of (1) failing to place preferred HIV Agents on Tier 2; and (2) placing an excessive amount of HIV Agents that are part of a multi-drug regimen on Tier 3, or a specialty tier, and (3) placing less widely used HIV Agents on Tier 1. The Department is continuing to review this issue through other initiatives and more guidance will be forthcoming.

## **XVII. DATA INTEGRITY**

As part of the examination, the Company was sent a preliminary examination packet in accordance with NAIC uniformity standards and provided specific information relative to the exam. The purpose of the packet was to provide certain basic examination information, identify preliminary requirements and to provide specific requirements for requested data call information. Once the Company provided all requested information and data contained within the data call, the Department reviewed and validated the data to ensure its accuracy and completeness to determine compliance with the Insurance Department Act of 1921, Section 904(b) (40 P.S. §323.4(b)). Several data integrity issues were found during the exam.

The data integrity issue of each area of review is identified below:

### **Autism Spectrum Disorders Paid Claims – OSCAR**

Situation: As the examiners reviewed the Autism Spectrum Disorders Paid Claims – OSCAR platform, it was noted that not all of the 109 paid claims selected for review were paid claims.

Finding: Of the 109 paid claims reviewed, 13 claims were not autism claims.

### **Autism Spectrum Disorders Partially Paid Claims – OSCAR**

Situation: As the examiners reviewed the Autism Spectrum Disorder Partially Paid Claims – OSCAR platform, it was noted that not all of the 108 claims selected for review were partially paid claims.

Finding: Of the 108 partially paid claims reviewed, 19 claims were not autism claims.

### **Autism Spectrum Disorders Partially Paid Claims – FACETS**

Situation: As the examiners reviewed the Autism Spectrum Disorders Partially Paid Claims – FACETS platform, it was noted that not all 37 claims were partially paid claims.

Finding: Of the 37 partially paid claims reviewed, 10 were not autism claims.

### **Autism Spectrum Disorders Denied Claims – OSCAR**

Situation: As the examiners reviewed the Autism Spectrum Disorders Denied Claims – OSCAR platform, not all of the 108 denied claims were denied claims.

Finding: Of the 108 denied claims reviewed, 32 were not autism claims.

### **Ambulance Partially Paid Claims – FACETS**

Situation: As the examiners reviewed the Ambulance Partially Paid Claims – FACETS platform, not all of the nine claims were Ambulance Partially Paid Claims – Facets claims.

Finding: The examiners determined there were only four claims; the remaining five were identified as lines included in the first four claims.

The following violation was noted:

### **General Violation 40 P.S. §323.4(b)**

Requires every company or person from whom information is sought must provide the examiners timely, convenient and free access to all books, records, accounts, papers, documents and any and all computer or other recording relating to the property, assets business and affairs of the company being examined. The violation was the result of a failure to exercise sufficient due diligence to ensure compliance with the Insurance Department Act of 1921.

### ***XVIII. RECOMMENDATIONS***

The recommendations made below identify corrective measures the Department finds necessary as a result of the number of some violations, or the nature and severity of other violations, noted in the Report.

1. The Company must review and revise internal control procedures to ensure compliance with the mental health and substance use disorder parity compliance requirements of 40 P.S. §§ 908-11 et seq., 42 U.S.C. §300gg-26, and 45 C.F.R. §146.136(c)(4) and §147.160.
2. The Company must review and revise internal complaint review processes to complete the initial review within 30 days of the receipt of the complaint as per 40 P.S. §991.2141(b)(4).
3. The Company must review its producer termination process as per 40 P.S. §310.71a.
4. The Company must review and revise its internal controls to ensure that all records and documents are maintained in accordance with 40 P.S. §323.4 so that the violation noted in the Report does not occur in the future.
5. The Company must implement procedures to ensure compliance with the requirements of 40 P.S. §1171.5(a)(10)(v), Insurance Department Act of 1921 "Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices." The Company must affirm or deny coverage of claims within 45 days after proof of loss for the claims is received.

6. The Company must implement procedures to ensure compliance with the requirements of 31 Pa. Code §146.3 to maintain complete claim files and documentation of third party vendor claim adjudication and documentation specific to Behavioral Health, Mental Health, Substance Use Disorder and Pharmacy claims.
7. The Company must review and revise internal control procedures to ensure compliance with the claims handling requirements of 31 Pa. Code, Chapter 146, Unfair Claims Settlement Practices, so that the violations relating to claim acknowledgement, status letters and acceptance or denials, as noted in the Report, do not occur in the future.
8. The Company must review its external review requirements for compliance with 45 C.F.R. §§147.136(b), incorporating 29 C.F.R. §2560.503-1(i)(ii), to ensure that the violations noted in the Report do not occur in the future.
9. The Company must review 40 P.S. §991.2141(c)(3) to ensure a second level of review for complaints is completed within 45 days of receipt of a request for such review.
10. The Company must review 40 P.S. §991.2166(a) to ensure that all clean claims are paid within 45 days of receipt.
11. The Company must review 40 P.S. §991.2166(b) and 31 Pa. Code §154.18(c) to ensure all requirements are met related to interest payments.
12. The Company must review 31 Pa. Code §154.18(a) to ensure all clean claims and the uncontested portions of a contested claim are paid within 45 days of receipt of the claim from the health care provider.
13. The Company must review 31 Pa. Code §154.18(d) to ensure that the violations noted within the Report relative to clean claims do not occur in the future.



14. The Company must review 40 P.S. §§908-2 et seq. to ensure the violations noted in the Report relative to substance use disorder benefits do not occur in the future.
15. The Company must review 42 U.S.C. §18022 to ensure the violation noted in the Report relative to essential health benefits does not occur in the future.
16. The Company must review 40 P.S. §764h to ensure diagnostic assessment of autism spectrum disorders and treatment of autism spectrum disorders coverage for covered individuals under 21 years of age.
17. The Company must review 45 C.F.R §156.115(a)(1)&(5) to ensure violations noted in the Report relative to habilitative services do not occur in the future.
18. The Company must review 40 P.S. §764g to ensure the violation noted in the Report related to outpatient mental health services for serious mental illnesses does not occur in the future.
19. The Company must review 40 P.S. §1171.5(a)(10)(vi) to ensure prompt, fair and equitable settlements are being provided to claimants.
20. The Company must review 40 P.S. §1171.5(a)(10)(i), 42 U.S.C. §18022, and 42 U.S.C. §300gg-6 to ensure violations noted in the Report relative to out-of-pocket expenses for Essential Health Benefits and cost-sharing requirements do not occur in the future.

***XIX. COMPANY RESPONSE***



January 24, 2018

Donna Fleischauer  
Life & Health Division Chief  
Office of Market Regulation  
Bureau of Market Actions  
Pennsylvania Insurance Department  
1321 Strawberry Square  
Harrisburg, PA 17120

Re: Market Conduct Examination, Warrant Number -- 16-M33-009  
First Priority Life Insurance Company (d/b/a First Priority Life)  
HMO of Northeastern Pennsylvania (d/b/a First Priority Health)

Dear Ms. Fleischauer:

This letter is in response to the recommendations provided by the Pennsylvania Insurance Department's ("Department") Market Conduct Examination team's review of the policies and procedures of First Priority Life Insurance Company (d/b/a, First Priority Life ("FPLIC")) and HMO of Northeastern Pennsylvania (d/b/a First Priority Health ("FPH")) covering the experience period of January 1, 2015 through March 31, 2016.

As you are aware, Highmark Inc. assumed majority interest of FPLIC and FPH (collectively, the "Company") on June 1, 2015. At that time, the Company began a transition period to Highmark Inc.'s systems and processes. This transition period is important to note as many of the recommendations made by the Examiners have since been mitigated due to the transition.

Highmark Inc. would also like to note that the majority of the claims examined processed correctly. While we acknowledge the Department's concern with the small number of claims that processed incorrectly, we do not believe that the number of these claim irregularities occur with such frequency so as to constitute a regular business practice. On the contrary, the fact that the majority of the claims have processed correctly should lead to the conclusion that the irregularities identified by the Department are, in fact, anomalies within the Company's claims processing systems that warrant examination and correction.

The Company respectfully offers the following comments on the recommendations noted by the Examiners below:

***Recommendation 1:***

The Company must review and revise internal control procedures to ensure compliance with the mental health and substance use disorder parity compliance requirements of 40 P.S. §§ 908-11 et seq., 42 U.S.C. §300gg-26, and 45 C.F.R. §146.136(c)(4) and §147.160.

***Company Response:***

The Company will review its procedures to ensure compliance with the mental health and substance use disorder parity compliance requirements of 40 P.S. §§ 908-11 et seq., 42 U.S.C. §300gg-26, and 45 C.F.R. §146.136(c)(4) and §147.160. Further, it should be noted that the Company provided documentation to evidence its compliance with the law and regulation.

***Recommendations 2 and 9:***

The Company must review and revise internal complaint review processes to complete the initial review within 30 days of the receipt of the complaint per 40 P.S. §991.2141(b)(4).

The Company must review 40 P.S. §991.2141(c)(3) to ensure a second level of review for complaints is completed within 45 days of receipt of a request for such review.

***Company Response:***

The Company will review its procedures to ensure compliance with 40 P.S. §991.2141 (b)(4) and (c)(3). Further, it asserts that the issues related to its internal complaint review processes have been mitigated due to the transition to Highmark Inc.'s processes.

***Recommendation 3:***

The Company must review its producer termination process as per 40 P.S. §310.71a.

***Company Response:***

The Company will review its procedures to ensure compliance with 40 P.S. §310.71a. Further, it asserts that the issues related to its producer termination process have been mitigated due to the transition to Highmark Inc.'s processes.

***Recommendation 4:***

The Company must review and revise its internal controls to ensure that all records and documents are maintained in accordance with 40 P.S. §323.4 so that the violation noted in the Report does not occur in the future.

***Company Response:***

The Company will review its procedures to ensure compliance with 40 P.S. §323.4. Further, it asserts that the single violation noted by the examiners has been mitigated due to the transition to Highmark Inc.'s processes.

***Recommendations 5 and 19:***

The Company must implement procedures to ensure compliance with the requirements of 40 P.S. §1171.5(a)(10)(v), Insurance Department Act of 1921 "Unfair Methods of Competition" and "Unfair or Deceptive Acts or Practices." The Company must affirm or deny coverage of claims within 45 days after proof of loss for the claims is received.

The Company must review 40 P.S. §1171.5(a)(10)(vi) to ensure prompt, fair and equitable settlements are being provided to claimants.

***Company Response:***

The Company will review its procedures to ensure compliance with 40 P.S. §1171.5(a)(10)(vi) and the Insurance Department Act of 1921. Further, it is the Company's position that the small number of claim violations do not evidence that the acts were performed "with such frequency as to indicate a business practice" as required by the Unfair Insurance Practice Act.

***Recommendations 6 and 7:***

The Company must implement procedures to ensure compliance with the requirements of 31 Pa. Code § 146.3 to maintain complete claim files and documentation of third party vendor claim adjudication and documentation specific to Behavioral Health, Mental Health, Substance Use Disorder and Pharmacy claims.

The Company must review and revise internal control procedures to ensure compliance with the claims handling requirements of 31 Pa. Code, Chapter 146, Unfair Claims Settlement Practices, so that the violations relating to claim acknowledgement, status letters and acceptance or denials, as noted in the Report, do not occur in the future.

***Company Response:***

The Company will review its procedures to ensure compliance with 31 Pa. Code, Chapter 146 and 146.3. Further, it asserts that these issues have been mitigated due to the transition to Highmark Inc.'s processes. Additionally, it is the Company's position that the small number of violations do not evidence that the acts were performed "with such frequency as to indicate a business practice" as required by the Unfair Insurance Practice Act.

***Recommendation 8:***

The Company must review its external review requirements for compliance with 45 C.F.R. §§147.136(b), incorporating 29 C.F.R. §2560.503-1(i)(ii), to ensure that the violations noted in the Report do not occur in the future.

***Company Response:***

The Company will review its procedures to ensure compliance with 45 C.F.R. §§147.136(b), incorporating 29 C.F.R. §2560.503-1(i)(ii). Further, it asserts that these issues have been mitigated due to the transition to Highmark Inc.'s processes.

***Recommendations 10, 11, 12 and 13:***

The Company must review 40 P.S. §991.2166(a) to ensure that all clean claims are paid within 45 days of receipt.

The Company must review 40 P.S. §991.2166(b) and 31 Pa. Code §154.18(c) to ensure all requirements are met related to interest payments.

The Company must review 31 Pa. Code §154.18(a) to ensure all clean claims and the uncontested portions of a contested claim are paid within 45 days of receipt of the claim from the health care provider.

The Company must review 31 Pa. Code § 154.18(d) to ensure that the violations noted within the Report relative to clean claims do not occur in the future.

***Company Response:***

The Company will review its procedures to ensure compliance with 40 P.S. §991.2166(a-b) and Pa. Code § 154.18 (a, c and d) and the Insurance Department Act of 1921. Further, it is the Company's position that the small number of violations do not evidence that the acts were performed "with such frequency as to indicate a business practice" as required by the Unfair Insurance Practice Act.

***Recommendation 14:***

The Company must review 40 P.S. §§908-2 et seq. to ensure the violations noted in the Report relative to substance use disorder benefits do not occur in the future.

***Company Response:***

The Company will review its procedures to ensure compliance with 40 P.S. §§908-2 et seq. It should be noted that the Company did provide the examiners documentation to evidence its compliance with the law and regulation. Finally, it is the Company's position that the small number of violations do not evidence that the acts were performed "with such frequency as to indicate a business practice" as required by the Unfair Insurance Practice Act.

***Recommendation 15:***

The Company must review 42 U.S.C. §18022 to ensure the violation noted in the Report relative to essential health benefits does not occur in the future.

***Company Response:***

The Company will review its procedures to ensure compliance with 42 U.S.C. §18022. It should be noted that the Company did provide the examiners documentation to evidence its compliance with the law and regulation. Finally, it is the Company's position that the small number of violations do not evidence that the acts were performed "with such frequency as to indicate a business practice" as required by the Unfair Insurance Practice Act.

***Recommendation 16:***

The Company must review 40 P.S. §764h to ensure diagnostic assessment of autism spectrum disorders and treatment of autism spectrum disorders coverage for covered individuals under 21 years of age.

***Company Response:***

The Company will review its procedures to ensure compliance with 40 P.S. §764h. It should be noted that the Company did provide the examiners documentation to evidence its compliance with the law and regulation. Finally, it is the Company's position that the small number of violations do not evidence that the acts were performed "with such frequency as to indicate a business practice" as required by the Unfair Insurance Practice Act.

***Recommendation 17:***

The Company must review 45 C.F.R. §156.115(a)(1)&(5) to ensure violations noted in the Report relative to habilitative services do not occur in the future.

***Company Response:***

The Company will review its procedures to ensure compliance with 45 C.F.R §156.115(a)(1)&(5). Additionally, it is the Company's position that the small number of violations do not evidence that the acts were performed "with such frequency as to indicate a business practice" as required by the Unfair Insurance Practice Act.

***Recommendation 18:***

The Company must review 40 P.S. §764g to ensure the violation noted in the Report related to outpatient mental health services for serious mental illnesses does not occur in the future.

***Company Response:***

The Company will review its procedures to ensure compliance with 40 P.S. §764g. It should be noted that the Company did provide the examiners documentation to evidence its compliance with the law and regulation. Finally, it is the Company's position that the small number of violations do not evidence that the acts were performed "with such frequency as to indicate a business practice" as required by the Unfair Insurance Practice Act.

***Recommendation 20:***

The Company must review 40 P.S. §1171.5(a)(10)(i), 42 U.S.C. §18022, and 42 U.S.C. §300gg-6 to ensure violations noted in the Report relative to out-of-pocket expenses for Essential Health Benefits and cost-sharing requirements do not occur in the future.

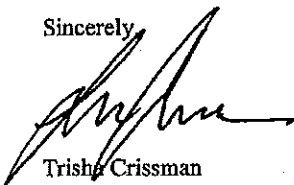
***Company Response:***

The Company will review its procedures to ensure compliance with 40 P.S. §1171.5(a)(10)(i), 42 U.S.C. §18022, and 42 U.S.C. §300gg-6. It is the Company's position that the small number of violations do not evidence that the acts were performed "with such frequency as to indicate a business practice" as required by the Unfair Insurance Practice Act.

In closing, the Company acknowledges the Department's recommendations and believes that the market conduct examination is a useful process in identifying potential issues. The Company will utilize the recommendations in order to improve our processes.

We would like to thank you and your staff for the courtesy and cooperation extended to us during this exam. If you have any questions or require additional information, please contact me at (412) 544-7870 or [trisha.crissman@highmarkhealth.org](mailto:trisha.crissman@highmarkhealth.org). Thank you.

Sincerely,



Trisha Crissman  
Vice President, External Audit Services and Strategic Audit Analytics