DELAWARE DEPARTMENT OF INSURANCE

MARKET CONDUCT EXAMINATION REPORT

HIGHMARK BCBSD INC.

800 Delaware Avenue
Wilmington, DE 19801-1368

NAIC #53287

As of

September 30, 2018

Trinidad Navarro
Commissioner

Delaware Department of Insurance

I, Trinidad Navarro, Insurance Commissioner of the State of Delaware, do hereby certify that the attached REPORT ON EXAMINATION, made as of September 30, 2018 on

HIGHMARK BCBSD INC.

is a true and correct copy of the document filed with this Department.

Attest By:

Insurance Commissioner of the State of Delaware

In Witness Whereof, I have hereunto set my hand and affixed the official seal of this Department at the City of Dover, this 19 day of November 2020.

Trinidad Navarro
Insurance Commissioner

Trinidad Navarro
Commissioner

Delaware Department of Insurance

REPORT ON EXAMINATION

OF THE

HIGHMARK BCBSD INC.

AS OF

September 30, 2018

The above-captioned Report was completed by examiners of the Delaware Department of Insurance.

Consideration has been duly given to the comments, conclusions and recommendations of the examiners regarding the status of the Company as reflected in the Report.

This Report is hereby accepted, adopted and filed as an official record of this Department.

Insurance Commissioner of the State of Delaware

In Witness Whereof, I have hereunto set my hand and affixed the official seal of this Department at the City of Dover, this 19 day of November, 2020.

Trinidad Navarro
Insurance Commissioner

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Honorable Trinidad Navarro
Insurance Commissioner
State of Delaware
841 Silver Lake Boulevard
Dover, Delaware 19904

Dear Commissioner Navarro:

In compliance with the instructions contained in Exam Authority Number 53287-ACA-18-967, and pursuant to statutory provisions including 18 *Del. C*. §§ 318-322, a market conduct examination has been conducted of the affairs and practices of:

Highmark BCBSD, Inc. NAIC #53287

The examination consisted of two phases, an on-site phase and an off-site phase. The on-site phase of the examination was conducted at the following Company location:

120 Fifth Avenue
Pittsburgh, PA 15222

The off-site examination phase was performed at the offices of the Delaware Department of Insurance, hereinafter referred to as the Department or DDOI, or other suitable locations.

The report of examination herein is respectfully submitted.

EXECUTIVE SUMMARY

The examination was announced as part of a series of examinations on companies in the health insurance marketplace in Delaware. The examination focused on the Company's practices and procedures relating to the following lines of business: group accident and health, individual accident and health, preauthorization, complaint handling, appeals, grievances and claims. The purpose of the examination is to determine compliance by the Company with Delaware insurance laws and regulations related to the Company's consumer complaints, appeals and grievances and claims handling with special focus on mental health parity.

According to the Schedule T of their 2017 annual statement for the State of Delaware, the Company reported accident and health insurance premiums, including policy, membership and other fees of $638,296,954.

There were no exceptions in the Company Operation and Management, Forms, and Underwriting and Rating, and eviCore Paid Claims sections. Producer Licensing and Policyholder Services were not requested, thus not reviewed.

The following exceptions were noted:

- **54 Exceptions**
  18 Del. C. § 332(c)(4) Prompt response to written grievances
  (c)(4). The IRP shall provide that within 5 business days of receipt of a written grievance, the carrier shall provide written acknowledgement of the grievance, including the name, address and telephone number of the individual or department designated by the carrier to respond to the grievance.

  The Company failed to specifically acknowledge receipt of a written grievance within 5 business days.

- **5 Exceptions**
  18 Del. C. § 332(c)(5) Speedy review of grievances
  (c)(5). The IRP shall require that all grievances be decided in an expeditious manner, and in any event, no more than (i) 72 hours after the receipt of all necessary information relating to an emergency review, (ii) 30 days after the receipt of all necessary information in the case of requests for referrals or determinations concerning whether a requested benefit is covered pursuant to the contract, and (iii) 45 days after the receipt of all necessary information in all other instances. A grievance shall be considered decided when the carrier has made its final decision on the subject of the review and has deposited written notice of that decision in the mail, in accordance with paragraphs (7) and (8) of this subsection.

  The Company failed to specifically render a decision of a written grievance within 30 days.

- **6 Exceptions**
  18 *Del. Admin. C.* 1301 § 5.2 IHCAP Procedures
  5.1 A covered person or his authorized representative may request review of a final coverage decision based, in whole or in part, on medical necessity or appropriateness of services by filing an appeal with the carrier within four months of receipt of the final coverage decision.
  5.2 Upon receipt of an appeal, the carrier shall transmit the appeal electronically to the Department as soon as possible, but within no more than three business days.

  The Company failed to transmit the IURO request to the Department within 3 days.

- **1 Exception**
  18 Del. C. § 3343(b)(1)b Insurance coverage for serious mental illness, and 18 Del. C.§ 3350(b) Prescription medication; 45 CFR 146.136 (c)(4)(i) General rule and 45 CFR 146.136 (c)(4)(ii)(A)

  18 Del. C. § 3343(b)(1)b: Subject to subsections (a), (c) through (f), and (h) of this section, no carrier may issue for delivery, or deliver, in this State any health benefit plan containing terms that place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan, including terms for deductibles, co-pays, monetary limits, coinsurance factors, limits in the numbers of visits, limits in the length of inpatient stays, durational limits, or limits in the coverage of prescription medicines.

  18 Del. C. § 3350(b): Every policy or contract of health insurance described in subsection (a) of this section shall provide coverage for any outpatient drug prescribed to treat a covered person for a covered chronic, disabling or life-threatening illness if the drug:
  (1) Has been approved by the Food and Drug Administration for at least 1 indication; and
  (2) Is recognized for treatment of the indication for which the drug is prescribed in:
  a. A prescription drug reference compendium approved by the Insurance Commissioner for purposes of this section; or
  b. Substantially accepted peer reviewed medical literature.

  45 CFR 146.136(c)(4) Nonquantitative treatment limitations -
  (i) General rule: A group health plan 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 plan 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, except to the extent that recognized clinically appropriate standards of care may permit a difference, and

(ii) Illustrative list of nonquantitative treatment limitations. Nonquantitative treatment limitations include -

(A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness.

The Company excluded methadone medication treatment in 2016, 2017, and all preceding years for opioid use disorder (OUD) at outpatient/ambulatory care prior to 1/1/2018.

- **5 Exceptions**
  18 Del. C. § 3343(b)(2)a. Insurance coverage for serious mental illness

  18 Del. C. § 3343(b)(2)a: A health benefit plan that provides coverage for prescription drugs must provide coverage for the treatment of serious mental illnesses and drug and alcohol dependencies that includes immediate access, without prior authorization, to a 5-day emergency supply of prescribed medications covered under the health benefit plan for the medically necessary treatment of serious mental illnesses and drug and alcohol dependencies where an emergency medical condition, as defined in § 3349(e) of this title, exists, including a prescribed drug or medication associated with the management of opioid withdrawal or stabilization, except where otherwise prohibited by law.

  The Company imposed a restrictive prior authorization with a 60-day lookback on medication fills greater than a 5-day supply of buprenorphine sublingual tablets (monotherapy) for Opioid Use Disorder (OUD) thus denying immediate access in emergency situations.

- **83 exceptions**
  18 Del. C. § 3343(b)(1)b Insurance coverage for serious mental illness, 18 Del. C. § 3350(b) Prescription medication; 45 CFR 146.136 (c)(4)(i) General rule and 45 CFR 146.136 (c)(4)(ii)(A),(B),(E).

  18 Del. C. § 3343(b)(1)b: Subject to subsections (a), (c) through (f), and (h) of this section, no carrier may issue for delivery, or deliver, in this State any health benefit plan containing terms that place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan, including terms for deductibles, co-pays, monetary limits, coinsurance factors, limits in the numbers of visits, limits in the length of inpatient stays, durational limits, or limits in the coverage of prescription medicines.

18 Del. C. § 3350(b): Every policy or contract of health insurance described in subsection (a) of this section shall provide coverage for any outpatient drug prescribed to treat a covered person for a covered chronic, disabling or life-threatening illness if the drug:

(1) Has been approved by the Food and Drug Administration for at least 1 indication; and

(2) Is recognized for treatment of the indication for which the drug is prescribed in:

a. A prescription drug reference compendium approved by the Insurance Commissioner for purposes of this section; or

b. Substantially accepted peer reviewed medical literature.

45 CFR 146.136(c)(4) Nonquantitative treatment limitations -

(i) General rule A group health plan 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 plan 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, except to the extent that recognized clinically appropriate standards of care may permit a difference, and

(ii) Illustrative list of nonquantitative treatment limitations. Nonquantitative treatment limitations include -

(A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness.

(B) Formulary design for prescription drugs.

(E) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols).

The Company imposed a Non-Quantitative Treatment Limitation (NQTL) on higher doses of venlafaxine ER 150mg capsules for the treatment of Major Depressive Disorder (MDD) by establishing a step therapy policy that is more stringently applied to this medication than compared to Medical/Surgical medications.

- **10 Exceptions**
  18 Del. C. § 3343(b)(1)b Insurance coverage for serious mental illness; 45 CFR 146.136(c)(4)(i) General rule and 45 CFR 146.136(c)(4)(ii)(B),(E)

  18 Del. C. § 3343(b)(1)b: Subject to subsections (a), (c) through (f), and (h) of this section, no carrier may issue for delivery, or deliver, in this State any health benefit plan containing terms that place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan, including terms for

deductibles, co-pays, monetary limits, coinsurance factors, limits in the numbers of visits, limits in the length of inpatient stays, durational limits, or limits in the coverage of prescription medicines.

45 CFR 146.136(c)(4) Nonquantitative treatment limitations -

(i) General rule A group health plan 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 plan 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, except to the extent that recognized clinically appropriate standards of care may permit a difference, and

(ii) Illustrative list of nonquantitative treatment limitations. Nonquantitative treatment limitations include -

(B) Formulary design for prescription drugs.

(E) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols).

The Company imposed a more restrictive Non-Quantitative Treatment Limitation (NQTL) on Brintellix/Trintellix, desvenlafaxine ER, Fetzima, Khedezla, Pristiq, and Viibryd for the treatment of Major Depressive Disorder (MDD) than used on Medical/Surgical medications.

- **421 Exceptions**
  18 Del. C. § 3343(b)(1)b Insurance coverage for serious mental illness; 45 CFR 146.136(c)(4)(i) General rule and 45 CFR 146.136(c)(4)(ii)(A),(B)

18 Del. C. § 3343(b)(1)b: Subject to subsections (a), (c) through (f), and (h) of this section, no carrier may issue for delivery, or deliver, in this State any health benefit plan containing terms that place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan, including terms for deductibles, co-pays, monetary limits, coinsurance factors, limits in the numbers of visits, limits in the length of inpatient stays, durational limits, or limits in the coverage of prescription medicines.

45 CFR 146.136(c)(4) Nonquantitative treatment limitations -

(i) General rule A group health plan 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 plan 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, except to the extent that recognized clinically appropriate standards of care may permit a difference, and

(ii) Illustrative list of nonquantitative treatment limitations. Nonquantitative treatment limitations include -

(A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness.

(B) Formulary design for prescription drugs.

The Company imposed a Non-Quantitative Treatment Limitation (NQTL) based on policies J-645 and J-646, on various atypical antipsychotics (quetiapine, risperidone, and ziprasidone). The Company did not impose similar restrictions to Medical/Surgical medications.

- **6 Exceptions**
  18 Del. C. § 3343(b)(1)b Insurance coverage for serious mental illness and 18 Del. C. § 3343(b)(2)b; 45 CFR 146.136(c)(4)(i) General rule and 45 CFR 146.136 (c)(4)(ii)(A)(B)

  18 Del. C. § 3343(b)(1)b: Subject to subsections (a), (c) through (f), and (h) of this section, no carrier may issue for delivery, or deliver, in this State any health benefit plan containing terms that place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan, including terms for deductibles, co-pays, monetary limits, coinsurance factors, limits in the numbers of visits, limits in the length of inpatient stays, durational limits, or limits in the coverage of prescription medicines.

  18 Del. C. § 3343(b)(2)b: Coverage of an emergency supply of prescribed medications must include medication for opioid overdose reversal otherwise covered under the health benefit plan prescribed to a covered person.

  45 CFR 146.136(c)(4) Nonquantitative treatment limitations -

  (i) General rule A group health plan 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 plan 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, except to the

extent that recognized clinically appropriate standards of care may permit a difference, *and*

(ii) Illustrative list of nonquantitative treatment limitations. Nonquantitative treatment limitations include -

(A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness.

(B) Formulary design for prescription drugs.

The Company imposed a restrictive Nonquantitative Treatment Limitation (NQTL) on Evzio and Narcan nasal spray (vials, syringes) of 4 doses every 360 days. This policy was more stringently applied to these emergency medications and was not comparable to Medical/Surgical medications

- **6 Exceptions**
  18 Del. C. § 3343(b)(1)b Insurance coverage for serious mental illness, 18 Del. C. § 3350(b) Prescription medication; 45 CFR 146.136 (c)(4)(i) General rule and 45 CFR 146.136 (c)(4)(ii)(A),(B),(E)

  18 Del. C. § 3343(b)(1)b: Subject to subsections (a), (c) through (f), and (h) of this section, no carrier may issue for delivery, or deliver, in this State any health benefit plan containing terms that place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan, including terms for deductibles, co-pays, monetary limits, coinsurance factors, limits in the numbers of visits, limits in the length of inpatient stays, durational limits, or limits in the coverage of prescription medicines.

  18 Del. C. § 3350(b): Every policy or contract of health insurance described in subsection (a) of this section shall provide coverage for any outpatient drug prescribed to treat a covered person for a covered chronic, disabling or life-threatening illness if the drug:

  (1) Has been approved by the Food and Drug Administration for at least 1 indication; and

  (2) Is recognized for treatment of the indication for which the drug is prescribed in:

  a. A prescription drug reference compendium approved by the Insurance Commissioner for purposes of this section; or

  b. Substantially accepted peer reviewed medical literature.

  45 CFR 146.136(c)(4) Nonquantitative treatment limitations –

  (i) General rule: A group health plan (or health insurance coverage) 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 plan (or health insurance 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.

(ii) *Illustrative list of nonquantitative treatment limitations. Nonquantitative treatment limitations include —*

(A) Medical management standards limiting or excluding benefits based on medical appropriateness.

(B) Formulary design for prescription drugs).

(E) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols).

The Company's criteria in these policies are more stringently applied to these mental health medications and are not comparable to policies for Medical/Surgical medications.

- **1 Exception**
  18 *Del. C.* § 3578(b) Insurance coverage for serious mental illness
  (b) *Coverage of serious mental illness and drug and alcohol dependency. —*
  (1)a. Carriers shall provide coverage for serious mental illnesses and drug and alcohol dependencies in all health benefit plans delivered or issued for delivery in this State. Coverage for serious mental illnesses and drug and alcohol dependencies must provide:
  1. Inpatient coverage for the diagnosis and treatment of drug and alcohol dependencies.
  2. Unlimited medically necessary treatment for drug and alcohol dependencies as required by the Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a) and determined by the use of the full set of ASAM criteria, in all of the following:
  A. Treatment provided in residential setting.
  B. Intensive outpatient programs.
  C. Inpatient withdrawal management.

  The Company failed to correctly identify ASAM criteria when used with Substance Use Disorder.

- **2 Exceptions**
  18 *Del. Admin. C.* 902 § 1.2.1.5 Authority for Regulation; Basis for Regulation
  1.2.1.5. Failing to affirm or deny coverage or a claim or advise the person presenting the claim, in writing, or other proper legal manner, of the reason for the inability to do so, within 30 days after proof of loss statements have been received by the insurer.

  The Company failed to provide notice of acceptance or denial or status within 30 days for the noted claim.

SCOPE OF EXAMINATION

The Market Conduct Examination was conducted pursuant to the authority granted by 18 *Del. C.* § 318-322 and covered the experience period of January 1, 2016, through September 30, 2018, unless otherwise noted. The scope of the examination included, but was not limited to, the Company's practices and procedures relating to the following lines of business, written in Delaware: group accident and health, individual accident and health, preauthorization, complaint handling, appeals, grievances and claims to determine compliance by the Company with Delaware insurance laws and regulations related to the Company's consumer complaints, appeals and grievances and claims handling with special focus on mental health parity.

METHODOLOGY

This examination was performed in accordance with Market Regulation standards established by the Department and examination procedures suggested by the NAIC. While examiners report on the errors found in individual files, the examiners also focus on general business practices of the Company.

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.

Delaware Market Conduct Examination Reports generally note only those items to which the Department, after review, takes exception. An exception is any instance of Company activity that does not comply with an insurance statute or regulation. Exceptions contained in the Report may result in imposition of penalties. Generally, practices, procedures, or files that were reviewed by Department examiners during the course of an examination may not be referred to in the Report if no improprieties were noted. However, 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.

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 exceptions identified during the examination and to review written summaries provided on the exceptions found.

COMPANY OPERATIONS AND MANAGEMENT

Company History

The Company was originally incorporated, by the filing of a Certificate of Incorporation with the

Secretary of State on August 16, 1935, as a private non-profit, non-stock corporation and is operated as a health service corporation in the State of Delaware.

On December 30, 2011, the Delaware Commissioner approved an affiliation between Highmark Inc. and the Company (Affiliation Approval) imposing 49 conditions on the affiliation that, among other things, were intended to preserve the Company's surplus and reserves and make it possible for the Company to disaffiliate if necessary. Effective January 1, 2012, Highmark became the sole member of the Company, which thereupon changed its name to Highmark BCBSD Inc. Highmark became the primary licenses of the BCBSA for Blue Cross® and Blue Shield® Service Marks in Delaware. As the sole member of the Company, Highmark has the authority to elect the Company's Board of Directors. The Company is a separate legal entity and is not liable for Highmark's obligations. In accordance with its articles of incorporation, in the event of dissolution of the Company, the Directors shall cause any remaining assets of the Company to be distributed to a foundation created pursuant to Delaware law or to a federally tax-exempt organization.

On April 26, 2013, the Delaware Commissioner approved the indirect acquisition of the control of the Company by the Ultimate Parent Entity (UPE) if and when the PID approved the Highmark/West Penn Allegheny Health System (WPAHS) affiliation. That approval modified 5 of the 49 original conditions. The April 29, 2013 closing of the Highmark/WPAHS transaction resulted in the Company's ultimate controlling parent, UPE, later re-named Highmark Health.

The Federal Affordable Care Act (ACA) enacted significant reforms to various aspects of the U.S. health insurance industry, including the establishment of federally facilitated or state-based exchanges which provide individuals and small businesses access to affordable and quality health insurance. The Corporation participates in the Delaware health insurance exchange.

Internal Audit

The Company provided a list of 131 internal audits conducted within the last three (3) years during the exam period. Internal audits include those audits completed by an internal audit function within the company or those conducted via a contracted vendor on behalf of the company. A review of all 19 audit reports covering underwriting and claim operations and functions reveal no irregularities.

COMPLAINTS HANDLING

The Company identified 111 consumer complaints received during the experience period. Of the 111 complaints identified, 111 were forwarded from the Department. The 111 complaints files were requested, received and reviewed. The company also provided complaint logs as requested. The Department’s list of written consumer complaints that were forwarded to the Company during the experience period was compared to the Company’s complaint log.

The complaint files were reviewed for compliance with the Delaware statutes and regulations including but not limited to 18 *Del. C*. § 2304(17). This Section of the Code requires

maintenance of a complete record of all complaints received since the date of its last examination. The record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of the complaint and the time it took to process each complaint.

No exceptions were noted.

INDEPENDENT UTILIZATION REVIEW ORGANIZATION

The Company was requested to provide a list of all Independent Utilization Review Organization (IUROs) requests during the experience period. The Company identified 27 IUROs during the period. The Company is required to transmit to the DDOI all requests from consumers, or their representatives, for external reviews.

6 Exceptions – 18 *Del. C.* § 332(c)(4) Prompt response to written grievances.

The Company failed to specifically acknowledge receipt of a written grievance within 5 business days.

Recommendation: It is recommended that the Company specifically acknowledge receipt of a written grievance within 5 business days pursuant to 18 Del. Admin. C. § 332(c)(4).

1 Exception – 18 *Del. C.* § 332(c)(5)(b) Speedy review of grievances.

The Company failed to specifically render a decision of a written grievance within 30 days.

Recommendation: It is recommended that the Company specifically render a decision of a written grievance within 30 days pursuant to 18 Del. Admin. C. § 332(c)(5).

6 Exceptions – 18 *Del. Admin. C.* 1301§ 5.2 IHCAP Procedures

The Company failed to transmit the IURO request to the Department within 3 days.

Recommendation: It is recommended that the Company transmit all request for external review within 3 days pursuant to 18 Del. Admin. C. 1301§ 5.2.

GRIEVANCES AND APPEALS

A) Member Grievances and Appeals

The Company was requested to provide a list of all grievances and appeals during the experience period. The Company identified 60 grievances and appeals during the period. All 60 files were requested, received and reviewed. The Company then determined that 4 files were duplicate listings and that 5 were Administrative Service Only (ASO) files.

16 Exceptions – 18 *Del. C.* §332(c)(4) Prompt response to written grievances.

The Company failed to specifically acknowledge receipt of a written grievance within 5 business days.

Recommendation: It is recommended that the Company specifically acknowledge receipt of a written grievance within 5 business days pursuant to 18 Del. Admin. C. § 332(c)(4).

1 Exception – 18 *Del. C.* §332 (c)(5) Speedy review of grievances.

The Company failed to specifically render a decision of a written grievance within 30 days.

Recommendation: It is recommended that the Company specifically render a decision of a written grievance within 30 days pursuant to 18 Del. Admin. C. § 332(c)(5).

B) Provider Grievances and Appeals

The Company was requested to provide a list of all grievances and appeals during the experience period. The Company identified 118 grievances and appeals during the period.

32 Exceptions – 18 *Del. C.* §332(c)(4) Prompt response to written grievances.

The Company failed to specifically acknowledge receipt of a written grievance within 5 business days.

Recommendation: It is recommended that the Company specifically acknowledge receipt of a written grievance within 5 business days pursuant to 18 Del. Admin. C. § 332(c)(4).

3 Exceptions – 18 *Del. C.* §332 (c)(5) Speedy review of grievances.

The Company failed to specifically render a decision of a written grievance within 30 days.

Recommendation: It is recommended that the Company specifically render a decision of a written grievance within 30 days pursuant to 18 Del. Admin. C. § 332(c)(5).

UNDERWRITING AND RATING

The Company. provided copies of their rate filings in use during the examination period. The off-exchange and the on-exchange rates were compared using the website of https://www.healthcare.gov/ The Company was also requested to provide a listing of all individuals who were denied coverage during the examination period. The Company indicated

that it was Guaranteed Issue for the Individual Market so there were no individuals denied coverage as long as they submitted the proper documentation and effectuated their coverage.

The underwriting and rate files were reviewed for compliance with the Centers for Medicare & Medicaid Services Compliance Review Protocols and Standards and applicable Delaware Statutes.

There were no exceptions noted.

PHARAMCY REVIEW

The Company's documentation was reviewed for compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA), ACA regulations, and applicable Delaware Laws and Regulations.

The following exceptions were noted:

1 Exception - 18 Del. C. § 3343(b)(1)b Insurance coverage for serious mental illness, and 18 Del. C.§ 3350(b) Prescription medication; 45 CFR 146.136 (c)(4)(i) General rule and 45 CFR 146.136 (c)(4)(ii)(A)

The Company's excluded methadone medication treatment in 2016, 2017, and all preceding years for opioid use disorder (OUD) at outpatient/ambulatory care prior to 1/1/2018. This was a violation of both the Mental Health Parity and Addiction Equity Act (MHPAEA) and Delaware Statutes. It is noted that the exclusion was removed 01/01/2018, and the Company accepted contracts for Opioid Treatment Programs (OTP) in order to treat Opioid Use Disorder (OUD) with methadone.

Recommendation: It is recommended the company continue to allow for methadone medication treatment for opioid disorders as instituted by the Company effective 1/1/2018.

5 Exceptions - 18 Del. C. § 3343(b)(2)a Insurance coverage for serious mental illness

The Company imposed a restrictive prior authorization with a 60-day lookback on medication fills greater than a 5 day supply of buprenorphine sublingual tablets (monotherapy) for Opioid Use Disorder (OUD). This practice is in violation of this Delaware statute by preventing immediate access, without prior authorization, to a 5-day emergency supply of prescribed medications covered under the health benefit plan for the medically necessary treatment of serious mental illnesses and drug and alcohol dependencies where an emergency medical condition exist, including a prescribed drug or medication associated with the management of opioid withdrawal or stabilization.

Recommendation: It is recommended that the Company allow access to a 5 day emergency supply of prescribed medications without a prior authorization or 60 day lookback for the medically necessary treatment of serious mental illnesses and drug and alcohol dependencies

where an emergency medical condition exist, including a prescribed drug or medication associated with the management of opioid withdrawal or stabilization as per 18 Del. C. § 3343(b)(2)a.

83 Exceptions - 18 Del. C. § 3343(b)(1)b Insurance coverage for serious mental illness, 18 Del. C. § 3350(b) Prescription medication; 45 CFR 146.136 (c)(4)(i) General rule and 45 CFR 146.136 (c)(4)(ii)(A),(B),(E)

The Company's criteria in this step therapy policy on venlafaxine ER 150mg taken twice a day for a total daily dose of 300mg/day is more stringently applied and is not comparable to Medical/Surgical medications. The Company imposed a Non-Quantitative Treatment Limitations (NQTL) on venlafaxine ER 150mg capsules for the treatment of Major Depressive Disorder (MDD) by establishing two antidepressant medications in the 3 medication step therapy policy to be at the maximum effective dose before being considered a fail. The dose of 225mg of venlafaxine is required before any dose above 225mg will be approved is the third medication requiring the maximum tolerable dose before being considered a fail. Additionally, there is documentation (recommended dosage range according to the APA) stating the need for doses above 225mg/day (300mg/day or even 375mg/day) which has been determined to be safe and effective, in accordance with the patient's tolerable side effects, and the quantity and quality of clinical trial data for more severely depressed patients under the physician/provider's discretion/guidance.

Recommendation: It is recommended that the Company not impose Non-Quantitative Treatment Limitations (NQTLs) more stringently applied to mental health medications compared to Medical/Surgical medications as per 18 Del. C. § 3343(b)(1)b Insurance coverage for serious mental illness, 18 Del. C. § 3350(b) Prescription medication; 45 CFR 146.136 (c)(4)(i) General rule and 45 CFR 146.136 (c)(4)(ii)(A),(B),(E).

10 Exceptions - 18 Del. C. § 3343(b)(1)b Insurance coverage for serious mental illness; 45 CFR 146.136(c)(4)(i) General rule and 45 CFR 146.136(c)(4)(ii)(B),(E)

The Company has imposed a more restrictive Non-Quantitative Treatment Limitation (NQTL) on the step therapy guidelines for Brintellix/Trintellix, desvenlafaxine ER, Fetzima, Khedezla, Pristiq, and Viibryd for the treatment of Major Depressive Disorder (MDD). These 6 mental health medications had a lookback for target medication of a 120-day limit which was more stringently applied compared to Medical/Surgical medications which have a lookback of 180 days or greater.

Recommendation: It is recommended that the Company not impose Non-Quantitative Treatment Limitations (NQTLs) that are more restrictive or stringently applied to mental health medications compared to Medical/Surgical medications as per 18 Del. C. § 3343(b)(1)b Insurance coverage for serious mental illness; 45 CFR 146.136(c)(4)(i) General rule and 45 CFR 146.136(c)(4)(ii)(B),(E).

421 Exceptions - 18 Del. C. § 3343(b)(1)b Insurance coverage for serious mental illness; 45 CFR 146.136(c)(4)(i) General rule and 45 CFR 146.136(c)(4)(ii)(A),(B)

The Company imposed a Non-Quantitative Treatment Limitation (NQTL) based on policies J-645 and J-646, on various atypical antipsychotics (quetiapine, risperidone, and ziprasidone). These mental health medications were restricted to one tablet per day when each medication is dosed either once, twice, or three times a day (quetiapine). The Company did not impose similar restrictions to Medical/Surgical mediations.

Recommendation: It is recommended that the Company not impose Non-Quantitative Treatment Limitations (NQTLs) that are more stringently applied to mental health medications compared to Medical/Surgical medications as per 18 Del. C. § 3343(b)(1)b Insurance coverage for serious mental illness; 45 CFR 146.136(c)(4)(i) General rule and 45 CFR 146.136(c)(4)(ii)(A),(B).

6 Exceptions - 18 Del. C. § 3343(b)(1)b Insurance coverage for serious mental illness and 18 Del. C. § 3343(b)(2)b; 45 CFR 146.136(c)(4)(i) General rule and 45 CFR 146.136 (c)(4)(ii)(A)(B)

The Company imposed a restrictive Nonquantitative Treatment Limitation (NQTL) on Evzio and Narcan nasal spray (vials, syringes) of 4 doses every 360 days. According to polices J-645 and J-646, the Company has a nonquantitative treatment limitation (NQTL) of 4 doses every 360 days on these medications which creates a barrier to emergency treatment on these medications, and the Company failed to identify where this policy was clinically based off of. This policy was more stringently applied to these emergency medications for opioid overdose, and was not comparably applied to Medical/Surgical medications.

Recommendation: It is recommended that the Company not impose Non-Quantitative Treatment Limitations (NQTLs) that are more stringently applied to substance abuse medications compared to Medical/Surgical medications as per 18 Del. C. § 3343(b)(1)b Insurance coverage for serious mental illness and 18 Del. C. § 3343(b)(2)b; 45 CFR 146.136(c)(4)(i) General rule and 45 CFR 146.136 (c)(4)(ii)(A)(B).

UTILIZATION REVIEW

The Company provided a list of all DE (non-exchange) utilization reviews processed during the experience period. The examiners reviewed a sample of Utilization Reviews (URs) for both approved and denied claims.

6 Exceptions - 18 Del. C. § 3343(b)(1)b Insurance coverage for serious mental illness, 18 Del. C. § 3350(b) Prescription medication; 45 CFR 146.136 (c)(4)(i) General rule and 45 CFR 146.136 (c)(4)(ii)(A),(B),(E)

ACA Mental Health/Substance Use Disorder Denied Claims (4)
DE Mental Health/Substance Use Disorder Denied Claims (2)

The Company's criteria in this step therapy policy for this dose on venlafaxine ER 150mg taken twice a day is more stringently applied and is not comparable to the Medical/Surgical medications mentioned based on two sample claims. Additionally, the Company's medical management standards limiting or excluding benefits based on medical appropriateness concerning once a day dosing on quetiapine, risperidone, and ziprasidone places a dosing restriction on these medications based on four sample claims. These medications are dosed at once, twice, and three times a day, and the Company did nott restrict Medical/Surgical medications to the same standard.

Recommendation: It is recommended that the Company's criteria for these pharmaceuticals be no more stringent applied to mental health medications compared to Medical/Surgical pharmaceuticals as per 18 Del. C. § 3343(b)(1)b Insurance coverage for serious mental illness, 18 Del. C. § 3350(b) Prescription medication; 45 CFR146.136 (c)(4)(i) General rule and 45 CFR 146.136 (c)(4)(ii)(A),(B),(E)

1 Exception – 18 *Del. C.* § 3578(b) Insurance coverage for serious mental illness

The Company failed to correctly identify ASAM criteria when used with Substance Use Disorder in accordance with 18 *Del. C.* § 3578(b) Insurance coverage for serious mental illness**,** and as required by the Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a.

*Recommendation**:*** It is recommended that the Company utilize the correct criteria guidelines when Substance Use Disorder is involved pursuant to 18 Del. C. § 3578(b).

2 Exceptions – 18 Del. Admin. C. 902 §1.2.1.5

The Company failed to provide notice of acceptance or denial or status within 30 days for the noted claim.

Recommendation: It is recommended that the Company provide a notice of acceptance or denial or status within 30 days pursuant to 18 Del. Admin. C. 902 § 1.2.1.5.

CONCLUSION

The recommendations made below identify corrective measures the Department finds necessary as a result of the Exceptions noted in the Report. Location in the Report is referenced in parenthesis.

1. It is recommended that the Company specifically acknowledge receipt of a written grievance within 5 business days pursuant to 18 Del. Admin. C. § 332(c)(4). *(Member Grievances and Appeals; Provider Grievances and Appeals; IUROs)*

2. It is recommended that the Company specifically render a decision of a written grievance within 30 days pursuant to 18 Del. Admin. C. § 332(c)(5). *(Member Grievances and Appeals; Provider Grievances and Appeals; IUROs)*

3. It is recommended that the Company transmit all request for external review within 3 days pursuant to 18 Del. Admin. C. 1301§ 5.2. *(IURO)*

4. It is recommended the company continue to allow for methadone medication treatment for opioid disorders as instituted by the Company effective 1/1/2018. 18 Del. C. § 3343(b)(1)b Insurance coverage for serious mental illness, and 18 Del. C.§ 3350(b) Prescription medication; 45 CFR 146.136 (c)(4)(i) General rule and 45 CFR 146.136 (c)(4)(ii)(A) *(Pharmacy)*

5. It is recommended that the Company allow access to a 5 day emergency supply of prescribed medications without a prior authorization or 60 day lookback for the medically necessary treatment of serious mental illnesses and drug and alcohol dependencies where an emergency medical condition exist, including a prescribed drug or medication associated with the management of opioid withdrawal or stabilization as per 18 Del. C. § 3343(b)(2)a. *(Pharmacy)*

6. It is recommended that the Company not impose Non-Quantitative Treatment Limitations (NQTLs) that are more restrictive or stringently applied to mental health medications compared to Medical/Surgical medications as per 18 Del. C. § 3343(b)(1)b Insurance coverage for serious mental illness, 18 Del. C. § 3350(b) Prescription medication; 45 CFR 146.136 (c)(4)(i) General rule and 45 CFR 146.136 (c)(4)(ii)(A),(B),(E). *(Pharmacy)*

7. It is recommended that the Company not impose Non-Quantitative Treatment Limitations (NQTLs) that are more stringently applied to mental health medication compared to Medical/Surgical medications as per 18 Del. C. § 3343(b)(1)b Insurance coverage for serious mental illness; 45 CFR 146.136(c)(4)(i) General rule and 45 CFR 146.136(c)(4)(ii)(B),(E). *(Pharmacy)*

8. It is recommended that the Company not impose Non-Quantitative Treatment Limitations (NQTLs) that are more stringently applied to substance abuse medications compared to Medical/Surgical medications as per 18 Del. C. § 3343(b)(1)b Insurance coverage for serious

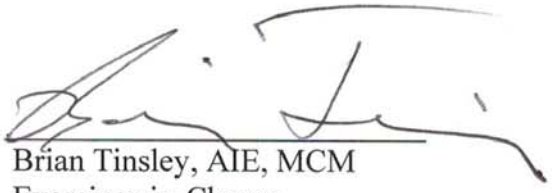
mental illness; 45 CFR 146.136(c)(4)(i) General rule and 45 CFR 146.136(c)(4)(ii)(A),(B). *(Pharmacy)*

9. It is recommended that the Company's criteria for these pharmaceuticals be no more stringently applied to mental health medications compared to Medical Surgical pharmaceuticals as per 18 Del. C. § 3343(b)(1)b Insurance coverage for serious mental illness, 18 Del. C. § 3350(b) Prescription medication; 45 CFR 146.136 (c)(4)(i) General rule and 45 CFR 146.136 (c)(4)(ii)(A),(B),(E). *(DE and ACA MH/SUD Denied Claims / Utilization Review).*

10. It is recommended that the Company utilize the correct criteria guidelines when Substance Use Disorder is involved pursuant to 18 Del. C. § 3578(b). *(Utilization Review)*

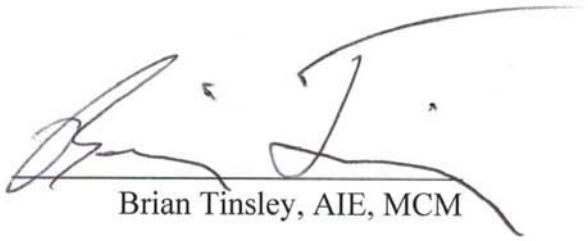
11. It is recommended that the Company provide a notice of acceptance or denial or status within 30 days pursuant to 18 Del. Admin. C. 902 § 1.2.1.5. *(Utilization Review)*

The examination conducted by Joseph Krug, Brian Tinsley, Kirk Stephan and Pete Salvatore is respectfully submitted.



Brian Tinsley, AIE, MCM
Examiner-in-Charge
Market Conduct
Delaware Department of Insurance

I, Brian Tinsley, hereby verify and attest, under penalty of perjury, that the above is a true and correct copy of the examination report and findings submitted to the Delaware Department of Insurance pursuant to examination authority 53287-ACA-18-967.



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