DELAWARE DEPARTMENT OF INSURANCE

MARKET CONDUCT EXAMINATION REPORT

Cigna Health and Life Insurance Company

NAIC #67369
900 Cottage Grove Road
Bloomfield, CT 06152-5026

As of

June 30, 2019

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Honorable Trinidad Navarro
Insurance Commissioner
State of Delaware
1351 West North Street, Suite #101
Dover, Delaware 19904

Dear Commissioner Navarro:

In compliance with the instructions contained in Exam Authority #67369-MHP-19-717, and pursuant to statutory provisions including 18 *Del. C*. §§ 318-322, a market conduct examination has been conducted of the affairs and practices of:

Cigna Health and Life Insurance Company #67369

The exam was performed off-site. 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 Company's main administrative offices are located in Bloomfield, CT.

The examination was announced as part of a series of examinations on companies in the health insurance marketplace in Delaware. The examination focused on Cigna Health and Life Insurance Company's (Company or CHLIC) 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. 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.

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 $40,884,103.

There were no exceptions in the Company Operations and Management, Forms, and eviCore Paid Claims sections. Producer Licensing and Policyholder Services were not requested, thus not reviewed. Exceptions were noted in the Complaint Handling, Underwriting & Rating, Claims, Utilization Review and Pharmacy review sections of the examination. Pharmacy exceptions are noted in two different types of exception count. In some instances, an exception with a formulary was noted, but the number of consumers affected could not be determined due to system and examinations limitations. In those cases, the problem with the system was noted as a single exception and it is recommended the system be revised. In other Pharmacy exceptions a specific number of violations could be determined and are noted. In both cases, the Company is recommended to revise their related systems.

The following exceptions were noted:

- **48 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.

- **20 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.

- **127 Exceptions**
  18 *Del. Admin. C.* 902 § 1.2.1.2 Authority for Regulation; Basis for Regulation
  1.2.1.2. Failing to acknowledge and respond within 15 working days, upon receipt by the insurer, to communications with respect to claims by insureds arising under insurance policies.

  The Company failed to acknowledge and respond within 15 days to communications with respect to claims by insureds arising under insurance policies.

- **23 Exceptions**
  18 *Del. Admin. C.* 1301 § 5.0 IHCAP Procedure
  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 send requests for Independent Utilization Reviews (IURO's) within 3 business days.

- **39 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.

- **41 Exceptions**
  18 *Del. Admin. C.* 1310 § 6.0 Processing of Clean Claim
  6.1 No more than 30 days after receipt of a clean claim from a provider or policyholder, a carrier shall take one of the following four actions:
  6.1.1 if the entire claim is deemed payable, pay the total allowed amount of the claim;

6.1.2 if a portion of the claim is deemed payable, pay the allowable portion of the claim that is deemed payable and specifically notify the provider or policyholder in writing why the remaining portion of the claim will not be paid;
6.1.3 if the entire claim is deemed not payable, specifically notify the provider or policyholder in writing why the claim will not be paid;
6.1.4 if the carrier needs additional information from a provider or policyholder who is submitting the claim to determine the propriety of payment of a claim, the carrier shall request in writing that the provider or policyholder provide documentation that is relevant and necessary for clarification of the claim.

The Company failed to specifically notify the provider or policyholder in writing why the claim will not be paid within 30 days.

- **9 Exceptions**
  18 Del. C. § 3570A(a) Autism spectrum disorder coverage
  (a) All group and blanket health benefit plans as defined in § 3578(a) of this title shall provide coverage for the screening and diagnosis of autism spectrum disorders and the treatment of autism spectrum disorders in individuals less than 21 years of age. To the extent that the diagnosis of autism spectrum disorders and the treatment of autism spectrum disorders are not already covered by a health benefit plan, coverage under this section shall be included in health benefit plans that are delivered, issued, executed or renewed in this State pursuant to this title after December 11, 2012. No insurer shall terminate coverage or refuse to deliver, execute, issue, amend, adjust, or renew coverage to a group solely because an individual in that group or a family member of an individual in that group is diagnosed with 1 of the autism spectrum disorders or has received treatment for autism spectrum disorders. Coverage under this section shall not be denied on the basis that the treatment is habilitative or nonrestorative in nature.

  The Company failed to correctly cover a mandated treatment as required by 18 Del. C. § 3570A.

- **21 Exceptions**
  45 *CFR* § 146.136(c)(4)(i)(ii)(A) Parity in mental health and substance use disorder benefits.
  (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 necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

The Company failed to treat Mental Health Substance Use Disorder claims similar to Medical Surgical claims by imposing a Non-Quantitative Treatment Limitation. The plan does not cover a long and short acting ADHD medication without a utilization review, in order to obtain a doctor's authorization.

- **18 Exception**
  18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 *CFR* § 146.136(c)(4)(i) and 45 CFR 146.136(c)(4)(ii)(A) Parity in mental health and substance use disorder benefits.
  18 Del. C. § 3578(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.*
  and
  45 CFR 146.136(c)(4)(i)
  (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.
  and
  45 CFR 146.136(c)(4)(ii)(A)
  (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, or based on whether the treatment is experimental or investigative;

  The Company failed to treat Mental Health Substance Use Disorder claims similar to Medical Surgical claims by imposing a Non-Quantitative Treatment Limitation. The plan requires a utilization review in order to obtain a doctor's authorization for the member to take two different strengths of the same medication.

- **1 Exception**
  18 Del. C. § 3556(i)(2) Obstetrical and gynecological coverage.
  (i)(2) All group and blanket health insurance policies, contracts, or certificates that are delivered, issued for delivery, renewed, extended, or modified in this State by any health insurer, health service corporation, or health maintenance organization and that provide for medical or hospital expenses shall include coverage for fertility care services, including in vitro fertilization services for individuals who suffer from a disease or condition that results in the inability to procreate or to carry a pregnancy to live birth and standard fertility preservation services for individuals who must undergo medically necessary treatment that may cause iatrogenic infertility. Such benefits must be provided to covered individuals, including covered spouses and covered nonspouse dependents, to the same extent as other pregnancy-related benefits and include the following:
  a. Intrauterine insemination.
  b. Assisted hatching.
  c. Cryopreservation and thawing of eggs, sperm, and embryos.
  d. Cryopreservation of ovarian tissue.
  e. Cryopreservation of testicular tissue.
  f. Embryo biopsy.
  g. Consultation and diagnostic testing.
  h. Fresh and frozen embryo transfers.
  i. Six completed egg retrievals per lifetime, with unlimited embryo transfers in accordance with the guidelines of the American Society for Reproductive Medicine, using single embryo transfer ("SET") when recommended and medically appropriate.
  j. In vitro fertilization ("IVF"), including IVF using donor eggs, sperm, or embryos, and IVF where the embryo is transferred to a gestational carrier or surrogate.
  k. Intra-cytoplasmic sperm injection ("ICSI").
  l. Medications.
  m. Ovulation induction.
  n. Storage of oocytes, sperm, embryos, and tissue.
  o. Surgery, including microsurgical sperm aspiration.
  p. Medical and laboratory services that reduce excess embryo creation through egg cryopreservation and thawing in accordance with an individual's religious or ethical beliefs.

  The Company failed to provide coverage for infertility claims and pharmaceutical claims after the effective date of the law or renewal of a contract after the effective date of the law (June 30, 2018). The mandated coverage for infertility was not loaded into the system until 7/31/19. The Company failed to approve the noted claims as required by 18 Del. C. § 3556(i)(2) between June 30, 2018 and July 31, 2019.

- **1 Exception**
  18 Del. C. § 3556(i)(4) Obstetrical and gynecological coverage.
  (i)(4) A policy, contract, or certificate may not impose any exclusions, limitations, or other restrictions on coverage of fertility medications that are different from those imposed on

any other prescription medications, nor may it impose deductibles, copayments, coinsurance, benefit maximums, waiting periods, or any other limitations on coverage for required fertility care services, which are different from those imposed upon benefits for services not related to infertility.

The Company failed to provide coverage for infertility claims and pharmaceutical claims after the effective date of the law or renewal of a contract after the effective date of the law (June 30, 2018). The mandated coverage for infertility was not loaded into the system until 7/31/19. The Company failed to approve the noted claims as required by 18 Del. C. § 3556(i)(2) between June 30, 2018 and July 31, 2019.

- **8 Exceptions**
  18 Del. C. § 3583(a) Utilization review entity's obligations with respect to pre-authorizations in nonemergency circumstances.
  (a) If a utilization review entity requires pre-authorization of a pharmaceutical, the utilization review entity must complete its process or render an adverse determination and notify the covered person's health-care provider within 2 business days of obtaining a clean pre-authorization or of using services described in § 3377 of this title.

  The Company failed to complete its process or render an adverse determination and notify the provider within 2 business days.

- **1 Exception**
  18 Del. C. § 3583(b) Utilization review entity's obligations with respect to pre-authorizations in nonemergency circumstances.
  (b) If a utilization review entity requires pre-authorization of a health-care service, the utilization review entity must grant a pre-authorization or issue an adverse determination and notify the covered person's healthcare provider of the determination within 8 business days of receipt of a clean pre-authorization not submitted through electronic pre-authorization. For purposes of this subsection, a clean pre-authorization includes the results of any face-to-face clinical evaluation or second opinion that may be required.

  The Company failed to complete its process or render an adverse determination and notify the provider within 8 business days for non-electronic pre-authorization requests.

- **3 Exceptions**
  18 Del. C. § 3586(a) Length of pre-authorization.
  (a) A pre-authorization for pharmaceuticals shall be valid for 1 year from the date the health-care provider receives the pre-authorization, subject to confirmation of continued coverage and eligibility and to policy changes validly delivered as per § 3582 of this title and except as otherwise set by evidence-based treatment protocol.

  The Company failed to provide pre-authorization for pharmaceuticals valid for 1 year.

- **3 Exceptions**
  18 Del. C. § 3586(b) Length of pre-authorization.
  (b) A pre-authorization for a health-care service shall be valid for a period of time that is reasonable and customary for the specific service, but no less than 60 days, from the date the health-care provider receives the pre-authorization, subject to confirmation of continued coverage and eligibility and to policy changes validly delivered as per § 3582 of this title.

  The Company failed to provide pre-authorization for pharmaceuticals valid for not less than 60 days.

- **1 Exception**
  18 Del. C. § 3578(d)(1)(c) Insurance coverage for serious mental illness.
  (d) Benefit management. —
  (1) A carrier may, directly or by contract with another qualified entity, manage the benefit prescribed by subsection (b) of this section in order to limit coverage of services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency to those services that are deemed medically necessary as follows:
  a. The management of benefits for serious mental illnesses and drug and alcohol dependencies may be by methods used for the management of benefits provided for other medical conditions or may be by management methods unique to mental health benefits. Such may include, by way of example and not limitation, pre-admission screening, prior authorization of services, utilization review and the development and monitoring of treatment plans.
  b. A carrier may not impose precertification, prior authorization, pre-admission screening, or referral requirements for the diagnosis and medically necessary treatment, including in-patient treatment, of drug and alcohol dependencies.
  c. The benefit prescribed by paragraph (b)(1) of this section may not be subject to concurrent utilization review during the first 14 days of any inpatient admission to a facility approved by a nationally recognized health-care accrediting organization or the Division of Substance Abuse and Mental Health, 30 days of intensive outpatient program treatment, or 5 days of inpatient withdrawal management, provided that the facility notifies the carrier of both the admission and the initial treatment plan within 48 hours of the admission. The facility shall perform daily clinical review of the patient, including the periodic consultation with the carrier to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the carrier which is designated by the American Society of Addiction Medicine ("ASAM") or, if applicable, any state-specific ASAM criteria, and appropriate to the age of the patient, to ensure that the inpatient treatment is medically necessary for the patient.

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

- **2 Exceptions**
  18 Del. C. § 3583(c) Utilization review entity's obligations with respect to pre-authorizations in nonemergency circumstances.
  (c) If a utilization review entity requires pre-authorization of a health-care service, the utilization review entity must grant a pre-authorization or issue an adverse determination and notify the covered person's healthcare provider of the determination within 5 business days of receipt of a clean pre-authorization through electronic pre-authorization. For purposes of this subsection, a clean pre-authorization includes the results of any face-to-face clinical evaluation or second opinion that may be required.

  The Company failed to complete its process or render an adverse determination and notify the provider within 5 business days for electronic pre-authorizations requests.

- **1 Exception**
  18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 *CFR* § 146.136(c)(4)(i)(ii)(A)(B)(E) Parity in mental health and substance use disorder benefits.
  18 Del. C. § 3578(b)(1)(b).
  (b) Subject to subsections (a) and (c) through (g) 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. By way of example, such terms include 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.
  and
  45 CFR 146.136(c)(4)(i)(ii)
  (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 failed by having a quantity limitations restriction is more stringently applied on this substance abuse medication than for medical surgical quantity limitations.

- **1 Exception**
  18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 CFR 146.136 (c)(4)(i) Parity in mental health and substance use disorder benefits.
  18 Del. C. § 3578(b)(1)(b)
  (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.
  and
  45 CFR 146.136(c)(4)(i)
  (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.

  The Company had a step therapy limitation on two mental health medications based on a limitation of depression diagnosis only on form 1109. The Company removed the language on its form 1109 stating "Limited to depression diagnosis only" in 2018. These two medications, Cymbalta and Irenka, also share MED/SURG FDA approved indications that don't have the same step therapy limitation applied. Although the Company stated that they used the same processes and strategies when applying this NQTL to all medications in step therapy policy 1109, restricting both of these medications with a step therapy limitation only on their mental health indication and not their MED/SURG indications is not comparable and is more stringently applying this limitation.

- **1 Exception**
  45 CFR 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits.
  (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.

The Company has step therapy polices (1109, 1801, 1802, and 1803) with no age exemption (age inclusion) on members who are prescribed medications for ADHD under 18 years old. This is the only medication classification with this age limitation included in these step therapy policies despite the Company stating they used the same factors and strategies when developing these polices. Every NQTL must be comparable and no more stringently applied regarding MH/SUD medications compared to MED/SURG medications to be in compliance with MHPAEA.

- **1 Exception**
  18 Del. C. § 3580(d) Specialty tier prescription coverage:
  (d) A health plan that provides coverage for prescription drugs shall be prohibited from placing all drugs in a given class of drugs on a specialty tier.

  The Company placed all drugs in a given class of drugs on a specialty tier (tier 4) on various formularies. Formularies are an extension of the health plan and provide tier information to members whereas this information is not found anywhere else. All formularies within the scope of this exam are documents available to consumers/members and should be in compliance with this statute.

- **1 Exception**
  18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 CFR 146.136 (c)(4)(i) Parity in mental health and substance use disorder benefits.
  18 Del. C. § 3578(b)(1)(b)
  (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.*
  and
  45 CFR 146.136(c)(4)(i)
  (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.

The Company imposed a prior authorization and formulary exclusion on various formularies on Vyvanse. Vyvanse is understood as the only medication indicated for Binge Eating Disorder (BED) as per the Company, placing any treatment limitation or formulary exclusion has to be comparable and not more stringently applied compared to MED/SURG medications.

- **1 Exception**
  18 Del. C. § 3566(b) Prescription medication.
  (a) This section applies to every group or blanket policy or contract of health insurance, including each policy or contract issued by a health service corporation, which is delivered or issued for delivery in this State and which provides coverage for outpatient prescription drugs.
  (b) Every group or blanket 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.
  (c) Coverage of a drug required by this section shall include coverage of medically necessary services associated with administration of the drug.

  The Company excluded Vyvanse on various formularies. Binge eating disorder (BED) is a chronic, disabling or life-threatening illness, and Vyvanse has been approved by the Food and Drug administration for at least 1 indication, and is recognized for treatment of the indication for which the drug is prescribed in. Binge eating disorder was a covered benefit during the exam period, therefore the medications used to BED have to be included for coverage based on this statute.

- **1 Exception**
  18 Del. C. § 3556(i)(4) Obstetrical and gynecological coverage
  (i)(4) A policy, contract, or certificate may not impose any exclusions, limitations, or other restrictions on coverage of fertility medications that are different from those imposed on any other prescription medications, nor may it impose deductibles, copayments, coinsurance, benefit maximums, waiting periods, or any other limitations on coverage for required fertility care services, which are different from those imposed upon benefits for services not related to infertility.

  Formularies are an extension of the health plan and provide information such as tier placement and treatment limitations to members not found in the member's plan documents. The Company imposed exclusions, limitations, or other restrictions on coverage of fertility medications that are different from those imposed on other prescription medications. All formularies included in the scope of this exam are

documents available to consumers/members, as an information resource, and should be designed in compliance with the statute.

- **1 Exception**
  18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 CFR 146.136 (c)(4)(i) Parity in mental health and substance use disorder benefits.
  18 Del. C. § 3578(b)(1)(b)
  (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.
  and
  45 CFR 146.136(c)(4)(i)
  (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.

  When designing the step therapy requirement on all medications in 1109, 1801, 1802, and 1803 policies, error code 147 triggers on concomitant antidepressant treatment within a 5-day window resulting in the policy being more discriminatory towards antidepressant medications. Based on common prescribing practices of antidepressant medications, error code 147 is applied more stringently and not comparable to MED/SURG medications in these policies.

- **1 Exception**
  45 *CFR* § 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits.
  (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.

  When designing the step therapy requirement on all medications in 1109, 1801, 1802,

and 1803 policies, error code 147 triggers on concomitant ADHD medication treatment within a 5-day window resulting in the policy being more discriminatory towards ADHD medications. Based on common prescribing practices of ADHD medications, error code 147 is applied more stringently and not comparable to MED/SURG medications in these policies.

- **1 Exception**
  18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 *CFR* § 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits.
  18 Del. C. § 3578(b)(1)(b)
  (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.
  and
  45 CFR 146.136(c)(4)(i)
  (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.

  The Company placed all brand name antidepressants on a non-preferred tier (tier 3) compared to MED/SURG medications/categories that offered brands on the preferred tier (tier 2). Despite the Company stating they used the same factors, all brand name antidepressants were placed in higher tiers/non-preferred tiers (tier 3), while many MED/SURG brand name medications/categories were placed on the preferred tier (tier 2) which is not comparable and more stringently applying tier placement to brand name antidepressants. This is discriminatory to all members prescribed and taking any brand name antidepressant resulting in higher copays/tier placement compared to many brand name MED/SURG medications/categories offered in a lower cost sharing tier.

- **1 Exception**
  18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 *CFR* § 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits.
  18 Del. C. § 3578(b)(1)(b)

(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.
and
45 CFR 146.136(c)(4)(i)
(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.

The Company placed all brand name antipsychotics on a non-preferred tier (tier 3) compared to many MED/SURG medications/categories that offered brands on the preferred tier (tier 2). Despite the Company stating they used the same factors, all brand name antipsychotics were placed in higher tiers/non-preferred tiers (tier 3), while many MED/SURG brand name medications/categories were placed on the preferred tier (tier 2) which is not comparable and more stringently applying tier placement to brand name antipsychotics. This is discriminatory to all members prescribed and taking a brand name antipsychotic resulting in higher copays/tier placement compared to brand name MED/SURG medications/categories offered in a lower cost sharing tier.

- **1 Exception**
  45 *CFR* § 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits.
  (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.

  When designing the step therapy requirement on all medications in 1109, 1801, 1802, and 1803 policies, error code 147 triggers on concomitant antipsychotic medication treatment within a 5-day window resulting in the policy being more discriminatory towards antipsychotic medications. Based on common prescribing practices of

antipsychotic medications, error code 147 is applied more stringently and not comparable to MED/SURG medications in these policies.

- **1 Exception**
  45 *CFR* § 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits.
  (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.

  The Company placed all brand name ADHD medications on a non-preferred tier (tier 3) compared to many MED/SURG medications/categories that offered brands on the preferred tier (tier 2). Despite the Company stating they used the same factors, all brand name ADHD medications were placed in higher tiers/non-preferred tiers (tier 3), while many MED/SURG brand name medications/categories were placed on the preferred tier (tier 2) which isn't comparable and more stringently applying tier placement to brand name ADHD medications. This is discriminatory to all members prescribed and taking a brand name ADHD medication resulting in higher copays/tier placement compared to many brand name MED/SURG medications/categories offered in a lower cost sharing tier.

- **1 Exception**
  18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 *CFR* § 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits.
  18 Del. C. § 3578(b)(1)(b)
  (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.
  and
  45 CFR 146.136(c)(4)(i)
  (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.

It is discriminatory to limit buprenorphine/naloxone 2mg/0.5mg and 8mg/2mg (both brand and generic) to 2 films per day used for substance abuse when its dosage guidelines or evidentiary standards allow for doses such as 6mg/1.5mg or 3 films a day of the 2mg/0.5mg dose, or a maximum dose of 24mg/6mg (3 films a day of the 8mg/2mg dose) when there is no commercially available dose at these strengths. Compared to MED/SURG film medications included in the provided spreadsheet and 1201 forms, MED/SURG film medications were dosed and given quantity limits based on FDA approved labeling on appropriate dosing and safe medication use whereas buprenorphine/naloxone film formulations were limited based on arbitrary default quantity limits set by the Company which is discriminatory towards these substance abuse medications.

- **1 Exception**
  18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 *CFR* § 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits.
  18 Del. C. § 3578(b)(1)(b)
  (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.
  and
  45 CFR 146.136(c)(4)(i)
  (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.

  From 1/1/2017 to 2/1/2017, all strengths of Bunavail were also restricted to 1 film per day based on the film dosage spreadsheet the Company provided which is against evidentiary standards for this medication. Compared to MED/SURG film medications included in the provided spreadsheet and 1201 forms, MED/SURG film medications were dosed and given quantity limits based on FDA approved labeling on appropriate dosing and safe medication use whereas buprenorphine/naloxone film formulations were limited based on arbitrary default quantity limits set by the Company which is

discriminatory towards these substance abuse medications.

- **1 Exception**
  18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 *CFR* § 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits.
  18 Del. C. § 3578(b)(1)(b)
  (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.
  and
  45 CFR 146.136(c)(4)(i)
  (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.

  The Company placed all brand name smoking cessation medications on a non-preferred tier (tier 3) compared to many MED/SURG medications/categories that offered brands on the preferred tier (tier 2). Despite the Company stating they used the same factors, all brand name smoking cessation medications were placed in higher tiers/non-preferred tiers (tier 3), while many MED/SURG brand name medications/categories were placed on the preferred tier (tier 2) which is not comparable and more stringently applying tier placement to brand name smoking cessation medications. This is discriminatory to all members prescribed and taking a brand name smoking cessation medication resulting in higher copays/tier placement compared to many brand name MED/SURG medications/categories offered in a lower cost sharing tier.

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, 2017, through June 30, 2019, unless otherwise noted. The examination will review the Company's activities related to health insurance. Attention will be focused on the Company's compliance with Delaware statutes, rules and regulations. Functional areas to be reviewed include Company Operations and Management, Forms, Complaint/Grievance/Appeals Handling, Policyholder Services, Underwriting and Rating,

Claims, Provider Relationships, Utilization Review, Pharmacy Review and compliance with all aspects of Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). If other issues are identified during the course of the examination, the examination may be expanded. The Company will be notified in writing should that occur.

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 in the state of Florida as Orange State Life Insurance Company on May 2, 1963. In 1994, the Company re-domesticated to Ohio. In 1995, the Company became a wholly owned subsidiary of Anthem Insurance Companies, Inc., a subsidiary of Anthem Companies, Inc. In 1996, the Company re-domesticated to Indiana and changed its name to Anthem Health & Life Insurance Company.

On July 8, 1998, the Company became a wholly owned subsidiary of Great-West Life & Annuity Insurance Company, a Colorado-domiciled life insurance company. Power Corporation of Canada, a publicly traded, Montréal-based financial service company was the Company's ultimate parent.

On June 15, 1999, the Company changed its name to Alta Health & Life Insurance Company (AHL).

On April 1, 2008, Connecticut General Life Insurance Company (CGLIC), an indirect, wholly owned subsidiary of Cigna Corporation (Cigna), acquired the healthcare division of Great-West Life & Annuity Insurance Company through a fully assumed indemnity reinsurance agreement. This acquisition included AHL, which became a direct, wholly owned subsidiary of CGLIC.

On March 3 and 5, 2010, respectively, AHL re-domesticated from Indiana to Connecticut and changed its name to Cigna Health and Life Insurance Company (CHLIC).

On August 31, 2012, CHLIC acquired the Great American Supplemental Benefits Group from American Financial Group. As part of this purchase agreement, CHLIC acquired Loyal American Holding Corporation, an Ohio corporation, and Ceres Sales, LLC, a Delaware limited liability company.

CHLIC's principal products include group health benefit plans and professional services provided to employers and other groups. The Company is domiciled in the state of Connecticut and licensed in all 50 states, the District of Columbia, Puerto Rico, and the U.S Virgin Islands.

According to the Schedule T of their 2018 annual statement for the State of Delaware, the Company reported accident and health insurance premiums, including policy, membership and other fees of $53,814,268.

Internal Audit

The Company provided a list of 14 internal audits conducted within the last five (5) years. 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 14 audit reports covering underwriting and claim operations and functions reveal no irregularities.

COMPLAINTS HANDLING

The Company identified 45 consumer complaints received during the experience period. Of the 45 complaints identified 7 were forwarded from the Department. The remaining 38 complaint 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 Company also identified 2,718 appeals/grievances which consisted of appeals upheld (1,716) and appeals overturned (1,002).

In addition, the Company was requested to provide a list of all Independent Utilization Review Organization (IUROs) requests during the experience period. The Company identified 43 IUROs during the period. The Company is required to transmit to the DDOI all requests from consumers, or their representatives, for external reviews.

All the complaints, appeals and grievances were reviewed in accordance with Delaware law, regulations and bulletins.

The following exceptions were noted:

48 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).

Company Name: Cigna MHP	Sample size	Exceptions
Appeals Upheld	114	33
Appeals Overturned	113	15
Totals	**227**	**48**

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

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

Company Name: Cigna MHP	Sample size	Exceptions
Appeals Upheld	114	12
Appeals Overturned	113	8
Totals	**227**	**20**

2 Exceptions – 18 Del. Admin. C. 902 § 1.2.1.2

The Company failed to acknowledge and respond within 15 days to communications with respect to claims by insureds arising under insurance policies.

Recommendation: It is recommended that the Company specifically respond to claims by the insured within 15 days pursuant to 18 Del. Admin. C. 902 § 1.2.1.2.

Company Name: Cigna MHP	Sample size	Exceptions
Complaints	46	2
Totals	**46**	**2**

23 Exceptions – 18 Del. Admin. C. 1301 § 5.0

The Company failed to send requests for IUROs within 3 business days.

Recommendation: It is recommended that the Company specifically send claims for IURO to the Department within 3 business days pursuant to 18 Del. Admin. C. 1301 § 5.0.

Company Name: Cigna MHP	Sample size	Exceptions
IUROs	43	23
Totals	**43**	**23**

UNDERWRITING AND RATING

The Company provided documentation for underwriting and rating. The examiners reviewed documents pertaining to: mandated disclosures; rebating, commission cutting and inducements; non-discrimination; renewability; cancellations and non-renewals; HIPAA, COBRA and several other categories. The documents were reviewed for compliance with Delaware statutes, regulations and bulletins.

No exceptions were noted.

CLAIMS

The Company utilizes several platforms (systems) in the processing of claims. These platforms consisted of the Diamond, CCX, eviCore, ASH, CHM, and GHB (Overseas). Random samples of claims were requested from each of the platforms and reviewed in accordance with Delaware laws, regulations and bulletins.

The following exceptions were noted:

Paid Medical Claims

23 Exceptions – 18 Del. Admin. C. 902 § 1.2.1.2 Authority for Regulation; Basis for Regulation

The Company failed to acknowledge and respond within 15 days to communications with respect to claims by insureds arising under insurance policies.

Recommendation: It is recommended that the Company specifically respond to claims by the insured within 15 days pursuant to 18 Del. Admin. C. 902 § 1.2.1.2.

Company Name: Cigna MHP	Sample size	Exceptions
Paid Medical Claims Diamond Platform	109	2
Paid Medical Claims eviCore Platform	109	1
Paid Medical Claims CCX Platform	109	10
Paid Medical Claims CHLIC Platform	109	1
Paid Overseas Medical Claims Platform	116	9
Totals	552	23

15 Exceptions – 18 Del. Admin. C. 902 § 1.2.1.5 Authority for Regulation; Basis for Regulation

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.

Company Name: Cigna MHP	Sample size	Exceptions
Paid Medical Claims Diamond Platform	109	1
Paid Medical Claims CCX Platform	109	13
Paid Medical Claims CHLIC Platform	109	1
Totals	327	15

15 Exceptions – 18 Del. Admin. C. 1310 § 6.0 Processing of Clean Claim

The Company failed to notify the provider or policyholder in writing why the claim will not be paid within 30 days.

Recommendation: It is recommended that the Company process all claims in accordance with 18 Del. Admin. C. 1310 § 6.0.

Company Name: Cigna MHP	Sample size	Exceptions
Paid Medical Claims Diamond Platform	109	1
Paid Medical Claims CCX Platform	109	13
Paid Medical Claims CHLIC Platform	109	1
Totals	327	15

Denied Medical Claims

The Company utilizes several platforms (systems) in the processing of claims. These platforms consisted of the Diamond, CCX, eviCore, ASH, CHM, and GHB (Overseas). Random samples were requested from each of the platforms and reviewed in accordance with Delaware laws, regulations and bulletins.

16 Exceptions – 18 Del. Admin. C. 902 § 1.2.1.2 Authority for Regulation; Basis for Regulation

The Company failed to acknowledge and respond within 15 days to communications with respect to claims by insureds arising under insurance policies.

Recommendation: It is recommended that the Company specifically respond to claims by the insured within 15 days pursuant to 18 Del. Admin. C. 902 § 1.2.1.2.

Company Name: Cigna MHP	Sample size	Exceptions
Denied Medical Claims CHLIC Platform	109	11
Denied Medical Claims Diamond Combined Platform	109	3
Denied Medical Claims ASH Platform	108	2
Totals	**326**	**16**

5 Exceptions – 18 Del. Admin. C. 902 § 1.2.1.5 Authority for Regulation; Basis for Regulation

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.

Company Name: Cigna MHP	Sample size	Exceptions
Denied Medical Claims CCX Platform	107	2
Denied Medical Claims CHLIC Platform	109	1
Denied Medical Claims Diamond Combined Platform	109	1
Denied Medical Claims ASH Platform	108	1
Totals	**433**	**5**

5 Exceptions – 18 Del. Admin. C. 1310 § 6.0 Processing of Clean Claim

The Company failed to notify the provider or policyholder in writing why the claim will not be paid within 30 days.

Recommendation: It is recommended that the Company process all claims in accordance with 18 Del. Admin. C. 1310 § 6.0.

Company Name: Cigna MHP	Sample size	Exceptions
Denied Medical Claims CCX Platform	107	2
Denied Medical Claims CHLIC Platform	109	1
Denied Medical Claims Diamond Combined Platform	109	1
Denied Medical Claims ASH Platform	108	1
Totals	**433**	**5**

Paid Mental Health Substance Use Disorder Claims

The Company utilizes several platforms (systems) in the processing of claims. These platforms consisted of the Diamond, CCX, eviCore, ASH, CHM, and GHB (Overseas). Random samples

were requested from each of the platforms and reviewed in accordance with Delaware laws, regulations and bulletins.

The following exceptions were noted:

40 Exceptions – 18 Del. Admin. C. 902 § 1.2.1.2 Authority for Regulation; Basis for Regulation

The Company failed to acknowledge and respond within 15 days to communications with respect to claims by insureds arising under insurance policies.

Recommendation: It is recommended that the Company specifically respond to claims by the insured within 15 days pursuant to 18 Del. Admin. C. 902 § 1.2.1.2.

Company Name: Cigna MHP	Sample size	Exceptions
Paid MH-SUD Claims Diamond Platform	109	5
Paid MHSUD CHLIC Platform	109	6
Paid Autism Claims CHLIC Platform	84	9
Paid Autism Claims Diamond Platform	109	20
Totals	**411**	**40**

9 Exceptions – 18 Del. Admin. C. 902 § 1.2.1.5 Authority for Regulation; Basis for Regulation

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.

Company Name: Cigna MHP	Sample size	Exceptions
Paid MH-SUD Claims Diamond Platform	109	1
Paid MHSUD CHLIC Platform	109	2
Paid Autism Claims CHLIC Platform	84	2
Paid Autism Claims Diamond Platform	109	4
Totals	**411**	**9**

9 Exceptions – 18 Del. Admin. C. 1310 § 6.0 Processing of Clean Claim

The Company failed to notify the provider or policyholder in writing why the claim will not be paid within 30 days.

Recommendation: It is recommended that the Company process all claims in accordance with 18 Del. Admin. C. 1310 § 6.0.

Company Name: Cigna MHP	Sample size	Exceptions
Paid MH-SUD Claims Diamond Platform	109	1
Paid MHSUD CHLIC Platform	109	2
Paid Autism Claims CHLIC Platform	84	2
Paid Autism Claims Diamond Platform	109	4
Totals	**411**	**9**

Denied Mental Health Substance Use Disorder Claims

46 Exceptions – 18 Del. Admin. C. 902 § 1.2.1.2 Authority for Regulation; Basis for Regulation

The Company failed to acknowledge and respond within 15 days to communications with respect to claims by insureds arising under insurance policies.

Recommendation: It is recommended that the Company specifically respond to claims by the insured within 15 days pursuant to 18 Del. Admin. C. 902 § 1.2.1.2.

Company Name: Cigna MHP	Sample size	Exceptions
Denied MH-SUD Claims CHLIC Platform	109	11
Denied MH-SUD Claims Diamond Platform	109	7
Denied Overseas MH-SUD Claims	116	4
Denied Autism Claims CHLIC Platform	79	6
Denied Autism Claims Diamond Platform	82	12
Denied Overseas Autism Claims	84	6
Totals	**579**	**46**

10 Exceptions – 18 Del. Admin. C. 902 § 1.2.1.5 Authority for Regulation; Basis for Regulation

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.

Company Name: Cigna MHP	Sample size	Exceptions
Denied MH-SUD Claims Diamond Platform	109	4
Denied Autism Claims CHLIC Platform	79	1
Denied Autism Claims Diamond Platform	82	5
Totals	**270**	**10**

12 Exceptions – 18 Del. Admin. C. 1310 § 6.0 Processing of Clean Claim

The Company failed to notify the provider or policyholder in writing why the claim will not be paid within 30 days.

Recommendation: It is recommended that the Company process all claims in accordance with 18 Del. Admin. C. 1310 § 6.0.

Company Name: Cigna MHP	Sample size	Exceptions
Denied MH-SUD Claims Diamond Platform	109	4
Denied Overseas MH-SUD Claims	116	2
Denied Autism Claims CHLIC Platform	79	1
Denied Autism Claims Diamond Platform	82	5
Totals	**386**	**12**

9 Exceptions – 18 Del. C. § 3570A(a) Autism spectrum disorder coverage

It was noted that several autism spectrum disorder treatment procedures (ABA) were not processed correctly, so all ABA claims were reviewed.

The Company failed to provide necessary testing or treatment for autism claims.

Recommendation: It is recommended that the Company review its procedures in the processing of claims pertaining to autism in accordance with 18 Del. C. § 3570A(a).

Company Name: Cigna MHP	Sample size	Exceptions
Denied Autism Claims Diamond Platform	82	8
Denied Overseas Autism Claims	84	1
Totals	**166**	**9**

2 Exceptions – 45 CFR 146.136(c)(4)(i),(ii)(A) Parity in mental health and substance use disorder benefits.

The Company failed to treat Mental Health similar to Medical Surgical by imposing a Non-Quantitative Treatment Limitation.

Recommendation: It is recommended that the company review its procedures in the processing of claims pertaining to mental parity in accordance with 45 CFR 146.136(c)(4)(i) and (ii)(A).

Company Name: Cigna MHP	Sample size	Exceptions
Denied Pharmacy MH-SUD Claims Platform	109	2
Totals	**109**	**2**

16 Exceptions – 18 Del. C. § 3578(b)(1)(b), and 45 CFR 146.136(c)(4)(i) and 45 CFR 146.136(c)(4)(ii)(A)

The Company failed to treat Mental Health Substance Use Disorder claims similar to Medical Surgical claims by imposing a Non-Quantitative Treatment Limitation. The plan requires a utilization review in order to obtain a doctor's authorization for the member to take two different strengths of the same medication.

Recommendation: It is recommended that the company review its procedures in the processing of claims pertaining to mental parity in accordance with 18 Del. C. § 3578(b)(1)(b), and 45 CFR 146.136(c)(4)(i) and **45 CFR 146.136(c)(4)(ii)(A)**.

Company Name: Cigna MHP	Sample size	Exceptions
Denied Pharmacy MH-SUD Claims Platform	109	16
Totals	**109**	**16**

Infertility Claims Denied

The examiners noted that several contracts did not contain the correct provisions for the treatment of infertility. Upon further discussion with the Department, it was determined to target infertility claims.

1 Exception – 18 Del. C. § 3556((i)(2)

The Company failed to provide coverage for infertility claims after the effective date of the law or renewal of a contract after the effective date of the law (June 30, 2018). The mandated coverage for infertility was not loaded into the system until 7/31/19. The examiners determined this was a systematic error.

Recommendation: It is recommended the Company update contracts upon issue or renewal for infertility claims to reflect all laws that are enacted in accordance with 18 Del. C. § 3556(i)(2).

Company Name: Cigna MHP	Sample size	Exceptions
Infertility Medical Claims Denied	2,737	215
Totals	**2,737**	**215**

1 Exception – 18 Del. C. § 3556((i)(4)

The Company failed to provide coverage for infertility pharmaceutical claims after the effective date of the law or renewal of a contract after the effective date of the law (June 30, 2018). The mandated coverage for infertility was not loaded into the system until 7/31/19. The examiners determined this was a systematic error.

Recommendation: It is recommended the Company update contracts upon issue or renewal for infertility pharmaceutical claims to reflect all laws that are enacted in accordance with 18 Del. C. § 3556(i)(4).

Company Name: Cigna MHP	Sample size	Exceptions
Infertility Pharmaceutical Claims Denied	488	195
Totals	**488**	**195**

UTILIZATION REVIEWS

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

Approved Utilization Reviews

2 Exception – 18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness and 45 CFR 146.136(c)(4)(i) and 45 CFR 146.136(c)(4)(ii)(A)

The Company failed to treat Mental Health Substance Use Disorder claims similar to Medical Surgical claims by imposing a Non-Quantitative Treatment Limitation. The plan requires a utilization review in order to obtain a doctor's authorization for the member to take two different strengths of the same medication.

Recommendation: It is recommended that the Company not impose mental health substance use disorder quantitative limitations that are more restrictive than medical surgical quantitative limitations in accordance with 18 Del. C. § 3578(b)(1)(b), and 45 CFR 146.136(c)(4)(i) and 45 CFR 146.136(c)(4)(ii)(A).

5 Exceptions – 18 Del. C. § 3583(a) Utilization review entity's obligations with respect to pre-authorizations in nonemergency circumstances.

The Company failed to complete its process or render an adverse determination and notify the provider within 2 business days.

Recommendation: It is recommended that the Company process or render and adverse determination and notify the provider within 2 business days in accordance with 18 Del. C. § 3583(a).

Company Name: Cigna MHP	Sample size	Exceptions
Pharmacy Med/Surg Approved	113	5
Totals	**113**	**5**

1 Exception – 18 Del. C. § 3583(b) Utilization review entity's obligations with respect to pre-authorizations in nonemergency circumstances.

The Company failed to complete its process or render an adverse determination and notify the provider within 8 business days for non-electronic pre-authorization requests or 5 business days for electronic pre-authorizations requests.

Recommendation: It is recommended that the Company notify the provider within the required timeframe in accordance with 18 Del. C. § 3583(b).

Company Name: Cigna MHP	Sample size	Exceptions
Outpatient Med/Surg Approved - Combined Platform	116	1
Totals	**116**	**1**

3 Exceptions – 18 Del. C. § 3586(a) Length of pre-authorization.

The Company failed to provide pre-authorization for pharmaceuticals valid for 1 year.

Recommendation: It is recommended that the Company review its processes to ensure pre-authorizations for pharmaceuticals are valid for 1 year in accordance with 18 Del. C. § 3586(a).

3 Exceptions – 18 Del. C. § 3586(b) Length of pre-authorization.

The Company failed to provide pre-authorization for pharmaceuticals valid for no less than 60 days

Recommendation: It is recommended that the Company review its processes to ensure pre-authorizations for pharmaceuticals are valid for no less than 60 days in accordance with 18 Del. C. § 3586(b).

Denied Utilization Reviews

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

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

Recommendation: It is recommended that the Company follow ASAM criteria when used with Substance Use Disorder in accordance with 18 Del. C. § 3578(d)(1)(c).

Company Name: Cigna MHP	Sample size	Exceptions
Inpatient MH/SUD Denied - Combined Platform	79	1
Totals	**79**	**1**

3 Exceptions – 18 Del. C. § 3583(a) Utilization review entity's obligations with respect to pre-authorizations in nonemergency circumstances.

The Company failed to complete its process or render an adverse determination and notify the provider within 2 business days.

Recommendation: It is recommended that the Company process or render and adverse determination and notify the provider within 2 business days in accordance with 18 Del. C. § 3583(a).

2 Exceptions– 18 Del. C. § 3583(c) Utilization review entity's obligations with respect to pre-authorizations in nonemergency circumstances.

The Company failed to complete its process or render an adverse determination and notify the provider within 8 business days for non-electronic pre-authorization requests or 5 business days for electronic pre-authorizations requests.

Recommendation: It is recommended that the Company notify the provider within the required timeframe in accordance with 18 Del. C. § 3583(c).

1 Exception – 18 Del. C. § 3578(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)(i),(ii)(A)(B)(E)

The Company failed to include smoking cessation under certain plans. The examiners determined this was a systematic error.

Recommendation: It is recommended that the Company include smoking cessation in accordance with *18 Del. C. § 3578(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)(E)*.

Company Name: Cigna MHP	Sample size	Exceptions
Pharmacy MH/SUD Denied	47	23
Totals	**47**	**23**

PHARMACY REVIEW

The Pharmacy review was performed with the goal of determining parity between mental health and medical/surgical medications and the systems and formularies utilized by the company in applicable claims. Due to the complicated nature of this review, there are instances where it would have been difficult, if not impossible due to system limitations and examination logistics, to obtain

and review the data needed to determine the total number of claims or members impacted by a policy found to have a Nonquantitative Treatment Limitation (NQTL). In other instances, the Company was able to provide a detailed count of claims affected by a specific policy. As a result, pharmacy exceptions are noted in two different exception counts. In some instances, an exception with a formulary was noted, but the number of consumers or claims affected could not be determined due to system and examinations limitations. In those cases, the problem with the system was noted as a single exception and it is recommended the system is revised. In other Pharmacy exceptions a specific number of violations could be determined and are noted. In both cases, the Company is recommended to revise their related systems.

1 Exception (form 1109 limitations) – 18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 *CFR* § 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits.

The Company had a step therapy limitation on two mental health medications based on a limitation of depression diagnosis only on form 1109. The Company removed the language on its form 1109 stating "Limited to depression diagnosis only" in 2018. These two medications, Cymbalta and Irenka, also share MED/SURG FDA approved indications that do not have the same step therapy limitation applied. Although the Company stated that they used the same processes and strategies when applying this NQTL to all medications in step therapy policy 1109, restricting both of these medications with a step therapy limitation only on their mental health indication and not their MED/SURG indications isn't comparable and is more stringently applying this limitation.

Recommendation: It is recommended that the Company review its policies and modify its procedures, regarding form 1109 limitations, in accordance with 18 Del. C. § 3578(b)(1)(b) and 45 CFR 146.136(c)(4)(i) General rule and not limit step therapy to depression diagnosis on certain drugs.

1 Exception (ADHD step therapy age limitation) – 45 CFR 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits.

The Company has step therapy polices (1109, 1801, 1802, and 1803) with no age exemption (age inclusion) on members who are prescribed medications for ADHD under 18 years old. This is the only medication classification with this age limitation included in these step therapy policies despite the Company stating they used the same factors and strategies when developing these polices. Every NQTL has to be comparable and no more stringently applied regarding MH/SUD medications compared to MED/SURG medications in order to be in compliance with MHPAEA. The examiners determined this was a systematic error.

Recommendation: It is recommended that the Company review its policies and modify its procedures, regarding step therapy policies with no age limitation, in accordance with 45 CFR 146.136 (c)(4)(i) General rule.

1 Exceptions – 18 Del. C. § 3580(d) Specialty tier prescription coverage.

The Company placed all drugs in a given class of drugs on a specialty tier (tier 4) on various formularies. Formularies are an extension of the health plan and provide tier information to

members whereas this information is not found anywhere else. All formularies within the scope of this exam are documents available to consumers/members and should be in compliance with this statute. The examiners determined this was a systematic error.

Recommendation: It is recommended that the Company review its policies and modify its procedures, regarding specialty tier prescription coverage, in accordance with 18 Del. C. § 3580(d).

1 Exception – 18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 CFR 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits.

The Company imposed a prior authorization and formulary exclusion on various formularies on Vyvanse. Vyvanse is understood as the only medication indicated for Binge Eating Disorder (BED) as per the Company and placing any treatment limitation or formulary exclusion has to be comparable and not more stringently applied compared to MED/SURG medications. The examiners determined this was a systematic error.

Recommendation: It is recommended that the Company review its policies and modify its procedures, regarding Vyvanse, in accordance with 18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 CFR 146.136(c)(4)(i) General rule.

1 Exception – 18 Del. C. § 3566(b) Prescription medication

The Company excluded Vyvanse on various formularies. Binge eating disorder (BED) is a chronic, disabling or life-threatening illness, and Vyvanse has been approved by the Food and Drug administration for at least 1 indication, and is recognized for treatment of the indication for which the drug is prescribed in. Binge eating disorder was a covered benefit during the exam period, therefore the medications used to BED have to be included for coverage based on this statute. The examiners determined this was a systematic error.

Recommendation: It is recommended that the Company review its policies and modify its procedures, regarding Vyvanse, in accordance with 18 Del. C. § 3566(b) Prescription medication.

1 Exceptions – 18 Del. C. § 3556(i)(4) Obstetrical and gynecological coverage

Formularies are an extension of the health plan and provide information such as tier placement and treatment limitations to members not found in the member's plan documents. The Company imposed exclusions, limitations, or other restrictions on coverage of fertility medications that are different from those imposed on other prescription medications. All formularies included in the scope of this exam are documents available to consumers/members, as an information resource, and should be designed to be in compliance with the statute. The examiners determined this was a systematic error.

Recommendation: It is recommended that the Company review its policies and modify its procedures, regarding infertility formularies, in accordance with 18 Del. C. § 3556(i)(4) Obstetrical and gynecological coverage.

1 Exception (Antidepressant - error code 147) – 18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 CFR 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits.

When designing the step therapy requirement on all medications in 1109, 1801, 1802, and 1803 policies, error code 147 triggers on concomitant antidepressant treatment within an arbitrary 5-day window resulting in the policy being more discriminatory towards antidepressant medications. Based on common prescribing practices of antidepressant medications, error code 147 is applied more stringently and not comparable to MED/SURG medications in these policies. The examiners determined this was a systematic error.

Recommendation: It is recommended that the Company review its policies and modify its procedures, regarding antidepressant – error code 147, in accordance with 18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 CFR 146.136(c)(4)(i) General rule.

1 Exception (ADHD medication - error code 147) – 45 *CFR* § 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits.

When designing the step therapy requirement on all medications in 1109, 1801, 1802, and 1803 policies, error code 147 triggers on concomitant ADHD medication treatment within an arbitrary 5-day window resulting in the policy being more discriminatory towards ADHD medications. Based on common prescribing practices of ADHD medications, error code 147 is applied more stringently and not comparable to MED/SURG medications in these policies. The examiners determined this was a systematic error.

Recommendation: It is recommended that the Company review its policies and modify its procedures, regarding ADHD medication – error code 147, in accordance with 45 CFR 146.136(c)(4)(i) General rule.

1 Exception (Antidepressant preferred brand) – 18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 *CFR* § 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits.

The Company placed all brand name antidepressants on a non-preferred tier (tier 3) compared to MED/SURG medications/categories that offered brands on the preferred tier (tier 2). Despite the Company stating they used the same factors, all brand name antidepressants were placed in higher tiers/non-preferred tiers (tier 3), while many MED/SURG brand name medications/categories were placed on the preferred tier (tier 2) which is not comparable and more stringently applying tier placement to brand name antidepressants. This is discriminatory to all members prescribed and taking any brand name antidepressant resulting in higher copays/tier placement compared to many brand name MED/SURG medications/categories offered in a lower cost sharing tier. The examiners determined this was a systematic error.

Recommendation: It is recommended that the Company review its policies and modify its procedures, regarding antidepressant preferred brand, in accordance with 18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 CFR 146.136(c)(4)(i) General rule.

1 Exception (Antipsychotics preferred brand) – 18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 *CFR* § 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits.

The Company placed all brand name antipsychotics on a non-preferred tier (tier 3) compared to many MED/SURG medications/categories that offered brands on the preferred tier (tier 2). Despite the Company stating they used the same factors, all brand name antipsychotics were placed in higher tiers/non-preferred tiers (tier 3), while many MED/SURG brand name medications/categories were placed on the preferred tier (tier 2) which is not comparable and more stringently applying tier placement to brand name antipsychotics. This is discriminatory to all members prescribed and taking a brand name antipsychotic resulting in higher copays/tier placement compared to brand name MED/SURG medications/categories offered in a lower cost sharing tier. The examiners determined this was a systematic error.

Recommendation: It is recommended that the Company review its policies and modify its procedures, regarding antipsychotics preferred brand, in accordance with 18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 CFR 146.136(c)(4)(i) General rule.

1 Exception (Antipsychotic - error code 147) – 45 *CFR* § 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits.

When designing the step therapy requirement on all medications in 1109, 1801, 1802, and 1803 policies, error code 147 triggers on concomitant antipsychotic medication treatment within an arbitrary 5-day window resulting in the policy being more discriminatory towards antipsychotic medications. Based on common prescribing practices of antipsychotic medications, error code 147 is applied more stringently and not comparable to MED/SURG medications in these policies. The examiners determined this was a systematic error.

Recommendation: It is recommended that the Company review its policies and modify its procedures, regarding antipsychotic - error code 147, in accordance with 18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 CFR 146.136(c)(4)(i) General rule.

1 Exceptions (ADHD - preferred brand) – 45 *CFR* § 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits.

The Company placed all brand name ADHD medications on a non-preferred tier (tier 3) compared to many MED/SURG medications/categories that offered brands on the preferred tier (tier 2). Despite the Company stating they used the same factors, all brand name ADHD medications were placed in higher tiers/non-preferred tiers (tier 3), while many MED/SURG brand name medications/categories were placed on the preferred tier (tier 2) which is not comparable and more stringently applying tier placement to brand name ADHD medications. This is discriminatory to all members prescribed and taking a brand name ADHD medication resulting in higher copays/tier placement compared to many brand name MED/SURG medications/categories offered in a lower cost sharing tier. The examiners determined this was a systematic error.

Recommendation: It is recommended that the Company review its policies and modify its procedures, regarding ADHD - preferred brand, in accordance with 45 CFR 146.136(c)(4)(i)

General rule.

1 Exception (buprenorphine/naloxone film quantity limit/dose restriction)– 18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 *CFR* § 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits.

It is discriminatory to limit buprenorphine/naloxone 2mg/0.5mg and 8mg/2mg (both brand and generic) to 2 films per day used for substance abuse when its dosage guidelines or evidentiary standards allow for doses such as 6mg/1.5mg or 3 films a day of the 2mg/0.5mg dose, or a maximum dose of 24mg/6mg (3 films a day of the 8mg/2mg dose) when there is no commercially available dose at these strengths. All strengths of Bunavail were also restricted to 1 film per day which is against evidentiary standards for this medication from 1/1/2017 to 2/1/2017. Compared to MED/SURG film medications included in the provided spreadsheet and 1201 forms, MED/SURG film medications were dosed and given quantity limits based on FDA approved labeling on appropriate dosing and safe medication use whereas buprenorphine/naloxone film formulations were limited based on arbitrary default quantity limits set by the Company which is discriminatory towards these substance abuse medications. The examiners determined this was a systematic error.

Recommendation: It is recommended that the Company review its policies and modify its procedures, regarding limits to buprenorphine/naloxone, in accordance with 18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 CFR 146.136(c)(4)(i) General rule.

1 Exception (Bunavail film-buprenorphine/naloxone quantity limit/dose restriction) – 18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 CFR 146.136(c)(4)(i) General rule

From 1/1/2017 to 2/1/2017, all strengths of Bunavail were also restricted to 1 film per day based on the film dosage spreadsheet the Company provided which is against evidentiary standards for this medication. Compared to MED/SURG film medications included in the provided spreadsheet and 1201 forms, MED/SURG film medications were dosed and given quantity limits based on FDA approved labeling on appropriate dosing and safe medication use whereas buprenorphine/naloxone film formulations were limited based on arbitrary default quantity limits set by the Company which is discriminatory towards these substance abuse medications. The examiners determined this was a systematic error.

Recommendation: It is recommended that the Company review its policies and modify its procedures, regarding Bunavail film-buprenorphine/naloxone quantity limit/dose restriction, in accordance with 18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 CFR 146.136(c)(4)(i) General rule.

1 Exceptions (Smoking Cessation - preferred brand)– 18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 *CFR* § 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits.

The Company placed all brand name smoking cessation medications on a non-preferred tier (tier 3) compared to many MED/SURG medications/categories that offered brands on the preferred tier (tier 2). Despite the Company stating they used the same factors, all brand name smoking cessation medications were placed in higher tiers/non-preferred tiers (tier 3), while many MED/SURG brand name medications/categories were placed on the preferred tier (tier 2) which is not comparable and more stringently applying tier placement to brand name smoking cessation medications. This is discriminatory to all members prescribed and taking a brand name smoking cessation medications resulting in higher copays/tier placement compared to many brand name MED/SURG medications/categories offered in a lower cost sharing tier. The examiners determined this was a systematic error.

Recommendation: It is recommended that the Company review its policies and modify its procedures, regarding Smoking Cessation - preferred brand, in accordance with 18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 CFR 146.136(c)(4)(i) General rule.

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). (Appeals Upheld; Appeals Overturned)*

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). (Appeals Upheld; Appeals Overturned)*

3. *It is recommended that the Company specifically respond to claims by the insured within 15 days pursuant to 18 Del. Admin. C. 902 § 1.2.1.2. (Complaints; Paid Medical Claims; Denied Medical Claims; Paid Mental Health Substance Use Disorder; Denied Mental Health Substance Use Disorder)*

4. *It is recommended that the Company specifically send claims for IUROs to the Department within 3 business days pursuant to 18 Del. Admin. C. 1301 § 5.0. (IUROs)*

5. *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. (Paid Medical Claims; Denied Medical Claims; Paid Mental Health Substance Use Disorder; Denied Mental Health Substance Use Disorder)*

6. *It is recommended that the Company process all claims in accordance with 18 Del. Admin. C. 1310 § 6.0. (Paid Medical Claims; Denied Medical Claims; Paid Mental Health Substance Use Disorder; Denied Mental Health Substance Use Disorder)*

7. *It is recommended that the Company review its procedures in the processing of claims pertaining to autism in accordance with 18 Del. C. § 3570A(a). (Denied Mental Health Substance Use Disorder)*

8. *It is recommended that the company review its procedures in the processing of claims pertaining to mental parity in accordance with 45 CFR 146.136(c)(4)(i) and (ii)(A). (Denied Mental Health Substance Use Disorder)*

9. *It is recommended that the company review its procedures in the processing of claims pertaining to mental parity in accordance with 18 Del. C. § 3578(b)(1)(b), and 45 CFR 146.136(c)(4)(i) and (ii)(A). (Denied Mental Health Substance Use Disorder)*

10. *It is recommended the Company update contracts upon issue or renewal for infertility claims to reflect all laws that are enacted in accordance with 18 Del. C. § 3556(i)(2). (Infertility Claims)*

11. *It is recommended the Company update contracts upon issue or renewal for infertility pharmaceutical claims to reflect all laws that are enacted in accordance with 18 Del. C. § 3556(i)(4). (Pharmacy Claims)*

12. *It is recommended that the Company not impose mental health substance use disorder quantitative limitations that are more restrictive than medical surgical quantitative limitations in accordance with 18 Del. C. § 3578(b)(1)(b), and45 CFR 146.136(c)(4)(i) and 45 CFR 146.136(c)(4)(ii)(A). (Approved Utilization Reviews)*

13. *It is recommended that the Company process or render and adverse determination and notify the provider within 2 business days in accordance with 18 Del. C. § 3583(a). (Approved Utilization Reviews)*

14. *It is recommended that the Company notify the provider within the required timeframe in accordance with 18 Del. C. § 3583(b). (Approved Utilization Reviews; Denied Utilization Reviews)*

15. *It is recommended that the Company review its processes to ensure pre-authorizations for pharmaceuticals are valid for 1 year in accordance with 18 Del. C. § 3586(a). (Approved Utilization Reviews)*

16. *It is recommended that the Company review its processes to ensure pre-authorizations for pharmaceuticals are valid for no less than 60 days in accordance with 18 Del. C. § 3586(b). (Approved Utilization Reviews)*

17. *It is recommended that the Company follow ASAM criteria when used with Substance Use Disorder in accordance with 18 Del. C. § 3578(d)(1)(c). (Approved Utilization Reviews)*

18. *It is recommended that the Company notify the provider within the required timeframe in accordance with 18 Del. C. § 3583(c). (Denied Utilization Reviews)*

19. *It is recommended that the Company include smoking cessation in accordance with 18 Del. C. § 3578(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)(E). (Denied Utilization Reviews)*

20. *It is recommended that the Company review its policies and modify its procedures, regarding form 1109 limitations, in accordance with 18 Del. C. § 3578(b)(1)(b) and 45 CFR 146.136(c)(4)(i) General rule and not limit step therapy to depression diagnosis on certain drugs. . (Pharmacy Review)*

21. *It is recommended that the Company review its policies and modify its procedures, regarding step therapy policies with no age limitation, in accordance with 45 CFR 146.136 (c)(4)(i) General rule. (Pharmacy Review)*

22. *It is recommended that the Company review its policies and modify its procedures, regarding specialty tier prescription coverage, in accordance with 18 Del. C. § 3580(d). (Pharmacy Review)*

23. *It is recommended that the Company review its policies and modify its procedures, regarding Vyvanse, in accordance with 18 Del. C. § 3566(b) Prescription medication. (Pharmacy Review)*

24. *It is recommended that the Company review its policies and modify its procedures, regarding infertility formularies, in accordance with 18 Del. C. § 3556(i)(4) Obstetrical and gynecological coverage. (Pharmacy Review)*

25. *It is recommended that the Company review its policies and modify its procedures, regarding antidepressant – error code 147, in accordance with 18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 CFR 146.136(c)(4)(i) General rule. (Pharmacy Review)*

26. *It is recommended that the Company review its policies and modify its procedures, regarding ADHD medication – error code 147, in accordance with 45 CFR 146.136(c)(4)(i) General rule. (Pharmacy Review)*

27. *It is recommended that the Company review its policies and modify its procedures, regarding antidepressant preferred brand), in accordance with 18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 CFR 146.136(c)(4)(i) General rule. (Pharmacy Review)*

28. *It is recommended that the Company review its policies and modify its procedures, regarding antipsychotics preferred brand, in accordance with 18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 CFR 146.136(c)(4)(i) General rule. (Pharmacy Review)*

29. *It is recommended that the Company review its policies and modify its procedures, regarding antipsychotic - error code 147, in accordance with 18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 CFR 146.136(c)(4)(i) General rule. (Pharmacy Review)*

30. *It is recommended that the Company review its policies and modify its procedures, regarding ADHD - preferred brand, in accordance with 45 CFR 146.136(c)(4)(i) General rule. (Pharmacy Review)*

31. *It is recommended that the Company review its policies and modify its procedures, regarding limits to buprenorphine/naloxone, in accordance with 18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 CFR 146.136(c)(4)(i) General rule. (Pharmacy Review)*

32. *It is recommended that the Company review its policies and modify its procedures, regarding Bunavail film-buprenorphine/naloxone quantity limit/dose restriction, in accordance with 18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 CFR 146.136(c)(4)(i) General rule. (Pharmacy Review)*

33. *It is recommended that the Company review its policies and modify its procedures, regarding Smoking Cessation - preferred brand, in accordance with 18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness; 45 CFR 146.136(c)(4)(i) General rule. (Pharmacy Review)*

The examination conducted by Joseph Krug, Brian Tinsley 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.

Brian Tinsley, AIE, MCM