DELAWARE DEPARTMENT OF INSURANCE

MARKET CONDUCT EXAMINATION REPORT

HIGHMARK BCBSD INC.
NAIC # 53287

800 Delaware Ave. Suite 900
Wilmington, DE 19801

As of

March 31, 2022

TRINIDAD NAVARRO
COMMISSIONER

STATE OF DELAWARE
DEPARTMENT OF INSURANCE

I, Trinidad Navarro, Insurance Commissioner of the State of Delaware, do hereby certify that the attached REPORT ON EXAMINATION, made as of March 31, 2022 on

HIGHMARK BCBSD INC.

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

Attest By: ______________________

In Witness Whereof, I have hereunto set my hand and affixed the official seal of this Department at the City of Dover, this 28th day of August , 2024.

____
Trinidad Navarro
Insurance Commissioner

TRINIDAD NAVARRO
COMMISSIONER

STATE OF DELAWARE
DEPARTMENT OF INSURANCE

REPORT ON EXAMINATION

OF THE

HIGHMARK BCBSD INC.

AS OF

March 31, 2022

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

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

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

In Witness Whereof, I have hereunto set my hand and affixed the official seal of this Department at the City of Dover, this 28th day of August, 2024.

Trinidad Navarro
Insurance Commissioner

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

Dear Commissioner Navarro:

In compliance with the instructions contained in Certificate of Examination Authority Number: 53287-22-701 and pursuant to statutory provisions including 18 Delaware Code §§ 318-322, a market conduct examination has been conducted of the affairs and practices of:

Highmark BCBSD INC.
NAIC # 53287

This examination was performed as of March 31, 2022.

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

The report of examination herein is respectfully submitted.

EXECUTIVE SUMMARY

The examination was called as a follow-up to the Mental Health Parity examination that was conducted as of September 30, 2018. This examination focused on Highmark BCBSD INC. (Highmark or Company) healthcare lines in the following areas of operation: Complaint and Grievance Handling, Policyholder Services, Claims, Utilization Review, Mental Health Parity, and Pharmacy Review. The following exceptions were noted and the details for the cited code references are included below:

- **4 Exceptions**
  45 *C.F.R.* § 156.1010(f) Standards.
  (f) For cases received from HHS, QHP issuers operating in a Federally-facilitated Exchange are required to notify complainants regarding the disposition of the as soon as possible upon resolution of the case, but in no event later than three (3) business days after the case is resolved.

  Highmark failed to notify the complainants of the disposition within three business days after the cases were resolved.

- **5 Exceptions**
  45 *C.F.R.* § 156.1010(g)(2) Standards.
  (g) For cases received from HHS, QHP issuers operating in a Federally-facilitated Exchange must use the casework tracking system developed by HHS, or other means as determined by HHS, to document the following:
  (2) A resolution summary of the case no later than seven (7) business days after resolution of the case. The record must include a clear and concise narrative explaining how the case was resolved including information about how and when the complainant was notified of the resolution.

  Highmark failed to document a resolution summary within seven business days, that included a clear and concise narrative explaining how the case was resolved including information about how and when the complainant was notified of the resolution.

- **12 Exceptions**
  FORMS AND RATES BULLETIN NO. 39.
  The purpose of this bulletin is to notify all insurance carriers that as of July 17, 2019, the Department of Insurance will be moving from its current Silver Lake Office to 1351 West North St., Suite 101, Dover, DE 19904.
  Carriers will need to update all of their forms currently in use that reference the Department's Silver Lake office address as follows:
    - *Carriers are not required to re-file forms currently in use solely for purposes of reflecting the Department's new address.*
    - *Carriers should ensure that all forms currently in use promptly updated so that consumers are directed to the new address.*

- *At such time as a carrier makes a substantive change to a form currently in use that requires re-filing with the Department, the form filing should reflect the Department's new address.*

The complaint files included Explanation of Benefits (EOBs) that had the incorrect address for the Delaware Department of Insurance.

- **37 Exceptions**
  18 *Del. C.* § 2304(16)(f) Unfair claim settlement practices.
  (16) No person shall commit or perform with such frequency as to include a general business practice any of the following:
  (f) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear.

  Highmark failed to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear.

- **33 Exceptions**
  18 *Del. Admin. C.* § 332(c)(4) Arbitration of disputes involving health insurance coverage.
  (c) The Insurance Commissioner shall approve those IRPs that meet the following minimum criteria:
  (4) Prompt response to written grievances. — 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.

  Highmark failed to acknowledge receipt of the appeals within five business days of receipt.

- **2 Exceptions**
  18 *Del. C.* § 332(c)(5) Speedy review of grievances.
  That IRP shall require that all grievances be decided in an expeditious manner, and in any event, no more than:

  a. 72 hours after the receipt of all necessary information relating to an emergency review;

  b. 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

  c. 45 days after the receipt of all necessary information in all other instances.

  Highmark failed to decide the grievances in an expeditious manner.

- **17 Exceptions**
  18 *Del. Admin. C.* § 1301-5.2 IHCAP Procedure.

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 3 business days.

Highmark failed to transmit the appeals to the Department within 3 business days.

- **9 Exceptions**
  18 *Del. Admin. C.* § 1301-5.5 IHCAP Procedure.
  5.5 Within 7 calendar days after the receipt of the notification required in subsection 5.3 of this regulation, the carrier shall provide to the assigned IURO the documents and any information considered in making the final coverage decision.

  Highmark failed to provide documents to the assigned IURO within 7 calendar days.

- **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.

  Highmark failed to validate pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization.

- **13 Exceptions**
  18 *Del. C. §* 3560A(b)(1) Cost Sharing In Prescription Insulin Drugs.
  (b) A group or blanket health insurance policy, contract, or certificate that is delivered, issued for delivery, renewed, extended, or modified in this State that provides coverage for prescription insulin drugs must do all of the following:
  (1) Cap the total amount that a covered individual is required to pay for covered prescription insulin drugs at no more than $100 per month for each enrolled individual, regardless of the amount or types of insulin needed to fill the covered individual's prescriptions. The $100 per month cap includes deductible payments and cost-sharing amounts charged once a deductible is met.

  Highmark failed to cap the total amount that the covered individuals were required to pay for prescription insulin drugs at $100 per month.

- **289 Exceptions**
  FORMS AND RATES BULLETIN NO. 39.
  The purpose of this bulletin is to notify all insurance carriers that as of July 17, 2019, the Department of Insurance will be moving from its current Silver Lake Office to 1351 West North St., Suite 101, Dover, DE 19904.
  Carriers will need to update all of their forms currently in use that reference the Department's Silver Lake office address as follows:
  - *Carriers are not required to re-file forms currently in use solely for purposes of reflecting the Department's new address.*

- *Carriers should ensure that all forms currently in use promptly updated so that consumers are directed to the new address.*
- *At such time as a carrier makes a substantive change to a form currently in use that requires re-filing with the Department, the form filing should reflect the Department's new address.*

The Utilization Review files included notices to the insured that had the incorrect address for the Delaware Department of Insurance

- **1 Exception**
  18 *Del. C.* § 3583(c) Utilization Review Entity's Obligations with Respect To Pre-Authorizations In Non-Emergency Circumstances.
  (c) If a utilization review entity requires pre-authorization of a health-care service, the utilization review entity must grant a preauthorization or issue an adverse determination and notify the covered person's health-care 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.

  Highmark failed to issue an adverse determination and notify the covered person's health-care provider of the determination within 5 business days of receipt of a clean pre-authorization.

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

  Highmark denied a member medically necessary treatment for drug and alcohol dependencies in an intensive outpatient program.

- **3 Exceptions**
  18 *Del. C.* § 3376(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 § 3372 of this title and except as otherwise set by evidence-based treatment protocol.

Highmark failed to validate pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization.

- **1 Exception**
  18 *Del. C.* § 3342(2) Obstetrical and gynecological coverage.
  2) All individual 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…

  Highmark failed to provide obstetrical and gynecological coverage including in vitro fertilization services to a member.

- **2 Exceptions**
  18 *Del. C.* § 3381(a)(5) Step therapy exception process.
  (a) When coverage of a prescription drug for the treatment of any medical condition is restricted for use by an insurer, health plan, or utilization review entity through the use of a step therapy protocol, the patient and prescribing practitioner shall have access to a clear, readily accessible and convenient process to request a step therapy exception determination. An insurer, health service corporation, health plan, or utilization review entity may use its existing medical exceptions process to satisfy this requirement. The process shall be made easily accessible via the insurer's, health plan's, or utilization review entity's website. A step therapy exception determination shall be expeditiously granted in any one of the following circumstances:
  (5) The patient is stable, for the medical condition under consideration, on a prescription drug prescribed by the patient's health-care provider or while the patient was insured by the patient's current or a previous insurance or health benefit plan.

  Highmark failed to expeditiously grant a step therapy exception when the patient was stable for the medical condition under consideration on a prescription medication prescribed by the member's healthcare provider.

- **8 Exceptions**
  18 *Del. C.* § 3591(a)(5) Step therapy exception process.
  (a) When coverage of a prescription drug for the treatment of any medical condition is restricted for use by an insurer, health plan, or utilization review entity through the use of a step therapy protocol, the patient and prescribing practitioner shall have access to a clear, readily accessible and convenient process to request a step therapy exception determination. An insurer, health service corporation, health plan, or

utilization review entity may use its existing medical exceptions process to satisfy this requirement. The process shall be made easily accessible via the insurer's, health plan's, or utilization review entity's website. A step therapy exception determination shall be expeditiously granted in any one of the following circumstances:
(5) The patient is stable, for the medical condition under consideration, on a prescription drug prescribed by the patient's health-care provider or while the patient was insured by the patient's current or a previous insurance or health benefit plan.

Highmark failed to expeditiously grant a step therapy exception when the patient was stable for the medical condition under consideration on a prescription medication prescribed by the members healthcare provider.

- **12 Exceptions**
  18 *Del. C.* § 3571X Medication assisted treatment for drug and alcohol dependencies.
  (a) For purposes of this section, "medication-assisted treatment" means the use of U.S. Food and Drug Administration-approved medications, in combination with counseling and behavioral therapies, to provide a whole patient approach to the treatment of drug and alcohol dependencies.
  (d) A health insurer shall provide benefits under this section as follows:
  (1) Not impose a prior authorization requirement.

  Highmark imposed a prior authorization on buprenorphine monotherapy for quantities over 5 days or for anything other than induction treatment, (a prior authorization is required for pregnancy or when there is an allergy, intolerance, or hypersensitivity to naloxone). The Company indicated there were 12 approved and denied cases for quantities greater than 5 days (for pregnancy or a medical necessity exception if there is an allergy, intolerance, or hypersensitivity to naloxone) on buprenorphine sublingual tablets (monotherapy) from the exam period.

- **4 Exceptions**
  18 *Del. C.* § 3571X Medication assisted treatment for drug and alcohol dependencies.
  (a) For purposes of this section, "medication-assisted treatment" means the use of U.S. Food and Drug Administration-approved medications, in combination with counseling and behavioral therapies, to provide a whole patient approach to the treatment of drug and alcohol dependencies.
  (d) A health insurer shall provide benefits under this section as follows:
  (1) Not impose a prior authorization requirement.

  Highmark imposed a prior authorization on buprenorphine/naloxone-based mediations per Medication policy J-0331 (006, 007, 008 and 009). The Company indicated that 4 members were affected by this policy.

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

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

Highmark imposed a more restrictive policy criteria on several drugs which were Mental Health/Substance Use Disorder (MH/SUD) medications, when compared to Medical/Surgical (MED/SURG) medication policies, which are identified in the charts below.

In three cases below the MH/SUD medication policies were found to be more restrictive than comparable MED/SURG medication policies:

Drug name and Medical Policy number
Vivitrol (Medical Policy I-92)
Zercapli (Medication Policy J-1164)
Lybalvi (Medication Policy J-1119)

- **3 Exceptions**
  18 *Del. C.* § 3578(b) Insurance coverage for serious mental illness.
  (b) Coverage of serious mental illness and drug and alcohol dependency. — (1) a. Carriers shall provide coverage for serious mental illnesses and drug and alcohol dependencies in all health benefit plans delivered or issued for delivery in this State.

Coverage for serious mental illnesses and drug and alcohol dependencies must provide:
1. Inpatient coverage for the diagnosis and treatment of drug and alcohol dependencies.
2. Unlimited medically necessary treatment for drug and alcohol dependencies as required by the Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a) and determined by the use of the full set of ASAM criteria, in all of the following:
A. Treatment provided in residential setting.
B. Intensive outpatient programs.
C. Inpatient withdrawal management.
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.

See the explanation and charts in the 18 *Del. C.* § 3343(b) citation above.

- **3 Exceptions**
  26 *C.F.R.* § 54.9812-1(c)(4)(i), 29 *C.F.R.* § 2590.712(c)(4)(i), 45 *C.F.R.* § 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits.
  A group health plan (or health insurance coverage) may not impose a non-quantitative 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 non-quantitative 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.

  See the explanation and charts in the 18 *Del. C.* § 3343(b) citation above.

- **1 Exception**
  18 *Del. C.* § 3376(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 § 3372 of this title and except as otherwise set by evidence-based treatment protocol.

  Highmark failed to validate a 1-year pre-authorization on Zercapli (Medication Policy J-1164) from the date the health-care provider receives the pre-authorization.

- **4 Exceptions**
  18 *Del. C.* § 3583(a) Utilization Review Entity's Obligations with Respect to Pre-Authorizations In Non-Emergency 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.

  Highmark failed to 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.

- **162 Exceptions**
  18 *Del. C.* § 2304(16)(f) Unfair claim settlement practices.
  (16) No person shall commit or perform with such frequency as to include a general business practice any of the following:
  (f) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear.

  Highmark failed to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. The Company did not cover Methadone for Opioid Use Disorder (OUD) across all plans for out-of-network providers/facilities.

- **24 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.

  Highmark failed to validate pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization. There were 24 policies with 1,698 drug utilization reviews affecting 1,132 members.

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

Highmark imposed a 14-day supply limit every 90 days (90-day lock-out) on Lucemyra and did not allow a member to have access to additional 5-day supplies within the 90-day lock-out period from 1/1/2021 to 12/9/2021 until the coding was updated.

- **1 Exception**
  18 *Del. C.* § 3578(b)(2)a Insurance coverage for serious mental illness.
  (b)(2) a. A health benefit plan that provides coverage for prescription drugs must provide coverage for the treatment of serious mental illnesses and drug and alcohol dependencies that includes immediate access, without prior authorization, to a 5-day emergency supply of prescribed medications covered under the health benefit plan for the medically necessary treatment of serious mental illnesses and drug and alcohol dependencies where an emergency medical condition, as defined in § 3349(e) of this title, exists, including a prescribed drug or medication associated with the management of opioid withdrawal or stabilization, except where otherwise prohibited by law.

  Highmark imposed a 14-day supply limit every 90 days (90-day lock-out) on Lucemyra and did not allow a member to have access to additional 5-day supplies within the 90-day lock-out period from 1/1/2021 to 12/9/2021 until the coding was updated.

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, 2021, through March 31, 2022, unless otherwise noted. The focus of the examination was to re-examine the areas where issues were identified on the previous examination dated September 30, 2018, Chapters 33 and 35, and compliance with any related updated Delaware Code requirements. The scope was expanded on October 26, 2022, to include the Company's relationships and oversight of contracted Pharmacy Benefit Managers (PBMs) and Third-Party Administrators (TPAs).

METHODOLOGY

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

Highmark 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. General 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, Highmark's 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 Highmark's officials to discuss the various types of exceptions identified during the examination and review written summaries provided on the exceptions found.

COMPLAINT, GRIEVANCES, AND APPEALS HANDLING

A. Complaint Policies and Procedures

The Company was requested to provide a copy of the Consumer/Provider Complaint Handling guidelines and procedures during the exam period of January 1, 2021, through March 31, 2022. The Company's complaints consisted of Executive and Legislative complaints received. The Company's policies and procedures related to the handling and processing of complaints were provided and reviewed. The policies and procedures were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

B. Grievance and Appeals Policies and Procedures

The Company was requested to provide all appeals and grievances policies and procedures in effect during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of eight documents that pertained to appeals and grievances. All the documents were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

C. Member and Affordable Care Act Complaints

The Company was requested to provide a listing of all complaints filed with the Company during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 24 Member complaints and 36 Affordable Care Act complaints for a total of 60 complaints. All 60 complaints were reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

<u>3 Exceptions</u> - 45 *C.F.R.* § 156.1010(f) Standards.

Highmark failed to notify the complainants of the disposition within three business days after the cases were resolved.

Recommendation: It is recommended that the Company notify complainants of the disposition within three business days after the cases are resolved as required by 45 *C.F.R.* § 156.1010(f).

<u>3 Exceptions</u> - 45 *C.F.R.* § 156.1010(g)(2) Standards.

Highmark failed to document a resolution summary within seven business days that included a clear and concise narrative explaining how the case was resolved including information about how and when the complainant was notified of the resolution.

Recommendation: It is recommended that the Company document the resolution summary of cases that should include a clear and concise narrative explaining how the case was resolved including information about how and when the complainant was notified of the resolution as required by 45 *C.F.R.* § 156.1010(g)(2).

D. Delaware Department of Insurance Complaints

The Company was requested to provide a listing of all complaints filed with the Company during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 90 DDOI complaints. A random sample of 79 complaints were reviewed.

The Delaware Department of Insurance (DDOI) provided a list of complaints that were received during the examination period. The listing was reconciled with the Company's complaint listing for any discrepancies.

All complaint files and associated policies and procedures were reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

<u>12 Exceptions</u> – FORMS AND RATES BULLETIN NO. 39.

The complaint files included Explanation of Benefits (EOBs) that had the incorrect address for the Delaware Department.

Recommendation: It is recommended that the Company update all of their forms and documents to include the current address for the DDOI as required by FORMS AND RATES BULLETIN NO. 39.

<u>35 Exceptions</u> – 18 *Del. C.* § 2304(16)(f) Unfair methods of competition and unfair or deceptive acts or practices defined.

Highmark failed to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear.

Recommendation: It is recommended that the Company effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear as required by 18 *Del. C.* § 2304(16)(f).

<u>1 Exception</u> – 45 *C.F.R.* § 156.1010(f) Standards.

Highmark failed to notify the complainant of the disposition within three business days after the cases were resolved.

Recommendation: It is recommended that the Company notify complainants of the disposition within three business days after the cases are resolved as required by 45 *C.F.R.* § 156.1010(f).

<u>2 Exceptions</u> – 45 *C.F.R.* § 156.1010(g)(2) Standards.

Highmark failed to document a resolution summary within seven business days that included a clear and concise narrative explaining how the case was resolved including information about how and when the complainant was notified of the resolution.

Recommendation: It is recommended that the Company document the resolution summary of cases that should include a clear and concise narrative explaining how the case was resolved including information about how and when the complainant was notified of the resolution as required by 45 *C.F.R.* § 156.1010(g)(2).

<u>3 Exceptions</u> – 18 *Del. Admin. C.* § 332(c)(4) Arbitration of disputes involving health insurance coverage.

Highmark failed to acknowledge receipt of the appeals within five business days of receipt.

Recommendation: It is recommended that the Company provide written acknowledgement of grievances within 5 business days of receipt as required by 18 *Del. Admin. C.* § 332(c)(4).

E. Other Complaints

The Company was requested to provide a listing of all complaints filed with the Company during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 75 Other Complaints. These Other Complaints consisted of Executive and Legislative complaints received by the Company. All 75 Other Complaints were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

F. First Level Appeals

The Company was asked to provide a listing of all first level appeals during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 610 first level appeals. A random sample of 86 was reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

<u>30 Exceptions</u> – 18 *Del. Admin. C.* § 332(c)(4) Arbitration of disputes involving health insurance coverage.

Highmark failed to acknowledge receipt of the appeals within five business days of receipt.

Recommendation: It is recommended that the Company provide written acknowledgement of grievances within 5 business days of receipt as required by 18 *Del. Admin. C.* § 332(c)(4).

<u>2 Exceptions</u> – 18 *Del. C.* § 332(c)(5) Speedy review of grievances.

Highmark failed to decide the grievances in an expeditious manner.

Recommendation: It is recommended that the Company decide grievances in an expeditious manner as required by 18 *Del. C.* § 332(c)(5).

G. Second Level Appeals

The Company was asked to provide a listing of all second level appeals during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 59 second level appeals. All 59 second level appeals were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

H. Independent Utilization Review Organization

The Company was requested to provide a listing of all Independent Utilization Review Organizations (IUROs) filed with the Delaware Department of Insurance during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of four IUROs. The Department provided a listing of 21 IUROs. The listing was provided to the Company and were unable to locate 17 of the 21 IUROs. We received additional information from the Department and the Company was able to locate the missing 17 IUROs. All 21 were reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

<u>17 Exceptions</u> - 18 *Del. Admin. C.* § 1301-5.2 IHCAP Procedure

Highmark failed to transmit the appeals to the Department within 3 business days.

Recommendation: It is recommended that the Company transmit appeals electronically to the Department within 3 business days as required by 18 *Del. Admin. C.* § 1301-5.2.

<u>9 Exceptions</u> - 18 *Del. Admin. C.* § 1301-5.5 IHCAP Procedure.

Highmark failed to provide documents to the assigned IURO within 7 calendar days.

Recommendation: It is recommended that the Company provide documents to the assigned IURO within 7 calendar days as required by 18 *Del. Admin. C.* § 1301-5.5.

POLICYHOLDER SERVICES

Highmark was requested to provide a copy of the policies and procedures related to the handling and reimbursement of chronic care management and documentation showing how much of the total cost of medical care is spent on primary care during the exam period of January 1, 2021, through March 31, 2022. The Company's policies and procedures related to the handling and reimbursing of chronic care management were provided and reviewed.

All policy and procedure files were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

CLAIMS

A. Chronic Care Management Paid Claims

The Company was asked to provide a listing of all Chronic Care Management Claims paid during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 96 paid claims. A random sample of 76 were reviewed for compliance with applicable Statutes and Regulations.

There were no exceptions noted.

B. Chronic Care Management Denied Claims

The Company was asked to provide a listing of all Chronic Care Management Claims denied during the exam period of January 1, 2021, through March 31, 2022. The Company

provided a listing of 29 denied claims. All 29 claims were reviewed for compliance with applicable Statutes and Regulations.

There were no exceptions noted.

C. Insulin Pump Paid Claims

The Company was asked to provide a listing of all Insulin Pump Claims paid during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 707 paid claims. A random sample of 83 claims were reviewed for compliance with applicable Statutes and Regulations.

There were no exceptions noted.

D. Insulin Pump Denied Claims

The Company was asked to provide a listing of all Insulin Pump Claims denied during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 58 denied claims. All 58 claims were reviewed for compliance with applicable Statutes and Regulations.

There were no exceptions noted.

E. Experimental Claims

The Company was asked to provide a listing of all Experimental Claims during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 77 experimental claims. All 77 claims were reviewed for compliance with applicable Statutes and Regulations.

There were no exceptions noted.

F. Commercial Pharmacy Mental Health Paid Claims

The Company was asked to provide a listing of all the Commercial Pharmacy Mental Health paid claims filed with the Company during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 68,818 paid claims. A random sample of 109 claims were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

G. Commercial Pharmacy Substance Use Disorder Paid Claims

The Company was requested to provide a listing of all the Commercial Pharmacy Substance Use Disorder paid claims filed with the Company during the exam period of

January 1, 2021, through March 31, 2022. The Company provided a listing of 2,475 paid claims. A random sample of 107 claims were reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

<u>2 Exceptions</u> – 18 *Del. C.* § 2304(16)(f) Unfair claim settlement practices.

Highmark failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.

Recommendation: It is recommended that the Company effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear as required by 18 *Del. C.* § 2304(16)(f).

H. Commercial Pharmacy Medical Surgical Paid Claims

The Company was requested to provide a listing of all the Commercial Pharmacy Medical Surgical paid claims filed with the Company during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 247,070 paid claims. A random sample of 109 claims were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

I. ACA Pharmacy Mental Health Paid Claims

The Company was requested to provide a listing of all ACA Pharmacy Mental Health paid claims during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 128,221 paid claims. A random sample of 109 claims were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

J. ACA Pharmacy Substance Use Disorder Paid Claims

The Company was asked to provide a listing of all ACA Substance Use Disorder paid claims during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 4,499 paid claims. A random sample of 108 claims were reviewed for compliance with the applicable State Statutes and Regulations.

There were no exceptions noted.

K. ACA Pharmacy Medical Surgical Paid Claims

The Company was requested to provide a listing of all the ACA Pharmacy Medical Surgical paid claims during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 534,056 paid claims. A random sample of 109 claims were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

L. Commercial Pharmacy Mental Health Denied Claims

The Company was asked to provide a listing of all Commercial Pharmacy Mental Health denied claims during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 18,140 denied claims. A random sample of 109 claims were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

M. Commercial Pharmacy Substance Use Disorder Denied Claims

The Company was asked to provide a listing of all Commercial Pharmacy Substance Use Disorder denied claims during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 18,140 denied claims. A random sample of 109 claims were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

N. Commercial Pharmacy Medical Surgical Denied Claims

The Company was asked to provide a listing of all Commercial Pharmacy Medical Surgical denied claims during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 95,341 denied claims. A random sample of 109 claims were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

O. ACA Pharmacy Mental Health Denied Claims

The Company was asked to provide a listing of all ACA Pharmacy Mental Health denied claims during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 67,359 denied claims. A random sample of 109 claims were reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

<u>3 Exceptions</u> – 18 *Del. C.* § 3586(a) Length of Pre-Authorization.

Highmark failed to validate pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization.

Recommendation: It is recommended that the Company approve pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization as required by 18 *Del. C.* § 3586(a).

P. ACA Pharmacy Substance Use Disorder Denied Claims

The Company was asked to provide a listing of all ACA Substance Use Disorder denied claims during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 2,538 denied claims. A random sample of 107 claims were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

Q. Pharmacy ACA Medical Surgical Denied Claims

The Company was asked to provide a listing of all ACA Pharmacy Medical Surgical Denied claims during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 300,864 denied claims. A random sample of 109 claims were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

R. Pharmacy Insulin Paid Claims

The Company was requested to provide a listing of all the Pharmacy Insulin paid claims filed with the Company during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 8,207 paid claims. A random sample of 108 claims were reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

7 Exceptions – 18 *Del. C. §* 3560A(b)(1) Cost Sharing In Prescription Insulin Drugs.

Highmark failed to cap the total amount that the covered individuals were required to pay for prescription insulin drugs at $100 per month.

Recommendation: It is recommended that the Company cap the total amount that covered individuals are required to pay for prescription insulin drugs at $100 per month as required by 18 *Del. C.* § 3560A(b)(1).

S. Pharmacy Insulin Denied Claims

The Company was requested to provide a listing of all the Pharmacy Insulin denied claims filed with the Company during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 6,584 denied claims. A random sample of 108 claims were reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

6 Exceptions – 18 *Del. C. §* 3560A(b)(1) Cost Sharing In Prescription Insulin Drugs.

Highmark failed to cap the total amount that the covered individuals were required to pay for prescription insulin drugs at $100 per month.

Recommendation: It is recommended that the Company cap the total amount that covered individuals are required to pay for prescription insulin drugs at $100 per month as required by 18 *Del. C.* § 3560A(b)(1).

UTILIZATION REVIEW

A. Utilization Review Policies and Procedures

The Company was requested to provide a copy of the Utilization Review Policies and Procedures that were in effect during the exam period of January 1, 2021, through March 31, 2022. The policies and procedures were related to disclosures, determination timeliness, written notice of adverse determinations, written procedures for standard and expedited appeals, and timeliness determination for emergency procedures. The policies and procedures were reviewed for compliance with applicable statutes and regulations.

There were no exceptions noted.

B. Utilization Review Medical Approved

The Company was requested to provide a listing of all Utilization Reviews for the Medical approved cases filed with the Company during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 45,304 approved cases. A random sample of 116 cases were reviewed for compliance with the applicable State Statutes and Regulations.

There were no exceptions noted.

C. Utilization Review Medical Denied

The Company was requested to provide a listing of all Utilization Review Medical denied cases filed with the Company during the exam period of January 1, 2021, through March 31,

2022. The Company provided a listing of 4,622 denied cases. A random sample of 115 cases were reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

77 Exceptions – FORMS AND RATES BULLETIN NO. 39.

The Utilization Review files included notices to the insured that had the incorrect address for the Delaware Department.

Recommendation: It is recommended that the Company update all of their forms and documents to include the current address for the DDOI as required by FORMS AND RATES BULLETIN NO. 39.

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

Highmark failed to issue an adverse determination and notify the covered person's health-care provider of the determination within 5 business days of receipt of a clean pre-authorization.

Recommendation: It is recommended that the Company issue an adverse determination and notify the covered person's health-care provider of the determination within 5 business days of receipt of a clean pre-authorization as required by 18 *Del. C.* § 3583(c).

D. Utilization Review Medical Surgical Modified

The Company was requested to provide a listing of all Utilization Review Medical Surgical modified cases filed with the Company during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 6,804 modified cases. A random sample of 114 cases were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

E. Utilization Review Behavioral Health Approved

The Company was requested to provide a listing of all Utilization Reviews for the Behavioral Health approved cases filed with the Company during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 1,048 approved cases. A random sample of 113 cases were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

F. Utilization Review Behavioral Health Denied

The Company was requested to provide a listing of all Utilization Review Behavioral Health denied cases filed with the Company during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 37 denied cases. All 37 cases were reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

2 Exceptions – FORMS AND RATES BULLETIN NO. 39.

The Utilization Review files included notices to the insured that had the incorrect address for the Delaware Department.

Recommendation: It is recommended that the Company update all of their forms and documents to include the current address for the DDOI as required by FORMS AND RATES BULLETIN NO. 39.

1 Exception – 18 *Del. C.* § 3578(b)(2)(B) Coverage of Serious Mental Illness and Drug and Alcohol Dependencies.

Highmark denied a member medically necessary treatment for drug and alcohol dependencies in an intensive outpatient program.

Recommendation: It is recommended that the Company provide coverage for medically necessary treatment for drug and alcohol dependencies which includes intensive outpatient programs as required by 18 *Del. C.* § 3578(b)(2)(B).

G. Utilization Review Behavioral Health Modified

The Company was requested to provide a listing of all Utilization Reviews for the Utilization Review Behavioral Health modified cases filed with the Company during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 52 modified cases. All 52 cases were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

H. Pharmacy Utilization Review Medical Surgical Approved

The Company was requested to provide a listing of all Pharmacy Utilization Reviews for the Medical Surgical approved cases filed with the Company during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 6,893 approved cases. A random sample of 115 cases were reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

<u>1 Exception</u> – 18 *Del. C.* § 3376(a) Length of pre-authorization.

Highmark failed to validate pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization.

Recommendation: It is recommended that the Company approve pre-authorizations for pharmaceuticals for 1 year as required by 18 *Del. C*. § 3376(a).

<u>3 Exceptions</u> – 18 *Del. C.* § 3583(a) Utilization Review Entity's Obligations with Respect to Pre-Authorizations In Non-Emergency Circumstances.

Highmark failed to 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.

Recommendation: It is recommended that the Company 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 as required by 18 *Del. C.* § 3583(a).

I. Pharmacy Utilization Review Medical Surgical Denied

The Company was requested to provide a listing of all Utilization Review Pharmacy Medical Surgical denied cases filed with the Company during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 4,154 denied cases. A random sample of 115 cases were reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

<u>110 Exceptions</u> – FORMS AND RATES BULLETIN NO. 39.

The Utilization Review files included notices to the insured that had the incorrect address for the Delaware Department.

Recommendation: It is recommended that the Company update all of their forms and documents to include the current address for the DDOI as required by FORMS AND RATES BULLETIN NO. 39.

<u>1 Exception</u> – 18 *Del. C.* § 3342(2) Obstetrical and gynecological coverage.

Highmark failed to provide obstetrical and gynecological coverage including in vitro fertilization services to a member.

Recommendation: It is recommended that all of the Company's contracts include coverage for fertility care services, including in vitro fertilization services as required by 18 *Del. C.* § 3342(2).

<u>2 Exceptions</u> – 18 *Del. C.* § 3376(a) Length of pre-authorization.

Highmark failed to validate pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization.

Recommendation: It is recommended that the Company approve pre-authorizations for pharmaceuticals for 1 year as required by 18 *Del. C.* § 3376(a).

<u>1 Exception</u> – 18 *Del. C.* § 3381(a)(5) Step therapy exception process.

Highmark failed to expeditiously grant a step therapy exception when the patient was stable for the medical condition under consideration on a prescription medication prescribed by the members healthcare provider.

Recommendation: It is recommended that the Company grant a step therapy exception when the patient is stable, for the medical condition under consideration, on a prescription drug prescribed by the patient's health-care provider or while the patient was insured by the patient's current, or a previous insurance or health benefit plan as required by 18 *Del. C.* § 3381(a)(5).

<u>3 Exceptions</u> – 18 *Del. C.* § 3591(a)(5) Step therapy exception process.

Highmark failed to expeditiously grant a step therapy exception when the patient was stable for the medical condition under consideration on a prescription medication prescribed by the members healthcare provider.

Recommendation: It is recommended that the Company grant a step therapy exception when the patient is stable, for the medical condition under consideration, on a prescription drug prescribed by the patient's health-care provider or while the patient was insured by the patient's current, or a previous insurance or health benefit plan as required by 18 *Del. C.* § 3591(a)(5).

J. Pharmacy Utilization Review Mental Health Approved

The Company was requested to provide a listing of all Pharmacy Utilization Reviews for the Mental Health approved cases filed with the Company during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 1,136 approved cases. A random sample of 113 cases were reviewed for compliance with the applicable Statutes and Regulations.

The following exception was noted:

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

Highmark failed to 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.

Recommendation: It is recommended that the Company 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 as required by 18 *Del. C.* § 3583(a).

K. Pharmacy Utilization Review Mental Health Denied

The Company was requested to provide a listing of all Utilization Review Pharmacy Mental Health denied cases filed with the Company during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 488 denied cases. While there are laws for both individual and group policies, for brevity only the group citation are included in the summary. A random sample of 84 cases were reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

83 Exceptions – FORMS AND RATES BULLETIN NO. 39.

The Utilization Review files included notices to the insured that had the incorrect address for the Delaware Department.

Recommendation: It is recommended that the Company update all of their forms and documents to include the current address for the DDOI as required by FORMS AND RATES BULLETIN NO. 39.

5 Exceptions – 18 *Del. C.* § 3591(a)(5) Step therapy exception process.

Highmark failed to expeditiously grant a step therapy exception when the patient was stable for the medical condition under consideration on a prescription medication prescribed by the member's healthcare provider.

Recommendation: It is recommended that the Company grant a step therapy exception when the patient is stable, for the medical condition under consideration, on a prescription drug prescribed by the patient's health-care provider or while the patient was insured by the patient's current, or a previous insurance or health benefit plan as required by 18 *Del. C.* § 3591(a)(5).

L. Utilization Review Pharmacy Substance Use Disorder Approved

The Company was requested to provide a listing of all Utilization Reviews Pharmacy Substance Use Disorder approved cases filed with the Company during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 9 approved cases. All 9 cases were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

M. Utilization Review Pharmacy Substance Use Disorder Denied

The Company was requested to provide a listing of all Utilization Review Pharmacy Substance Use Disorder denied cases filed with the Company during the exam period of January 1, 2021, through March 31, 2022. The Company provided a listing of 23 denied cases. All 23 cases were reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

17 Exceptions – FORMS AND RATES BULLETIN NO. 39.

The Utilization Review files included notices to the insured that had the incorrect address for the Delaware Department.

Recommendation: It is recommended that the Company update all of their forms and documents to include the current address for the DDOI as required by FORMS AND RATES BULLETIN NO. 39.

1 Exception – 18 *Del. C.* § 3578(b)(2)a Insurance coverage for serious mental illness.

Highmark failed to provide a 5-day emergency supply of prescribed medications.

Recommendation: It is recommended that the Company provide immediate access, without prior authorization, to a 5-day emergency supply of prescribed medications covered under the health benefit plan for the medically necessary treatment of serious mental illnesses and drug and alcohol dependencies where an emergency medical condition, as defined in § 3349(e) of this title, exists, including a prescribed drug or medication associated with the management of opioid withdrawal or stabilization as required by 18 *Del. C.* § 3578(b)(2)a

1 Exception – 18 *Del. C.* § 3381(a)(5) Step therapy exception process.

Highmark failed to expeditiously grant a step therapy exception when the patient was stable for the medical condition under consideration on a prescription medication prescribed by the members healthcare provider.

Recommendation: It is recommended that the Company grant a step therapy exception when the patient is stable, for the medical condition under consideration, on a prescription drug prescribed by the patient's health-care provider or while the patient was insured by the patient's current, or a previous insurance or health benefit plan as required by 18 *Del. C.* § 3381(a)(5).

MENTAL HEALTH PARITY

The Company was requested to provide a copy of the current, up to date Mental Health Parity and Addiction Equity Act report during the exam period of January 1, 2021, through March 31, 2022. The report was to include a description of the process used to develop or select the medical necessity criteria for mental illness and drug and alcohol dependencies benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits.

A. Non-Pharmacy Non-Quantitative Treatment Limitations Review

The report identified all non-quantitative treatment limitations (NQTLs) that are applied to mental illness and drug and alcohol dependencies benefits and medical and surgical benefits within each classification of benefits. The Company identified the following five (5) Non-Pharmacy NQTL Analyses: Prior Authorization, Concurrent Review, Retrospective Review, Medical Necessity Review, and Experimental and Investigational. The Company provided a copy of the results of the analysis that demonstrates that the medical necessity criteria and NQTLs identified, as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each NQTL to mental illness and drug and alcohol dependencies benefits within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each NQTL to medical and surgical benefits within the corresponding classification of benefits.

It was noted that the appeal rates were significantly higher for MH/SUD than Med/Surg for both the Overall Enterprise and Delaware only metrics for the Prior Authorization NQTL. This trend was noted in both 2021 and 2022. This does not indicate that there is a disparity in the application of Prior Authorization NQTL to MH/SUD benefits compared to Med/Surg. This single data metric by itself does not constitute a violation; however, it could be a warning sign.

Highmark indicated it is currently investigating the reasons for the difference in appeal rates for MH/SUD and M/S denials. Appeal rates fluctuate considerably depending on the sample that is analyzed, but to date Highmark has not been able to definitively identify the specific causes for such fluctuation. Preliminary findings of Highmark's investigation into the causes for the difference in appeal rates for the fully insured market in Delaware in 2022 include:

- Highmark's review of policies and procedures for making medical necessity determinations have been relatively stable over recent years and are aligned across markets.
- Discussions with reviewers to identify causes for the difference in denial rates in Delaware or for the variability across time periods and markets have not generated clear answers.
- An analysis of variability across markets (including between self-insured and fully insured products and across states) did not identify any clear trends.

There were no exceptions noted.

B. Pharmacy Non-Quantitative Treatment Limitations Review

The report identified all non-quantitative treatment limitations (NQTLs) that are applied to mental illness and drug and alcohol dependencies benefits and medical and surgical benefits within each classification of benefits. The report consisted of the following Pharmacy NQTL Analyses: Prior Authorization, Step Therapy, Formulary Tiering and Quantity Limits. The Company included operational data for the NQTLs with the exception of the Quantity Limits.

There were no exceptions in the Pharmacy NQTL Analyses for Prior Authorization, Step Therapy, and Formulary Tiering. There were exceptions that were found with Prior Authorization with pharmaceuticals and Step Therapy that are addressed in the Pharmacy Review Section. The Mental Health Parity and Addiction Equity Act report was reviewed for compliance with applicable Statutes and Regulations.

There were no exceptions noted.

PHARMACY REVIEW

Highmark was requested to provide the written utilization management (UM) and/or drug utilization review (DUR) policies, Pharmacy and Therapeutics (P&T) Committee notes, formularies, formulary designs, and amendments in effect, step therapy protocols, and multiple information requests. The Company's documentation was reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

<u>12 Exceptions</u> – 18 *Del. C.* § 3571X Medication assisted treatment for drug and alcohol dependencies.

Highmark imposed a prior authorization on buprenorphine monotherapy for quantities over 5 days or for anything other than induction treatment, (a prior authorization is required for pregnancy or when there is an allergy, intolerance, or hypersensitivity to naloxone). The Company indicated there were 12 approved and denied cases for quantities greater than 5 days (for pregnancy or a medical necessity exception if there is an allergy, intolerance, or

hypersensitivity to naloxone) on buprenorphine sublingual tablets (monotherapy) from the exam period.

Recommendation: It is recommended that the Company not impose prior authorization requirements on medication-assisted treatments as required by 18 *Del. C.* § 3571X.

4 Exceptions – 18 *Del. C.* § 3571X Medication assisted treatment for drug and alcohol dependencies.

Highmark imposed a prior authorization on buprenorphine/naloxone-based medications per Medication policy J-0331 (006, 007, 008 and 009). The Company indicated that 4 members were affected by this policy.

Recommendation: It is recommended that the Company not impose prior authorization requirements on medication-assisted treatments as required by 18 *Del. C.* § 3571X.

1 Exception - 18 *Del. C.* § 3343(b) Insurance coverage for serious mental illness.

Highmark applied more stringent criteria on Vivitrol (Medical Policy I-92) which is a Substance Use Disorder medication (behavioral health policy), than compared to Medical/Surgical medication policies.

Recommendation: It is recommended that the Company not impose stricter limits on Mental Health/Substance Use Disorder medications than on Medical Surgical medications as required by 18 *Del. C.* § 3343(b).

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

Highmark applied more stringent criteria on Vivitrol (Medical Policy I-92) which is a Substance Use Disorder medication (behavioral health policy), than compared to Medical/Surgical medication policies.

Recommendation: It is recommended that the Company not impose stricter limits on Mental Health/Substance Use Disorder medications than on Medical/Surgical medications as required by 18 *Del. C.* § 3578(b).

1 Exception - 26 *C.F.R.* § 54.9812-1(c)(4)(i), 29 *C.F.R.* § 2590.712(c)(4)(i), 45 *C.F.R.* § 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits

Highmark applied more stringent criteria on Vivitrol (Medical Policy I-92) which is a Substance Use Disorder medication (behavioral health policy), than compared to Medical/Surgical medication policies.

Recommendation: It is recommended that the Company not impose stricter limits on Mental Health/Substance Use Disorder medications than on Medical/Surgical medications

as required by 26 *C.F.R.* § 54.9812-1(c)(4)(i), 29 *C.F.R.* § 2590.712(c)(4)(i), 45 *C.F.R.* § 146.136(c)(4)(i).

1 Exception - 18 *Del. C.* § 3343(b) Insurance coverage for serious mental illness

Highmark imposed more restrictive policy criteria on Zercapli (Medication Policy J-1164) which is a Mental Health medication, compared to Medical/Surgical medication policies.

Recommendation: It is recommended that the Company not impose stricter limits on Mental Health/Substance Use Disorder medications than on Medical Surgical medications as required by 18 *Del. C.* § 3343(b).

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

Highmark imposed more restrictive policy criteria on Zercapli (Medication Policy J-1164) which is a Mental Health medication, compared to Medical/Surgical medication policies.

Recommendation: It is recommended that the Company not impose stricter limits on Mental Health/Substance Use Disorder medications than on Medical/Surgical medications as required by 18 *Del. C.* § 3578(b).

1 Exception - 26 *C.F.R.* § 54.9812-1(c)(4)(i), 29 *C.F.R.* § 2590.712(c)(4)(i), 45 *C.F.R.* § 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits

Highmark imposed more restrictive policy criteria on Zercapli (Medication Policy J-1164) which is a Mental Health medication, compared to Medical/Surgical medication policies.

Recommendation: It is recommended that the Company not impose stricter limits on Mental Health/Substance Use Disorder medications than on Medical/Surgical medications as required by 26 *C.F.R.* § 54.9812-1(c)(4)(i), 29 *C.F.R.* § 2590.712(c)(4)(i), 45 *C.F.R.* § 146.136(c)(4)(i).

1 Exception – 18 *Del. C.* § 3376(a) Length of pre-authorization.

Highmark failed to validate a 1-year pre-authorization on Zercapli (Medication Policy J-1164) from the date the health-care provider receives the pre-authorization.

Recommendation: It is recommended that the Company approve pre-authorizations for pharmaceuticals for 1 year as required by 18 *Del. C.* § 3376(a).

1 Exception - 18 *Del. C.* § 3343(b) Insurance coverage for serious mental illness

Highmark imposed more restrictive policy criteria on Lybalvi (Medication Policy J-1119) which is a Mental Health medication, compared to Medical/Surgical medication policies.

Recommendation: It is recommended that the Company not impose stricter limits on Mental Health/Substance Use Disorder medications than on Medical Surgical medications as required by 18 *Del. C.* § 3343(b).

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

Highmark imposed more restrictive policy criteria on Lybalvi (Medication Policy J-1119) which is a Mental Health medication, compared to Medical/Surgical medication policies.

Recommendation: It is recommended that the Company not impose stricter limits on Mental Health/Substance Use Disorder medications than on Medical/Surgical medications as required by 18 *Del. C.* § 3578(b).

1 Exception - 26 *C.F.R.* § 54.9812-1(c)(4)(i), 29 *C.F.R.* § 2590.712(c)(4)(i), 45 *C.F.R.* § 146.136(c)(4)(i) Parity in mental health and substance use disorder benefits

Highmark imposed more restrictive policy criteria on Lybalvi (Medication Policy J-1119) which is a Mental Health medication, compared to Medical/Surgical medication policies.

Recommendation: It is recommended that the Company not impose stricter limits on Mental Health/Substance Use Disorder medications than on Medical/Surgical medications as required by 26 *C.F.R.* § 54.9812-1(c)(4)(i), 29 *C.F.R.* § 2590.712(c)(4)(i), 45 *C.F.R.* § 146.136(c)(4)(i).

162 Exceptions – 18 *Del. C.* § 2304(16)(f) Unfair methods of competition and unfair or deceptive acts or practices defined.

Highmark failed to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. The Company did not cover Methadone for Opioid Use Disorder (OUD) across all plans for out-of-network providers/facilities.

Recommendation: It is recommended that the Company effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear as required by 18 *Del. C.* § 2304(16)(f).

24 Exceptions – 18 *Del. C.* § 3586(a) Length of Pre-Authorization.

Highmark failed to validate pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization. There were 24 policies with 1,698 drug utilization reviews affecting 1,132 members.

Recommendation: It is recommended that the Company approve pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization as required by 18 *Del. C.* § 3586(a).

<u>1 Exception</u> – 18 *Del. C.* § 3343(b)(2)a Insurance coverage for serious mental illness.

Highmark imposed a 14-day supply limit every 90 days (90-day lock-out) on Lucemyra and did not allow a member to have access to additional 5-day supplies within the 90-day lock-out period from 1/1/2021 to 12/9/2021 until the coding was updated.

Recommendation: It is recommended that the Company provide immediate access, without prior authorization, to a 5-day emergency supply of prescribed medications covered under the health benefit plan for the medically necessary treatment of serious mental illnesses and drug and alcohol dependencies where an emergency medical condition, as defined in § 3349(e) of this title, exists, including a prescribed drug or medication associated with the management of opioid withdrawal or stabilization as required by 18 *Del. C.* § 3343(b)(2)a.

<u>1 Exception</u> – 18 *Del. C.* § 3578(b)(2)a Insurance coverage for serious mental illness.

Highmark imposed a 14-day supply limit every 90 days (90-day lock-out) on Lucemyra and did not allow a member to have access to additional 5-day supplies within the 90-day lock-out period from 1/1/2021 to 12/9/2021 until the coding was updated.

Recommendation: It is recommended that the Company provide immediate access, without prior authorization, to a 5-day emergency supply of prescribed medications covered under the health benefit plan for the medically necessary treatment of serious mental illnesses and drug and alcohol dependencies where an emergency medical condition, as defined in § 3349(e) of this title, exists, including a prescribed drug or medication associated with the management of opioid withdrawal or stabilization as required by 18 *Del. C.* § 3578(b)(2)a.

PHARMACY BENEFIT MANAGER AND THIRD-PARTY ADMINISTRATOR OVERSIGHT

The Company was asked to provide documentation for Pharmacy Benefit Manager (PBM) and Third-Party Administrators (TPAs) during the exam period of January 1, 2021, through March 31, 2022. The Company provided 78 documents for review. Documentation requested was clarification of the PBM and TPA operational process including policies and procedures, audits, and licenses/registrations. All the documents were reviewed for compliance with the applicable State Statutes and Regulations.

The Company utilizes Express Scripts, Inc. (ESI) in a quasi-dual capacity as a PBM and a TPA. ESI is not only the Pharmacy Benefit Manager but also the processor of all pharmacy claims.

The Company is utilizing properly licensed Third-Party Administrators and have procedures in place to monitor the activity of the TPAs. The Company provided numerous assurance reports that were reviewed by Vendor Risk Assessment performed by the Company's Growth Enablement Office, Vendor Management Compliance Oversight team. There were no exceptions noted.

A. Rebates

The scope of the examination was expanded on October 26, 2022, to include Pharmacy Benefit Manager (PBM) and Third-Party Administrator (TPA) relationships and oversight. As part of the expansion the company was asked to provide documentation of how rebates are received, the amount of rebates received, how they were distributed back to policyholders, and how they were accounted for in the annual reports and rate filings during the examination period of January 1, 2021, through March 31, 2022

The Company provided the amount of rebates received for the exam period, market-wide base rate development calculation, and annual statements reflecting the rebates.

The Company was unwilling to provide the rebate guarantees as they indicated they are proprietary and confidential. However, they did advise that eligible scripts are multiplied by the appropriate formulary/channel guarantee to determine rebate revenue and that this revenue is collected from the PBM approximately four months after the date of service.

The amounts of rebates provided were reconciled with the amounts reported in the annual statements. The Company uses the rebates in a socialized method of reducing premiums amongst all members, which was reflected in their market-wide base rate development calculation. All the documents were reviewed for compliance with the applicable State Statutes and Regulations.

There were no exceptions noted.

CONCLUSION

As stated in the Scope of Examination section, the purpose of the examination was to determine compliance by Highmark BCBDS, INC with applicable insurance laws and regulations related to the healthcare lines.

The recommendations made below identify corrective measures the Department finds necessary as a result of the exceptions noted in the Report.

1. It is recommended that the Company notify complainants of the disposition within three business days after the cases are resolved as required by 45 *C.F.R.* § 156.1010(f).

2. It is recommended that the Company document the resolution summary of cases that should include a clear and concise narrative explaining how the case was resolved including information about how and when the complainant was notified of the resolution as required by 45 *C.F.R.* § 156.1010(g)(2).

3. It is recommended that the Company update all of their forms and documents to include the current address for the DDOI as required by FORMS AND RATES BULLETIN NO. 39.

4. It is recommended that the Company effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear as required by 18 *Del. C.* § 2304(16)(f).

5. It is recommended that the Company provide written acknowledgement of grievances within 5 business days of receipt as required by 18 *Del. Admin. C.* § 332(c)(4).

6. It is recommended that the Company decide grievances in an expeditious manner as required by 18 *Del. C.* § 332(c)(5).

7. It is recommended that the Company transmit appeals electronically to the Department within 3 business days as required by 18 *Del. Admin. C.* § 1301-5.2.

8. It is recommended that the Company provide documents to the assigned IURO within 7 calendar days as required by 18 *Del. Admin. C.* § 1301-5.5.

9. It is recommended that the Company approve pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization as required by 18 *Del. C.* § 3586(a).

10. It is recommended that the Company cap the total amount that covered individuals are required to pay for prescription insulin drugs at $100 per month as required by 18 *Del. C.* § 3560A(b)(1).

11. It is recommended that the Company issue an adverse determination and notify the covered person's health-care provider of the determination within 5 business days of receipt of a clean pre-authorization as required by 18 *Del. C.* § 3583(c)..

12. It is recommended that the Company provide coverage for medically necessary treatment for drug and alcohol dependencies which includes intensive outpatient programs as required by 18 *Del. C.* § 3578(b)(2)(B).

13. It is recommended that the Company approve pre-authorizations for pharmaceuticals for 1 year as required by 18 *Del. C.* § 3376(a).

14. It is recommended that the Company 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 as required by 18 *Del. C.* § 3583(a).

15. It is recommended that all of the Company's contracts include coverage for fertility care services, including in vitro fertilization services as required by 18 *Del. C.* § 3342(2).

16. It is recommended that the Company grant a step therapy exception when the patient is stable, for the medical condition under consideration, on a prescription drug prescribed by the patient's health-care provider or while the patient was insured by the patient's current, or a previous insurance or health benefit plan as required by 18 *Del. C.* § 3381(a)(5).

17. It is recommended that the Company grant a step therapy exception when the patient is stable, for the medical condition under consideration, on a prescription drug prescribed by the patient's health-care provider or while the patient was insured by the patient's current, or a previous insurance or health benefit plan as required by 18 *Del. C.* § 3591(a)(5).

18. It is recommended that the Company not impose stricter limits on Mental Health/Substance Use Disorder medications than on Medical/Surgical medications as required by 18 *Del. C.* § 3578(b).

19. It is recommended that the Company not impose stricter limits on Mental Health/Substance Use Disorder medications than on Medical/Surgical medications as required by 26 *C.F.R.* § 54.9812-1(c)(4)(i), 29 *C.F.R.* § 2590.712(c)(4)(i), 45 *C.F.R.* § 146.136(c)(4)(i).

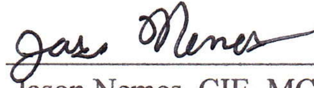
20. It is recommended that the Company provide immediate access, without prior authorization, to a 5-day emergency supply of prescribed medications covered under the health benefit plan for the medically necessary treatment of serious mental illnesses and drug and alcohol dependencies where an emergency medical condition, as defined in § 3349(e) of this title, exists, including a prescribed drug or medication associated with the management of opioid withdrawal or stabilization as required by 18 *Del. C.* § 3343(b)(2)a.

21. It is recommended that the Company provide immediate access, without prior authorization, to a 5-day emergency supply of prescribed medications covered under the health benefit plan for the medically necessary treatment of serious mental illnesses and drug and alcohol dependencies where an emergency medical condition, as defined in § 3349(e) of this title, exists, including a prescribed drug or medication associated with the management of opioid withdrawal or stabilization as required by 18 *Del. C.* § 3578(b)(2)a.

22. It is recommended that the Company not impose prior authorization requirements on medication-assisted treatments as required by 18 *Del. C.* § 3571X

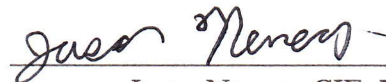
23. It is recommended that the Company not impose stricter limits on Mental Health/Substance Use Disorder medications than on Medica/Surgical medications as required by 18 *Del. C.* § 3343(b).

The examination conducted by Joseph Krug, Jason Nemes, Peter Salvatore, Gwendolyn Douglas, Michael Vogel, Kirk Stephan, and Jeffrey Smith is respectfully submitted.



Jason Nemes, CIE, MCM
Examiner-in-Charge
Market Conduct
Delaware Department of Insurance

I, Jason Nemes, 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 53287-22-701.



Jason Nemes, CIE, MCM