

DELAWARE DEPARTMENT OF INSURANCE

MARKET CONDUCT EXAMINATION REPORT

UNITEDHEALTHCARE INSURANCE COMPANY

NAIC #79413

**4 Research Drive
Shelton, CT 06474**

As of

December 31, 2022

TRINIDAD NAVARRO
COMMISSIONER



STATE OF DELAWARE
DEPARTMENT OF INSURANCE

REPORT ON EXAMINATION
OF THE

UNITEDHEALTHCARE INSURANCE COMPANY

AS OF

December 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 12 day of September, 2025.



Trinidad Navarro
Insurance Commissioner

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 December 31, 2022 on

UNITEDHEALTHCARE INSURANCE COMPANY

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

Attest By: *Trinidad Navarro*



In Witness Whereof, I have hereunto set my hand and affixed the official seal of this Department at the City of Dover, this 12 day of September, 2025.

Trinidad Navarro
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: 79413-23-MHP-535 and pursuant to statutory provisions including 18 Delaware Code §§ 318-322, a market conduct examination has been conducted of the affairs and practices of:

UnitedHealthcare Insurance Company
NAIC #79413

This examination was performed as of December 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 June 30, 2019. This examination focused on UnitedHealthcare Insurance Company (UnitedHealthcare, UHIC or the Company) healthcare lines in the following areas of operation: Complaint and Grievance Handling, Policyholder Services, Claims, Utilization Review, Mental Health Parity, Pharmacy Review, and the Company's relationships and oversight of contracted Pharmacy Benefit Managers (PBMs) and Third-Party Administrators (TPAs). The scope of the examination was expanded on May 15, 2023, to include the Insurer application and monitoring of medical necessity criteria. Those exceptions that were cited in the previous exam will be indicated below. The following exceptions were noted and the details for the cited code references are included below:

- **10 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.*

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

- **1 Exception**

- **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.*

UnitedHealthcare failed to decide the grievance 30 days after the receipt of all necessary information.

- **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.

UnitedHealthcare 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.

- **1 Exception**

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.

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

- **1 Exception**

18 Del. C. § 3571V(b) Time of submitting claim for reimbursement.

(b) Regardless of network status, a carrier shall permit a provider a minimum of 180 days from the date a covered service is rendered to submit a claim for reimbursement. Any contract between a carrier and provider that prohibits a provider from submitting a claim beyond the minimum time limit required under this section shall not be deemed a violation of this section.

UnitedHealthcare failed to permit a provider a minimum of 180 days from the date a covered service is rendered to submit a claim for reimbursement.

- **5 Exceptions**

18 Del. Admin. C. § 1310-6.1.1 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.

UnitedHealthcare failed to pay the total allowed amount of the claims deemed payable within 30 days after receipt of the clean claim. This was cited in the previous examination.

- **2 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.*

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

- **2 Exceptions**

- **18 Del. Admin. C. § 1310-6.1.2 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.*

UnitedHealthcare failed to pay the allowable portion of the claims that were deemed payable within 30 days after receipt. This was cited in the previous examination.

- **4 Exceptions**

- **18 Del. Admin. C. § 1310-6.1.3 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.

UnitedHealthcare failed to notify in writing why the claims would not be paid within 30 days. This was cited in the previous examination.

- **2 Exceptions**

- **18 Del. Admin. C. § 1310-6.1.4 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.*

UnitedHealthcare failed to request in writing that the provider or policyholder provide documentation that is relevant and necessary for the claim within 30 days. This was cited in the previous examination.

- **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.*

UnitedHealthcare 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.

- **3 Exceptions**

- **18 Del. C. § 3578(b)(2) 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:

- 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.*

UnitedHealthcare failed to use the full set of ASAM criteria.

- **1 Exception**

- **18 Del. C. § 3578(d)(1)b 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:

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.

UnitedHealthcare imposed a precertification for alcohol dependency.

- **1 Exception**

- **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.

UnitedHealthcare failed to provide a 60-day authorization period.

- **32 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.

UnitedHealthcare 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. § 3591(a)(1) 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:

(1) The required prescription drug is contraindicated or will likely cause an adverse reaction by or physical or mental harm to the patient.

UnitedHealthcare failed to expeditiously grant a step therapy exception determination when the member was likely to have an adverse reaction from the medication being required.

- **3 Exceptions**

18 Del. C. § 3591(a)(3) 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:

(3) The patient has tried the required prescription drug while under the patient's current or previous health insurance or health benefit plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action, and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

UnitedHealthcare failed to expeditiously grant a step therapy exception determination when a member had tried the required prescription drug or another prescription drug in the same pharmacologic class or with the same mechanism of action, and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

- **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.

UnitedHealthcare 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.

- **1 Exception**

- **18 Del. C. § 2304(16)a Unfair methods of competition and unfair or deceptive acts or practices defined.**

- *(16) Unfair claim settlement practices. — No person shall commit or perform with such frequency as to indicate a general business practice any of the following:*

- *a. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;*

- UnitedHealthcare failed to use the pertinent facts relating to coverage when making a decision

- **2 Exceptions**

- **18 Del. C. § 3571U Mental Health Parity and Addiction Equity Act reporting requirements.**

- *Each health insurer offering group health insurance coverage that provides mental illness and drug and alcohol dependencies benefits must submit a report to the Delaware Health Information Network and Commissioner on or before July 1 2019, and any year thereafter during which the insurer makes significant changes to how it designs and applies its medical management protocols; the report must contain the following information:*

- *(1) 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.*

- *(2) Identification of all nonquantitative treatment limitations (NQTs) that are applied to mental illness and drug and alcohol dependencies benefits and medical and surgical benefits within each classification of benefits; there may be no separate NQTs that apply to mental illness and drug and alcohol dependencies benefits that do not also apply to medical and surgical benefits within any classification of benefits.*

- (3) The results of an analysis that demonstrates that for the medical necessity criteria described in paragraph (1) of this section and for each NQTL identified in paragraph (2) of this section, 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; at a minimum, the results of the analysis shall:*
- a. Identify the factors used to determine that an NQTL will apply to a benefit, including factors that were considered but rejected.*
 - b. Identify and define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each NQTL.*
 - c. Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each NQTL, as written, for mental illness and drug and alcohol dependencies benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each NQTL, as written, for medical and surgical benefits.*
 - d. Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each NQTL, in operation, for mental illness and drug and alcohol dependencies benefits are comparable to, and applied no more stringently than, the processes or strategies used to apply each NQTL, in operation, for medical and surgical benefits.*
 - e. Disclose the specific findings and conclusions reached by the insurer that the results of the analyses above indicate that the carrier is in compliance with this section and the Mental Health Parity and Addiction Equity Act of 2008 [P.L. 104-204] and its implementing regulations, which includes 45 C.F.R. 146.136 and any other related federal regulations found in the Code of Federal Regulations.*
- (4) Any information submitted to the Delaware Health Information Network and Commissioner by a carrier that is considered proprietary by the carrier shall not be made public record.*
- (5) The Insurance Commissioner shall retain the authority to enforce the provisions of this section. The provisions of this section shall not give rise to a private cause of action.*

UnitedHealthcare's Formulary Design and Prior Auth/Step Therapy NQTL Analyses are not sufficiently specific, detailed, and reasoned to demonstrate whether the processes, strategies, evidentiary standards, or other factors used in developing and applying the NQTL are comparable and applied no more stringently to MH/SUD benefits than to MED/SURG benefits.

- **2 Exceptions**
 - 42 U.S. Code § 300gg-26 Parity in mental health and substance use disorder benefits.**
 - (8) Compliance requirements*
 - (A) Nonquantitative treatment limitation (NQTL) requirements*

In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits and that imposes nonquantitative treatment limitations (referred to in this section as “NQTLs”) on mental health or substance use disorder benefits, such plan or issuer shall perform and document comparative analyses of the design and application of NQTLs and, beginning 45 days after December 27, 2020, make available to the applicable State authority (or, as applicable, to the Secretary of Labor or the Secretary of Health and Human Services), upon request, the comparative analyses and the following information:

(i) The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all mental health or substance use disorder and medical or surgical benefits to which each such term applies in each respective benefits classification.

(ii) The factors used to determine that the NQTLs will apply to mental health or substance use disorder benefits and medical or surgical benefits.

(iii) The evidentiary standards used for the factors identified in clause (ii), when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to mental health or substance use disorder benefits and medical or surgical benefits.

(iv) The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification.

(v) The specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results of the analyses described in this subparagraph that indicate that the plan or coverage is or is not in compliance with this section.

UnitedHealthcare’s Formulary Design and Prior Auth/Step Therapy NQTL Analyses are not sufficiently specific, detailed, and reasoned to demonstrate whether the processes, strategies, evidentiary standards, or other factors used in developing and applying the NQTL are comparable and applied no more stringently to MH/SUD benefits than to MED/SURG benefits.

- **412 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.*

UnitedHealthcare failed to validate pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization. There were 409

policies with 82 drug utilization reviews affecting 62 members. This was cited in the previous examination.

- **211 Exceptions**

18 Del. C. § 3578(b)(1)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.

UnitedHealthcare imposed more restrictive terms or limits in the coverage of prescription MH/SUD medications when compared to MED/SURG medications.

Pharmacy Summaries	Exceptions
30-Day Retail Limit on Mental Health Medications	4
Buprenorphine (Probuphine Sublocade) Medical Benefit Drug Policy D0057M	4
30-Day Retail Limit on Substance Abuse Medications	186
Lithobid Prior Authorization Requirements	2
Spravato Prior Authorization Requirements	14
Lybalvi Prior Authorization	1
Total	218

- **211 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.

UnitedHealthcare imposed more restrictive terms or limits in the coverage of prescription MH/SUD medications when compared to MED/SURG medications.

Pharmacy Summaries	Exceptions
30-Day Retail Limit on Mental Health Medications	4
Buprenorphine (Probuphine Sublocade) Medical Benefit Drug Policy D0057M	4
30-Day Retail Limit on Substance Abuse Medications	186
Lithobid Prior Authorization Requirements	2
Spravato Prior Authorization Requirements	14
Lybalvi Prior Authorization	1
Total	218

- **9 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.

UnitedHealthcare imposed prior authorization requirements on medication-assisted treatments.

- **1 Exception**
18 Del. C. § 3580(g) Specialty tier prescription coverage.
(g) Nothing contained in any other provision of Delaware law or regulation shall preclude a health plan or other entity subject to this chapter from requiring specialty drugs to be obtained through a designated pharmacy or other source of such drugs.

UnitedHealthcare is requiring drugs, which do not meet the definition of specialty drug(s) pursuant to 18 Del. C. § 3580(a)(7), to be obtained through Company designated specialty pharmacies.

- **3 Exceptions**

18 Del. C. § 3578(b)(1)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.

UnitedHealthcare imposed more restrictive terms or limits in the coverage of prescription MH/SUD medications when compared to MED/SURG medications by excluding MH/SUD medications from the following programs.

Pharmacy Summaries	Exceptions
Contingency Edit Program	1
Dx2Rx Program	1
Silent Auth Program	1
Total	3

- **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.

UnitedHealthcare imposed more restrictive terms or limits in the coverage of prescription MH/SUD medications when compared to MED/SURG medications by excluding MH/SUD medications from the following programs.

Pharmacy Summaries	Exceptions
Contingency Edit Program	1
Dx2Rx Program	1
Silent Auth Program	1
Total	3

- **17 Exceptions**

18 Del. C. § 2304(1)a Unfair methods of competition and unfair or deceptive acts or practices defined.

The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(1) Misrepresentations and false advertising of insurance policies. — No person shall make, issue, circulate or cause to be made, issued or circulated any estimate, circular, statement, sales presentation, omission or comparison which:

a. Misrepresents the benefits, advantages, conditions or terms of any insurance policy;

UnitedHealthcare included misleading information in the Schedule of Benefits or Certificate of Coverages by listing incorrect monetary limits and/or age restrictions for infertility coverage which is prohibited in accordance with 18 Del. C. § 3556.

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 December 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 June 30, 2019, Chapters 33 and 35, and compliance with any related updated Delaware Code requirements. The scope was expanded on May 15, 2023, to include the Insurer application and monitoring of medical necessity criteria.

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.

UnitedHealthcare 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, UHIC'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 UHIC'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 December 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 a copy of the Company's Appeals and Grievances policies and procedures during the exam period of January 1, 2021, through December 31, 2022. The Company's policies and procedures related to the handling and processing of appeals and grievances were provided and reviewed. The policies and procedures were reviewed for compliance with applicable Statutes and Regulations.

There were no exceptions noted.

C. 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 December 31, 2022. The Company provided a universe of 5 Delaware complaints. All 5 were reviewed for compliance with the applicable Statutes and Regulations.

The Delaware Department of Insurance provided a list of (three) 3 complaints that were received during the examination period. The listing was reconciled with the Company's complaint listing for any discrepancies.

No exceptions were noted.

D. 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 December 31, 2022. The Company provided a listing of 89 first level appeals. A random sample of 79 first level appeals was reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

10 Exceptions – 18 Del. Admin. C. § 332(c)(4) Arbitration of disputes involving health insurance coverage.

UnitedHealthcare 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).

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

UnitedHealthcare failed to decide the grievance 30 days after the receipt of all necessary information.

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

E. 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 December 31, 2022. The Company provided a listing of two (2) second level appeals. Both level appeals were reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

2 Exceptions – 18 Del. C. § 3381(a)(5) Step therapy exception process.

UnitedHealthcare 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. § 3381(a)(5).

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 December 31, 2022. The Company provided a universe of two (2) IUROs. Both IUROs were reviewed for compliance with the applicable Statutes and Regulations.

The following exception was noted:

1 Exception - 18 Del. Admin. C. § 1301-5.2 IHCAP Procedure

UnitedHealthcare 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.

POLICYHOLDER SERVICES

The Company was requested to provide a copy of the policies and procedures related to the handling and reimbursement of chronic care management, 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 December 31, 2022, and the 2021 and 2022 annual statements. The Company's policies and procedures, documentation, and annual statements were reviewed for compliance with applicable statutes and regulations.

There were no exceptions noted.

CLAIMS

A. Claims Policies and Procedures

The Company was requested to provide the policies and procedures related to the acceptance of electronic claims, internal claim audit reports specific to mental health or substance use disorders and claims handling and processing for the exam period of January 1, 2021, through December 31, 2022. The Company's policies and procedures were reviewed for compliance with applicable Statutes and Regulations.

There were no exceptions noted.

B. Chronic Care Management Paid Claims

The Company was asked to provide a listing of all Chronic Care Management Paid Claims during the exam period of January 1, 2021, through December 31, 2022. The Company provided a listing of 126 paid claims. A random sample of 76 paid claims was reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

C. Chronic Care Management Denied Claims

The Company was asked to provide a listing of all Chronic Care Management Denied Claims during the exam period of January 1, 2021, through December 31, 2022. The Company provided a listing of 7 denied claims. All 7 denied claims were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

D. Insulin Pump Paid Claims

The Company was asked to provide a listing of all Insulin Pump Paid Claims during the exam period of January 1, 2021, through December 31, 2022. The Company provided a listing of three (3) Insulin pump paid claims. All three (3) paid claims were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

E. Medical Paid Claims

The Company was asked to provide a listing of all Medical Paid Claims during the exam period of January 1, 2021, through December 31, 2022. The Company provided a listing of 91,380 paid claims. A random sample of 109 paid claims was reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

1 Exception - 18 Del. C. § 3571V(b) Time of submitting claim for reimbursement.

UnitedHealthcare failed to permit a provider a minimum of 180 days from the date a covered service is rendered to submit a claim for reimbursement.

Recommendation: It is recommended that the Company permit a provider a minimum of 180 days from the date a covered service is rendered to submit a claim for reimbursement as required by 18 Del. C. § 3571V(b).

1 Exception – 18 Del. Admin. C. § 1310-6.1.1 Processing of Clean Claim.

UnitedHealthcare failed to pay the total allowed amount of the claims deemed payable within 30 days after receipt of the clean claim.

Recommendation: It is recommended that the Company pay the total allowed amount of the claim deemed payable within 30 days as required by 18 Del. Admin. C. § 1310-6.1.1.

F. Medical Denied Claims

The Company was asked to provide a listing of all Medical Claims Denied during the exam period of January 1, 2021, through December 31, 2022. The Company provided a listing of 1,306 denied claims. A random sample of 82 denied claims was reviewed for compliance with the applicable Statutes and Regulations.

The following exception was noted:

1 Exception – 18 Del. C. § 2304(16)(f) Unfair claim settlement practices.

UnitedHealthcare 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).

G. Medical Closed Claims

The Company was asked to provide a listing of all Medical Claims Closed during the exam period of January 1, 2021, through December 31, 2022. The Company provided a listing of 3,047 closed claims. A random sample of 107 closed claims was reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

2 Exceptions – 18 Del. Admin. C. § 1310-6.1.1 Processing of Clean Claim.

UnitedHealthcare failed to pay the total allowed amount of the claims deemed payable within 30 days after receipt of the clean claim.

Recommendation: It is recommended that the Company pay the total allowed amount of the claim deemed payable within 30 days as required by 18 Del. Admin. C. § 1310-6.1.1.

H. Mental Health Paid Claims

The Company was asked to provide a listing of all Mental Health Paid Claims during the exam period of January 1, 2021, through December 31, 2022. The Company provided a listing of 5,143 paid claims. A random sample of 108 paid claims was reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

I. Mental Health Denied Claims

The Company was asked to provide a listing of all Mental Health Denied Claims during the exam period of January 1, 2021, through December 31, 2022. The Company provided a listing of 1,306 denied claims. A random sample of 82 denied claims was reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

2 Exceptions – 18 Del. Admin. C. § 1310-6.1.2 Processing of Clean Claim.

UnitedHealthcare failed to pay the allowable portion of the claims that were deemed payable within 30 days after receipt.

Recommendation: It is recommended that the Company 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 within 30 days as required by 18 Del. Admin. C. § 1310-6.1.2.

3 Exceptions – 18 Del. Admin. C. § 1310-6.1.3 Processing of Clean Claim.

UnitedHealthcare failed to notify in writing why the claims would not be paid within 30 days.

Recommendation: It is recommended that if the entire claim is deemed not payable, the Company notify the provider or policyholder in writing why the claim will not be paid within 30 days as required by 18 Del. Admin. C. § 1310-6.1.3.

J. Mental Health Closed Claims

The Company was asked to provide a listing of all Mental Health Closed Claims during the exam period of January 1, 2021, through December 31, 2022. The Company provided a listing of 75 closed claims. A random sample of 75 closed claims was reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

2 Exceptions – 18 Del. Admin. C. § 1310-6.1.1 Processing of Clean Claim.

UnitedHealthcare failed to pay the total allowed amount of the claims deemed payable within 30 days after receipt of the clean claim.

Recommendation: It is recommended that the Company pay the total allowed amount of the claim deemed payable within 30 days as required by 18 Del. Admin. C. § 1310-6.1.1.

1 Exception – 18 Del. Admin. C. § 1310-6.1.4 Processing of Clean Claim.

UnitedHealthcare failed to request in writing that the provider or policyholder provide documentation that is relevant and necessary for the claim within 30 days.

Recommendation: It is recommended that if the Company needs additional information from a provider or policyholder that they request in writing that the provider or policyholder provide documentation that is relevant and necessary within 30 days as required by 18 Del. Admin. C. § 1310-6.1.4.

K. Substance Use Disorder Paid Claims

The Company was asked to provide a listing of all Substance Use Disorder Paid Claims during the exam period of January 1, 2021, through December 31, 2022. The Company provided a listing of 633 paid claims. A random sample of 83 paid claims was reviewed for compliance with the applicable Statutes and Regulations. Four additional claims were selected as four Medicare claims were included in the sampling.

There were no exceptions noted.

L. Substance Use Disorder Denied Claims

The Company was asked to provide a listing of all Substance Use Disorder Claims Denied during the exam period of January 1, 2021, through December 31, 2022. The Company provided a listing of 78 denied claims. A random sample of 76 denied claims was reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

M. Substance Use Disorder Closed Claims

The Company was asked to provide a listing of all Substance Use Disorder Closed Claims during the exam period of January 1, 2021, through December 31, 2022. The Company provided a listing of 15 closed claims. All 15 closed claim samples were reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

1 Exception – 18 Del. Admin. C. § 1310-6.1.3 Processing of Clean Claim.

UnitedHealthcare failed to notify in writing why the claim would not be paid within 30 days.

Recommendation: It is recommended that if the entire claim is deemed not payable, the Company notify the provider or policyholder in writing why the claim will not be paid within 30 days as required by 18 Del. Admin. C. § 1310-6.1.3.

1 Exception – 18 Del. Admin. C. § 1310-6.1.4 Processing of Clean Claim.

UnitedHealthcare failed to request in writing that the provider or policyholder provide documentation that is relevant and necessary for the claim within 30 days.

Recommendation: It is recommended that if the Company needs additional information from a provider or policyholder that they request in writing that the provider or policyholder provide documentation that is relevant and necessary within 30 days as required by 18 Del. Admin. C. § 1310-6.1.4.

N. Pharmacy Medical Surgical Paid Claims

The Company was asked to provide a listing of all Pharmacy Medical Paid Claims during the exam period of January 1, 2021, through December 31, 2022. The Company provided a listing of 19,265 paid claims. A random sample of 109 paid claims was reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

O. Pharmacy Medical Surgical Denied Claims

The Company was asked to provide a listing of all Pharmacy Medical Denied Claims during the exam period of January 1, 2021, through December 31, 2022. The Company provided a listing of 7125 denied claims. A random sample of 108 denied claims was reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

P. Pharmacy Mental Health Paid Claims

The Company was requested to provide a listing of all the Pharmacy Mental Health Paid claims during the exam period of January 1, 2021, through December 31, 2022. The Company provided a universe of 4311 claims for the Pharmacy Mental Health Paid claims. A random sample of 108 paid claims was reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

Q. Pharmacy Mental Health Denied Claims

The Company was asked to provide a listing of all Pharmacy Mental Health Denied Claims during the exam period of January 1, 2021, through December 31, 2022. The Company provided a listing of 1,306 denied claims. A random sample of 105 denied claims was reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

R. Pharmacy Substance Use Disorder Paid Claims

The Company was asked to provide a listing of all Pharmacy Substance Use Disorder Paid Claims during the exam period of January 1, 2021, through December 31, 2022. The Company provided a listing of 127 paid claims. A random sample of 76 paid claims was reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

S. Pharmacy Substance Use Disorder Denied Claims

The Company was asked to provide a listing of all Pharmacy Substance Use Disorder denied claims during the exam period of January 1, 2021, through December 31, 2022. The Company provided a listing of 85 paid claims. A random sample of 76 paid claims was reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

T. Pharmacy Insulin Paid Claims

The Company was requested to provide a listing of all the Pharmacy Insulin Paid claims during the exam period of January 1, 2021, through December 31, 2022. The Company provided a universe of 238 claims for the Pharmacy Insulin Paid claims. A random sample

of 76 paid claims were reviewed for compliance with the applicable State Statutes and Regulations.

There were no exceptions noted.

U. Pharmacy Insulin Denied Claims

The Company was requested to provide a listing of all the Pharmacy Insulin Denied claims during the exam period of January 1, 2021, through December 31, 2022. The Company provided a universe of 155 claims for the Pharmacy Insulin Paid claims. A random sample of 76 paid claims were reviewed for compliance with the applicable State Statutes and Regulations.

There were no exceptions noted.

UTILIZATION REVIEW

A. Utilization Review Policies and Procedures

The Company was requested to provide the Utilization Review Policies and Procedures used during the exam period of January 1, 2021, through December 31, 2022. The Company's Utilization Review 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 asked to provide a listing of all Medical Surgical Approved Utilization Reviews during the exam period of January 1, 2021, through December 31, 2022. The Company provided a listing of 358 approved utilization reviews. A random sample of 79 approved utilization reviews was reviewed for compliance with the applicable Statutes and Regulations.

The following exception was noted:

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

UnitedHealthcare 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).

C. Utilization Review Medical Denied

The Company was asked to provide a listing of all Medical Surgical Denied Utilization Reviews during the exam period of January 1, 2021, through December 31, 2022. The Company provided a listing of 61 denied utilization reviews. All 61 denied utilization reviews were reviewed for compliance with the applicable Statutes and Regulations.

No exceptions were noted.

D. Utilization Review Medical Mixed

The Company was asked to provide a listing of all Medical Surgical Mixed Utilization Reviews during the exam period of January 1, 2021, through December 31, 2022. The Company provided a listing of 16 mixed utilization reviews. All 16 mixed utilization reviews were reviewed for compliance with the applicable Statutes and Regulations.

No exceptions were noted.

E. Utilization Review Mental Health Approved

The Company was asked to provide a listing of all Mental Health Approved Utilization Reviews during the exam period of January 1, 2021, through December 31, 2022. The Company provided a listing of 104 approved utilization reviews. A random sample of 79 approved utilization reviews was reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

F. Utilization Review Mental Health Denied

The Company was asked to provide a listing of all Mental Health Denied Utilization Reviews during the exam period of January 1, 2021, through December 31, 2022. The Company provided a listing of 2 denied utilization reviews. Both denied utilization reviews were reviewed for compliance with the applicable Statutes and Regulations.

No exceptions were noted.

G. Utilization Review Substance Used Disorder Approved

The Company was asked to provide a listing of all Substance Use Disorder Approved Utilization Reviews during the exam period of January 1, 2021, through December 31, 2022. The Company provided a listing of 58 approved utilization reviews. All 58 approved utilization reviews were reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

3 Exceptions - 18 Del. C. § 3578(b)(2) Insurance coverage for serious mental illness.

UnitedHealthcare failed to use the full set of ASAM criteria.

Recommendation: It is recommended that the Company provide 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 as required by 18 Del. C. § 3578(b)(2).

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

UnitedHealthcare imposed a precertification for alcohol dependency.

Recommendation: It is recommended that the Company 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 as required by 18 Del. C. § 3578(d)(1)b.

1 Exception - 18 Del. C. § 3586(b) Length of pre-authorization.

UnitedHealthcare failed to provide a 60-day authorization period.

Recommendation: It is recommended that the Company grant pre-authorizations for health-care services that are 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 as required by 18 Del. C. § 3586(b).

H. Utilization Review Retrospective

The Company was requested to provide listings of all the Retrospective Approved Reviews and the Retrospective Denied Reviews during the exam period of January 1, 2021, through December 31, 2022. The Company provided 16 Retrospective Approved Reviews as follows: 3 Routine Prospective files, 10 Retrospectives, 2 Concurrent files, and 1 Non-Urgent Pre-Service file. The Company provided 10 Retrospective Denied Reviews as follows: 1 Routine Prospective, 3 Concurrent Routines and 6 Retrospective files. All Approved and Denied Retrospective Reviews were reviewed for compliance with applicable Statutes and Regulations.

There were no exceptions noted.

I. Pharmacy Utilization Review Medical Surgical Approved

The Company was requested to provide a listing of all Pharmacy Medical Surgical Approved Utilization Reviews during the exam period of January 1, 2021, through

December 31, 2022. The Company provided a listing of 6,893 approved utilization reviews. A random sample of 115 approved utilization reviews was reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

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

UnitedHealthcare failed to approve 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).

J. Pharmacy Utilization Review Medical Surgical Denied

The Company was asked to provide a listing of all Pharmacy Medical Surgical Denied Utilization Reviews during the exam period of January 1, 2021, through December 31, 2022. The Company provided a listing of 187 denied utilization reviews. A random sample of 79 denied utilization reviews was reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

1 Exception – 18 Del. C. § 2304(16)(f) Unfair claim settlement practices.

UnitedHealthcare 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).

1 Exception – 18 Del. C. § 3591(a)(1) Step therapy exception process.

UnitedHealthcare failed to expeditiously grant a step therapy exception determination when the member was likely to have an adverse reaction to the medication being required.

Recommendation: It is recommended that the Company expeditiously grant a step therapy exception determination when the prescription drug is contraindicated or will likely cause an adverse reaction as required by 18 Del. C. § 3591(a)(1).

3 Exceptions – 18 Del. C. § 3591(a)(3) Step therapy exception process.

UnitedHealthcare failed to expeditiously grant a step therapy exception determination when a member had tried the required prescription drug or another prescription drug in the same pharmacologic class or with the same mechanism of action, and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

Recommendation: It is recommended that the Company expeditiously grant a step therapy exception determination when the patient has tried the required prescription drug while under the patient's current or previous health insurance or health benefit plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action, and such prescription drug was discontinued due to lack of efficacy or effectiveness as required by 18 *Del. C.* § 3591(a)(3).

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

UnitedHealthcare 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).

K. Pharmacy Utilization Review Mental Health Approved

The Company was asked to provide a listing of all Pharmacy Mental Health Approved Utilization Reviews during the exam period of January 1, 2021, through December 31, 2022. The Company provided a listing of 42 approved utilization reviews. All 42 approved utilization reviews were reviewed for compliance with the applicable Statutes and Regulations.

The following exception was noted:

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

UnitedHealthcare 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).

L. Pharmacy Utilization Review Mental Health Denied

The Company was asked to provide a listing of all Pharmacy Mental Health Denied Utilization Reviews during the exam period of January 1, 2021, through December 31, 2022. The Company provided a listing of 21 denied utilization reviews. All 21 denied utilization reviews were reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

1 Exception – 18 Del. C. § 2304(16)a Unfair methods of competition and unfair or deceptive acts or practices defined.

UnitedHealthcare failed to use the pertinent facts relating to coverage when making a decision.

Recommendation: It is recommended that the Company does not misrepresent pertinent facts or insurance policy provisions relating to coverages at issue as required by 18 Del. C. § 2304(16)a.

M. Utilization Review Pharmacy Substance Use Disorder Approved

The Company was asked to provide a listing of all Pharmacy Substance Use Disorder Approved Utilization Reviews during the exam period of January 1, 2021, through December 31, 2022. The Company provided a listing of 11 substance use disorder approved utilization reviews. All 11 substance use disorder approved utilization reviews were reviewed for compliance with the applicable Statutes and Regulations.

The following exceptions were noted:

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

UnitedHealthcare 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).

N. Utilization Review Pharmacy Substance Use Disorder Denied

The Company was asked to provide a listing of all Pharmacy Substance Use Disorder Denied Utilization Reviews during the exam period of January 1, 2021, through December 31, 2022. The Company provided a listing of 2 substance use disorder denied utilization reviews. Both substance use disorder denied utilization reviews were reviewed for compliance with the applicable Statutes and Regulations.

There were no exceptions noted.

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 December 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 NQTLs, Medical Necessity (Medical Surgical or Med/Surg), Medical Necessity (Mental Health or MH), Medical Necessity (Substance Use Disorder or SUD), Prior Authorization (Med/Surg), Prior Authorization (MH), Prior Authorization (SUD), Concurrent Review (Med/Surg), Concurrent Review (MH), Concurrent Review (SUD), Retrospective Review (Med/Surg), Retrospective Review (MH), and the Retrospective Review (SUD). 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 were comparable.

The MHPAEA Report and NQTL analyses were reviewed for compliance with applicable statutes and regulations.

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: Formulary Design, Prior Authorization and Step Therapy.

The following exceptions were noted:

2 Exceptions – 18 Del. C. § 3571U Mental Health Parity and Addiction Equity Act reporting requirements.

UnitedHealthcare's Formulary Design and Prior Auth/Step Therapy NQTL Analyses are not sufficiently specific, detailed, and reasoned to demonstrate whether the processes, strategies, evidentiary standards, or other factors used in developing and applying the

NQTL are comparable and applied no more stringently to MH/SUD benefits than to MED/SURG benefits.

Recommendation: It is recommended that the Company provide comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each NQTL, as written and in operation, for mental illness and drug and alcohol dependencies benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each NQTL, as written and in operation, for medical and surgical benefits as required by 18 *Del. C.* § 3571U.

2 Exceptions - 42 U.S. Code § 300gg-26 Parity in mental health and substance use disorder benefits.

UnitedHealthcare's Formulary Design and Prior Auth/Step Therapy NQTL Analyses are not sufficiently specific, detailed, and reasoned to demonstrate whether the processes, strategies, evidentiary standards, or other factors used in developing and applying the NQTL are comparable and applied no more stringently to MH/SUD benefits than to MED/SURG benefits.

Recommendation: It is recommended that the Company provide comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each NQTL, as written and in operation, for mental illness and drug and alcohol dependencies benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each NQTL, as written and in operation, for medical and surgical benefits as required by 42 *U.S. Code* § 300gg-26.

PHARMACY REVIEW

The Company was requested to provide the written utilization management (UM) and/or drug utilization review (DUR) policies including all versions, Pharmacy and Therapeutics (P&T) Committee notes, formularies, formulary changes, 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:

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

UnitedHealthcare failed to validate pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization. There were 412 policies with 82 drug utilization reviews affecting 62 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).

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

UnitedHealthcare imposed more restrictive terms or limits in the coverage of prescription mental health medications used for chronic conditions to a 30-day supply at the retail level compared to MED/SURG medications which were allowed up to a 90-day supply for chronic conditions at the retail level.

Recommendation: It is recommended that the Company not impose more restrictive terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications compared to Medical/Surgical medications as required by 18 Del. C. § 3578(b)(1)b.

4 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.

UnitedHealthcare imposed more restrictive terms or limits in the coverage of prescription mental health medications used for chronic conditions to a 30-day supply at the retail level compared to MED/SURG medications which were allowed up to a 90-day supply for chronic conditions at the retail level.

Recommendation: It is recommended that the Company not impose more restrictive terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications compared to 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).

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

UnitedHealthcare required a prior authorization on methadone dispensed at an opioid treatment program.

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

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

UnitedHealthcare imposed a prior authorization requirement on the medication assisted treatments, Bunavail and Brand Suboxone.

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.

UnitedHealthcare imposed a prior authorization requirement on the medication assisted treatments, Probuphine and Sublocade.

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.* § 3578(b)(1)b Insurance coverage for serious mental illness

UnitedHealthcare applied more restrictive terms or limits in the coverage of the prescription medication, Sublocade, which is a substance use disorder medication, compared to MED/SURG medications under the medical benefit.

Recommendation: It is recommended that the Company not impose more restrictive terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications than on Medical/Surgical medications as required by 18 *Del. C.* § 3578(b)(1)b.

4 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.

UnitedHealthcare applied more restrictive terms or limits in the coverage of the prescription medication, Sublocade, which is a substance use disorder medication, compared to MED/SURG medications under the medical benefit.

Recommendation: It is recommended that the Company not impose more restrictive terms or limits in the coverage of prescription 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).

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

UnitedHealthcare did not approve pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization. (Medical Benefit Drug Policies 2020D0057J, 2020D0057K, 2022D0057L, and 2022D0057M).

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).

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

UnitedHealthcare imposed more restrictive terms or limits on all prescription substance abuse medications limiting them to a 30-day supply used for chronic conditions at the retail level compared to MED/SURG medications used for chronic conditions.

Recommendation: It is recommended that the Company not impose more restrictive terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications compared to Medical/Surgical medications as required by 18 *Del. C.* § 3578(b)(1)b.

186 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.

UnitedHealthcare imposed more restrictive terms or limits on all prescription substance abuse medications limiting them to a 30-day supply used for chronic conditions at the retail level compared to MED/SURG medications used for chronic conditions.

Recommendation: It is recommended that the Company not impose more restrictive terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications compared to 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).

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

UnitedHealthcare did not approve pre-authorizations for pharmaceuticals for 1 year from the date the health-care provider receives the pre-authorization. (Medical Benefit Drug Policies 2020D0057J, 2020D0057K, 2022D0057L, and 2022D0057M and Prior Authorization/Medical Necessity Program 2020P2018-13, 2021P2018-14, and 2022P2018-15.).

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).

1 Exception – 18 *Del. C.* § 3580(g) Specialty tier prescription coverage.

UnitedHealthcare is requiring drugs, which do not meet the definition of specialty drug(s) pursuant to 18 *Del. C.* § 3580(a)(7), to be obtained through Company designated specialty pharmacies.

Recommendation: It is recommended that the Company review their listing of medications to ensure that only those medications that meet the definition of specialty drug(s) pursuant to 18 *Del. C.* § 3580(a)(7) may be obtained through Company designated pharmacies according to 18 *Del. C.* § 3580(g).

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

UnitedHealthcare imposed more restrictive terms or limits by way of prior authorization requirements on brand Lithobid compared to MED/SURG medications. The Company provided 2021 P 2233-1 and 2022 P 2233-2 Prior Authorization/Medical Necessity – Lithobid (brand only).

Recommendation: It is recommended that the Company not impose more restrictive terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications compared to Medical/Surgical medications as required by 18 Del. C. § 3578(b)(1)b.

2 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.

UnitedHealthcare had applied more stringent prior authorization requirements on brand Lithobid compared to MED/SURG medications. The Company provided 2021 P 2233-1 and 2022 P 2233-2 Prior Authorization/Medical Necessity – Lithobid (brand only).

Recommendation: It is recommended that the Company not impose more restrictive terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications compared to 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. § 3578(b)(1)b Insurance coverage for serious mental illness.

UnitedHealthcare imposed more restrictive terms or limits in the coverage of prescription MH/SUD medications by excluding them from their Contingency Edit Program compared to MED/SURG medications that were included.

Recommendation: It is recommended that the Company not impose more restrictive terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications compared to Medical/Surgical medications as required by 18 Del. C. § 3578(b)(1)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.

UnitedHealthcare imposed more restrictive terms or limits in the coverage of prescription MH/SUD medications by excluding them from their Contingency Edit Program compared to MED/SURG medications that were included.

Recommendation: It is recommended that the Company not impose more restrictive terms or limits in the coverage of prescription Mental Health/Substance Use Disorder

medications compared to 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. § 3578(b)(1)b Insurance coverage for serious mental illness.

UnitedHealthcare imposed more restrictive terms or limits in the coverage of prescription MH/SUD medications by excluding them from the Dx2Rx Program when compared to MED/SURG medications that were included.

Recommendation: It is recommended that the Company not impose more restrictive terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications compared to Medical/Surgical medications as required by 18 Del. C. § 3578(b)(1)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.

UnitedHealthcare imposed more restrictive terms or limits in the coverage of prescription MH/SUD medications by excluding them from the Dx2Rx Program when compared to MED/SURG medications that were included.

Recommendation: It is recommended that the Company not impose more restrictive terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications compared to 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. § 3578(b)(1)b Insurance coverage for serious mental illness.

UnitedHealthcare imposed more restrictive terms or limits in the coverage of prescription MH/SUD medications by excluding them from their Silent Auth Program when compared to MED/SURG medications that were included.

Recommendation: It is recommended that the Company not impose more restrictive terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications compared to Medical/Surgical medications as required by 18 Del. C. § 3578(b)(1)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.

UnitedHealthcare imposed more restrictive terms or limits in the coverage of prescription MH/SUD medications by excluding them from their Silent Auth Program when compared to MED/SURG medications that were included.

Recommendation: It is recommended that the Company not impose more restrictive terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications compared to 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).

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

UnitedHealthcare imposed more restrictive terms or limits on Spravato, which is a mental health medication, compared to MED/SURG medications under both the pharmacy and medical benefit. (Spravato Prior Authorization/Medical Necessity: 2020 P 2168-3, 2020 P 2168-4, 2021 P 2168-5, 2022 P 2168-6, and 2022 P 2168-7; and Spravato Prior Authorization/Notification: 2020 P 1279-2, 2020 P 1279-3, 2021 P 1279-4, and 2022 P 1279- 5; and Ketalar/Spravato Drug Policy: 2020D0069G, 2020D0069H, 2021D0069J, 2021D0069K, and 2022D0069L).

Recommendation: It is recommended that the Company not impose more restrictive terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications compared to Medical/Surgical medications as required by 18 Del. C. § 3578(b)(1)b.

14 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.

UnitedHealthcare imposed more restrictive terms or limits on Spravato, which is a mental health medication, compared to MED/SURG medications under both the pharmacy and medical benefit. (Spravato Prior Authorization/Medical Necessity: 2020 P 2168-3, 2020 P 2168-4, 2021 P 2168-5, 2022 P 2168-6, and 2022 P 2168-7; and Spravato Prior Authorization/Notification: 2020 P 1279-2, 2020 P 1279-3, 2021 P 1279-4, and 2022 P 1279- 5; and Ketalar/Spravato Drug Policy: 2020D0069G, 2020D0069H, 2021D0069J, 2021D0069K, and 2022D0069L).

Recommendation: It is recommended that the Company not impose more restrictive terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications compared to 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).

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

UnitedHealthcare limited the initial prior authorization approval to 3 months and the reauthorization approval to 6 months on Spravato under both the pharmacy and medical benefit. (Spravato Prior Authorization/Medical Necessity: 2020 P 2168-3, 2020 P 2168-4, 2021 P 2168-5, 2022 P 2168-6, and 2022 P 2168-7; and Spravato Prior Authorization/Notification: 2020 P 1279-2, 2020 P 1279-3, 2021 P 1279-4, and 2022 P 1279- 5; and Ketalar/Spravato Drug Policy: 2020D0069G, 2020D0069H, 2021D0069J, 2021D0069K, and 2022D0069L)

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).

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

UnitedHealthcare imposed more restrictive terms or limits on the mental health medication, Lybalvi, in Policy 2022 P 2271-1 Prior Authorization/Medical Necessity when compared to MED/SURG medications.

Recommendation: It is recommended that the Company not impose more restrictive terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications compared to Medical/Surgical medications as required by 18 *Del. C.* § 3578(b)(1)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.

UnitedHealthcare imposed more restrictive terms or limits on the mental health medication, Lybalvi, in Policy 2022 P 2271-1 Prior Authorization/Medical Necessity when compared to MED/SURG medications.

Recommendation: It is recommended that the Company not impose more restrictive terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications compared to 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).

17 Exceptions – 18 *Del. C.* § 2304(1)a Unfair methods of competition and unfair or deceptive acts or practices defined.

UnitedHealthcare included misleading information in the Schedule of Benefits or Certificate of Coverages by listing incorrect monetary limits and/or age restrictions for infertility coverage which is prohibited in accordance with 18 *Del. C.* § 3556.

Recommendation: It is recommended that the Company not issue Schedule of Benefits or Certificate of Coverages which misrepresents the benefits, advantages, conditions or terms of any insurance as required by 18 *Del. C.* § 2304(1)a.

PHARMACY BENEFIT MANAGER AND THIRD-PARTY

The Company was asked to provide documentation on Pharmacy Benefit Manager (PBM) and Third-Party Administrator (TPA) relationships and oversight and audit information. This documentation included how rebates are received, 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 December 31, 2022.

The Company provided the amount of rebates received for the exam period, market-wide base rate development calculation, annual statements reflecting the rebates and audit listing. The documents were reviewed for compliance with the applicable State Statutes and Regulations.

No exceptions were noted.

MEDICAL NECESSITY REVIEW

The scope of the examination was expanded on May 15, 2023, to include the Insurer application and monitoring of medical necessity criteria. The Company was asked to provide their policy definition of Medical Necessity, the policy definition of Medically Necessary Services, to identify the associates responsible for making medical necessity decisions and audits. They were also asked to identify and explain the use of automation and Artificial Intelligence (AI) in making medical necessity determinations.

The Company indicated it uses ICES (Ingenix Claims Edit System), a proprietary code review system that works in conjunction with their claim systems (UNET/USP CIRRUS). The Company indicated that prior authorization requests are not denied based on automated system logic and that the claims systems receive and process providers' claims. The ICES edits generally apply coding requirements to the claims. The Company further clarified that "Optum Rx notes that drug coverage review guidelines (criteria), as provided by the plan, are configured as a decision tree within the system. Once provider responses are processed through the decision tree, these responses are analyzed and reviewed by physicians...". The Company advised they do not use AI to make medical necessity determinations. When the Company was asked about specific articles they indicated the following: "The Company notes that there is no regulatory definition of AI. Optum and UnitedHealthcare are subsidiaries of UnitedHealth Group. Regarding the specific articles referenced in your question, Optum uses AI for risk adjustment analysis related to Medicare Advantage program requirements. Optum also uses AI to support payment integrity and fraud, waste, and abuse initiatives, enhance actuarial operations, identify patients with unmet needs to offer additional support, and supplement back-office needs, such as letter creation and call center staff support.

UnitedHealthcare does not use AI to deny claims for lack of medical necessity, during the claim, appeal, or utilization review processes. The claims system (via ICES) can apply coding edits that are based on medical policies developed by clinicians. Providers can utilize the provider portal to answer decision tree questions which may result in automated approvals, based on the member's condition, applicable clinical criteria and the terms of the member's plan, being issued more quickly." The Company indicated that "In 2019, UnitedHealth Group launched a program focused on the responsible use of AI. This program is focused on establishing and maintaining a uniform approach to using AI responsibly and brings consistency to how teams create, procure, and use AI solutions by

providing guidance, governance and learning resources.” The Company was specifically asked about use of their AI system nH Predict and they have advised that “nH Predict has not been used for commercial plans under the Department’s jurisdiction. nH Predict is currently used only in connection with Medicare Advantage post-acute care benefits. At this time, UHC does not have any plans to use nH Predict in any evaluation process related to other types of benefits.”

There were no internal nor external audits related to medical necessity performed during the examination period. There were performance monitoring activities that occurred quarterly during 2021 and 2022. These monitoring activities were not specific to Delaware or UHIC.

The Company’s medical necessity documentation was reviewed for compliance with applicable 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 UnitedHealthcare Insurance Company 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. Location in the Report is referenced in parenthesis.

1. 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). (Complaint, Grievances and Appeals Handling).
2. It is recommended that the Company decide grievances in an expeditious manner as required by 18 *Del. C.* § 332(c)(5). (Complaint, Grievances and Appeals Handling).
3. 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). (Complaint, Grievances and Appeals Handling).
4. 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. (Complaint, Grievances and Appeals Handling).
5. It is recommended that the Company permit a provider a minimum of 180 days from the date a covered service is rendered to submit a claim for reimbursement as required by 18 *Del. C.* § 3571V(b). (Claims).
6. It is recommended that the Company pay the total allowed amount of the claim deemed payable within 30 days as required by 18 *Del. Admin. C.* § 1310-6.1.1. (Claims).
7. 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). (Claims) (Utilization Review).
8. It is recommended that the Company 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 within 30 days as required by 18 *Del. Admin. C.* § 1310-6.1.2. (Claims).
9. It is recommended that if the entire claim is deemed not payable, the Company notify the provider or policyholder in writing why the claim will not be paid within 30 days as required by 18 *Del. Admin. C.* § 1310-6.1.3. (Claims).
 10. It is recommended that if the Company needs additional information from a provider or policyholder that they request in writing that the provider or policyholder provide documentation that is relevant and necessary within 30 days as required by 18 *Del. Admin. C.* § 1310-6.1.4. (Claims).
 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). (Utilization Review).
 12. It is recommended that the Company provide 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 as required by 18 *Del. C.* § 3578(b)(2). (Utilization Review).
 13. It is recommended that the Company 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 as required by 18 *Del. C.* § 3578(d)(1)b. (Utilization Review).
 14. It is recommended that the Company grant pre-authorizations for health-care services that are 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 as required by 18 *Del. C.* § 3586(b). (Utilization Review).
 15. 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). (Utilization Review) (Pharmacy Review).
 16. It is recommended that the Company expeditiously grant a step therapy exception determination when the prescription drug is contraindicated or will likely cause an adverse reaction as required by 18 *Del. C.* § 3591(a)(1). (Utilization Review).

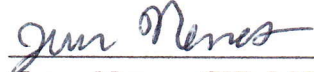
17. It is recommended that the Company expeditiously grant a step therapy exception determination when the patient has tried the required prescription drug while under the patient's current or previous health insurance or health benefit plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action, and such prescription drug was discontinued due to lack of efficacy or effectiveness as required by 18 *Del. C.* § 3591(a)(3). (Utilization Review).
18. 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). (Utilization Review).
19. It is recommended that the Company does not misrepresent pertinent facts or insurance policy provisions relating to coverages at issue as required by 18 *Del. C.* § 2304(16)a. (Utilization Review).
20. It is recommended that the Company provide comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each NQTL, as written and in operation, for mental illness and drug and alcohol dependencies benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each NQTL, as written and in operation, for medical and surgical benefits as required by 18 *Del. C.* § 3571U. (Mental Health Parity).
21. It is recommended that the Company provide comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each NQTL, as written and in operation, for mental illness and drug and alcohol dependencies benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each NQTL, as written and in operation, for medical and surgical benefits as required by 42 *U.S. Code* § 300gg-26. (Mental Health Parity).
22. It is recommended that the Company not impose more restrictive terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications compared to Medical/Surgical medications as required by 18 *Del. C.* § 3578(b)(1)b. (Pharmacy Review).
23. It is recommended that the Company not impose more restrictive terms or limits in the coverage of prescription Mental Health/Substance Use Disorder medications compared to 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). (Pharmacy Review).

24. It is recommended that the Company not impose prior authorization requirements on medication-assisted treatments as required by 18 Del. C. § 3571X. (Pharmacy Review).

25. It is recommended that the Company review their listing of medications to ensure that only those medications that meet the definition of specialty drug(s) pursuant to 18 *Del. C.* § 3580(a)(7) may be obtained through Company designated pharmacies according to 18 *Del. C.* § 3580(g). (Pharmacy Review).

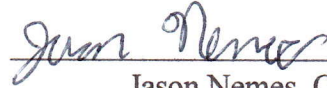
26. It is recommended that the Company not issue Schedule of Benefits or Certificate of Coverages which misrepresents the benefits, advantages, conditions or terms of any insurance policy as required by 18 *Del. C.* § 2304(1)a. (Pharmacy Review).

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 79413-23-MHP-535.



Jason Nemes, CIE, MCM