Final Report Federal Targeted Market Conduct Examination of
UnitedHealthcare Insurance Company, HIOS ID #98809
State of Texas as of July 13, 2021

Examination Report: 98809– 2018 – FED – 1

In accordance with Title 45 of the Code of Federal Regulations (C.F.R.), section 150.313, the Center for Consumer Information and Insurance Oversight (CCIIO) has completed a targeted Market Conduct Examination (Examination) of UnitedHealthcare Insurance Company (Issuer), HIOS ID #98809, in the State of Texas. The Examination review period was July 1, 2016 through June 30, 2017. The Examination was called to assess the Issuer's compliance with the requirements of the following:

- Coverage of Preventive Health Services – 42 U.S.C. §300gg-13 and 45 C.F.R. §147.130;
- The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) – 42 U.S.C. §300gg-26, 45 C.F.R. §§146.136 and 147.160;
- Patient Protections – 42 U.S. C. §300gg-19a and 45 C.F.R. §147.138(a)(3); and
- Essential Health Benefits – 42 U.S.C. §300gg-6, 45 C.F.R. §§147.150 and 156.100, et seq.

Table of Contents

I. Executive Summary

The Center for Consumer Information and Insurance Oversight (CCIIO) has conducted a targeted Market Conduct Examination (Examination) of UnitedHealthcare Insurance Company (Issuer) to assess the Issuer's compliance with the requirements of The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended: 42 U.S.C. §300gg-26, 45 C.F.R §§146.136 and 147.160; Coverage of Preventive Health Services: 42 U.S.C. §300gg-13 and 45 C.F.R §147.130; Patient Protections: 42 U.S.C. §300gg–19a and 45 C.F.R. §147.138(a)(3); and Essential Health Benefits: 42 U.S.C. §300gg-6, 45 C.F.R. §§147.150 and 156.100, et seq. The period covered by the Examination was July 1, 2016 through June 30, 2017 (Examination Period).

A random sample of 3,175 Issuer-generated documents and claims were reviewed. Of the selected samples, CCIIO found 31 violations related to four areas reviewed. All 31 violations were found in certificates. The violations included a discriminatory benefit design in 10 products, a failure to provide benefits that are substantially equal to the Texas EHB-benchmark plan in 10 products, an emergency services violation in eight products, and one MHPAEA violation in two products. Through this Examination report, the Issuer is directed to modify certain policies and procedures to ensure future compliance, complete a self-audit to identify any inappropriately denied claims, and re-adjudicate the identified claims, as appropriate.

This report is by exception; therefore, the Examination Results section only indicates areas where findings were noted and includes criticism responses from the Issuer (when provided). In summary, findings were identified for the following Federal requirements:

a. 42 U.S.C. §§300gg-6 and 18022, and 45 C.F.R. §156.125: Essential Health Benefits (EHB) – Prohibition on Discrimination;
b. 42 U.S.C. §§300gg-6 and 18022, and 45 C.F.R. §§156.115(a)(1)(i), (ii) and 156.115(b): Provision of EHB – Providing EHB Substantially Equal to the Texas EHB-benchmark plan;
c. 42 U.S.C. §300gg-26(a)(3)(A)(i), 45 C.F.R. §§146.136(c)(2)(i), and 156.115(a)(3): MHPAEA – Financial requirements. Applying a financial requirement to Mental Health/Substance Use Disorder benefits in a classification that is more restrictive than the predominant financial requirement applied to substantially all medical and surgical benefits in the same classification; and
d. 42 U.S.C. §300gg-19a(b), 45 C.F.R. §147.138(b)(2)(iv) and (b)(3)(i): Patient Protections – Emergency Services Coverage of benefits with respect to out-

of-network (OON) emergency services in an amount at least equal to the greatest of the three amounts specified in 45 C.F.R. §147.138(b)(3)(i)(A), (B) and (C).

Additional details regarding these findings are in the Examination Results section of this report.

The Examination identified practices that do not comply with applicable Federal requirements, some of which may also violate State insurance laws and regulations.

The Issuer is directed to take immediate corrective action to demonstrate its ability and intention to conduct business in accordance with Federal requirements. When applicable, corrective actions for other jurisdictions and/or affiliates should also be addressed.

II. Scope of Examination

CCIIO conducted an Examination pursuant to 45 C.F.R. §150.313. The Examination Period was July 1, 2016 through June 30, 2017. The purpose of the Examination was to assess the Issuer's compliance with select applicable Federal requirements.

Some non-compliant practices may not have been discovered or noted in this report. Failure to identify or address business practices that do not comply with Federal requirements does not constitute acceptance of such practices.

The Examination and testing methodologies followed standards established by the National Association of Insurance Commissioners and procedures developed by CCIIO. All samples were selected using a computer-generated, random sample program unless otherwise stated.

Area	Population	Sample Size
MHPAEA small group paid claims	73,137	257
MHPAEA small group denied claims	12,650	182
MHPAEA small group paid Rx claims	211,294	232
MHPAEA small group denied Rx claims	95,517	232
Preventive Service small group paid claims	401,973	184
Preventive Service small group denied claims	47,166	109
Preventive Service small group Rx paid claims	92,729	232
Preventive Service small group Rx denied claims	87,863	159
Other medical small group Rx paid claims	1,017,793	230
Other medical small group Rx denied claims	587,804	230
MHPAEA student health paid claims	1,612	160

Area	Population	Sample Size
MHPAEA student health denied claims	283	105
MHPAEA student health paid Rx claims	3,050	109
MHPAEA student health denied Rx claims	13,322	108
Preventive Service student health paid claims	13,648	108
Preventive Service student health denied claims	2,741	107
Preventive Service student health Rx paid claims	10,423	108
Preventive Service student health Rx denied claims	6,855	105
Other medical student health Rx paid claims	6,653	109
Other medical student health Rx denied claims	2,806	109

The Issuer's responses to criticisms issued during the Examination process appears after the finding in the Examination Results section of this report.

III. Summary of Findings

Findings #	Summary	Citation	Completed or Required Corrective Actions
1	Failure to provide EHB by implementing a discriminatory benefit design that covered methadone maintenance treatment for pain management and not for opioid addiction.	42 U.S.C. §§300gg-6 and 18022, and 45 C.F.R. §156.125.	For plan documents, no further action is required as the Issuer's certificates were updated to reflect coverage of methadone maintenance treatment for opioid addiction. The Issuer is directed to conduct a self-audit and re-adjudicate any claims for methadone maintenance treatment for opioid addiction that were improperly denied during the Examination Period. Results from the self-audit and any resultant re-adjudicated claims are to be provided to CCIIO within 45 calendar days of the date of the final report. The results shall contain the claim number, date of service, date of original denial or payment, date of re-adjudication, and amount paid on the date of re-adjudication.

Findings #	Summary	Citation	Completed or Required Corrective Actions
2	Failure to provide EHBs that are substantially equal to the Texas EHB-benchmark plan.	42 U.S.C. §§300gg-6 and 18022, and 45 C.F.R. §156.115(a)(1)(i), (ii), and (b).	For plan documents, no further action is required as the Issuer's certificates have been updated to reflect that benefits are provided for: a. Court-ordered medically necessary services; and b. FDA-approved mechanical organs for transplants For court-ordered medically necessary services, the Issuer is directed to conduct a self-audit and re-adjudicate any claims denied during the Examination Period. Results from the self-audit and any resultant re-adjudicated claims are to be provided to CCIIO within 45 calendar days of the date of the final report. The results shall contain the claim number, date of service, date of original denial or payment, date of re-adjudication, and amount paid on the date of re-adjudication. No further action is required with regard to claims involving transplants of FDA-approved artificial organs since the Issuer confirmed no such claims were denied by the Issuer during the Examination Period.

Findings #	Summary	Citation	Completed or Required Corrective Actions
3	Failure to demonstrate that the financial requirements applied to mental health/substance use disorder (MH/SUD) benefits in a classification are no more restrictive than those applied to substantially all medical/surgical benefits in the same classification.	42 U.S.C. §300gg-26 (a)(3)(A)(i), 45 C.F.R. §§146.136(c)(2)(i) and 156.115(a)(3).	The Issuer shall revise the policy, certificate, summary of benefits and coverage (SBCs) and any other documents that provide information on the financial requirements for the affected benefits in order to demonstrate compliance with parity requirements for financial requirements applied to MH/SUD benefits in the outpatient, in-network classification. The Issuer shall identify the predominant copayment applied to substantially all outpatient, in-network medical/surgical benefits. The Issuer has conducted a self-audit and re-adjudicated any claims for outpatient, in-network MH/SUD benefits processed during the Examination Period with a higher copayment than the copayment applied to substantially all outpatient, in-network medical/surgical benefits. The results from the self-audit included 83 re-adjudicated claims that were provided to CCIIO. The results contained the claim number, date of service, date of original denial or payment, date of re-adjudication, and amount paid on the date of re-adjudication.

Findings #	Summary	Citation	Completed or Required Corrective Actions
4	Failure to provide benefits for OON emergency services in an amount at least equal to the greatest of the three amounts specified in 45 C.F.R. §147.138(b)(3)(i)(A), (B), and (C).	42 U.S.C. §300gg-19a(b) and 45 C.F.R. §147.138 (b)(2)(iv) and (b)(3)(i)(A),(B), and (C).	The Issuer shall revise the plan documents to clarify benefits for OON emergency services are provided in an amount at least equal to the greatest of the three amounts specified in the regulation. The Issuer is directed to conduct a self-audit and re-adjudicate any claims for OON emergency services initially processed during the Examination Period where the applied payment was less than the greatest of three amounts specified in the regulation. Results from the self-audit and any resultant re-adjudicated claims are to be provided to CCIIO within 45 calendar days of the date of the final report. The results shall contain the claim number, date of service, date of original denial or payment, date of re-adjudication, and amount paid on the date of re-adjudication.

IV. Issuer Profile

UnitedHealthcare Insurance Company (UHIC), a Connecticut corporation, has its home and principal executive offices at 185 Asylum Street, Hartford, Connecticut 06103. UHIC is licensed as a life, accident and health insurer in the Virgin Islands, District of Columbia, Commonwealth of the Northern Mariana Islands, American Samoa, Puerto Rico, Guam, and in all states except New York. UHIC is a direct wholly-owned subsidiary of UHIC Holdings, Inc. (formerly known as Unimerica, Inc.), a Delaware general business corporation. UHIC Holdings, Inc. is a direct wholly-owned subsidiary of United HealthCare Services, Inc. (UHS), a Minnesota general business corporation. UHS is a direct wholly-owned subsidiary of UnitedHealth Group Incorporated (United), the ultimate parent in the insurance holding company system.

V. Examination Results

A. Essential Health Benefit (EHB) – Prohibition on Discrimination

Finding 1 – Violation of 42 U.S.C. §§300gg-6 and 18022, and 45 C.F.R. §156.125.

42 U.S.C. §300gg-6 states in the pertinent part:

> "Comprehensive health insurance coverage
>
> (a) Coverage for essential health benefits package A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 18022(a) of this title."

42 U.S.C. §18022 states in the pertinent part:

> "In defining the essential health benefits under paragraph (1), the Secretary shall—
>
> (D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;"

45 C.F.R. §156.125 states:

> "An issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions."

The Issuer failed to meet the above requirements by implementing a discriminatory benefit design that covered methadone maintenance treatment for pain management but excluded coverage for methadone maintenance treatment for opioid addiction.

EHB Findings – Prohibition on Discrimination

For 10 products in the individual and small group markets, the corresponding certificates for individual market student health plans (SHPs) and small group

market qualified health plans (QHPs) and off-Exchange health plans (non-QHPs) excluded coverage for methadone for opioid addiction, but provided such coverage for treatment of pain management.

On page 39 of its National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use (2015), the American Society of Addiction Medicine (ASAM) states:

> "Pregnant women with opioid use disorder are candidates for opioid agonist treatment if a return to opioid use is likely during pregnancy. Methadone is the accepted standard of care for use during pregnancy. Buprenorphine mono-product is a reasonable and recommended alternative to methadone for pregnant women."

The identified products provided coverage for buprenorphine, which is approved for the treatment of pregnant women, but excluded coverage for methadone for opioid addiction. However, methadone remains the favored treatment for opioid addicted pregnant women. By failing to provide coverage for methadone maintenance treatment for opioid addiction, the Issuer is limiting access to clinically appropriate and effective treatment for opioid addiction. This limits access to the preferred method of treatment for pregnant women, a particularly vulnerable segment of the population, and could have a severe impact on the health of the mother and unborn child. For these individuals, the choice between buprenorphine treatment and methadone should be made based on the needs and condition of the pregnant patient and clinical opinion of the treating physician.

Methadone has FDA-approved indications for drug detoxification and maintenance therapy of opioid abuse, and also for pain management. Providing coverage for methadone when used for pain and denying coverage when used for opioid abuse discriminates against individuals based upon their health condition (opioid addiction).

The Issuer agreed stating, "The Company acknowledges this Criticism. However, we would like to clarify that the forms filed in 2016 for the 2017 plan year were already revised to remove this exclusion."

Area Reviewed	Population	Sample Size
MHPAEA small group paid claims	73,137	257
MHPAEA small group denied claims	12,650	182

Area Reviewed	Population	Sample Size
MHPAEA small group paid Rx claims	211,294	232
MHPAEA small group denied Rx claims	95,517	232
Preventive Service small group paid claims	401,973	184
Preventive Service small group denied claims	47,166	109
Preventive Service small group Rx paid claims	92,729	232
Preventive Service small group Rx denied claims	87,863	159
Other medical small group Rx paid claims	1,017,793	230
Other medical small group Rx denied claims	587,804	230
MHPAEA student health paid claims	1,612	160
MHPAEA student health denied claims	283	105
MHPAEA student health paid Rx claims	3,050	109
MHPAEA student health denied Rx claims	13,322	108
Preventive Service student health paid claims	13,648	108
Preventive Service student health denied claims	2,741	107
Preventive Service student health Rx paid claims	10,423	108
Preventive Service student health Rx denied claims	6,855	105
Other medical student health Rx paid claims	6,653	109
Other medical student health Rx denied claims	2,806	109

Required Action:

No further action with respect to plan documents is required as the Issuer indicated it updated its certificates to address this finding beginning with the 2017 plan year. A random sample of 2017 certificates verified the exclusion for methadone maintenance treatment for opioid addiction had been removed.

However, the Issuer is directed to conduct a self-audit of denied claims during the Examination Period to identify and re-adjudicate all improperly denied claims involving methadone maintenance treatment for opioid addiction. Results from the self-audit and any resultant re-adjudicated claims are to be provided to CCIIO within 45 calendar days of the date of the final report. The results shall contain the claim number, date of service, date of original denial or payment, date of re-adjudication, and amount paid on the date of re-adjudication.

Issuer Response: The Company conducted a self-audit of claims incurred during the examination period, between July 1, 2016 and June 30, 2017 and did not identify any claims related to methadone maintenance treatment for opioid addiction that were improperly denied.

CCIIO concurs with the Issuer's position.

B. Essential Health Benefits – Failure to Provide Benefits Substantially Equal to the Texas EHB-Benchmark

Finding 2 – Violation of 42 U.S.C. §§300gg-6 and 18022, and 45 C.F.R. §156.115(a)(1)(i), (ii) and (b).

42 U.S.C. §300gg-6 states in the pertinent part:

> "Comprehensive health insurance coverage
>
> (a) Coverage for essential health benefits package A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 18022(a) of this title."

42 U.S.C. §18022 states in the pertinent part:

> "Essential health benefits
>
> (a) Essential Health Benefits Package—In this title, the term "essential health benefits package" means, with respect to any health plan, coverage that—
>
> (1) provides for the essential health benefits defined by the Secretary under subsection (b);
> (2) limits cost sharing for such coverage in accordance with subsection (c); and
> (3) subject to subsection (e), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).
>
> (b) Essential Health Benefits—
>
> (1) In general—Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items

and services covered within the categories:

(A) Ambulatory patient services.
(B) Emergency services.
(C) Hospitalization.
(D) Maternity and newborn care.
(E) Mental health and substance use disorder services, including behavioral health treatment.
(F) Prescription drugs.
(G) Rehabilitative and habilitative services and devices.
(H) Laboratory services.
(I) Preventive and wellness services and chronic disease management.
(J) Pediatric services, including oral and vision care." 45 C.F.R. §156.115 states in the pertinent part:

"Provision of EHB.

(a) Provision of EHB means that a health plan provides benefits that—
(1) Are substantially equal to the EHB-benchmark plan including:
(i) Covered benefits; [and],
(ii) Limitations on coverage including coverage of benefit amount, duration, and scope…"

(b) Unless prohibited by applicable State requirements, an issuer of a plan offering EHB may substitute benefits if the issuer meets the following conditions—

(1) Substitutes a benefit that:
(i) Is actuarially equivalent to the benefit that is being replaced as determined in paragraph (b)(2) of this section;
(ii) Is made only within the same essential health benefit category; and
(iii) Is not a prescription drug benefit.
(2) Submits evidence of actuarial equivalence that is:
(i) Certified by a member of the American Academy of Actuaries;
(ii) Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;
(iii) Based on a standardized plan population; and
(iv) Determined regardless of cost-sharing.

EHB Findings – Not Substantially Equal

For two products in the small group market and 10 products in the individual market, the corresponding certificates did not provide EHBs that were substantially equal to the Texas EHB-benchmark plan. The 2016 Texas EHB-benchmark plan (page 37) and the 2017 Texas EHB-benchmark plan (page 50) provide coverage for FDA-approved artificial devices for transplants, with no exclusions for court- ordered medically necessary services. The Issuer's certificates excluded coverage for court-ordered medically necessary services and/or Food and Drug Administration (FDA) approved artificial devices for transplants. The Issuer also did not submit evidence that an actuarially equivalent substitution was provided for either of the two EHBs that are the basis for the finding.

Finding 2.a.

Court-ordered medically necessary services.

Two products in the small group market failed to provide the benefit covered by the EHB-benchmark plan.

The Issuer agreed with the finding, stating, "The Company acknowledges this Criticism. However, we would like to clarify that the forms filed in 2017 for 2018 implementation were already revised to reflect 'This exclusion does not apply to services determined to be medically necessary.'"

Area Reviewed	Population	Sample Size
MHPAEA small group paid claims	73,137	257
MHPAEA small group denied claims	12,650	182
MHPAEA small group paid Rx claims	211,294	232
MHPAEA small group denied Rx claims	95,517	232
Preventive Service small group paid claims	401,973	184
Preventive Service small group denied claims	47,166	109
Preventive Service small group Rx paid claims	92,729	232
Preventive Service small group Rx denied claims	87,863	159
Other medical small group Rx paid claims	1,017,793	230
Other medical small group Rx denied claims	587,804	230

Required Action:

No further action is required with respect to plan documents as the Issuer indicated it had updated its certificates to address this finding beginning with the 2018 plan year. A random sample of 2018 certificates verified coverage of medically necessary court-ordered services.

However, the Issuer is directed to conduct a self-audit of claims processed during the Examination Period to identify and re-adjudicate all denied claims involving medically necessary court-ordered services. Results from the self-audit and any resultant re-adjudicated claims are to be provided to CCIIO within 45 calendar days of the date of the final report. The results shall contain the claim number, date of service, date of original denial or payment, date of re-adjudication, and amount paid on the date of re-adjudication.

Finding 2.b.

Food and Drug Administration (FDA) approved artificial devices for transplants.

Ten products in the individual and small group markets failed to provide the benefit covered by the EHB-benchmark plan.

The Issuer agreed with the finding stating:

> "The Company acknowledges this criticism. However, we would like to clarify that the exclusion related to health services for transplants involving permanent mechanical organs has already been under review. Subsequently, revisions to the documents were made in the 2018 filing for the 2019 plan year submitted on 6/19/18 under submission IDs 988090009 and 988090050. Upon approval, they will go into production in 2019."

Area Reviewed	Population	Sample Size
MHPAEA small group paid claims	73,137	257
MHPAEA small group denied claims	12,650	182
MHPAEA small group paid Rx claims	211,294	232
MHPAEA small group denied Rx claims	95,517	232
Preventive Service small group paid claims	401,973	184

Area Reviewed	Population	Sample Size
Preventive Service small group denied claims	47,166	109
Preventive Service small group Rx paid claims	92,729	232
Preventive Service small group Rx denied claims	87,863	159
Other medical small group Rx paid claims	1,017,793	230
Other medical small group Rx denied claims	587,804	230
MHPAEA student health paid claims	1,612	160
MHPAEA student health denied claims	283	105
MHPAEA student health paid Rx claims	3,050	109
MHPAEA student health denied Rx claims	13,322	108
Preventive Service student health paid claims	13,648	108
Preventive Service student health denied claims	2,741	107
Preventive Service student health Rx paid claims	10,423	108
Preventive Service student health Rx denied claims	6,855	105
Other medical student health Rx paid claims	6,653	109
Other medical student health Rx denied claims	2,806	109

Required Action:

No further action is required with respect to plan documents as the Issuer indicated it had updated its certificates to address this finding beginning with the 2019 plan year. A random sample of 2019 certificates verified coverage of FDA-approved artificial organs was included.

No further action is required with respect to re-adjudication of claims as the Issuer was asked to provide a list of all denied claims involving transplants of artificial organs that occurred during the Examination Period. In response the Issuer stated, "We have reviewed our denied claim records related to artificial organ transplant claims. The results of this review indicate there were no denied claims involving permanent mechanical organs for members covered under UnitedHealthcare Insurance Company during the scope of this examination." CCIIO conducted a search of the related claims data for claims for artificial transplant devices. There were two claims paid, and no claims denied, confirming the Issuer's statement.

Issuer Response: The Company conducted a self-audit of claims incurred during

the examination period, between July 1, 2016 and June 30, 2017 and did not identify any claims for court-ordered medically necessary services that were improperly denied.

CCIIO concurs with the Issuer's position.

C. Mental Health Parity and Addiction Equity Act – Financial Requirements

Finding 3 – Violation of 42 U.S.C. §300gg-26(3)(A)(i), 45 C.F.R. §§146.136(c)(2)(i), and 156.115(a)(3).

42 U.S.C. §300gg-26(a)(3)(A)(i) states:

> "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, such plan or coverage shall ensure that —
>
> > (i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits."

45 C.F.R. §146.136(c)(2)(i) states:

> "(2) General parity requirement—(i) General rule. A group health plan (or health insurance coverage offered by an issuer in connection with a group health plan) that provides both medical/surgical benefits and mental health or substance use disorder benefits may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. Whether a financial requirement or treatment limitation is a predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in a classification is determined separately for each type of financial requirement or treatment limitation..."

45 C.F.R. §156.115(a)(3) states:

> "(a) Provision of EHB means that a health plan provides benefits that—
>
> (3) With respect to the mental health and substance use disorder services, including behavioral health treatment services, required under
>
> §156.110(a)(5) of this subpart, comply with the requirements of §146.136 of this subchapter."

MHPAEA Findings:

Finding 3 – Violation of 42 U.S.C. §300gg-26(a)(3)(A)(i) and 45 C.F.R. §§146.136(c)(2)(i), and 156.115(a)(3).

The Issuer failed to meet the above requirement. With respect to the outpatient, in-network classification of services covered under its small group plans, the Issuer applied financial requirements to MH/SUD benefits that were more restrictive than the predominant financial requirement of that type applied to substantially all outpatient, in-network medical/surgical benefits. These non-grandfathered small group plans are required to provide coverage of MH/SUD services as one of the 10 EHB categories, and pursuant to 45 C.F.R. 156.115(a)(3), the benefits are required to comply with the requirements of the MHPAEA regulation.

During the review for compliance with parity requirements, the following limitation was noted in the certificates reviewed:

One MHPAEA violation was found in two products in the small group market. For three plans within each product, it was noted that the issuer applied a financial requirement to outpatient, in-network MH/SUD benefits that was more restrictive than the predominant financial requirement of that type applied to substantially all outpatient, in-network medical/surgical benefits.

Specifically, the certificates imposed a higher copayment for outpatient, in-network MH/SUD services, than the predominant copayment applied to substantially all outpatient, in-network medical/surgical benefits.

The Issuer agreed with this finding stating:

> "Cost shares in the attached examples were incorrectly aligned to the non-designated specialist Physician's Office Services Copayment identified in

the benefit documents referenced. We are taking steps to correct and reprocess all impacted claims during the period. Current plans are selecting the appropriate behavioral health copayment."

Area Reviewed	Population	Sample Size
MHPAEA small group paid claims	73,137	257
Preventive Service small group Rx denied claims	87,863	159

Required Action:

In any and all plan documents (e.g. policies, contracts, certificates, Schedule of Benefits, SBCs, and plan brochures) that provide cost sharing information of the product or plan, the Issuer shall revise the information on financial requirements applied to outpatient, in-network MH/SUD covered services to demonstrate compliance with parity requirements for financial requirements applied to MH/SUD benefits. In such documents, the Issuer shall identify the predominant copayment applied to substantially all outpatient, in-network medical/surgical benefits.

The Issuer conducted a self-audit to identify and re-adjudicate any claims for outpatient, in-network MH/SUD benefits processed with a higher co-payment than the predominant copayment applied to substantially all outpatient, in-network medical/surgical benefits. Results from the self-audit and the re-adjudicated claims listing were provided to CCIIO. The list of 83 re-adjudicated claims contained the claim number, date of service, date of original denial or payment, date of re-adjudication, and amount paid on the date of re-adjudication.

Issuer Response: Following review, the Company determined plan document updates are not needed. Texas small group ACA compliant plans starting with enrollment and renewals for plan year 2018 are set up to pay Outpatient MH/SUD services at the lowest cost PCP copay or better based on our mental health parity testing. Current plan documents for applicable plans are compliant.

The Issuer provided proof of the completed self-audit to CCIIO. As a result of the self-audit, the Issuer paid $2,259.53 for sixty-three claims and $3,049.70 in interest, for a total amount paid (including interest) of $5,309.23 for MH/SUD claims that were processed with higher co-payment amounts.

CCIIO concurs with the Issuer's position.

D. Patient Protections, Emergency Services

Failure to Provide Benefits With Respect To OON Emergency Services In An Amount At Least Equal To The Greatest Of The Three Amounts Specified In Paragraphs (b)(3)(i)(A), (b)(3)(i)(B), and (b)(3)(i)(C) of the Regulation

Finding 4 – Violation of 42 U.S.C. §300gg - 19a(b) and 45 C.F.R. §147.138(b)(2)(iv) and (b)(3)(i).

42 U.S.C. §300gg - 19a(b) states in the pertinent part:

(b) Coverage of emergency services
(1) In general

If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

(II) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

45 C.F.R. §147.138(b)(2)(iv) states:

> "(b) Coverage of emergency services— (1) Scope. If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides any benefits with respect to services in an emergency department of a hospital, the plan or issuer must cover emergency services (as defined in paragraph (b)(4)(ii) of this section) consistent with the rules of this paragraph (b).
>
> (2) General rules. A plan or issuer subject to the requirements of this paragraph (b) must provide coverage for emergency services in the following manner—
> …
> (iv) If the emergency services are provided out-of-network, by complying with the cost-sharing requirements of paragraph (b)(3) of this section…"

45 C.F.R. §147.138(b)(3)(i) states:

"(3) Cost-sharing requirements—

(i) Copayments and coinsurance. Any cost-sharing requirement expressed as a copayment amount or coinsurance rate imposed with respect to a participant, beneficiary, or enrollee for out-of-network emergency services cannot exceed the cost-sharing requirement imposed with respect to a participant, beneficiary, or enrollee if the services were provided in-network. However, a participant, beneficiary, or enrollee may be required to pay, in addition to the in-network cost-sharing, the excess of the amount the out-of-network provider charges over the amount the plan or issuer is required to pay under this paragraph (b)(3)(i). A group health plan or health insurance issuer complies with the requirements of this paragraph (b)(3) if it provides benefits

with respect to an emergency service in an amount at least equal to the greatest of the three amounts specified in paragraphs (b)(3)(i)(A), (B), and (C) of this section (which are adjusted for in-network cost-sharing requirements).

(A) The amount negotiated with in-network providers for the emergency service furnished, excluding any in-network copayment or coinsurance imposed with respect to the participant, beneficiary, or enrollee. If there is more than one amount negotiated with in-network providers for the emergency service, the amount described under this paragraph (b)(3)(i)(A) is the median of these amounts, excluding any in-network copayment or coinsurance imposed with respect to the participant, beneficiary, or enrollee. In determining the median described in the preceding sentence, the amount negotiated with each in-network provider is treated as a separate amount (even if the same amount is paid to more than one provider). If there is no per-service amount negotiated with in-network providers (such as under a capitation or other similar payment arrangement), the amount under this paragraph (b)(3)(i)(A) is disregarded.

(B) The amount for the emergency service calculated using the same method the plan generally uses to

> determine payments for out-of-network services (such as the usual, customary, and reasonable amount), excluding any in-network copayment or coinsurance imposed with respect to the participant, beneficiary, or enrollee. The amount in this paragraph (b)(3) (i)(B) is determined without reduction for out-of-network cost sharing that generally applies under the plan or health insurance coverage with respect to out-of-network services. Thus, for example, if a plan generally pays 70 percent of the usual, customary, and reasonable amount for out-of-network services, the amount in this paragraph (b)(3)(i)(B) for an emergency service is the total (that is, 100 percent) of the usual, customary, and reasonable amount for the service, not reduced by the 30 percent coinsurance that would generally apply to
>
> out-of-network services (but reduced by the in-network copayment or coinsurance that the individual would be responsible for if the emergency service had been provided in-network).
>
> (C) The amount that would be paid under Medicare (part A or part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the emergency service, excluding any in-network copayment or coinsurance imposed with respect to the participant, beneficiary, or enrollee."

The Issuer failed to meet the above requirements because it did not provide benefits with respect to OON emergency services in an amount at least equal to the greatest of the three amounts specified in paragraphs (b)(3)(i)(A), (B), and (C) of the regulation.

Emergency Services Findings

For eight products in the individual market, the corresponding certificates stated that for an in-network emergency service, members would pay the "preferred allowance." The Issuer indicates the "preferred allowance" is 80% of the negotiated rate. For OON emergency services, the amount paid is based on a percentage of "usual and customary" charges (typically 80% or 90%). The Issuer did not ensure that benefits with respect to OON emergency services were paid in an amount at least equal to the greatest of the three amounts specified in regulation.

The Issuer agreed with the finding, stating in response to Criticism #31:

"The Company agrees with this Criticism."

Area Reviewed	Population	Sample Size
MHPAEA student health paid claims	1,612	160
MHPAEA student health denied claims	283	105
MHPAEA student health paid Rx claims	3,050	109
MHPAEA student health denied Rx claims	13,322	108
Preventive Service student health paid claims	13,648	108
Preventive Service student health denied claims	2,741	107
Preventive Service student health Rx paid claims	10,423	108
Preventive Service student health Rx denied claims	6,855	105
Other medical student health Rx paid claims	6,653	109
Other medical student health Rx denied claims	2,806	109

Required Action:

The Issuer is directed to conduct a self-audit of claims processed during the Examination Period to identify and re-adjudicate all OON emergency services claims found to have been paid applying the incorrect payment amount. Results from the self-audit and any resultant re-adjudicated claims are to be provided to CCIIO within 45 calendar days of the date of the final report. The results shall contain the claim number, date of service, date of original denial or payment, date of re-adjudication, and amount paid on the date of re-adjudication. In addition, the Issuer shall ensure applicable product or plan documents are updated to reflect that OON emergency services claims will be paid in an amount at least equal to the greatest of the three amounts specified in regulation.

Issuer Response: Plan Documents will be updated to clarify that benefits for Out-of-Network emergency services are provided in an amount at least equal to the greatest of the three amounts specified in 45 C.F.R. §147.138(b)(3)(i)(A), (B), and (C). The plan documents will be filed for review and approval with CMS and the Texas Department of Insurance (TDI). Upon approval, the Company will implement the changes beginning with the 2021/2022 academic year and thereafter.

The Company conducted a self-audit of claims incurred during the examination period, between July 1, 2016 and June 30, 2017 and identified two emergency-services claims that had been erroneously processed.

The Issuer provided proof of the completed self-audit to CCIIO. As a result of the self-audit, the Issuer identified two emergency claims that were incorrectly denied. The total amount of claims processed was $1,302.40, plus interest payment in the amount of $894.80, for a grand total of $2197.20.

CCIIO concurs with the Issuer's position.

VI. Closing

A total of 3,175 randomly selected Issuer-generated documents and claims were reviewed. Of the selected samples, CCIIO found 31 violations related to four areas reviewed. All 31 violations were found in product certificates. The violations included a discriminatory benefit design in 10 products, a failure to provide benefits that are substantially equal to the Texas EHB-benchmark plan in 10 products, an emergency services violation in eight products, and a MHPAEA violation in two products.

Violations included:

- Failure to provide EHB by implementing a discriminatory benefit design by providing coverage of methadone maintenance treatment for pain management while excluding coverage of methadone maintenance treatment for opioid addiction;
- Failure to provide EHBs that are substantially equal to the Texas EHB-benchmark plan by failing to provide coverage of court-ordered medically necessary services and/or FDA-approved artificial devices for transplants, which are covered by the EHB-benchmark plan;
- Failure to demonstrate that the financial requirements applied to outpatient, in-network MH/SUD benefits are no more restrictive than those applied to outpatient, in-network medical/surgical benefits; and
- Failure to provide benefits with respect to OON emergency services in an amount at least equal to the greatest of the three amounts specified in paragraphs (b)(3)(i)(A), (B), and (C) of 45 C.F.R. §147.138.

VII. Examination Report Submission

The courtesy and cooperation extended by the officers and employees of the Issuer during the course of the Examination are hereby acknowledged.

Mary M. Nugent -S

Digitally signed by Mary M. Nugent -S
Date: 2021.07.20 12:51:55 -04'00'

_____

Mary Nugent, Director, CIE, FLMI, AIRC, MCM, ACS
Compliance and Enforcement Division
Oversight Group
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
U.S. Department of Health & Human Services

In addition, the following individuals participated in this Examination and in the preparation of this report:

Center for Consumer Information and Insurance Oversight

- Mary Nugent, CIE, FLMI, AIRC, MCM, ACS - Compliance and Enforcement Division Director
- Angela Britton, MCM
- Kathy Forno, CCP, DCP, HIA, MCM
- Darshell Shepphard, MCM Examination Resources, LLC

Examination Resources, LLC