

DELAWARE DEPARTMENT OF INSURANCE

MARKET CONDUCT EXAMINATION REPORT

OPTIMUM CHOICE, INC.

NAIC # 96940

4 Research Drive
Shelton, CT 06474-6280

As of

June 30, 2019

Trinidad Navarro
Commissioner



Delaware Department of Insurance

I, Trinidad Navarro, Insurance Commissioner of the State of Delaware, do hereby certify that the attached REPORT ON EXAMINATION, made as of June 30, 2019 on

OPTIMUM CHOICE, INC.

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

Attest By:

A handwritten signature in blue ink, appearing to read "Trinidad Navarro", written over a horizontal line.



In Witness Whereof, I have hereunto set my hand and affixed the official seal of this Department at the City of Dover, this 22 day of March, 2021.

A handwritten signature in blue ink, appearing to read "Trinidad Navarro", written over a horizontal line.
Trinidad Navarro
Insurance Commissioner

Trinidad Navarro
Commissioner



Delaware Department of Insurance

REPORT ON EXAMINATION

OF THE

OPTIMUM CHOICE, INC.

AS OF

June 30, 2019

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 22 day of March, 2021.


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: 96940-MHP-19-716 and pursuant to statutory provisions including 18 Del. CODE §318-322, a market conduct examination has been conducted of the affairs and practices of:

Optimum Choice, Inc.
NAIC # 96940

This examination was performed as of June 30, 2019.

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 or DDOI, or other suitable locations.

The report of examination herein is respectfully submitted.

EXECUTIVE SUMMARY

The main offices of Optimum Choice, Inc. (Optimum, OCI or the Company) are located in Rockville, Maryland with an administrative office in Shelton, Connecticut. The Company's 2018 annual statement filed with the Department reported total premiums written for all states of \$279,180,244 of which Delaware has a market share of 0.3% or approximately \$866,276.

This examination focused on Optimum's healthcare lines in the following areas of operation: Company Operations and Management, Forms, Grievances and Appeals, Policyholder Services, Underwriting and Rating, Claims, Provider Relationships, Utilization Review, Pharmacy, and Mental Health Parity. The following exceptions were noted and the details for the cited code references are included:

- **3 Exceptions**

- **18 Del. Admin. C. § 902-1.2.1.2 Authority for Regulation; Basis for Regulation.**

- *1.2.1.2 Failing to acknowledge and respond within 15 working days, upon receipt by the insurer, to communications with respect to claims by insureds arising under insurance policies.*

- Optimum failed to acknowledge and respond within 15 working days to communications with respect to claims.

- **15 Exceptions**

- **18 Del. Admin. C. § 902-1.2.1.5 Authority for Regulation; Basis for Regulation.**

- *1.2.1.5 Failing to affirm or deny coverage or a claim or advise the person presenting the claim, in writing, or other proper legal manner, of the reason for the inability to do so, within 30 days after proof of loss statements have been received by the insurer.*

- Optimum failed to affirm or deny the claims within 30 days after proof of loss was received.

- **9 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.*

Optimum failed to pay the allowable portion of the claim amounts deemed payable within 30 after receipt of the clean claim.

- **33 Exceptions**

- **18 Del. Admin. C. § 1310 - 6.2 Processing of Clean Claim.**

- *6.2 The request pursuant to section 6.1.4 must describe with specificity the clinical information requested and relate only to information the carrier can demonstrate is specific to the claim or the claim's related episode of care. A provider is not required to provide information that is not contained in, or is not in the process of being incorporated into, the patient's medical or billing record maintained by the provider whose services are the subject of inquiry. A carrier may make only one request under this subsection in connection with a claim. A carrier who requests information under this subsection shall take action under sections 6.1.1 through 6.1.3 within 15 days of receiving properly requested information.*

Optimum failed to provide a determination of the claims within 15 days following receipt of additional requested information.

- **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.*

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

- **5 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.

Optimum failed to specifically notify the provider or policyholder in writing why the claim will not be paid within 30 after receipt of the clean claim.

- **1 Exception**

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

- *(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.*

Optimum placed greater limits in the coverage of prescription medicines 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. The exception was noted in several sections, for purposes of this summary it is only listed once to highlight the system error.

- **1 Exception**

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

- *(i) General rule A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference, and*

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

- (A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness.*
- (B) Formulary design for prescription drugs.*

Optimum has imposed a Non-Quantitative Treatment Limitation (NQTL) of a prior authorization that is applied more stringently to mental health or substance use disorder benefits than to medical/surgical benefits in the classification. The exception was noted in several sections, for purposes of this summary it is only listed once to highlight the system error.

- **1 Exception**

- **18 Del. C. § 2304(16)(f) Unfair claim settlement practices.**

- *f. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;*

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

- **2 Exceptions**

- **18 Del. Admin. C. § 902-1.2.1.3 Authority for Regulation; Basis for Regulation.**

- *1.2.1.3 Failing to implement prompt investigation of claims arising under insurance policies within 10 working days upon receipt of the notice of loss by the insurer.*

- Optimum failed to implement prompt investigation of claims within 10 working days upon receipt of the notice of loss by the insurer.

- **1 Exception**

- **18 Del. C. § 2304(16)(a) Unfair claim settlement practices.**

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

- Optimum misrepresented pertinent facts or insurance policy provisions relating to coverages at issue.

- **1 Exception**

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

- *(i) General rule A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to*

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

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

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

(B) Formulary design for prescription drugs.

Optimum imposed a Non-Quantitative Treatment Limitation (NQTL) of a prior authorization being required for the use of Current Procedural Terminology (CPT) codes by mental health professionals but there is no prior authorization required for the corresponding Evaluation and Management (E/M) codes used by medical professionals.

- **6 Exceptions**

- **18 Del. C. § 3343(d)(c) Benefit management.**

- *c. The benefit prescribed by paragraph (b)(1) of this section may not be subject to concurrent utilization review during the first 14 days of any inpatient admission to a facility approved by a nationally recognized health-care accrediting organization or the Division of Substance Abuse and Mental Health, 30 days of intensive outpatient program treatment, or 5 days of inpatient withdrawal management, provided that the facility notifies the carrier of both the admission and the initial treatment plan within 48 hours of the admission. The facility shall perform daily clinical review of the patient, including the periodic consultation with the carrier to ensure that the facility is using the evidence-based and peer reviewed clinical review tool utilized by the carrier which is designated by the American Society of Addiction Medicine (“ASAM”) or, if applicable, any state-specific ASAM criteria, and appropriate to the age of the patient, to ensure that the inpatient treatment is medically necessary for the patient.*

Optimum subjected benefits to concurrent utilization review during the first 14 days of inpatient admission or 5 days of inpatient withdrawal management.

- **1 Exception**

- **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.*

Optimum failed to grant pre-authorization for pharmaceuticals that is valid for 1 year from the date the health-care provider received the pre-authorization.

- **1 Exception**

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

(i) General rule A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference, and

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

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

(B) Formulary design for prescription drugs.

Optimum imposed a prior authorization/notification which is a NQTL on all stimulant based ADHD medications. Placing a prior authorization on the entire class of medications is discriminatory towards mental health members. Additionally, the medical necessity criteria has an age limit restriction of 12 and older due to the potential for abuse of these medications. Other commonly abused medications do not have an age limitation enforced or a prior authorization/notification on all medications such as opioids (some long acting until March 2018 and the majority of short acting), tranquilizers, sedatives, and sleep aids.

- **1 Exception**

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

18 Del. C. § 3578(b)(1)(b): (b) Coverage of serious mental illnesses and drug and alcohol dependencies. — (1) a. Carriers shall provide coverage for serious mental illnesses and drug and alcohol dependencies in all health benefit plans delivered or issued for delivery in this State. Coverage for serious mental illnesses and drug and alcohol dependencies must provide all of the following:

1. Inpatient coverage for the diagnosis and treatment of drug and alcohol dependencies.

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.

45 CFR § 146.136(c)(4)(i)(ii): (i) General rule A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference, and

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

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

(B) Formulary design for prescription drugs.

Optimum has imposed a prior authorization which is a NQTL on all smoking cessation medications. Placing a prior authorization on the entire class of smoking cessation medications is discriminatory towards substance abuse members. Additionally, all smoking cessation medications had a maximum coverage of 2 (3 month) cycles of smoking cessation medications per 12-month period whereas this was not enforced on MED/SURG policies.

- **1 Exception**

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

18 Del. C. § 3578(b)(1)(b): (b) Coverage of serious mental illnesses and drug and alcohol dependencies. — (1) a. Carriers shall provide coverage for serious mental illnesses and drug and alcohol dependencies in all health benefit plans delivered or issued for delivery in this State. Coverage for serious mental illnesses and drug and alcohol dependencies must provide all of the following:

1. Inpatient coverage for the diagnosis and treatment of drug and alcohol dependencies.

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.

45 CFR § 146.136(c)(4)(i)(ii): (i) General rule A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference, and

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

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

(B) Formulary design for prescription drugs.

Optimum has imposed a prior authorization, which is a Non-Quantitative Treatment Limitation (NQTL), on all buprenorphine containing medications used for opioid dependence treatment. Placing a prior authorization on the entire class of buprenorphine containing medications is discriminatory towards substance abuse members. As of 3/1/17, Zubsolv became the preferred buprenorphine/naloxone containing medication, and the prior authorization requirement was removed. All other buprenorphine/naloxone containing medications were either excluded from coverage, or continued to require a prior authorization. Only allowing one preferred buprenorphine/naloxone containing medication and placing all others on higher tiers cost the member more money (including the only generic formulation, buprenorphine/naloxone sublingual tablets). Also excluding from coverage, or a step therapy requirement of the preferred medication causes a barrier/delay to treatment for these members.

- **1 Exception**

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

18 Del. C. § 3578(b)(1)(b): (b) Coverage of serious mental illnesses and drug and alcohol dependencies. — (1) a. Carriers shall provide coverage for serious mental illnesses and drug and alcohol dependencies in all health benefit plans delivered or issued for delivery in this State. Coverage for serious mental illnesses and drug and alcohol dependencies must provide all of the following:

1. Inpatient coverage for the diagnosis and treatment of drug and alcohol dependencies.

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.

45 CFR § 146.136(c)(4)(i)(ii): (i) General rule A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference, and

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

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

(B) Formulary design for prescription drugs.

Optimum had a quantity limit restriction on buprenorphine HCL sublingual tablets of a maximum allowance of a 5-day supply. This quantity limitation on this medication is discriminatory to substance abuse members compared to other controlled substance prescriptions such as immediate release opioids which did not have this quantity restriction. The Company removed this restriction in the middle of 2017.

- **1 Exception**

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

18 Del. C. § 3578(b)(1)(b): (b) Coverage of serious mental illnesses and drug and alcohol dependencies. — (1) a. Carriers shall provide coverage for serious mental illnesses and drug and alcohol dependencies in all health benefit plans delivered or issued for delivery in this State. Coverage for serious mental illnesses and drug and alcohol dependencies must provide all of the following:

1. Inpatient coverage for the diagnosis and treatment of drug and alcohol dependencies.

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.

45 CFR § 146.136(c)(4)(i)(ii): (i) General rule A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference, and

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

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

(B) Formulary design for prescription drugs.

Optimum has a policy of a dose restriction on Suboxone 2mg/0.5mg films based on CFIPDL ClinicalComboGrid 121216, CFIPDL ClinicalComboGrid 12.15.2017 for 1.1, CFIPDL ClinicalComboGrid 7.1.2017, CFIPDL ClinicalComboGrid 7.1.2018, CFIPDL ClinicalComboGrid 1.1.2019, and CFIPDL ClinicalComboGrid 6.1.2019 when the member requires 3 films per day. According to FDA approved and the manufacturer's dosage guidelines, the following is appropriate maintenance treatment: "2.1 Maintenance: SUBOXONE sublingual film is indicated for maintenance treatment. The recommended target dosage of SUBOXONE sublingual film is 16/4 mg buprenorphine/naloxone/day as a single daily dose. The dosage of SUBOXONE sublingual film should be progressively adjusted in increments/decrements of 2/0.5 mg or 4/1 mg buprenorphine/naloxone to a level that holds the patient in treatment and suppresses opioid withdrawal signs and symptoms. The maintenance dose of SUBOXONE sublingual film is generally in the range of 4/1 mg buprenorphine/naloxone to 24/6 mg buprenorphine/naloxone per day depending on the individual patient. Dosages higher than this have not been demonstrated to provide any clinical advantage." With 4 available dosage strengths (2mg/0.5mg, 4mg/1mg, 8mg/2mg, and 12mg/3mg), taking multiple films per day is the only way to achieve dosages that aren't commercially available. If a member requires one of these doses in between strengths (example would be 6mg/1.5mg or 3 films per day) as a dose reduction, titration, or is stable at a particular dosage (example would be 6mg/1.5mg or

3 films per day), they would require a DUR override from their doctor. This type of quantity limitation restriction is more stringently applied on this medication for substance abuse, and is not comparable to MED/SURG medications when multiple dosage units are required to achieve a dose that is not commercially available (still within FDA approved guidelines).

- **1 Exception**

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

18 Del. C. § 3578(b)(1)(b): (b) Coverage of serious mental illnesses and drug and alcohol dependencies. — (1) a. Carriers shall provide coverage for serious mental illnesses and drug and alcohol dependencies in all health benefit plans delivered or issued for delivery in this State. Coverage for serious mental illnesses and drug and alcohol dependencies must provide all of the following:

1. Inpatient coverage for the diagnosis and treatment of drug and alcohol dependencies.

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.

45 CFR § 146.136(c)(4)(i)(ii): (i) General rule A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference, and

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

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

(B) Formulary design for prescription drugs.

Optimum's Prior authorization/Notification policy on Vyvanse for Binge Eating Disorder (BED) is not comparable to, and is applied 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. Once a member gets approval for Vyvanse for BED, based on these policies, authorization will be issued for three months for Moderate to Severe Binge Eating Disorder and 12 months for all other approved indications. This initial three-month approval is in violation of § 3586 Length of pre-authorization, § 3578 Insurance coverage for serious mental illness (b)(1)b and 45 CFR 146.136 (c)(4)(i)(ii) compared to MED/SURG medication policies. Additionally, all off label MED/SURG indications included in these aforementioned policies (narcolepsy, hypersomnia of central origin, mental fatigue secondary to traumatic brain injury, and fatigue associated with medical illness in patients in palliative or end of life care) don't have an initial 3-month medical necessity/prior authorization approval (all these off label indications are approved for 12 months). This would also apply to the reauthorization criteria as well since the requirement for a BED diagnosis requires updated clinical information as per reauthorization guidelines: "*Documentation of positive clinical response (e.g., meaningful reduction in the number of binge eating episodes or binge days per week from baseline, improvement in the signs and symptoms of binge eating disorder) to Vyvanse therapy.*" This reauthorization criteria only applies to the BED diagnosis and not to any other diagnosis including all off label MED/SURG indications (narcolepsy, hypersomnia of central origin, mental fatigue secondary to traumatic brain injury, and fatigue associated with medical illness in patients in palliative or end of life care). Additionally, Vyvanse was designated a tier 4 medication and excluded from coverage on all Essential formularies for the scope of the exam.

- **1 Exception**

- **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.*

Optimum failed to grant pre-authorizations for Vyvanse for BED that is valid for one year from the date the healthcare provider received the pre-authorization. Once a member gets approval for Vyvanse for BED authorization will be issued for 3 months for Moderate to Severe Binge Eating Disorder and 12 months for all other approved indications. This initial 3-month approval is in violation of 18 Del. C. § 3586(a) Length of pre-authorization, of 18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness (b)(1)b and 45 CFR 146.136 (c)(4)(i)(ii) compared to MED/SURG medication policies. Additionally, all off label MED/SURG indications included in these aforementioned policies (narcolepsy, hypersomnia of central origin, mental fatigue secondary to traumatic brain injury, and fatigue associated with medical illness in patients in palliative or end of life care) don't have an initial 3-month medical necessity/prior authorization approval (all these off label indications are approved for 12 months).

- **1 Exception**

18 Del. C. § 3337A(a) Prior authorization of prescriptions for chronic or long-term conditions.

(a) A prior authorization form for a prescription medication shall include a question regarding whether the prescription medication is for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient.

Optimum failed to include a question regarding whether the prescription medication is for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient on prior authorization forms.

- **1 Exception**

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

18 Del. C. § 3578(b)(1)(b): (b) Coverage of serious mental illnesses and drug and alcohol dependencies. — (1) a. Carriers shall provide coverage for serious mental illnesses and drug and alcohol dependencies in all health benefit plans delivered or issued for delivery in this State. Coverage for serious mental illnesses and drug and alcohol dependencies must provide all of the following:

1. Inpatient coverage for the diagnosis and treatment of drug and alcohol dependencies.

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.

45 CFR § 146.136(c)(4)(i)(ii): (i) General rule A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference, and

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

- (A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness.*
- (B) Formulary design for prescription drugs.*

Optimum did not include any mental health or substance abuse medications in their Refill and Save program. The Company removed Pristiq from their Refill and Save program on or about 7/1/2017. The Company indicated that “The Refill and Save program provides members who refill their prescription for a qualifying medication to save on their usual copayment or coinsurance. The program is designed to drive adherence for certain medications. Members who refill their prescriptions on a regular basis through retail and OptumRx® home delivery will get a reduction on their copayment. Members do not have to sign up or complete a participation form within the program. If the member fills the medications timely, they will receive the reduction in copay on their next fill. For inclusion within the Refill and Save program, products are selected based upon financial factors. UHC was able to obtain a rebate on Pristiq while keeping it in Tier 3 and able to provide a reduced copayment for those that were adherent. Pristiq was removed from the program when the AB-rated generic launched because the AB-rated generic launched was placed in Tier 2 at a reduced copayment.” The Company didn’t place any other mental health or substance abuse medications in this program for the remainder of the exam period. This exclusion from the Refill and Save Program is discriminatory to mental health and substance abuse members as they would not benefit from any reduction in coinsurance/copayment for any medications that they consistently filled, were compliant with, or adherent to during the remainder of the exam period as opposed to MED/SURG medications that continued to be included in the program. The programs design was to drive adherence for certain medications, but any adherence program would benefit any medication regimen whether it’s for MH/SUD or MED/SURG treatment regimens.

- **1 Exception**

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

18 Del. C. § 3578(b)(1)(b): (b) Coverage of serious mental illnesses and drug and alcohol dependencies. — (1) a. Carriers shall provide coverage for serious mental illnesses and drug and alcohol dependencies in all health benefit plans delivered or issued for delivery in this State. Coverage for serious mental illnesses and drug and alcohol dependencies must provide all of the following:

- 1. Inpatient coverage for the diagnosis and treatment of drug and alcohol dependencies.*
- 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.

45 CFR § 146.136(c)(4)(i)(ii): (i) General rule A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference, and

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

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

(B) Formulary design for prescription drugs.

Optimum imposed a dosing limit on duloxetine 30mg capsules for a quantity of three capsules a day or a 90mg dose. The member would be required to get a DUR/quantity limit override for this dose from their doctor. This is discriminatory for mental health members for having a restrictive dosing limitation on doses of 90mg/day which only includes this medication's mental health indications (Major Depressive Disorder and Generalized Anxiety Disorder) and not its MED/SURG indications (Diabetic Peripheral Neuropathic Pain, Fibromyalgia, and Chronic Musculoskeletal Pain) which have a maximum dose of 60mg/day. Furthermore, the Company did not have a dosing limitation on FDA approved MED/SURG medications that required multiple dosage units to achieve other FDA approved doses when clinically relevant.

- **1 Exception**

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

18 Del. C. § 3578(b)(1)(b): (b) Coverage of serious mental illnesses and drug and alcohol dependencies. — (1) a. Carriers shall provide coverage for serious mental illnesses and drug and alcohol dependencies in all health benefit plans delivered or issued for delivery in this State. Coverage for serious mental illnesses and drug and alcohol dependencies must provide all of the following:

1. Inpatient coverage for the diagnosis and treatment of drug and alcohol dependencies.

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.

45 CFR § 146.136(c)(4)(i)(ii): (i) General rule A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference, and

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

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

(B) Formulary design for prescription drugs.

Optimum has restrictive medical necessity criteria on Evzio injection for members who require rescue naloxone and are treated with medication assisted treatment (MAT). This medical necessity criteria is discriminatory towards substance abuse members being treated with naltrexone for opioid dependence treatment if Evzio is their only viable option to have on hand.

- **1 Exception**

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

18 Del. C. § 3578(b)(1)(b): (b) Coverage of serious mental illnesses and drug and alcohol dependencies. — (1) a. Carriers shall provide coverage for serious mental illnesses and drug and alcohol dependencies in all health benefit plans delivered or issued for delivery in this State. Coverage for serious mental illnesses and drug and alcohol dependencies must provide all of the following:

1. Inpatient coverage for the diagnosis and treatment of drug and alcohol dependencies.

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.

45 CFR § 146.136(c)(4)(i)(ii): (i) General rule A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference, and

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

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

(B) Formulary design for prescription drugs.

Optimum has imposed a NQTL of higher tier placement or entirely excluded two generic mental health medications, duloxetine and desvenlafaxine on their Advantage and Essential formularies. The Company failed to provide an adequate explanation or detailed NQTL analysis as to why these two generic medications had higher tier placement or were excluded entirely compared to MED/SURG medications.

- **1 Exception**

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

18 Del. C. § 3578(b)(1)(b): (b) Coverage of serious mental illnesses and drug and alcohol dependencies. — (1) a. Carriers shall provide coverage for serious mental illnesses and drug and alcohol dependencies in all health benefit plans delivered or issued for delivery in this State. Coverage for serious mental illnesses and drug and alcohol dependencies must provide all of the following:

1. Inpatient coverage for the diagnosis and treatment of drug and alcohol dependencies.

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.

45 CFR § 146.136(c)(4)(i)(ii): (i) General rule A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference, and

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

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

(B) Formulary design for prescription drugs.

Optimum has imposed a NQTL of higher tier placement, quantity limitations, step therapy, and non-formulary status for generic antipsychotics (aripiprazole, ziprasidone, and quetiapine ER) on Advantage and Essential formularies. The Company failed to provide an adequate explanation or detailed NQTL analysis as to why these generic antipsychotics had higher tier placement, quantity limitations, step therapy, and non-formulary status compared to MED/SURG medications.

- **1 Exception**

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

18 Del. C. § 3578(b)(1)(b): (b) Coverage of serious mental illnesses and drug and alcohol dependencies. — (1) a. Carriers shall provide coverage for serious mental illnesses and drug and alcohol dependencies in all health benefit plans delivered or issued for delivery in this State. Coverage for serious mental illnesses and drug and alcohol dependencies must provide all of the following:

1. Inpatient coverage for the diagnosis and treatment of drug and alcohol dependencies.

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.

45 CFR § 146.136(c)(4)(i)(ii): (i) General rule A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference, and

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

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

(B) Formulary design for prescription drugs.

Optimum excluded coverage for methadone maintenance treatment (MMT) from outpatient treatment facilities approved by SAMSHA in accordance with ASAM guidelines. This Non-Quantitative Treatment Limitation (NQTL) is discriminatory towards substance abuse members.

- **1 Exception**

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

18 Del. C. § 3578(b)(1)(b): (b) Coverage of serious mental illnesses and drug and alcohol dependencies. — (1) a. Carriers shall provide coverage for serious mental illnesses and drug and alcohol dependencies in all health benefit plans delivered or issued for delivery in this State. Coverage for serious mental illnesses and drug and alcohol dependencies must provide all of the following:

1. Inpatient coverage for the diagnosis and treatment of drug and alcohol dependencies.

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.

45 CFR § 146.136(c)(4)(i)(ii): (i) General rule A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference, and

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

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

(B) Formulary design for prescription drugs.

Optimum has imposed a NQTL of higher tier placement, quantity limitations, and non-formulary status for brand name antipsychotics (Fanapt, Latuda, Rexulti, Saphris, and Vraylar) on different formularies. The Company failed to provide an adequate explanation or detailed NQTL analysis as to why these brand name antipsychotics had higher tier placement, quantity limitations, and non-formulary status compared to MED/SURG medications.

- **1 Exception**

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

18 Del. C. § 3578(b)(1)(b): (b) Coverage of serious mental illnesses and drug and alcohol dependencies. — (1) a. Carriers shall provide coverage for serious mental illnesses and drug and alcohol dependencies in all health benefit plans delivered or issued for delivery in this State. Coverage for serious mental illnesses and drug and alcohol dependencies must provide all of the following:

1. Inpatient coverage for the diagnosis and treatment of drug and alcohol dependencies.

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.

45 CFR § 146.136(c)(4)(i)(ii): (i) General rule A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference, and

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

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

(B) Formulary design for prescription drugs.

Optimum has imposed a NQTL of higher tier placement, step therapy, quantity limitations, and non-formulary status for brand name antidepressants that did not have generic equivalents (Fetzima, Trintellix, and Viibryd) on different formularies. The Company failed to provide an adequate explanation or detailed NQTL analysis as to why these brand name antidepressants had higher tier placement, step therapy, quantity limitations, and non-formulary status compared to MED/SURG medications.

SCOPE OF EXAMINATION

The Market Conduct Examination was conducted pursuant to the authority granted by 18 Del. C. §§318-322 and covered the experience period of January 1, 2017 through June 30, 2019 unless otherwise noted. The purpose of the examination was to determine compliance by the Company with Delaware insurance laws and regulations related to the healthcare lines.

The examination was a targeted market conduct examination of the healthcare lines for the period of January 1, 2017 through June 30, 2019.

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.

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

COMPANY HISTORY AND PROFILE

Optimum Choice, Inc. has its principal executive office at 800 King Farm Boulevard, Rockville, Maryland 20850. OCI was incorporated as a stock corporation on May 7, 1987, under the laws of Maryland as Physicians Health Services of Maryland, Inc. On August 3, 1987, OCI amended its Articles of Incorporation to change its name to Physicians Health Services, Inc. OCI again amended its Articles of Incorporation on August 18, 1988, to change its name to Optimum Choice, Inc.

OCI was primarily created to establish, own, and operate alternative health care delivery systems including, but not limited to, health maintenance organizations and to address the needs of the small business market segment. On September 1, 1988, OCI was issued a certificate of authority to operate as a health maintenance organization by the Maryland Insurance Administration (MIA). OCI is licensed to transact business in the states of Delaware, Maryland, Virginia, West Virginia, and the District of Columbia.

Until February 10, 2004, OCI was owned by Mid Atlantic Medical Services, Inc. (MAMSI)

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Optimum Choice, Inc.**

an insurance holding company domiciled in the State of Maryland.

On November 3, 2003, UnitedHealth Group Incorporated (formerly known as United HealthCare Corporation “United”) filed a Form A with the MIA seeking approval of the acquisition of MAMSI and its subsidiary companies, which Form A was approved on February 10, 2004. MU Acquisition LLC (MU), a then newly formed Delaware limited liability company and wholly owned subsidiary of United, merged with MAMSI with MU becoming the surviving entity. Simultaneously, MU changed its name to Mid Atlantic Medical Services, LLC (MAMSL). As a result of the merger, the separate corporate existence of MAMSI ceased and all of its direct and indirect subsidiaries, including OCI, became members of the United holding company system.

Effective January 1, 2012, MAMSL merged with and into United HealthCare Services, Inc., a Minnesota corporation and wholly owned subsidiary of United. As a result of this merger, OCI became a wholly owned subsidiary of United HealthCare Services, Inc.

OCI is authorized to transact the business in the states of Delaware, Maryland, Virginia, West Virginia and the District of Columbia. In 2018, OCI reported \$279,180,244 premium of which \$866,276 was written in Delaware. In 2017, UHIC reported \$224,338,987 premium of which \$329,557 was written in Delaware.

COMPANY OPERATIONS AND MANAGEMENT

The Company provided the following company operations and management documentation:

- Internal Control Methods.
- Internal Audits.
- Company Overview and History.
- Third Party Administrators.
- The Company’s Annual Report for 2017 and 2018.
- Fines and Penalties.
- Records Retention

The documents were reviewed to ensure compliance with the State of Delaware Laws and Regulations. There were no exceptions noted.

FORMS

Optimum was requested to provide a list of all individual/group policies, certificate forms, conversion contracts, applications, amendments and endorsements used and/or approved during the experience period for newly issued Health Coverage in Delaware. The list was to include the form number, descriptive name and the Delaware filing/approval date. The Company provided a list of 63 forms that were utilized during the examination period. All 63 forms were reviewed.

There were no exceptions noted.

GRIEVANCES AND APPEALS

Optimum was requested to provide a listing of all Appeals and Grievances filed with the Company during the examination period of January 1, 2017 through June 30, 2019. The Company provided a list with one (1) appeal and grievance that was received during the examination period. The complaint file was reviewed.

The grievance and appeal file and associated documentation was reviewed for compliance with applicable Delaware Department of Insurance statutes and regulations.

There were no exceptions noted.

POLICYHOLDER SERVICES

Optimum Choice, Inc., was requested to provide the behavioral health accessibility and availability analyses, including the process by which the Company ensures that provider directories (online and/or hard copy) are current and accurate.

Requests were made regarding definitions, differences in listings as well as requests for all reports related to the results of the program during the examination period of January 1, 2017 to June 30, 2019. Additionally, requests were made for the number of members to the number of providers for the Counties of Kent, New Castle and Sussex.

The documents were reviewed for compliance with applicable Delaware Department of Insurance statutes.

There were no exceptions noted.

UNDERWRITING AND RATING

Optimum was requested to provide copies of all rates approved for use in Delaware during the examination period. Additionally, they were requested to provide their underwriting and rating policies, procedures, guidelines, documentation, and disclosures.

All of the policies, procedures, guidelines, documentation, and disclosures were reviewed for compliance with applicable Delaware Department of Insurance statutes and regulations, The Health Insurance Portability and Accountability Act (HIPAA), Consolidated Omnibus Budget Reconciliation Act (COBRA), U.S. Department of Health and Human Services (HHS), the U.S. Department of Labor (DOL), and the U.S. Department of the Treasury (Treasury).

There were no exceptions noted.

A. Group Policy Cancellations:

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Optimum Choice, Inc.**

Optimum Choice, Inc., provided a listing of 13 Delaware situs group policies that were cancelled during the examination period of January 1, 2017 through June 30, 2019. All 13 group policy cancellation files were requested and reviewed.

The group cancellation files were reviewed for compliance with applicable Delaware Department of Insurance statutes.

There were no exceptions noted.

CLAIMS

UnitedHealthcare was requested to provide listings of all claims that occurred during the examination period. The original listings only contained residents of Delaware. A request was sent for the listings of all claims for Delaware situs policies regardless of member residency. The claims samples that are labeled Non-Delaware (Non-DE) are those which were received from members of Delaware situs policies that reside outside of Delaware. The following claim types were reviewed: Medical/Surgical (Med/Surg), Mental Health/Substance Use Disorder (MH/SUD), Mental Health (MH), SUD (SUD), Pharmacy, and Autism.

A. Claims Manuals

Optimum was requested to provide documentation related to claim policies and procedures. This included claim procedure and processing manuals, claim audit reports and bulletins. Also requested and provided were policies and procedures and other documentation demonstrating that the health plan complies with the requirements of the Federal Mental Health Parity Act of 1996 (MHPA) and revisions made in the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

The policies, procedures and documentation were reviewed for compliance with applicable Delaware Department of Insurance statutes and regulations and the requirements of MHPA and MHPAEA.

There were no exceptions noted.

B. Med/Surg Paid Claims:

Optimum was requested to provide a list of all Med/Surg claims that were paid during the examination period of January 1, 2017 through June 30, 2019. The Company provided a list of 2,601 Med/Surg claims that were paid during the examination period. A random sample of 107 claims was selected for review.

The following exceptions were noted:

1 Exception - 18 Del. Admin. C. § 902-1.2.1.2 Authority for Regulation; Basis for Regulation.

Optimum failed to acknowledge and respond within 15 working days to communications with respect to claims.

Recommendation: It is recommended that the Company acknowledge and respond within 15 working days to communications with respect to claims as required by 18 *Del. Admin. C. § 902–1.2.1.2.*

4 Exceptions - 18 *Del. Admin. C. § 902–1.2.1.5 Authority for Regulation; Basis for Regulation.*

Optimum failed to affirm or deny the claims within 30 days after proof of loss was received.

Recommendation: It is recommended that the Company affirm or deny claims within 30 days as required by 18 *Del. Admin. C. § 902 – 1.2.1.5.*

5 Exceptions – 18 *Del. Admin. C. § 1310–6.1.2 Processing of Clean Claim.*

Optimum failed to pay the allowable portion of the claim amounts deemed payable within 30 after receipt of the clean claim.

Recommendation: It is recommended that the Company pay the allowable portion of the claim amounts deemed payable within 30 days 18 *Del. Admin. C. § 1310–6.1.2.*

2 Exceptions - 18 *Del. Admin. C. § 1310 - 6.2 Processing of Clean Claim.*

Optimum failed to provide a determination of the claims within 15 days following receipt of additional requested information.

Recommendation: It is recommended that the Company provide a determination of the claim within 15 days following receipt of additional requested information as required by 18 *Del. Admin. C. § 1310 - 6.2.*

C. Med/Surg Denied Claims:

UnitedHealthcare was requested to provide a list of all Med/Surg claims that were denied during the examination period of January 1, 2017 through June 30, 2019. The Company provided a list of 809 Med/Surg claims that were denied that were denied during the examination period. A random sample of 83 claims was selected for review.

The following exception was noted:

1 Exception – 18 *Del. Admin. C. § 1310–6.1.2 Processing of Clean Claim.*

Optimum failed to pay the allowable portion of the claim amounts deemed payable within 30 after receipt of the clean claim.

Recommendation: It is recommended that the Company pay the allowable portion of the claim amounts deemed payable within 30 days 18 *Del. Admin. C.* § 1310–6.1.2.

D. MH Paid Claims:

Optimum was requested to provide a list of all MH claims that were paid during the examination period of January 1, 2017 through June 30, 2019. The Company provided a list of 84 MH claims that were paid. A random sample of 76 claims was selected for review.

The following exceptions were noted:

6 Exceptions - 18 *Del. Admin. C.* § 902–1.2.1.5 Authority for Regulation; Basis for Regulation.

Optimum failed to affirm or deny the claims within 30 days after proof of loss was received.

Recommendation: It is recommended that the Company affirm or deny claims within 30 days as required by 18 *Del. Admin. C.* § 902 – 1.2.1.5.

5 Exceptions – 18 *Del. Admin. C.* § 1310–6.1.1 Processing of Clean Claim.

Optimum 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 - 6.2 Processing of Clean Claim.

Optimum failed to provide a determination of the claim within 15 days following receipt of additional requested information.

Recommendation: It is recommended that the Company provide a determination of the claim within 15 days following receipt of additional requested information as required by 18 *Del. Admin. C.* § 1310 - 6.2.

E. MH Denied Claims:

Optimum was requested to provide a list of all MH Claims that were denied during the examination period of January 1, 2017 through June 30, 2019. The Company provided a list of 48 MH claims that were denied. All 48 claims were selected for review.

There were no exceptions noted.

F. SUD Paid Claims:

Optimum was requested to provide a list of all SUD Claims that were paid during the examination period of January 1, 2017 through June 30, 2019. The Company provided a list of two (2) SUD claims that were paid during the examination period. The two (2) claims were reviewed.

The following exception was noted:

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

Optimum failed to specifically notify the provider or policyholder in writing why the claim will not be paid within 30 after receipt of the clean claim.

Recommendation: It is recommended that the Company provide a determination of claims within 30 days as required by 18 Del. Admin. C. § 1310 – 6.1.3.

G. Med/Surg Pharmacy Paid Claims:

Optimum was requested to provide a list of all Med/Surg Pharmacy claims that were paid during the examination period of January 1, 2017 through June 30, 2019. The Company provided a list of 2,671 pharmacy claims that were paid during the examination period. A random sample of 107 pharmacy claims was selected for review.

There were no exceptions noted.

H. Med/Surg Pharmacy Denied Claims:

Optimum was requested to provide a list of all Med/Surg Pharmacy claims that were denied during the examination period of January 1, 2017 through June 30, 2019. The Company provided a list of 830 pharmacy claims that were denied during the examination period. A random sample of 83 pharmacy claims was selected for review.

There were no exceptions noted.

I. MH/SUD Pharmacy Paid Claims:

Optimum was requested to provide a list of MH/SUD Pharmacy claims that were paid during the examination period of January 1, 2017 through June 30, 2019. The Company provided a list of 452 MH/SUD Pharmacy claims that were paid during the examination period. A random sample of 82 pharmacy claims was selected for review.

There were no exceptions noted.

J. MH/SUD Pharmacy Denied Claims:

Optimum was requested to provide a list of all MH/SUD Pharmacy claims that were denied during the examination period of January 1, 2017 through June 30, 2019. The Company provided a list of 820 MH/SUD Pharmacy claims that were denied during the examination period. A random sample of 76 pharmacy claims was selected for review.

The following exceptions were noted:

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

Optimum placed greater limits in the coverage of prescription medicines 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.

Recommendation: It is recommended that the Company not issue for delivery, or deliver, in this State any health benefit plan containing terms that place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan, including terms for deductibles, co-pays, monetary limits, coinsurance factors, limits in the numbers of visits, limits in the length of inpatient stays, durational limits, or limits in the coverage of prescription medicines as required by 18 Del. C. § 3578(b)(1)(b).

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

Optimum has imposed a Non-Quantitative Treatment Limitation (NQTL) of a prior authorization that is applied more stringently to mental health or substance use disorder benefits than to medical/surgical benefits in the classification.

Recommendation: It is recommended that the Company not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required by 45 CFR § 146.136(c)(4)(i)(ii).

K. Med/Surg Closed Claims:

Optimum was requested to provide a list of all Med/Surg claims that were closed during the examination period of January 1, 2017 through June 30, 2019. The Company provided a list of 76 Med/Surg individual claim lines that were closed during the examination period. All 76 individual claim lines representing 55 unique claims were selected for review.

The following exceptions were noted:

1 Exception - 18 Del. Admin. C. § 902–1.2.1.2 Authority for Regulation; Basis for Regulation.

Optimum failed to acknowledge and respond within 15 working days to communications with respect to claims.

Recommendation: It is recommended that the Company acknowledge and respond within 15 working days to communications with respect to claims as required by 18 Del. Admin. C. § 902–1.2.1.2.

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

Optimum failed to affirm or deny the claims within 30 days after proof of loss was received.

Recommendation: It is recommended that the Company affirm or deny claims within 30 days as required by 18 Del. Admin. C. § 902 – 1.2.1.5.

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

Optimum failed to pay the allowable portion of the claim amounts deemed payable within 30 after receipt of the clean claim.

Recommendation: It is recommended that the Company pay the allowable portion of the claim amounts deemed payable within 30 days 18 Del. Admin. C. § 1310–6.1.2.

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

Optimum failed to specifically notify the provider or policyholder in writing why the claim will not be paid within 30 after receipt of the clean claims.

Recommendation: It is recommended that the Company provide a determination of claims within 30 days as required by 18 Del. Admin. C. § 1310 – 6.1.3.

14 Exceptions – 18 Del. Admin. C. § 1310 - 6.2 Processing of Clean Claim

Optimum failed to provide a determination of the claim within 15 days following receipt of additional requested information.

Recommendation: It is recommended that the Company provide a determination of the claim within 15 days following receipt of additional requested information as required by 18 Del. Admin. C. § 1310 - 6.2.

L. MH/SUD Closed Claims:

Optimum was requested to provide a list of all MH/SUD claims that were closed during the examination period of January 1, 2017 through June 30, 2019. The Company provided a list of four (4) MH/SUD claims that were closed during the examination period. All four (4) claims were reviewed.

There were no exceptions noted.

M. Med/Surg Partially Paid Claims:

Optimum was requested to provide a list of all Med/Surg claims that were partially paid during the examination period of January 1, 2017 through June 30, 2019. The Company provided a list of 1,156 Med/Surg individual claim lines that were partially paid during the examination period. A random sample of 105 individual claim lines representing 85 unique claims was selected for review.

The following exceptions were noted:

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

Optimum failed to specifically notify the provider or policyholder in writing why the claim will not be paid within 30 after receipt of the clean claim.

Recommendation: It is recommended that the Company provide a determination of claims within 30 days as required by 18 Del. Admin. C. § 1310 – 6.1.3.

2 Exceptions – 18 Del. Admin. C. § 1310 - 6.2 Processing of Clean Claim.

Optimum failed to provide a determination of the claims within 15 days following receipt of additional requested information.

Recommendation: It is recommended that the Company provide a determination of the claim within 15 days following receipt of additional requested information as required by 18 Del. Admin. C. § 1310 - 6.2.

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

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

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

N. MH/SUD Partially Paid Claims:

Optimum was requested to provide a list of all MH/SUD claims that were partially paid during the examination period of January 1, 2017 through June 30, 2019. The Company provided a list of 75 MH/SUD individual claim lines that were partially paid during the examination period. All 75 individual claim lines representing 39 unique claims were selected for review.

The following exceptions were noted:

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

Optimum failed to specifically notify the provider or policyholder in writing why the claim will not be paid within 30 after receipt of the clean claim.

Recommendation: It is recommended that the Company provide a determination of claims within 30 days as required by 18 Del. Admin. C. § 1310 – 6.1.3.

13 Exceptions – 18 Del. Admin. C. § 1310 - 6.2 Processing of Clean Claim.

Optimum failed to provide a determination of the claims within 15 days following receipt of additional requested information.

Recommendation: It is recommended that the Company provide a determination of the claim within 15 days following receipt of additional requested information as required by 18 Del. Admin. C. § 1310 - 6.2.

O. Med/Surg Non-DE Resident Paid Claims:

Optimum was requested to provide a list of all Med/Surg claims that were paid during the examination period of January 1, 2017 through June 30, 2019. The Company provided a list of 274 Med/Surg Non-DE resident claims that were paid during the examination period. A random sample of 76 claims was selected for review.

The following exceptions were noted:

2 Exceptions - 18 Del. Admin. C. § 902–1.2.1.3 Authority for Regulation; Basis for Regulation.

Optimum failed to implement prompt investigation of claims within 10 working days upon receipt of the notice of loss by the insurer.

Recommendation: It is recommended that the Company implement prompt investigation of claims arising under insurance policies within 10 working days upon receipt of the notice of loss as required by 18 Del. Admin. C. § 902–1.2.1.3.

P. Med/Surg NON-DE Resident Partially Paid Claims:

Optimum was requested to provide a list of all Med/Surg claims that were partially paid during the examination period of January 1, 2017 through June 30, 2019. The Company provided a list of 58 Med/Surg Non-DE resident individual claim lines that were partially paid during the examination period. All 58 individual claim lines representing 46 unique claims was selected for review.

The following exceptions were noted:

1 Exception - 18 Del. C. § 2304(16)(a) Unfair claim settlement practices.

Optimum misrepresented pertinent facts or insurance policy provisions relating to coverages at issue.

Recommendation: It is recommended that the Company accurately represent pertinent facts or insurance policy provisions relating to coverages at issue as required 18 Del. C. § 2304(16)(a).

1 Exception – 18 Del. Admin. C. § 1310 - 6.2 Processing of Clean Claim.

Optimum failed to provide a determination of the claim within 15 days following receipt of additional requested information.

Recommendation: It is recommended that the Company provide a determination of the claim within 15 days following receipt of additional requested information as required by 18 Del. Admin. C. § 1310 - 6.2.

Q. Med/Surg Non-DE Resident Denied Claims:

Optimum was requested to provide a list of all Med/Surg claims that were denied during the examination period of January 1, 2017 through June 30, 2019. The Company provided a list of 104 Med/Surg Non-DE resident individual claim lines that were denied during the examination period. A random sample of 76 individual claim lines representing 50 unique claims was selected for review.

The following exceptions were noted:

1 Exception - 18 Del. Admin. C. § 902–1.2.1.2 Authority for Regulation; Basis for Regulation.

Optimum failed to acknowledge and respond within 15 working days to communications with respect to claims.

Recommendation: It is recommended that the Company acknowledge and respond within 15 working days to communications with respect to claims as required by 18 Del. Admin. C. § 902–1.2.1.2.

1 Exception - 18 Del. Admin. C. § 902–1.2.1.5 Authority for Regulation; Basis for Regulation.

Optimum failed to affirm or deny the claim within 30 days after proof of loss was received.

Recommendation: It is recommended that the Company affirm or deny claims within 30 days as required by 18 Del. Admin. C. § 902 – 1.2.1.5.

1 Exception – 18 Del. Admin. C. § 1310–6.1.2 Processing of Clean Claim.

Optimum failed to pay the allowable portion of the claim amounts deemed payable within 30 after receipt of the clean claim.

Recommendation: It is recommended that the Company pay the allowable portion of the claim amounts deemed payable within 30 days 18 Del. Admin. C. § 1310–6.1.2.

1 Exception – 18 Del. Admin. C. § 1310 - 6.2 Processing of Clean Claim.

Optimum failed to provide a determination of the claim within 15 days following receipt of additional requested information.

Recommendation: It is recommended that the Company provide a determination of the claim within 15 days following receipt of additional requested information as required by 18 Del. Admin. C. § 1310 - 6.2.

R. Med/Surg Non-DE Resident Closed Claims:

Optimum was requested to provide a list of all Med/Surg claims that were closed during the examination period of January 1, 2017 through June 30, 2019. The Company provided a list of 897 Med/Surg Non-DE resident claims that were closed during the examination period. A random sample of 83 claims was selected for review

There were no exceptions noted.

S. MH Non-DE Resident Denied Claims:

Optimum was requested to provide a list of all Mental Health claims that were denied during the examination period of January 1, 2017 through June 30, 2019. The Company provided a list of six (6) MH Non-DE resident claims that were denied during the examination period. All six (6) claims were reviewed.

The following exceptions were noted:

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

Optimum imposed a Non-Quantitative Treatment Limitation (NQTL) of a prior authorization being required for the use of Current Procedural Terminology (CPT) codes by mental health professionals but there is no prior authorization required for the corresponding Evaluation and Management (E/M) codes used by medical professionals.

Recommendation: It is recommended that the Company not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required by 45 *CFR* § 146.136(c)(4)(i)(ii).

T. SUD Non-DE Resident Paid Claims:

Optimum was requested to provide a list of all SUD claims that were paid during the examination period of January 1, 2017 through June 30, 2019. The Company provided a list of one (1) SUD Non-DE resident claim that was paid during the examination period. The claim was reviewed.

There were no exceptions noted.

U. SUD Non-DE Resident Denied Claims:

Optimum was requested to provide a list of all SUD claims that were denied during the examination period of January 1, 2017 through June 30, 2019. The Company provided a list of one (1) SUD Non-DE resident claim that was denied during the examination period. The claim was reviewed.

There were no exceptions noted.

V. Autism Paid Claims:

Optimum was requested to provide a list of all Autism Claims paid during the examination period of January 1, 2017 through June 30, 2019. The Company provided a list of one (1) Autism claim that was paid. The claim was reviewed.

There were no exceptions noted.

PROVIDER RELATIONS

Optimum was requested to provide the provider relations analyses, reports and summaries prepared on a regular recurring basis and identify the recipients of those reports and to

provide examples of each analyses, report and/or summary documentation. The Company was also requested to provide policies and procedures related to handling provider concerns, inquiries, and complaints, as well as documentation demonstrating that the Company takes adequate steps to finalize and dispose of the provider concerns, inquiries, and complaints.

The Company provided the requested documentation which was reviewed for compliance with applicable Delaware Statutes.

There were no exceptions noted.

UTILIZATION REVIEW

A. Utilization Review Policies and Procedures:

Optimum was requested to provide documentation related to utilization review policies and procedures. This included documentation demonstrating that the Company establishes and maintains a utilization review program in compliance with applicable statutes, rules and regulations. The documentation should include the requirements related to the medical management methods unique to mental health and substance use disorder benefits, diagnosis and medically necessary treatment.

Further, documentation demonstrating the Company's response to participant requests for medical necessity criteria for mental health and substance use disorder services and medical services disclosure requests for medical necessity criteria and information on non-quantitative treatment limits (NQTLs) was requested and provided.

The policies, procedures and documentation were reviewed for compliance with applicable Delaware Department of Insurance statutes, rules, regulations and Federal Mental Health Parity Act of 1996 and revisions made in the Mental Health Parity and Addiction Equity Act of 2008 requirements.

There were no exceptions noted.

B. Med/Surg Inpatient Approved Utilization Review:

Optimum was requested to provide a listing of all Inpatient Approved Utilization Reviews that occurred during the examination period of January 1, 2017 through June 30, 2019. The Company identified 10 Med/Surg Inpatient Utilization Review files that were approved. All 10 files were selected for review.

There were no exceptions noted.

C. Med/Surg Inpatient Denied Utilization Review:

Optimum was requested to provide a listing of all Inpatient Denied Utilization Reviews that occurred during the examination period of January 1, 2017 through June 30, 2019. The Company identified one (1) Med/Surg Inpatient Utilization Review files that were denied. The file was selected for review.

There were no exceptions noted.

D. Med/Surg Outpatient Approved Utilization Review:

Optimum was requested to provide a listing of all Outpatient Approved Utilization Reviews that occurred during the examination period of January 1, 2017 through June 30, 2019. The Company identified nine (9) Med/Surg Outpatient Utilization Review files that were approved. All nine (9) files were selected for review.

There were no exceptions noted.

E. Med/Surg Outpatient Denied Utilization Review:

Optimum was requested to provide a listing of all Outpatient Denied Utilization Reviews that occurred during the examination period of January 1, 2017 through June 30, 2019. The Company identified two (2) Med/Surg Outpatient Utilization Review files that were denied. Both files were selected for review.

There were no exceptions noted.

F. MH/SUD Inpatient Approved Utilization Review:

Optimum was requested to provide a listing of all Approved Utilization Reviews that occurred during the examination period of January 1, 2017 through June 30, 2019. The Company identified eight (8) MH/SUD Utilization Review files that were approved. All eight (8) files were selected for review.

There following exceptions were noted:

6 Exceptions - 18 Del. C. § 3343(d)(c) Benefit management.

Optimum subjected benefits to concurrent utilization review during the first 14 days of inpatient admission or 5 days of inpatient withdrawal management.

Recommendation: It is recommended that the Company not subject to concurrent utilization review during the first 14 days of any inpatient admission to a facility approved by a nationally recognized health-care accrediting organization or the Division of Substance Abuse and Mental Health, 30 days of intensive outpatient program treatment, or 5 days of inpatient withdrawal management, provided that the facility notifies the carrier

of both the admission and the initial treatment plan within 48 hours of the admission as required by 18 *Del. C.* § 3343(d)(c).

G. Med/Surg Non-DE Outpatient Approved Utilization Review:

Optimum was requested to provide a listing of all Outpatient Approved Utilization Reviews for policies situs in Delaware that occurred during the examination period of January 1, 2017 through June 30, 2019. The Company identified 10 Med/Surg Outpatient Utilization Review files for Non-DE residents that were approved. All 10 files were selected for review.

There were no exceptions noted.

H. Med/Surg Non-DE Outpatient Denied Utilization Review:

Optimum was requested to provide a listing of all Outpatient Denied Utilization Reviews for policies situs in Delaware that occurred during the examination period of January 1, 2017 through June 30, 2019. The Company identified one (1) Med/Surg Outpatient Utilization Review files for Non-DE residents that were denied. The file was selected for review.

There were no exceptions noted.

I. MH/SUD Non-DE Inpatient Approved Utilization Review:

Optimum was requested to provide a listing of all Approved Utilization Reviews that occurred during the examination period of January 1, 2017 through June 30, 2019. The Company identified one (1) MH/SUD Inpatient Utilization Review files for Non-DE residents that were approved. The file was selected for review.

There were no exceptions noted.

J. MH/SUD Pharmacy Approved Utilization Review:

Optimum was requested to provide a listing of all Pharmacy Approved Utilization Reviews that occurred during the examination period of January 1, 2017 through June 30, 2019. The Company identified nine (9) MH/SUD Pharmacy Utilization Review files that were approved. All nine (9) files were selected for review.

The following exceptions were noted:

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

Optimum placed greater limits in the coverage of prescription medicines 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.

Recommendation: It is recommended that the Company not issue for delivery, or deliver, in this State any health benefit plan containing terms that place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan, including terms for deductibles, co-pays, monetary limits, coinsurance factors, limits in the numbers of visits, limits in the length of inpatient stays, durational limits, or limits in the coverage of prescription medicines as required by 18 *Del. C.* § 3578(b)(1)(b).

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

Optimum has imposed a Non-Quantitative Treatment Limitation (NQTL) of a prior authorization that is applied more stringently to mental health or substance use disorder benefits than to medical/surgical benefits in the classification.

Recommendation: It is recommended that the Company not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required by 45 *CFR* § 146.136(c)(4)(i)(ii).

K. MH/SUD Pharmacy Denied Utilization Review:

Optimum was requested to provide a list of all Pharmacy Denied Utilization Reviews that occurred during the examination period of January 1, 2017 through June 30, 2019. The Company identified seven (7) MH/SUD Pharmacy Utilization Review files that were denied. All seven (7) files were selected for review.

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

Optimum placed greater limits in the coverage of prescription medicines 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.

Recommendation: It is recommended that the Company not issue for delivery, or deliver, in this State any health benefit plan containing terms that place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan, including terms for deductibles, co-pays, monetary limits, coinsurance factors, limits in the

numbers of visits, limits in the length of inpatient stays, durational limits, or limits in the coverage of prescription medicines as required by 18 *Del. C.* § 3578(b)(1)(b).

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

Optimum has imposed a Non-Quantitative Treatment Limitation (NQTL) of a prior authorization that is applied more stringently to mental health or substance use disorder benefits than to medical/surgical benefits in the classification.

Recommendation: It is recommended that the Company not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required by 45 *CFR* § 146.136(c)(4)(i)(ii).

L. Med/Surg Pharmacy Approved Utilization Review:

Optimum was requested to provide a list of all Pharmacy Utilization Reviews that occurred during the examination period of January 1, 2017 through June 30, 2019. The Company identified 16 Med/Surg Pharmacy Utilization Review files that were approved. All 16 files were selected for review.

The following exception was noted:

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

Optimum failed to grant pre-authorization for pharmaceuticals that is valid for 1 year from the date the health-care provider received the pre-authorization.

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

M. Med/Surg Pharmacy Denied Utilization Review:

Optimum Insurance Company was requested to provide a list of all Pharmacy Utilization Reviews that were denied during the examination period of January 1, 2017 through June 30, 2019. The Company identified 14 Med/Surg Pharmacy Utilization Review files that were denied. All 14 files were selected for review.

There were no exceptions noted.

PHARMACY REVIEW

Optimum was requested to provide the written utilization management (UM) and/or drug utilization review (UR) policies, UM/UR Committee meeting notes, all formularies, formulary designs, and amendments in effect, step therapy protocols, and multiple Information requests.

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

The following exceptions were noted:

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

Optimum imposed a prior authorization/notification which is a NQTL on all stimulant based ADHD medications. Placing a prior authorization on the entire class of medications is discriminatory towards mental health members. Additionally, the medical necessity criteria has an age limit restriction of 12 and older due to the potential for abuse of these medications. Other commonly abused medications do not have an age limitation enforced or a prior authorization/notification on all medications such as opioids (some long acting until March 2018 and the majority of short acting), tranquilizers, sedatives, and sleep aids.

Recommendation: It is recommended that the Company not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required by 45 CFR § 146.136(c)(4)(ii)(b).

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

Optimum has imposed a prior authorization which is a NQTL on all smoking cessation medications. Placing a prior authorization on the entire class of smoking cessation medications is discriminatory towards substance abuse members. Additionally, all smoking cessation medications had a maximum coverage of 2 (3 month) cycles of smoking cessation medications per 12-month period whereas this was not enforced on MED/SURG policies.

Recommendation: It is recommended that the Company not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required by 18 *Del. C.* § 3578(b)(1)(b) and 45 *CFR* § 146.136(c)(4)(i)(ii).

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

Optimum has imposed a prior authorization which is a NQTL on all buprenorphine containing medications used for opioid dependence treatment. Placing a prior authorization on the entire class of buprenorphine containing medications is discriminatory towards substance abuse members. As of 3/1/17, Zubsolv became the preferred buprenorphine/naloxone containing medication, and the prior authorization requirement was removed. All other buprenorphine/naloxone containing medications were either excluded from coverage or continued to require a prior authorization. Only allowing one preferred buprenorphine/naloxone containing medication and placing all others on higher tiers cost the member more money (including the only generic formulation, buprenorphine/naloxone sublingual tablets). Also excluding from coverage, or a step therapy requirement of the preferred medication causes a barrier/delay to treatment for these members.

Recommendation: It is recommended that the Company not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required by 18 *Del. C.* § 3578(b)(1)(b) and 45 *CFR* § 146.136(c)(4)(i)(ii).

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

Optimum had a quantity limit restriction on buprenorphine HCL sublingual tablets of a maximum allowance of a 5-day supply. This quantity limitation on this medication is discriminatory to substance abuse members compared to other controlled substance prescriptions such as immediate release opioids which did not have this quantity restriction. The Company removed this restriction in the middle of 2017.

Recommendation: It is recommended that the Company not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required by 18 *Del. C.* § 3578(b)(1)(b) and 45 *CFR* § 146.136(c)(4)(i)(ii).

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

Optimum has a policy of a dose restriction on Suboxone 2mg/0.5mg films based on CFIPDL ClinicalComboGrid 121216, CFIPDL ClinicalComboGrid 12.15.2017 for 1.1, CFIPDL ClinicalComboGrid 7.1.2017, CFIPDL ClinicalComboGrid 7.1.2018, CFIPDL ClinicalComboGrid 1.1.2019, and CFIPDL ClinicalComboGrid 6.1.2019 when the member requires 3 films per day. According to FDA approved and the manufacturer's dosage guidelines, the following is appropriate maintenance treatment: *"2.1 Maintenance: SUBOXONE sublingual film is indicated for maintenance treatment. The recommended target dosage of SUBOXONE sublingual film is 16/4 mg buprenorphine/naloxone/day as a single daily dose. The dosage of SUBOXONE sublingual film should be progressively adjusted in increments/decrements of 2/0.5 mg or 4/1 mg buprenorphine/naloxone to a level that holds the patient in treatment and suppresses opioid withdrawal signs and symptoms. The maintenance dose of SUBOXONE sublingual film is generally in the range of 4/1 mg buprenorphine/naloxone to 24/6 mg buprenorphine/naloxone per day depending on the individual patient. Dosages higher than this have not been demonstrated to provide any clinical advantage."* With 4 available dosage strengths (2mg/0.5mg, 4mg/1mg, 8mg/2mg, and 12mg/3mg), taking multiple films per day is the only way to achieve dosages that aren't commercially available. If a member requires one of these doses in between strengths (example would be 6mg/1.5mg or 3 films per day) as a dose reduction, titration, or is stable at a particular dosage (example would be 6mg/1.5mg or 3 films per day), they would require a DUR override from their doctor. This type of quantity limitation restriction is more stringently applied on this medication for substance abuse, and is not comparable to MED/SURG medications when multiple dosage units are required to achieve a dose that is not commercially available (still within FDA approved guidelines).

Recommendation: It is recommended that the Company change its policy on SUBOXONE so that it does not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment

limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required by 18 *Del. C.* § 3578(b)(1)(b) and 45 *CFR* § 146.136(c)(4)(i)(ii).

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

Optimum's Prior authorization/Notification policy on Vyvanse for Binge Eating Disorder (BED) is not comparable to, and is applied 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. Once a member gets approval for Vyvanse for BED, based on these policies, authorization will be issued for 3 months for Moderate to Severe Binge Eating Disorder and 12 months for all other approved indications. This initial 3-month approval is in violation of § 3586 Length of pre-authorization, § 3578 Insurance coverage for serious mental illness (b)(1)b and 45 *CFR* 146.136 (c)(4)(i)(ii) compared to MED/SURG medication policies. Additionally, all off label MED/SURG indications included in these aforementioned policies (narcolepsy, hypersomnia of central origin, mental fatigue secondary to traumatic brain injury, and fatigue associated with medical illness in patients in palliative or end of life care) don't have an initial 3-month medical necessity/prior authorization approval (all these off label indications are approved for 12 months). This would also apply to the reauthorization criteria as well since the requirement for a BED diagnosis requires updated clinical information as per reauthorization guidelines: "*Documentation of positive clinical response (e.g., meaningful reduction in the number of binge eating episodes or binge days per week from baseline, improvement in the signs and symptoms of binge eating disorder) to Vyvanse therapy.*" This reauthorization criteria only applies to the BED diagnosis and not to any other diagnosis including all off label MED/SURG indications (narcolepsy, hypersomnia of central origin, mental fatigue secondary to traumatic brain injury, and fatigue associated with medical illness in patients in palliative or end of life care). Additionally, Vyvanse was designated a tier 4 medication and excluded from coverage on all Essential formularies for the scope of the exam.

Recommendation: It is recommended that the Company change its Prior authorization/Notification policy on Vyvanse so that it does not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required by 18 *Del. C.* § 3578(b)(1)(b) and 45 *CFR* § 146.136(c)(4)(i)(ii).

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

Optimum failed to grant pre-authorizations for Vyvanse for BED that is valid for 1 year from the date the health-care provider received the pre-authorization. Once a member gets approval for Vyvanse for BED authorization will be issued for 3 months for Moderate to Severe Binge Eating Disorder and 12 months for all other approved indications. This initial 3-month approval is in violation of 18 Del. C. § 3586(a) Length of pre-authorization, of 18 Del. C. § 3578(b)(1)(b) Insurance coverage for serious mental illness (b)(1)b and 45 CFR 146.136 (c)(4)(i)(ii) compared to MED/SURG medication policies. Additionally, all off label MED/SURG indications included in these aforementioned policies (narcolepsy, hypersomnia of central origin, mental fatigue secondary to traumatic brain injury, and fatigue associated with medical illness in patients in palliative or end of life care) don't have an initial 3-month medical necessity/prior authorization approval (all these off label indications are approved for 12 months).

Recommendation: It is recommended that the Company pre-authorize pharmaceuticals to be valid 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. § 3337A(a) Prior authorization of prescriptions for chronic or long-term conditions.

Optimum failed to include a question regarding whether the prescription medication is for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient on prior authorization forms.

Recommendation: It is recommended that the Company include a question regarding whether the prescription medication is for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient on prior authorization forms as required by 18 Del. C. § 3337A(a).

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

Optimum did not include any mental health or substance abuse medications in their Refill and Save program. The Company removed Pristiq from their Refill and Save program on or about 7/1/2017. The Company indicated that “The Refill and Save program provides members who refill their prescription for a qualifying medication to save on their usual copayment or coinsurance. The program is designed to drive adherence for certain medications. Members who refill their prescriptions on a regular basis through retail and OptumRx® home delivery will get a reduction on their copayment. Members do not have to sign up or complete a participation form within the program. If the member fills the medications timely, they will receive the reduction in copay on their next fill. For inclusion within the Refill and Save program, products are selected based upon financial factors. UHC was able to obtain a rebate on Pristiq while keeping it in Tier 3 and able to provide a

reduced copayment for those that were adherent. Pristiq was removed from the program when the AB-rated generic launched because the AB-rated generic launched was placed in Tier 2 at a reduced copayment.” The Company did not place any other mental health or substance abuse medications in this program for the remainder of the exam period. This exclusion from the Refill and Save Program is discriminatory to mental health and substance abuse members as they would not benefit from any reduction in coinsurance/copayment for any medications that they consistently filled, were compliant with, or adherent to during the remainder of the exam period as opposed to MED/SURG medications that continued to be included in the program. The programs design was to drive adherence for certain medications, but any adherence program would benefit any medication regimen whether it’s for MH/SUD or MED/SURG treatment regimens.

Recommendation: It is recommended that the Company change its policy to include Pristiq in its Refill and Save program so that it does not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required by 18 *Del. C.* § 3578(b)(1)(b) and 45 *CFR* § 146.136(c)(4)(i)(ii).

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

Optimum imposed a dosing limit on duloxetine 30mg capsules for a quantity of 3 capsules a day or a 90mg dose. The member would be required to get a DUR/quantity limit override for this dose from their doctor. This is discriminatory for mental health members for having a restrictive dosing limitation on doses of 90mg/day which only includes this medication’s mental health indications (Major Depressive Disorder and Generalized Anxiety Disorder) and not it’s MED/SURG indications (Diabetic Peripheral Neuropathic Pain, Fibromyalgia, and Chronic Musculoskeletal Pain) which have a maximum dose of 60mg/day. Furthermore, the Company did not have a dosing limitation on FDA approved MED/SURG medications that required multiple dosage units to achieve other FDA approved doses when clinically relevant.

Recommendation: It is recommended that the Company change its policy on imposing a dosing limit on duloxetine so that it does not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation

with respect to medical/surgical benefits in the classification as required by 18 *Del. C.* § 3578(b)(1)(b) and 45 *CFR* § 146.136(c)(4)(i)(ii).

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

Optimum has restrictive medical necessity criteria on Evzio injection for members who require rescue naloxone and are treated with medication assisted treatment (MAT). This medical necessity criteria is discriminatory towards substance abuse members being treated with naltrexone for opioid dependence treatment if Evzio is their only viable option to have on hand.

Recommendation: It is recommended that the Company change its restrictive medical necessity criteria policy on Evzio so that it does not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required by 18 *Del. C.* § 3578(b)(1)(b) and 45 *CFR* § 146.136(c)(4)(i)(ii).

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

Optimum has imposed a NQTL of higher tier placement or entirely excluded two generic mental health medications (duloxetine and desvenlafaxine) on their Advantage and Essential formularies. The Company failed to provide an adequate explanation or detailed NQTL analysis as to why these two generic medications had higher tier placement or were excluded entirely compared to MED/SURG medications.

Recommendation: It is recommended that the Company not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required by 18 *Del. C.* § 3578(b)(1)(b) and 45 *CFR* § 146.136(c)(4)(i)(ii).

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

Optimum has imposed a NQTL of higher tier placement, quantity limitations, step therapy, and non-formulary status for generic antipsychotics (aripiprazole, ziprasidone, and quetiapine ER) on their on the Advantage and Essential formularies. The Company failed to provide an adequate explanation or detailed NQTL analysis as to why these generic antipsychotics had higher tier placement, quantity limitations, step therapy, and non-formulary status compared to MED/SURG medications.

Recommendation: It is recommended that the Company not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required by 18 Del. C. § 3578(b)(1)(b) and 45 CFR § 146.136(c)(4)(i)(ii).

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

Optimum excluded coverage for methadone maintenance treatment (MMT) from outpatient treatment facilities approved by SAMSHA in accordance with ASAM guidelines. This Non-Quantitative Treatment Limitation (NQTL) is discriminatory towards substance abuse members.

Recommendation: It is recommended that the Company not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required by 18 Del. C. § 3578(b)(1)(b) and 45 CFR § 146.136(c)(4)(i)(ii).

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

Optimum has imposed a NQTL of higher tier placement, quantity limitations, and non-formulary status for brand name antipsychotics (Fanapt, Latuda, Rexulti, Saphris, and

Vraylar) on different formularies. The Company failed to provide an adequate explanation or detailed NQTL analysis as to why these brand name antipsychotics had higher tier placement, quantity limitations, and non-formulary status compared to MED/SURG medications.

Recommendation: It is recommended that the Company not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required by 18 *Del. C.* § 3578(b)(1)(b) and 45 *CFR* § 146.136(c)(4)(i)(ii).

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

Optimum has imposed a NQTL of higher tier placement, step therapy, quantity limitations, and non-formulary status for brand name antidepressants that did not have generic equivalents (Fetzima, Trintellix, and Viibryd) on different formularies. The Company failed to provide an adequate explanation or detailed NQTL analysis as to why these brand name antidepressants had higher tier placement, step therapy, quantity limitations, and non-formulary status compared to MED/SURG medications.

Recommendation: It is recommended that the Company not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required by 18 *Del. C.* § 3578(b)(1)(b) and 45 *CFR* § 146.136(c)(4)(i)(ii).

MENTAL HEALTH PARITY

Optimum was requested to provide the Company's Mental Health Parity analysis (including any third-party contractor who performed actuarial testing of health plans) and the project plan for implementation. Additionally, the definition of Mental Health Benefits and Substance Use Disorder Benefits, the classification of benefits and the standards used to create it were requested. The Company was also requested to identify all nonquantitative treatment limitations (NQTLs), and to complete an interrogatory to identify the written and operational processes and factors for provider reimbursements. They were also requested to provide documentation demonstrating that NQTLs are applied no more stringently to

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Optimum Choice, Inc.**

mental health or substance use disorder benefits than to medical/surgical benefits. This documentation is to demonstrate the process used to develop or select the medical necessity criteria, and their disclosure policies and procedures.

The Company's documentation was reviewed for compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA), 18 Del C § 3343 and 18 Del C § 3578 in terms of defining mental health or substance use disorder benefits, classifying benefits, financial requirements, quantitative treatment limitations (QTLs) and NQTLs, requiring disclosures, and vendor coordination.

There were no exceptions noted.

CONCLUSION

As stated in the Scope of Examination section, the purpose of the examination was to determine compliance by the Optimum Choice, Inc. with Delaware 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 acknowledge and respond within 15 working days to communications with respect to claims as required by 18 *Del. Admin. C.* § 902–1.2.1.2. (Claims).
2. It is recommended that the Company affirm or deny claims within 30 days as required by 18 *Del. Admin. C.* § 902 – 1.2.1.5. (Claims).
3. It is recommended that the Company pay the allowable portion of the claim amounts deemed payable within 30 days 18 *Del. Admin. C.* § 1310–6.1.2. (Claims).
4. It is recommended that the Company provide a determination of the claim within 15 days following receipt of additional requested information as required by 18 *Del. Admin. C.* § 1310 - 6.2. (Claims).
5. 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).
6. It is recommended that the Company provide a determination of claims within 30 days as required by 18 *Del. Admin. C.* § 1310 – 6.1.3. (Claims).
7. It is recommended that the Company not issue for delivery, or deliver, in this State any health benefit plan containing terms that place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of a serious

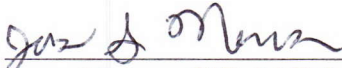
- mental illness and drug and alcohol dependency than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan, including terms for deductibles, co-pays, monetary limits, coinsurance factors, limits in the numbers of visits, limits in the length of inpatient stays, durational limits, or limits in the coverage of prescription medicines as required by 18 *Del. C.* § 3578(b)(1)(b). (Claims)(Utilization Review).
8. It is recommended that the Company not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required by 45 *CFR* § 146.136(c)(4)(ii)(b). (Claims)(Utilization Review)(Pharmacy Review).
 9. 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).
 10. It is recommended that the Company implement prompt investigation of claims arising under insurance policies within 10 working days upon receipt of the notice of loss as required by 18 *Del. Admin. C.* § 902–1.2.1.3. (Claims).
 11. It is recommended that the Company accurately represent pertinent facts or insurance policy provisions relating to coverages at issue as required 18 *Del. C.* § 2304(16)(a). (Claims).
 12. It is recommended that the Company not subject to concurrent utilization review during the first 14 days of any inpatient admission to a facility approved by a nationally recognized health-care accrediting organization or the Division of Substance Abuse and Mental Health, 30 days of intensive outpatient program treatment, or 5 days of inpatient withdrawal management, provided that the facility notifies the carrier of both the admission and the initial treatment plan within 48 hours of the admission as required by 18 *Del. C.* § 3343(d)(c). (Utilization Review).
 13. It is recommended that the Company pre-authorize pharmaceuticals to be valid for one year from the date the healthcare provider receives the pre-authorization as required by 18 *Del. C.* § 3586(a). (Utilization Review)(Pharmacy Review).
 14. It is recommended that the Company not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other

- factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required by 18 *Del. C.* § 3578(b)(1)(b) and 45 *CFR* § 146.136(c)(4)(i)(ii). (Pharmacy Review).
15. It is recommended that the Company change its policy on SUBOXONE so that it does not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required by 18 *Del. C.* § 3578(b)(1)(b) and 45 *CFR* § 146.136(c)(4)(i)(ii). (Pharmacy Review).
 16. It is recommended that the Company change its Prior authorization/Notification policy on Vyvanse so that it does not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required by 18 *Del. C.* § 3578(b)(1)(b) and 45 *CFR* § 146.136(c)(4)(i)(ii). (Pharmacy Review).
 17. It is recommended that the Company change its Prior authorization/Notification policy on Vyvanse so that it does not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required by 18 *Del. C.* § 3578(b)(1)(b) and 45 *CFR* § 146.136(c)(4)(i)(ii). (Pharmacy Review).
 18. It is recommended that the Company include a question regarding whether the prescription medication is for a chronic or long-term condition for which the

- prescription medication may be necessary for the life of the patient on prior authorization forms as required by 18 *Del. C.* § 3337A(a). (Pharmacy Review).
19. It is recommended that the Company change its policy to include MH/SUD medications in its Refill and Save program so that it does not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required by 18 *Del. C.* § 3578(b)(1)(b) and 45 *CFR* § 146.136(c)(4)(i)(ii).
 20. It is recommended that the Company change its policy on imposing a dosing limit on duloxetine so that it does not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required by 18 *Del. C.* § 3578(b)(1)(b) and 45 *CFR* § 146.136(c)(4)(i)(ii). (Pharmacy Review).
 21. It is recommended that the Company change its restrictive medical necessity criteria policy on Evzio so that it does not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required by 18 *Del. C.* § 3578(b)(1)(b) and 45 *CFR* § 146.136(c)(4)(i)(ii). (Pharmacy Review).

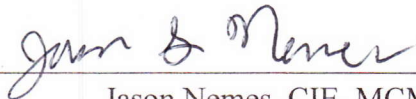
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Optimum Choice, Inc.

The examination conducted by Joseph Krug, Jason Nemes, Jack Rucidlo, and Gwen Douglas 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 96940-MHP-19-716.



Jason Nemes, CIE, MCM