

DELAWARE DEPARTMENT OF INSURANCE

MARKET CONDUCT EXAMINATION REPORT

UNITEDHEALTHCARE INSURANCE COMPANY

NAIC # 79413

4 Research Drive
Shelton, CT 06474-6280

As of

June 30, 2019

Trinidad Navarro
Commissioner



Delaware Department of Insurance

REPORT ON EXAMINATION
OF THE
UNITEDHEALTHCARE INSURANCE COMPANY
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 4th day of March, 2021.


Trinidad Navarro
Insurance Commissioner

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

UNITEDHEALTHCARE INSURANCE COMPANY

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

Attest By:

A handwritten signature in blue ink, appearing to read "Robert H. David".



In Witness Whereof, I have hereunto set my hand
and affixed the official seal of this Department at the
City of Dover, this 4 day of March, 2021.

A handwritten signature in blue ink, appearing to read "Trinidad Navarro".

Trinidad Navarro
Insurance Commissioner

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

Dear Commissioner Navarro:

In compliance with the instructions contained in Certificate of Examination Authority Number: 79413-MHP-19-715 and pursuant to statutory provisions including 18 Del. CODE §318-322, a market conduct examination has been conducted of the affairs and practices of:

UnitedHealthcare Insurance Company
NAIC # 79413

This examination was performed as of 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 UnitedHealthcare Insurance Company (UnitedHealthcare, UHIC or the Company) are located in Hartford, Connecticut 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 \$53,759,998,448 of which Delaware has a market share of 0.3% or approximately \$174,062,233.

This examination focused on UnitedHealthcare's healthcare lines in the following areas of operation: Company Operations and Management, Forms, Complaint Handling, 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:

- **1 Exception**

- **18 Del. Admin. C. § 1406-7.3 Responsibilities of the Insurer**

- *7.3 In cases where an administrator administers benefits for more than one hundred certificate holders on behalf of an insurer, the insurer shall, at least semiannually, conduct a review of the operations of the administrator. At least one such review shall be an on-site audit of the operations of the administrator.*

- UnitedHealthcare failed to conduct any semiannual reviews of the operations of an administrator. At least one on-site review is required but was not performed.

- **1 Exception**

- **18 Del. C. § 332(c)(5) Speedy review of grievances.**

- *That IRP shall require that all grievances be decided in an expeditious manner, and in any event, no more than:*

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

- *b. 30 days after the receipt of all necessary information in the case of requests for referrals or determinations concerning whether a requested benefit is covered pursuant to the contract; and*

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

- UnitedHealthcare failed to decide a grievance in an expeditious manner.

- **1 Exception**

- **18 Del. C. § 3343(c)(2) Eligibility for coverage.**

- *(2) A health benefit plan may further condition coverage of services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency in the same manner and to the same extent as coverage for all other illnesses and diseases is conditioned. Such conditions include precertification and referral requirements.*

UnitedHealthcare did not condition the coverage of service provided in the diagnosis and treatment of a serious mental illness in the same manner and to the same extent as coverage for all other illnesses and diseases.

- **7 Exceptions**

- **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;*

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

- **48 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.*

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

- **18 Exceptions**

- **18 Del. Admin. C. § 1310 - 6.1.3 Processing of Clean Claim.**

- *6.1 No more than 30 days after receipt of a clean claim from a provider or policyholder, a carrier shall take one of the following four actions:*

- *6.1.1 if the entire claim is deemed payable, pay the total allowed amount of the claim;*

- *6.1.2 if a portion of the claim is deemed payable, pay the allowable portion of the claim that is deemed payable and specifically notify the provider or policyholder in writing why the remaining portion of the claim will not be paid;*

- *6.1.3 if the entire claim is deemed not payable, specifically notify the provider or policyholder in writing why the claim will not be paid;*

- *6.1.4 if the carrier needs additional information from a provider or policyholder who is submitting the claim to determine the propriety of payment of a claim, the carrier shall request in writing that the provider or policyholder provide documentation that is relevant and necessary for clarification of the claim.*

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

- **7 Exceptions**

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

- *6.1.4 if the carrier needs additional information from a provider or policyholder who is submitting the claim to determine the propriety of payment of a claim, the carrier shall request in writing that the provider or policyholder provide documentation that is relevant and necessary for clarification of the claim.*

UnitedHealthcare requested additional information that was not necessary for clarification of the claim.

- **1 Exception**

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

6.1 No more than 30 days after receipt of a clean claim from a provider or policyholder, a carrier shall take one of the following four actions:

6.1.1 if the entire claim is deemed payable, pay the total allowed amount of the claim;

6.1.2 if a portion of the claim is deemed payable, pay the allowable portion of the claim that is deemed payable and specifically notify the provider or policyholder in writing why the remaining portion of the claim will not be paid;

6.1.3 if the entire claim is deemed not payable, specifically notify the provider or policyholder in writing why the claim will not be paid;

6.1.4 if the carrier needs additional information from a provider or policyholder who is submitting the claim to determine the propriety of payment of a claim, the carrier shall request in writing that the provider or policyholder provide documentation that is relevant and necessary for clarification of the claim.

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

- **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.

UnitedHealthcare 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.

UnitedHealthcare 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.

- **28 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.

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

- **31 Exceptions**

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

6.1 No more than 30 days after receipt of a clean claim from a provider or policyholder, a carrier shall take one of the following four actions:

6.1.1 if the entire claim is deemed payable, pay the total allowed amount of the claim;

6.1.2 if a portion of the claim is deemed payable, pay the allowable portion of the claim that is deemed payable and specifically notify the provider or policyholder in writing why the remaining portion of the claim will not be paid;

6.1.3 if the entire claim is deemed not payable, specifically notify the provider or policyholder in writing why the claim will not be paid;

6.1.4 if the carrier needs additional information from a provider or policyholder who is submitting the claim to determine the propriety of payment of a claim, the carrier shall request in writing that the provider or policyholder provide documentation that is relevant and necessary for clarification of the claim.

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

- **70 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.*

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

- **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;*

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

- **7 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.*

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

- **6 Exceptions**

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

- *b. Failing to acknowledge and act reasonably promptly upon communication with respect to claims arising under insurance policies;*

UnitedHealthcare failed to acknowledge and act reasonably promptly upon communication with respect to claims.

- **1 Exception**

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

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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.

UnitedHealthcare 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. § 320(c) Conduct of examination; access to records; correction.**

- (c) Every person being examined, the person’s officers, attorneys, employees, agents and representatives, shall make freely available to the Commissioner, or the Commissioner’s examiners, the accounts, records, documents, files, information, assets and matters of such person, in the person’s possession or control, relating to the subject of the examination and shall facilitate the examination.*

UnitedHealthcare failed to provide a complete listing of all forms in use during the examination period.

- **1 Exception**

- **18 Del. C. § 320(c) Conduct of examination; access to records; correction.**

- (c) Every person being examined, the person’s officers, attorneys, employees, agents and representatives, shall make freely available to the Commissioner, or the Commissioner’s examiners, the accounts, records, documents, files, information, assets and matters of such person, in the person’s possession or control, relating to the subject of the examination and shall facilitate the examination.*

UnitedHealthcare failed to include the certificate in its forms listing.

- **1 Exception**

- **18 Del. C. § 320(c) Conduct of examination; access to records; correction.**

- (c) Every person being examined, the person’s officers, attorneys, employees, agents and representatives, shall make freely available to the Commissioner, or the Commissioner’s examiners, the accounts, records, documents, files, information, assets and matters of such person, in the person’s possession or control, relating to the subject of the examination and shall facilitate the examination.*

UnitedHealthcare was inconsistent in the parameters used to pull the data for the grievances and appeals, claims, and utilization review listings. When it was discovered that members of Delaware situs policies that did not reside in Delaware were excluded from the listings, the Company was advised that the listing should include all members of Delaware situs policies regardless of residency. Per the Company's response to an information request it was clear that different criteria were used and that this caused data to appear in one area that was excluded from the other.

- **1 Exception**

- **18 Del. C. § 332(c)(7) Written notice of decisions.**

- *(7) Written notice of decisions. — The IRP shall provide that within 5 days after a grievance is decided in the manner described above, the insured shall be provided with written notice of the disposition of that grievance. In cases where the grievance has been decided in a manner that does not pay the claim in its entirety, the carrier shall provide the insured with a letter fully stating the reasons for the disposition (including specific policy language relied upon and any other documents relied upon) and the clinical rationale for the determination in cases where the determination has a clinical basis. The carrier's written notice shall also inform the insured of the appropriate manner for the insured to pursue an external review of the carrier's decision. Finally, the carrier's written notice shall inform the insured of the mediation services offered by the Department of Insurance, but shall clearly inform the insured in layman's terms that mediation does not change the deadlines imposed by § 6416 of this title or this section. The Department of Insurance shall inform any person with rights under § 6416 of this title or this section of those rights.*

UnitedHealthcare failed to inform the insured of the mediation services offered by the Department of Insurance on the written notice of decision.

- **2 Exceptions**

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

- *(a) If a utilization review entity requires pre-authorization of a pharmaceutical, the utilization review entity must complete its process or render an adverse determination and notify the covered person's health-care provider within 2 business days of obtaining a clean pre-authorization or of using services described in § 3377 of this title.*

UnitedHealthcare failed to render an adverse determination and notify the covered person's health-care provider within two business days of obtaining a clean pre-authorization.

- **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.

UnitedHealthcare 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.

UnitedHealthcare 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 have 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.

UnitedHealthcare 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.

UnitedHealthcare 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.

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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.

UnitedHealthcare 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.

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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.

UnitedHealthcare has a dose restriction on Suboxone 2mg/0.5mg films based on policy 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.

UnitedHealthcare'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.*

UnitedHealthcare 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 three-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) do not have an initial three-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.*

UnitedHealthcare 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.

UnitedHealthcare 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.

UnitedHealthcare 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 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.

- **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.

UnitedHealthcare has restrictive medical necessity criteria on Evzio injections 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.

- **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.

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UnitedHealthcare Insurance Company**

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.

UnitedHealthcare 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:

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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.

UnitedHealthcare 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.

**Delaware Market Conduct Examination Report
UnitedHealthcare Insurance Company**

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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.

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(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.

UnitedHealthcare 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

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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.

UnitedHealthcare 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.

UnitedHealthcare 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.

UnitedHealthcare was requested to identify the universe of files for each segment of the review. Based on the universe sizes identified, random sampling was utilized to select the files reviewed for this examination.

Delaware Market Conduct Examination Reports generally note only those items, to which the Department, after review, takes exception. An exception is any instance of Company activity that does not comply with an insurance statute or regulation. Exceptions contained in the Report may result in imposition of penalties. General practices, procedures, or files that were reviewed by Department examiners during the course of an examination may not be referred to in the Report if no improprieties were noted. However, the Examination Report may include management recommendations addressing areas of concern noted by the Department, but for which no statutory violation was identified. This enables company management to review these areas of concern in order to determine the potential impact upon Company operations or future compliance.

Throughout the course of the examination, UnitedHealthcare'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 UnitedHealthcare'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

UnitedHealthcare Insurance Company, a Connecticut corporation has its home and principal executive offices at 185 Asylum Street, Hartford, Connecticut 06103. In November 1994, UHIC redomesticated from the State of Illinois to the State of Connecticut and changed its name to The MetraHealth Insurance Company. On January 3, 1995, UHIC became a direct wholly owned subsidiary of The MetraHealth Companies, Inc., a Delaware general business corporation, by contribution of its outstanding stock from The Travelers Group Inc. On October 2, 1995, UnitedHealth Group Incorporated (United), a Minnesota general business corporation acquired The MetraHealth Companies, Inc., and its subsidiaries.

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On May 31, 1996, The MetraHealth Companies, Inc., the sole shareholder of UHIC, merged with and into UHIC with UHIC as the surviving corporation. As a result of the merger, The MetraHealth Companies, Inc., ceased to exist as a separate entity and United now owned all the outstanding shares of UHIC directly. Effective as of January 1, 1997, United Health and Life Insurance Company, a Minnesota domiciled insurance company and affiliate of UHIC, merged with and into UHIC with UHIC as the surviving corporation. As a result of the merger, United Health and Life Insurance Company's two subsidiaries, (1) United HealthCare Insurance Company of Illinois and (2) United HealthCare Insurance Company of Ohio became direct wholly-owned subsidiaries of UHIC and United Health and Life Insurance Company ceased to exist as a separate legal entity. Also, on January 1, 1997, the Registrant changed its name to United HealthCare Insurance Company from The MetraHealth Insurance Company.

Effective as of June 30, 2000, UnitedHealthcare Insurance Company became a direct wholly owned subsidiary of UHIC Holdings, Inc. (f/k/a Unimerica, Inc.), a Delaware general business corporation, pursuant to approval of the Connecticut Department of Insurance. UHIC Holdings, Inc. is a direct wholly owned subsidiary of United HealthCare Services, Inc. (UHS), a Minnesota general business corporation. UHS is a direct wholly owned subsidiary of United. As of December 31, 2004, UHIC Holdings, Inc. owns all of the outstanding shares of the Registrant and United is the ultimate parent in the insurance holding company system.

UHIC is licensed as a life, accident and health insurer in the Virgin Islands, District of Columbia, Commonwealth of the Northern Mariana Islands, American Samoa, Puerto Rico, Guam and in 49 states except New York. In 2018, UHIC reported \$53,759,998,448 premium of which \$174,062,233 was written in Delaware. In 2017, UHIC reported \$49,548,186,693 premium of which \$180,887,355 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. The only exceptions are noted below:

A. Third Party Administrators

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UnitedHealthcare Insurance Company was requested to provide copies of contracts with any third-party entity, including managing general agents (MGAs), general agents (GAs), third-party administrators (TPAs) and vendors conducting activities on behalf of the insurer during the examination period. UnitedHealthcare and Optimum were also requested to provide a list of all entities that were involved in the sale or servicing of products.

The Company was requested to provide policies and procedures for ensuring availability of health carrier information needed for vendor analysis of compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA). The Company was requested to provide a narrative summary outlining how the vendor and the carrier coordinate benefit designs and applications to ensure compliance with MHPAEA as well as any written communications between the carrier and the vendor regarding the administration of mental health and substance use disorder benefits.

In addition, the Company was to provide documentation that it was adequately monitoring the activities of any entity that contractually assumes a business function or was acting on behalf of the Company, and to include copies of audit reports produced for the listed entities at any time since the contract inception.

The third-party entities and the associated policies and procedures were reviewed for compliance with applicable Delaware Department of Insurance statutes and MHPAEA. The following exception was noted:

1 Exception – 18 Del. Admin. C. § 1406-7.3 Responsibilities of the Insurer.

UnitedHealthcare failed to conduct any semiannual reviews of the operations of an administrator. At least one on-site review is required but was not performed.

Recommendation: It is recommended that the Company change its policy so that it conducts semiannual reviews of the operations of administrators, one of which should be held on-site as required by 18 Del. Admin. C. § 1406-7.3.

FORMS

UnitedHealthcare 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 128 forms that were utilized during the examination period. All 128 forms were reviewed.

There were no exceptions noted during the original review of Forms as provided by the Company, however exceptions were noted in later, more detailed reviews in various sections of the Report. Those exceptions are noted in the sections where they were discovered in the examination process.

COMPLAINT HANDLING

A. Complaints

UnitedHealthcare was requested to provide a list of all complaints filed with the Company during the examination period of January 1, 2017 through June 30, 2019. This list was to include complaints received from the Delaware Department of Insurance as well as complaints made directly to the Company on behalf of Delaware consumers. The Company provided a list of 3 complaints that were received during the examination period. All 3 complaint files were reviewed.

The complaints were reviewed for compliance with applicable Delaware Department of Insurance statutes and regulations.

There were no exceptions noted.

B. DDOI Complaints

The Delaware Department of Insurance (DDOI) and UnitedHealthcare provided listings of complaints that were received during the examination period of January 1, 2017 through June 30, 2019. A reconciliation of the Company and DDOI lists indicated that not all of the complaints on the DDOI list were on the Company's list. A subsequent explanation and clarification for each of the complaints from the Company cleared all of the issues.

There were no exceptions noted.

GRIEVANCES AND APPEALS

A. Grievance and Appeals:

UnitedHealthcare was requested to provide a listing of all Appeals and Grievances filed during the examination period of January 1, 2017 through June 30, 2019. The Company provided a list of 19 appeals and grievances that were received during the examination period. All 19 complaint files were reviewed.

All grievance and appeal files and associated policies and procedures were reviewed for compliance with applicable Delaware Department of Insurance statutes.

The following exceptions were noted:

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

UnitedHealthcare failed to decide a grievance in an expeditious manner.

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

1 Exception - 18 Del. C. § 3343(c)(2) Eligibility for coverage.

UnitedHealthcare did not condition the coverage of service provided in the diagnosis and treatment of a serious mental illness in the same manner and to the same extent as coverage for all other illnesses and diseases.

Recommendation: It is recommended that the Company change its policy to condition the coverage of services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency in the same manner and to the same extent as coverage for all other illnesses and diseases as required by 18 Del. C. § 3343(c)(2).

B. Grievances and Appeals- Non-Delaware Residents:

UnitedHealthcare was requested to provide a listing of all Appeals and Grievances for policies with situs in Delaware filed during the examination period of January 1, 2017 through June 30, 2019. The Company provided a list of 19 appeals and grievances for Non-Delaware residents that were received during the examination period. All 19 files were reviewed.

The grievance and appeal files and associated policies and procedures were reviewed for compliance with applicable Delaware Department of Insurance statutes and regulations.

There were no exceptions noted.

POLICYHOLDER SERVICES

UnitedHealthcare Insurance Company 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 and regulations.

There were no exceptions noted.

UNDERWRITING AND RATING

UnitedHealthcare 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:

UnitedHealthcare provided a listing of 32 Delaware situs group policies that were cancelled during the examination period of January 1, 2017 through June 30, 2019. All 32 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

UnitedHealthcare Insurance Company 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).

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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:

UnitedHealthcare 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 13,635 Med/Surg claims that were paid during the examination period. A random sample of 109 claims was selected for review.

There were no exceptions noted.

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 1,755 Med/Surg claims that were denied that were denied during the examination period. A random sample of 85 claims was selected for review.

There were no exceptions noted.

D. MH Paid Claims:

UnitedHealthcare 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 491 MH claims that were paid. A random sample of 82 claims was selected for review.

There were no exceptions noted.

E. MH Denied Claims:

UnitedHealthcare 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 82 MH claims that were denied. A random sample of 76 claims was selected for review.

There were no exceptions noted.

F. SUD Paid Claims:

UnitedHealthcare 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

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a list of 40 SUD claims that were paid during the examination period. All 40 claims were selected for review.

There were no exceptions noted.

G. SUD Denied Claims:

UnitedHealthcare 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 61 SUD claims that were denied during the examination period. All 61 claims were selected for review.

The following exceptions were noted:

7 Exceptions – 18 Del. C. § 2304(16)(f) Unfair claim settlement practices.

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

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

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

UnitedHealthcare 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.

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

UnitedHealthcare 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.

7 Exceptions – 18 Del. Admin. C. § 1310–6.1.4 Processing of Clean Claim.

UnitedHealthcare requested additional information that was not necessary for clarification of the claim.

Recommendation: It is recommended that the Company request in writing that the provider or policyholder provide documentation that is relevant and necessary for clarification of the claim as required by 18 Del. Admin. C. § 1310–6.1.4.

H. Med/Surg Paid Pharmacy Claims:

UnitedHealthcare 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 25,730 pharmacy claims that were paid during the examination period. A random sample of 109 pharmacy claims was selected for review.

There were no exceptions noted.

I. Med/Surg Denied Pharmacy Claims:

UnitedHealthcare Insurance Company 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 7,652 pharmacy claims that were denied during the examination period. A random sample of 108 pharmacy claims was selected for review.

No exceptions were noted.

J. MH/SUD Pharmacy Paid Claims:

UnitedHealthcare Insurance Company 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 4,957 MH/SUD Pharmacy claims that were paid during the examination period. A random sample of 108 pharmacy claims was selected for review.

There were no exceptions noted.

K. MH/SUD Pharmacy Denied Claims:

UnitedHealthcare 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 1,580 MH/SUD Pharmacy claims that were denied during the examination period. A random sample of 105 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.

UnitedHealthcare 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.

UnitedHealthcare 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 Closed Claims:

UnitedHealthcare 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 1,381 Med/Surg claims that were closed during the examination period. A random sample of 105 claims was selected for review.

The following exceptions were noted:

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

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

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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.

UnitedHealthcare 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.

UnitedHealthcare 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.

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

UnitedHealthcare 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.

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

UnitedHealthcare 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.

M. MH/SUD Closed Claims:

UnitedHealthcare 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 seven (7) MH/SUD claims that were closed during the examination period. All seven (7) claims were reviewed.

There were no exceptions noted.

N. Med/Surg Partially Paid Claims:

UnitedHealthcare 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 3,365 Med/Surg individual claim lines that were partially paid during the examination period. A random sample of 107 individual claim lines representing 95 unique claims was selected for review.

The following exceptions were noted:

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

UnitedHealthcare 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.

UnitedHealthcare 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.

UnitedHealthcare 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.

O. MH/SUD Partially Paid Claims:

UnitedHealthcare 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 28 MH/SUD individual claim lines that were partially paid during the examination period. All 28 individual claim lines representing 13 unique claims were selected for review.

There were no exceptions noted.

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

UnitedHealthcare 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 44,996 Med/Surg Non-DE resident claims that were paid during the examination period. A random sample of 109 claims was selected for review.

The following exceptions were noted:

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

UnitedHealthcare 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.

UnitedHealthcare 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.

UnitedHealthcare 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.

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

UnitedHealthcare 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 2,781 Med/Surg Non-DE resident claims that were partially paid during the examination period. A random sample of 107 claims was selected for review.

There were no exceptions noted.

R. Med/Surg Non-DE Resident 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 4,950 Med/Surg Non-DE resident individual claim lines that were denied during the examination period. A random sample of 108 individual claim lines representing 107 unique claims was selected for review.

The following exceptions were noted:

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

UnitedHealthcare 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.

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

UnitedHealthcare 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.

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

UnitedHealthcare 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.

UnitedHealthcare 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.

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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.

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

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

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

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

UnitedHealthcare 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.

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

UnitedHealthcare 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

The following exceptions were noted:

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

UnitedHealthcare 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.

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

UnitedHealthcare 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.

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

UnitedHealthcare 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.

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

UnitedHealthcare 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.

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

UnitedHealthcare 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.

T. MH Non-DE Resident Paid Claims:

UnitedHealthcare was requested to provide a list of all Mental Health claims that were paid during the examination period of January 1, 2017 through June 30, 2019. The Company provided a list of 1,085 MH Non-DE resident claims that were paid during the examination period. A random sample of 105 claims was reviewed.

The following exceptions were noted:

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

UnitedHealthcare 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.

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

UnitedHealthcare 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.

U. MH Non-DE Resident Partially Paid Claims:

UnitedHealthcare was requested to provide a list of all Mental Health claims that were partially paid during the examination period of January 1, 2017 through June 30, 2019. The Company provided a list of 76 MH Non-DE resident claims that were partially paid during the examination period. All 76 claims were reviewed.

The following exceptions were noted:

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

UnitedHealthcare 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.

UnitedHealthcare 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.

V. MH Non-DE Resident Denied Claims:

UnitedHealthcare 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 63 MH Non-DE resident claims that were denied during the examination period. All 63 claims were reviewed.

The following exceptions were noted:

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

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UnitedHealthcare 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.

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

UnitedHealthcare 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.

W. MH Non-DE Resident Closed Claims:

UnitedHealthcare was requested to provide a list of all Mental Health Claims Closed during the examination period of January 1, 2017 through June 30, 2019. The Company provided a list of 13 MH Non-DE resident closed claims. All 13 claims were reviewed.

The following exceptions were noted:

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

UnitedHealthcare 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.

X. SUD Non-DE Resident Paid Claims:

UnitedHealthcare 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 four (4) SUD Non-DE resident claims that were paid during the examination period. All four (4) claims were reviewed.

There were no exceptions noted.

Y. Autism Paid Claims:

UnitedHealthcare 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 268 Autism claims that were paid. A random sample of 76 claims was selected for review.

The following exceptions were noted:

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

UnitedHealthcare 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.

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

UnitedHealthcare 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.

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

UnitedHealthcare 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. § 1310–6.1.1 Processing of Clean Claim.

UnitedHealthcare failed to pay the total allowed amount of the claim 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.

Z. Autism Denied Claims:

UnitedHealthcare Insurance Company was requested to provide a list of all Autism Claims denied during the examination period of January 1, 2017 through June 30, 2019. The Company provided a list of 10 Autism claims that were denied. All 10 claims were selected for review.

The following exception was noted:

1 Exception - 18 Del. Admin. C. § 902–1.2.1.3 Authority for Regulation; Basis for Regulation.

UnitedHealthcare 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.

PROVIDER RELATIONS

UnitedHealthcare Insurance Company 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 policies and procedures, or other 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.

Concern: A review of all documents submitted in reference to the Quality Improvement Program was completed. While no violations are evident, the examiners noted that there are no network community behavioral health providers represented on the various committees responsible for delineating goals and evaluating outcomes of the program. This is noted as a concern given the valuable input that community providers as stakeholders can offer into the performance of a Quality Improvement Program. The examiners recommend, as a best practice, that the Company solicit and include such participation in the future.

UTILIZATION REVIEW

A. Utilization Review Policies and Procedures:

UnitedHealthcare Insurance Company 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

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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:

UnitedHealthcare 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 18 Med/Surg Inpatient Utilization Review files that were approved. All 18 files were selected for review.

The following exception was noted:

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

The Company failed to acknowledge and act reasonably promptly upon communication with respect to claims arising under insurance policies.

Recommendation: It is recommended that the Company acknowledge and act reasonably promptly upon communication with respect to claims as required by 18 Del. C. § 2304(16)(b).

C. Med/Surg Inpatient Denied Utilization Review:

UnitedHealthcare 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 nine (9) Med/Surg Inpatient Utilization Review files that were denied. All nine (9) files were selected for review.

There were no exceptions noted.

D. Med/Surg Outpatient Approved Utilization Review:

UnitedHealthcare 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,

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2019. The Company identified 18 Med/Surg Outpatient Utilization Review files that were approved. All 18 files were selected for review.

There were no exceptions noted.

E. Med/Surg Outpatient Denied Utilization Review:

UnitedHealthcare 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 eight (8) Med/Surg Outpatient Utilization Review files that were denied. All eight (8) files were selected for review.

There were no exceptions noted.

F. MH/SUD Approved Utilization Review:

UnitedHealthcare 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 11 MH/SUD Utilization Review files that were approved. All 11 files were selected for review.

There were no exceptions noted.

G. MH/SUD Denied Utilization Review:

UnitedHealthcare was requested to provide a listing of all Denied Utilization Reviews that occurred during the examination period of January 1, 2017 through June 30, 2019. The Company identified three (3) MH/SUD Utilization Review files that were approved. All three (3) files were selected for review.

The following exception was noted:

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

UnitedHealthcare subjected benefits to concurrent utilization review during the first 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).

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

UnitedHealthcare 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 65 Med/Surg Outpatient Utilization Review files for Non-DE residents that were approved. All 65 files were selected for review.

There were no exceptions noted.

I. Med/Surg Non-DE Inpatient Approved Utilization Review:

UnitedHealthcare was requested to provide a listing of all Inpatient 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 34 Med/Surg Inpatient Utilization Review files for Non-DE residents that were approved. All 34 files were selected for review.

The following exceptions were noted:

5 Exceptions - 18 Del. C. § 2304(16)(b) Unfair claim settlement practices.

The Company failed to acknowledge and act reasonably promptly upon communication with respect to claims arising under insurance policies.

Recommendation: It is recommended that the Company acknowledge and act reasonably promptly upon communication with respect to claims as required by 18 Del. C. § 2304(16)(b).

J. Med/Surg Outpatient Denied Utilization Review:

UnitedHealthcare 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 28 Med/Surg Outpatient Utilization Review files for Non-DE residents that were denied. All 28 files were selected for review.

The following exceptions were noted:

1 Exception - 18 Del. C. § 320(c) Conduct of examination; access to records; correction.

UnitedHealthcare failed to provide a complete listing of all forms in use during the examination period.

Recommendation: It is recommended that the Company change its procedures to ensure that all forms are included in the listing provided and shall make freely available to the

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Commissioner, or the Commissioner's examiners, the accounts, records, documents, files, information, assets and matters of such person, in the person's possession or control, relating to the subject of the examination and shall facilitate the examination as required by 18 *Del. C.* § 320(c).

1 Exception - 18 *Del. C.* § 320(c) Conduct of examination; access to records; correction.

UnitedHealthcare was requested to provide forms listings that included both forms that were in use as well as those that were filed during the exam period. The Company did not include all forms that were in use during the examination period it only included those that were filed.

Recommendation: It is recommended that the Company change its procedures to ensure that both forms that were in use and filed during the examination period are included in listings provided to the examiners and shall make freely available to the Commissioner, or the Commissioner's examiners, the accounts, records, documents, files, information, assets and matters of such person, in the person's possession or control, relating to the subject of the examination and shall facilitate the examination as required by 18 *Del. C.* § 320(c).

1 Exception - 18 *Del. C.* § 320(c) Conduct of examination; access to records; correction.

UnitedHealthcare was inconsistent in the parameters used to pull the data for the grievances and appeals, claims, and utilization review listings. When it was discovered that members of Delaware situs policies that did not reside in Delaware was excluded from the listings, the Company was advised that the listing should include all members of Delaware situs policies regardless of residency. Per the Company's response to an information request it was clear that different criteria were used and that this caused data to appear in one area that was excluded from the other.

Recommendation: It is recommended that the Company exercise greater care when pulling data for the grievances and appeals, claims, and utilization review listings to ensure that it includes all members and shall make freely available to the Commissioner, or the Commissioner's examiners, the accounts, records, documents, files, information, assets and matters of such person, in the person's possession or control, relating to the subject of the examination and shall facilitate the examination as required by 18 *Del. C.* § 320(c).

K. Med/Surg Non-DE Inpatient Denied Utilization Review:

UnitedHealthcare was requested to provide a listing of all Inpatient 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 eight (8) Med/Surg Inpatient Utilization Review files for Non-DE residents that were denied. All eight (8) files were selected for review.

The following exception was noted:

1 Exception - 18 Del. C. § 332(c)(7) Written notice of decisions.

UnitedHealthcare failed to inform the insured of the mediation services offered by the Department of Insurance on the written notice of decision.

Recommendation: It is recommended that the Company provide the insured with written notice of the disposition of their grievance. In cases where the grievance has been decided in a manner that does not pay the claim in its entirety, the carrier shall provide the insured with a letter fully stating the reasons for the disposition (including specific policy language relied upon and any other documents relied upon) and the clinical rationale for the determination in cases where the determination has a clinical basis. The carrier's written notice shall also inform the insured of the appropriate manner for the insured to pursue an external review of the carrier's decision. Finally, the carrier's written notice shall inform the insured of the mediation services offered by the Department of Insurance as required by 18 Del. C. § 332(c)(7).

L. MH/SUD Non-DE Outpatient Approved Utilization Review:

UnitedHealthcare 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 50 MH/SUD Outpatient Utilization Review files for Non-DE residents that were approved. All 50 files were selected for review.

There were no exceptions noted.

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

UnitedHealthcare 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 15 MH/SUD Inpatient Utilization Review files for Non-DE residents that were approved. All 15 files were selected for review.

There were no exceptions noted.

N. MH/SUD Non-DE Outpatient Denied Utilization Review:

UnitedHealthcare was requested to provide a listing of all Denied Utilization Reviews that occurred during the examination period of January 1, 2017 through June 30, 2019. The Company identified three (3) MH/SUD Outpatient Utilization Review files for Non-DE residents that were denied. The three (3) files were selected for review.

There were no exceptions noted.

O. MH/SUD Non-DE Inpatient Denied Utilization Review:

UnitedHealthcare was requested to provide a listing of all Denied 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 file for Non-DE residents that was denied. The file was selected for review.

There were no exceptions noted.

P. MH/SUD Pharmacy Approved Utilization Review:

UnitedHealthcare 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 138 MH/SUD Pharmacy Utilization Review files that were approved. A random sample of 79 files was selected for review.

The following exceptions were noted:

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

UnitedHealthcare 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.

UnitedHealthcare 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).

Q. MH/SUD Pharmacy Denied Utilization Review:

UnitedHealthcare 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 67 MH/SUD Pharmacy Utilization Review files that were denied. All seven 67 files were selected for review.

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

UnitedHealthcare 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.

UnitedHealthcare 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).

R. Med/Surg Pharmacy Approved Utilization Review:

UnitedHealthcare 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

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Company identified 138 Med/Surg Pharmacy Utilization Review files that were approved. A random sample of 79 files was selected for review.

The following exceptions were noted:

1 Exception – 18 Del. C. § 3583(a) Utilization Review Entity's Obligations with Respect to Pre-Authorizations In Non-Emergency Circumstances.

UnitedHealthcare failed to render an adverse determination and notify the covered person's health-care provider within 2 business days of obtaining a clean pre-authorization.

Recommendation: It is recommended that the Company complete its process or render an adverse determination and notify the covered person's health-care provider within 2 business days of obtaining a clean pre-authorization as required by 18 Del. C. § 3583(a).

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

UnitedHealthcare 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).

S. Med/Surg Pharmacy Denied Utilization Review:

UnitedHealthcare 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 238 Med/Surg Pharmacy Utilization Review files that were denied. A random sample of 79 files was selected for review.

The following exceptions were noted.

1 Exception – 18 Del. C. § 3583(a) Utilization Review Entity's Obligations with Respect To Pre-Authorizations In Non-Emergency Circumstances.

UnitedHealthcare failed to render an adverse determination and notify the covered person's health-care provider within 2 business days of obtaining a clean pre-authorization.

Recommendation: It is recommended that the Company complete its process or render an adverse determination and notify the covered person's health-care provider within 2 business days of obtaining a clean pre-authorization as required by 18 Del. C. § 3583(a).

PHARMACY REVIEW

UnitedHealthcare 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.

UnitedHealthcare 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.

UnitedHealthcare 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.

UnitedHealthcare 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.

UnitedHealthcare 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.

UnitedHealthcare has a dose restriction on Suboxone 2mg/0.5mg films based on policy 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.

UnitedHealthcare'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.

UnitedHealthcare 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 change its pre-authorization policy on Vyvanse for BED 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.

UnitedHealthcare 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.

UnitedHealthcare 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.

UnitedHealthcare 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.

UnitedHealthcare 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.

UnitedHealthcare 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.

UnitedHealthcare 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.

UnitedHealthcare 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.

UnitedHealthcare 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).

10 Exceptions - 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.

UnitedHealthcare 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

UnitedHealthcare 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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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 UnitedHealthcare Insurance Company 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 change its policy so that it conducts semiannual reviews of the operations of administrators, one of which should be held on-site as required by 18 *Del. Admin. C.* § 1406-7.3. (Company Operations and Management).
2. It is recommended that the Company decide grievances in an expeditious manner as required by 18 *Del. C.* § 332(c)(5). (Grievances and Appeals)
3. It is recommended that the Company change its policy to condition the coverage of services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency in the same manner and to the same extent as coverage for all other illnesses and diseases as required by 18 *Del. C.* § 3343(c)(2). (Grievances and Appeals).
4. It is recommended that the Company effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear as required by 18 *Del. C.* § 2304(16)(f). (Claims).
5. 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).
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 request in writing that the provider or policyholder provide documentation that is relevant and necessary for clarification of the claim as required by 18 *Del. Admin. C.* § 1310–6.1.4. (Claims).
8. 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).
9. 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

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- 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).
10. 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). (Claims)(Utilization Review).
 11. 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).
 12. 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).
 13. 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).
 14. It is recommended that the Company should accurately represent pertinent facts or insurance policy provisions relating to coverages at issue as required 18 *Del. C.* § 2304(16)(a). (Claims).
 15. 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. (Utilization Review).
 16. It is recommended that the Company acknowledge and act reasonably promptly upon communication with respect to claims as required by 18 *Del. C.* § 2304(16)(b). (Utilization Review).
 17. 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

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- 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).
18. It is recommended that the Company acknowledge and act reasonably promptly upon communication with respect to claims as required by 18 *Del. C.* § 2304(16)(b). (Utilization Review).
 19. It is recommended that the Company change its procedures to ensure that all forms are included in the listings provided and shall make freely available to the Commissioner, or the Commissioner's examiners, the accounts, records, documents, files, information, assets and matters of such person, in the person's possession or control, relating to the subject of the examination and shall facilitate the examination as required by 18 *Del. C.* § 320(c). (Utilization Review).
 20. It is recommended that the Company change its procedures to ensure that both forms that were in use and filed during the examination period are included in listings provided to the examiners and shall make freely available to the Commissioner, or the Commissioner's examiners, the accounts, records, documents, files, information, assets and matters of such person, in the person's possession or control, relating to the subject of the examination and shall facilitate the examination as required by 18 *Del. C.* § 320(c). (Utilization Review).
 21. It is recommended that the Company exercise greater care when pulling data for the grievances and appeals, claims, and utilization review listings to ensure that it includes all members and shall make freely available to the Commissioner, or the Commissioner's examiners, the accounts, records, documents, files, information, assets and matters of such person, in the person's possession or control, relating to the subject of the examination and shall facilitate the examination as required by 18 *Del. C.* § 320(c). (Utilization Review).
 22. It is recommended that the Company provide the insured with written notice of the disposition of their grievance. In cases where the grievance has been decided in a manner that does not pay the claim in its entirety, the carrier shall provide the insured with a letter fully stating the reasons for the disposition (including specific policy language relied upon and any other documents relied upon) and the clinical rationale for the determination in cases where the determination has a clinical basis. The carrier's written notice shall also inform the insured of the appropriate manner for the insured to pursue an external review of the carrier's decision. Finally, the carrier's written notice shall inform the insured of the mediation services offered by the Department of Insurance as required by 18 *Del. C.* § 332(c)(7). (Utilization Review).
 23. It is recommended that the Company complete its process or render an adverse determination and notify the covered person's health-care provider within 2

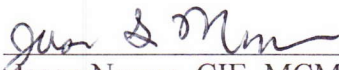
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- business days of obtaining a clean pre-authorization as required by 18 *Del. C.* § 3583(a). (Utilization Review).
24. It is recommended that the Company pre-authorize pharmaceuticals to be valid for 1 year from the date the health-care provider receives the pre-authorization as required by 18 *Del. C.* § 3586(a). (Utilization Review)(Pharmacy Review).
 25. 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).
 26. 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).
 27. 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).
 28. It is recommended that the Company change its pre-authorization policy on Vyvanse for BED 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). (Pharmacy Review).

29. 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).
30. 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). (Pharmacy Review).
31. 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).
32. 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).

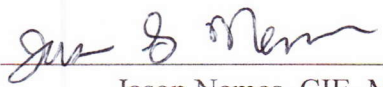
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The examination conducted by Joseph Krug, Jason Nemes, Jack Rucidlo, and Gwen Douglas is respectfully submitted.



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 79413-MHP-19-715.



Jason Nemes, CIE, MCM