STATE OF MAINE BUREAU OF INSURANCE

MARKET CONDUCT EXAMINATION REPORT

For the Period January 1, 2005 through December 31, 2008

Harvard Pilgrim Health Care Inc.
93 Worcester Street
Wellesley, MA 02481-3609

NAIC Number: 96911

February 4, 2011

EXAMINATION REPORT PREPARED BY INDEPENDENT CONTRACTORS FOR THE MAINE BUREAU OF INSURANCE

Pursuant to Title 24-A M.R.S.A. §221, I have caused a Targeted Market Conduct Examination to be conducted of Harvard Pilgrim Health Care Inc. I hereby accept this Report of Examination and make it an official record of the Bureau of Insurance.

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Mila Kofman
Superintendent of Insurance
Maine Bureau of Insurance

April 4, 2011
Date

Contents

March 30, 2011

Mila Kofman
Superintendent of Insurance
State of Maine Bureau of Insurance
34 State House Station
Augusta, ME 04333

Dear Superintendent Kofman:

Pursuant to Title 24-A M.R.S.A. § 221(5), a targeted Market Conduct examination (the Examination) of selected focus areas including behavioral health-related complaint handling, appeals, policyholder services, provider network, utilization review and pre-authorization practices, company operations and claims practices has been conducted of:

Harvard Pilgrim Health Care Inc. (the Company)

The Company's records were examined at the Company's offices in Wellesley, Westborough and Quincy, Massachusetts.

The Examination covered the period from January 1, 2005 to December 31, 2008.

A Report of the Examination of Harvard Pilgrim Health Care Inc. is, herewith, respectfully submitted.

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RSM McGladrey
Independent Market Conduct Examiner

SECTION I - EXECUTIVE SUMMARY

Background and Examination Objectives

The Maine Bureau of Insurance (the Bureau) conducted a targeted market conduct Examination of the Company to assess the behavioral health services provided by the Company. The Bureau's primary objective in conducting the Examination is to evaluate whether mental health and substance abuse benefits are at least equal to those by a person receiving medical treatment. More specifically, the Bureau's goals and objectives in conducting the Examination includes but is not limited to the following:

1. Test the Company's processes to ensure that the Company is providing accurate and timely information to both enrollees and health care providers.
2. Evaluate the insurer's compliance with applicable statutes and regulations as well as timeliness and accuracy of claim payments.
3. Determine the Company's compliance with applicable statutes and regulations concerning complaint handling, appeals and grievance procedures, policyholder service, claims handling, and pre-authorization and utilization review procedures.
4. Determine the timeliness of the Company's pre-authorization process, and the appropriateness of the decisions. Determine the reasonableness of the Company's process for obtaining and documenting receipt and disposition of treatment plans from providers, including both participating and non-participating providers.
5. Determine the accuracy and completeness of the Company's provider directory.

Examination Approach

RSM McGladrey, Inc. (McGladrey or the Examiners) relied primarily on the review and testing of records and information maintained by the Company concerning certain of their operations included within the scope of the Examination. Where appropriate, the Examiners tendered follow-up inquiries to the Company for response. Interviews with Company representatives were also conducted. Targeted attribute testing was performed consistent with examination processes and sampling methodologies of the Bureau in concert with the applicable State of Maine insurance statutes, rules and regulations and the NAIC Market Regulation Handbook (the Handbook), which was used as a guide. The Examiners reviewed and tested, where applicable, the following areas:

1. Company Operations and Management
2. Claims Handling and Settlement
3. Utilization Review and Pre-Authorization
4. Complaints, Appeals and Grievance Handling
5. Policyholder Services and Provider Network

The Examination scope, workplan and testing was developed consistent with the requirements of the Bureau's Rider A - Specification of Work to Be Performed, of the Agreement to Purchase Services (the Agreement). Rider A also establishes the Company's operational areas to be tested. In consultation with the Bureau, certain tests conducted during the Examination may have been

modified from that set out in Rider A to meet the needs of the Bureau and to reflect statutes, rules and regulations referenced herein.

In testing the above referenced areas, the Examiners were directed to evaluate whether mental health and substance abuse benefits were at least equal to those for physical illnesses for a person receiving medical treatment. In so doing, the Examiners used random samples where appropriate for the areas tested. Also, where applicable and consistent with the requirements of the Bureau, the Examiners utilized qualified clinical professionals, approved by the Bureau, to conduct peer reviews to perform the following:

- Review medical records to determine whether an adverse decision was appropriately rendered.
- Determine whether the Company conducted a fair review of medical necessity before issuing a denial; for example, they determined that medical records were reviewed or there was a substantive collection of medical information (written or verbal) before determining the lack of medical necessity.
- Review the Company's utilization review peer reviewers' qualifications for appropriateness.
- Review that the Company's reviewer had the appropriate expertise (personally or through a qualified consultant) in cases involving experimental/investigational treatment denials; for example, they determined that denials were appropriate and based upon scientific evidence or lack thereof.
- Determine that the Company's reviewer had knowledge or familiarity with neuropsychological testing and other cognitive-related issues, if applicable.

Findings

The Examiners noted findings regarding the Company's claims handling practices, which are listed below in order of priority:

Finding #1

The Examiners identified one (1) of 130 denied and zero-paid claims which was not paid within 30 days of receipt, representing a potential violation of Title 24-A Chapter 27 §2436(1) of the Maine Insurance Code. The Company agreed the claim was not paid within 30 days, but disagrees this is a violation since they paid appropriate interest.

Finding # 2

The Examiners identified four (4) of 130 denied and zero-paid claims, representing potential violations of Title 24-A Chapter 23 §2436 (1) of the Maine Insurance Code. Specifically, two (2) claims were denied as not having authorizations, when authorizations were on file. Another claim was denied noting the provider's tax ID number was incorrect, however; upon review the number was determined to be correct. Finally, one claim was denied as not a covered service, when the service was covered under the plan. The Company disagreed that the four (4) errors

represent a violation of Title 24-A Chapter 23 §2436 (1) or other law, and indicated all four (4) claims were corrected and paid with interest prior to the Examination.

Finding #3

The Examiners identified a potential general business practice that is non-compliant with Maine regulations where the Second Level adverse determination notices did not comply with Chapter 850, §9C(l)(b). of the Maine Insurance Rule. Specifically, the Company's Decision Letter did not reveal the names of all of the reviewers involved in the appeal, as required by statute.

Finding #4

The Examiners identified one (1) of 43 appeal files as possible violations of Chapter 850, §9C(l)(a) of the Maine Insurance Rule. Specifically, the Company did not issue a decision within 20 days, as required by this regulation.

Finding #5

The Examiners identified two (2) of 43 appeal files as possible violations of Chapter 850, Section 9C(l) (b) of the Maine Insurance Rule. Specifically, the adverse determination letter did not disclose the description of the process to obtain a Second Level grievance review.
The details for each of the above referenced findings are discussed in Section V of this Report. Additionally, where applicable, the Examiners have included Additional Observations in each relevant area of the Examination.

SECTION II - SCOPE OF EXAMINATION

The scope of the Bureau's Examination was to determine the Company's compliance with applicable mental health parity provisions of the Maine Insurance Code, Title 24-A M.R.S.A §§ 2842-2844, 4234-A and 4303 as well as Maine's Health Plan Improvement Act and Bureau of Insurance Rule Chapters 191 and 850 for the period of the Examination (the Period), January 1, 2005 through December 31, 2008. The Examination was conducted under the supervision of the Bureau's Director of Consumer Health Care Division and the Director of Financial Analysis.

The Report of Examination (the Report) is a report by exception with modification, as references to practices, procedures or files that did not contain exceptions are limited. All unacceptable or non-complying practices may not have been identified. The failure to identify specific Company practices does not constitute acceptance of these practices.

McGladrey personnel participated in this Examination in their capacity as Market Conduct Examiners. McGladrey provides no representations regarding questions of legal interpretation or opinion. Determination of findings constituting violations or potential violations is the sole responsibility of the Bureau.

SECTION III - COMPANY PROFILE

HPHC and its affiliate, Harvard Pilgrim Health Care of New England, Inc., operate as not-for-profit health insurance plans providing comprehensive health insurance, access to health care and other related services in Massachusetts and Maine and New Hampshire, respectively, to group, individual, and Medicare Advantage (Maine, Massachusetts and New Hampshire) members through contracts with physicians, established primary care and multi-specialty physician groups, hospitals and other health care providers.

HPHC affiliate's, HPHC Insurance Company, Inc., underwrites accident and health risks related to out-of-network coverage for HPHC's Massachusetts POS plan members as well as group health insurance through its PPO indemnity and Medicare indemnity products in Massachusetts, Maine and New Hampshire.

United Behavioral Health, Inc. (UBH) is a division of United Health Group and offers health benefit management services to health insurers and is contracted by HPHC to provide certain behavioral management services, including claim processing.

The UBH provider network includes psychiatrists, psychologists, social workers, psychiatric nurses and other mental health and employee assistance providers. The facility network includes hospital inpatient units, residential treatment centers, partial hospitalization programs and outpatient programs.

On January 1, 2008, the Company began administrating the Dirigo Choice Plan in collaboration with Dirigo Health Agency. The Dirigo Plan is private health insurance coverage covering small businesses (fewer than 50 employees), sole proprietors, and individuals.

SECTION IV - EXAMINERS METHODOLOGY

In accordance with the Bureau's requirements, the Examiners developed random samples, where applicable, to review and test specific attributes associated with policies that were marketed and sold to State of Maine residents. These populations included large group policies, small group policies with more than twenty (20) covered employees and State of Maine employee plan and city and local governmental plans. Also, where applicable, the samples included groups with twenty (20) or fewer employees for which the policyholders had elected mental health parity. Administrative services business, with the exception of the State of Maine employee plan, was excluded from the sample testing. The Company did not underwrite any individual policies in the State of Maine during the Period. The Examiner's sampling methodology was reviewed and approved by the Bureau. The Examiners' testing of each focus area was designed to evaluate whether mental health and substance abuse benefits are at least equal to those for physical illnesses for a person receiving medical treatment for any of the categories of mental illness as defined by Maine Insurance Code, Title 24-A M.R.S.A §§2843 (5-C) and 4234-A (6) and (7).

The categories of mental illness were identified in the Bureau's Rider A as defined in the Diagnostic and Statistical Manual (DSM), except for those that are designated as "V" codes by the DSM. The categories include the following:

1. Psychotic disorders, including schizophrenia;
2. Dissociative disorders;
3. Mood disorders;
4. Anxiety disorders;
5. Personality disorders;
6. Paraphilias;
7. Attention deficit and disruptive behavior disorders;
8. Pervasive developmental disorders;
9. Tic disorders,
10. Eating disorders, including bulimia and anorexia; and
11. Substance abuse-related disorders

Company Operations and Management

Testing of this focus area included the Examiners requesting certain operational data along with policies and procedures from the Company in effect during the Period. The requested information included:

- An overview of relevant Company systems.
- The Company's corporate legal entity and functional organization charts.
- The Company's policies and procedures for oversight of behavioral health vendors, service providers, and other companies that provide insurance-related services.
- Functional organizational charts for all areas responsible for handling and overseeing behavioral health claims, complaints, appeals and grievances, utilization reviews, pre-authorizations, enrollee inquiries and policyholder services.

Upon receipt of the above requested information, the Examiners evaluated the Company's responses for compliance with Maine's mental health parity laws as may be applicable and other related rules and regulations. The results are summarized in Section V.

Claims Handling and Settlement

Testing of this focus area included requesting a population of mental health claim data and the supporting policies and procedures for the Period. The information requested included:

- The population of denied and zero-paid claim lines, which had a primary, secondary or tertiary behavioral health diagnosis. Zero-paid claims are defined as those matters involving instances where the service is covered, however, co-insurance applies or the member's deductible has not yet been met and therefore no payment was due by the Company.
- The Company's claim manual.

In response to the Examiner's requests, the Company provided a population of 34,902 denied and zero-paid claim lines which had a behavioral health diagnosis as outlined above. The population included data from three claims systems (HPHC medical claims processed by Dell Perot; Dirigo Health Claims processed by Health Plans Inc. and HPHC behavioral health claims -processed by

UBH.) The Examiners developed samples approved in consultation with the Bureau and utilized Audit Control Language (ACL) to select a random sample of 130 denied and zero-paid claims using a 95% confidence level. The Examiners' methodology regarding the Company's claim adjudication practices included reviewing sampled claims as well as any prior or subsequent adjudication of the sample claim. The prior or subsequent claims may have included a payment or denial of the sampled claims. The claims were reviewed to ensure compliance with Maine Mental Health Parity Laws as outlined in Rider A. The Examiners also reviewed the member's insurance policy for each sampled claim to determine if mental health coverages and limits were at least equal to the member's medical benefits.

The Examiners also conducted interviews with Company representatives and received training from the Company related to the Company's systems to which the Examiners would need access. The results of the claims review are summarized in Section V.

Utilization Review and Pre-Authorization

Testing of this focus area involved requesting a population of UR and pre-authorization denials and the policies and procedures the Company had in place during the Period. The information requested included:

Utilization Review

- The Company's policies and procedures related to the Company's UR program in effect during the Period.
- A listing of all behavioral health-related claims having had a UR performed as well as the disposition of the claim as a result of the UR.
- A listing of all behavioral health-related UR requests that were denied during the Period.
- A listing of all behavioral health utilization review peer reviewers, including authorization areas or limitations, as well as documentation to support each reviewer's qualifications.
- An overview of the process utilized to determine whether a reviewer's qualifications are appropriate, including any written policies or procedures for evaluating qualifications.

In response to the Examiners' data requests, the Company provided documentation and a population of sixty-seven (67) URs performed that had a partial or a full denial of coverage. The Examiners developed samples approved in consultation with the Bureau and utilized ACL to select a random sample of forty-three (43) denied requests using a 95% confidence level.

HPHC's UR files were reviewed to ensure compliance with Maine Mental Health Parity Laws as outlined in Rider A. Additionally, the Examiners reviewed HPHC's mental health UR processes in order to determine if the processes were equivalent to HPHC's UR medical processes.

Pre-Authorization

- The Company's policies and procedures for obtaining and documenting the receipt and disposition of treatment plans from providers (both participating and non-participating) in a timely manner.
- Written policies and procedures used by specialists in the review and documentation of pre-authorization requests, including denied pre-authorizations.
- A listing of all pre-authorization requests that were denied during the Period.
- A listing of all provider network specialists in the Company and their authorization levels for approving behavioral health-related services.

In response to the Examiners' data requests, the Company provided documentation and a population of one hundred fourteen (114) denied pre-authorization requests. The Examiners developed samples approved in consultation with the Bureau and utilized Audit Command Language (ACL) to select a random sample of forty-three (43) requests using a 95% confidence level.

HPHC's pre-authorization files were reviewed to test compliance with Maine's Mental Health Parity Laws as outlined in Rider A. Additionally, the Examiners reviewed the Company's mental health pre-authorization processes in order to determine if the processes were equivalent to HPHC's medical pre-authorization processes.

The Examiners also conducted interviews with Company representatives and reviewed the Company's responses to information requests. In addition, all requests denied for medical necessity were reviewed by an independent clinical peer reviewer. The results are summarized in Section V below.

Complaints, Appeals and Grievances

Testing of this focus area commenced with the Examiners requesting separate populations of complaints, appeals and grievances from the records or logs maintained by the Company and which only involved behavioral health matters. The terms appeals and grievances are used interchangeably throughout this Report. The Examiners also requested the related policies and procedures the Company had in place for the Period. Information requested from the Company to conduct the review of these areas included:

Complaints

- A copy of the written policy and procedures for processing complaints relating to residents of the State of Maine.
- A listing of training to educate the specialists on the Company's policies and procedures.
- The Company's general complaint log which included both complaints received from the Bureau and complaints from members and/or providers related to behavioral health.
- A listing of behavioral health pharmacy-related complaints received from the Bureau, members or providers.
- Complaint management reports.

- The Company's definition of a complaint as applied to complaints relating to residents of the State of Maine.
- A detailed explanation of the escalation/tiering process for complaints established by the Company.
- The description and composition of an established formal committee, which reviewed complaints specific to behavioral health services on a routine basis.

In response to the Examiners' data request, the Company provided documentation and a listing of fifty-seven (57) complaints received during the Period. The Examiners reviewed all complaints identified by the Company.

Also included in the scope of the Examination was testing of complaints to identify any matters related to pharmacy benefits. The Company had no pharmacy complaints for the Period.

The results are summarized in Section V.

Appeals and Grievances

- Written policies and procedures for processing First and Second Level appeals and grievances for residents of the State of Maine.
- A complete log of all appeals and grievances related to behavioral health received from members and providers.
- The Company's definition of appeals and grievances as applied to those received in connection with residents of the State of Maine.
- A detailed explanation of the escalation/tiering process for appeals and grievances established by the Company.
- The description and composition of an established formal committee, which reviewed appeals and grievances specific to behavioral health services on a routine basis.

In response to the Examiner's data requests, the Company provided documentation and a population of ninety-eight (98) behavioral health related appeals (including administrative and clinical levels I and II). The Examiners developed samples approved in consultation with the Bureau and utilized ACL to select a random sample of forty-three (43) denied requests using a 95% confidence level.

The Examiners reviewed HPHC's mental health appeal procedures and related notices to determine whether they comply with Maine's requirements and whether the Company's procedures and notices for behavioral health appeals are equivalent to medical appeals procedures and notices.

The Examiners also conducted interviews with Company representatives and reviewed the Company's responses. In addition, complaints and appeals relating to claims or requests for authorizations for services denied for medical necessity were reviewed by an independent clinical peer reviewer. The results are summarized in Section V below.

Policyholder Services and Provider Network

Testing of this focus area involved requesting information related to policyholder services and provider network and the policies and procedures applicable during the Period. The information requested included:

Policyholder Services

- Written policies and procedures in place to ensure compliance with the new mental health parity requirements (Federal and State of Maine).
- Written policies and procedures provided to and used by the policyholder service representatives when responding to and documenting instances when an enrollee contacts the Company (verbally or in writing) for information on behavioral health matters.
- The Company's process, including the levels of review or escalation, for handling behavioral health inquiries (verbal or written).
- The number of inquiries (verbal or written) received per year related to behavioral health.
- A listing of all insurance policies (and certificates of coverage, where applicable) that were marketed to Maine residents.

Provider Network

- Copies of the provider directories (hard copy and electronic) for each year of the Examination.
- A description of the process used by the Company to ensure that the provider directory is accurate and up-to-date, including timelines for updating, adding and deleting providers from the directory.
- A listing of all provider contracts in effect during the Period.
- Policies and procedures for claims filing and any additional requirements applicable to providers filing behavioral health claims.
- A description of the methodology used by the Company (or an external vendor) to ascertain the Maximum Allowable Charges (the Charges).
- A description of any differences in the determination of the Charges (in the calculation factors or percentages) for behavioral health services compared to those for general medical services and the rationale for differences, if any.
- Policies and procedures in place to verify whether the methodology for determining the Charges considered relevant information specific to the State of Maine such as whether there was sufficient data to constitute a representative sample of Charges for the same or comparable service.
- The process for updating the Charges in the Company's claims system and the frequency of the updates.
- The process used by the Company to audit whether the appropriate Charges were loaded into the system.

To review and test the accuracy of a provider's network status on the date of service, the Examiners reviewed a random sample of forty-three (43) from the 130 denied and zero-paid

claim sample and compared the network status on the date of service to the Company Provider Directories and a listing of the Company's providers contracted at any time during the Period.

The Examiners also determined the Company's compliance with the State of Maine's mental health parity laws and other applicable rules and regulations. The results are summarized in Section V.

As previously noted, in addition to reviewing the documentation and performing the testing discussed above, the Examiners also conducted interviews with Company representatives responsible for certain HPHC functional areas, including claims, complaints, appeals, pre-authorizations, UR, policyholder services and provider network.

SECTION V - RESULTS OF THE EXAMINATION

The Examination identified one (1) potential business practice violation and eight (8) potential individual violations of Maine insurance laws. In addition, other findings were noted regarding inconsistencies with the Company's policies and procedures or represent the Examiners' observations for possible improvements in the Company's practices. The following summarizes the results of the Examination:

Company Operations and Management

No exceptions were noted.

Claims Handling and Settlement

The Examiners tested a sample of one hundred thirty (130) denied and zero-paid claims. Testing included assessing the Company's compliance with applicable Maine statutes in addition to testing the Company's general claim processing. Based on the review of the claim sample, the Examiners determined that during the Period, the Company did not appear to impose more restrictive filing requirements on providers who filed behavioral health related claims when compared to medical claim submissions.

Testing identified five (5) potential violations regarding one Maine statute. The Maine statute and the exceptions noted are as follows:

1. Title 24-A Chapter 27 §2436(1) of the Maine Insurance Code, which reads in part:

   1. A claim for payment of benefits under a policy or certificate of insurance delivered or issued for delivery in this State is payable within 30 days after proof of loss is received by the insurer and ascertainment of the loss is made either by written agreement between the insurer and the insured or beneficiary or by filing with the insured or beneficiary of an award by arbitrators as provided for in the policy. For purposes of this section, "insured or beneficiary" includes a person to whom benefits have been assigned. A claim that is neither disputed nor paid within 30 days is overdue.

Four (4) of the 130 denied and zero-paid claims, or 3.2%, involved a potential violation of Title 24-A Chapter 27 §2436 (1). The Examiners' review revealed four (4) instances where the Company denied a claim incorrectly. All four (4) claims were re-processed and paid with appropriate interest prior to the Examination. The errors are explained below:

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
Title 24-A, §2436(1)	Two claims were denied as not authorized by the Company. Both claims had authorizations on file.	2	1.6%
Title 24-A, §2436(1)	One claim was denied noting the provider's tax ID number was incorrect, however; upon review the number was determined to be correct.	1	.8%
Title 24-A, §2436(1)	One claim was denied as not a covered service, when the service was covered under the plan.	1	.8%
TOTAL		**4**	**3.2%**

2. Title 24-A Chapter 27 §2436(1) of the Maine Insurance Code, which reads in part:

   "A claim for payment of benefits under a policy or certificate of insurance delivered or issued for delivery in this State is payable within 30 days after proof of loss is received by the insurer and ascertainment of the loss is made either by written agreement between the insurer and the insured or beneficiary or by filing with the insured or beneficiary of an award by arbitrators as provided for in the policy. For purposes of this section, "insured or beneficiary" includes a person to whom benefits have been assigned. A claim that is neither disputed nor paid within 30 days is overdue."

The Company failed to affirm or deny coverage within 30 calendar days for one (1) of the 130 denied and zero-paid claims or .8%. The claim was paid with appropriate interest prior to the Examination. The error is explained below:

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
Title 24-A § 2436 (1)	The Company failed to affirm or deny coverage within 30 calendar days.	1	.8%
TOTAL		**1**	**.8%**

Utilization Review and Pre-Authorization

Utilization Review

The testing of a sample of forty-three (43) UR files that were denied included assessing the Company's compliance with applicable Maine statutes in addition to testing the Company's general processing. Based upon the results of the Examiners' testing of the sample UR population, it was determined that HPHC's UR processes for managing mental health benefits were equivalent to the Company's UR processes for managing medical benefits. No exceptions were noted.

Additional Observations

The Company had policies and procedures in place requiring that UR denials be made by a qualified peer reviewer. With respect to behavioral health issues, a qualified peer, depending upon the situation, is described by the Bureau in Rider A as one that is in the provider's discipline and is equally qualified as the provider ordering the treatment or service. This would include but not be limited to a mental health professional (e.g., psychologist, psychiatrist or psychiatric nurse practitioner) or physician (e.g., M.D., D.O.).

As part of the Examiner's review and at the request of the Bureau, the Examiners referred certain files that the Company denied for medical necessity to an Independent Peer Reviewer. The Examiners identified thirty-two (32) Utilization Reviews that were denied by the Company for not meeting the medical necessity criteria as defined by the Company, and not overturned through the Company's appeal process.

In two (2) of the 32 UR files referred for Peer Review, or 6.2%, the Independent Peer Reviewer did not concur with the Company's decision to deny benefits based on the medical information in the file. In one (1) of the 32 UR files referred for peer review, or 3.1%, the Independent Peer Reviewer did not concur that the file contained enough clinical information to make a determination. The Bureau has reviewed and evaluated the results of the Peer Review and will address the findings with the Company to determine any appropriate corrective actions which may be deemed necessary.

Pre-Authorization

The testing of a sample of forty-three (43) Pre-Authorization files that were denied included assessing the Company's compliance with applicable Maine statutes in addition to testing the Company's policies and procedures. Based upon the results of the Examiner's testing of the sample of pre-authorizations, it was determined that HPHC's processes for pre-approval of mental health benefits were equivalent to HPHC's pre-authorization process for pre-approval of medical benefits. No exceptions were noted.

Additional Observations

The Company had policies and procedures in place requiring that Pre-Authorization denials be made by a qualified peer reviewer. With respect to behavioral health issues, a qualified peer reviewer, depending upon the situation, is described by the Bureau in Rider A as one that is in the provider's discipline and is equally qualified as the provider ordering the treatment or service. This would include but not be limited to a mental health professional (e.g., psychologist, psychiatrist or psychiatric nurse practitioner) or physician (e.g., M.D., D.O.).

As part of the Examiner's review and at the request of the Bureau, the Examiners referred certain files that the Company denied for medical necessity to an Independent Peer Reviewer. The Examiners identified twelve (12) Pre-Authorization requests that were denied by the Company for not meeting the medical necessity criteria as defined by the Company, and not overturned through the Company's appeal process.

In seven (7) of the 12 pre-authorization files referred for peer review, or 58.3%, the Independent Peer Reviewer did not concur with the Company's decision to deny benefits, based upon the medical information in the file. Three (3) of the pre-authorizations the independent reviewer disagreed with were related to neuropsychological testing. The Bureau has reviewed and evaluated the results of the Peer Review and will address the findings with the Company and discuss any appropriate corrective action which may be necessary.

Complaints, Appeals and Grievance Handling

Complaints

The testing of the population of fifty-seven (57) complaints included assessing the Company's compliance with applicable Maine statutes and testing the Company's complaint handling procedures. No exceptions were noted.

Pharmacy Complaints

The Company represented that they did not have any pharmacy complaints.

Appeals

The testing of a sample of forty-three (43) appeals included assessing the Company's compliance with applicable Maine statutes and testing the Company's appeals processing procedures. HPHC's appeal process for mental health claim denials was determined to be equivalent to that related to medical claim denial appeals, based upon the results of the Examiner's review of the Company's processes.

The Examiners identified one area of possible non-compliance with Chapter 850, Section 9 C(l)(b). Specifically the decision letter for Second Level appeals does not contain the names of the reviewers, as required by statute. This is deemed a general business practice that is non-compliant with Maine statutes.

In addition to the one (1) general business practice that is non-compliant with Maine regulations, appeal testing identified three (3) potential violations of two provisions under Chapter 850, Section 9. The Maine regulations and the exceptions noted are as follows:

1. Chapter 850, Section 9 C(1) (a) that states the following:

   A health carrier shall issue a written decision to the covered person within 20 working days after receiving a grievance. Additional time is permitted where the carrier can establish the 20 day timeframe cannot reasonably be met due to the carrier's inability to obtain necessary information from a person or entity not affiliated with or under contract with the carrier. The carrier shall provide written notice of the delay to the covered person. The notice shall explain the reasons for the delay. In such instances, decisions must be issued within 20 days of the carrier's receipt of all necessary information. The person or persons reviewing the grievance shall not be the same person or persons who made the initial determination denying a claim or handling the matter that is the subject of the grievance.

   The Examiners identified one (1) instance, or 2.3%, involving a First Level appeal wherein the Company failed to complete the review within 20 days. The error is explained below:

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
Chapter 850, §9C(1)(a)	The Company did not issue a written decision within 20 working days.	1	2.3%
TOTALS		**1**	**2.3%**

2. Chapter 850, Section 9 C(1) (b) states the following:

   If the decision is adverse to the covered person, the written decision shall contain:

   i. The names, titles and qualifying credentials of the person or persons participating in the first level grievance review process (the reviewers).
   ii. A statement of the reviewers' understanding of the covered person's grievance and all pertinent facts.
   iii. The reviewers' decision in clear terms and the basis for the decision.
   iv. A reference to the evidence or documentation used as the basis for the decision.
   v. Notice of the covered person's right to contact the Superintendent's office. The notice shall contain the toll-free telephone number and address of the Bureau of Insurance.
   vi. Notice to the enrollee describing any subsequent external review rights, if required by 24-A M.R.S.A. §4312(3).
   vii. A description of the process to obtain a second level grievance review of a decision, the procedures and timeframes governing a second level grievance review, and the rights specified in subsection D(3)(c). This requirement does not apply to carriers who do not subject benefit determinations to utilization review and do offer managed care plans as defined by this rule.

The Examiners identified two (2) instances, or 4.6%, wherein the notice did not contain a description of the process to obtain a Second Level grievance review (part vii above). The errors are explained below:

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
Chapter 850, §9C(1)(a)	The Company's notification did not include information regarding Second Level appeals.	2	4.6%
TOTALS		**2**	**4.6%**

Additional Observations

As part of the Examiners' review and at the request of the Bureau, the Examiners referred certain files that the Company denied for medical necessity to an Independent Peer Reviewer. The Examiners identified eleven (11) appeals that were upheld by the Company for not meeting the medical necessity criteria as defined by the Company, and not overturned through the Company's appeal process rights. The complete files provided by the Company were reviewed and referred for peer-to-peer review. The Independent Peer Reviewer agreed with the Company's decision on all files.

Policyholder Services and Provider Network

Policyholder Services

The testing of policyholder services involved assessing the Company's compliance with applicable Maine statutes. The Company had separate policies, procedures and training on how to respond to behavioral health inquiries. No exceptions were noted.

Provider Network

The accuracy of a provider's network status on the date of service was tested through a review of forty-three (43) of the 130 denied and zero paid claim files. No exceptions were noted.

ADDENDUM - COMPANY'S RESPONSE

Addendum

Harvard Pilgrim
HealthCare

December 2, 2010

Via Email & U.S. Mail

Superintendent Mila Kofman
Maine Bureau of Insurance
34 State House Station
Augusta, Maine 0433-0034

ATTN: Glenn Griswold

Re: Harvard Pilgrim Health Care, Inc. Market Conduct Examination

Dear Superintendent Kofman:

This is in response to the draft Market Conduct Examination Report issued by RSM McGladrey, Inc. on behalf of the Bureau of Insurance concerning compliance with Maine's mental health parity law and related laws by Harvard Pilgrim Health Care, Inc. (HPHC).

We appreciate the opportunity to review the Report and to recommend changes to it pursuant to 24-A M.R.S.A. § 226. As you know, RSM McGladrey made five (5) findings concerning HPHC's conduct. HPHC respectfully recommends the following changes with respect to each such finding:

Finding # 1

The Examiners identified one (I) of 130 denied and zero-paid claims which was not paid within 30 days of receipt, representing a potential violation of Title 24-A Chapter 27 §2436(1) of the Maine Insurance Rule. The Company agreed the claim was not paid within 30 days, but disagrees this is a violation since they paid appropriate interest.

Finding # 1: Recommended Change

HPHC respectfully recommends that the above finding be revised to conclude that there was no violation of Maine's prompt payment law, 24-A M.R.S.A. § 2436, notwithstanding the late payment of the claim because statutory interest was paid on it.

As you know, this matter was initially raised by RSM McGladrey in Concern Form #7 with respect to Claim Sample 118. Claim Sample 118 was received by HPHC's behavioral health vendor, United Behavioral Health (UBH), on September 5, 2007 and adjudicated on October 17, 2007. As originally

explained, the claim could not be uploaded and processed electronically and instead was manually processed. As a result of the delay related to the manual processing of the claim, all appropriate interest, which amounted to $6.21, was paid.

While the examiners correctly noted that claims must be processed within 30 days, Maine's prompt payment law also contemplates situations where claims are not paid within such a time period and imposes a resulting obligation to pay interest. HPHC contends that through the payment of interest on the claim, a carrier ultimately meets the requirements of the law. More specifically, the initial requirement to process claims within 30 days cannot be divorced from the subsequent requirement to pay interest on late claims when considering compliance with the prompt payment law. By its own terms, the statute recognizes that there may be situations where a claim is not paid within 30 days and provides an internal remedy for such circumstances -an interest penalty. If a carrier was late in paying a claim and also failed to pay the statutorily mandated interest, there would then be a violation of the law.

In this case, HPHC's vendor, UBH, self-identified the late payment at the time of processing and subsequently issued payment of interest as required by the law. HPHC and its vendor ultimately complied with the law in these circumstances. Moreover, as indicated by the error percentage rate of .8% identified by the examiners, the late payment of a single claim in the overall sample does not demonstrate a larger systematic problem with claims processing in relation to Maine's prompt payment law.

HPHC therefore respectfully requests that the finding be revised to indicate that while there was a late payment of one claim there was no violation of the law by virtue of the payment of the statutory interest at the time.

Finding #2

The Examiners identified four (4) of 130 denied and zero-paid claims, representing potential violations of Title 24-A Chapter 23 §2164-D(3) of the Maine Insurance Rule concerning Unfair Claims Practices. Specifically, two (2) claims were denied as not having authorizations, when authorizations were on file. Another claim was denied noting the provider's tax ID number was incorrect, however; upon review the number was determined to be correct. Finally, one claim was denied as not a covered service, when the service was covered under the plan. The Company disagreed that the four (4) errors represent an Unfair Claims Practice, and indicated all four (4) claims were corrected and paid with interest prior to the Examination.

Finding #2: Recommended Change

HPHC respectfully recommends that the above finding be revised to conclude that there was no violation of Maine's unfair claims practices law, 24-A M.R.S.A. 2164-D (3).

As the examiners have noted, there were four (4) claims out of the total sample which HPHC's behavioral health vendor, UBH, self-identified and corrected at the time of processing. Three involved simple human error and one involved an unusual billing practice that has since been addressed in UBH's system. In particular, these claims involved the following:

5205-025. This involved examiner error. The claim was originally denied incorrectly with the reason: "Tax ID on claim doesn't match our records." The error was due to the provider tax ID

already being listed in the system. This resulted in an adjustment that paid $282.76 as well as interest in the amount of $5.88. At the time of reprocessing in 2007, UBH would have followed up with the original examiner and his or her supervisor to reinforce correct claims processing.

5205-038. This was a clinical staff data entry error. In particular, an authorization was entered under the incorrect family member, which resulted in the incorrect denial of the claim. The claim was adjusted to pay $200.00 along with interest of $12.04. At the time of reprocessing in 2007, UBH would have followed up with the clinical staff member and his or her supervisor to reinforce the correct handling of the claim.

5205-045. This was a system error. It specifically involved an obscure system error due to the unusual billing practice of a provider who billed a common outpatient behavioral health service code on a UBH form using a non-specific revenue code. The code is very seldom billed to UBH and is not typically considered as a valid code for coverage. However, in this case, the provider was contracted in an unusual way to bill its outpatient services using revenue codes. UBH did not have the revenue code on the system configuration setup that was in place to bypass auto-adjudication, and the claim auto-denied. The claim was adjusted to pay $81.00 along with interest in the amount of $0.44. UBH subsequently added this specific revenue code to the bypass auto-adjudication functionality in its claims system thereby allowing the established manual process to ensure correct adjudications in these unusual situations.

5205-061. This involved examiner error. The claim was originally denied incorrectly by an examiner for "Date of service outside of authorization range." The claim was subsequently adjusted to pay $67.97 as well as interest of $3.69. Per the "MD Waive Authorization" program, prescribing providers do not require an authorization. At the time of reprocessing in 2008, UBH would have followed up with the examiner and his or her supervisor to address the error.

Under these circumstances, HPHC contends that there was no violation of Maine's unfair claims practices law.

Maine's unfair claims practices law requires a violation of both subsections 2 and 3. Subsection 2 states that an insurer has committed an unfair claims practice if the act listed in Subsection 3 has been committed either (1) in conscious disregard of the statute and any rules under the statute or (2) with such frequency to indicate a general business practice to engage in that type of practice. Subsection 3 enumerates several unfair claims practices, such as committing knowing misrepresentations or refusing to pay claims without a reasonable investigation.

Based on the facts outlined above, there was neither a conscious disregard of the law nor a frequency of conduct that would indicate a "general business practice." The isolated nature of these claims mistakes is manifested by the error percentage rate of 3.2% of the overall total zero-paid claims sample. In addition, none of the impermissible acts or omissions set forth in Subsection 3 occurred. Instead, with respect to the claims at issue, three were the result of simple human error and one was the result of an isolated disconnection between an unusual billing practice by a provider and UBH's system. In sum, these actions occurred as a result of inadvertent errors and were self-identified and corrected, including through the payment of interest, at the time.

HPHC therefore respectfully requests that the finding be revised to indicate that the initial, incorrect denials of four (4) claims were properly rectified and that no violation of Maine's unfair claims practices law occurred.

Finding #3

The Examiners identified a potential general business practice that is non-compliant with Maine statutes where the Second Level adverse determination notices did not comply with Chapter 850, §9C(l)(b) of the Maine Insurance Rule. Specifically, the Company's Decision Letter did not reveal the names of all of the reviewers involved in the appeal, as required by statute.

Finding #3: Recommended Change

HPHC reiterates its position originally provided in response to Concern Form No. 4. As previously stated, HPHC provides a generic "name" of each appeal hearing member by listing his or her position and department within the company. HPHC respectfully contends that its provision of the title and department of reviewers at the second-level appeals for the appeals in questions meets the intent and purpose of the requirements of Chapter 850, § 9 (C)(l)(b) and (D)(3)(f).

Moreover, the names of second-level appeal hearing members are documented in case files and minutes and are therefore available. Additionally, HPHC is concerned about the potential safety issues posed by an interpretation of Chapter 850, § 9 (C)(l)(b) that would require the disclosure of specific employee names. In the past, members have attempted to contact reviewers directly outside of the appeals process and, in some cases, have personally harassed reviewers.

To the extent the Bureau insists on the disclosure of specific employees' names, HPHC would appreciate the opportunity to review this matter further with the Bureau as it believes that there are important countervailing reasons for continuing the current practice, which has previously been reviewed by the Bureau of Insurance during past periodic examinations of HPHC without objection.

HPHC respectfully requests that the Bureau find either no violation of Chapter 850, § 9 (C)(l)(b) or mitigating circumstances that support no further action by the Bureau on the finding.

Finding #4

The Examiners identified one (1) of 43 appeal files as possible violations of Chapter 850, §9C(l)(a) of the Maine Insurance Rule. Specifically, the Company did not issue a decision within 20 days, as required by this statute.

Finding #4: Recommended Change

HPHC respectfully recommends that the above finding be revised to conclude that there was no violation of Chapter 850, § 9(c)(l)(a) based on the corrective action taken by its vendor, UBH.

With respect to this finding, a single appeal was not processed within the required 20-day period. HPHC's behavioral health vendor, UBH, self-identified this oversight at the time, which was the result of human error, and in response overturned the claims denial at issue and authorized the additional requested services. Therefore, there was ultimately no "denial" of the claim.

HPHC contends that the reason for the appeal was ultimately rendered moot by UBH's subsequent reversal of the initial benefit denial on service recovery grounds. (This reversal occurred even though the initial denial on the grounds of benefit exhaustion was proper).

While HPHC understands the finding with respect to the failure to meet the initial 20 working day time frame, it suggests that its vendor's contemporaneous corrective steps to address the situation should be considered within the broader intent of Chapter 850.

HPHC therefore respectfully requests that the finding be revised to conclude that while the 20-day deadline for the issuance of a single appeals decision was missed there was no violation of Chapter 850, § 9 (C)(l)(a) because of the corrective actions taken at the time.

Finding #5

The Examiners identified two (2) of 43 appeal files as possible violations of Chapter 850, Section 9 C(1) (b) of the Maine Insurance Rule. Specifically, the adverse determination letter did not disclose the description of the process to obtain a Second Level grievance review.

Finding #5: Recommended Change

HPHC respectfully recommends that the above finding be revised to conclude that there were either mitigating circumstances or excusable human error with respect to two adverse determination letters that omitted information on the second-level grievance review process.

With respect to one adverse determination letter (Appeal Sample 20), HPHC omitted information on the availability of a second-level appeal in direct response to the member's representative. The case involved the denial of an expedited appeal. The representative explicitly declined a second-level clinical review and stated her desire to go directly to MaineCare, which was reflected in the case file. In fact, an earlier draft of the decision letter included information on the second-level appeal process, which was also documented. The subsequent removal of the second-level appeal information was in direct response to the representative's stated desire under the specific circumstances in a single case.

Chapter 850, 9(C)(l)(b), like any law or regulation, must be applied to the facts of a given situation. The facts surrounding Appeal Sample 20 illustrate that there was not a violation of

Chapter 850 or, at a minimum, that there were mitigating circumstances. HPHC respectfully requests that no violation be found in relation to this claim sample.

With respect to the other adverse benefit determination letter (Appeal Sample 21), HPHC acknowledges that a reference to the second-level appeal was inadvertently omitted from the appeal decision letter. This was a result of simple human error. HPHC accepts responsibility for this error. However, in light of the isolated nature of this error, HPHC respectfully requests that the Bureau refrain from further action in response to it.

Conclusion

In summary, HPHC appreciates the opportunity to recommend several changes to the above findings set forth in the draft Market Conduct Examination Report sent to it on November 12, 2010 by RSM McGladrey.

The examination involved a wide ranging review into compliance by HPHC and its vendor with Maine's mental health parity law as well as many other requirements involving claims handling, utilization review and pre-authorization, complaints, appeals and grievances, and policyholder services.

HPHC recognizes that there are opportunities for improvement presented by the Report. However, HPHC believes that the issues identified by the examiners generally represent isolated incidents resulting predictably from human error as opposed to systematic problems with its administrative procedures. HPHC respectfully requests that the Bureau reach a similar conclusion and that further action, if any, reflect this.

Please feel free to contact me with any further questions or comments. Thank you again.

Sincerely,

Matthew H. Herndon
Senior Associate General Counsel

cc: Kendra Godbout, BOI (via email)
Barry Wells, RSM (via email)
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