REPORT OF MARKET CONDUCT EXAMINATION

Maine Community Health Options

150 Mill Street, Suite 3
Lewiston, Maine 04240

NAIC Company Code 15077

NAIC Examination Tracking System Number ME114-4

Examination Period:

October 1, 2017 through September 30, 2018

January 27, 2021

Honorable Eric A. Cioppa
Superintendent
Maine Bureau of Insurance
34 State House Station
Augusta, ME 04333-0034

Dear Superintendent Cioppa:

Pursuant to 24-A M.R.S. §§ 211 and 221(5), and in accordance with your instructions, a regularly scheduled targeted market conduct examination (Examination) has been made of:

Maine Community Health Options

The Examination reviewed certain of Maine Community Health Options' (Company) Maine appeal handling practices and claim denials for the Accident and Health line of business. The Examination covered the period from October 1, 2017 through September 30, 2018 (Review Period). The Maine Bureau of Insurance (Bureau) staff conducted the on-site phase of the Examination from August 12, 2019, through August 23, 2019 at the Company's offices located at 150 Mill Street, Suite 3, Lewiston, Maine. Additional examination work conducted at the Bureau included preliminary review of information provided by the Company, transactional testing, and follow-up communications.

The following report is respectfully submitted.

Mary Masi

Mary T. Masi, CPCU, CIE, MCM

Pursuant to 24-A M.R.S. §§ 211 and 221(5), I have caused a regularly scheduled targeted market conduct examination to be conducted of Maine Community Health Options. I hereby accept this Report of Examination and make it an official record of the Bureau of Insurance.

Eric A Cioppa

Honorable Eric A. Cioppa

1/29/2021

Date

Superintendent
Maine Bureau of Insurance

TABLE OF CONTENTS

COMPANY PROFILE

The Company was incorporated in the State of Maine on September 26, 2011, and commenced writing and issuing polices effective January 1, 2014. Per the 2018 Management's Discussion and Analysis report, the Company, a Consumer Operated and Oriented Plan (CO-OP) organized under Section 1322 of the Patient Protection and Affordable Care Act, as amended, completed its fifth full year of operation at the end of December 31, 2018. Domiciled in the State of Maine, the company is a nonprofit, member-led health plan providing comprehensive health insurance benefits to individuals, families, and businesses with its home office located in Lewiston, Maine.

The Company's products are primarily marketed to individual, small group and large group health insurance markets in Maine. Although it is also licensed in New Hampshire, it is currently only active in Maine.

The Company offers coverage on and off the Federally Facilitated Marketplace. On October 2, 2017, the health maintenance organization (HMO) line of business was added to the Company's certificate of authority, and on January 1, 2018 the Company wrote its first HMO policies. Prior to 2018, the Company only offered preferred provider organization (PPO) products.

The Company became licensed in New Hampshire on May 27, 2014 and began offering health insurance products for individuals and groups effective January 1, 2015. In October of 2016, the Company withdrew from the New Hampshire market to focus on its primary market in Maine. A small number of New Hampshire group policies remained on the books during 2017, after renewing in 2016 and remaining in effect until the end of their policy periods. The Company has retained its license in New Hampshire but as of September 30, 2018, the end of the review period, the Company wrote business solely in Maine.

The Company's 2018 Maine Annual Report Supplement (Rule 945) reflects that there were 50,052 covered lives[1] in force as of December 31, 2018, and the Company's 2017 Maine Annual Report Supplement (Rule 945) reflects that there were 38,134 covered lives[2] in force as of December 31, 2017. The Rule 945 Reports also reflect that the Company realized over $381 million and $258 million in total revenues in 2017 and 2018, respectively.

[1] See, http://www.maine.gov/pfr/insurance/publications_reports/yearly_reports/rule945/rule945_reports.html.
[2] See, http://www.maine.gov/pfr/insurance/publications_reports/yearly_reports/rule945/rule945_reports.html.

EXECUTIVE SUMMARY

In 2009, 24-A M.R.S. § 221 was amended with the addition of subsection 5. Subsection 5, Examination of Health Carriers, states in its entirety that "[t]he superintendent shall examine the market conduct of each domestic health carrier, as defined in section 4301-A, subsection 3, and each foreign health carrier with at least 1,000 covered lives in this State, offering a health plan as defined in section 4301-A, subsection 7, no less frequently than once every 5 years. An examination under this subsection may be comprehensive or may target specific issues of concern observed in the State's health insurance market or in the company under examination. In lieu of an examination conducted by the superintendent, the superintendent may participate in a multistate examination, or, in the case of a foreign company, approve an examination by the company's domiciliary regulator upon a finding that the examination and report adequately address relevant aspects of the company's market conduct within this State."

This examination was called as a statutorily required examination.

The examination was a targeted examination of the Company's Accident and Health product line focusing on whether the Company is complying with certain provisions of Maine Bureau of Insurance Rule 850. Rule 850 sets forth certain rights and protections available to individuals who are insured by health plans in Maine. During the planning stage of the examination, the scope was narrowed so that the examiners tested the Company's compliance with sections 8 and 9 of Rule 850 only for adverse healthcare treatment decisions and adverse benefit determinations that were upheld. Accordingly, adverse healthcare treatment decisions and adverse benefit determinations that were overturned on appeal were not reviewed. The scope and methodology of the examination, therefore, involved the use of targeted subpopulations.

Sections 8 and 9 of Rule 850 list the required notices that must be sent to Maine consumers with all adverse healthcare treatment decisions and adverse benefit determinations, which include adverse appeal decision letters. These notices ensure, among other things, that Maine consumers are provided with specific instructions on how to proceed with an appeal of an adverse decision and that they are made aware of their rights to appeal, to contact the Bureau of Insurance, to proceed with an external review of a carrier's adverse appeal decision, and to file a complaint against their health insurer. Due to the scope and methodology of the examination, no overturned appeals were reviewed. An appeal decision that overturns the original treatment or benefit denial is not an adverse action. These sections of Rule 850 also describe the requirements that are the responsibilities of the insurers who will be conducting first and second level appeal reviews. As more fully detailed in the body of this report, the examiners tested the Company's compliance with sections 8 and 9 of Rule 850, applicable to the targeted subpopulation, by reviewing 225 files.

Two categories of standard appeals were tested: those involving health care treatment decisions (HC) and those not involving health care treatment decisions (NHC). Each group includes both level one appeals (L1) and level two appeals (L2). Expedited appeals involving situations where the timeframe applicable to standard appeals would have seriously jeopardized the life or health of the covered person were also tested. In addition to the standard and expedited appeals, the examiners reviewed the Company's initial adverse benefit determinations (claim denials) that did not involve medical issues by reviewing their explanations of benefits (EOBs).

For tests 1 – 5, the Company identified the initial universe of files for each segment of the review, which included all adverse healthcare treatment decisions and adverse benefit determinations (both upheld and overturned on appeal). These files demonstrated that the Company handled a total of 394 L1HC appeals, 49 L2HC appeals, 426 L1NHC appeals, 37 L2NHC appeals, and 127 expedited appeals during the Review Period, including those handled by the Company's pharmacy benefit manager. For purposes of this exam, however, the examiners' target population excluded their pharmacy benefit manager's handling of pharmacy-related claims. Pharmacy-related claims are not included in any subsequent discussion in this report.

During the Review Period, the Company used two different TPAs for processing level 1 appeals of medical necessity determinations, depending on the medical issue. The files of these TPAs were included in the subpopulations from which the examiners drew their samples. From December 22, 2017 through October 31, 2018, eviCore processed level 1 appeals of their own medical necessity determinations for advanced imaging, cardiac imaging, interventional pain management, joint surgery, spine surgery, chiropractic treatment, physical therapy, speech therapy, occupational therapy, obstetric ultrasounds and non-obstetric ultrasounds. After October 31, 2018, the Company assumed most level 1 appeal processing responsibilities, but eviCore continued to process level 1 appeals of medical necessity determinations for advanced imaging, cardiac imaging, interventional pain management, joint surgery, spine surgery and non-obstetric ultrasounds until December 31, 2018. Prior to taking over some of the level 1 appeals, the Company would process appeals for eviCore's determinations on a case-by-case basis. Behavioral HealthCare Program began processing level 1 appeals of medical necessity determinations relating to behavioral health services beginning October 15, 2014 and continuing to the present. The universe of non-pharmacy claims handled by the Company and these TPAs included 281 L1HC appeals, 37 L2HC appeals, 408 1NHC appeals, 30 2NHC appeals and 20 expedited appeals.

From the initial universe of files identified by the Company for each segment of the review, which included all adverse healthcare treatment decisions and adverse benefit determinations (both upheld and overturned on appeal), the examiners eliminated those files in which the Company overturned the underlying adverse healthcare treatment decision or adverse benefit determination. This resulted in targeted subpopulations for review. Thus, removal of the overturned appeal decisions left the examiners with targeted subpopulations that represented 43.3% (123) of the total L1HC appeals, 51.4% (19) of the total L2HC appeals, 38.5% (157) of the total L1NHC appeals, 66.7% (20) of the total L2NHC appeals, and 30.0% (6) of the total expedited appeals. It was from these targeted subpopulations that the examiners drew their samples, if necessary.

The total universe of files for Test 6 included all adverse benefit determinations not involving medical issues after the examiners eliminated the files that were coded as duplicates, involved non-members or unknown persons, or the coverage lapsed due to non-payment of premium. Based on the universe sizes of the targeted subpopulations, random samples were selected and reviewed for Tests 1 and 3, while all of the files were reviewed for Tests 2, 4, and 5. For Test 6, a random sample of the total universe of files was selected and reviewed.

The examiners found that the Company was responsive to Bureau requests and comments and provided meaningful feedback to the written criticisms issued by the examiners. The written criticisms, commonly

referred to as "Crits," are the means by which the examiners notified the Company of potential violations of Rule 850 noted during the Examination.

As explained, the examiners tested compliance with sections 8 and 9 of Rule 850, as applicable, only for those appeals in which the Company upheld the underlying adverse healthcare treatment decision or adverse benefit determination. Overall, the examiners found that for the files examined the Company was not compliant with all the applicable subsections of Bureau Rule 850 in its handling of adverse appeals or with its written notices for adverse benefit determinations.

Some tests were marked "n/a" because that subsection of Rule 850 did not apply to the reviewed files. For example, some reasons for claim denials do not involve specific plan provisions, therefore, the provision of 850 requiring a denial notice to include reference to a specific plan provision did not apply to the sample file being tested. Additionally, some of the subtests applied to certain of the files being reviewed but not to others.

The Company utilizes a form entitled "Appeal Rights and Information," which accompanies all adverse healthcare treatment decisions and adverse benefit determinations. Given the nature of this exam, where this form did not include language required by a test, all sample files necessarily failed that test because each sample file included the same form. The exam findings note when this occurred.

SCOPE OF EXAMINATION

The objective of the Examination was to review adverse appeal files and denied claims for the Company's Accident and Health product line to determine compliance with Rule 850 using transactional testing.[1] The scope of the examination evaluated the Company's compliance with sections 8 and 9 of Rule 850 for adverse healthcare treatment decisions and adverse benefit determinations that were upheld.[2] Adverse healthcare treatment decisions and adverse benefit determinations that the Company overturned on appeal were not reviewed.

The examination was conducted in accordance with 24-A M.R.S. §§ 211, 221 and 223. It was conducted in a manner that was consistent with the standards set forth in the National Association of Insurance Commissioners' Market Regulation Handbook, 2018 ed. (The Handbook) as required by 24-A M.R.S. § 223(2). The Handbook was used for purposes of sample determination and overall guidance. Some unacceptable or non-compliant practices may not have been discovered in the course of the Examination. Failure to identify or comment on specific practices does not constitute the Bureau's approval of such practices.

This report is by test rather than by exception. Each test applied is stated, and the results are reported. The Handbook has established a benchmark error rate of 7 percent for auditing claim practices. Error rates exceeding this benchmark are presumed to indicate a general business practice.

[1] Transactional testing is the review of actual appeals.

[2] It was from these targeted subpopulations of denied appeals that the examiners drew their samples. The majority of the requirements of Rule 850 being tested only apply to adverse appeal decisions. Thus, the adverse healthcare treatment decision and adverse benefit determination required notices are the elements of Test 1, subsections 4 – 11; Test 2, subsections 4 – 11; Test 3, subsections 3 – 10; Test 4, subsections 5 – 11; and Test 5, subsections 6 – 13.

METHODOLOGY

Using the standards set forth in the Handbook as guidance in accordance with 24-A M.R.S. § 223(2), the examiners reviewed the Company's handling of certain adverse appeal files and denied claims to evaluate compliance with the applicable requirements of Rule 850. All files reviewed were initiated during the Review Period of October 1, 2017 through September 30, 2018. Targeted subpopulations of files were used in the examination, exclusive of Test 6. Thus, from the total universe of files provided by the Company, the examiners first excluded files handled by the Company's pharmacy benefit manager from all populations and then excluded files where the Company overturned prior denials from the appeals populations. For Tests 1 through 5, either a random sample of files was selected and reviewed from the targeted subpopulation or, in some circumstances, all of the files in the targeted subpopulation were reviewed.[1] A random sample of the total universe of files for Test 6 was selected and reviewed, after excluding from the population files that were denied for the following reasons: coverage lapsed due to non-payment of premium, patient cannot be identified, duplicate claim, and claim incurred outside of coverage period.

[1] Random samples of the applicable files were drawn for Tests 1, 3, and 6; all of the applicable files were used for Tests 2, 4, and 5.

FINDINGS

The data and findings in Tests 1 – 5 below are limited to the review of the Company's compliance with the applicable portions of sections 8 and 9 of Rule 850 for adverse healthcare treatment decisions and adverse benefit determinations that were upheld. This report does not include a review of the handling of appeals that were overturned by the Company.

1. Claims –1st Level Adverse Health Care Treatment Decisions

Standard: All adverse health care treatment decisions denying benefits to a covered person are subject to the appeals procedures set forth in subsections 8(G) and 8(G-1).

Bureau Rule Chapter 850 § 3(A)

A. **TEST 1**: Did the Company comply with the subsections of Rule 850 § 8 that are applicable to Level 1 appeals involving adverse health care treatment decisions?

B. **REVIEW PROCESS**: A random sample of 60 files from the targeted subpopulation was reviewed. Three of the original sample files were replaced because one should have been coded as a level one appeal not involving an adverse health care treatment decision, one was within New Hampshire's jurisdiction, and one file was processed as an appeal in error.

C. **RESULTS BY TEST SUBSECTION**:

Subsection 1: Did the health carrier provide the following in compliance with 850 § 8(G)(1)(a)?

Note: To pass this test all of the following elements must be met.

a. Were the rights in 850 § (8)(G)(1)(a) made known to the covered person within 3 working days after receiving an appeal request?

Result: 93.3% compliance

b. Did the notice state that the carrier will give the covered person the opportunity to review the claim file and present evidence and testimony as part of the internal appeals process?

Result: 0% compliance

c. Did the notice state that the carrier will provide the covered person, free of charge, any new or additional evidence considered, relied upon, or generated by the carrier (or at the direction of the carrier) in connection with the claim; and will provide such evidence as soon as possible and sufficiently in advance of the decision to give the covered person a reasonable opportunity to respond?

Result: 0% compliance

d. Did the notice state that, prior to issuing a final internal adverse benefit determination based on a new or additional rationale, the carrier will provide the covered person with the rationale, free of charge, sufficiently in advance of the decision to allow a reasonable opportunity to respond?

Result: 0% compliance

e. Did the notice provide the name, address and telephone number of a person designated to coordinate the appeal on behalf of the health carrier?

Result: 56.7% compliance

Subsection 1 Result: 0% compliance

Note: The Company's "Appeals Rights and Information" form did not include all of the required rights in 850 § (8)(G)(1)(a). These omissions impacted subsections 1.b, c, and d.

Subsection 2: Was the appeal evaluated by an appropriate clinical peer or peers as required by 850 § 8(G)(1)(b)?

Result: 95% compliance

Subsection 3: For standard appeals, did the health carrier or the carrier's designated URE notify in writing both the covered person and the attending or ordering provider of the decision within 30 days following the request for an appeal? If additional time was permitted under 850 § 8(G)(1)(c): Did the carrier provide written notice of the delay to the covered person explaining the reason for the delay? Was the decision issued within 30 days after the carrier's or designee's receipt of all necessary information?

Result: 93.3% compliance

Subsection 4: Did the adverse appeal decision contain the names, titles and qualifying credentials of the person or persons evaluating the appeal? 850 § 8(G)(1)(c)(i)

Result: 91.7% compliance

Subsection 5: Did the adverse appeal decision contain a statement of the reviewers' understanding of the reason for the covered person's request for an appeal? 850 § 8(G)(1)(c)(ii)

Result: 85% compliance

Subsection 6: Did the adverse appeal decision reference the specific plan provisions upon which the decision is based? 850 § 8(G)(1)(c)(iii)

Result: 98.3% compliance

Subsection 7: Did the adverse appeal decision contain the reviewers' decision in clear terms and the clinical rationale in sufficient detail for the covered person to respond further to the health carrier's position? 850 § 8(G)(1)(c)(iv)

Result: 100% compliance

Subsection 8: Did the adverse appeal decision contain a reference to the evidence or documentation used as the basis for the decision, including the clinical review criteria used to make the determination? The decision shall include instructions for requesting copies, free of charge, of information relevant to the claim, including any referenced evidence, documentation or clinical review criteria not previously provided to the covered person. Where a covered person had previously submitted a written request for the clinical review criteria relied upon by the health carrier or the carrier's designated URE in rendering its initial adverse decision, the decision shall include copies of any additional clinical review criteria utilized in arriving at the decision.
850 § 8(G)(1)(c)(v)

Result: 95% compliance

Subsection 9: If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, did the adverse appeal decision include either the specific rule, guideline, protocol, or other similar criterion; or a statement referring to the rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse decision and explaining that a copy will be provided free of charge to the covered person upon request? 850 § 8(G)(1)(c)(vi)

Result: 96.6% compliance

Subsection 10: Did the adverse appeal decision contain notice of any subsequent appeal rights, and the procedure and time limitation for exercising those rights? Notice of external review rights must be provided to the enrollee as required by 24-A M.R.S. §4312(3). A description of the process for submitting a written request for second level appeal must include the rights specified in subsection G-1. 850 § 8(G)(1)(c)(vii)

Result: 0% compliance

Note: The Company's "Appeals Rights and Information" form did not include all of the required rights listed in 24-A M.R.S. § 4312(3). As this form is used for all types of appeals, this omission also affected the compliance with Test 2 subsection 10 and Test 5 subsection 12.

Subsection 11: Did the adverse appeal decision contain notice of the covered person's right to contact the Superintendent's office? The notice shall contain the toll-free telephone number, website address, and mailing address of the Bureau of Insurance. 850 § 8(G)(1)(c)(ix)

Result: 100% compliance

Finding 1

The Company did not comply with all the applicable subsections of Bureau Rule 850 § 8 in its handling of first level appeals involving adverse health care treatment decisions that were upheld.

2. Claims – 2nd Level Appeals of Adverse Health Care Treatment Decisions

Standard: All adverse health care treatment decisions denying benefits to a covered person are subject to the appeals procedures set forth in subsections 8(G) and 8(G-1).

Bureau Rule Chapter 850 § 3(A)

A. TEST 2: Did the Company comply with the subsections of Rule 850 § 8 that are applicable to Level 2 appeals involving adverse health care treatment decisions?

B. REVIEW PROCESS: The total universe of 20 files from the targeted subpopulation was reviewed, which included one appeal file that was added to the population during the exam once the examiners saw it had been incorrectly identified by the company as an adverse benefit determination that did not involve a health care treatment decision.

C. RESULTS BY TEST SUBSECTION:

Subsection 1: Did the health carrier's review panel include one or more panelists who are disinterested clinical peers? 850 § 8(G-1)(2)

Result: 100% compliance

Subsection 2: If the covered person requested the opportunity to appear in person, was the review meeting held within 45 days of receiving the request for the second level review? 850 § 8(G-1)(3)

Result: 100% compliance

Subsection 3: Did the health carrier's review panel issue a written decision to the covered person within 5 working days after completing the review meeting? 850 § 8(G-1)(3)(f)

Result: 100% compliance

Subsection 4: Did the adverse appeal decision contain the names, titles and qualifying credentials of the person or persons evaluating the appeal? 850 § 8(G)(1)(c)(i)

Result: 95% compliance

Subsection 5: Did the adverse appeal decision contain a statement of the reviewers' understanding of the reason for the covered person's request for an appeal? 850 § 8(G)(1)(c)(ii)

Result: 80% compliance

Subsection 6: Did the adverse appeal decision contain a reference to the specific plan provisions upon which the decision is based? 850 § 8(G)(1)(c)(iii)

Result: 100% compliance

Subsection 7: Did the adverse appeal decision contain the reviewers' decision in clear terms and the clinical rationale in sufficient detail for the covered person to respond further to the health carrier's position? 850 § 8(G)(1)(c)(iv)

Result: 100% compliance

Subsection 8: Did the adverse appeal decision contain a reference to the evidence or documentation used as the basis for the decision, including the clinical review criteria used to make the determination? The decision shall include instructions for requesting copies, free of charge, of information relevant to the claim, including any referenced evidence, documentation or clinical review criteria not previously provided to the covered person. Where a covered person had previously submitted a written request for the clinical review criteria relied upon by the health carrier or the carrier's designated URE in rendering its initial adverse decision, the decision shall include copies of any additional clinical review criteria utilized in arriving at the decision. 850 § 8(G)(1)(c)(v)

Result: 100% compliance

Subsection 9: Did the adverse appeal decision contain the identification of or a statement referring to any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination, and an explanation that a copy (of the rule, guideline, protocol or other similar criterion) will be provided free of charge to the covered person upon request? 850 § 8(G)(1)(c)(vi)

Result: 100% compliance

Subsection 10: Did the adverse appeal decision contain a notice of external review rights as required by 24 A M.R.S. §4312(3)? The notice must include the following:

A. A description of the external review procedure and the requirements for making a request for external review;

B. A statement informing an enrollee how to request assistance in filing a request for external review from the carrier; and

C. A statement informing an enrollee of the right to attend the external review, submit and obtain supporting material relating to the adverse health care treatment decision under review, ask questions of any representative of the carrier and have outside assistance; and D. A statement informing an enrollee of the right to seek assistance or file a complaint with the bureau and the toll-free number of the bureau. 850 § 8(G)(1)(c)(vii)

Result: 0% compliance

Note: The Company's "Appeals Rights and Information" form did not include all of the required rights listed in 24-A M.R.S. § 4312(3). As this form is used for all types of appeals, this omission also affected the compliance with Test 1 subsection 10 and Test 5 subsection 12.

Subsection 11: Did the adverse appeal decision contain notice of the covered person's right to contact the Superintendent's office? The notice shall contain the toll-free telephone number, website address, and mailing address of the Bureau of Insurance. 850 § 8(G)(1)(c)(ix)

Result: 100% compliance

Finding 2

The Company did not comply with all the applicable subsections of Bureau Rule 850 § 8 in its handling of second level appeals involving adverse health care treatment decisions that were upheld.

3. Claims – 1st Level Appeals of Adverse Benefit Determinations

Standard: All requests for review of "adverse benefit determinations," other than "health care treatment decisions," are subject to the grievance review procedures set forth in section 9.

Bureau Rule Chapter 850 § 3(A)

A. **TEST 3**: Did the Company comply with the subsections of Rule 850 § 9 that are applicable to Level 1 appeals of adverse benefit determinations that did not involve health care treatment decisions?

B. **REVIEW PROCESS:** A random sample of 60 files from the targeted subpopulation was reviewed. Two of the original sample files were replaced because both were New Hampshire jurisdiction.

C. **RESULTS BY TEST SUBSECTION**:

Subsection 1: Did the health carrier inform the covered person within 3 working days after receiving a grievance of the following: the name, address and telephone number of a person designated to coordinate the grievance review on behalf of the health carrier and the right to submit written material to the reviewer? 850 § 9(B)(2)

Result: 96.7% compliance

Subsection 2: Did the health carrier issue a written decision to the covered person within 30 days after receiving a grievance? If additional time was permitted under 850 § 9(B)(2)(a): Did the carrier provide written notice of the delay to the covered person explaining the reason for the delay? Was the decision issued within 30 days after the carrier's or designee's receipt of all necessary information?

Result: 88.3% compliance

Subsection 3: Did the adverse appeal decision contain the names, and titles of the person or persons participating in the first level grievance review process (the reviewers)? 850 § 9(B)(2)(b)(i)

Result: 100% compliance

Subsection 4: Did the adverse appeal decision contain a statement of the reviewers' understanding of the covered person's grievance and all pertinent facts? 850 § 9(B)(2)(b)(ii)

Result: 78.3% compliance

Subsection 5: Did the adverse appeal decision contain a reference to the specific plan provisions on which the benefit determination is based? 850 § 9(B)(2)(b)(iii)

Result: 81.5% compliance

Subsection 6: Did the adverse appeal decision contain the reviewers' decision in clear terms, including the specific reason or reasons for the adverse benefit determination? 850 § 9(B)(2)(b)(iv)

Result: 98.3% compliance

Subsection 7: Did the adverse appeal decision contain a reference to the evidence or documentation used as the basis for the decision? The decision shall include instructions for requesting copies, free of charge, of all documents, records and other information

relevant to the claim, including any referenced evidence or documentation not previously provided to the covered person. 850 § 9(B)(2)(b)(v)

Result: 97.7% compliance

Subsection 8: Did the adverse appeal decision contain the identification of or a statement referring to an internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse benefit determination, did the appeal decision include either the specific rule, guideline, protocol, or other similar criterion; or a statement referring to the rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination and explaining that a copy will be provided free of charge to the covered person upon request? 850 § 9(B)(2)(b)(vi)

Result: 97.6% compliance

Subsection 9: Did the adverse appeal decision contain a description of the process to obtain a second level grievance review of a decision, the procedures and time frames governing a second level grievance review, and the rights specified in subparagraph (C)(3)(c)? 850 § 9(B)(2)(b)(vii)

Result: 100% compliance

Subsection 10: Did the adverse appeal decision contain notice of the covered person's right to contact the Superintendent's office? The notice shall contain the toll-free telephone number, website address, and mailing address of the Bureau of Insurance. 850 § 9(B)(2)(b)(ix)

Result: 100% compliance

Finding 3

The Company did not comply with all the applicable subsections of Bureau Rule 850 § 9 in its handling of first level appeals of adverse benefit determinations that did not involve health care treatment decisions that were upheld.

4. Claims – 2nd Level Appeals of Adverse Benefit Determinations

Standard: All requests for review of "adverse benefit determinations," other than "health care treatment decisions," are subject to the grievance review procedures set forth in section 9.

Bureau Rule Chapter 850 § 3(A)

A. TEST 4: Did the Company comply with the subsections of Rule 850 § 9 that are applicable to Level 2 appeals of adverse benefit determinations that did not involve health care treatment decisions?

B. REVIEW PROCESS: The total universe of 20 files from the targeted subpopulation was reviewed, however one of those was eliminated because it was an adverse health care treatment decision leaving the examiners with 19 files.

C. RESULTS BY TEST SUBSECTION:

Subsection 1: Did the health carrier provide adequate notice to the covered person that s/he has the option to appear in person before the carrier? 850 § 9(C)(1)

Result: 94.7% compliance

Subsection 2: Did the health carrier appoint a second level grievance review panel for each grievance subject to review under this subsection? A majority of the panel shall consist of employees or representatives of health carrier who were not previously involved in the grievance. 850 § 9(C)(2)

Result: 100% compliance

Subsection 3: If the covered person requested the opportunity to appear in person, was the review meeting held within 45 days of receiving the request for the second level review? 850 § 9(C)(3)(a)

Result: 33.3% compliance

Subsection 4: Did the health carrier's review panel issue a written decision to the covered person within 5 working days after completing the review meeting? 850 § 9(C)(3)(f).

Result: 100% compliance

Subsection 5: Did the adverse appeal decision contain the names, and titles of the person or persons participating in the first level grievance review process (the reviewers)? 850 § 9(B)(2)(b)(i)

Result: 100% compliance

Subsection 6: Did the adverse appeal decision contain a statement of the reviewers' understanding of the covered person's grievance and all pertinent facts? 850 § 9(B)(2)(b)(ii)

Result: 94.7% compliance

Subsection 7: Did the adverse appeal decision contain a reference to the specific plan provisions on which the benefit determination is based? 850 § 9(B)(2)(b)(iii)

Result: 50% compliance

Subsection 8: Did the adverse appeal decision contain the reviewers' decision in clear terms, including the specific reason or reasons for the adverse benefit determination? 850 § 9(B)(2)(b)(iv)

Result: 100% compliance

Subsection 9: Did the adverse appeal decision contain a reference to the evidence or documentation used as the basis for the decision? The decision shall include instructions for requesting copies, free of charge, of all documents, records and other information relevant to the claim, including any referenced evidence or documentation not previously provided to the covered person. 850 § 9(B)(2)(b)(v)

Result: 100% compliance

Subsection 10: Did the adverse appeal decision contain identification of or a statement referring to any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse benefit determination, and an explanation that a copy (of the rule, guideline, protocol or other similar criterion) will be provided free of charge to the covered person upon request? 850 § 9(B)(2)(b)(vi)

Result: 100% compliance

Subsection 11: Did the adverse appeal decision contain notice of the covered person's right to contact the Superintendent's office? The notice shall contain the toll-free telephone number, website address, and mailing address of the Bureau of Insurance. 850 § 9(B)(2)(b)(ix)

Result: 94.7% compliance

Finding 4

The Company did not comply with all the applicable subsections of Bureau Rule 850 § 9 in its handling of second level appeals of adverse benefit determinations that did not involve health care treatment decisions that were upheld.

5. Claims – Expedited Appeals of Adverse Health Care Treatment Decisions

Standard: All adverse health care treatment decisions denying benefits to a covered person are subject to the appeals procedures set forth in subsections 8(G) and 8(G-1).

Bureau Rule Chapter 850 § 3(A)

A. **TEST 5**: Did the Company comply with the subsections of Rule 850 § 8 that are applicable to expedited appeals involving adverse health care treatment decisions?

B. **REVIEW PROCESS**: The total universe of 6 files from the targeted subpopulation was reviewed, however one of those was eliminated because it was not a situation where Rule 850 would require expedited treatment.

C. **RESULTS BY TEST SUBSECTION**:

Subsection 1: Was the expedited appeal evaluated by an appropriate clinical peer or peers as required by 850 § 8(G)(2)(a)?

a. The clinical peers shall not have been involved in the initial adverse determination, unless the appeal presents additional information the decision maker was unaware of at the time of rendering the initial adverse health care treatment decision.

b. The clinical peer may not be a subordinate of a clinical peer involved in the prior decision.

Result: 100% compliance

Subsection 2: Did the carrier or the carrier's designated URE provide expedited review to all requests concerning an admission, availability of care, continued stay or health care service for a covered person who had received emergency services but had not been discharged from a facility? 850 § 8(G)(2)(b)

Result: n/a

Subsection 3: Was all necessary information, including the decision, transmitted between the health carrier or the carrier's designated URE and the covered person or the provider acting on behalf of the covered person by telephone, facsimile, electronic means or the most expeditious method available? 850 § 8(G)(2)(c)

Result: 100% compliance

Subsection 4: Did the carrier or the carrier's designated URE make a decision and notify the covered person and the provider acting on behalf of the covered person via telephone as expeditiously as the covered person's medical condition requires, but in no event more than 72 hours after the review was initiated? If the expedited review was a concurrent review determination of emergency services under subsection H of this section or of an initially authorized admission or course of treatment, was the service continued without liability to the covered person until the covered person was notified of the decision? 850 § 8(G)(2)(d)

Result: 100% compliance

Subsection 5: If the initial notification was not in writing, did the carrier or the carrier's designated URE provide written confirmation of its decision concerning an expedited review within 2 working days after providing notification of the decision? 850 § 8(G)(2)(e)

Result: n/a

Subsection 6: Did the adverse appeal decision contain the names, titles and qualifying credentials of the person or persons evaluating the appeal? 850 § 8(G)(1)(c)(i)

Result: 100% compliance

Subsection 7: Did the adverse appeal decision contain a statement of the reviewers' understanding of the reason for the covered person's request for an appeal? 850 § 8(G)(1)(c)(ii)

Result: 100% compliance

Subsection 8: Did the adverse appeal decision reference the specific plan provisions upon which the decision is based? 850 § 8(G)(1)(c)(iii)

Result: 100% compliance

Subsection 9: Did the adverse appeal decision contain the reviewers' decision in clear terms, and the clinical rationale in sufficient detail for the covered person to respond further to the health carrier's position? 850 § 8(G)(1)(c)(iv)

Result: 100% compliance

Subsection 10: Did the adverse appeal decision contain a reference to the evidence or documentation used as the basis for the decision, including the clinical review criteria used to make the determination; and Instructions for requesting copies, free of charge, of information relevant to the claim, including any referenced evidence, documentation or clinical review criteria not previously provided to the covered person If a written

request for the clinical review criteria had previously been submitted, did the decision include copies of any additional clinical review criteria utilized in arriving at the decision? 850 § 8(G)(1)(c)(v)

Result: 100% compliance

Subsection 11: Did the adverse appeal decision contain the identification of or a statement referring to any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination, and an explanation that a copy (of the rule, guideline, protocol or other similar criterion) will be provided free of charge to the covered person upon request? 850 § 8(G)(1)(c)(vi)

Result: 100% compliance

Subsection 12: Did the adverse appeal decision contain notice of any subsequent appeal rights, and the procedure and time limitation for exercising those rights? Notice of external review rights must be provided to the enrollee as required by 24-A M.R.S. §4312(3). A description of the process for submitting a written request for second level appeal must include the rights specified in subsection G-1. 850 § 8(G)(1)(c)(vii)

Result: 0% compliance

Note: The Company's "Appeals Rights and Information" form did not include all of the required rights listed in 24-A M.R.S. § 4312(3). As this form is used for all types of appeals, this omission also affected the compliance with Test 1 subsection 10 and Test 2 subsection 10.

Subsection 13: Did the adverse appeal decision contain notice of the covered person's right to contact the Superintendent's office? The notice shall contain the toll-free telephone number, website address, and mailing address of the Bureau of Insurance. 850 § 8(G)(1)(c)(ix)

Result: 100% compliance

Finding 5

The Company did not comply with all the applicable subsections of Bureau Rule 850 § 8 in its handling of Expedited appeals involving adverse health care treatment decisions that were upheld.

6. Claims – Adverse Benefit Determinations (Denials)

Standard: For any adverse benefit determination that does not involve medical issues, the carrier shall provide written notice that includes the information required [by § 9(A)(1) through § 9(A)(11)].

Bureau Rule Chapter 850 § 9(A)

A. TEST 6: Did the Company comply with Rule 850 § 9 when issuing its written notices of adverse benefit determinations not involving medical issues?

B. REVIEW PROCESS: A random sample of 60 files from the total universe was reviewed.

C. RESULTS BY TEST SUBSECTION:

Subsection 1: Did the health carrier's written adverse notification include the principal reason or reasons for the determination? 850 § 9(A)(1)

Result: 95% compliance

Subsection 2: Did the adverse notice include reference to the specific plan provisions on which the determination is based? 850 § 9(A)(2).

Result: 85.2% compliance

Subsection 3: Did the adverse notice include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount if applicable), and a statement that the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, will be provided upon request? 850 § 9(A)(3)

Result: 0% compliance

Subsection 4: Did the adverse notice include a description of any additional material or information necessary for the covered person to perfect the claim and an explanation as to why such material or information is necessary? 850 § 9(A)(4)

Result: n/a

Subsection 5: Did the adverse notice include the instructions and time limits for initiating an appeal or reconsideration of the determination? 850 § 9(A)(5)

Result: 100% compliance

Subsection 6: Did the adverse notice include the following information in compliance with 24 A M.R.S. §4303(13): the date of service, provider of the service, an identification of the

service for which the claim is made, any amount the insured is obligated to pay for copayment or coinsurance, a telephone number and address where the insured may obtain clarification of the explanation of benefits, a notice of appeal right, and a notice of the right to file a complaint with the Bureau after exhausting any appeals under the carrier's internal appeals process? 850 § 9(A)(6)

Result: 100% compliance

Subsection 7: Did the adverse notice include identification of or statement referring to any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse benefit determination, and explanation that a copy will be provided free of charge to the covered person upon request? 850 § 9(A)(7)

Result: n/a

Subsection 8: Did the adverse notice include a phone number the covered person may call for information on and assistance with initiating an appeal or reconsideration or requesting review criteria? 850 § 9(A)(8)

Result: 100% compliance

Finding 6

The Company did not comply with all the applicable subsections of Bureau Rule 850 § 9 when issuing its written notices of adverse benefit determinations not involving medical issues.

RECOMMENDATION

The Bureau recommends that the Company enact practices and procedures to ensure compliance with Rule 850. The examiners note that, prior to the issuance of this report, the Company has already begun updating its "Appeal Rights and Information" form and its EOBs to include missing notices that were identified during this exam.

ACKNOWLEDGMENT

The courtesy and hospitality extended by the officers and employees of the Company during the course of the Examination are gratefully acknowledged. The Examination was conducted and is respectfully submitted by the undersigned.

STATE OF MAINE

COUNTY OF KENNEBEC, SS

Mary Masi, CPCU, CIE, MCM, Examiner in Charge, being duly sworn according to law, deposes and says that in accordance with the authority vested in her by Eric A. Cioppa, Superintendent of Insurance, pursuant to the Insurance Laws of the State of Maine, she has made an Examination on the condition and affairs of

Maine Community Health Options

as of September 30, 2018, and that the foregoing report of Examination, subscribed to by her, is true to the best of her knowledge and belief.
The following examiner from the Bureau assisted:

Connie M. Mayette, MCM, AU, AIC, AINS
Market Conduct Managing Examiner

Mary Masi

Mary Masi, CPCU, CIE, MCM
Examiner-in-Charge

Subscribed and sworn to before me
This xx day of Month, Year February 1, 2021

Karma Lombard

Notary Public

My commission expires:

KARMA LOMBARD
Notary Public, Maine
My Commission Expires June 12, 2023

Notarized remotely, in accordance with Executive Order 37 FY 19/20