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Governor

ARUNA MILLER
Lt. Governor

KATHLEEN A. BIRRANE
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TAMMY R. J. LONGAN
Acting Deputy Commissioner

Maryland
INSURANCE ADMINISTRATION

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June 8, 2023

CERTIFIED MAIL/RETURN RECEIPT REQUESTED
REGULAR MAIL/ELECTRONIC MAIL

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Re: *Maryland Insurance Administration v. UnitedHealthcare Ins Co; MAMSI Life and Health Ins Co; UnitedHealthcare of the Mid-Atlantic, Inc.; and Optimum Choice, Inc. (collectively ""UnitedHealthcare")*
Case No.: MIA-2023-06-023

Dear Mr. Ochipinti:

The Maryland Insurance Commissioner has entered an Order taking disciplinary action against your company. A copy of the Order is attached and is self-explanatory. This Order is subject to your right to request a hearing as set forth on the last page of the Order.

Please include the above case number on all future correspondence to the administration. **Payment of administrative penalties must also reference the above case number or include a copy of this letter when making payment.**

If you have any questions regarding this Order, you may contact the Associate Commissioner of Life and Health at 410-468-2215.

Sincerely,

/s/ *Angelique Jones*
Angelique Jones
Hearings & Appeals Coordinator

Enclosure

cc: Tammy R. J. Longan, Acting Deputy Commissioner
David Cooney, Associate Commissioner, Life & Health
Mary Kwei, Associate Commissioner, Market Regulation and Professional Licensing
Robert D. Morrow, VP, Regulatory Affairs-Deputy General Counsel
J. Van Lear Dorsey, Principal Counsel
Brianna Davidson Jarrett, Assistant Attorney General
Craig Ey, Chief, Communications & Public Engagement

BEFORE THE MARYLAND INSURANCE ADMINISTRATION

MARYLAND INSURANCE ADMINISTRATION **200 ST. PAUL PLACE, SUITE 2700** **BALTIMORE, MARYLAND 21202**	*	
vs.	*	
MAMSI LIFE AND HEALTH INSURANCE COMPANY **9800 HEALTH CARE LANE** **MN006-W500** **MINNETONKA MN 55343** **NAIC# 60321**	*	**MIA FILE NO: MIA-2023-06-023**
OPTIMUM CHOICE, INC. **2020 INNOVATION COURT** **WI054-1000** **DE PERE WI 54115** **NAIC# 96940**	*	
UNITEDHEALTHCARE INSURANCE COMPANY **185 ASYLUM AVENUE** **HARTFORD CT 06103** **NAIC# 79413**	*	
UNITEDHEALTHCARE OF THE MID-ATLANTIC, INC. **2020 INNOVATION COURT** **WI054-1000** **DE PERE WI 54115** **NAIC# 95025**	*	

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ORDER

Pursuant to the authority granted in §§ 2-108 and 2-204 of the Insurance Article, Maryland Code Annotated, the Insurance Commissioner for the State of Maryland ("the Commissioner") has determined that MAMSI LIFE AND HEALTH INSURANCE COMPANY ("MLHIC"), OPTIMUM CHOICE, INC. ("OCI"), UNITEDHEALTHCARE

INSURANCE COMPANY ("UHIC"), and UNITEDHEALTHCARE OF THE MID-ATLANTIC, INC. ("UHCMA") (collectively ""UnitedHealthcare") have failed to comply with the Parity Act[1] reporting requirements as provided in § 15-144(c)(1) through (e) of the Insurance Article. UnitedHealthcare has the right to request a hearing regarding the above violation under § 2-210 of the Insurance Article.

I. RELEVANT REGULATORY FRAMEWORK

1. Under § 15-144 of the Insurance Article, certain carriers are required to submit a report to the Commissioner to demonstrate their compliance with the Parity Act. These reports are known as Non-Quantitative Treatment Limitation Analysis Reports ("NQTL reports").

> (c)(1) On or before March 1, 2022, and March 1, 2024, each carrier subject to this section shall:
>
> (i) identify the five health benefit plans with the highest enrollment for each product offered by the carrier in the individual, small, and large group markets; and
>
> (ii) submit a report to the Commissioner to demonstrate the carrier's compliance with the Parity Act.
>
> (2) The report submitted under paragraph (1) of this subsection shall include the following information for the health benefit plans identified under item (1)(i) of this subsection:
>
> (i) a description of the process used to develop or select the medical necessity criteria for mental health benefits and substance use disorder benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits;
>
> (ii) for each Parity Act classification, identification of nonquantitative treatment limitations that are applied to mental health benefits and substance use disorder benefits and medical and surgical benefits;
>
> (iii) identification of the description of the nonquantitative treatment limitations identified under item (ii) of this paragraph in

[1] "Parity Act" means the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

documents and instruments under which the plan is established or operated; and

(iv) the results of the comparative analysis as described under subsections (d) and (e) of this section.

(d) (1) A carrier subject to this section shall conduct a comparative analysis for the nonquantitative treatment limitations identified under subsection (c)(2)(ii) of this section as nonquantitative treatment limitations are:

(i) written; and

(ii) in operation.

(2) The comparative analysis of the nonquantitative treatment limitations identified under subsection (c)(2)(ii) of this section shall demonstrate that the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to mental health benefits and substance use disorder benefits in each Parity Act classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to medical and surgical benefits within the same Parity Act classification.

(e) In providing the analysis required under subsection (d) of this section, a carrier shall:

(1) identify the factors used to determine that a nonquantitative treatment limitation will apply to a benefit, including:

(i) the sources for the factors;

(ii) the factors that were considered but rejected; and

(iii) if a factor was given more weight than another, the reason for the difference in weighting;

(2) identify and define the specific evidentiary standards used to define the factors and any other evidence relied on in designing each nonquantitative treatment limitation;

(3) include the results of the audits, reviews, and analyses performed on the nonquantitative treatment limitations identified under subsection (c)(2)(ii) of this section to conduct the analysis required under subsection (d)(2) of this section for the plans as

written;

(4) include the results of the audits, reviews, and analyses performed on the nonquantitative treatment limitations identified under subsection (c)(2)(ii) of this section to conduct the analysis required under subsection (d)(2) of this section for the plans as in operation;

(5) identify the measures used to ensure comparable design and application of nonquantitative treatment limitations that are implemented by the carrier and any entity delegated by the carrier to manage mental health benefits, substance use disorder benefits, or medical/surgical benefits on behalf of the carrier;

(6) disclose the specific findings and conclusions reached by the carrier that indicate that the health benefit plan is in compliance with this section and the Parity Act and its implementing regulations, including 45 C.F.R. 146.136 and 29 C.F.R. 2590.712 and any other related federal regulations found in the Code of Federal Regulations; and

(7) identify the process used to comply with the Parity Act disclosure requirements for mental health benefits, substance use disorder benefits, and medical/surgical benefits, including:

(i) the criteria for a medical necessity determination;

(ii) reasons for a denial of benefits; and

A "carrier" is defined in § 15-144(a)(2) to include insurers that provide health insurance, nonprofit health service plans, organizations that provide health benefit plans, and health maintenance organizations.

A "health benefit plan" is defined in § 15-144(a)(3) to include large group plans, small group plans, individual plans, and student health plans.

2. According to Code of Maryland Regulations ("COMAR") 31.10.51, carriers are required to use the template form on the Administration's website ("the template;" COMAR 31.10.51.04, §§ 15-144(g)(1) and 15-144(m)(1) of the Insurance Article). There are 14 different NQTLs on the template. Each NQTL category has 7-steps in the analysis. Additionally, there are two initial questions regarding Plan Information and Benefit

Classification. The 14 NQTLs include: definition of medical necessity; prior authorization review process; concurrent review process; retrospective review process; emergency services; pharmacy services; prescription drug formulary design; case management; process for assessment of new technologies; standards for provider credentialing and contracting; exclusions for failure to complete a course of treatment; restrictions that limit duration or scope of benefits for services; restrictions for provider specialty; and reimbursement for in-network providers, out-of-network providers, in-network facilities and out-of-network facilities ("Provider Reimbursement".)

3. The 7 steps on the template are:

Step 1

(a) Provide a description of the plan's applicable NQTLs as applied to medical/surgical and MH/SUD benefits in the table below.

NQTL's Applicable to Med/Surg Benefits	NQTL's Applicable to MH/SUD Benefits

(b) For each NQTL listed in Step 1 (a), identify whether the NQTL is applicable to medical/surgical or MH/SUD benefits for each applicable benefit classification and sub-classification in the table below. Indicate whether the NQTL applies by classification and sub-classification by entering "Yes" or "No" in the appropriate box. If the NQTL applies only to certain services within such classification and/or sub-classification, list each covered service to which the NQTL applies.

Classifications and Sub-Classifications							
Is NQTL applied to In Network Inpatient classification?	Is NQTL applied to Out of Network Inpatient classification?	Is NQTL applied to In Network Outpatient-Office sub-classification?	Is NQTL applied to Out of Network Outpatient-Office sub-classification?	Is NQTL applied to In Network Outpatient-All Other sub-classification?	Is NQTL applied to Out of Network Outpatient-All Other sub-classification?	Is NQTL applied to Emergency classification?	Is NQTL applied to Prescription classification?

[Identify all Applicable NQTLs for each classification or sub-classification.]							

(c) For each NQTL listed in the Step 1(b), explain the methodology used to determine whether to apply the NQTL to either the entire classification and/or sub-classification of benefits or to apply the NQTL to certain identified services within such classification and/or sub-classification.

Step 2

For each NQTL listed in Step 1, identify the factors and the source for each factor used to determine that it is appropriate to apply each NQTL to each classification, sub-classification or certain services within such classification or sub-classification for both MH/SUD and M/S benefits. Also, identify factors that were considered, but rejected. If any factor was given more weight than another, what is the reason for the difference in weighting? (§15-144(e)(1)).

Step 3

Each factor must be defined. Identify and define the specific evidentiary standard(s) for each of the factors identified in Step 2 and any other evidence relied upon to design and apply each NQTL. Also, identify the source for each evidentiary standard. (§15-144(e)(2)).

Step 4

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, as written. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(3)).

Step 5

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, in operation. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(4)).

Step 6

Identify the measures used to ensure comparable design, development and application of each NQTL that is implemented by the carrier and any entity delegated by the carrier to manage MH benefits, SUD benefits, or M/S benefits on behalf of the carrier. (§15-144(e)(5)).

Step 7
Disclose the specific findings and conclusions reached by the carrier that indicate compliance with the Parity Act. (§15-144(e)(6)).

4. Carriers are required to provide complete answers for each NQTL category. COMAR 31.10.51.04G sets forth the specific information that must be included in an NQTL report for it to be considered complete, and this includes "all of the information identified in Insurance Article, §15-144(e), Annotated Code of Maryland, in the manner and format specified in the standard reporting form and associated instructions provided on the Administration's website." The instructions on the Administration's website include the following specific examples of responses that may result in a finding that a carrier failed to submit a complete NQTL report:

1) Production of documents without a clear explanation of how and why each document pertains to the comparative analysis. This includes how each document has been analyzed in a comparative manner and how the comparability and stringency NQTL tests have been met, both in writing and in operation;

2) Generalized statements concerning factors, processes, standards, procedures, etc., as well as mere recitations of the legal standard and conclusions regarding compliance, without specific supporting evidence and detailed explanations of comparative analyses;

3) Identification of factors, evidentiary standards, and strategies without a clear description of how the factors, evidentiary standards, and strategies are defined and applied for M/S or MH/SUD benefits;

4) Identification of processes, strategies, sources, and factors without the required clear and detailed comparative analyses;

5) Statements that all factors, evidentiary standards and/or criteria, processes and/or strategies are the same for M/S and MH/SUD without detailed definitions and specific comparative analyses for each factor, evidentiary standard, criteria, process, strategy, etc. that substantiate such statements;

6) Reference to factors, evidentiary standards, and/or criteria that inherently rely on quantitative measures and/or are defined or applied in a quantitative manner, without the precise quantitative definitions;

7) Responses that do not to [sic] include comparative analyses, including results, and information necessary to examine the development and/or application of each NQTL, and do not clarify the methodologies utilized for such comparative analyses;

8) Analysis that is not for the applicable time period;

9) Analysis that is obsolete due to the passage of time, a change in plan structure, or for any other reason;

10) Failure to include specific data used in an analysis or audit to determine whether the NQTL is comparable to and no more stringently applied to MH/SUD benefits than to M/S benefits in operation.

II. FINDINGS

5. MLHIC and UHIC each currently hold a Certificate of Authority from the State of Maryland to act as an insurer. OCI and UHCMA each currently hold a Certificate of Authority from the State of Maryland to act as a health maintenance organization.

6. MLHIC offers health benefit plans in the State of Maryland in the small group market; UHCMA offers health benefit plans in the State of Maryland in the small and large group markets; and OCI and UHIC offer health benefit plans in the State of Maryland in the individual, small, and large group markets. The health benefit plans offered by UHIC in the individual market are student health plans.

7. On February 1, 2022, the Commissioner issued Bulletin 22-04, reminding carriers of the March 1, 2022 due date and specifying the submission method for the reports required by § 15-144 of the Insurance Article.

8. On March 1, 2022, UnitedHealthcare submitted NQTL analyses and data reports ("reports") for twenty-one health benefit plans.

9. On March 1, 2022, UnitedHealthcare stated in an email to the Maryland Insurance Administration ("the Administration") that "… there was an error in identifying

the top ranking plans by enrollment for each product; this error was discovered on 2/28/22…. We are in the process of correcting our error, identifying the remaining top plans, and providing the required analyses." The email did not identify the number of additional plans and products for which reports were not submitted by the March 1, 2022 due date.

10. Between March 11, 2022 and April 29, 2022, the Administration corresponded with UnitedHealthcare regarding the reports that were not submitted by the March 1, 2022 due date, and UnitedHealthcare submitted additional reports on April 1, 2022 and April 29, 2022.

11. On July 26, 2022, the Administration issued Order MIA-2022-07-025 against UnitedHealthcare, imposing an administrative penalty of $100,000 for failure to submit the required reports by the March 1, 2022 due date, in violation of § 15-144(c)(1) and (f) of the Insurance Article. The Order stated, in pertinent part, that the Administration "issues this Order solely in response to the late filing in violation of the Insurance Article and Bulletin 22-04. It should be noted, however, that this Order in no way precludes the Administration from determining whether the content of the reports is sufficient or reflects additional violations of the Insurance Article."

12. On November 28, 2022, the Administration sent a follow-up letter to UnitedHealthcare informing them that their reports were insufficient to show compliance with 15-144 of the Insurance Article. The Administration requested additional information on each NQTL. The letter included 105 comments, which focused on the UHIC Large Group PPO products Plan Code KYG and Plan Code KYI. The comments provided detailed guidance on the precise additional information that was needed for the reports to be considered complete, and the letter cited the specific sections of the instructions on

the Administration's website that required this information to be submitted. In comment 100 of the letter, it was advised that the comments for Plan Code KYG and Plan Code KYI were also applicable for all other plans. The letter also stated, in pertinent part:

> "We have reviewed the revised NQTL Analysis Reports submitted on April 1, 2022 in response to our letters dated March 22 and March 23, 2022. The information provided in the reports does not appear sufficient to demonstrate compliance with § 15-144(c)-(e) of the Insurance Article, Annotated Code of Maryland. Refer to COMAR 31.10.51.04A. Furthermore, certain responses appear contrary to the instructions for completing the analysis reports, which are posted on the Maryland Insurance Administration's website. Refer to COMAR 31.10.51.04C and D. Please address the following issues.
>
> As explained more fully below, the filing appears to be incomplete, and therefore may be subject to penalties described in § 15-144(j) of the Insurance Article.
>
> * * *
>
> Additionally, please note that by requesting additional information and giving a deadline for the response, the Administration is not extending the deadline under the statute for submission of a complete report."

The letter included a staggered due date, with NQTLs 10, 12, and 14 due within 45 days, and the remaining NQTLs due within 60 days.

11. While the specific comments included in the Administration's November 28, 2022 letter focused on the UHIC Large Group PPO products Plan Code KYG and Plan Code KYI, Administration staff compared the NQTL reports for Plan Code KYG and Plan Code KYI to the NQTL reports for all the other plans submitted by UnitedHealthcare, and confirmed that the nature and extent of the deficiencies noted for the Plan Code KYG and Plan Code KYI reports were common across the reports for all submitted plans.

12. Between December 13, 2022 and December 22, 2022, UnitedHealthcare communicated with the Administration via email to discuss requests for extensions of the

resubmission deadlines. The Administration agreed to extend the deadlines for the resubmissions as follows:

- January 31, 2023 - NQTLs 10, 12, and 14 due for UHIC only;
- February 15, 2023 – Half of the remaining NQTLs due for UHIC only;
- March 1, 2023 – Remaining NQTLs due for UHIC only;
- March 22, 2023 – All NQTLs due for UHCMA, OCI, and MLHIC.

13. On January 18, 2023, the Administration sent a follow-up letter to UnitedHealthcare providing additional guidance on the expected format for UnitedHealthcare's responses to the November 28, 2023 letter.

14. On January 31, 2023, February 15, 2023, March 1, 2023, and March 22, 2023, UnitedHealthcare provided responses to the Administration for specific NQTLs in accordance with the deadline extensions granted by the Administration on December 22, 2022.

15. Even after receiving specific additional guidance in the Administration's November 28, 2022 letter explaining the failure to include information required by the instructions on the Administration's website, UnitedHealthcare's responses were insufficient, non-responsive, or missing essential information. Therefore, the Administration cannot determine if UnitedHealthcare is in compliance with the Parity Act for any of the NQTLs that were audited. The responses were deficient for every NQTL category that was audited, and the Administration is providing examples of the most common types of deficiencies. However, this is not an exhaustive list of noncompliant responses.

A. <u>Example A:</u> failure to follow the instructions for Step 3; non-responsiveness to a specific request for follow-up information; and a response

identified in Examples 3, 5, and 6 of the Administration's instructions as a type of response that may result in a finding that a carrier failed to submit a complete analysis report

For the "Definition of Medical Necessity" NQTL, UnitedHealthcare failed to define the three items identified as factors and failed to define and explain the evidentiary standards for these factors in Step 3.[2]

In Comment 14 of the Administration's November 28, 2022 letter, the Administration noted the required information was missing, requested definitions for the factors, and advised UnitedHealthcare that "[i]f specific thresholds are not used to determine when the factor will implicate the NQTL, a specific, detailed, and reasoned explanation of how the carrier ensures the factors are being applied comparably and no more stringently to MH/SUD services must be provided." The Administration also requested specific additional information and provided examples of expected responses with respect to explanations and definitions for the evidentiary standards listed in the April 1, 2022 report for M/S and MH/SUD.

In its March 1, 2023 response, UnitedHealthcare provided definitions for the three items listed as factors. The response stated that the evidentiary standards are not defined in a quantitative manner, but failed to include the required specific, detailed, and reasoned explanation of how the carrier ensures the factors are being applied comparably and no more stringently to MH/SUD. Additionally, the response did not address any of the Administration's specific requests for additional information, nor the examples of expected

[2] See UnitedHealthcare's April 1, 2022 report.

responses with respect to explanations and definitions for the evidentiary standards, as described in comment 14(c) of the Administration's November 28, 2022 letter.

B. <u>Example B:</u> failure to follow the instructions for Step 3; non-responsiveness to a specific request for follow-up information; and a response identified in Examples 3 and 4 of the Administration's instructions as a type of response that may result in a finding that a carrier failed to submit a complete analysis report

For the "Standards for Provider Credentialing and Contracting" NQTL, UnitedHealthcare failed to include the required definitions and sources for the evidentiary standards in Step 3.[3]

In comment 75 of the Administration's November 28, 2022 letter, the Administration noted that the response provided by UnitedHealthcare on April 1, 2022, included sources cited for factors in Step 2 which were then also listed as evidentiary standards in Step 3, without any additional required explanation or definition for the standards.

The Administration instructed UnitedHealthcare to provide the requested missing information and also noted that one of the evidentiary standards listed for the third factor mentioned "NCQA." The Administration advised UnitedHealthcare that the instructions for Step 3 specifically state: " 'If a source such as NCQA is used in determining comparability, the standards for that source and any analyses developed internally or provided to NCQA or other external agencies must be provided.' "

[3] See UnitedHealthcare's April 1, 2022 report.

In its January 31, 2023 response, UnitedHealthcare failed to provide the missing detail for the evidentiary standards, and continued to list the same items both as sources for the factors in Step 2 and as evidentiary standards in Step 3.[4] UnitedHealthcare stated that the evidentiary standards are not defined in a quantitative manner, but did not provide a specific, detailed, and reasoned explanation of how the carrier ensures that factors are being applied comparably and no more stringently to MH/SUD services.

UnitedHealthcare added a cross-reference to a source that did not actually cite NCQA; the language for the NCQA standard was not provided; and no analyses were included that were developed internally or provided to NCQA or other external agencies.

C. <u>Example C:</u> failure to follow the instructions for Step 4; non-responsiveness to a specific request for follow-up information; and a response identified in Examples 2, 5, and 7 of the Administration's instructions as a type of response that may result in a finding that a carrier failed to submit a complete analysis report

For the "Standards for Provider Credentialing and Contracting" NQTL, UnitedHealthcare failed to provide required comparative analysis information required for Step 4.[5]

Comment 76 of the Administration's November 28, 2022 letter noted that the response to Step 4 appeared to be more appropriate for Step 5 and did not include all the required information noted in the instructions. The Administration specifically noted the absence of a comparative analysis for the information in the UHC and UBH credentialing plans "as

[4] For example, for Step 2, of this NQTL, UnitedHealthcare lists one of the factors as "[t]he provider or facility continue to meet the requirements set forth in the credentialing plan while they are contracted with the Plan." It notes one of the sources for this factor is Section 6 of the Medicare Managed Care Manual. In Step 3, Section 6 of the Medicare Managed Care Manual is also listed a definition of a specific evidentiary standard for this factor.
[5] See UnitedHealthcare's April 1, 2022 report.

written," and the methodology used to complete such a comparative analysis. The Administration requested specific information on the composition and deliberations of the decision-making staff responsible for the credentialing plans and the annual review, expressly required by the instructions for Step 4. The Administration requested the results of the comparative analyses performed for the past two years which UnitedHealthcare claimed it conducts annually. Finally, the Administration requested additional information on delegated credentialing arrangements, including identification of the factors considered in determining whether an entity is eligible.

In its January 31, 2023 response, UnitedHealthcare provided a side-by-side comparison of M/S and MH/SUD credentialing application and required documentation, as well as excerpts from the M/S and MH/SUD credentialing plans documenting the written policies related to delegated credentialing. The comparison incorporated conclusory statements indicating that the comparative analyses confirmed parity between M/S and MH/SUD for: credentialing committee structure, credentialing plans, credentialing application/documentation requirements, and credentialing delegation pre-assessment.

UnitedHealthcare did not provide the specific information on the composition and deliberations of the decision-making staff requested by the Administration, and asserted that the information "is not relevant to the parity analysis of this NQTL and not indicative of or material to whether the Plan is compliant not relevant to the parity analysis." Additionally, the comparative analysis for the credentialing plans identified differences in the frequency of reviews of the plans and in the scheduling for appeal hearings, while the comparative analysis for credentialing delegation pre-assessment identified a different scoring methodology for MH/SUD. An analysis of these differences in accordance with

COMAR 31.10.51.04G(4)(c) was not provided to support UnitedHealthcare's conclusory statements of parity.

D. <u>Example D:</u> failure to follow the instructions for Step 5; non-responsiveness to a specific request for follow-up information; and a response identified in Examples 5, 7, and 10 of the Administration's instructions as a type of response that may result in a finding that a carrier failed to submit a complete analysis report

For the "Definition of Medical Necessity" NQTL, UnitedHealthcare failed to provide the information regarding results of comparative analyses required in Step 5.[6]

Comment 16 of the Administration's November 28, 2022 letter included examples of the specific data and information required for a sufficient "in operation" comparative analysis, as outlined in COMAR 31.10.51.04G(4) and in the instructions on the Administration's website. The Administration noted that *no results* were provided even though UnitedHealthcare stated that a comparative analysis was conducted, and instructed UnitedHealthcare to provide both the methodology and results.

The Administration also advised UnitedHealthcare that while its interrater reliability (IRR) auditing program is a positive step in validating consistency in how reviewers interpret and apply M/S and MH/SUD criteria, it does not address the comparability of the actual criteria themselves. The Administration requested the results from an in operation comparative analysis for specific medical necessity criteria, or an explanation of why the analysis was not available. Finally, the Administration identified specific results included in the MHPAEA Data Report for UHIC Large Group PPO KYG potentially indicating

[6] See UnitedHealthcare's April 1, 2022 report.

greater stringency in application of medical necessity criteria in operation for MH/SUD services.

UnitedHealthcare's March 1, 2023 response addressed these issues as follows:

(i) UnitedHealthcare rephrased the statement indicating that a comparative analysis had been performed, and included additional information about the responsibilities and protocols of the committees overseeing the M/S and MH/SUD medical/clinical policy development.

(ii) In response to the request for comparative analyses, UnitedHealthcare stated: "The completion of the NQTL Analysis Report Template itself serves as the responsive analysis which identifies the results of the analysis. The comparative analysis outcome summary is listed in Steps 4 and 5." *Results of the comparative analyses were not provided in Step 5 of the template*, however, except for a high level summary for all prescription drugs.

(iii) In response to the MIA's comment that IRR does not address the comparability of the actual criteria themselves, UnitedHealthcare stated: "The Plan generally assesses the stringency of its application of its medical necessity criteria in operation by comparing the results of its mandatory M/S and MH/SUD IRR testing outcomes, and by conducting comparative analyses of the Plan's medical necessity denial rates for M/S and MH/SUD services within each classification of benefits." *The results of these analyses were not provided* with the response.

(iv) *UnitedHealthcare did not provide any results for an in operation comparative analysis for the specific medical necessity criteria requested* by the Administration, and stated that they were unable to provide the results because they had not conducted the

specifically requested comparative analyses as federal regulations and guidance do not explicitly require an analysis for these specific services.

(v) In response to the comment about disparate results in the MHPAEA Data Report for UHIC Large Group PPO KYG, UnitedHealthcare asserted that the sample sizes were too small to draw meaningful conclusions and that disparate results alone are not dispositive of Parity Act compliance, but provided no explanation for the differences to refute potential greater stringency of application of the NQTL to MH/SUD services.

E. Example E: failure to follow the instructions for Step 7; non-responsiveness to a specific request for follow-up information; and a response identified in Examples 2, 4, 5, 7, and 10 of the Administration's instructions as a type of response that may result in a finding that a carrier failed to submit a complete analysis report

For the "Standards for Provider Credentialing and Contracting" NQTL, UnitedHealthcare failed to provide the information required in Step 7, including instead conclusory, unsupported statements in its responses to the Administration.

In Comment 79 of the Administration's November 28, 2022 letter, the Administration noted that UnitedHealthcare's response was a conclusory statement without documentation. The Administration advised UnitedHealthcare repeatedly[7] that the carrier must explain the basis for its conclusion regarding comparability and stringency; and that a general or conclusory statement of compliance is not sufficient. The analysis required for Step 7 is not a restatement of prior sections of the report; and the carrier must provide a detailed summary of specific findings and conclusions.

[7] Comment 79 of the Administration's November 28, 2022 letter mistakenly referred to earlier comments under "NQTL 18" instead of "comment 18."

The Administration also directed UnitedHealthcare to ensure the revised response addressed the requirement from the instructions for Step 7 that to the extent there are disparities in any comparative data analyses, including quantitative disparities shown in the required data supplement forms or other in operation analyses, the carrier must explain in detail how these disparities are not evidence of parity non-compliance, and indicate whether steps have been taken to ensure/improve access to in-network M/S providers and whether the same or comparable steps have been taken for MH/SUD.

In its January 31, 2023 response, UnitedHealthcare expanded the findings section for Step 7 to refer to the specific steps in the prior sections of the report on which the conclusions of comparability were based, but again provided conclusory statements of compliance without a detailed summary of the findings. Furthermore, the prior sections referenced in Step 7 included sections that were noted as deficient in the April 1, 2022 reports, as described in comments 75-77 of the Administration's November 28, 2022 letter. Deficiencies included a lack of detailed analysis and disparate data results requiring explanation. These prior sections were revised to include some additional analysis in the January 31, 2023 response, but the additional analyses remained deficient and revealed further disparities that were not sufficiently described, as noted above for comment 76 under Example C. The revised explanation for Step 7 did not address any of these disparities or explain steps that would be taken to reduce the disparities.

III. CONCLUSIONS OF LAW

UnitedHealthcare's reports and subsequent responses to the Administration's requests for additional or revised information were insufficient, non-responsive, or missing essential information. Therefore, the Administration cannot determine if UnitedHealthcare is in compliance with the Parity Act for any of the NQTLs that were

audited. The Commissioner finds that UnitedHealthcare failed to submit the complete reports identified above and, therefore, has not complied with § 15-144(c)(1) through 15-144(e) of the Insurance Article,

WHEREFORE, for the reasons set forth above, and subject to your right to request a hearing, it is this _8_ day of June 2023, **ORDERED:** That, pursuant to § 4-113 of the Insurance Article based on consideration of § 15-144(l) of the Insurance Article and COMAR 31.02.04.02, within thirty (30) days of the date of this Order, UnitedHealthcare pay an administrative penalty of $500,000 for violation of § 15-144 of the Insurance Article.

Kathleen A. Birrane
INSURANCE COMMISSIONER

By: David Cooney
Associate Commissioner
Life & Health

Date: June 8, 2023

RIGHT TO REQUEST A HEARING

Any person aggrieved by this Order has the right to request a hearing. A request for a hearing must be made in writing and received by the Maryland Insurance Administration within thirty (30) days of the date of this Order. The request must be

addressed to the Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202. Attention: Angelique Jones. Failure to request a hearing in a timely fashion, or to appear at a scheduled hearing, will result in a waiver of your right to contest the Commissioner's action, and the Order will be final on the effective date. If a hearing is requested within ten (10) days of the date of the letter accompanying this Order, the effective date of the Order will be stayed until the matter is adjudicated. Should an aggrieved party request a hearing, the hearing officer may reduce, increase, or affirm the penalty amount sought by the Commissioner.

All administrative penalties should be made payable to the Maryland Insurance Administration and sent to the attention of Angelique Jones, Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202-2272. Please include the MIA Order number on all correspondence to the Administration.