REPORT OF MARKET CONDUCT EXAMINATION

Maine Energy Marketers Association Health Insurance Trust

25 Greenwood Road

Brunswick, ME 04011

ME Lic.
MWD316507

Examination Period:
2021-2022

Date: 12/20/2023

Honorable Timothy N. Schott
Acting Superintendent
Maine Bureau of Insurance
34 State House Station
Augusta, ME 04333-0034

Dear Acting Superintendent Schott:

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

Maine Energy Marketers Association Health Insurance Trust (MEMA)

The Examination reviewed certain of MEMA's appeal handling practices for the Accident and Health line of business. The Examination covered the review period of 1/1/2021 - 12/31/2022. The Maine Bureau of Insurance conducted the Examination on a remote basis, with all preliminary review, transactional testing and follow-up communications conducted at the Bureau.

The following report is respectfully submitted.

Connie Mayette

Connie Mayette, CPCU, AIE, MCM, AU, AIC, AINS

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 Energy Marketers Health Insurance Trust. I hereby accept this Report of Examination and make it an official record of the Bureau of Insurance.

Honorable Timothy N. Schott

12/27/2023

Date

Acting Superintendent
Maine Bureau of Insurance

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Company Profile

The Maine Energy Marketers Association ("MEMA" or "the Company") is a non-profit 501c(6) trade association representing more than 300 members, including heating oil, propane, biofuels and motor fuels providers as well as convenience store owners. MEMA also has associate members who provide goods and services to Maine's petroleum dealers and their customers.

The MEMA Health Insurance Trust was first licensed as a multiple-employer welfare arrangement to provide health benefits to their employees or the beneficiaries of their members effective 01/01/2017.

Executive Summary

Title 24-A, M.R.S. § 221(5) states in relevant part "[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 section may be comprehensive or may target specific issues of concern observed in the State's health insurance market or in the company under examination." The definition of carrier in § 4301-A(3) includes "a multiple-employer welfare arrangement licensed pursuant to chapter 81." When appropriate, the Bureau may accomplish this exam requirement by examining a carrier acting as an administrator, for a MEWA or other plan type, that is also subject to examination under §221(5). MEMA's administrator is Diversified Administration Corporation, the third-party administration (TPA) subsidiary of Diversified Group; an entity not subject to §221(5). Accordingly, a separate examination of MEMA is required.

This examination was called as a statutorily required examination.

The examination was a targeted examination 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.

Sections 8 and 9 of Rule 850 list the required notifications to Maine consumers with all adverse decisions. The notices are to ensure that Maine consumers are informed of their rights to appeal an adverse decision and how to proceed with that appeal, to request an external review of a carrier's adverse healthcare treatment decision, and to seek assistance from and/or file a complaint with the Bureau of Insurance. These sections of Rule 850 also describe how carriers shall conduct first and second level appeal reviews. The examiners tested MEMA's compliance with these sections by reviewing its Plan documents, claims and appeals procedure guidelines, and a selection of its appeal files. As only two appeals had been decided in 2021, which included Level 1 and Level 2 adverse healthcare treatment decisions, and there were no adverse benefit determinations that did not involve healthcare treatment decisions, the scope was expanded to include 2022. Two additional appeals decided in 2022 were included in the review, providing a Level 1 appeal of an adverse benefit determination that did not involve a healthcare treatment decision and an additional Level 1 adverse healthcare treatment appeal.

Two types of appeals were tested; those involving health care treatment decisions (HC) and those not involving health care treatment decisions (NHC). Level 1 and Level 2 HC appeals and Level 1 NHC appeals were reviewed. There were no Expedited appeals, Level 2 NHC Appeals, or External Reviews in the two-year time period. In addition, the notices provided with initial adverse benefit determinations (claim denials) were tested by reviewing the explanations of benefits (EOBs) included in the appeal files.

The Company was responsive to Bureau requests, and accepting of the criticisms issued by the examiners. The written criticisms commonly referred to as "Crits" are the means by which examiners notify an examined entity of potential violations noted during an examination.

Overall, the files reviewed showed compliance concerns with the requirements of these sections of Rule 850.

Scope of Examination

The objective of the examination was to review MEMA's handling of its health insurance appeal files and adverse benefit determination notices for compliance with Rule 850. The examiners used transactional testing[1] to determine compliance with the applicable regulations.

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, 2022 ed. ("the Handbook") as required by 24-A, M.R.S. § 223(2). The Handbook was used for overall guidance; as total populations were reviewed, sample determination was not necessary. Some unacceptable or non-compliant practices may not have been discovered in the course of this examination; failure to identify or comment on specific practices does not constitute the Bureau's approval of such practices.

This report is by exception, so only exceptions or errors are noted.

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 appeal files to evaluate compliance with the applicable requirements of Rule 850. The files reviewed encompassed the population of appeals that were closed during the review period of 2021 - 2022 after eliminating those that were not applicable to the Rule sections being tested. The applicable policies and procedures established and provided by the Company were also reviewed, so that the Company's practices both as written and in operation were examined.

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

Findings

Findings represent issues of non-compliance for which a Corrective Action Plan may be requested to correct the identified Finding.

Adverse Health Care Treatment Decisions

As stated in Rule 850 §3(A) - "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)."

1. Level 1 Adverse Health Care Treatment Decisions §8(G)

   The total population of two (2) applicable appeals files was reviewed and tested for compliance with Rule 850 §8(G). As there were no expedited appeals in the period, §8(G)(2) was not tested.

   A. Section 8(G)(1)(a) states: *"A health carrier or the carrier's designated URE shall establish written procedures for a standard appeal of an adverse health care treatment decision. HMO enrollees shall retain the right to pursue an appeal directly with the HMO. Appeal procedures shall be available to the covered person and to the provider acting on behalf of the covered person.*

   i) The carrier must allow the covered person to review the claim file and to present evidence and testimony as part of the internal appeals process.

   ii) The carrier must provide the covered person, free of charge, with 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; such evidence must be provided as soon as possible and sufficiently in advance of the decision to give the covered person a reasonable opportunity to respond.

   iii) Before a carrier can issue a final internal adverse benefit determination based on a new or additional rationale, the covered person must be provided with the rationale, free of charge, sufficiently in advance of the decision to give the covered person a reasonable opportunity to respond.

   iv) The health carrier must provide the covered person the name, address, and telephone number of a person designated to coordinate the appeal on behalf of the health carrier.

   v) The health carrier must make the rights in this subparagraph known to the covered person within 3 working days after receiving an appeal.

   The two appeal files were not in compliance with this section. An acknowledgement letter indicating receipt of the appeal was sent timely in one appeal, but none of the required information in subparagraphs i - iv were provided. No letter was sent in the other appeal.

   B. Section 8(G)(1)(b) states: *"An appeal of an adverse health care treatment decision, except for a rescission determination or an initial coverage eligibility determination, shall be evaluated by an appropriate clinical peer or peers of the treating provider. The clinical peer/s shall not have been involved in the initial adverse determination, unless additional*

information not previously considered during the initial review is provided on appeal. The clinical peer may not be a subordinate of a clinical peer involved in the prior decision."

One of the two appeal files was not in compliance with this section. The file documentation did not contain sufficient information to determine if the reviewer was a clinical peer, or if the reviewer had been involved in the initial adverse determination or was a subordinate of a clinical peer involved in the prior determination.

C. **Section 8(G)(1)(c)** states in relevant part: *"An adverse health care treatment decision shall contain:*

i) The names, titles and qualifying credentials of the person or persons evaluating the appeal;

ii) A statement of the reviewers' understanding of the reason for the covered person's request for an appeal;

iii) Reference to the specific plan provisions upon which the decision is based.

iv) 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;*

v) 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.

vi) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit decision, 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.

vii) 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.A. §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.

viii) This item is not tested as part of this exam.

ix) 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.

The two appeal files were not in compliance with all elements of this section. Neither adverse decision letter provided the name, title and qualifying credentials of the person evaluating the appeal *(subpart i)*; the subsequent appeal rights and external review rights *(subpart vii);* or the information to contact the Bureau of Insurance *(subpart ix)*. The letter in one appeal file also did not reference the plan provision upon which the decision was based *(subpart iii)*. The letter in the other appeal file also did not provide the information required in *subparts v and vi*.

2. Level 2 Adverse Health Care Treatment Decisions §8(G-1)

The total population of one (1) applicable appeal was reviewed and tested for compliance with Rule 850 §8(G-1).

A. Section 8(G-1)(1) states in relevant part, *"...The covered person requesting a second level appeal has the right to appear in person before authorized representatives of the health carrier, and shall be provided adequate notice of that option by the carrier..."*

Notice of the right to appear can be satisfied by including that information with the underlying Level 1 adverse decision letter, or by providing a timely notification upon receipt of the request for the second level appeal. The reviewed appeal file did not convey this right at either of those two opportunities.

B. Section 8(G-1)(2) states: *"The carrier shall appoint a panel for each second level appeal, which shall include one or more panelists who are disinterested clinical peers of the treating provider. For purposes of this paragraph, a provider is disinterested if he or she was not involved in the prior decision, is not a subordinate of a panelist involved in the prior decision, and has no financial or other personal interest in the outcome of the review. A second level appeal decision adverse to the covered person must have the concurrence of a majority of the disinterested clinical peers on the panel."*

The reviewed file identified one reviewer in the adverse decision letter; a panel requires more than one panelist. Additionally, while the reviewer's cited credentials indicate that the reviewer was an appropriate clinical peer pursuant to the definition in Rule 850 §5(H) and Title 24-A M.R.S. §4301-A(4), the documentation was insufficient to conclude that the clinical peer was disinterested.

C. Section 8(G-1)(3) - Pursuant to §8(G-1)(3)(f), the requirements set forth in 850 § 8(G)(1)(c) for adverse health care treatment decision letters apply to second level adverse decision letters. *These requirements are listed above in Section 1(C).* The remaining requirements of paragraph 3, pertaining to when a covered person has requested the opportunity to appear in person for the Level 2 appeal review, were not tested as that did not occur in the sole Level 2 appeal file.

The adverse decision letter in the reviewed file did not provide the name, title and qualifying credentials of the person evaluating the appeal *(subpart i)*; and did not reference the plan provision upon which the decision was based *(subpart iii),* the external review rights *(subpart vii),* or the information to contact the Bureau of Insurance *(subpart ix).*

Adverse Benefit Determinations Not Involving Health Care Treatment Decisions

As stated in Rule 850 §3(A) - "All requests for review of 'adverse benefit determinations,' other than 'adverse health care treatment decisions,' are subject to the grievance review procedures set forth in section 9."

3. Notice of Adverse Benefit Determinations Not Involving Health Care Treatment Decisions §9(A)

Section 9(A) states in relevant part *"For any adverse benefit determination that does not involve medical issues, the carrier shall provide written notice that includes the information required below:*

1) *the principal reason or reasons for the determination;*
2) *reference to the specific plan provisions on which the determination is based;*
3) *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;*
4) *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;*
5) *the instructions and time limits for initiating an appeal or reconsideration of the determination;*
6) *notice of the right to file a complaint with the Bureau of Insurance after exhausting any appeals under a carrier's internal review process. In addition, an explanation of benefits (EOB) must comply with the requirements of 24-A M.R.S.A. §4303(13) and any rules adopted pursuant thereto.*
7) *if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, 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;*
8) *a phone number the covered person may call for information on and assistance with initiating an appeal or reconsideration or requesting review criteria;*
9) *This item is not applicable.*
10) *This item is not tested as part of this exam.*
11) *This item is not tested as part of this exam.*

The Explanation of Benefits forms (and the accompanying form "Important Information About Your Appeal Rights) included in the one applicable appeal file were not in compliance with all elements of this section. They did not include a statement that the diagnosis code and treatment code, and their corresponding meanings, would be provided upon request *(paragraph 3);* or a statement that any rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination would be provided free of charge upon request *(paragraph 7).*

4. First Level Review of Adverse Benefit Determinations Not Involving Health Care Treatment Decisions §9(B)

Section §9(B)(1) states: "A grievance concerning any matter may be submitted by a covered person or a covered person's representative. Appeals of adverse health care treatment decisions are subject to the requirements of subsections 8(G) and 8(G-1) of this rule. Review of other grievances is subject to this subsection and subsection C of this section."

The total population of one (1) applicable appeal file was tested for compliance with Rule 850 §9(B). As there were no such Second Level reviews, §9(C) was not tested.

A. **Section §9(B)(2)** states: *"A covered person does not have the right to attend, or to have a representative in attendance, at the first level grievance review, but is entitled to submit written material to the reviewer. The health carrier shall provide the covered person the name, address and telephone number of a person designated to coordinate the grievance review on behalf of the health carrier. The health carrier shall make these rights known to the covered person within 3 working days after receiving a grievance."*

   The reviewed file did not include notification of the rights in this paragraph timely or otherwise.

B. **Section §9(B)(2)(a)** states in relevant part, *"...A health carrier shall issue a written decision to the covered person within 30 days after receiving a grievance..."*

   Although the provider was notified timely of the decision, no written decision was issued to the covered person.

Recommendation

The Bureau recommends that MEMA enact practices and procedures to ensure compliance with these sections of Rule 850. A separate Corrective Action Plan for each item identified has been provided to the company. The examiners note that corrective measures were already being implemented prior to the issuance of this report.

Acknowledgement

The examiners would like to acknowledge the cooperation and assistance extended by MEMA and its Third-Party Administrator during the course of this examination.

Attestation

STATE OF MAINE
COUNTY OF KENNEBEC, SS

Connie Mayette, CPCU, AIE, MCM, AU, AIC, AINS, Examiner-in-Charge, being duly sworn according to law, deposes and says that in accordance with the authority vested in her by Acting Superintendent Timothy N. Schott, pursuant to the Insurance Laws of the State of Maine, she has made an Examination on the condition and affairs of:

Maine Energy Management Association Health Insurance Trust

As of December 31, 2022, 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 in the Examination:

Miranda Rampulla, MCM, PIR
Senior Market Conduct Examiner

Connie Mayette

Connie Mayette, CPCU, AIE, MCM, AU, AIC, AINS
Managing Examiner

Subscribed and sworn to before me
This 27 day of December, 2023

Karma Y Lombard

Notary Public

My commission expires: June 12, 2030

Karma Y. Lombard
Notary Public, State of Maine
My Commission Expires June 12, 2030