STATE OF NORTH DAKOTA

TARGETED MARKET CONDUCT EXAMINATION REPORT

SANFORD HEALTH PLAN

SIOUX FALLS, SOUTH DAKOTA

As of December 31, 2020

By Representatives of the

North Dakota Insurance Department

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SALUTATION

October 20, 2023

Honorable Jon Godfread
North Dakota Insurance Commissioner
600 E. Boulevard Ave.
Bismarck, ND 58505

Commissioner Godfread:

Pursuant to your instructions and in compliance with the provisions of North Dakota Century Code ("N.D.C.C."), Chapter 26.1-03 and procedures of the North Dakota Insurance Department ("NDID"), and the procedures established by the National Association of Insurance Commissioners ("NAIC"), a targeted examination ("Examination") of the market conduct activities has been conducted of:

Sanford Health Plan
300 Cherapa Place, Suite 201
Sioux Falls, SD 57103

The report thereon, as of December 31, 2020, is herein respectfully submitted.

North Dakota Insurance Department
Market Conduct Examination
Sanford Health Plan

AFFIDAVIT

STATE OF NORTH DAKOTA

COUNTY OF BURLEIGH

Thomas D. McIntyre, of lawful age, being first duly sworn, upon oath state that I have been charged with examining Sanford Health Plan, as of December 31, 2020. I have prepared and read the foregoing Report of Market Conduct Examination, that I am knowledgeable of the matters set forth therein, and I certify the Report is true and complete to the best of my knowledge and belief.

Thomas D. McIntyre

Thomas D. McIntyre

Subscribed and sworn before me by Thomas D. McIntyre

On this 11th day of January, 2024

Notary Public

DEBORAH J. BEALS
MY COMMISSION # HH 275777
EXPIRES: June 13, 2026

My commission Expires:

SCOPE OF EXAMINATION

Representatives of the North Dakota Insurance Department conducted an Examination of Sanford Health Plan ("Company" or "SHP") under the authority delegated by the Commissioner pursuant to N.D.C.C. §26.1-03. The Examination covered the period of January 1, 2016 through December 31, 2020 ("Examination Period").

The scope of the Examination included, but was not limited to, the following areas:

- Claims Processing
- Mental and Behavioral Health and Substance Abuse Claims, including Mental Health Parity and Addiction Equity Act ("MHPAEA") compliance
- Comparative analyses for Non-quantitative Treatment Limitations ("NQTL") and quantitative Treatment Limitations ("QTL") associated with Mental Health Parity and Addiction Equity Act
- Telehealth Claims
- Independent External Review assignment and procedures
- Coordination of Benefits with Automobile Insurance
- Advertising and Issuance of Medicare Supplement Products
- Insurance Fraud Reporting
- Policy Form Filing
- Agents Licensing, in conjunction with Medicare Plans Issued
- Corporate Governance
- Pharmacy Benefit Management Contracts
- Complaints
- Tier Rating

This report of Examination ("Report") reflects the North Dakota ("ND") insurance activities of the Company. The NDID Examination procedures were conducted at the direction and overall management and control of representatives of the NDID.

The Report is a report by exception. Files or materials reviewed containing no improprieties by the Company have been omitted from the Report. All unacceptable or non-complying practices may not have been identified. The failure to identify specific Company practices does not constitute acceptance of these practices.

Procedures were performed in accordance with the NAIC's Market Regulation Handbook ("Handbook") as adopted by the NAIC and consistent with the predetermined market conduct program presented to and approved by the NDID.

The purpose of the Examination was to make factual determinations of business practices in which the Company was engaged during the Period. The focus of the Examination was to determine if the Company fulfilled its obligations, based on the nature of its operations, to afford proper

treatment to members, and its compliance with all applicable North Dakota statutes, rules, bulletins, insurer policies, contractual obligations, and federal law.

Personnel from Risk & Regulatory Consulting, LLC participated in this Examination in their capacity as Market Conduct Examiners under the direction and supervision of the NDID. The Examiners provide no representations regarding questions of legal interpretation or opinion, which is the sole responsibility of the NDID.

COMPANY HISTORY

Sanford Health is a wholly owned subsidiary of Sanford. Sanford Health is the parent company of SHP, a South Dakota domestic health maintenance organization ("HMO"). SHP was formed as a South Dakota nonprofit corporation on July 10, 1997, under the name Sioux Valley Health Plan and was first licensed as an HMO on September 12, 1997. On May 2, 2007, the name of the corporation was changed to Sanford Health Plan.

The Sanford Health Plan Group (SHPG) is comprised of Sanford Health Plan (SHP), Sanford Health Plan of Minnesota (SHP of MN) and Good Samaritan Insurance Plan, LLC (GSIP). SHP and SHP of MN are taxable nonprofit HMOs which are wholly owned subsidiaries of Sanford Health. GSIP is wholly owned by SHP, having three subsidiaries: Good Samaritan Plan of Nebraska, Inc. (GSIP-NE), Good Samaritan Plan of South Dakota, Inc. (GSIP-SD) and Good Samaritan Plan of North Dakota Inc (GSIP-ND). Both GSIP-SD and GSIP-ND are wholly owned by GSIP. GSIP-NE is owned 35% by Vetter Health, the remaining 65% by GSIP.

The Company's North Dakota health premiums written for individual and group plans from 2016 through 2020 are provided in the table below:

2016	2017	2018	2019	2020
$363,481,977	$366,985,843	$395,041,907	$430,483,040	$475,213,552

The Company's North Dakota membership enrollments for individual and group plans from 2016 through 2020 are provided in the table below:

2016	2017	2018	2019	2020
99,681	97,715	99,241	104,158	117,335

COMPANY OPERATIONS

I. The regulated entity is licensed for the lines of business that are being written.

Chapter 16, Operations/Management - Standard 8 – The regulated entity is licensed for the lines of business that are being written.

The Company is an authorized accident and health insurer in the state of North Dakota.

II. The regulated entity cooperates on a timely basis with examiners performing the examination.

Chapter 16, Operations/Management - Standard 9 – The regulated entity cooperates on a timely basis with examiners performing the examination.

The Examination commenced on April 7, 2022 and concluded October 13, 2023. Company personnel were cooperative throughout the Examination. The Company generally responded timely to data requests and findings ("Criticisms") in accordance with the original deadlines, and in general, requests for extensions were tendered to the examiner-in-charge when the Company could not meet the deadlines. However, issues regarding the Company providing accurate and complete data occurred during testing performed in the following areas: Claims, External Reviews and Complaints.

INSURANCE FRAUD REPORTING

I. Determine if the Company took the appropriate action to report fraud cases to the Insurance Department.

The Company stated that it did not have records of any fraud cases reported to the NDID during the Examination Period.

From 2016 through 2018, the Company used Optum to perform analysis of claims data and this was the only review completed from 2016 through 2018, where the Company noted any activities for the detection of fraudulent activities. The Company did not have a Special Investigations Unit ("SIU") during this period. The Company's policies, processes and procedures to detect fraud from 2016 through 2018 were inadequate and not in compliance with best practices. The Company should have had an antifraud plan that incorporated receiving and reacting to allegations of fraud, the establishment of an investigative team, a determination on how to conduct preliminary assessments, a determination on how to analyze

financial, business, and electronic records including underwriting, and claims analysis concerning provider billings, and a determination on the preservation of data and collection of evidence.

In November of 2018, the Company contracted with Optum for SIU services and opened 20 provider billing issues during 2019, and in 2020 the Company opened 13 provider billing issues. Most of the cases were resolved with provider education. However, the contractual agreement between the Company and Optum did not include SIU services for member enrollments in either the individual or group markets. Considering that North Dakota premiums collected by the Company for non-Medicaid medical services during 2020 was $477,885,467, the review of 33 cases over a two year period appears to be an inadequate number of cases to detect potential fraud. This may indicate a lack of appropriate oversight of its fraud detection policies, practices and procedures, and a lack of effective corporate governance concerning its detection of fraud. Because of the lack of adequate policies, practices and procedures during the Examination Period, the Company did not have the ability to detect or report potential fraud to the Commissioner in writing within sixty days of having knowledge or reasonable belief that a suspected fraudulent insurance act had been committed. Therefore, the Company's failure to have policies, processes and procedures to detect fraud, or to investigate for the detection of suspected fraudulent acts failed to allow for compliance with the requirements of N.D.A.C. §45-15-01-01. The Company agreed that the ability to identify and detect fraud is an essential first step in reporting potential fraud cases to the North Dakota Insurance Department and acknowledged that its processes were not as robust as they currently have and were limited in the ability to detect potential fraud. The Company agreed with this finding and is going to work with the NDID to develop a corrective action plan ("CAP") concerning fraud detection and reporting.

CONTRACT REVIEW

I. <u>Review contracts/policies during phases of the examination to determine if the Company's allowances were in compliance with ND law.</u>

The Company's Mental Health and Substance Use Disorder Benefits for Applied Behavior Analysis for Treatment of Autism Spectrum Disorder in its Good Sam (GSM) joint venture plan with effective dates of January 1, 2018 through December 31, 2019, limited ABA maximum benefits for certain age groups. The Company's GSM plan provided the following:

- "Limits are subject to the Plan's medical management policies and determinations of Medical Necessity. Coverage for ABA shall have an annual maximum benefit not less than the following:
    a. Through age 6 $36,000
    b. Age 7 through age 13 $25,000
    c. Age 14 through age 18 $12,500"

ND Bulletin 2018-1 provides financial requirements (such as deductibles and co-payments) and treatment limitations (such as the number of visits or days of coverage) that apply to mental health/substance use disorder benefits which must be no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical ("M/S") benefits in a classification. Therefore, the GSM plan failed to comply with the requirements of ND Bulletin 2018-1. The Company agreed with this finding and noted that a Company internal analysis showed no members were impacted by these limits and the plan was discontinued during 2019.

II. Review contracts/policies during phases of the examination to determine if the Company's allowed mental health and substance use services are in compliance with N.D.C.C. 26.1-36-08(2)(d) and N.D.C.C. 26.1-36-09(2)(f)(4).

The Company had a manual process for applying mental health and substance use disorder accumulators in its claims systems (calculating hours and visits). The Company had two accumulators that were at times applied correctly. However, during testing it was determined that several of the groups did not have the accumulators inserted into claims programming for each group, or for each year of the Examination Period. Without the accumulator applied for members of a group, the Company failed to provide five (5) free visits for substance use disorders outpatient procedures and five (5) free hours for mental health outpatient procedures. Therefore, in those cases it was a violation of both N.D.C.C. 26.1-36-08(2)(d) and N.D.C.C. 26.1-36-09(2)(f)(4).

In addition, during testing it was determined the Company used hours for its mental health accumulators during 2016 and converted to visits for the balance of the Examination Period. At times there were no accumulators applied. The failure to not apply hours versus visits could have harmed members by not allowing for more than five (5) visits during 2017 through 2020. Therefore, the Company's practices and procedures for not allowing hours versus visits within the mental health accumulators was a violation of N.D.C.C. 26.1-36-09(2)(f)(4).

The findings noted above collectively indicate a lack of effective corporate governance concerning its practices and procedures related to claims adjudication for substance use disorders outpatient procedures and mental health outpatient procedures. The Company agreed with this finding and has put in place a CAP to ensure compliance with N.D.C.C. 26.1-36-08(2)(d) and N.D.C.C. 26.1-36-09(2)(f)(4).

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

I. Determine if the health carrier complies with the requirements of the Mental Health Parity and Addiction Equity Act of 2008 concerning Non-Quantitative Treatment Limitations. The health carrier shall not apply NQTLs to mental health or substance use disorder benefits within a classification of benefits or sub-classification so that any processes, strategies evidentiary standards, or other factors used to apply a limitation, (as written and in operation) are comparable to the processes, strategies, evidentiary standards, or other factors used to apply the limitation to medical/surgical benefits within the classification or subclassification.

The Company was asked to complete the required comparative analysis for all NQTLs the Company imposes on mental health/substance use disorder ("MH/SUD") benefits. As part of the Examination, the Company was asked to complete this analysis for 12 plans, including the largest and median HMO and PPO plans in the individual, small group, and large group markets.

1. The Company provided documentation in support of its medical necessity program including the NQTL concurrent review. A Company response stated, in part, ". . . Concurrent review within the policy is not exclusive to behavioral health; rather, policy language emphasis of "also include care for" was provided to demonstrate inclusion of behavioral health as all concurrent review processes are handled in uniform and consistent with our evidence-based guidelines module (MCG) application. Extended stay criteria review and approval of additional days apply to all reviews, both medical and behavioral. In the application of these policies, staff members understand and apply these policies universally to both Medical/Surgical benefits as well as Mental Health benefits. There is no evidence that this language has changed practice or caused variation in review between behavioral and medical guidelines, but it is our desire for these policies to be clear to internal staff and external individuals. SHP is more than willing to update the policy to provide more descriptive language on the intent and applicability of concurrent review processes to M/S & MH services." The Company's procedures manuals were evaluated from the language as written.

   The Company's analysis of its imposition of the NQTL of its utilization management program for concurrent review, as written, was not sufficient to demonstrate that its application of this limitation to MH/SUD benefits is comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S benefits. This matter represents violations of N.D.C.C. §26.1-02-29, 42 U.S.C. 300gg-26(a)(8)(A)(iv) and (v) as amended by The Consolidated Appropriations Act, 2021 SEC. 203, and 45 CFR §146.136(c)(4). The Company agreed with this finding.

2. Documentation supporting the description of the Company's application of medical necessity criteria appeared to have information in the document indicated that the program had the potential to be used in a discriminatory manner. Concerning this matter, the Company stated, "Data collection and analysis methodology are used to ensure that SHP members receive continuity and coordination of care between their behavioral and medical provider and select opportunities for improvement as part of NCQA requirements" and provided a list of the activities data that was collected for 2021/2022. The list included 11 areas of collection. Three of them were medical/physical, three were neutral, and five were related to behavioral health. The focus on behavioral health does not demonstrate parity, 'as written'. The Company failed to provide results of its 'in operations' testing for this program.

   The Company's analysis of its imposition of the NQTL of its application of coordination of care criteria was not sufficient to demonstrate that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits both as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply to M/S benefits in each benefit classification. This matter represents violations of N.D.C.C. §26.1-02-29, 42 U.S.C. 300gg-26(a)(8)(A)(iv) and (v) as amended by The Consolidated Appropriations Act, 2021 SEC. 203, and 45 CFR §146.136(c)(4). The Company agreed with this finding.

3. The Company provided its appeals and grievances documentation as part of its support for the Company's medical necessity program. The Company provided two documents related to the five (5) categories (Quality of Care, Access, Attitude and Service, Billing and Financial Issues and Quality of Practitioner Office Site), but did not separate behavioral items from non-behavioral, and only referenced behavioral health in one statement. The reports failed to separate the number of complaints and appeals in each category by behavioral health and non-behavioral health. These reports indicated that the Company had not conducted detailed analysis to determine if its application of medical necessity, whether through prior authorization, concurrent review, or retrospective review, to MH/SUD benefits was more stringent than its application to M/S benefits.

   The Company's analysis of its imposition of the NQTLs for its appeals and grievances programs in operation was not sufficient to demonstrate that its imposition on MH/SUD benefits is comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to M/S requests. This matter represents violations of N.D.C.C. §26.1-02-29, 42 U.S.C. 300gg-26(a)(8)(A)(iv) and (v) as amended by The Consolidated Appropriations Act, 2021 SEC. 203, and 45 CFR §146.136(c)(4). The Company agreed with this finding.

4. The Company provided its comparative analysis of its imposition of prior authorization, concurrent review, and retrospective review separately, however, the information provided

in each was substantially similar and they shared the same issue. While this is written as one error, it should be noted that the error applied to three distinct NQTLs.

After evaluating the Company's documents, it was determined that the comparative analyses provided by the Company related to prior authorization, concurrent review, and retrospective review, was not sufficient to demonstrate that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH/SUD benefits in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply prior authorization to M/S benefits in each benefit classification. This matter represents violations of N.D.C.C. §26.1-02-29, 42 U.S.C. 300gg-26(a)(8)(A)(iv) and (v) as amended by The Consolidated Appropriations Act, 2021 SEC. 203, and 45 CFR §146.136(c)(4). The Company agreed with this finding.

5. The Company provided a comparative analysis that combined two (2) NQTLs imposed on pharmacy benefits, step-therapy and prior authorization. A Company response associate with this review stated, "Agreed. Step therapy and Prior Authorization create separate rejection notices and are reviewed separately." The requirement for comparative analysis is that each NQTL and each applicable benefit classification (inpatient, in-network; inpatient, out-of-network; outpatient, in-network; outpatient, out-of-network; emergency; and pharmacy) also be evaluated separately. While step therapy and prior authorization in this case are both applicable to only one benefit classification, pharmacy, they are each a separate NQTL, and were analyzed separately.

   The Company's combined analysis of its imposition of the two (2) NQTLs for step therapy and prior authorization to pharmacy benefits as written, was not sufficient to demonstrate that its imposition on MH/SUD benefits is comparable to, and imposed no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTLs to M/S requests. This matter represents violations of N.D.C.C. §26.1-02-29, 42 U.S.C. 300gg-26(a)(8)(A)(iv) and (v) as amended by The Consolidated Appropriations Act, 2021 SEC. 203, and 45 CFR §146.136(c)(4). The Company agreed with this finding.

6. The Company's comparative analysis of the combined two (2) NQTLs on pharmacy benefits, step-therapy and prior authorization included a step that documented as written parity, which included the following statement "All Medications are approved through the Pharmacy and Therapeutics committee." This response on its own was not sufficient to document as written parity. The Company also provided two other documents, which documented the Company's policies related to adding drugs to the formulary, the credentials required by Committee members and the policies related to applying limitations to drugs. A Company's response concerning one of those documents stated, "Limits are applied identically to all classifications of drugs and are not applied more stringently by benefit type." An NQTL can have the same policy for both MH/SUD and M/S benefits and in practice have the policy applied more stringently on MH/SUD benefits.

The Company's analysis of its imposition of the NQTLs for step therapy and prior authorization to pharmacy benefits in operation was not sufficient to demonstrate that its imposition on MH/SUD benefits is comparable to, and imposed no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTLs to M/S requests. This matter represents violations of N.D.C.C. §26.1-02-29, 42 U.S.C. 300gg-26(a)(8)(A)(iv) and (v) as amended by The Consolidated Appropriations Act, 2021 SEC. 203, and 45 CFR §146.136(c)(4). The Company agreed with this finding.

7. The documentation provided by the Company only included one (1) NQTL related to providers or networks for Network Access. In the definition of the NQTL, the Company described the benefits to the member in utilizing an in-network provider, versus an out-of-network provider. A Company response stated, "For any provider participating in the network, SHP has processes related to credentialing, malpractice insurance, and reimbursement rates." However, the Company did not provide any additional analysis concerning these NQTLs. In addition, another Company response stated, "Sanford Health Plan performs continual analysis of NQTL related processes. Much of this analysis comes from day to day activities and is not produced into a formal report. Sanford Health Plan does not have additional reports to provide at this time." Given the Company's statement that all providers are able to negotiate, and no information about what factors are considered during the negotiations, there is a greater chance of having rates for MH/SUD providers that are not comparable to M/S providers.

   The Company's comparative analysis for the NQTL of Network Access which encompasses provider reimbursement, credentialing, and adequacy as outlined was not sufficient to demonstrate that its, in operation imposition of the NQTL was comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required. This matter represents violations of N.D.C.C. §26.1-02-29, 42 U.S.C. 300gg-26(a)(8)(A)(iv) and (v) as amended by The Consolidated Appropriations Act, 2021 SEC. 203, and 45 CFR §146.136(c)(4). The Company agreed with this finding.

8. The Company's analysis included several NQTLs that were not formally evaluated in the Company's seven-step process, which included, Emergency 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 the Limit Duration of Scope of Benefits for Services and Restrictions for Provider Specialty. However, there was no in operation evaluation provided for any one of the NQTLs. A Company response to these NQTLs stated, "Sanford Health Plan performs continual analysis of NQTL related processes. Much of this analysis comes from day-to-day activities and is not produced into a formal report. Sanford Health Plan does not have additional reports to provide at this time."

The Company's comparative analysis for the above listed NQTLs was not sufficient to demonstrate that its, in operation imposition of the NQTLs on MH/SUD benefits was comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitations with respect to M/S benefits in the classification as required. This matter represents violations of N.D.C.C. §26.1-02-29, 42 U.S.C. 300gg-26(a)(8)(A)(iv) and (v) as amended by The Consolidated Appropriations Act, 2021 SEC. 203, and 45 CFR §146.136(c)(4). The Company agreed with this finding.

9. The Company provided several documents that described its case management program including workflows for identifying and enrolling members in the Company's case management program. A Company response concerning case management stated, "The High Risk BH program enrolls members with high risk behavioral health conditions and the CCM program enrolls members with high risk medical conditions. Based upon the program, this is the area of primary focus for case management services and coordination of care. If additional conditions exist, consultation is done between the medical and BH teams to ensure all health needs are addressed. Members in the behavioral health program are contacted by the BH case managers who are licensed counselors or social workers where as [sic] the CCM case managers are all RNs." The separate workflow documents contained differences that could be demonstrative of a lack of parity 'as written' and created concerns for the program "in operation". The Company failed to provide any in operations testing outcomes, which could provide evidence of parity "in operation".

   The Company's comparative analysis for the NQTL of care management was not sufficient to demonstrate that its imposition of care management with respect to MH/SUD benefits, both written and in operation, was comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to M/S benefits in the classification as required. This matter represents violations of N.D.C.C. §26.1-02-29, 42 U.S.C. 300gg-26(a)(8)(A)(iv) and (v) as amended by The Consolidated Appropriations Act, 2021 SEC. 203, and 45 CFR §146.136(c)(4). The Company agreed with this finding.

II. ***Determine if the health carrier complies with the requirements of the Mental Health Parity and Addiction Equity Act of 2008 concerning Quantitative Treatment Limitations ("QTLs"). The health carrier shall not apply any QTL on mental health or substance use disorder benefits in any classification or subclassification that is more restrictive than the predominant QTL of that type applied to substantially all medical/surgical benefits in the same classification or subclassification.***

The mental health parity law requires the Company to complete testing of its plans to ensure that limits applied to mental health and substance use disorder benefits within a classification are not greater than the predominant limit applied to substantially all medical surgical benefits

in that classification. As part of the Examination, the Company was asked to complete this testing for 12 plans, including the largest and median HMO and PPO plans in the individual, small group, and large group markets.

Summary of Errors by Plan

Plan	Application of an Impermissible Financial Requirement or Treatment Limitation North Dakota Century Code § 26.1-02-29, 42 U.S. Code § 300gg–26(a)(3)(A)(ii), and 45 CFR §146.136(c)(2)(i)
Individual PPO Largest	1
Individual PPO Median	1
Large Group HMO Median	1
Large Group PPO Median	2
Small Group PPO Largest	1
Small Group PPO Median	1
Total Errors by Plan	7

1. Individual PPO Largest Plan – Sanford Simplicity 4750

The Company's plan urgent care benefits are placed in the outpatient, office visit classification for both in-network and out-of-network classifications with a $50 copay. This limit met the substantially all test when applied in-network. However, as all other benefits within the outpatient, out-of-network, office visit classification had a coinsurance applied, the copay represented 3.37% of the limitations applied in that classification. The $50 copay did not meet the substantially all test and the limitation of copay may not be applied to any MH/SUD benefit in the outpatient, out-of-network, office visit classification. Therefore, the Company's plan was designed to apply the copay treatment limitation for MH/SUD benefits in the outpatient, out-of-network, office visit classification when that limitation was not applied to substantially all M/S benefits in the classification, in violation of N.D.C.C. §26.1-02-29, 42 U.S.C. 300gg-26(a)(3)(A)(ii), and 45 CFR §146.136(c)(2)(i). The Company disagreed with this finding. The

Company noted that the Tool utilized for testing is still under development by the NAIC and was not in place during the examination period.

2. Individual PPO Median Plan – Sanford Simplicity 2800

The Company's plan urgent care benefits were placed in the outpatient, office visit classification for both in-network and out-of-network classifications with a $50 copay. This limit met the substantially all test when applied in-network. In the outpatient, out-of-network, office visit classification, in addition to urgent care, the classification also indicated a copay of $80 was applied to primary care physician office visits. However, regardless of the amount, a copay was only applied to 30.75% of benefits with a coinsurance being applied to 69.25% of the benefits in that classification. The copay did not meet the substantially all test and the limitation of a copay may not be applied to any MH/SUD benefit in the outpatient, out-of-network, office visit classification. Therefore, the Company's plan was designed to apply the treatment limitation of copay to MH/SUD benefits in the outpatient, out-of-network, office visit classification when that limitation was not applied to substantially all M/S benefits in the classification, in violation of N.D.C.C. §26.1-02-29, 42 U.S.C. 300gg-26(a)(3)(A)(ii), and 45 CFR §146.136(c)(2)(i). The Company disagreed with this finding. The Company noted that the Tool utilized for testing is still under development by the NAIC and was not in place during the applicable examination period.

3. Large Group HMO Median Plan – Mandan Public 2500 True

The Company's plan urgent care benefits were placed in the outpatient, office visit classification for both in-network and out-of-network classifications with a $25 copay. While there were no claims payments made for this benefit within the outpatient, out-of-network, office visit classification, as this is the only covered benefit in this classification; if any claims payments were made in this classification, it would be for this benefit and would represent 100% of the benefits paid in the classification and would meet the substantially all test. However, emergency transportation provided a coinsurance and deductible, which represented 4.29% of the benefits in the emergency classification. Neither the coinsurance nor deductible met the substantially all test and neither the limitation of coinsurance, nor deductible may be applied to any MH/SUD benefit in the outpatient, out-of-network, office visit classification. Therefore, the Company's plan was designed to apply the treatment limitations of coinsurance and deductible to MH/SUD benefits in the emergency classification when those limitations were not applied to substantially all M/S benefits in the classification, in violation of N.D.C.C. §26.1-02-29, 42 U.S.C. 300gg-26(a)(3)(A)(ii), and 45 CFR §146.136(c)(2)(i). The Company disagreed with this finding. The company noted that the Tool utilized for testing is still under development by the NAIC and was not in place during the applicable examination period.

4. Large Group PPO Median Plan – Ward County 500

The Company's plan urgent care benefits were placed in the outpatient, office visit classification for both in-network and out-of-network with a $35 copay. This limit met the substantially all test when applied in-network. However, as all other benefits within the outpatient, out-of-network, office visit classification had a coinsurance applied, the copay represented 3.27% of the limitations applied in the classification. Therefore, the copay did not meet the substantially all test and the limitation of the copay may not be applied to any MH/SUD benefit in the outpatient, out-of-network, office visit classification.

In addition, the plan information indicated emergency transportation represented 14.48% of the benefits in this classification. Therefore, the coinsurance and deductible did not meet the substantially all test and the limitation may not be applied to any MH/SUD benefit in the emergency classification.

A. The Company's plan was designed to apply the treatment limitation of a copay to MH/SUD benefits in the outpatient, out-of-network, office visit classification when that limitation is not applied to substantially all M/S benefits in the classification, in violation of N.D.C.C. §26.1-02-29, 42 U.S.C. 300gg-26(a)(3)(A)(ii), and 45 CFR §146.136(c)(2). The Company disagreed with this finding. The Company noted that the Tool utilized for testing is still under development by the NAIC and was not in place during the applicable audit years.

B. The Company's plan was designed to apply the treatment limitations of a coinsurance and deductible to MH/SUD benefits in the emergency classification when those limitations were not applied to substantially all M/S benefits in the classification, in violation of N.D.C.C. §26.1-02-29, 42 U.S.C. 300gg-26(a)(3)(A)(ii), and 45 CFR §146.136(c)(2)(i). The Company disagreed with this finding. The Company noted that the Tool utilized for testing is still under development by the NAIC and was not in place during the applicable examination period.

5. Small Group PPO Largest Plan – Sanford Simplicity 2250

The Company's plan urgent care benefits were placed in the outpatient, office visit classification for both in-network and out-of-network classifications with a $40 copay. This limit met the substantially all test for in-network. For the outpatient, out-of-network, office visit classification, which included urgent care, the classification indicated a copay of $70 applied to primary care physician office visits, with a 60% coinsurance and deductible applied to all other benefits in the classification. In substantially all testing, a copay regardless of the amount, was applied to 50.14% of the benefits, while a coinsurance and deductible was applied to 49.86% of the benefits in this classification. The copay, coinsurance, and deductible all

failed to meet the 2/3rds substantially all requirement, and no limitation may be applied to any MH/SUD benefits in the outpatient, out-of-network, office visit classification. Therefore, the Company's plan was designed to apply the treatment limitations of copay, coinsurance and deductible to MH/SUD benefits in the outpatient, out-of-network, office visit classification when those limitations were not applied to substantially all M/S benefits in the classification, in violation of N.D.C.C. §26.1-02-29, 42 U.S.C. 300gg-26(a)(3)(A)(ii), and 45 CFR §146.136(c)(2)(i). The Company disagreed with this finding. The Company noted that the Tool utilized for testing is still under development by the NAIC and was not in place during the applicable examination period.

6. Small Group PPO Median Plan – Sanford Simplicity 1750

The Company's plan urgent care benefits were placed in the outpatient, office visit classification for both in-network and out-of-network classifications with a $40 copay. This limit met the substantially all test in-network. However, as all other benefits within the outpatient, out-of-network, office visit classification had a coinsurance applied, the copay represented 0% of the benefits in the outpatient, out-of-network, office visit classification. The $40 copay did not meet the substantially all test and the copay limitation may not be applied to any MH/SUD benefits in the outpatient, out-of-network, office visit classification. Therefore, the Company's plan was designed to apply the treatment limitation of a copay to MH/SUD benefits in the outpatient, out-of-network, office visit classification when those limitations were not applied to substantially all M/S benefits in the classification, in violation of N.D.C.C. §26.1-02-29, 42 U.S.C. 300gg-26(a)(3)(A)(ii), and 45 CFR §146.136(c)(2)(i). The Company disagreed with this finding. The Company noted that the Tool utilized for testing is still under development by the NAIC and was not in place during the applicable examination period.

MEDICARE SUPPLEMENT MARKETING, UNDERWRITING AND PRODUCERS

I. <u>Determine if the Company issued Medicare Supplement plans in compliance with ND law.</u>

The Company provided 1,096 Medicare Supplement application files and there were a total of 524 files with at least one issue noted during testing. In some cases, the Examiners identified multiple issues with the applications. Therefore, 47% of the application files failed.

A. For two (2) of the 1,096 Medicare Supplement application files tested, the Company could not locate those files and therefore those files could not be tested for any issues in the applications in violation of N.D.A.C. §45-06-01.1-18. The Company agreed with this finding.

B. For five (5) of the 1,096 Medicare Supplement application tested, the Company's agents failed to sign the Medicare Supplement applications in violation of N.D.A.C. §45-06-01.1-15(4). In addition, in 176 cases the Company failed to have the agent complete the application, or complete the agent section with the agent number, the date, or the previous policies information in violation of N.D.A.C. §45-06-01.1-15(4). Furthermore, in 17 cases, the Company's agents failed to list Medicare Supplement policies sold in the last 5 years that are no longer in force on the form in violation of N.D.A.C. §45-06-01.1-15(2)(b). The Company agreed with this finding.

C. For 52 of the 1,096 Medicare Supplement application files tested, either the Company failed to have the applicant provide the medical questions necessary for underwriting when required, had the applicant complete the medical questions when not applicable, or failed to have an approved guaranteed issue policy form for use in the offer of a Medicare Supplement policy without underwriting, in violation of N.D.A.C. §45-06-01.1-18. The Company agreed with this finding.

D. For 94 of the 1,096 Medicare Supplement application files tested, either the Company failed to have the applicant provide a replacement form when required, or had the applicant and agent complete a replacement form when not required in violation of N.D.A.C. §45-06-01.1-15(4) & (5). In addition, the Company accepted 16 incomplete or inaccurate replacement forms in violation of N.D.A.C. §45-06-01.1-15(4) & (5) and N.D.A.C. §45-06-01.1-18. Furthermore, for three (3) files the agent, applicant, or both failed to date the replacement form in violation of N.D.A.C. §45-06-01.1-15(4) & (5). The Company agreed with this finding.

E. For eight (8) of the 1,096 Medicare Supplement application files tested, the Company failed to have the applicant provide a signed HIPAA authorization or it was not provided in violation of N.D.A.C. §45-14-01-05(1) and §45-14-01-18 (1)(d). The Company agreed with this finding.

F. For 300 of the 1,096 Medicare Supplement application files tested, the Company either allowed an applicant to indicate they were not eligible, not indicate the applicant's correct age, or failed to complete all applicable required eligibility questions in violation of N.D.A.C. §45-06-01.1-18. The Company agreed with this finding.

G. For 29 of the 1,096 Medicare Supplement application files tested, either the Company failed to have the applicant provide a Select Disclosure form when required, or had the applicant

complete a Select Disclosure form when not applicable in violation of N.D.A.C. §45-06-01-08(9) & (10). The Company agreed with this finding.

H. For seven (7) of the 1,096 Medicare Supplement application files tested, the Company allowed the agent and applicant to back-date the application in violation of N.D.A.C. §45-06-01.1-18. The Company agreed with this finding. The Company should develop a CAP associated with only Medicare Supplement renewals and replacements, as the Company indicated it no longer markets or writes new business in the state of ND.

The Company lacked oversight of its Medicare Supplement application processes and procedures during the Examination Period, which indicated a lack of effective corporate governance.

II. Determine if the Company's Medicare Supplement Producers are appointed and licensed in compliance with ND law.

For 10 of the 1,096 Medicare Supplement applications, the agents were not appointed at the time those 10 applications were accepted and policies were issued in violation of N.D.C.C. §26.1-26-13.1(1), N.D.C.C. §26.1-26-06 and N.D.A.C. §45-02-02-06. One percent (1%) of the files were failed. The Company agreed with this finding.

DENIED PREAUTHORIZATIONS FOR MENTAL HEALTH AND SUBSTANCE USE DISORDERS

I. Determine if denied preauthorizations for mental health and substance use disorders are handled in accordance with policy provisions, the Company's medical policies and procedures, and state law.

The Company provided a population of 107 MH/SUD preauthorization files, and all were tested.

Of the 107 preauthorization files tested, three (3) files failed because the Company failed to allow medically necessary services that should have been approved based on the Milliman Care Guidelines or ASAM Criteria. In all three (3) cases, the Company's actions were a violation of N.D.C.C. §§26.1-04-03(7)(b) & 9(a) and 26.1-04-07. Therefore, three percent (3%) of the files failed. The Company disagreed in each case.

II. Determine if denied preauthorizations for mental health and substance use disorders are handled in accordance with policy provisions, its policies and procedures and state law.

For 17 of the 107 preauthorization case files, the Company issued network exception denial letters to members that contained language that misrepresented the out-of-network benefits and network exception provisions of the policy contracts to the members. The Company's misrepresentation of out-of-network benefits and network exceptions had the potential to lead members to receive services from in-network providers when the members could have received out-of-network benefits for services received from out-of-network providers. Therefore, the Company was in violation of N.D.C.C. §26.1-04-03(1). Therefore, fifteen percent (15%) of the files failed. The Company agreed with this finding and stated in part, "During the examination period, there was an evolution of this type of letter and language used in three major revisions. These revisions were associated with feedback from NCQA reviews and guidance of these processes. Sanford Health Plan has included a current example of one of these letters demonstrating additional clarifying language since the examination period. We are open to feedback on these letters and happy to make any additional updates or additions."

III. Determine if denied preauthorizations for mental health and substance use disorders are handled in accordance with policy provisions and state law.

During review of the preauthorization files it was determined that the Company used the term "independent review organization" ("IRO") within its adverse benefit determination letters and member correspondence during the initial adverse determination stage of the Company's internal provider review process. The Company's practice when using an outside hired medical provider to review medical necessity for members was to describe the reviewer as an IRO to its members in its adverse benefit determination letters.

However, because the Company used the term 'independent review organization" or "IRO" in member documents and correspondence at the initial internal appeals/adverse benefit determination stage of the pre-authorization review, the Company could have led members to interpret the term IRO in the member documents to have the same meaning as "independent review organization" under N.D.C.C. §26.1-36-46(1)(g) which is defined as "an entity that conducts independent external reviews of adverse benefit determinations" and N.D.C.C. §26.1-36-46(3)(b). By using the term IRO, the Company's letter may have been interpreted as an external entity having already completed an independent review of the preauthorization denial. The Company's letter indicated the external review is "final and binding", therefore, when reading the letter in its entirety, a member could have concluded that the Company's determination was final and binding, which could lead a member to believe there were no further external review rights at that point. The Company's use of the term IRO in member correspondence during the Examination Period failed to provide an effective written notice of the claimant's rights to an external review of an adverse benefit determination, which could

have led members to believe there were no further external review rights, and failed to provide an effective written notice of the claimant's rights to an external review of an adverse benefit determination in violation of N.D.C.C. §§26.1-36-46(3)(b) and N.D.C.C. 26.1-36-46(1). The Company agreed with this finding and during the Examination the Company eliminated the term IRO in its adverse determination letters as a result of the examination and thereby eliminating the final and binding issue in its external review letters.

TELEHEALTH SERVICES COVERAGE AND CLAIMS

I. Determine if Telehealth Paid and Denied Claims were adjudicated in compliance with ND laws (NDCC 26.1-36-09.15) and rules, and allowed for compliance with the contract/policy language.

For one (1) of the 109 telehealth claim files sampled, the Company allowed a deductible or copayment during the first five (5) hours in any calendar year, which was not in compliance with N.D.C.C. 26.1-36-09(f)(4). Therefore, less than one percent (1%) of the files were failed. The Company agreed with this finding, but stated in part, "DSM-5 classifications were updated on October 1st, 2016 and began using the new code F42.2 versus the previous F42. Sanford Health Plan's updates to our configuration to include this new code were after this claim was adjudicated in November of 2016. Since that time Sanford Health Plan uses additional sources beyond DSM-5 to assist in accurate benefit configuration."

COORDINATION OF BENEFITS

I. Determine if the Company's policies and procedures and its adjudication of claims for coordination of benefits ("COB") with automobile insurers were in compliance with ND statutes, rules and Bulletin 2015-1.

There were 84 COB claims with an automobile carrier sampled and tested. Of the 84 files tested, there were 16 files that were not processed in compliance with ND law. Therefore, 19% of the files failed. Seven (7) of the files were not adjudicated in compliance with N.D.C.C. §26.1-41-13(3), N.D.A.C. §45-08-01.2-05 and Bulletin 2015-1. For the other nine (9) files, the Company paid the claim as primary when coordination of benefits was applicable, which was not in compliance with N.D.A.C. §45-08-01.2-05. In addition, the Company failed to follow its contract/policy language when it paid the claim as primary, when paying as secondary was appropriate. The Company agreed with these findings.

II. Determine if the Company's policies and procedures for its explanation of benefits ("EOB") when coordinating benefits with automobile insurers were in compliance with ND statutes, rules and Bulletin 2015-1.

The EOBs stated in part, "The total member responsibility for this claim is . . ." and then gives an amount, which matches the noted member cost shares applied and not owed, and therefore the EOBs were a misrepresentation to the member and did not allow compliance with N.D.C.C. §26.1-04-03(1). Testing of the COB files revealed that when the Company issues an EOB after it has calculated the benefits it would have paid on the claim, in the absence of other health care coverage, applied that calculated amount to any allowable expense under its plan that is unpaid by the primary plan and the Company includes a patient responsibility for the calculated amounts when the member may not be responsible. The Company, as the secondary plan then credits to its plan any deductible amounts it would have credited to its deductible in the absence of other health care coverage. This was applicable to all of the files tested with a cost share applied for COB with an auto carrier. Without clarifying language this practice and procedure misrepresented to the member the patient responsibility for cost share(s) when none may be applicable and therefore, did not comply with N.D.C.C. §26.1-04-03(1). The Company made corrections to the EOBs during 2020, which contained additional clarifying language, therefore it will not be required to create a corrective action plan for this issue. The Company agreed with this finding.

PHARMACY BENEFIT MANAGERS ("PBM") REVIEW

I. Determine if the Company complied with N.D.C.C. §26.1-27.1-06.2, which requires "covered entities" subject to examination by the commissioner to make an annual disclosure to the commissioner.

The Company failed to file the annual disclosure required during the four (4) annual periods associated with the Examination Period in violation of N.D.C.C. §26.1-27.1-06.2. The Company agreed with this finding.

II. Determine if the Company contractual provisions comply with N.D.C.C. §26.1-27.1-05(2).

The Company had constraints in the Client Audit provision of the Company's Prescription Drug Benefit Administration Agreement with OptumRx that failed to comply with the requirements of N.D.C.C. § 26.1-27.1-05(2), which mandates the Covered Entity to have audited books, accounts, and records as necessary to confirm that the benefit of a payment received by the pharmacy benefits manager is being shared as required by the contract. The Company agreed with this finding.

RECOMMENDATIONS

I. The Company has agreed to develop and implement a CAP associated with investigating and reporting of fraud or potential fraudulent activity for compliance with N.D.A.C. §45-15-01.01. The NDID has provided a recommendation letter to the Company associated with fraud investigations and reporting of fraud.

II. The Company has developed a CAP as noted above in the Contracts Section of this report for the accumulators applied for group members to ensure compliance with N.D.C.C. 26.1-36-08(2)(d) and N.D.C.C. 26.1-36-09(2)(f)(4). The CAP should ensure the accumulators always provide group members five (5) free visits for substance use disorders outpatient procedures and five (5) free hours for mental health outpatient procedures.

III. A CAP should be developed and implemented wherein the Company can demonstrate that the processes, strategies, evidentiary standards, and other factors used to apply NQTLs to MH/SUD benefits in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply M/S benefits in each benefit classification for compliance with N.D.C.C. §26.1-02-29, 42 U.S.C. 300gg-26(a)(8)(A)(iv) and (v) as amended by The Consolidated Appropriations Act, 2021 SEC. 203, and 45 CFR §146.136(c)(4).

IV. A CAP should be developed and implemented wherein the Company can demonstrate that its plans are designed to comply with the predominant and substantially all testing to ensure that spending on M/S benefits in a classification are not applied more stringently to MH/SUD benefits in the same classification for compliance with N.D.C.C. §26.1-02-29, 42 U.S.C. 300gg-26(a)(3)(A)(ii), and 45 CFR §146.136(c)(2)(i).

V. A CAP should be developed and implemented wherein the Company ensures its Medicare Supplement renewals and replacements are processed in compliance with N.D.A.C. §45-06-01.1-18, N.D.A.C. §45-06-01.1-15(4) & (5), N.D.A.C. §45-06-01.1-15(2)(b), N.D.A.C. §45-14-01-05(1) and N.D.A.C. §45-06-01-08(9) & (10).

VI. A CAP should be developed and implemented wherein the Company ensures its agents are appointed at the time applications are accepted in compliance with N.D.C.C. §26.1-26-13.1(1), N.D.C.C. §26.1-26-06 and N.D.A.C. §45-02-02-06.

VII. A CAP should be developed and implemented wherein the Company ensures it allows medically necessary services based on the Milliman Care Guidelines or the ASAM Criteria for compliance with N.D.C.C. §§26.1-04-03(7)(b) & 9(a) and 26.1-04-07.

VIII. A CAP should be developed and implemented wherein the Company ensures its 52 preauthorization exception denial letters contain language that does not misrepresent the out-of-network benefits and network exception provisions of its policy contracts for compliance with N.D.C.C. §26.1-04-03(1).

IX. A CAP should be developed and implemented wherein the Company ensures its COB with automobile insurers are adjudicated in compliance with N.D.C.C. §26.1-41-13(3), N.D.A.C. §45-08-01.2-05 and Bulletin 2015-1.

X. A CAP should be developed and implemented wherein the Company ensures it files its PBM annual disclosure in compliance with N.D.C.C. §26.1-27.1-06.2.

XI. A CAP should be developed and implemented wherein the Company ensures its PBM Administration Agreements allow the Covered Entity to have audited books, accounts, and records as necessary to confirm that the benefit of a payment received by the pharmacy benefits manager is being shared as required by the contract for compliance with the requirements of N.D.C.C. § 26.1-27.1-05(2).

The Company is to respond to the twelve CAPS listed above with 45 days of receipt of this report.

STATE OF NORTH DAKOTA

INSURANCE DEPARTMENT

I, the undersigned, Commissioner of Insurance of the State of North Dakota, do hereby certify that I have compared the annexed copy of the Targeted Market Conduct Examination Report of the

Sanford Health Plan

Sioux Falls, South Dakota

as of December 31, 2020, with the original on file in this Department and that the same is a correct transcript therefrom and of the whole of said original.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal at my office in the City of Bismarck, this 24th day of January, 2024.

Jon Godfread
Commissioner