

Final Report Federal Targeted Market Conduct Examination Report of  
**Allegiance Life and Health Insurance Company, Inc. HIOS ID #42133**  
Montana as of June 23, 2020

Examination Report: 42133 - 2016 – FED – 1

June 23, 2020

In accordance with Title 45 of the Code of Federal Regulations (C.F.R.), § 150.313, the Center for Consumer Information and Insurance Oversight (CCIIO) has completed a targeted Market Conduct Examination (Examination) of Allegiance Life and Health Insurance Company, Inc., HIOS ID #42133, (Issuer) in the State of Montana. The Examination review period was January 1, 2014 through October 31, 2015, and focused on compliance with the requirements under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) under 42 U.S.C. §300gg-26 and 45 C.F.R §§ 146.136 and 147.160.

## Table of Contents

I. Executive Summary .....	4
II. Scope of Examination .....	5
III. Summary of Findings .....	6
IV. Issuer Profile .....	7
V. Examination Results .....	8
VI. Closing .....	15
VII. Examination Report Submission .....	16

## **I. Executive Summary**

The Center for Consumer Information and Insurance Oversight (CCIIO) has conducted a targeted Market Conduct Examination (Examination) of Allegiance Life and Health Insurance Company, Inc. (Issuer) to assess the Issuer's compliance with the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended, for health insurance coverage it issued in the State of Montana. In the course of the Examination, it was noted that an affiliate of the Issuer, Allegiance Benefit Plan Management, Inc. (ABPM), is a Third-Party Administrator (TPA) for self-funded, non-Federal governmental (non-Fed) plans. CCIIO therefore also requested and reviewed samples from and policies and procedures used by the Issuer's affiliate, ABPM, as the TPA for self-funded, non-Fed plans during the Examination. The period covered by the Examination was January 1, 2014 through October 31, 2015 (Examination Period).

A random sample of 858 claims were reviewed. CCIIO found a total of one MHPAEA violation that impacted 37 claims during the Examination Period that ABPM administered for self-funded, non-Fed plans. In addition, the Allegiance Policies and Procedures Manual included a non-quantitative treatment limitation (NQTL) that did not comply with the parity requirements for NQTLs.. The Allegiance Policies and Procedures Manual was used for both the Issuer's insured plans and the self-funded, non-Fed plans to which ABPM provides TPA services. CCIIO requested that the Issuer modify certain policies and procedures to ensure future compliance of its insured plans and the self-funded, non-Fed plans to which ABPM provides TPA services. In addition, the Issuer completed a self-audit of the Issuer's insured plans and self-funded, non-Fed plans to which ABPM provides TPA services relating to the MHPAEA violations. The Issuer identified claims that should have been paid, re-adjudicated the identified claims, and made payments (as necessary).

This report is by exception. Therefore, the only areas indicated in the report are areas where findings were noted. A finding was identified for the following Federal statute and regulation: MHPAEA, 42 U.S.C. §300gg-26(a)(3) and 45 C.F.R. § 146.136(c)(4)(i). Additional details regarding the finding are described in the Examination Results section of this report.

The Examination identified practices that do not comply with applicable Federal requirements, some of which may also violate State insurance laws and regulations. The Issuer was directed to take immediate corrective action to demonstrate its ability and intention to conduct business in accordance with Federal statutes and regulations. When applicable, corrective actions for other jurisdictions should be addressed.

## II. Scope of Examination

CCIIO conducted an Examination pursuant to 45 C.F.R. § 150.313. The Examination Period was January 1, 2014 through October 31, 2015. The purpose of the Examination was to assess the Issuer's compliance with MHPAEA.

Some non-compliant practices may not have been discovered or noted in this report. Failure to identify or address business practices that are not compliant with Federal statutes and regulations or other jurisdictions does not constitute acceptance of such practices.

The Examination and testing methodologies followed standards established by the National Association of Insurance Commissioners (NAIC) and procedures developed by CCIIO. All sample files were selected using a computer-generated random sample unless otherwise stated.

Area	Population	Sample Size
Inpatient / In-Network paid claims	4,236	44
Inpatient / In-Network denied claims	159	34
Inpatient / Out-of-Network paid claims	749	34
Inpatient / Out-of-Network denied claims	507	43
Outpatient / In-Network paid claims	60,150	180
Outpatient / In-Network denied claims	4,023	52
Outpatient / Out-of-Network paid claims	7,804	55
Outpatient / Out-of-Network denied claims	14,891	114
Emergency Care paid claims	2,821	47
Emergency Care denied claims	399	37
Prescription drugs (RX) paid claims	43,472	109
Prescription drugs (RX) denied claims	19,316	109

The Issuer's and ABPM's responses to criticisms issued during the Examination process appears after the finding in the Examination Results section of this report. CCIIO requested that the Issuer and ABPM take certain actions to ensure that the Issuer's insured plans and the self-funded, non-Fed plans to which ABPM provides services as a TPA are in compliance with MHPAEA. The actions taken in response to these requests are noted in the Examination Results section of this report.

### III. Summary of Finding(s)

Finding #	Summary	Citation	Completed Corrective Actions
1	Failure to demonstrate that non-quantitative treatment limitations (NQTLs) applied to mental health/substance use disorder (MH/SUD) benefits are no more restrictive than those applied to Medical/Surgical (M/S) benefits.	MHPAEA, 42 U.S.C. §300gg-26(a)(3); 45 C.F.R. § 146.136(c)(4)(i)	The Issuer and ABPM have stated to CCIIO that they have removed NQTLs in processes and procedures that did not comply with the MHPAEA regulations for both the insured plans and the self-funded non-Fed plans to which ABPM provides services as a TPA. The Issuer and ABPM have also provided proof to CCIIO, within the requested time frame, that they have completed a self-audit of denied claims, made determinations of coverage, re-adjudicated claims, and made payment, as needed, for the Issuer's insured plans and the self-funded, non-Fed plans where ABPM provides services as the TPA.

#### IV. Issuer Profile

The Issuer was incorporated under the laws of the State of Montana as Allegiance Life & Health Insurance Company, Inc. and a certificate of authority was granted on November 30, 2006.

The Issuer is a subsidiary of Benefit Management Corporation, a holding company. In 2008, the Issuer became a wholly-owned subsidiary of Connecticut General Life Insurance Company (CGLIC), a subsidiary of Cigna Corporation, when CGLIC purchased the Benefit Management Corp. The Issuer, ABPM, StarPoint, and Allegiance COBRA Services are all subsidiaries of Benefit Management Corp. ABPM provides third party administration services to employee benefit plans for companies, associations, and government agencies.

The above information is based on the Issuer's website. The Issuer was asked to provide the types of products offered and information about acquisitions and mergers and the Issuer directed CCIO to the Issuer's website. The following is an excerpt from the State of Montana's Market Conduct report of the Issuer dated 4/18/2016:<sup>1</sup>

“The Company entered into an administrative services agreement with Allegiance Benefit Plan Management, Inc. (ABPM). Under the terms of the agreement, ABPM performs virtually all of the services necessary to operate the Company, including, but not limited to, providing accounting, contracting with subscribers and providers, processing and adjudicating claims, utilization management services, pharmacy benefit management services, legal and regulatory services, information technology services, as well as production and mail room services. The Company is charged administrative fees for these services.

The Company entered into an agreement January 1, 2009 with StarPoint, LLC, doing business as StarPoint Healthcare Group (StarPoint). Under the terms of the agreement StarPoint provides 1) case management, 2) disease and chronic care management, 3) predictive modeling to identify individuals with high clinical risk and to develop optimal medical management for those individuals, and 4) utilization management for the review of health care services to determine the medical necessity or the appropriate level of care. The StarPoint agreement was amended in 2010 to eliminate the predictive modeling component of the contract.”

---

<sup>1</sup> Available at [http://csimt.gov/wp-content/uploads/MarketConduct\\_Allegiance\\_2016.pdf](http://csimt.gov/wp-content/uploads/MarketConduct_Allegiance_2016.pdf).

## V. Examination Results

### **Finding 1: MHPAEA – Violations of MHPAEA, 42 U.S.C. §300gg-26(a)(3); 45 C.F.R. § 146.136(c)(4)(i)**

During the review for compliance with MHPAEA requirements, the following limitations were noted based on the claims sample from the self-funded, non-Fed plans to which ABPM provides TPA services and the policies and procedures applicable to both insured plans offered by the Issuer and the self-funded, non-Fed plans to which ABPM provides TPA services:

- a. There were 37 claims ABPM processed in its capacity as a TPA for self-funded, non-Fed plans for drug screening tests based on processes, strategies, and evidentiary standards with respect to medical necessity requirements for drug screening tests for a substance use disorder diagnosis that were not comparable to those applied for a M/S diagnosis. The self-funded, non-Fed plans<sup>2</sup> failed to comply with the MHPAEA regulations by imposing a nonquantitative treatment limitation (NQTL) on MH/SUD benefits that is more stringent than that imposed on M/S benefits in the same classification.

42 U.S.C. §300gg-26(a)(3) provides:

#### **(3) FINANCIAL REQUIREMENTS AND TREATMENT LIMITATIONS**

**(A)** In general. In the case of a group health plan or a health insurance issuer offering group or individual health insurance coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that—

**(i)** the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

**(ii)** the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

**(B)** Definitions. In this paragraph:

**(i)** Financial requirement

---

<sup>2</sup> If a non-Fed plan is sponsored by two or more employers, the plan is the entity responsible for the applicable violation. See 45 C.F.R. § 150.305(b). If a non-Fed plan is sponsored by a single employer, the employer is the entity responsible for the applicable violation. See 45 C.F.R. § 150.305(c).



The term “financial requirement” includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit subject to paragraphs (1) and (2).

**(ii) Predominant**

A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement.

**(iii) Treatment limitation**

The term “treatment limitation” includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

45 C.F.R. § 146.136(c)(4)(i) provides in pertinent part:

(4) Nonquantitative treatment limitations—(i) General rule. A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are 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.

The drug testing policy provided by ABPM that it used in its capacity as a TPA for self-funded, non-Fed plans states, “drug screening for substance abuse is not treating an active illness or injury and therefore it is not considered medically necessary.” The policy indicates that while drug screening, absent a diagnosis of substance use disorder, will be allowed, it will be denied if there is a diagnosis of substance use disorder. The policy also indicates all line items in a claim are to be denied, and outpatient labs tied to a substance abuse inpatient stay should also be denied.

The Issuer and APBM disagreed with the finding, stating:

“Allegiance respectfully disagrees with CMS’s criticism that the policy presents a technical violation of MHPAEA’s non-quantitative treatment limitation (“NQTL”) rule. Under the NQTL rule, a plan may impose an NQTL with respect to mental health/substance use disorder (“MH/SUD”) benefits, like the benefits in question here, in a given classification if the plan applies comparable “processes, strategies, evidentiary standards or other factors” to medical/surgical benefits within a classification and to MH/SUD benefits

within the corresponding classification; and does not apply the NQTL more stringently to the MH/SUD benefits in a classification than is applied across the medical/surgical benefits in the corresponding classification. 45 C.F.R. 146.136(c)(4).

The Final Rule makes clear that medical management techniques that apply to both medical/surgical and MH/SUD benefits can be based on numerous factors, including “cost of treatment; high cost growth; variability in cost and quality; elasticity of demand; provider discretion in determining diagnosis, or type or length of treatment; clinical efficacy of any proposed treatment or service; licensing and accreditation of providers; and claim types with a high percentage of fraud.” 45 C.F.R. 146.136(c)(4)(iii)(Example 8). The Final Rule also makes clear that the application of an NQTL need not have the same result for both MH/SUD benefits and M/S benefits. See 45 C.F.R. 146.136(c)(4)(iii)(Example 4) (A NQTL was held permissible “even if the application of the evidentiary standards does not result in similar numbers of visits, days of coverage, or other benefits utilized for mental health conditions or substance use disorders as it does for any particular medical/surgical condition.”).

Here, Allegiance’s policy pays claims for diagnostic services for SUD benefits, but does not cover therapeutic screenings or screenings when a diagnosis of a substance use disorder has already been made. For medical/surgical benefits, Allegiance pays claims for therapeutic drug screenings, but not for diagnostic ones, e.g., a drug screening claim will not be paid when associated with a specific medical diagnosis. These limitations were based on Allegiance’s approach to medical necessity which focused on the use of drug diagnostic tools, and not therapeutic in the context of substance use disorders; whereas, drug screenings have a therapeutic role for medical/surgical benefits. Because these limitations are based on comparable strategies, processes, and other factors for both MH/SUD and medical/surgical benefits, and those strategies are applied no more stringently to MH/SUD benefits, the policy meets the requirements of MHPAEA’s NQTL rule, even though the NQTL is not identical for both MH/SUD and medical/surgical benefits.

Finally, the Final Rule made clear that MHPAEA is not a benefit mandate, and that it does not “affect the terms and conditions relating to the amount, duration, or scope of mental health or substance use disorder benefits under the plan (or health insurance coverage) except” to the extent required under the rule 45 C.F.R. 146.136(e)(3)(iii). Because the Final Rule does not mandate a certain scope of services be covered for MH/SUD benefits, there is no mandate that Allegiance cover drug screenings for non-diagnostic purposes, as the Criticism suggests.

Allegiance appreciates CMS’s feedback on its drug testing policy. While Allegiance believes that its previous drug screening policy met the technical requirements of MHPAEA, Allegiance has discontinued its use, while it develops a new drug screening policy to be applied in the future.”

### CCIIO Response

We disagree with the response. Drug screening is often a part of an individual’s ongoing treatment for drug addiction. In fact, federal requirements for methadone maintenance treatment programs mandate a minimum number of drug screenings be performed on individuals participating in these programs in order for the program to maintain its certification.

In addition, there are medical tests, such as those for individuals with chronic illnesses, which are done strictly for monitoring purposes and not for diagnostic reasons. Therefore, determination of coverage for drug testing to monitor substance use disorder conditions must be made using factors and evidentiary standards that are comparable to and applied no more stringently than those used for coverage of drug screenings for such medical conditions.

The automatic denial of coverage for drug testing based upon an individual’s diagnosis of a substance use disorder applies factors to the outpatient, in-network and outpatient, out-of-network classifications in a manner that is not comparable to M/S benefits in the same classifications.

The self-funded, non-Fed plans<sup>3</sup> are in violation of 42 U.S.C. §300gg-26(a)(3) and 45 C.F.R. § 146.136(c)(4)(i). The following chart provides information on the number of instances and the claim samples related to this violation.

Area Reviewed	Population	Sample Size	Instances	% of Error	Exhibit
Outpatient/In-Network denied claims	4,023	52	8	15%	Criticism #1
Inpatient/Out-of-Network denied claims	507	43	3	7%	Criticism #1
Outpatient/Out-of-Network denied claims	14,891	114	24	21%	Criticism #1
Outpatient/In-Network paid claims	60,150	180	2	1%	Criticism #1

---

<sup>3</sup> Ibid.

## Completed Corrective Actions:

CCIIO directed that the Issuer and ABPM implement a process to ensure compliance with Federal statutes and regulations for both insured plans and self-funded, non-Fed plans and submit to CCIIO the new Allegiance drug screening policy for CCIIO's review to ensure the violation has been addressed. CCIIO requested that the Issuer and ABPM complete a self-audit for the Examination Period of its insured plans and of the self-funded, non-Fed plans for which it provides TPA services, provide a list of all denied drug screening claims to CCIIO, re-adjudicate and pay the denied claims, and provide evidence of the paid claims (such as member explanations of benefits and provider explanations of payment) to CCIIO. In addition, the Issuer and ABPM were directed to provide CCIIO with documentation regarding the processes, strategies, evidentiary standards, or other factors used for the outpatient, in-network and outpatient, out-of-network classifications to determine coverage of the blood tests for drug screenings for both M/S and MH/SUD treatments for the affected insured plans and self-insured non-Fed plans.

The Issuer and ABPM provided the requested documentation and completed the self-audit of the insured plans and of the self-insured, non-Fed plans to which ABPM provides services as a TPA. A total of \$642,553.97 in benefits were reprocessed as a result of the self-audit of self-insured, non-Fed plans, and \$8,549.74 in benefits were reprocessed as a result of the self-audit of insured plans.

- b. The Allegiance Policies and Procedures Manual, which was used for both insured plans and the self-funded, non-Fed plans, requires a medical necessity review after 30 visits for MH/SUD outpatient visits. Pages 742-743 of the Allegiance Policies and Procedures Manual states:

“The system is built to allow up to 20 outpatient visits for each (mental nervous and substance abuse) at which time the system will stop, indicating the threshold has been reached. This system mapping to stop at 20 visits allows us to inform the provider and member that we will allow 10 more visits before a medical review will be completed to determine continued medically necessity beyond 30 visits. Upon reaching 20 visits, the examiner will need to enter an authorization for 10 more visits and send out the appropriate letter (listed below) to the provider indicating that once the 30 visits have been exhausted a review of medical necessity will be conducted.”

The medical necessity review for outpatient MH/SUD visits applies to all outpatient MH/SUD benefits; however, it only applies to physical, occupational, and speech therapies for M/S outpatient benefits. The Issuer and ABPM failed to establish that requiring a medical necessity review for all outpatient MH/SUD services after reaching a visit threshold was a no more stringent application of the process, strategies, evidentiary standards, and other factors for medical necessity reviews

of outpatient MH/SUD benefits than applied to outpatient M/S benefits. This practice is therefore not compliant with parity requirements for NQTLs.

The Issuer and the self-funded non-Fed plans<sup>4</sup> are in violation of 42 U.S.C. §300gg-26(a)(3) and 45 C.F.R. § 146.136(c)(4)(i).

The Issuer and APBM disagreed with the finding, stating:

“As you know, the benefit design in question is not a visit limitation (or any other type of quantitative treatment limitation under MHPAEA). Rather, it is a threshold at which point during the benefit period Allegiance conducts a medical necessity review to determine if ongoing outpatient treatment continues to be medically appropriate, or if some other form of treatment will better serve the member. Under the previous policy, such a review would occur for visits in excess of 30 during the 12 month period. Under the new policy, the threshold was extended to 52 visits. Under both policies, no review was conducted for the initial 30 and 52 visits, respectively.

The increase in the threshold used to conduct medical necessity review for mental health visits was based on input from mental health providers suggesting that the 30 visit threshold did not reflect the needs of covered members with chronic mental health/substance use conditions, and an effort by Allegiance to update its medical necessity review policies to reflect the clinical needs of its members.

Allegiance did not document the change in the threshold from 30 visits to 52 visits because, as described below, the 30-visit threshold met the requirements of MHPAEA's NQTL rule. The original 30-visit threshold was historically in line with the threshold for medical necessity review applicable to outpatient medical/surgical benefits that [are] require a series of visits, like Physical Therapy/Occupational Therapy/Speech Therapy ("PT/OT/ST") (policy attached). The current threshold for PT/OT/ST is set at 20 visits, except for cases where the therapy is the result of a covered surgical procedure. In those cases, the threshold is set at 30 visits.

Under MHPAEA, plans may impose nonquantitative treatment limitations ("NQTLs") if the processes, strategies, evidentiary standards, and other factors used in applying the NQTL to mental health/substance use disorder benefits are comparable to those applied to medical/surgical benefits, and are applied no more stringently to mental health/substance use benefits. Under the 30-visit threshold, the same strategy applied to both MH/SUD and M/S benefits; Allegiance sought to determine whether the ongoing therapy continued to be medically necessary, or if some other type of treatment was indicated.

---

<sup>4</sup> Ibid.

Importantly, the broader application for mental health/substance use disorder benefits, as compared to medical/surgical benefits does not represent a more stringent application of the requirement, but reflects the very different nature of medical versus mental health/substance use disorder treatments.

Moreover, because the threshold applicable to comparable medical benefits is more stringent than that applied to outpatient MH/SUD benefits, the 30-visit limit meets the requirements of MHPAEA's NQTL rule.

As a result of the 30-visit policy meeting the NQTL rule's requirements, the even less stringent version of the requirement, the 52-visit threshold, necessarily meets these requirements.”

### **CCIIO Response**

We disagree with the response. Under MHPAEA regulations, a plan or issuer may not impose an NQTL on MH/SUD benefits unless, under the terms of the plan or coverage as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, those used in applying the limitation with respect to M/S benefits in the same classification.

Although medical necessity review is applied both to MH/SUD benefits and to M/S benefits for outpatient, in-network and outpatient, out-of-network classified services, and the processes, strategies, evidentiary standards, and factors used in applying medical necessity reviews may be comparable, they are applied more stringently to MH/SUD services. A medical necessity review is triggered for all MH/SUD outpatient, in-network and outpatient, out-of-network classified services after reaching a visit threshold and was not developed or applied based upon the type of MH/SUD service being provided, whereas a medical necessity review is triggered after reaching a visit threshold only for PT/OT/ST outpatient, in-network and outpatient, out-of-network classified services, and this standard is applied based upon the type of M/S service being provided.

In addition, the Issuer's internal processes and procedures for the processing of PT/ST/OT claims for its insured plans and the self-funded, non-Fed plans to which ABPM provides TPA services provide that once the visit threshold is met, there is a medical records review, and the review is only sent for an independent medical review (IMR) if it cannot be cleared internally. For all MH/SUD services, once the visit threshold is met, a request for the submission of a treatment plan is sent, and additional visits are approved if there are continued goals to be met, and the recommended length of treatment is appropriate and reasonable based upon the goals listed. No such requirement for the submission of a treatment plan and the

need for proof of continued goals to be met is applied to the medical necessity review for M/S services.

The Issuer and non-Fed plans<sup>5</sup> are therefore in violation of 45 C.F.R. § 146.136(c)(4)(i) because their medical necessity reviews, policies, and procedures are not compliant with parity requirements for NQTLs.

**Completed Corrective Actions:**

The Issuer and ABPM have changed their medical necessity review policy for insured plans and the self-funded, non-Fed plans to which ABPM provides TPA services to apply no more stringently to MH/SUD benefits than to M/S benefits and have provided proof of such change to CCIIO. In addition, the Issuer and ABPM have confirmed that no MH/SUD claims were denied due to their medical necessity review policy.

CCIIO accepts the Issuer and ABPM's responses and corrective actions.

---

<sup>5</sup> Ibid.

## VI. Closing

- A total of 858 randomly selected claim samples were reviewed as part of this Examination. Of the selected files, a total of one MHPAEA violation was identified. The violation was found in 37 instances during the Examination Period in claims handled for self-funded, non-Fed plans administered by ABPM as a TPA. In addition, the violation was found in the Allegiance Policies and Procedures Manual, which included a non-quantitative treatment limitation that did not comply with the parity requirements for NQTLs.. The Allegiance Policies and Procedures Manual was used for both the Issuer's insured plans and the self-funded, non-Fed plans to which ABPM provides TPA services.

CCIIO requested that the Issuer conduct a self-audit of insured plans and self-funded, non-Fed plans ABPM provides TPA services to for denied drug screening tests. A total of \$651,103.71 in additional benefits were paid based on the self-audit. The breakdown of benefits paid as a result of the self-audit is:

- Self-funded, non-Fed plans: \$642,553.97
- Insured plans: \$8,549.74.



## **VII. Examination Report Submission**

The examination report is respectfully submitted.

---

Mary Nugent, Director, CIE, FLMI, AIRC, AMCM, ACS  
Compliance and Enforcement Division  
Oversight Group  
Center for Consumer Information and Insurance Oversight  
Centers for Medicare & Medicaid Services  
U.S. Department of Health & Human Services