STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

IN RE: Anthem Health Plans of Maine, Inc. NAIC Company Code: 52618 Maine License No. LHD70566 Docket No. INS-25-201	**CONSENT AGREEMENT AND ORDER**

Anthem Health Plans of Maine, Inc. ("Anthem" or "the Company"), the Superintendent of the Maine Bureau of Insurance ("Superintendent"), and the Maine Office of the Attorney General ("Attorney General") hereby enter into this Consent Agreement pursuant to 10 M.R.S. § 8003(5)(B) to resolve, without resort to an adjudicatory proceeding, violations of the Maine Insurance Code, Maine Bureau of Insurance Rule Chapter 850 ("Rule 850") and the Wellstone Domenici Mental Health Parity and Addiction Equity Act (MHPAEA), which is enforced by the Superintendent. A market conduct examination identified these violations, which are set forth below in detail.

STATUTORY AUTHORITY

1. Under 24-A M.R.S. § 12-A, the Superintendent may assess civil penalties, issue a cease and desist order, or take any combination of these and other actions listed within this section against any person who violates any law enforced by the Superintendent; any rule lawfully adopted by the Superintendent; or any lawful order of the Superintendent.

2. Pursuant to section 2723(a) of the Public Health Service Act (located at 42 U.S.C. § 300gg-22), States have primary enforcement authority over health insurance issuers regarding the provisions of Part A of Title XXVII of the Public Health Service Act, including MHPAEA, which is located at 42 U.S.C. § 300gg-26.

3. Under 24-A M.R.S. § 4309-A, all carriers shall comply with the Affordable Care Act (ACA), which includes the Essential Health Benefit requirements of 42 U.S.C. § 18022.

4. Pursuant to 10 M.R.S. § 8003(5)(B), the Superintendent may resolve an investigation without further proceedings by entering into a consent agreement with a licensee and with the consent of the Attorney General.

STATEMENT OF FACTS

A. Background

5. The Superintendent of Insurance is the State official charged with administering and enforcing Maine's insurance laws and regulations and certain federal insurance regulations, and the Bureau of Insurance is the administrative agency with such jurisdiction.

6. The Superintendent has jurisdiction over this matter pursuant to the powers set forth in the Insurance Code generally, as well as the specific provisions of 24-A M.R.S. §§ 12-A and 211 and 10 M.R.S. § 8003.

7. Anthem has been licensed in Maine as a domestic insurance company since 1938, holding Maine Certificate of Authority number LHD70566. Its NAIC Code is 52618, and it is domiciled in Maine.

8. 24-A M.R.S. § 221(5) requires the Superintendent to examine, no less frequently than once every five (5) years, each domestic health carrier offering a health plan in Maine. A targeted market conduct examination of Anthem, the results of which serve as the basis for this Consent Agreement, was accordingly called and conducted pursuant to 24-A M.R.S. §§ 211 and 221.

9. On October 25, 2021, the Superintendent designated Cynthia Fitzgerald of Regulatory Insurance Advisors (RIA) to examine Anthem pursuant to 24-A M.R.S. § 223(1).

10. Examiners from the Bureau's Market Conduct Division assisted with the examination and reviewed all findings included in the Market Conduct Examination Report.

B. Examination Process

11. The experience period for the examination included claim denials and appeal requests initiated from October 1, 2019, through September 30, 2021.

12. The examiners conducted the exam remotely and spent a short period of time on-site at Anthem's office in South Portland, Maine, from August 1, 2022, through August 3, 2022.

13. The examiners tested the Company's compliance across several different areas of its business operations including:
    a. Company Operations and Management
    b. Provider Contracting and Reimbursements
    c. Claims (non-pharmacy)
    d. Mental Health Parity and Addiction Equity Act (MHPAEA) Compliance
    e. Appeals
    f. Pharmacy Benefit Design and Pharmacy Claims

14. The examiners found areas of noncompliance in Anthem's claims processing, its handling of grievances and appeals, and in the information the Company submitted for MHPAEA testing of the quantitative treatment limitations (QTLs).

15. To conduct the examination, the examiners pulled samples of paid and denied claims in each of the following categories for non-pharmacy claims:
    a. General Medical
    b. Substance Use Disorder (SUD)
    c. Mental Health/Behavioral Health (MH/BH)
    d. Autism
    e. Emergency Room (ER)

16. The examiners pulled samples of paid and denied claims in each of the following categories for pharmacy claims:
    a. MH/BH
    b. SUD
    c. Diabetes Management
    d. Contraception
    e. Pain Management

17. The examiners pulled samples of utilization review files in each of the following categories:
    a. Prior authorization (pre-service determination)
    b. Concurrent review
    c. Post-service authorization
    d. Out-of-network utilization review requests

18. In this Agreement, and in the Market Conduct Examination Report, which is herein incorporated by reference, if a violation was not found in a sample group, that sample group is not counted in the number of claims reviewed in connection with the listed violation. For example, if a non-pharmacy claims violation is noted based upon a review of a certain number of General Medical claims, that means the violation was not identified in the other categories of non-pharmacy claims (SUD, MH/BH, Autism, Emergency Room).

ALLEGATIONS

C. Claims Processing Issues (non-pharmacy)

19. The examiners reviewed samples of individual claim files to evaluate Anthem's claims process and identified 6 issues across a variety of claim types.

    a. In a review of 218 paid claims for MH/BH and SUD services, the examiners identified one instance where the summary of benefits and explanation of coverage form did not accurately describe cost-sharing requirements associated with mental health and behavioral health services available under the plan in

violation of § 4303(15)(A) and where, as a result, Anthem did not maintain documented claim files supporting decisions made regarding its liability in violation of § 2164-D(3)(D).

b. In a review of 1,365 paid and denied claims in all categories, the examiners identified 31 instances where the claim was not paid or denied within 30 days of receipt of a clean claim in violation of § 2436(1).

c. In a review of 218 paid ER and SUD claims, the examiners identified 2 instances where Anthem failed to pay interest on an overdue claims payment as required by § 2436(3).

d. In a review of 327 paid and denied ER claims and General Medical denied claims, the examiners identified 7 instances where claim files did not include documents that the examiners would have expected to see in the claim files as support for the claim decisions made as contemplated by § 3408(1).

e. In a review of the 109 autism paid claims, the examiners noted 6 claims where MaineCare, not the member, was responsible for the cost shares associated with the autism treatment services.

    i. For these claims, the cost share amount owed by MaineCare was counted toward the member's out-of-pocket accumulators on one claim system but not counted on the other system.

    ii. This led similarly situated members to receive different treatment depending on which computer system processed claims under their member IDs.

    iii. This constitutes unfair discrimination in violation of § 2159(2).

    iv. Anthem took immediate steps to correct this issue when it was identified by the examiners.

20. In addition to reviewing sample files for claim level violations, the examiners also looked for global issues that impacted Anthem's claims process in general.

21. During the claims review, the examiners identified 310 mass adjustments that impacted a total of 72,315 claims within the experience period.

    a. Given the large number of impacted claims in the experience period, the examiners sent a Request for Information (RFI) to try to understand and analyze the root causes of these mass adjustments.

b. In its response to RFI #070, Anthem explained mass adjustments are used within its claims processing system to "initiate adjustments of two or more claims for the same reason."

c. Anthem confirmed in that same response that "[t]riggering events [for mass adjustments] could be calls, emails, faxes, internal system updates, adjustments to fee schedules, mandate implementation or any other way a concern with claims adjudication is identified."

d. Anthem was unable to completely explain the underlying reasons for many of the mass adjustments because several relevant fields in their internal sweep adjustment report form were not mandatory fields. Anthem confirmed that the mandatory fields constituted the information necessary for them to identify all impacted claims and address the root cause of an issue necessitating the mass adjustment.

e. While Anthem may be able to recreate how they were first alerted to an issue requiring a mass adjustment by reviewing emails, calendars, internal reports, etc., this information is not tracked in the sweep reports because it is not necessary to identify impacted claims and implement a systems fix.

f. The large number of mass adjustments during the experience period and the number of claims impacted by them suggest issues with the oversight of the claims processing system, which constitutes a violation of § 2164-D(3)(C) for failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies.

D. MHPAEA Compliance

22. Under MHPAEA, Anthem must ensure that financial requirements and treatment limitations it imposes on the mental health or substance use disorder (MH/SUD) benefits it provides are no more restrictive than those it imposes on medical or surgical benefits. This is providing benefits in parity.

23. To test MHPAEA compliance, the examiners reviewed benefits provided in the six classifications set forth in the MHPAEA regulations. The classifications are inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency care and prescription drugs.

24. The examiners reviewed Anthem's compliance with MHPAEA by testing their financial requirements (e.g. copays) and quantitative treatment limitations (QTLs) and reviewing their non-quantitative treatment limitations (NQTLs).

25. With respect to financial requirements, the examiners reviewed a sample of 15 different plan designs to determine whether Anthem had imposed financial requirements on MH/SUD benefits in any classification that either should not have been applied because

the financial requirement did not apply to substantially all medical/surgical benefits within that same classification or that exceeded the predominant level of the financial requirement as applied to the medical/surgical benefits in the same classification.

26. QTL testing identified issues with financial requirements in 2,240 MH/SUD claims.

27. These paid MH/SUD claims had copays, coinsurance, or deductibles applied that either should not have been applied because the plan indicated there was no cost share in the given classification, the cost share applied did not meet the substantially all requirement in the classification, or the cost share exceeded the predominant level allowed according to the testing.

28. This violates MHPAEA's requirements located at 42 U.S.C. § 300gg-26[1] and 45 C.F.R. § 146.36(c)(2)(i).

29. Failing to correctly identify cost-shares also constitutes a violation of 24-A M.R.S. § 4303(15)(A), for failing to provide summary of benefits and explanation of coverage forms that accurately describe cost sharing requirements.

E. Grievance Handling

30. The examiners reviewed 81 grievance files where consumers contacted Anthem to express concerns about Anthem's claims handling or company procedures and identified 2 issues within the files.

    a. The examiners noted 2 files where Anthem should have paid interest on a claims payment for a claim referenced in the grievance in violation of § 2436(3).

    b. The examiners noted 3 instances where the grievance files did not include documents that the examiners would have expected to see in the files in violation of § 3408(1).

F. Appeals

31. Rule 850 includes requirements for notices of adverse benefit determinations denying benefits in the context of claims, utilization review and appeals.

32. If the adverse benefit determination is an adverse health care treatment decision, it is subject to the appeals procedures set forth in subsection 8(G) and 8(G-1) of rule 850.

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[1] While MHPAEA's requirements, set forth in 42 U.S.C. § 300gg-26 and 45 C.F.R. § 146.36(c)(2)(i), do not directly apply to individual and small group plans, they indirectly apply to them through the operation of other federal provisions. 42 U.S.C. § 18022(b)(1)(E) makes "[m]ental health and substance use disorder services, including behavioral health treatment," essential health benefits (EHB). 45 CFR 156.115(a)(3) then clarifies that providing MH/SUD benefits as an EHB means providing them consistent with the requirements of the MHPAEA regulations. As a result, individual and small group plans are also required to comply with MHPAEA.

The specific requirements pertaining to expedited appeals are set forth in Rule 850 § 8(G)(2).

33. If the adverse benefit determination does not involve a health care treatment decision, it is subject to the grievance procedures set forth in Rule 850 § 9.

34. 24-A M.R.S. § 4303(13) includes requirements for explanations of benefits (EOB). An EOB is also an adverse benefit determination where it is notifying the consumer that a claim has been denied.

35. Where Rule 850 and 24-A M.R.S. § 4303(13), in part, are testing the presence of certain items in a form letter, a failure to include one item within a form letter will lead to a failure for all samples that use that form.

36. The examiners noted 5 form-related violations in a review of Anthem's 1st level, 2nd level and expedited appeal files:

    a. In 2 of the 119 1st level appeal files reviewed, the initial adverse benefit decision notices for claims not involving health care treatment decisions did not include a phone number the member could call for information on and assistance with initiating an appeal in violation of Rule 850 § 9(A)(8).

    b. In 80 of the 119 1st level appeal files reviewed, the appeal acknowledgment letters referred the covered person to the number on the Member ID card and did not provide an actual telephone number of a person designated to coordinate the appeal/grievance review on behalf of the health carrier in violation of Rule 850 §§ 8(G)(1)(a)(v) and 9(B)(2).

    c. In 19 of the 119 1st level appeals files reviewed, the appeal acknowledgment letters violated Rule 850 because they failed to list all rights carriers are required to provide in this letter under Rule 850 § 8(G)(1)(a).

    d. In 19 of the 163 expedited and 2nd level appeal files reviewed, the notice failed to identify the person evaluating the appeal in violation of § 8(G)(1)(c)(i).

    e. In 9 of 119 1st level appeal files reviewed, the notices failed to include information required by §§ 8 (G)(1)(c) and 9(B)(2)(b), including the name, title and qualifying credentials and the person evaluating the appeal; a statement of the reviewers' understanding of the reason for the appeal; or the specific plan provisions upon which the benefit determination was based.

37. Rule 850, and 24-A M.R.S. § 4304, also include requirements for procedures that carriers must follow when handling appeals.

38. The examiners noted 5 procedural violations in their review of Anthem's 1st level, 2nd level and expedited appeal files.

39. Anthem's appeals process failed to comply with the following procedural requirements:

a. In 6 of the 79 2nd level appeal files reviewed where the member did not request to appear in person, Anthem failed to issue a decision within 30 calendar days in violation of 24-A M.R.S. § 4303(4)(A)(2).

b. In 36 of the 119 1st level appeal files reviewed, Anthem either failed to send an acknowledgement letter or failed to send the acknowledgement letter within 3 working days in violation of §§ 8(G)(1)(a)(v) and 9(B)(2).

c. In 6 of the 84 expedited appeal files reviewed, Anthem failed to comply with 850 § 8(G)(2)(a), (d) and (e) by failing to use an appropriate clinical peer in 2 instances and failing to meet timing requirements for notifications of decisions in the remaining 4 instances.

d. In one of the 79 2nd level appeal files reviewed, Anthem failed to appoint a review panel where a majority of panel members were not involved in the 1st level appeal in violation of § 9(C).

e. In 8 of the 79 2nd level appeal files reviewed, Anthem failed to hold a review meeting within 45 days of receiving the request or failed to notify the covered person at least 15 days in advance of the review meeting date in violation of § 8(G-1)(3)(a) and § 9(C)(3)(a).

G. Pharmacy Benefit Design and Pharmacy Claims Handling

40. In a review of 108 denied SUD pharmacy claims, the examiners found Anthem denied one claim without conducting a reasonable investigation in violation of 24-A M.R.S. § 2164-D(3)(E).

41. In a review of 436 paid pharmacy claims, in all categories except contraception, the examiners identified 25 instances where pharmacy claim files did not include documents that the examiners would have expected to see in the claim files as support for the claim decisions made as contemplated by § 3408(1).

H. Utilization Review

42. The examiners reviewed utilization review files to ensure Anthem's process for handling prior authorization requests (pre-service determinations), concurrent review requests and post-service requests complied with 24-A M.R.S. § 2772 and Rule 850.

43. The examiners identified 4 issues with Anthem's handling of utilization review requests.

a. In a review of 40 prior authorization files, the examiners identified 5 claim files where Anthem failed to meet timing requirements for notifications in violation of 24-A M.R.S. § 2772(1) and Rule 850 § 8(E)(2)(a) and (b).

b. In a review of 20 concurrent review files, the examiners identified 3 claim files where Anthem failed to meet timing requirements for notifications in violation of 24-A M.R.S. § 2772(1) and Rule 850 § 8(E)(4)(a) and (b).

c. In a review of 60 prior authorization files and concurrent review files, the examiners identified one file that failed to properly advise of the ability to request reconsideration of the decision as required by 24-A M.R.S. § 2772(2) and Rule 850 § 8(F)(1).

d. In a review of the 80 utilization review files provided for prior authorization requests, concurrent review and post-service requests, the examiners identified 12 instances where the files did not include documents that the examiners would have expected to see in the files as support for the coverage decisions made as contemplated by § 3408(1).

VIOLATIONS OF LAW

44. As set forth in Paragraphs 19 through 43, Anthem's actions violated the Maine Insurance Code, Bureau Rule Ch. 850 and MHPAEA.

COVENANTS

45. Anthem agrees to the Allegations and Violations of Law stated above and agrees that such actions make it subject to disciplinary action.

46. No later than sixty (60) days after executing this Consent Agreement, Anthem will remit to the Maine Bureau of Insurance a company check in the amount of One Hundred Thousand Dollars ($100,000) payable to the Treasurer of the State of Maine.

47. Anthem will work with the Bureau to determine restitution amounts due, if any, based upon the application of incorrect cost-sharing on claims identified by the MHPAEA financial requirements testing.

48. In order to demonstrate that it has addressed concerning practices regarding the handling of claims, appeals and grievances identified during the examination, Anthem shall conduct a quarterly self-audit of the following randomly selected groups:

a. 25 claims paid and 25 claims denied within the quarter.
b. 25 Rx claims paid and 25 Rx claims denied within the quarter.
c. 10 grievances received within the quarter.
d. 25 prior authorization requests denied within the quarter

e. 25 first-level appeals denied within the quarter.
f. 10 second-level appeals denied within the quarter

49. The one-year self-audit review period will begin July 1, 2025, and end on June 30, 2026.

a. Within 30 days of the close of each quarter, Anthem shall deliver a summary report of its self-audit in an Excel spreadsheet with fields provided by the Superintendent.

b. The Company shall record its review of each file using a self-audit checklist provided by the Superintendent. The completed self-audit checklists for the 120 files shall be submitted with the self-audit summary report within 30 days of the close of each quarter.

c. When it delivers its final self-audit summary report, the Company must also submit a statement attesting to the accuracy of the information provided to the Superintendent pursuant to this Agreement.

50. The Superintendent has also provided Anthem with a Corrective Action Plan to ensure that Anthem has taken, or will take, steps to correct the deficiencies in its forms and procedures found during the Examination and set forth in this Agreement and the Market Conduct Examination Report.

51. This Consent Agreement is not subject to appeal. Anthem waives any right it might have to appeal any matter that is a subject of this Consent Agreement.

52. This Consent Agreement constitutes an Order of the Superintendent. A violation of its terms is enforceable by the Superintendent pursuant to 24-A M.R.S. §§ 12-A and 211.

53. This Consent Agreement is also enforceable by an action in Maine Superior Court pursuant to 24-A M.R.S. § 214, 10 M.R.S. § 8003(5)(B), and 14 M.R.S. § 3138.

54. The effective date of this Consent Agreement is the date of the Superintendent's signature.

55. This Consent Agreement may be modified only by a written agreement executed by all the parties hereto. Any decision to modify, continue or terminate any provision of this Consent Agreement rests in the discretion of the Superintendent and the Attorney General.

56. This Consent Agreement is a public record as that term is defined by 1 M.R.S. § 402(3). It is subject to the provisions of the Maine Freedom of Access Act, 1 M.R.S. § § 401 through 410, and it will be available for public inspection and copying as provided for by 1 M.R.S. § 408-A.

57. This Consent Agreement is also an adverse action and will be reported to the Regulatory Information Retrieval System ("RIRS") database at the National Association of Insurance Commissioners ("NAIC").

58. Nothing in this Consent Agreement shall be construed to affect any right or interest of any person not a party hereto.

59. The terms of this Consent Agreement constitute the entire agreement between and among the parties.

60. If any provision of this Consent Agreement is for any reason determined to be invalid, the effectiveness and enforceability of all other provisions of the Consent Agreement shall not be affected by such determination.

61. This Consent Agreement may be signed in counterparts, with all counterparts together constituting one original instrument.

62. By the duly-authorized signature of its representative on this Consent Agreement, Anthem warrants that it has consulted with counsel before signing the Consent Agreement or has knowingly and voluntarily decided to proceed in this matter without consulting counsel, that it understands this Consent Agreement, and that it enters into the Consent Agreement voluntarily and without coercion of any kind from any person.

63. As consideration for Anthem's execution of and compliance with the terms of this Consent Agreement, the Superintendent and the Attorney General agree to forego pursuing further disciplinary measures or other civil or administrative sanctions for the specific conduct described above in this Consent Agreement. However, should Anthem fail to comply with any term or condition of this Consent Agreement, it may be subject to any available remedy under the law for such a failure or violation.

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ANTHEM HEALTH PLANS OF MAINE, INC.

Dated: May 20, 2025

Denise F. McDonough
Denise F. McDonough
President

FOR THE OFFICE OF THE ATTORNEY GENERAL

Dated: May 21, 2025

Thomas C. Sturtevant
Thomas C. Sturtevant
Assistant Attorney General

THE MAINE SUPERINTENDENT OF INSURANCE

Dated: May 22, 2025

Robert Carey
Robert L. Carey
Superintendent