STATE OF MAINE
Department of Professional and Financial Regulation
Bureau of Insurance

EXAMINATION REPORT OF:

ANTHEM HEALTH PLANS OF MAINE, INC.

(NAIC #52618)

Examination Period:
October 1, 2019, through September 30, 2021

The following examiners participated in the examination and in the preparation of this examination report.

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COMPANY PROFILE

Anthem Health Plans of Maine, Inc. is a Maine domiciled insurance company, licensed to sell health insurance since 1938. Although the company only does business in Maine, it is a wholly owned subsidiary of ATH Holding Company, LLC ("ATH Holding"). ATH Holding is a wholly owned subsidiary of Elevance Health, Inc., formerly Anthem, Inc.[1] and one of the largest health benefits companies in terms of membership in the United States, serving approximately 47.5 million medical members as of December 31, 2022.[2]

Financial strength from ratings agencies reflects the agency's opinion as to the Company's financial strength, operating performance and ability to meet its claim obligations. As of December 31, 2021, A.M. Best rated the Company as A+ (excellent).

The Company is a licensee of the Blue Cross and Blue Shield Association (BCBSA) and markets its products under the Blue Cross Blue Shield trade name. It offers traditional indemnity products and a diversified mix of managed care products, preferred provider organizations (PPO), point of service (POS) and health maintenance organizations (HMO) plans to employers and individuals. Its products include comprehensive (hospital and medical), Medicare Supplement, Dental, Vision, and Federal Employee Health Benefits plans. The Company also provides administrative services such as claims processing, provider network access and medical cost management to certain customers under self-insured agreements.

Anthem Health Plans of Maine, Inc.	2019	2020	2021	2022
ME Covered Lives[3]	167,813	160,934	163,601	156,891
Market Share[4]	54.0%	53.4%	54.6%	53.1%
Premium income[5]	$1,169,039,000	$1,109,882,000	$1,166,425,000	$1,202,014,000
Net income	$71,986,000	$55,091,000	$29,225,000	$55,351,000

[1] Effective June 27, 2022, Anthem, Inc. became Elevance Health, Inc.
[2] From the Company's Management's Discussion & Analysis section of its 2022 Annual Financial Statement.
[3] **Covered lives** data is from the applicable year's Rule 945 Report filed by Anthem with the Bureau of Insurance, in their Individual, Small Group, and Large Group plans.
[4] **Market share** is derived from a comparison of the Covered Lives (representing Individual, Small Group, and Large Group plans) as reported by each health carrier that writes comprehensive health plans on their applicable year's Rule 945 reports.
[5] **Premium Income** and **Net Income** from the applicable year's Management's Discussion and Analysis section of each year's Annual Financial Statement. **Net Income** is **Premium Income** after deduction of claims and administrative expenses and after inclusion of investment gains/losses, other income, and federal income tax.

EXECUTIVE SUMMARY

The State of Maine Department of Professional and Financial Regulation, Bureau of Insurance (hereinafter "Bureau") conducted an examination of Anthem Health Plans of Maine, Inc. (hereinafter "the Company") pursuant to 24-A M.R.S. § 221(5), which states in relevant part "[t]he Superintendent shall examine the market conduct of each domestic health carrier, as defined in section 4301-A, subsection 3, and each foreign health carrier with at least 1,000 covered lives in this State, offering a health plan as defined in section 4301-A, subsection 7, no less frequently than once every 5 years. An examination under this section may be comprehensive or may target specific issues of concern observed in the State's health insurance market or in the company under examination." This examination was called as a statutorily required examination.

SCOPE OF EXAMINATION

The examination reviewed the Company's activities related to products in the individual, small and large group health insurance markets subject to requirements of the Mental Health Parity and Addiction and Equity Act (hereinafter "MHPAEA") and the Affordable Care Act (hereinafter "ACA"). Attention was focused on the Company's compliance with state and federal statutes, rules, and regulations with a focus on mental health parity and the ACA. Functional areas reviewed were: Operations and Management; Grievances; Provider Contracting and Reimbursements; Claims; Appeals; Utilization Review; Behavioral Health, Mental Health and Substance use Parity, Adequacy and Benefit Design; and Network Adequacy.

The examination was conducted in accordance with 24-A M.R.S. §§ 211, 221 and 223. It was conducted in a manner that was consistent with the standards set forth in the National Association of Insurance Commissioners (hereinafter "NAIC") 2020 Market Regulation Handbook as required by 24-A M.R.S. § 223(2). The examination focused on the targeted areas identified. Additional unacceptable or non-compliant practices may not have been discovered through the course of the examination. Failure to identify or comment on specific practices does not constitute the Bureau's approval of such practices.

Throughout the examination, the examination team requested additional information in the form of requests for information (RFI). The team issued eighty-one (81) requests for information for

the examination. The examination team issued one hundred seventeen (117) criticisms for this examination. The Company has responded to all criticisms that were issued. During the criticism process Company responses were reviewed to determine if the criticism could be removed from the potential findings. The criticism concerns with which the Company agreed and those that were not adequately explained in their responses were identified as examination findings and are listed in each section of the report.

METHODOLOGY

Using the standards set forth in the NAIC Market Regulation Handbook as guidance and in accordance with 24-A M.R.S. § 223(2), the examiners reviewed the Company's handling of Pharmacy Claims, Medical Claims, Utilization Management Cases, and matters coded as Grievances and Appeals. All files reviewed were initiated during the experience period of October 1, 2019, through September 30, 2021.

In response to data requested from the examiners, the Company provided spreadsheets containing the universe of claims processed during the examination period at the onset of the examination. The company submitted subsequent corrected universe files requested by the examiners throughout the examination process.

The examination team requested claim universe files for pharmacy claims and for non-pharmacy claims as indicated in Table 1 and Table 2 below. Additional universe files for other examination sections are represented in Table 3 for Grievances and Table 4 for Appeals.

To ensure clean claims universes, the examiners used Arbutus Analyzer, a data access and analysis solution software, to identify and remove duplicate claims, or claims that were outside of the scope of requested representations. The examiners then extrapolated a statistically valid sample from the universe of files. Sampling was based on the final clean universe representation.

Table 1 Non-Pharmacy Claim Universe Files

General Medical Non-EHB (Essential Health Benefits)	General Medical EHB (Essential Health Benefits)	Substance Use Disorder (SUD)	Mental and Behavioral Health (MHBH)	Autism	Emergency Room (ER)
Paid	Paid	Paid	Paid	Paid	Paid
Partially Paid	Partially Paid	Partially Paid	Partially Paid	Partially Paid	Partially Paid

Denied	Denied	Denied	Denied	Denied	Denied

Table 2 Pharmacy Claim Universe Files

Mental Health & Behavioral Health (MHBH)	Substance Use Disorder (SUD	Diabetes Management	Contraception	Pain Management
Paid	Paid	Paid	Paid	Paid
Denied	Denied	Denied	Denied	Denied

Table 3 Grievance Universe Files

Grievances submitted regarding the availability, delivery, or quality of health care services, including complaints regarding adverse health care treatment decisions made pursuant to utilization review.	Grievances submitted regarding claims payment, handling, or reimbursement for health care services.	Matters pertaining to the contractual relationships between a covered person and a health carrier.	Adverse benefit determinations

Table 4 Appeals Universe Files

First Level Appeals	Second Level Appeals	Expedited Appeals

SECTIONS OF REVIEW WITHOUT FINDINGS

Section A - Company Operations and Management

The Company Operations and Management section of the examination is designed to provide a view of how the Company operates and manages its daily activities. This includes reviewing the personnel involved in operations and management, obtaining information about internal controls and audits, and oversight of entities operating on behalf of the Company. In general, a company operations and management review is not based on sampling techniques, but rather a comprehensive review of policies and procedures, internal and external audits, and manuals to identify the daily operations of the Company and any potential gaps in the process. During the review of Company Operations and Management, the examination followed up on several requested items including audit reports. Examiners did not discover issues that constituted violations of the Maine Insurance Code.

Section B – Provider Contracting and Reimbursements

The Provider Contracting and Reimbursement section of the examination is designed to review the contracting process for providers and determine that reimbursements for services are consistent with contractual obligations. The examination team reviewed provider contracts and fee schedules and conducted data analytics on the information provided. Examiners did not discover issues that constituted violations of the Maine Insurance Code.

SECTIONS OF REVIEW WITH FINDINGS

Sections C – H represent the segments in which sample files were tested to identify potential Code violations. Each section includes a description of the purpose of the review followed by a chart listing the violations found for that section, and then each Finding is described. In areas where multiple categories of samples were reviewed, such as Section C - Claims, only those categories in which violations were found are noted.

Section C – Claims (Non-Pharmacy)

The review of Claims is designed to provide a comprehensive view of how the Company treats claimants regarding benefit consideration and ensures that the considerations are timely, accurate and in compliance with the benefits outlined in the Certificates of Coverage as well as applicable statutes and regulations. Specific claim types, as identified in the Methodology section, were reviewed separately for Paid Claims and Denied Claims in each segment. Universe files for Partially Paid Claims in those segments were obtained but were not included in the review.

Company claims policies and procedures were reviewed for compliance with applicable law.

Claim Findings (Non-Pharmacy)

Claims Finding Number	Claims Finding Subject
1	MISSING INFORMATION IN CERTIFICATES OF COVERAGE
2	TIMELINESS OF CLAIM DENIALS

3	FAILURE TO PAY INTEREST
4	ADEQUATE DOCUMENTATION
5	MEDICAID RECLAMATION CLAIMS
6	FAILURE TO ADOPT AND IMPLEMENT REASONABLE CLAIMS STANDARDS - MASS ADJUSTMENTS

C. Claims – Finding 1- Missing Information in Certificates of Coverage

24-A M.R.S. § 2164-D(3)(D). Unfair claims practices

Failing to develop and maintain documented claim files supporting decisions made regarding liability...

AND

24-A M.R.S. § 4303(15)(A). Plan requirements.

15. A carrier offering a health plan in this State shall:

> *A. Provide to applicants, enrollees and policyholders or certificate holders a summary of benefits and an explanation of coverage that accurately describe the benefits and coverage under the applicable plan or coverage. A summary of benefits and an explanation of coverage must conform with the requirements of the federal Affordable Care Act...*

Examiner Comment/Details:

The examiners reviewed one hundred nine (109) claim files in the categories listed below. Of those files reviewed, there was one (1) claim where Anthem failed to provide the certificate holder summaries of benefits and explanations of coverage that accurately described the benefits and coverage under the applicable plan or coverages and failed to develop and maintain a documented claim file supporting decisions made regarding liability. This was a result of insufficiencies in the schedule of benefits and certificate of coverage.

Section	Total Sample	Total Violations
MHBH Paid Claims	109	1

C. Claims – Finding 2 – Timeliness of Claim Denials

24-A M.R.S. § 2436(1).

> *1. A claim for payment of benefits under a policy or certificate of insurance delivered or issued for delivery in this State is payable within 30 days after proof of loss is received by the insurer and ascertainment of the loss is made either by written agreement between the insurer and the insured or beneficiary or by filing with the insured or beneficiary of an award by arbitrators as provided for in the policy. For purposes of this section, "insured or beneficiary" includes a person to whom benefits have been assigned.* ***A claim that is neither disputed nor paid within 30 days is overdue****. If, during the 30 days, the insurer, in writing, notifies the insured or beneficiary that reasonable additional information is required, the undisputed claim is not overdue until 30 days following receipt by the insurer of the additional required information...*

Examiner Comment/Details:

The examiners reviewed 1,365 claim files in the categories listed below. Of those files reviewed, there were thirty-one (31) claims in which Anthem failed to deny the claim in a timely fashion (i.e. within 30 days receipt of all claim information).

Section	Total Sample	Total Violations
ER Paid	109	3
ER Denied	109	5
Autism Paid	109	2
Autism Denied	108	2
General Medical Paid	385	5
General Medical Denied	109	2
SUD Paid	109	6
SUD Denied	109	2
MHBH Paid	109	2
MHBH Denied	109	2

C. Claims – Finding 3 – Failure to Pay Interest

24-A M.R.S. § 2436(3). Interest on Overdue Payments

> *3. If an insurer fails to pay an undisputed claim or any undisputed part of the claim when due, the amount of the overdue claim or part of the claim bears interest at the rate of 1 1/2% per month after the due date. Notwithstanding this subsection, the superintendent shall adopt rules that establish a minimum amount of interest payable on an overdue undisputed claim to a health care provider before a payment must be issued. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2A.*

Examiner Comment/Details:

The examiners reviewed two hundred eighteen (218) paid claim files in the categories listed below. Of those files reviewed, there were two (2) claims where Anthem failed to pay interest on a claim that was not paid within 30 days.

Section	Total Sample	Total Violations
ER Paid	109	1
SUD Paid	109	1

C. Claims – Finding 4 – Adequate Documentation

24-A M.R.S. § 3408(1). Home office, records, assets to be in State; exceptions

> *(1) Every domestic insurer shall have and maintain its principal place of business and home office in this State, and shall keep therein accurate and complete accounts and records of its assets, transactions and affairs in accordance with the usual and accepted principles and practices of insurance accounting and record keeping as applicable to the kinds of insurance transacted by the insurer.*

Examiner Comment/Details:

The examiners reviewed 327 claim files for the sections listed in the table below. Of those files reviewed, there were seven (7) claims where Anthem failed to maintain adequate claim files as required by 24-A M.R.S. § 3408. The files failed to include information the examiners would have expected to see in a complete claim file, such as a copy of an Explanation of Benefits (EOB) or a copy of the member's certificate of coverage.

Section	Total Sample	Total Violations
ER Paid	109	3
ER Denied	109	3
General Medical Denied	109	1

C. Claims – Finding 5 – Medicaid Reclamation Claims

24-A M.R.S. § 2159(2)

> *(2) No person may make or permit any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever. Nothing in this provision prohibits an insurer from providing incentives for insureds to use the services of a particular provider*.

Examiner Comment/Details:

The examiners reviewed the updated Medicaid reclamation sample files as well as the Company response to RFI #052. The examiners noted claims that were processed in one claim system counted cost-shares due from MaineCare toward the member's out-of-pocket accumulators while claims that were processed in the other claim system did not count cost-shares due from MaineCare toward the member's out-of-pocket accumulators. This practice of counting unpaid cost-share as paid for some members while not counting the same unpaid cost-share for others depending on which system a claim is processed in is unfairly discriminatory. The Explanation of Benefits uploaded for the Medicaid reclamation claims are misrepresentative to the claimant. The errors were noted in samples 002, 011, 049, 058, 061, and 065, but this citation is **applicable to all claims** that include the same scenarios identified above.

In its response to RFI #052, the Company explained how this happened on its two (2) claims systems, ACES and WGS. It stated "When the implementation was done for ACES, it was done systematically to apply cost-shares on professional claims based on member's benefits, despite the member not being liable for cost shares applied for services covered by Medicaid (MaineCare)… WGS was implemented to not apply member cost shares to the members out of pocket limit as the members are not responsible for cost shares applied by third-party payers to services covered by MaineCare."

The MaineCare Benefits Manual Section 1.07-3 states that "The Department is responsible for the payment of a copayment, deductible or coinsurance required by a third party payer when services have been appropriately obtained under MaineCare." This makes it clear that the Department and not the member is responsible for payment of any required cost share. However,

the manual is silent on whether cost-sharing not paid by the member shall be counted toward the member's accumulator by the Company. Therefore, the Company policy of counting unpaid cost-share as paid for some members while not counting the same unpaid cost-share for others depending on which system a claim is processed in is unfairly discriminatory. Company took immediate steps to correct this issue when it was identified by the Examiners.

Section	Total Sample	Total Violations
Autism Paid	109	6

C. Claims – Finding 6 – Failure to Adopt and Implement Reasonable Claims Standards - Mass Adjustments

24-A M.R.S. § 2164-D(3)(C). Unfair claims practices

> *3.(C) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies...*

Examiner Comment/Details:

The examination team requested information regarding mass adjustments in RFI #070, and followed up with RFI #070.1, #070.2 & #070.3. Anthem described "mass adjustments" as a tool used to initiate adjustments of two or more claims for the same reason, usually involving 2-199 claims. Larger groups of claims requiring adjustment are considered a "sweep." There were 310 mass adjustments or sweeps during the review period, which impacted 72,315 claims. Anthem tracks the root cause of the issues requiring mass adjustments or sweeps, which is the information the Company needs to identify impacted claims and create a systems fix; however, it does not track, and could not easily provide, the triggering events for these mass adjustments and sweeps. The triggering event would be the way the issue was first discovered, i.e. internal audit, consumer complaint, provider messages, etc. Since Anthem does not track this information, the only way to provide it would be to search through general historical items such as emails and calendar entries around the time of a particular adjustment. Without information regarding the triggering event, the examiners were unable to evaluate the timeliness of Anthem's decision to initiate a mass adjustment upon a report of a systems issue or the effectiveness of its approach to remediate reported claims processing errors. Anthem disagreed with this finding on the basis that there is no statutory or regulatory requirement to track this information.

The high number of mass adjustments and the quantity of claims impacted by them suggests Anthem should take additional steps to maintain closer oversight of its claims system. The need to reprocess 72,315 claims shows that, during the review period, Anthem failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies, which had an impact on Maine consumers and providers.

Section	Total Sample	Total Violations
All Claims	All Claims	1

Section D – Behavioral Health, Mental Health and Substance Use Parity, Adequacy, and Benefit Design.

Behavioral Health, Mental Health and Substance Use Disorder examinations are designed to ensure that the Company complies with the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, codified by 42 U.S.C. 300gg-26 and its implementing regulations found at 45 CFR 146.136 and 45 CFR 147.160. These bodies of law require benefit considerations for Behavioral Health, Mental Health and Substance Use Disorder to be paid at parity with benefit considerations for Medical/Surgical benefits. Examiners did not discover non-quantitative treatment limitation issues that indicated non-compliance with MHPAEA.

MHPAEA Findings

MPAEA Finding Number	MHPAEA Finding Subject
1	QTL – Quantitative Treatment Limits

D. Behavioral Health, Mental Health and Substance Use Disorder – Finding 1 – QTL

24-A M.R.S. § 4303(15)(A). Plan requirements.

15. A carrier offering a health plan in this State shall:

A. Provide to applicants, enrollees and policyholders or certificate holders a summary of benefits and an explanation of coverage that accurately describe the benefits and coverage under the applicable plan or coverage. A summary of benefits and an explanation of coverage must conform with the requirements of the federal Affordable Care Act...

AND

42 U.S.C. §§ 300gg-26 and 18022, and 45 C.F.R. § 146.136(c)(2)(i)

Under these federal provisions, licensed insurers are required to provide mental health and substance use disorder (SUD) benefits in parity with medical/surgical benefits. For quantitative treatment limitations (QTL), including financial requirements (FR), this means that a licensed insurer may not apply any QTL to mental health or SUD benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

Examiner Comment/Details:

To evaluate compliance, the examiners requested proof of compliance for each plan type affected for each classification of benefits and for each type of QTL or financial requirement separately. The Company imposed financial requirements with respect to mental health benefits not in parity with medical/surgical benefits. Specifically, Examiners found Company data demonstrated financial requirements applied to some mental health or SUD benefits failed the substantially all or predominant level tests for the specific benefit classification.

Examiners reviewed the universe of Autism Spectrum Disorder, Mental Health/Behavioral Health, and Substance Use Disorder Paid claims submitted by Company in conformity with Examiner's classification instruction. Using the results of the QTL templates and the previously mentioned claims universe, it was determined that 2,240 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 substantially all in

the classification, or the cost share exceeded the predominant level allowed according to the testing.

Section	Total Claims Subject to Review	Number of Errors
QTL Review	4,580	2,240

Section E – Grievance Handling

Grievance handling review is utilized as the baseline for identifying trends and emerging issues. To develop a comprehensive picture of the pattern of grievances, examiners reviewed a sample that included Grievances received as complaints filed with the Bureau of Insurance or another outside entity and Grievances received directly by the Company.

Grievance Handling Findings

Grievance Handling Finding Number	Grievance Handling Finding Subject
1	FAILURE TO PAY INTEREST
2	ADEQUATE DOCUMENTATION

E. Grievance Handling – Finding 1 – Failure to Pay Interest

24-A M.R.S. § 2436(3). Interest on overdue payments

> *3. If an insurer fails to pay an undisputed claim or any undisputed part of the claim when due, the amount of the overdue claim or part of the claim bears interest at the rate of 1 1/2% per month after the due date. Notwithstanding this subsection, the superintendent shall adopt rules that establish a minimum amount of interest payable on an overdue undisputed claim to a health care provider before a payment must be issued. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2A.*

Examiner Comment/Details:

The examiners reviewed eighty-one (81) grievance files. Of those files reviewed, there were two (2) files that documented Anthem failed to pay interest on a claim that was not paid within thirty (30) days.

Section	Total Sample	Total Violations
Grievances	81	2

E. Grievance Handling – Finding 2 – Adequate Documentation

24-A M.R.S. § 3408(1)

> *(I) Every domestic insurer shall have and maintain its principal place of business and home office in this State, and shall keep therein accurate and complete accounts and records of its assets, transactions and affairs in accordance with the usual and accepted principles and practices of insurance accounting and record keeping as applicable to the kinds of insurance transacted by the insurer*.

Examiner Comment/Details:

The examiners reviewed eighty-one (81) grievance files. Of those files reviewed, there were three (3) grievance files where Anthem failed to provide adequate documentation for the file, such as an acknowledgment letter or the Company's response to the consumer. The Company failed to provide adequate documentation for the grievance files in violation of 24-A M.R.S. § 3408(1).

Section	Total Sample	Total Violations
Grievances	81	3

Section F - Appeals

The review of the Company's handling of appeals provides a comprehensive view of its approach to adverse benefit determinations and ensures that the process is conducted in a timely manner and in compliance with applicable statutes and regulations.

Appeals Findings

Appeals Findings	Appeals Findings Subject
1	Timeliness of Decision
2	Appeal Information
3	Appeal Notification of Rights
4	Appeal Acknowledgement - Timeliness
5	Identification of Appeal Evaluator
6	Adverse Decision Information
7	Appropriate Clinical Peers
8	Review Panel
9	Review Meeting/Notification
10	Appeal Information

F. Appeals – Finding 1 – Timeliness of Decision

24-A M.R.S. § 4303(4)(A)(2)

A carrier offering or renewing a health plan in this State must meet the following requirements.

4. Grievance procedure for enrollees. A carrier offering or renewing a health plan in this State shall establish and maintain a grievance procedure that meets standards developed by the superintendent to provide for the resolution of claims denials or other matters by which enrollees are aggrieved.

> *A. The grievance procedure must include, at a minimum, the following:*
>
> *2. Timelines within which grievances must be processed, including expedited processing for exigent circumstances. Timelines must be sufficiently expeditious to resolve grievances promptly. Decisions for second level grievance reviews as defined by bureau rules must be issued within 30 calendar days if the insured has not requested the opportunity to appear in person before authorized representatives of the health carrier.*

Examiner Comment/Details:

The examiners reviewed seventy-nine (79) second level appeal files. Of those files reviewed, there were six (6) appeal files in which the covered person had not requested to appear in person and the decision was not issued within the required thirty (30) calendar days.

Section	Total Sample	Total Violations
Second Level Appeals	79	6

F. Appeals – Finding 2 – Appeal Information

Rule 850 § 8(G)(1)(a)(iv)

Section 8(G)(1) – Standard Appeals

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

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

Pursuant to section v., this information must be provided within 3 working days after receiving an appeal.

AND ***Rule 850 § 9(B)(2)***

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

Examiner Comment/Details:

The examiners reviewed one hundred nineteen (119) first level appeal files. Of those files reviewed, there were eighty (80) appeals files where Anthem sent an acknowledgement letter that referred the covered person to the number on the Member ID card and did not provide in this notification 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.

Section	Total Sample	Total Violations
First Level Appeals	119	80

F. Appeals – Finding 3 – Appeal Notification of Rights

Rule 850 § 8(G)(1)(a)(i-iii)

Section 8(G)(1) – Standard Appeals

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

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

ii) The carrier must provide the covered person, free of charge, with any new or additional evidence considered, relied upon, or generated by the carrier (or at the direction of the carrier) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the decision to give the covered person a reasonable opportunity to respond.

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

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

Examiner Comment/Details:

The examiners reviewed one hundred nineteen (119) first level appeal files. Of those files reviewed, there were nineteen (19) appeal files where Anthem sent a timely acknowledgement letter that failed to provide the required rights under Rule 850 § 8(G)(1)(a).

Section	Total Sample	Total Violations
First Level Appeals	119	19

F. Appeals – Finding 4 – Appeal Acknowledgement – Timeliness

Rule 850 § 8(G)(1)(a)(v)

Section 8(G)(1) – Standard Appeals

> *a) A health carrier or the carrier's designated URE shall establish written procedures for a standard appeal of an adverse health care treatment decision. HMO enrollees shall retain the right to pursue an appeal directly with the HMO. Appeal procedures shall be available to the covered person and to the provider acting on behalf of the covered person.*
>
> v) *The health carrier must make the rights in this subparagraph known to the covered person within 3 working days after receiving an appeal*.

AND

Rule 850 § 9(B)(2)

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

Examiner Comment/Details:

The examiners reviewed one hundred nineteen (119) first level appeal sample files. Of those files reviewed, there were six (6) appeal files where Anthem failed to send an acknowledgement with the required information, and thirty (30) appeal files in which an acknowledgement was sent, but not within the required three (3) working days.

Section	Total Sample	Total Violations
First Level Appeals	119	36

F. Appeals – Finding 5 – Failure to Provide All Rights Required with Adverse Decisions

Rule 850 § 8(G)(1)(c)

Chapter 850: Health Plan Accountability

The requirements set forth in 850 § 8(G)(1)(c) for adverse health care treatment decision letters apply to expedited decision letters pursuant to § 8(G)(2)(e) and second level adverse decision letters pursuant to § 8(G-1)(3)(f).

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

> *i. The names, titles and qualifying credentials of the person or persons evaluating the appeal...*
>
> *iii. Reference to the specific plan provisions upon which the decision is based.*

Examiner Comment/Details:

The examiners reviewed one hundred sixty-three (163) appeal files in the categories listed below. Of those files reviewed, there were eighteen (18) expedited appeal files where Anthem failed to identify the person evaluating the appeal and, in one (1) of those files, also failed to reference the specific plan provision upon which the decision is based, as required by Rule 850 § 8(G)(1)(c)(i) and (iii), which apply to expedited appeals through § 8(G)(2)(e). There was also one (1) second level appeal file where an attachment including the rights set forth in Rule 850 § 8(G)(1)(c) was not sent with the decision letter as required by Rule 850 § 8(G-1)(3)(f).

Section	Total Sample	Total Violations
Expedited Appeals	84	18
Second Level Appeals	79	1

F. Appeals – Finding 6– Adverse Decision Information

Rule 850 § 8 (G)(1)(c)

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

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

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

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

AND

Rule 850 § 9(B)(2)(b)

If the decision is adverse to the covered person, the written decision shall contain:

i. The names, titles and qualifying credentials of the person or persons participating in the first level grievance review process (the reviewers).

ii. A statement of the reviewers' understanding of the reason for the covered person's grievance and all pertinent facts.

iii. Reference to the specific plan provisions upon which the benefit determination is based…

Examiner Comment/Details:

The examiners reviewed one hundred nineteen (119) first level appeal sample files. Of those files reviewed, there were nine (9) in which one or more of the above requirements of Rule 850 were not met.

Section	Total Sample	Total Violations
First Level Appeals	119	9

F. Appeals – Finding 7 – Appropriate Clinical Peers

Rule 850 § 8(G)(2)(a), (d) and (e)

(G)(2). Appeals of Adverse Health Care Treatment Decisions, Expedited Appeals

A health carrier or the carrier's designated URE shall establish written procedures for the expedited review of an adverse health care treatment decision involving a situation where the time frame of the standard review procedures set forth in paragraph 1 would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function. An expedited appeal shall be available to, and may be initiated by, the covered person or the provider acting on behalf of the covered person.

a) An expedited appeal of an adverse health care treatment decision, except for a rescission determination or an initial coverage eligibility determination, shall be evaluated by an appropriate clinical peer or peers of the treating provider. The clinical peer/s shall not have been involved in the initial adverse health care treatment decision, unless additional information not previously considered during the initial review is provided on appeal. The clinical peer may not be a subordinate of a clinical peer involved in the prior decision.

d) In an expedited review, a health carrier or the carrier's designated URE shall make a decision and notify the covered person and the provider acting on behalf of the covered person via telephone as expeditiously as the covered person's medical condition requires, but in no event more than 72 hours after the review is initiated. If the expedited review is a concurrent review determination of emergency services under subsection H of this section or of an initially authorized admission or course of treatment, the service shall be continued without liability to the covered person until the covered person has been notified of the decision.

e) If the initial notification was not in writing, a health carrier or the carrier's designated URE shall provide written confirmation of its decision concerning an expedited review within 2 working days after providing notification of that decision. An adverse decision shall contain the provisions specified in subparagraph 1(c) above.

Examiner Comment/Details:

The examiners reviewed eighty-four (84) expedited appeal files. Of those files reviewed, there were six (6) appeal files where Anthem failed to meet the handling requirements of Rule 850. In two instances they failed to use appropriate clinical peers and in the remaining instances they failed to meet the timing requirements of Rule 850 § 8(G)(2)(d) or (e).

Section	Total Sample	Total Violations
Expedited Appeals	84	6

F. Appeals – Finding 8– Review Panel

Rule 850 § 9(C)

(C) Second Level Review of Adverse Benefit Determinations not Involving Health Care Treatment Decisions

> *2) The carrier shall appoint a second level grievance review panel for each grievance subject to review under this subsection. A majority of the panel shall consist of employees or representatives of the health carrier who were not previously involved in the grievance.*

Examiner Comment/Details:

The examiners reviewed seventy-nine (79) second level appeal files. Of those files reviewed, there was one (1) appeal file that failed the majority requirement.

Section	Total Sample	Total Violations
Second Level Appeals	79	1

F. Appeals – Finding 9– Review Meeting/Notification

Rule 850 § 8(G-1)(3)(a)

3) Whenever a covered person has requested the opportunity to appear in person before authorized representatives of the health carrier, a health carrier's procedures for conducting a second level panel review shall include the following:

a) The review panel shall schedule and hold a review meeting within 45 days after receiving a request from a covered person for a second level review. The review meeting shall be held during regular business hours at a location reasonably accessible to the covered person. The health carrier shall offer the covered person the opportunity to communicate with the review panel, at the health carrier's expense, by conference call, video conferencing, or other appropriate technology. The covered person shall be notified in writing at least 15 days in advance of the review date. The health carrier shall not unreasonably deny a request for postponement of the review made by a covered person.

AND

Rule 850 § 9(C)(3)(a)

3) Whenever a covered person has requested the opportunity to appear in person before authorized representatives of the health carrier, a health carrier's procedures for conducting a second level panel review shall include the following:

a) The review panel shall schedule and hold a review meeting within 45 days after receiving a request from a covered person for a second level review. The review meeting shall be held during regular business hours at a location reasonably accessible to the covered person. The health carrier shall offer the covered person the opportunity to communicate with the review panel, at the health carrier's expense, by conference call, video conferencing, or other appropriate technology. The covered person shall be notified in writing at least 15 days in advance of the review date. The health carrier shall not unreasonably deny a request for postponement of the review made by a covered person.

Examiner Comment/Details:

The examiners reviewed seventy-nine (79) second level appeal files. Of those files reviewed, there were eight (8) appeal files where Anthem failed to hold a review meeting within 45 days or failed to notify the covered person in writing at least 15 days in advance of the review date.

Section	Total Sample	Total Violations
Second Level Appeals	79	8

F. Appeals – Finding 10– Appeal Information

Rule 850 § 9(A)(8)

Section 9(A) Notice of Adverse Benefit Determinations not Involving Health Care Treatment Decisions

Adverse benefit determinations involving medical issues (adverse health care treatment decisions) are subject to the written notice requirements of paragraph 8(E)(5). For any adverse benefit determination that does not involve medical issues, the carrier shall provide written notice that includes the information required below:

> *8) a phone number the covered person may call for information on and assistance with initiating an appeal or reconsideration or requesting review criteria...*

Examiner Comment/Details:

The examiners reviewed one hundred nineteen (119) appeal files in the category listed below. Of those files reviewed, there were two (2) appeal files where Anthem failed to provide a phone number the covered person may call for information on and assistance with initiating an appeal or reconsideration or requesting review criteria in violation of Rule 850 § 9(A)(8). Instead, the decision letter directed members to call the number on their Member ID card.

Section	Total Sample	Total Violations
First Level Appeals	119	2

Section G – Pharmacy Benefit Design and Pharmacy Claims

The review of pharmacy benefit design and pharmacy claims is designed to provide a comprehensive view of how the Company treats claimants regarding pharmacy benefit considerations and ensures that the considerations are timely, accurate and in compliance with the benefits outlined in the Certificates of Coverage as well as applicable statutes and regulations.

Pharmacy Benefit Design and Pharmacy Claims Findings

Pharmacy Benefit Design and Pharmacy Claims Findings	Pharmacy Benefit Design and Pharmacy Claims Findings Subject
1	Reasonable Investigation
2	Adequate Claim Documentation

G. Pharmacy Benefit Design – Finding 1 – Reasonable Investigation

24-A M.R.S. § 2164-D. Unfair claims practices

3(E) Refusing to pay claims without conducting a reasonable investigation...

Examiner Comment/Details:

The examiners reviewed one hundred eight (108) denied claim files in the category listed below. Of those files reviewed, there was one (one) claim identified where Anthem refused to pay claims without conducting a reasonable investigation because the file stated only that claim was not processed.

Section	Total Sample	Total Violations
SUD Rx Denied	108	1

G. Pharmacy Benefit Design – Finding 2 – Adequate Claim Documentation

24-A M.R.S. § 3408. Home office, records, assets to be in State; exceptions

> *(1) Every domestic insurer shall have and maintain its principal place of business and home office in this State, and shall keep therein accurate and complete accounts and records of its assets, transactions and affairs in accordance with the usual and accepted principles and practices of insurance accounting and record keeping as applicable to the kinds of insurance transacted by the insurer.*

Examiner Comment/Details:

The examiners reviewed four hundred thirty-six (436) pharmacy claim files for the sections listed in the tables below. Of those files reviewed, there were twenty-five (25) pharmacy claims where Anthem failed to maintain adequate claim files as required by 24-A M.R.S. § 3408. The files failed to include information the examiners would have expected to see in a complete claim file, such as copies of prior authorizations or copies of accumulators reflecting the payment of the claim within the file.

Section	Total Sample	Total Violations
Diabetes Rx Paid	109	5
Pain Medication Rx Paid	109	6
MHBH Rx Paid	109	7
SUD Rx Paid	109	7

Section H – Utilization Review

The Utilization Review portion of the examination verifies that the Company and its designated representatives that provide or perform utilization review services comply with standards and criteria established by state statutes and regulations.

Utilization Review Findings

Findings	Utilization Review Findings Subject
1	Pre-Service Determinations
2	Concurrent Review
3	Requests for Reconsideration
4	Adequate Documentation

H. Utilization Review – Finding 1 – Pre-Service Determinations

24-A M.R.S. § 2772(1) Minimum Standards

A utilization review program of the applicant must meet the following minimum standards.

1. Notification of adverse decisions. Notification of an adverse decision by the utilization review agent must be provided to the insured or other party designated by the insured within a time period to be determined by the superintendent through rulemaking and must include the name of the utilization review agent who made the decision.

AND

Rule 850 § 8(E)(2)(a) and (b). Adverse Health Care Treatment Decisions

In addition to the requirements of Title 24-A, Chapter 34, any health carrier that provides or performs utilization review services, and any designee of the health carrier or URE that performs utilization review functions on the carrier's behalf, is subject to the requirements of this section. The requirements of this section are applicable to all "adverse health care treatment decisions" rendered by or on behalf of "carriers."

E. Procedures for Review Decisions

2) For initial determinations not involving exigent circumstances, a health carrier or the carrier's designated URE shall make the determination (whether adverse or not) and so notify the covered person and his or her provider within 72 hours or 2 business days, whichever is less, in accordance with the following standards:

a) If the carrier or the carrier's designated URE responds with a request for additional information, the carrier shall make a determination and so notify the covered person and his or her provider within 72 hours or 2 business days, whichever is less, after receiving the requested information.

b) If the carrier or the carrier's designated URE responds that outside consultation is necessary before making a determination, the carrier shall make a determination within 72 hours or 2 business days, whichever is less, from the time of the carrier's initial response.

Examiner Comment/Details:

The examiners reviewed forty (40) utilization management prior authorization files. Of those files reviewed, there were five (5) claim files where Anthem failed to make the determination and/or notification within the time requirements of 24-A M.R.S. § 2772 and Rule 850 § 8 cited above.

Section	Total Sample	Total Violations
Utilization Management/Review	40	5

H. Utilization Review – Finding 2 – Concurrent Review Determinations

24-A M.R.S. § 2772(1) Minimum Standards

A utilization review program of the applicant must meet the following minimum standards.

> *1. Notification of adverse decisions. Notification of an adverse decision by the utilization review agent must be provided to the insured or other party designated by the insured within a time period to be determined by the superintendent through rulemaking and must include the name of the utilization review agent who made the decision.*

AND

Rule 850 § 8(E)(4)(a) and (b). Adverse Health Care Treatment Decisions

In addition to the requirements of Title 24-A, Chapter 34, any health carrier that provides or performs utilization review services, and any designee of the health carrier or URE that performs utilization review functions on the carrier's behalf, is subject to the requirements of this section. The requirements of this section are applicable to all "adverse health care treatment decisions" rendered by or on behalf of "carriers."

E. Procedures for Review Decisions

4) For concurrent review determinations, a health carrier or the carrier's designated URE shall make the determination within one working day after obtaining all necessary information.

a) In the case of a determination to certify an extended stay or additional services, the carrier or the carrier's designated URE shall so notify the covered person and the provider rendering the service within one working day. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services

b) In the case of an adverse benefit determination, the carrier or the carrier's designated URE shall so notify the covered person and the provider rendering the service within one working day. The service shall be continued without liability to

the covered person until the covered person has been notified of the determination.

Examiner Comment/Details:

The examiners reviewed twenty (20) utilization management concurrent review files. Of those files reviewed, there were three (3) claim files where Anthem failed to meet the requirements of 24-A M.R.S. § 2772 and Rule 850 §8 because it failed to provide timely notice under those provisions.

Section	Total Sample	Total Violations
Utilization Management/Review	20	3

H. Utilization Review – Finding 3 – Requests for Reconsideration

24-A M.R.S. § 2772(2). Minimum Standards

A utilization review program of the applicant must meet the following minimum standards.

> *2. Reconsideration of determinations. All licensees shall maintain a procedure by which insureds, patients or providers may seek reconsideration of determinations of the licensee.*

AND

Rule 850 § 8(F)(1). Adverse Health Care Treatment Decisions

F. Requests for Reconsideration

> *1) In a case involving an initial health care treatment decision or a concurrent review decision, a health carrier or the carrier's designated URE shall give the provider rendering the service an opportunity to request by telephone, fax, electronically, or in writing on behalf of the covered person a reconsideration of an adverse decision by the reviewer making the adverse decision.*

Examiner Comment/Details:

The examiners reviewed sixty (60) utilization management files in which initial or concurrent review were applied. Of those files reviewed, one file with an adverse benefit determination failed to make clear to members and providers that requests for reconsideration were available independent of whether the member or provider had additional information.

Section	Total Sample	Total Violations
Utilization Management/Review	60	1

H. Utilization Review – Finding 4 – Adequate Documentation

24-A M.R.S. § 3408(1). Home office, records, assets to be in State; exceptions

> *(1) Every domestic insurer shall have and maintain its principal place of business and home office in this State and shall keep therein accurate and complete accounts and records of its assets, transactions and affairs in accordance with the usual and accepted principles and practices of insurance accounting and record keeping as applicable to the kinds of insurance transacted by the insurer.*

Examiner Comment/Details:

The examiners reviewed eighty (80) utilization management files. Of those files reviewed, Anthem failed to maintain adequate files in twelve (12) files as required by 24-A M.R.S. § 3408. The files failed to include information the examiners would have expected to see in a complete claim file, such as copies of letters that were sent or documentation that a search for an in-network provider was done prior to the approval of a request to see an out-of-network provider.

Section	Total Sample	Total Violations
Utilization Management/Review	80	12

BUREAU OF INSURANCE RECOMMENDATIONS

This examination took a comprehensive look at Anthem's claims processing practices across a variety of claim types. The goal was to determine compliance with the Maine Insurance Code and other laws and rules enforced by the Superintendent while also reviewing Anthem's processes to identify areas of improvement that would reduce the risk of future Code violations in the areas examined. While many individual areas of review did not reveal high error rates, when taken as a whole, the examination suggests Anthem should take steps to review whether it has adequate oversight of its claims system. A focus on oversight will ensure that Maine claims are processed timely and correctly, allow providers to better understand why claims are being processed in certain ways and reduce the number of mass adjustments Anthem will need to initiate to retroactively fix claims that processed incorrectly because of claims system errors.

The Bureau's Market Conduct Division has reviewed the examiners' findings. The Bureau is recommending the Company address the issues identified during the exam by its updating forms and processes as detailed in a Corrective Action Plan to be submitted to the Superintendent and by engaging in a self-audit process that will be monitored by the Superintendent. *A summary of specific recommendations is set forth below.* Additional details will be set forth in Anthen's Corrective Action Plan, which is herein incorporated by reference/attached at the close of this report.

SUMMARY OF RECOMMENDATIONS

Finding Section	Area of Examination	Examiner Findings	Company Position	Bureau Recommendations
C.01	Claims – Missing Information in Certificate of Coverage (COC)	1	Agreed	Anthem will engage in a self-audit process to be monitored by the Superintendent.
C.02	Claims – Timeliness of denials	31	Agreed	Anthem will engage in a self-audit process to be monitored by the Superintendent.
C.03	Claims – Failure to pay interest	2	Agreed	Anthem will engage in a self-audit process to be monitored by the Superintendent.
C.04	Claims – Adequate documentation	7	Agreed	Anthem will engage in a self-audit process to be monitored by the Superintendent.

C.05	Claims – Medicaid reclamation claims	6	Agreed	No further action required.
C.06	Claims – Mass adjustments	1	Disagreed	Anthem will continue to make improvements to procedures governing its claim processing systems to ensure updates and changes have fewer unintended consequences necessitating mass adjustments in the future.
D.01	MHPAEA – QTL/FR testing	2,240	Agreed	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
E.01	Grievances – Failure to pay interest	2	Agreed	Anthem will engage in a self-audit process to be monitored by the Superintendent.
E.02	Grievances – Adequate documentation	3	Agreed	Anthem will engage in a self-audit process to be monitored by the Superintendent.
F.01	Appeals – Timeliness of decision (2nd Level)	6	Agreed	Develop a process to ensure 2nd level appeal decisions are sent timely under Section 4303(4)(a)(2) when members do not request to appear at the review meeting.
F.02	Appeals – Information on Person to Coordinate Appeal (1st Level)	80	Agreed	Update acknowledgment letter to include name and phone number of person to coordinate the appeal as required by Rule 850 §8(G)(1)(a)(iv) & 9(B)(2)
F.03	Appeals – Notification of Rights (1st Level, involving health care treatment decisions)	19	Agreed	Update acknowledgment letter to include notification of rights required by Rule 850 §8(G)(1)(a)(iv) & 9(B)(2)
F.04	Appeals – Timeliness of acknowledgment (1st Level)	36	Agreed	Develop a process to ensure first level acknowledgment letters are sent within 3 working days as required by Rule 850 §8(G)(1)(a)(v) & 9(B)(2)
F.05	Appeals – Identification of appeal evaluator (2nd Level)	19	Agreed	Develop a process and/or template to ensure the name of the person evaluating the appeal is included in the adverse decision letters for expedited appeals and that all

				elements of Section 8(G)(1)(c) are included in the expedited appeal decision letters as required by Section 8(G)(2)(E). No further action required to address 1 file that was missing the appeals rights form in violation of Section 8(G-1)(3)(f).
F.06	Appeals – Adverse decision information (1st Level)	9	Agreed	Develop a process and/or template to ensure 1st level appeal decision letters contain all requirements of Section 8(G)(1)(c) for appeals involving health care treatment decisions and Section 9(B)(2)(b) for appeals that do not involve health care treatment decisions.
F.07	Appeals – Use of appropriate clinical peers (Expedited)	6	Agreed	Develop a process to ensure expedited appeals are handled in accordance with Section 8(G)(2).
F.08	Appeals – Composition of review panel (2nd Level)	1	Agreed	Develop a process to ensure majority of individuals on 2nd level appeal panels reviewing appeals not involving health care treatment decisions are disinterested as required by Section 9(C).
F.09	Appeals – Notification of review meeting (2nd Level)	8	Agreed	Develop a process to ensure all timing requirements from Section 8(G-1)(3) are met for notices and review meeting dates on 2nd level appeals involving health care treatment decisions.
F.10	Appeals – Information on how to initiate appeal (EOBs in 1st Level)	2	Agreed	Update EOBs to more clearly state the phone number listed can also be used to initiate an appeal.
G.01	Rx – Reasonable investigation	1	Agreed	Anthem will engage in a self-audit process to be monitored by the Superintendent.
G.02	Rx – Adequate documentation	25	Agreed	Anthem will engage in a self-audit process to be monitored by the Superintendent.
H.01	UR – Pre-service determinations/Prior authorizations	5	Agreed	Develop a process to ensure that pre-service determinations are sent timely according to the requirements set forth in Section 8(E)(2) and 24-A M.R.S. 2722.

H.02	UR - Concurrent review determinations	3	Agreed	Develop a process to ensure that concurrent review determinations are sent timely according to the requirements set forth in Section 8(E)(4) and 24-A M.R.S. 2722.
H.03	UR - Requests for reconsideration	1	Agreed	Update notices to clearly state that the re-review process based on additional information is available in addition to the reconsideration process required by Section 8(F)(1) and 24-A M.R.S. 2772.
H.04	UR - Adequate documentation	12	Agreed	Anthem will engage in a self-audit process to be monitored by the Superintendent.

Acknowledgment

The examiners wish to thank Anthem for its cooperation throughout this process.

Verified Report Submission

The report of examination is herewith respectfully submitted under oath.

Sincerely,

Holly L Blanchard
Examiner-in-Charge

Sworn before me this 2 day of April, 2025

Notary Public:

My Commission Expires:

General Notary - State of Nebraska
CHAD J. PALENSKY
My Comm. Exp. June 21, 2025.