

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



**EXAMINATION REPORT OF:**

**Harvard Pilgrim Health Care, Inc. (NAIC 96911, ME Lic. HMF39507)**

**And**

**HPHC Ins Company, Inc. (NAIC 18975, ME Lic. LHF115693)**

Examination Period:

October 1 – December 31, 2023

February 11, 2026

Honorable Robert L. Carey  
Superintendent  
Maine Bureau of Insurance

Dear Superintendent Carey:

Pursuant to 24-A M.R.S. §§ 211 and 221, in accordance with the instructions of your predecessor, a targeted market conduct examination has been made of:

Harvard Pilgrim Health Care, Inc., and  
HPHC Insurance Company, Inc.

The examination reviewed Harvard Pilgrim Health Care Inc. and HPHC Insurance Company Inc.'s utilization review procedures and handling practices of prior authorization requests for their Maine major medical line of business. The exam was called January 17, 2024, and covered the period from October 1, 2023, through December 31, 2023.

Maine Bureau of Insurance staff conducted the exam entirely off-site at the Bureau. The following examiners participated in the examination and in the preparation of this examination report:

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

Miranda Rampulla, MCM, PIR  
Senior Market Conduct Examiner


Justin Whalen, MCM  
Senior Market Conduct Examiner

The following report is respectfully submitted.



Connie Mayette  
Examiner-in-Charge

Pursuant to 24-A, M.R.S. §§ 211 and 221, I have caused a targeted market conduct examination to be conducted of Harvard Pilgrim Health Care, Inc. and HPHC Insurance Co, Inc. I hereby accept this Report of examination and make it an official record of the Bureau of Insurance.



Honorable Robert L. Carey  
Superintendent

February 17, 2026

Date

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## Company Profile

Harvard Pilgrim Health Care, Inc. and HPHC Insurance Company, Inc. are health insurers domiciled in the Commonwealth of Massachusetts. The original Plan was founded as Harvard Community Health Plan, Inc. in 1969, and merged with Pilgrim Health Care, Inc in 1994.

- Harvard Pilgrim Health Care, Inc. has been licensed as a Health Maintenance Organization in Maine since 1994; it provides individual and group health insurance coverage and Medicare products or benefit administration to members, including self-insured members in Massachusetts, Maine and Connecticut.
- HPHC Insurance Company, Inc. has been licensed in Maine as an insurance company since 2005; it provides individual and group health insurance coverage or benefit administration in Massachusetts, New Hampshire, Rhode Island and Maine for PPO products and Medicare Supplement.<sup>1</sup>

Harvard Pilgrim combined with the Tufts Health Plan family of companies, under one parent company, Health Plan Holdings, Inc. (formerly Tufts Health Plan, Inc.) in 2021, now Point32Health.

2023 Maine data from the companies' Rule 945<sup>2</sup> filings for 2023:

### HPHC Insurance Company, Inc. (LHF 115693)

	Large Group	Small Group	Individual	TOTAL
Covered Lives	11,868	338	141	12,347
Earned Premium	\$93,795,566	\$30,293,601	\$1,175,058	\$125,264,225

### Harvard Pilgrim Health Care, Inc. (HMF 39507)

	Large Group	Small Group	Individual	TOTAL
Covered Lives	18,022	15,657	19,332	53,011
Earned Premium	\$133,563,054	\$105,456,842	\$155,379,450	\$394,339,346

<sup>1</sup> Product details from the companies' 2023 Management Discussion & Analysis statement.

<sup>2</sup> Rule 945 is a Maine Annual Report Supplement for specific data from health insurers and HMOs including major medical insurance.

## Executive Summary

The State of Maine Department of Professional and Financial Regulation, Bureau of Insurance (“Bureau”) conducted an examination of Harvard Pilgrim Health Care, Inc. and HPHC Insurance Company, Inc. (collectively “Harvard” or “Company”). This examination was conducted 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.”

The examination was a targeted statutory examination of Harvard’s fully insured major medical plans to determine their compliance with certain provisions of the Maine Insurance Code, located within Title 24-A of the Maine Revised Statutes (M.R.S.) and Maine Bureau of Insurance Rule 850. It was subsequently expanded to include ACA-compliant student health plans underwritten by HPHC, Inc. but not administered by them.

Maine statutes and provisions of Rule 850 place certain requirements upon insurers and provide rights and protections to those individuals insured by health plans in Maine. Some covered services, treatments or prescriptions require advance approval from the health plan before coverage applies. The examiners specifically tested compliance with requirements in Rule 850 § 8(E) and related statutes in Title 24-A for the handling of these prior authorization or precertification requests. These provisions relate to the timing of decisions, the way the decision must be conveyed, and the specific information that must be provided when a request is denied. These requirements ensure that Maine consumers are notified promptly of their rights when prior authorization requests are denied.

The examiners tested 279 major medical and 30 student health prior authorization requests for compliance and reviewed written policies and procedures in the company’s utilization review program pertaining to prior authorization procedures.

Subsequent to the initial data request, 16 additional requests for information were issued for explanation or additional documentation regarding the companies’ procedures, quality management and oversight, sample files, and delegation relating to the student health plans.

Harvard was responsive to the examiners’ requests for information and provided prompt and meaningful responses to the criticisms issued. Written criticisms, commonly known as “crits,” are notifications to the company of potential compliance violations flagged by the examiners. Twelve crits were issued. Harvard agreed with the violations cited and promptly initiated corrective action in several instances.

## Scope of Examination

The focus of the examination was to determine Harvard's compliance with prior authorization requirements by reviewing prior authorization sample files from the review period of October 1 to December 31, 2023, and the written procedures governing its handling of such requests. The products included were the company's fully insured, ACA-compliant major medical plans situated in Maine and those self-funded governmental or church plans that are subject to state jurisdiction pursuant to ERISA. Other self-funded employer plans are not subject to state jurisdiction and were not included. As stated earlier, the scope was expanded to include the ACA-compliant student health plans underwritten by HPHC, Inc. and administered by UnitedHealthcare Services Inc. d/b/a UnitedHealthcare Student Resources.

The examination was conducted in accordance with 24-A M.R.S. §§ 211, 221 and 223, and consistent with the standards set forth in the *Market Regulation Handbook* (MRH) as required by Section 223(2). The MRH was used for purposes of sample determination and overall guidance.

Some unacceptable or noncompliant practices may not have been discovered in the course of the examination; failure to identify or comment on specific practices does not constitute the Bureau's approval of such practices.

This report is by exception rather than by test.

## Methodology

The examiners reviewed the companies' written utilization review policies and procedures and reviewed their handling of prior authorization requests that originated during the review period. With the initial data request for the written procedures, the examiners requested listings of universe files of all prior authorization (PA) requests received by the companies during the exam period, in four segments:

- Standard Pharmacy PA requests
- Standard non-Pharmacy PA requests
- Exigent<sup>3</sup> Pharmacy PA requests
- Exigent non-Pharmacy PA requests

Random samples were selected using the Excel RAND function following the sample sizes recommended by the MRH for the non-Pharmacy segments. For the Pharmacy segments, smaller pilot samples were selected instead of full random samples, as initial data analytics on those universe files indicated all the listed files were processed timely.

### Universe File Numbers and Sample Sizes

PA Level	Service Type	Total Requests	Sample Size
Standard (non-exigent)	Pharmacy	1666	40
Standard (non-exigent)	Non-Pharmacy	5765	116
Exigent	Pharmacy	258	10
Exigent	Non-Pharmacy	617	113

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<sup>3</sup> "Exigent circumstances" is defined in Rule 850 § 8(5)(Q-1) as circumstances that "exist when a covered person is suffering from a health condition that may seriously jeopardize the covered person's life, health or ability to regain maximum function or when a covered person is undergoing a current course of treatment using a nonformulary drug." Carriers often use the term "urgent" to describe "exigent circumstances."

## Examination Results

The regulatory requirements tested in the sample review involved three main areas of consideration: timely notification of determinations, wrongful denial of determinations that were not timely, and whether the appropriate information was provided when the request for authorization of a service or prescription was denied.

The *Market Regulation Handbook* has established a benchmark error rate of 7% for auditing claims practices and 10% for other practices to determine if it is a general business practice. While each instance of noncompliance reported by the examiners constitutes a violation of the rules and statutes applicable to this exam, the benchmark error rates are a useful reference to gauge the extent of non-compliance in a review area.

## FINDING 1. Non-Exigent Prior Authorizations – Timeliness of Notification

Determinations not involving exigent circumstances were not timely, and/or were not timely conveyed.

### 24-A, M.R.S. § 4304(2)

2. *Prior authorization of nonemergency services. Except for a request in exigent circumstances.... a request by a provider for prior authorization of a nonemergency service must be answered by a carrier within 72 hours or 2 business days, whichever is less, in accordance with this subsection...*
  - A. *Both the provider and the enrollee on whose behalf the authorization was requested must be notified by the carrier of its determination.*
  - B. *If the carrier responds to a request by a provider for prior authorization with a request for additional information, the carrier shall make a decision within 72 hours or 2 business days, whichever is less, after receiving the requested information.*

AND

### Rule 850 § 8(E)(2)

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...*

*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.*

The examiners reviewed 116 non-exigent prior authorization (PA) requests and found that seven (7) of the samples were not completed within the time frame required by 24-A M.R.S. § 4304(2) and 850 § 8(E)(2).

The examiners also reviewed a pilot sample of 40 non-exigent pharmacy PA requests from a universe of 1,666. None were found to be untimely.

### Non-Exigent Prior Authorizations

PA Segment	Population	Sample Size	Violations	Error Rate
Non-Pharmacy	5765	116	7	6.0%

## FINDING 2. Non-Exigent Prior Authorizations – Denial Not Within Timeframe

Requests not involving exigent circumstances which were not completed within the required time were wrongfully denied.

### 24-A, M.R.S. § 4304(2)

2. *Prior authorization of nonemergency services. Except for a request in exigent circumstances.... a request by a provider for prior authorization of a nonemergency service must be answered by a carrier within 72 hours or 2 business days, whichever is less, in accordance with this subsection...*

*If a carrier does not grant or deny a request for prior authorization within the time frames required under this subsection, the request for prior authorization by the provider is granted.*

AND

### Rule 850 § 8(E)(2)

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...*
  - c. *If the carrier or the carrier's designated URE does not grant or deny a request within the time frames required, the request is granted.*

Seven (7) sample files in the non-exigent non-pharmacy segment were untimely as described in Finding 1 above. Of those seven (7) untimely files, five (5) were approved, but two (2) were denied. As 24-A M.R.S. § 4304(2) and 850 § 8(E)(2)(c) require the request to be granted if it is not granted or denied within the required time frame, these two requests were wrongfully denied.

There were no untimely determinations in the non-exigent pharmacy review, therefore this requirement was not triggered for that segment.

### Non-Exigent Prior Authorizations

PA Segment	Total Samples	Untimely Notifications	Number Denied	Error Rate
Non-Pharmacy	116	7	2	28.6%

### FINDING 3. Exigent Prior Authorizations – Timeliness of Notification

Determinations involving exigent circumstances were not timely, and/or were not timely conveyed.

#### Rule 850 § 8(E)(3)

- 3. When exigent circumstances exist, 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 24 hours after receiving the request.*

The examiners reviewed 113 exigent non-pharmacy PA requests and found that 34 of the samples were not completed within the time frame required by 850 § 8(E)(3).

The examiners also reviewed a pilot sample of 10 exigent pharmacy PA requests from a universe of 258. None were found to be untimely.

#### Exigent Prior Authorizations

PA Segment	Population	Sample Size	Violations	Error Rate
Non-Pharmacy	617	113	34	30.1%

## FINDING 4. Required Information in Adverse Determination Notifications

The adverse determination letters did not include all the information required.

### Rule 850 § 8(E)(6)

6. *A health carrier shall provide written notification of any adverse health care treatment decision, which shall include:*

*b) reference to the specific plan provisions on which the decision is based;*

*i) a description of the expedited review process applicable to claims involving exigent circumstances...*

Under the definition set forth in Rule 850 § 5(Q-1), exigent circumstances include “*when a covered person is undergoing a current course of treatment using a nonformulary drug.*”

The examiners reviewed a total of 279 prior authorization requests in the segments indicated below, which included 63 adverse determinations. None of the denied requests provided all the required information, with each missing one or both of the elements identified above; therefore, they failed to comply with the requirements of 850 § 8(E)(6). The language in all letters failed to include “when an enrollee is undergoing a current course of treatment with a nonformulary drug” in the cited eligibility requirements for an expedited review. Harvard advised this issue relating to subpart (i) had been identified and was corrected in February 2025.

### All Prior Authorization Requests

PA Segment	Sample Size	Adverse Decisions	Violations	Error Rate
Non-Exigent Pharmacy	40	21	21	
Exigent Pharmacy	10	3	3	
Non-Exigent Non-Pharmacy	116	29	29	
Exigent Non-Pharmacy	113	10	10	
<b>Total</b>	<b>279</b>	<b>63</b>	<b>63</b>	<b>100%</b>

## **FINDING 5. Utilization Review Policies and Procedures**

A utilization review process was implemented that was not reflected in the written Utilization Review Program and was not the process described in plan documents.

### **Rule 850 § 8(C) Written Utilization Review Program**

- C. *A health carrier that provides or performs utilization review shall implement a written utilization review program that, consistent with the requirements of Title 24-A M.R.S.A. §2771(3) and this rule, shall comprehensively describe all utilization review activities and procedures, both delegated and non-delegated, applicable to any of its health plans. The utilization review program must be consistent with the requirements of this section.*

**AND**

### **24-A, M.R.S. § 4303(15)(A) Uniform explanation of coverage documents and standardized definitions.**

*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...*

This violation is based on a review of Harvard's submitted Utilization Review (UR) Program, the applicable plan documents as part of the samples analysis, and Harvard's responses to subsequent questions from the examiners. The examiners review these items to verify that the company maintains procedures for utilization review that are in accordance with applicable statutes and regulations. Examiners also review to confirm that the plan documents accurately reflect the procedures and that the process in operation matches what is written.

Examiners determined the company had implemented a revised process for concurrent review requests that was different from its written UR program and its plan documents. The choice to eliminate ongoing outpatient services like home health care and skilled nursing services from the concurrent review process and require prospective reviews conflicted with the description of concurrent review in the UR program and plan documents.

Harvard agreed that requests for these specific outpatient services that extend beyond the end date of an existing authorization as a continued course of treatment would be reviewed in accordance with concurrent review guidelines and standards going forward.

## FINDING 6. Required Information in Adverse Determination Notifications (Student Plan)

The adverse determination letters did not include all the information required.

### Rule 850 § 8(E)(6) subparts (b), (i) and (k)

7. *A health carrier shall provide written notification of any adverse health care treatment decision, which shall include:*
  - b) reference to the specific plan provisions on which the decision is based;*
  - i) a description of the expedited review process applicable to claims involving exigent circumstances...*
  - k) notice of the right to file a complaint with the Bureau of Insurance after exhausting any appeals under a carrier’s internal review process...*

Under the definition set forth in Rule 850 § 5(Q-1), exigent circumstances include “when a covered person is undergoing a current course of treatment using a nonformulary drug.”

The Student Health plan samples were assessed separately from Harvard’s samples. Harvard uses an administrator for this plan’s prior authorizations (PAs), which are reviewed under the administrator’s utilization review guidelines. Only pharmacy requests were reviewed as this plan did not require PAs for medical services.

The examiners reviewed the total population of PA requests in the segments indicated below, which included 13 adverse determinations. None of the denied requests provided all the required information, each missing two or more of the elements identified above. The language in all letters failed to include "when an enrollee is undergoing a current course of treatment with a nonformulary drug" in the cited eligibility requirements for an expedited review. All letters also failed to provide notice of the right to file a complaint with the Bureau of Insurance.

### All Prior Authorization Requests

PA Segment – Student Plan	Total Population	Adverse Decisions	Violations	Error Rate
Non-Exigent Pharmacy	21	9	9	
Exigent Pharmacy	9	4	4	
<b>Total</b>	<b>30</b>	<b>13</b>	<b>13</b>	<b>100%</b>

## **FINDING 7. Oversight of Utilization Review Entity and Administrator Requirements (Student Plan)**

Harvard underwrites a student health plan for which utilization review responsibilities are delegated to UnitedHealthcare Services, Inc. d/b/a UnitedHealthcare Student Resources. It was determined that no written delegation agreement or monitoring program was in place.

### **Rule 850 § 8**

#### **A. Corporate Oversight of Utilization Review Program**

*A health carrier that provides or performs utilization review shall implement a written utilization review program that, consistent with the requirements of Title 24-A M.R.S.A. §2771(3) and this rule, shall comprehensively describe all utilization review activities and procedures, both delegated and non-delegated, applicable to any of its health plans. The utilization review program must be consistent with the requirements of this section.*

#### **B. Contracting**

*Whenever a health carrier contracts to have a URE perform the utilization review functions required by this rule, the Superintendent shall hold the health carrier responsible for monitoring the activities of the utilization review entity with which it contracts and for ensuring that the requirements of this rule are met.*

**AND**

### **24-A, M.R.S. § 1906 Administrator Requirements**

- 2) An administrator shall provide services as an administrator only pursuant to a written agreement between the administrator and the plan sponsor, health care service plan, health maintenance organization or insurer...*
- 10) When acting as an administrator, the acts of an insurance administrator deemed to be the acts of the plan sponsor, health care service plan, health maintenance organization, fraternal benefits society, nonprofit hospital or medical service organization or insurer.*

The examiners requested documentation of Harvard's oversight of this entity to which it delegated the utilization review activities of the student health plan it underwrites. Harvard acknowledged there was no written delegation agreement or monitoring procedure for this delegated entity in place during the examination period. Additionally, there was no written administrative services agreement between the parties covering the services that were provided. The company immediately addressed this omission.

## Recommendations

The following are the recommended Corrective Actions for Harvard to address the compliance concerns noted during this examination.

1. Initiate training and/or staffing adjustments to ensure that prior authorizations are completed within the appropriate time frame. Many of the timing violations in the exigent segment appeared to result from handling these requests only during standard business hours.
2. Implement training and system protocols to ensure that non-exigent prior authorization requests that are denied beyond the required time frame are deemed approved as required by Maine law.
3. Review and amend adverse determination letter and appeal rights templates to include all the information and notifications required.
4. Ensure utilization review procedures, in practice, match the written utilization review program and plan document descriptions.
5. Develop procedures to ensure that any delegation of utilization review includes an appropriate written agreement documenting the delegated activities and procedures for monitoring.
6. Develop procedures to ensure that any delegation of administrative duties includes an appropriate written agreement documenting the duties of each party.

## Acknowledgement

The Maine Bureau of Insurance would like to acknowledge the cooperation and assistance extended to the examiners by the company's exam coordination team during the course of the examination.