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

EXAMINATION REPORT OF:

Aetna Life Insurance Company (NAIC 60054)

And

Aetna Health Inc., a Maine Corporation (NAIC 95517)

Examination Period:

July 1 – September 30, 2023

November 21, 2024

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:

Aetna Life Insurance Company and
Aetna Health Inc, a Maine corporation

The examination reviewed Aetna Life Insurance Company and Aetna Health Inc.'s utilization review procedures and handling practices of prior authorization requests for their Maine major medical line of business. It covered the period from July 1 - September 30, 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
Examiner-in-Charge
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
_____
Connie Mayette

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Company Profile

Aetna Health Inc ("AHI") was incorporated in the State of Maine on October 3, 1995, and was licensed in 1996 to do business in the state as a for-profit, privately held health maintenance organization (HMO). The company offers a variety of managed care products and services under commercial and Medicare plans. AHI's 2020 Management Discussion & Analysis ("MD&A") statement indicated that it was shifting its emphasis to the Medicare line of business, and the 2023 MD&A stated that the commercial group block of business is closed and not writing any new groups. In AHI's Maine Rule 945[1] filing for 2023, the company reported $4,594,177 direct premiums written in its commercial group major medical health insurance line. According to information provided separately by the company, AHI had 424 covered lives in the commercial block for 2023.

Aetna Life Insurance Company ("ALIC") is domiciled in Connecticut. It was licensed in the State of Maine in 1970 and currently writes life, accident and health insurance. Its health care products include commercial medical, government medical, dental and vision plans on both a fully insured basis and an employer self-funded basis. ALIC's commercial medical plans include point of service ("POS"), preferred provider organization ("PPO") and indemnity benefit plans. The company also offers individual Medicare Advantage plans as well as commercial medical stop loss coverage for self-insured employers. In ALIC's Rule 945 filing for 2023, the company reported 7,869 covered lives and $101,777,954 direct premiums written in its commercial group major medical health insurance.

Both companies are wholly owned subsidiaries of Aetna, Inc, whose ultimate parent since 2018 is CVS Health Corporation. The entities will be referred to collectively as "Aetna" or "the Companies" within this report.

[1] Rule 945 is a Maine Annual Report Supplement for specific data from health insurers and HMOs including major medical insurance. The long form, for those with $5 million or more in direct written health insurance premium for major medical and stop loss combined, includes premium and covered lives data. The short form, for those with less than $5 million, does not include covered lives data.

Executive Summary

The State of Maine Department of Professional and Financial Regulation, Bureau of Insurance ("Bureau") conducted an examination of Aetna Health Inc. and Aetna Life Insurance Company ("Aetna" or "companies") 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.

The examination was a targeted examination of Aetna's fully insured major medical plans to determine their compliance with certain provisions of Title 24-A and Maine Bureau of Insurance Rule 850. Maine statute and the Rule put forth certain requirements upon insurers and provide rights and protections to those individuals insured by health plans in Maine. Some 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 9(A) and related statutes in Title 24-A for the handling of such prior authorization or precertification requests. These requirements include the specific time period by which an approval or denial of the request must be conveyed, and also specific information that must be provided when the request is denied. The required information ensures that Maine consumers are notified promptly of their rights when coverage for requested services, care or medication is denied, including the right to appeal the denial, obtain documentation about the decision, and to file a complaint with the Bureau. The examiners tested 210 prior authorization requests for compliance and reviewed written policies and procedures in the companies' Utilization Review program that pertained to prior authorization procedures.

After reviewing the information provided in the initial data request, seven additional requests for information (RFIs) were issued for explanation or additional documentation regarding the companies' procedures, training, quality management and oversight. Two additional RFIs requested more information about Aetna's policy publishing system schedule and details on the forms represented in the samples. Four RFIs requested the sample files for the four types of prior authorizations related to Aetna's large group plans. As the companies' small group plans represented only a fraction of the plans sold in Maine in 2023, and with the company withdrawing from the small group market after 2024, the small group segment was dropped from the exam.

The companies were responsive to the examiners' requests for information, and provided prompt and meaningful replies to the criticisms issued. Written criticisms, commonly known as "crits" are notifications of potential compliance violations noted by the examiners. Thirteen crits were issued,

11 representing four specific compliance concerns across the four sample segments, one relating to the written utilization review procedures and one regarding form filing compliance. One crit was withdrawn by the examiners after Aetna provided additional information. The companies agreed to the remaining crits and promptly initiated corrective action.

Scope of Examination

The examination was performed to ascertain Aetna's compliance with the described requirements by reviewing prior authorization sample files from the review period of July 1 to September 30, 2023, and the companies' written procedures for prior authorization reviews. The products included were the companies' fully insured, ACA compliant major medical plans situsued 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.

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 2023 Edition* (MRH) as required by § 223(2). The MRH was used for purposes of sample determination and overall guidance.

Some unacceptable or non-compliant 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 policies and procedures and reviewed their handling of prior authorization requests that originated during the review period. The examiners reviewed files from the following universe of files of all prior authorization (PA) requests received by the companies during the review period:

Large Group, Standard PA requests – Pharmacy

Large Group, Standard PA requests – Non-Pharmacy

Large Group, Exigent[2] PA requests – Pharmacy

Large Group, Exigent PA requests – Non-Pharmacy

[2] "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."

The two Standard PA segments were of a sufficient size for random sampling. Both fell into the same bracket for 84 samples recommended by the MRH. The 84 samples were selected using the Excel RAND function, and five additional samples were identified for each population as replacements if needed. (All five of the additional samples were used in the Standard Non-Pharmacy section to replace five files that were found during review to be out of scope of the exam.) As the two Exigent segments were both below the recommended random sample size for the smallest population bracket, the total population of those segments was reviewed.

Universe File Numbers and Sample Sizes

PA Level	Service Type	ALIC Files	AHI Files	Total	Sample Size
Standard	Pharmacy	184	28	212	84
Standard	Non-Pharmacy	227	19	246	84
Exigent	Pharmacy	25	2	27	27
Exigent	Non-Pharmacy	10	5	15	15

Examination Results

FINDING 1. Written Procedures for Making Utilization Review

Written policies and procedures specific to prior authorization turnaround times for determination and notification were not up to date.

Rule 850 § 8(E)(1)

> *A health carrier or the carrier's designated URE shall maintain written procedures for making utilization review, experimental/investigational treatment and preexisting condition decisions, and for notifying covered persons and providers acting on behalf of covered persons of its decisions…*

The evaluation of this requirement is based on a review of Aetna's responses to document requests and subsequent questions from the examiners. This portion of the examination is intended to verify that Aetna maintains procedures for utilization review that are in accordance with applicable statutes, rules, and regulations.

Aetna provided various Maine-specific guidelines pertaining to each of the utilization review ("UR") entities. Examiners also reviewed the contractual agreements between Aetna and its third-party UR entities. Those agreements did not list Maine's specific requirements. Aetna stated in a follow-up response that the national agreement "does not list state requirements, only that the vendor has to meet whatever the state requirements are at the time."

- Prior Authorization turnaround times in the UR procedures for Aetna and CVS Caremark had not been fully updated to match the requirements that were revised in Rule 850 § 8(E)(2) and (3) effective 5/24/2020, even though the documents indicated they had been reviewed and updated since then.
    - These guidelines for these two entities still reflected the prior timing for exigent PA requests, which was "within 48 hours after receiving all necessary information." The 2020 revision to § 8(E)(3) changed both the time frame and the trigger for when it began to "within 24 hours after the request is received" for exigent requests.
    - The 2020 revision to § 8(E)(2) changed the required timing for standard requests from "within 2 working days" to "within 72 hours or 2 business days, whichever is less." The guidelines specific to Aetna's own UR activities for non-exigent PA requests had been updated in all but one section. The guideline regarding the time frame for company requests for additional information from the provider still indicated the prior timing.

- The eviCore[3] Clinical Certification of Services policy stated in its section for Maine that initial clinical review for prior authorization of nonemergency services was "based upon 24-A, MRSA §4304 SUB §2 as updated by PL 1999 c. 742 §12, effective 9/1/2019." The guideline displayed the entire statute. As § 4304(2) was last amended by PL 2021 ch 73 Sec. 1, effective 10/18/2021, the eviCore UR guidelines for prior authorization of non-emergency services were not up to date. [4]

Aetna immediately initiated corrections to the identified Aetna and CVS Caremark procedures to bring them up to date.

Sample Review – Procedures in Practice

Review of actual requests in sample files allows the examiners to see how the companies have put their written procedures into practice. The regulatory requirements under 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 prescriptions was denied.

The *Market Regulation Handbook* has historically established a benchmark error rate of 7% for auditing claims practices and 10% for other practices. 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 useful as a reference to gauge the extent of non-compliance in a reviewed area.

[3] eviCore is a third-party entity providing Utilization Review for Aetna.

[4] The change in 2021 affected only § 4304(2)(D), to specifically include prescription drugs and incorporate a requirement for electronic transmission of prior authorization requests for them. As eviCore's delegated duties for Aetna do not include utilization review for pharmacy, this failure to maintain current statutory requirements in their written procedures is a lesser concern.

FINDING 2. Timeliness of Determination and 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.*

Rule 850 § 8(E)(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...

(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.

The examiners reviewed 168 Standard (non-exigent) PA requests and found that 18 of the samples were not completed within the time frame required by 24-A M.R.S. § 4304(2) and § 8(E)(2).

PA Segment	Population	Sample Size	Violations	Sample error rate
Standard Non-Pharmacy	246	84	16	
Standard Pharmacy	212	84	2	
Total		**168**	**18**	**10.7%**

Despite the incorrect timing reflected in the UR procedures for exigent PA requests, none of the exigent requests processed by the company during the review period were untimely. The total population of 42 exigent PA requests, divided into Pharmacy and Non-Pharmacy segments, was reviewed. The companies were found to be in compliance in practice with § 8(E)(3) in the processing of the exigent requests.

FINDING 3. Denial Not Within Time Frame

Requests that 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.

Rule 850 § 8(E)(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 a carrier or the carrier's designated URE does not grant or deny a request within the timeframes required, the request is granted.*

18 sample files in the two non-exigent segments were found untimely as described in Finding 2 above. Ten of those requests were granted, but eight of them were denied. As 24-A M.R.S. § 4304(2) and § 8(E)(2)(c) require the request to be granted if it is not granted or denied within the required time frames, these eight requests were wrongfully denied.

PA Segment	Sample Size	Untimely	Violations	Sample error rate
Standard Non-Pharmacy	84	16	7	
Standard Pharmacy	84	2	1	
Total		**18**	**8**	**44.4%**

FINDING 4. Required Information in Adverse Determination Notifications – Health Care Treatment Decisions

Required information was not provided in pharmacy adverse determination letters.

Rule 850 § 8(E)(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 99 Non-Pharmacy PA requests (15 exigent, 84 non-exigent). These samples included a total of 16 requests that were denied. The information provided to the covered person with notification of these denied Non-Pharmacy requests complied with the stated requirements.

The examiners reviewed 111 Pharmacy PA requests (27 exigent, 84 non-exigent) which included a total of 46 requests that were denied, with 38 of them involving health care treatment decisions. None of the 38 denied Pharmacy requests involving health care treatment decisions provided all the required information, each missing one or both of the items identified above. The current language in all letters fails 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.

PA Segment	Sample Size	Adverse Decisions	Violations	Sample error rate
Exigent Pharmacy	27	12	12	
Standard Pharmacy	84	26	26	
Total	**111**	**38**	**38**	**100%**

FINDING 5. Required Information in Adverse Determination Notifications – Adverse Benefit Determinations Not Involving Medical Issues

Required information was not provided in pharmacy adverse determination letters.

Rule 850 § 9(A)

…For any adverse benefit determination that does not involve medical issues, the carrier shall provide written notice that includes the information required below:

6) *Notice of the right to file a complaint with the Bureau of Insurance after exhausting any appeals under a carrier's internal review process…*

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

The examiners reviewed 111 Pharmacy PA requests (27 exigent, 84 non-exigent) which included a total of 46 requests that were denied, with eight of them categorized as adverse benefit determinations not involving medical issues. None of the eight denied Pharmacy requests that did not involve medical issues provided all the required information, each missing one or both of the items identified above.

PA Segment	Sample Size	Adverse Decisions	Violations	Sample error rate
Exigent Pharmacy	27	1	1	
Standard Pharmacy	84	7	7	
Total	**111**	**8**	**8**	**100%**

FINDING 6. Plan Document Wording

Plan documents contained incorrect information about time frames for PA requests.

Part of the sample review included review of the Certificate of Coverage (COC) associated with each sample to verify plan provisions upon which denials were based. Examiners also evaluated the section of the COC that describes the PA process. Of the seven different COC forms present in the samples, the examiners discovered that one of the forms did not contain correct timing, although the forms had been submitted for review (and approved by the Bureau) with correct timing displayed. Aetna acknowledged that this was an issue with its publishing system not being updated at the time those plans were issued; however, examiners noted the form in question was filed and approved in 2021.

PA Segment	Population	Sample Size	Violations	Sample error rate
Exigent Pharmacy	27	27	11	
Exigent Non-Pharmacy	15	15	5	
Standard Non-Pharmacy	246	84	55	
Standard Pharmacy	212	84	33	
Total		**210**	**104**	**49.5%**

FINDING 7. Use of Approved Forms

Plan documents were filed with and approved by the Bureau for use in Plan Year 2023 that reflected the appropriate current statutory requirements for 2023. The approved forms were intended to replace prior forms. The outdated forms were still being issued in 2023.

24-A M.R.S. § 2412 Filing, approval of forms

1. *An insurance policy or annuity contract may not be delivered or issued for delivery in this State unless the form has been filed with an approved by the superintendent in accordance with the following.*
    A. *For purposes of this section, "form" includes:*
        1) *The basic form and any printed rider, endorsement or renewal form;*
        2) *An application if a written application is required and is made part of the policy or contract; and*
        3) *A certification of coverage under a group policy or contract that is delivered or issued for delivery in this State.*

Part of the examination included a review of the Companies' form filings to the Bureau and a comparison of the plan documents in the samples with the forms approved and expected to be in use during 2023.

The SERFF filing made in 2022 for the 2023 Plan Year replaced form AL HCOC 10 with new form AL HCOC 11 which updated the provisions to be consistent with regulations applicable to 2023. The replaced form, now outdated, should not have been used for 2023 plans as it was specifically identified as being replaced. The examiners found that 40 of the 210 total samples with effective dates of 01/01/2023 or later were issued on or after 01/01/2023 on the old form. Aetna acknowledged that the publishing system was not updated until 01/02/2023, however, all of the cited samples were issued after 01/02/2023. Those files that were issued after the filing approval of 9/23/2022 but before 01/01/2023 that were effective on or after 01/01/2023 were not included in this citation.

PA Segment	Population	Sample Size	Violations	Sample error rate
Exigent Pharmacy	27	27	3	
Exigent Non-Pharmacy	15	15	2	
Standard Non-Pharmacy	246	84	12	
Standard Pharmacy	212	84	23	
Total		**210**	**40**	**19%**

Recommendations

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

1. Written utilization procedures for Aetna and all delegated utilization review entities must be updated to reflect current Maine requirements, and a process implemented to ensure that future regulatory changes are incorporated in a timely manner.
2. Training and/or staffing adjustments should be initiated to ensure that prior authorizations are completed within the appropriate statutory time frame. Many of the violations appeared to indicate a lack of understanding when “72 hours” or “2 business days" was the lesser time frame that should be applied for the turnaround time for non-emergent requests. System programming to make this distinction may be helpful.
3. Training and system protocols should be implemented to ensure that non-emergent prior authorizations not granted or denied within the required time frame are granted as required by Maine law.
4. Adverse determination letter and appeal rights templates should be reviewed and amended to include all of the information and notifications required.
5. Form publishing systems and procedures should be evaluated to implement protocols to address the drafting errors encountered in this examination. The company should ensure that issued forms contain the approved wording and that the systems are updated to include the forms approved for a coverage year prior to January 1 of that year.

Acknowledgement

The BOI would like to acknowledge the cooperation and assistance extended to the examiners by the Companies’ exam coordination team during the course of the examination.