THE COMMONWEALTH OF MASSACHUSETTS

OFFICE OF CONSUMER AFFAIRS AND BUSINESS REGULATION

DIVISION OF INSURANCE

Report on the Limited Scope Market Conduct Examination of

Aetna Life Insurance Company
Aetna Health Inc.
Aetna Health Insurance Company

Cleveland, OH

For the Period January 1, 2022, through December 31, 2022

NAIC COMPANY CODE: 60054, 95109, 72052

EMPLOYER ID NUMBER: 06-6033492, 23-2169745, 23-2710210

TABLE OF CONTENTS

COMMONWEALTH OF MASSACHUSETTS
Office of Consumer Affairs and Business Regulation
DIVISION OF INSURANCE
One Federal Street, Suite 700 • Boston, MA 02110
(617) 521-7794 • Toll-free (877) 563-4467
www.mass.gov/doi

MAURA T. HEALEY
GOVERNOR

KIMBERLEY DRISCOLL
LIEUTENANT GOVERNOR

MICHAEL T. CALJOUW
COMMISSIONER OF INSURANCE

December 8, 2025

The Honorable Michael T. Caljouw
Commissioner of Insurance
Commonwealth of Massachusetts
Division of Insurance
One Federal Street, Suite 700
Boston, Massachusetts 02110-2012

Dear Commissioner Caljouw:

Pursuant to your instructions and in accordance with Massachusetts General Laws, Chapter 175, Section 4, the Massachusetts Division of Insurance ("Division") has performed a limited-scope market conduct examination ("Continuum of Regulatory Options/Interrogatory") of the market conduct affairs of **Aetna Life Insurance Company, Aetna Health Inc., and Aetna Health Insurance Company** ("Company"). The examination included but was not limited to the Company's 2022 calendar year health insurance business in Massachusetts.

The Company's home office:

151 Farmington Avenue
Hartford, CT 06156

The following report thereon is respectfully submitted.

ACRONYMS

Aetna Health Management LLC (“AHM”)
Aetna Market Fee Schedule (“AMFS”)
American Society of Addiction Medicine criteria (“ASAM”)
Applied Behavioral Analysis (“ABA”)
Better Business Bureau (“BBB”)
Child and Adolescent Level of Care Utilization System (“CALOCUS”)
Clinical Policy Bulletins (“CPBs”)
Council for Affordable Quality Healthcare (“CAQH”)
INS Regulatory Insurance Services, Inc. ("INS")
Level of Care Utilization System (“LOCUS”)
Massachusetts Attorney General’s Office (“AGO”)
Massachusetts Division of Insurance (“Division”)
Market Conduct Annual Statement (“MCAS”)
Market Regulation Handbook ("MRH” or “the Handbook")
Medical/Surgical (“M/S”)
Mental Health (“MH”)
Milliman Care Guidelines (“MCG”)
National Association of Insurance Commissioners ("NAIC")
Non-Quantitative Treatment Limitation (“NQTL”)
Obstetrics and Gynecology (“OB-GYN”)
Office of Patient Protection (“OPP”)
Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”)
Pharmacy Benefit Managers (“PBMs”)
Quantitative Treatment Limitation (“QTL”)
Substance Use Disorder (“SUD”)
System for Electronic Rate Form Filing (“SERFF”)
Third-Party Administrators (“TPAs”)
United States of America (“USA”)

BACKGROUND

On or about July 2023, the Massachusetts Division of Insurance (“Division") commenced a behavioral health parity compliance market conduct examination, pursuant to section 8K of Chapter 26 of the Massachusetts General Laws as amended by Chapter 177 of the Acts of 2022 (An Act Addressing Barriers to Care for Mental Health), section 4 of Chapter 175, section 10 of Chapter 176G and all other applicable statutes. Following the legislative mandate, the limited scope examination focused primarily but not exclusively on compliance with the applicable provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MPHAEA"), as amended, any federal guidance or regulations relevant to the act, including 45 CFR Part 146.136, 45 CFR Part 147.136, 45 CFR Part 147.160 and 45 CFR Part 156.115(a) (3), and applicable state mental health parity laws, including, but not limited to, section 47B of Chapter 175, section 8A of Chapter 176A, section 4A of Chapter 176B and sections 4, 4B and 4M of Chapter 176G.

The examination included an Interrogatory as provided under the Continuum of Regulatory Options ("Continuum") for market conduct examinations. The Continuum focused the examination on high-level aggregate data requests for areas such as utilization review, including prior authorization data, concurrent review, retrospective review, denials of authorization, step-therapy, network admission

standards/reimbursement rates, network adequacy, geographic restrictions, complaint/grievance data, information verifying compliance with MPHEA, and denials of payment and coverage. In addition, the examiners reviewed the Market Conduct Annual Statement ("MCAS"), National Association of Insurance Commissioners ("NAIC") financial filings, and Massachusetts health binder filings within the System for Electronic Rate and Form Filing ("SERFF"). In addition, for those companies that received a report from the Massachusetts Attorney General's Office ("AGO") in 2020, the examiners conducted an evaluation of the Company responses.

INS Regulatory Insurance Services, Inc. ("INS"), a consultant qualified to perform market analysis and market conduct examinations under the management and general direction of the Division, conducted the limited scope examination described in the preceding paragraphs.

SCOPE OF EXAMINATION

The examination was initiated with an interrogatory, one of the options outlined in the Continuum of Options section of the NAIC Market Regulation Handbook ("MRH" or "the Handbook"). The interrogatory focused on MHPAEA compliance in key areas, including utilization review, step therapy, network admission standards, network adequacy, denials of payment and coverage, quantitative treatment limitations, and the policies and procedures used to monitor compliance within the Company and with third-party administrators and vendors. Additionally, the interrogatory inquired about the methods employed to ensure the accuracy of the 2022 Health MCAS filed by the Company. The examiners used sources, including the Company responses, the MCAS filing, and existing reports within the Division, to assess the accuracy and completeness of company-reported data.

EXAMINATION APPROACH

The examination employed the guidance and standards in the 2022 Handbook, the examination standards of the Division, the Commonwealth of Massachusetts' insurance laws, regulations, bulletins, and applicable Federal laws and regulations. Examiners performed all procedures under the supervision of the Division's market conduct examination staff.

The Handbook provides guidance on optional processes and procedures for use during the examination and includes an approach designed to detect potential areas of non-compliance. The methodology outlined in the Handbook identifies key practices and controls used to operate the business and to meet essential business objectives, including measures designed to ensure compliance with applicable MHPAEA state and federal laws and regulations.

All unacceptable or non-compliant practices may not have been discovered or noted in this report. Failure to identify improper or non-compliant business practices does not constitute acceptance of such practices. The Company shall report to the Division on any such corrective actions taken.

Interested parties can review all Massachusetts laws, regulations, and bulletins cited in this report on the Division's website at http://www.mass.gov/doi.

EXECUTIVE SUMMARY

This summary provides a high-level overview of the examination results, while the remainder of the text summarizes all observations, conclusions, recommendations, and corrective actions required as a result of

the examination.

Required Company Corrective Action

Market Conduct Annual Statement

Examination Conclusions: The examiners noted that 23% of all out-of-exchange prior authorization requests were denied. This percentage is twice the statewide average. In addition, the examiners noted over one-half of all out-of-exchange prior authorizations for pharmacy were denied.

It should be noted that the total numbers reported for out-of-exchange were low and only reported for student health, so this can skew the percentage values. This percentage is twice the statewide average.

Corrective Action: The Company must explain the high number of prior authorization denials for pharmacy out-of-exchange. This updated information should be supplied to the Division by February 12, 2026.

Subsequent Company Actions: The Company explained that the primary reasons for out-of-exchange prior authorization denials include clinical reviews for medical necessity; requests for additional clinical information that were not received; not a covered service; and coordination of benefits. The companies' review and assessment of pharmacy prior authorization denials during the exam period is in progress but not yet complete.

I. COMPLAINTS/GRIEVANCES

Closed Consumer Complaints

The interrogatory requested a summary log of all closed consumer complaints submitted by consumers directly to the Company from January 1, 2022, through December 31, 2022. This log included any closed complaints submitted to the Division, the Massachusetts Office of the Attorney General ("AGO"), the Better Business Bureau ("BBB"), MyPatientsRights.org, and the Office of Patient Protection ("OPP").

Examination Procedures Performed: INS reviewed the complaint summary log for MHPAEA compliance and identified complaints and grievances related to potential network adequacy insufficiencies. INS also inquired whether there were processes and procedures in place with third-party administrators to ensure all complaints were correctly reported. Further, INS:

a) reviewed the Company's complaints and grievance registers to identify if there was a lack of in-network providers,
b) reviewed the Company's complaint and grievance register to identify if there were sufficient in-network providers for M/S, MH, and SUD,
c) reviewed the Company's complaint/grievance registers to detect any identifiable trends for out-of-network denials,
d) reviewed the Company's complaint/grievance registers to identify any trends related to consumers having to pay out-of-network rates due to a lack of in-network providers,
e) inquired if there were policies and procedures in place for any third-party administrators (especially those handling MH/SUD) to report complaints/grievances to the Company, and
f) reviewed to determine the final number of complaints and identify those that were of potential concern.

Examination Conclusions: Aetna Life Insurance Company reported 64 member appeals (62 medical and 2 mental health) reported, 42 were related to claims processing, 2 inpatient denials, 8 outpatient denials, 11 were related to the policy, and one was related to provider billing. Further, those appeals were divided into the following categories: 12 were related to referrals, authorizations, or precertification; 10 involved errors in out-of-pocket expenses; 12 involved incorrect deductibles/co-pay or co-insurance; eight (8) involved outpatient denials; four (4) experimental/investigational; three (3) for benefit limitations; three (3) related to medical necessity denials; two (2) for balanced billing, two (2) for eligibility; and 16 other complaints. Two appeals involved mental health claims citing out-of-pocket expense errors; in both, the Company's position was upheld. Sixty-one percent (61%) of the appeals resulted in the Company's position being upheld, while 39% resulted in the Company's position being overturned. Aetna Life Insurance Company reported a total of five (5) complaints, four (4) complaints received directly from consumers and one (1) DOI complaint of those, one (1) was related to mental health citing alleged fraud which resulted in education for the complainant.

Aetna Health Inc. reported two (2) member appeals, and both resulted in the Company's position being overturned.

Based on the information provided by the Companies, they are in compliance with state and federal complaint statutes and processes.

Closed Provider Complaints/Grievances

The interrogatory requested a summary log of all closed provider complaints submitted by consumers directly to the Company from January 1, 2022, through December 31, 2022. This log included any closed

complaints submitted to the Division, the AGO, the BBB, MyPatientsRights.org, and the OPP.

Examination Procedures Performed: INS reviewed the summary log for MHPAEA compliance and identified any complaints/grievances related to potential network adequacy insufficiencies. In addition, INS inquired whether there were processes and procedures in place with third-party administrators to ensure all complaints were correctly reported. Further, INS:

a) reviewed the Company's complaint/grievance registers to identify whether there were sufficient in-network providers.
b) reviewed the Company's complaint/grievance registers to identify whether there was a lack of in-network providers for M/S, MH, and SUD.
c) reviewed the Company's complaint/grievance registers to identify whether there were trends for out-of-network denials.
d) reviewed the Company's complaint/grievance registers to identify trends related to consumers having to pay out-of-network rates due to a lack of in-network providers.
e) inquired if there were policies and procedures in place for any third-party administrators (especially those handling MH/SUD) to report complaints/grievances to the Company, and
f) reviewed to determine the final number of complaints and identify those of potential concern.

Examination Conclusions: Aetna Life Insurance Company: The Company provided two (2) complaints, one (1) DOI complaint citing claim processing delays, which resulted in a letter, and one (1) complaint received directly from a consumer citing incorrect information provided, which also resulted in a letter. They also provided 328 appeals, including 324 medical and four (4) mental health. The appeals can be broken down into the following categories, policies (147), claims processing (127), inpatient denials (33), and provider reimbursements (18) and three (3) miscellaneous. The top four reasons for the appeal include 124 related to referrals/authorizations or precertification; 63 categorized as experimental or investigational; 26 are related to the timely filing of appeals, and 14 involve incorrect contracts or negotiated rates. The appeals resulted in the Company's position being upheld in 232 cases (70.7%), overturned in 93 cases (28.3%), and partially overturned in 3 cases (less than 1%0. The four (4) mental health appeals were related to behavioral health (3) and claim processing (1) and cite level of care for PHP and IP MH (3), and referrals, authorizations or precertifications (1). Of the behavioral health claims, two (2) resulted in the Company's position being upheld, one (1) was partially overturned, and one (1) was overturned.

Aetna Health Inc.: The Company reported 41 appeals; all related to medical issues. The majority of the appeals are related to claim processing (22) and policy coverage issues (16). Among these, 22 involve referrals, authorizations, or precertifications; four (4) are for experimental or investigational treatments; and four (4) are related to timely filing of appeals. Outcomes showed the Company's position was upheld in 30 cases , overturned in ten cases, (10) and partially overturned in one case (1). Aetna Group: The Company submitted six (6) provider complaints without identifying the product involved; three (3) were medical, and three (3) were mental health. The three medical complaints cite an executive/Regulatory clinical policy bulletin and payment policy. The three mental health complaints pertain to incorrect billing, requiring multiple calls to resolve the cited issue, and provider contract issues. Five (5) complaints resulted in education of the complainant, and one (1) resulted in payment and education.

Observations: The Companies should continue to monitor provider appeals based on the number of appeals reported for Aetna Life Insurance Company and Aetna Health Inc. related to referrals, authorizations, or precertifications, and experimental/investigational claims. Most of these appeals resulted in the Company's position being upheld.

Subsequent Company Actions: The Companies will continue to monitor provider appeals based on the

number of appeals reported for Aetna Life Insurance Company and Aetna Health Inc. related to referrals/authorizations/pre-certifications and experimental/investigational claims.

II. MARKET CONDUCT ANNUAL STATEMENT

Companies with $50,000 or more in yearly premium sales in certain lines of business must file the MCAS report annually. The companies were asked to verify the accuracy of their MCAS data or, if they had not filed MCAS, to supply the information contained in the MCAS to the examiners. The examiners verified with the Company that they attested to the accuracy of the data.

Examination Procedures Performed: INS reviewed the MCAS fields related to prior authorizations (pharmacy and excluding pharmacy), and external review data for both in-exchange and out-of-exchange. Further, INS:

a) developed statewide averages for each field for both in-exchange and out-of-exchange,
b) reviewed all prior authorization denials for non-pharmacy and pharmacy and compared the state data to the statewide medians and averages,
c) reviewed the percentage of MH/SUD prior authorization denials to see if they were higher than M/S prior authorization denials,
d) reviewed the consumer-requested external reviews (excluding pharmacy) that were overturned, and,
e) verified that addendums were filed about the accuracy of the MCAS data.

Examination Conclusions: The examiners noted that 23% of all out-of-exchange prior authorization requests were denied. This percentage is twice the statewide average. In addition, the examiners noted over one-half of all out-of-exchange prior authorizations for pharmacy were denied.

It should be noted that the total numbers reported for out-of-exchange were low and only reported for student health, so this can skew the percentage values. This percentage is twice the statewide average.

Corrective Action: The Company must explain the high number of prior authorization denials for pharmacy out-of-exchange. This updated information should be supplied to the Division by February 12, 2026.

Subsequent Company Actions: The Company explained that the primary reasons for out-of-exchange prior authorization denials include clinical reviews for medical necessity; requests for additional clinical information that were not received; not a covered service; and coordination of benefits. The companies' review and assessment of pharmacy prior authorization denials during the exam period is in progress but not yet complete.

III. DENIAL OF PAYMENT AND COVERAGE

Third-Party Administrator Claims Processing

The companies supplied the names of the internal and external third-party administrators ("TPAs") involved in claims processing. For this review, the request focused on any TPAs directly involved in claims processing, including those administrators who accept, deny, or otherwise adjudicate the claims. For example, the request might include pharmacy benefit managers ("PBMs"), administrators that process M/S and MH/SUD claims, and administrators that may process international claims. The list of requested TPAs should include those processing M/S claims, as well as those involved in MH/SUD claims processing. The examiners reviewed the response to identify which providers are used and for what purpose.

Examination Procedures Performed: INS reviewed the third-party entities involved with claims processing. Further, INS identified whether:

a) M/S claims are processed through a different vendor than those processing claims for MH/SUD,
b) a vendor (within the Company group or an outside vendor) is used for pharmacy claims, and
c) whether a PBM is utilized.

Examination Conclusions: Aetna provided a list of all third-party entities involved in claim determinations and identified the type of claims that each third-party processes. This response was complete and sufficient.

Policies and Procedures Related to Claim Denials

Examination Procedures Performed: INS reviewed the third-party policies and procedures for claim denials. Further, INS also identified whether:

a) the Company has adequate processes and procedures for claims processing,
b) if the Company writes in multiple jurisdictions, the policies and procedures for claims denials must include information about state-specific requirements,
c) the state-specific addendums have been reviewed to determine if all addendums are up to date with any recent bulletins, statutes, regulations, or related recent amendments or revisions, and
d) the information provided was adequate to determine if the individual at the Company making the denial decision is experienced in the area they are reviewing. Ideally, the individual should be board-certified in the area being reviewed (e.g., psychologist/board-certified, behavior analyst-doctoral, and/or a psychologist with clinical experience).

Examination Conclusions: Aetna submitted six policy and procedure documents related to denials. The first document is the National Clinical Services Denial of Coverage Policy. It covers behavioral health, care management, NME ("non-medical") Case Management, and precertification for all products. The denials are based on either administrative reasons or clinical criteria. It is recommended that the document be updated to include state-specific statute requirements, especially regarding benefit limitations for behavioral health and autism spectrum disorder. The section about notification of the "Coverage Denial" appears to primarily focus on Medicare Advantage denials, with some documentation specific to ERISA. The section outlining what should be contained in a written denial notification appears to be missing a section that explains what might have been missing from the initial request and what needs to be submitted in order to approve the request. It does provide information regarding the appeal process.

Observation: Based on the review, the examiners recommended that the Company ensure all claims processing-related documents and provider manuals are edited to clarify that mental health services do not have lifetime or annual limits. They should also update the Company's policies and procedures to reflect that there is no annual or lifetime limit for autism spectrum disorders per M.G.L. c. 6A § 16P (ARICA).

Subsequent Company Actions: The companies will take the recommendations under advisement. They note that the Companies' policies and procedures are administered in accordance applicable law, which precludes the application of such limits.

M/S, MH and SUD Claims Received, Paid, Denied (in part or in whole)

Examination Procedures Performed: The Company provided the claims received, paid, denied in part, and denied in whole, separated by M/S, MH, and SUD. The examiner totaled the data and created statewide

averages and medians to determine if companies were outside of the statewide thresholds; however, accommodations were made to exclude entities that did not meet minimum thresholds. Further, INS identified whether:

a) the claims paid were less than statewide averages and medians,
b) the percentage of total denials was over the statewide averages and medians,
c) the denials for M/S claims were higher than statewide averages and medians,
d) the denials for M/H claims were higher than statewide averages and medians,
e) the denials for SUD claims were higher than statewide averages and medians, and
f) the denials of MH and SUD claims were higher than M/S claim denials.

Examination Conclusions: The companies provided data for claims received, paid, and denied. All three companies were in line with statewide averages for the total number of claims paid, denied in part and denied in whole for M/S, MH and SUD. In line with overall state trends, the denial percentage for SUD is higher than for MH.

There are no recommendations for the claims paid, partially denied and whole denials.

IV. NETWORK ADEQUACY

The Companies were asked to supply processes and procedures to demonstrate their compliance with the state and Federal requirements for network adequacy. The Company were also asked to provide a listing of their MHPAEA plans. The examiners selected a plan from the Company's list and performed a search on the Company website, searching for an Obstetrics and Gynecology ("OB-GYN") provider and a MH or SUD provider.

Policies and Procedures Compliance with Federal Requirements on Provider Data Accuracy

Examination Procedures Performed: INS reviewed the Company's policies and procedures to determine if the Company complied with Federal requirements on provider data accuracy. The purpose of the INS review was:

a) to ensure the Company had documented policies and procedures,
b) to ensure compliance with the No Surprises Act (42 USCS § 300gg-115) for all provider types and
c) to confirm that the accuracy of provider data is reviewed every 90 days.

Examination Conclusions: The companies' documentation does not include what happens if a provider does not respond to quarterly verifications or how many opportunities the Company provides for non-responsiveness before they remove them from the directory.

Observation: The companies should also consider updating the policies and procedures for provider data accuracy to include the steps taken if the provider does not respond quarterly to data verification requests, and how long they can fail to respond before they are either suspended or removed from the directory.

Subsequent Company Actions: The companies explained that their *Data Validation and Quality – Proactive Outreach Validation* policies and procedures include proactive outreach validation for Mental Health and SUD providers. The companies will take the examiners' recommendation of updating the policies and procedures for provider data accuracy to include steps taken if the provider does not respond quarterly to verification requests, and how long they can fail to respond before they are either suspended

or removed from the directory in their ongoing implementation of 211 CMR 52.00.

List of Massachusetts Plans Subject to Mental Health Parity in 2022

Examination Procedures Performed: INS reviewed the Company's response to verify that the list of plans subject to the mental health parity requirement in 2022 was provided to the Division. Further, INS reviewed the Company's response to verify:

a) the Company responded to the question, and
b) the list provided matches the 2022 SERFF Filing Binder (if applicable).

Examination Conclusions: Based on the review of the plans supplied by the Company, the response is sufficient and accurate.

Basic Web Searches

Examination Procedures Performed:
The examiners selected a plan from the Company's list and performed a search on the Company website searching for an OB-GYN provider and a MH or SUD provider. Further, INS:

a) conducted a basic search without a login to find an OB-GYN within the plans service area,
b) conducted a basic search without a login to find an MH/SUD provider,
c) confirmed that the name of the plan displayed on the website was consistent with the Company name provided, and
d) reported challenges encountered in the search to the Company.

Examination Conclusions: The examiners reviewed the company's annual binder filing for the service area. They conducted a web search for a provider for both a substance use disorder professional and an OB-GYN.

Aetna Health Ins. (A Pennsylvania Corporation) – 95109
The examiners selected the Health Network HMO plan and searched for a drug/alcohol addiction provider in the following city/zip: 01370.
The closest provider was 3.51 miles and accepting new patients.

The examiners selected the same plan and searched on the company website for an OBGYN.
The closest location with providers was a facility within 6.52 miles.
Website: www.Aetna.com

Aetna Life Insurance Company - 60054
The examiners selected the Managed Care POS plan and searched for an eating disorder provider in the following city/zip: 01301. The examiners selected the same plan and searched on the company website for an OBGYN.
The closest provider was within 2.11 miles and accepting new patients.

The Company did not have any behavioral health parity plans in force at the time of the examination.
Website: www.Aetna.com

There were no concerns identified based on the review of the Company website.

V. NETWORK ADMISSION STANDARDS

The Company supplied the network admission standards, reimbursement rates and policies, and the number of network admissions during the examination period of review.

Network Admission Standards Policies/Procedures Data Submitted

Examination Procedures Performed: INS reviewed the network admission standards, reimbursement rates and policies, and the number of network admissions during the examination period of review to determine if ample processes and procedures were in place. Further, INS considered:

a) if any additional barriers exist that make it harder for MH/SUD providers to become a member of the network,
b) if the Company is using a TPA or another vendor for MH/SUD. If the Company have processes in place for the vendor to follow rather than relying solely on the vendor to determine what network admission standards will apply,
c) if there are differences between MH/SUD and M/S admission processes, evaluate the differences to ensure they do not result in more stringent or have extra requirements for MH/SUD applicants. (For example, what are the liability insurance requirements for M/S versus MH/SUD?)

Examination Conclusions: There are websites providing guidance to providers on how to navigate the Aetna credentialing process with helpful tips on how to navigate the detailed admissions process. There are several cites reporting that the credentialing process, especially for behavioral health credentialing to be considered an in-network provider takes a long time, some providers stating it can take between six months to a year. It is understood that the credentialing process may take time, especially if information uploaded is incomplete or expired. The process does require providers to remain highly engaged to avoid delays.

Observation: The Companies should continue to be transparent about rates with the prospective providers during the application process. Consider promoting the Provider Services Center so prospective providers can more easily obtain rate reimbursement information prior to signing the contract.

Subsequent Company Actions: The Companies' current standard application processing timeframes are 40 calendar days from receipt of a complete credentialing application for initial credentialing events, and 90 calendar days for recredentialing events. These standard application processing timeframes are more stringent than the current requirements for the state of Massachusetts (60 days for initial events; 120 days for recredentialing events). The examiners confirmed that the timelines for processing approved applicants was within the Massachusetts statutory requirements.

Contracting occurs outside of the Credentialing Department and is conducted prior to credentialing. Contracting is not included in the credentialing timeframes. Credentialing timeframes are determined from the date a completed application is received in the Credentialing Department to the date of the credentialing decision (approval or denial).

Compliance monitoring is also conducted for all Massachusetts initial and recredentialing events in the credentialing system to ensure the state mandated notification and credentialing timeframes are met. In instances where an event is approaching the state mandated timeframes, credentialing staff are notified to prioritize the event to maintain compliance with the established timeframes.

Aetna used the Council for Affordable Quality Healthcare ("CAQH") ProView application for credentialing in Massachusetts.

Reimbursement Rate Policies

Examination Procedures Performed: INS reviewed the reimbursement rate policies and procedures. Further, INS reviewed the reimbursement rate policies to:

a) ensure the rate policies were complete and detailed,
b) verify whether a third-party or internal entity handles the reimbursement rate policies, and
c) verify the reimbursement procedures/methods are not more stringent for MH/SUD than for M/S providers. (Additional software, etc.)

Examination Conclusions: The Companies submitted the *AMFS Rate Development PP for Non-Facility Providers* document. This Aetna Market Fee Schedule ("AMFS") document is the standard rate schedule for contracting with participating medical and behavioral health providers that are not facility-based providers. There is a team that provides data analysis to support the Medical and BH network teams in developing and refreshing the AMFS rates. The policy and procedures outlined in the document were developed to ensure compliance with the Mental Health Parity Addiction and Equity Act ("MHPAEA").

Providers are welcome to request a rate change/increase at any time. The companies' contracts are typically evergreen and renewed annually. They cannot guarantee rate increases for all providers immediately following the initial contract term.

Number of Network Admissions During the Period (M/S, MH and SUD)

Examination Procedures Performed: INS reviewed the network admissions for the examination period. Further, INS reviewed the data to ensure:

a) the information was separated into M/S and MH/SUD,
b) the information included facilities for M/S and MH/SUD,
c) the reasons for denial were included, and
d) the percentage of denials for MH/SUD was similar to those for M/S.

Examination Conclusions: The Company's response included 2,851 applicants for network admissions, 2,850 (99.96%) were accepted into the network and 1 (00.035%) was denied. Of the 2, 851 applicants approved, 734 were BH, 35 were MH and the remaining 941 were M/S.

Based on the review of the network admissions, the Company's network admissions meet Massachusetts statutory and regulatory requirements.

VI. POLICY AND PROCEDURES FOR COMPLIANCE WITH MHPAEA

Examination Procedures Performed: The companies supplied policies, procedures, and documentation to show the implementation of MHPAEA compliance. Further, INS reviewed the data to:

a) ensure the Company has policies and procedures for ensuring compliance with MHPAEA,
b) ensure the Company monitors/audits vendors for compliance and,
c) ensure the Company has an organized compliance plan for MHPAEA oversight.

Examination Conclusions: The Company submitted two documents, the *MHP Task Force Composition* and the *Mental Health Parity Task Force Charter,* which provide an overview/summary to ensure

adherence with MHPAEA compliance. The Mental Health Parity ("MHP") Task Force acts as a central point of oversight to ensure adherence with MHPAEA regulations across impacted business segments throughout the enterprise. The MHP Task Force will serve as the review and approval committee for any updates to Benefit Classifications, Quantitative Treatment Limitations/Financial Requirements ("QTL/FR"), and Non-Quantitative Treatment Limitations ("NQTL") master comparability analysis documents, including operational data reports and comparative analysis supplemental documents. The task force meets annually or may meet more frequently if a special session is needed. They approve analysis such as the NQTL analysis, track updates to state and federal regulation and modify policies and procedures accordingly. The Mental Health Parity Task Force is comprised of a variety of fifteen (15) internal representatives. These include managers and directors within the behavioral health arena, as well as one physician, one attorney, an actuary and key individuals representing BH clinical health, network management, quality care, products, etc.

Based on the review, the company meets Massachusetts statutory and regulatory requirements regarding compliance with MHPAEA.

VII. QUANTITATIVE TREATMENT LIMITATIONS

The Companies must demonstrate that QTL testing was conducted with indicators for pass/fail.

Examination Procedures Performed: The examiners reviewed the data to determine if the QTL testing was complete. Further, INS reviewed the data to:

a) ensure the Company provided testing results (pass/fail),
b) verify if the Company reported fail in any one or multiple categories,
c) verify if the QTL analysis included the substantially all testing,
d) verify if the QTL analysis includes predominant testing, and
e) verify if the Company demonstrated that the substantially all testing (2/3 threshold) was completed before the predominant testing.

Examination Conclusions: The Companies originally submitted nine QTL testing templates, four (4) for Aetna Health Insurance and five (5) for Aetna Life Insurance Company. The services covered for all plans appeared to only include medical/surgical care, excluding mental health and substance use disorder services.

Subsequent Company Actions: The Companies confirmed that MH/SUD is covered. They provided updated templates with this response in which MH/SUD is included in the Covered Services tab for AHI Plans 1-4 and ALIC Plans 1-5. They apologized for the oversight.

VIII. STEP THERAPY

The Company submitted the step-therapy requirements, the number of step-therapy requests, and how many were approved, denied in part, or denied in whole.

List of M/S, MH/SUD and Pharmacy Benefits Requiring Step-Therapy

Examination Procedures Performed: The examiners reviewed the data to determine if the step-therapy or fail first requirements distinguished between M/S, MH/SUD, and pharmacy. Further, INS reviewed the

data to:

a) ensure the Company provided step-therapy documentation,
b) verify the Company provided step-therapy for both M/S and MH/SUD,
c) identify if any MH/SUD medications should not require step-therapy (e.g., smoking cessation) and,
d) determine if all medications within a particular class of MH/SUD medications, including generic versions, require step therapy.

Examination Conclusions: The Company's original response did not provide information regarding the step therapy requirements. The list of medications included all types of drugs, many of which are brand names, including products that address sleep aids, major depressive disorder, diabetes medications, anxiety, arthritis, migraine headaches, anti-inflammatory, and narcotic drugs used for pain management (Fentanyl and Codeine), among others. There is some concern that many Buprenorphine medications require step therapy.

Subsequent Company Actions: The companies explained that step-therapy requirements were only listed for buprenorphine formulations indicated for the management of severe and persistent pain. Step therapy did not apply to buprenorphine formulations for substance abuse disorder (SUD). The companies provided their formularies which identify all the medications and whether they require step therapy. The statutory exception for step therapy protocols is documented in the Companies' policies and procedures for step therapy. The policy and procedure document the requirements for the Prior Authorization (PA) process for plans subject to Massachusetts State laws, unless a more stringent federal requirement applies.

Number of Step-Therapy Requests, Approved, Denied (in part or in whole)

Examination Procedures Performed: The examiners reviewed the data to determine the number of approved, partially denied, or fully denied step-therapy requests that were completed during the examination period. Further, INS reviewed the data to:

a) determine statewide averages and medians for approvals, partial denials, and whole denials,
b) determine if the Company had higher averages and medians than the statewide averages, and,
c) identify if the number/percentages of denials and partial denials are higher for MH and SUD as compared to M/S.

Examination Conclusions: The step therapy approval and denial percentages were within statewide averages.

Based on the review of the number of step-therapy requests approved, denied (in part or in whole), the Company complies with Massachusetts statutory and regulatory requirements.

IX. UTILIZATION REVIEW

The Company was requested to provide the TPAs for MH/SUD, the medical necessity guidelines criteria, and the sources for those guidelines. In addition, the Company was requested to provide the M/S, M/H, and SUD requests separated by approved, denied in part, and denied in whole, further classified by prior authorization, concurrent review, and retrospective review.

Third-Party Administrators and Medical Necessity Claim Determinations

Examination Procedures Performed: The examiners reviewed the list of third-party administrators provided by the Company. Further, INS reviewed the data to verify if:

a) the list included all TPAs and the role they play in determining medical necessity (type of claims, etc.),
b) the address was provided for the TPA vendor, and,
c) whether the TPA is affiliated with the Company or group.

Examination Conclusions: The Companies provided a list of the third-party vendors utilized by the Company for claims processing. Both are affiliated with the Companies. Aetna Health Management LLC ("AHM") conducts claim processing, CaremarkPCS Health, L.L.C. conducts claim administration, processing, and adjudication for pharmacy. Additionally, CaremarkPCS Health, L.L.C., also conducts pharmacy benefit management services.

There were no post-claim review companies listed. Although post- claim review entities may not have a direct impact on the initial claims processing, they can ultimately impact the results of the claim payment.

Observation: No post-claim review companies were included in the list. Although post-claim review entities may not have a direct impact on the initial claims processing, they can ultimately impact the results of the claim payment. The Companies should consider adding any post-claim review processing to the list of third-party claims processing vendors in the future.

Subsequent Company Actions: The companies will take the recommendation under advisement.

Medical Necessity Guidelines

Examination Procedures Performed: The examiners reviewed the utilization review medical necessity guidelines. Further, INS reviewed the data to:

a) verify that the M/S medical necessity guideline criteria were supplied,
b) verify that the MH/SUD medical necessity guideline criteria were supplied, and
c) review the medical necessity guidelines to determine if medical necessity criteria for MH/SUD are comparable to, or less strict than, those for medical/surgical care.

Examination Conclusions: The Companies provided the guidelines for the sources for medical necessity. There were direct links to most of the listed guidelines, with one exception, the Milliman Care Guidelines ("MCG"). The Companies reported that they could not share the unabridged MCG criteria due to licensure requirements.

Sources for Medical Necessity Guidelines

Examination Procedures Performed: The examiners reviewed the sources used for determining medical necessity guidelines. Further, INS reviewed the data to:

a) verify the list of sources used by the Company in the development of the criteria for M/S was provided,
b) verify the list of sources used by the Company in the development of criteria for MH/SUD was provided,
c) verify that the sources for M/S medical necessity criteria are consistent with scientifically based guidelines of national medical or healthcare coverage organizations or governmental agencies,
d) verify that the sources for MH/SUD medical necessity criteria are consistent with scientifically based guidelines of national medical or healthcare coverage organizations or governmental agencies, and

e) determine if the Company modified the medical necessity criteria used by a third-party to be in line with company objectives.

Examination Conclusions: The Companies provided a list of MH/SUD sources used to determine whether a prior authorization request is approved or denied. The list includes sources such as Level of Care Utilization System ("LOCUS"), Child and Adolescent Level of Care Utilization System ("CALOCUS"), the American Society of Addiction Medicine criteria ("ASAM")—for SUD level of care, Applied Behavioral Analysis ("ABA") Medical Necessity Guide—for ABA level-of care, and Aetna's Clinical Policy Bulletins ("CPBs")—for condition/service-specific medical necessity criteria (Company created criteria).

The Company provided a list of M/S sources used to determine whether a prior authorization request is approved or denied. The list includes Milliman Care Criteria for medical/surgical level of care and Aetna's CPBs for condition/service-specific medical necessity criteria. The Company stated that due to their software licensure with CPB, they are unable to share the medical necessity criteria, but they did provide a link for general care guidelines.

On the Company website there is a tool for providers, coders and consumers to see what could be covered by the plan and what is considered unproven/experimental and not covered.

Based on the review of the sources for medical necessity guidelines, the Company's medical necessity guidelines for M/S, MH, and SUD meet Massachusetts statutory and regulatory requirements.

The Companies also responded that they do not utilize a third-party source for the development of CPBs. ASAM, CALOCUS, and LOCUS are owned by external organizations, and the company is not permitted to alter their criteria or guidelines in any way.

Prior Authorization, Concurrent Review, and Retrospective Review

Note: Not all health insurance companies are required to perform concurrent and retrospective reviews in every instance. For example, a concurrent review typically focuses on treatments that are currently in progress. If a patient's treatment has been concluded or if the review is not pertinent to the ongoing care, a concurrent review may not be necessary. However, it should be noted that Massachusetts regulations do include requirements for concurrent review, primarily within the workers' compensation system and for health insurance carriers, to ensure the appropriateness and medical necessity of ongoing treatment, as outlined in Massachusetts General Laws, Chapter 176O, Section 12. Similarly, retrospective reviews may not be necessary in situations where the company has made an effort to verify concurrent reviews by analyzing documentation and coding before claims are submitted, thereby ensuring accuracy.

Examination Procedures Performed: The examiners reviewed the approved, partially denied, and whole denials for prior authorization, concurrent reviews, and retrospective reviews, divided into M/S, MH, and SUD. Further, INS reviewed the data to:

a) develop averages and medians for M/S, MH, and SUD prior authorization, concurrent reviews, and retrospective reviews,
b) verify the Company supplied the prior authorization data for M/S, MH, and SUD,
c) verify the prior authorization approvals, denials, and partial denials are in line with statewide averages,
d) review the prior authorizations and determine if the percentage of denials (partial and whole) is higher for MH or SUD than M/S,

e) review the prior authorizations and determine if the percentage of denials (partial and whole) is higher for both MH and SUD combined than it is for M/S,
f) verify that the Company supplied the concurrent review data for M/S, MH, and SUD,
g) verify the concurrent review approvals, denials and partial denials are in line with statewide averages,
h) evaluate the concurrent review numbers provided by the Company and determine if the percentage of denials (partial and whole) is higher for MH or SUD than M/S,
i) assess the concurrent review data and determine if the percentage of denials (partial and whole) is higher for both MH and SUD combined than it is for M/S,
j) verify that the company supplied the retrospective review data for M/S, MH, and SUD,
k) verify that the retrospective review approvals, denials, and partial denials are in line with statewide averages,
l) assess the retrospective review data and determine if the percentage of denials (partial and whole) is higher for MH or SUD than M/S,
m) assess the retrospective review data and determine if the percentage of denials (partial and whole) is higher for both MH and SUD combined than it is for M/S.

Examination Conclusions: The Companies had high denial percentages overall for M/S. Aetna Life Insurance Company was considered an outlier for the percentage of M/S concurrent reviews denied in whole (28.62%) and for the M/S retrospective reviews denied in whole (60.39%). Aetna Life Insurance Company was also considered an outlier for SUD retrospective review denials in whole; however, this is a result of very low total prior authorizations, and only 3 of the 40 requests were denied in whole. (It is important to note that the Companies had relatively low numbers of prior authorizations, concurrent reviews and retrospective reviews so the percentage values may be skewed as a result.)

Subsequent Company Actions: The companies explained that while each prior authorization request is handled on a case-by-case basis, and several different factors can apply to each individual case, the primary reasons for medical/surgical prior authorization denials can be summarized as follows:

1. Clinical reviews for medical necessity;
2. Requests for additional clinical information that were not received;
3. Not a covered service; and
4. Coordination of benefits.

SUMMARY

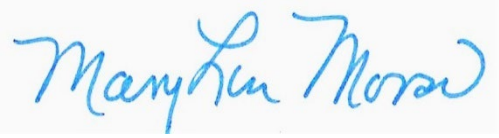
Based upon the procedures performed in this examination, INS has reviewed the Company responses to the interrogatory which included utilization review, prior authorization data, concurrent review, retrospective review, denials of authorization, step-therapy, network admission standards/reimbursement rates, network adequacy, complaint/grievance data, information verifying compliance with MHPAEA, and denials of payment and coverage, as set forth in the 2022 Handbook, the examination standards of the Division, and the Commonwealth of Massachusetts insurance laws, regulations, and bulletins.

ACKNOWLEDGEMENT

This acknowledgment is to certify that the undersigned is duly qualified and, in conjunction with INS, applied certain agreed-upon procedures to the Company's corporate records for the Division to perform a comprehensive market conduct examination of the Company.

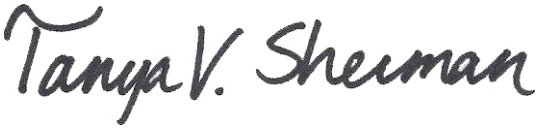
The undersigned's participation in this comprehensive market conduct examination as the Examiner-In-Charge encompassed responsibility for the coordination and direction of the examination performed, which was in accordance with, and substantially complied with, those standards established by the NAIC and the Handbook. In addition, this participation consisted of involvement in the planning (development, supervision, and review of agreed-upon procedures), communication, and status reporting throughout the examination, administration, and preparation of the examination report.

The Division acknowledges the cooperation and assistance extended to all examiners by the officers and employees of the Company during the comprehensive market conduct examination.



Commonwealth of Massachusetts
Division of Insurance
Boston, Massachusetts

The INS Companies
Market Regulation Division
Dallas, Texas



The INS Companies
Market Regulation Division
Dallas, Texas