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RE: Aetna Life Insurance Company, NAIC Company Code #60054
Response to Final Targeted Market Conduct Examination Report
Regarding Compliance with the Oregon Reproductive Health Equity Act
for the Period from January 1, 2019 to December 31, 2020

Dear Ms. Sizemore:

Aetna Life Insurance Company ("Aetna") respectfully submits this Response to the Final Targeted Market Conduct Examination Report Regarding Compliance with the Oregon Reproductive Health Equity Act for the period from January 1, 2019 through December 31, 2020.[1]

As a threshold matter, Aetna would again like to express its appreciation for the opportunity to present arguments and other information to DFR before, during, and after Aetna's hearing on this matter under ORS 731.312(3) on December 16, 2022 (the "Hearing"). Aetna is pleased that our productive discussion with Director Stolfi during the Hearing had a positive impact on the Final Report. Specifically, we are pleased that DFR excluded the Draft Reports' "Finding 4" (relating to NPI numbers) from the Final Report, given Aetna's assertion that it was outside the Examination's scope and was not supported by the evidence or applicable Oregon law. Additionally, Aetna appreciates that DFR has effectively consolidated the Draft Reports' "Finding 1," "Finding 2," and "Finding 5" into a single finding in the Final Report, given Aetna's argument that those three draft findings were, for all practical purposes, the same claims-processing issue.

[1] The Oregon Division of Financial Regulation ("DFR") examined Aetna (the "Examination") regarding the latter's compliance with the Oregon Reproductive Health Equity Act ("RHEA"). DFR staff and certain DFR-retained third-party examiners conducted the Examination (collectively, the "Examiners"). Aetna received DFR's initial and revised draft reports on the Examination on or about August 3, 2022 and October 13, 2022, respectively (collectively, the "Draft Reports"). Aetna received a notarized copy of DFR's final report on the Examination on January 25, 2023 (the "Final Report").

Despite these positive developments in the scaled-back Final Report, Aetna continues to dispute the remaining findings of fact and conclusions of law contained therein. Rather than provide specific examples of claims that Aetna processed during the Examination period in violation of RHEA, the Final Report instead makes general statements and draws inferences from hypothetical scenarios that are not supported by the data that Aetna actually submitted. In this letter, Aetna details its disputes with the remaining findings in the Final Report, and reiterates its serious concerns with the overall Examination process and the Examiners' failure to comply with NAIC market conduct examination standards.

Aetna understands that DFR intends to file and publish the Final Report on or about January 30, 2023. At DFR's invitation, Aetna hereby submits this letter and, pursuant to ORS 731.312(4), requests that DFR include a copy of this letter in the documentation relating to the Final Report (including without limitation by posting this letter on DFR's website).

SECTION I
OBJECTIONS TO THE FINAL REPORT

A. Concerns Regarding Exam Process

Aetna was entitled to have the Examination performed by examiners who have the appropriate skill level, training, and understanding of applicable state laws and examination guidelines—and who are unbiased. In this exam, the Examiners failed to satisfy these essential criteria. Furthermore, the Examiners failed to follow NAIC market conduct examination standards as described below. Conducting a market conduct exam in this manner has negative consequences for the insurance market in Oregon. It does not achieve the goals of improving compliance with the law or furthering consumer interests. Rather, the consequence is that (i) the Final Report contains legally and factually unsupported findings and outcomes, and (ii) Aetna is left without appropriate guidance on how to remediate the issues identified therein due to the lack of clarity on, and support for, DFR's interpretations of law in the Final Report.

1. Examiner Skills, Training, and Understanding of Oregon State Law

An examiner with the requisite experience would know that a market conduct examination is focused on whether the insurer complied with state law. Specifically, ORS 731.300(1) clarifies that the scope of a market conduct examination is limited to the insurer's "compliance with the Insurance Code [*i.e.*, Oregon state law]," as opposed to compliance with the laws of other jurisdictions. Likewise, the very first page of the NAIC Market Regulation Handbook (which provides the standards for conducting an examination) clarifies that an examination is limited to assessing compliance with state law, stating as follows:

> The purpose of a state insurance department's market regulation program is to assess how well the insurance marketplace as a whole, and the individual insurance companies that make up that market, **are in compliance with state regulations**, and then to take appropriate

> action if problems are identified. [Emphasis added.][2]

And yet, by examining whether Aetna complied with federal law—even though the Final Report ultimately excluded reference thereto—the Examiners chose to examine whether Aetna complied with laws *other than* Oregon law.

Similarly, an examiner with the requisite experience would know that a targeted market conduct examination is limited to the subject matter specified by DFR. Here, the Coordinator's Handbook that DFR issued for this Examination directed the Examiners to examine *solely* whether Aetna complied with RHEA. But again, the Examiners exceeded their limited scope of examination by investigating matters of federal law, rather than just compliance with RHEA.

The Final Report admittedly now excludes reference to federal law and findings related thereto. But the fact remains that because the Examination was not conducted in accordance with ORS 731.300(1), with the NAIC Market Regulation Handbook, or with the Coordinator's Handbook, the underlying validity of the Examination—and therefore the Final Report's findings—are called into question.

2. Examiner Bias

The NAIC Market Regulation Handbook instructs an examiner to act on an objective basis, without bias, when conducting the examination and preparing the report. But here, bias exists because the Examiners *published* the Preliminary Marketwide Compliance Report on Implementation of the Reproductive Health Equity Act (the "Marketwide Report") *before* any insurer, including Aetna, was given the opportunity to comment on their individual draft examination reports.[3] The Examiners inappropriately—and incorrectly—staked out a position in the Marketwide Report that "[t]he examinations have provisionally confirmed that insurers across the market failed to fully comply with RHEA . . . ." *Id.* at 5. By doing so, the Examiners relinquished their objectivity, as it would undermine their credibility to thereafter retract any findings and conclusions contained in the Marketwide Report based upon defenses subsequently presented by the insurers.

Indeed, the Draft Reports that DFR issued in 2022 reveal that the Examiners ostensibly had no intention of considering Aetna's response thereto, let alone using the content of Aetna's response as grounds for modifying the Draft Reports. Specifically, in the Draft Reports the Examiners stated:

> This examination report, relating to RHEA claims for the period of

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[2] Examiners are required to conduct market conduct examinations in accordance with the standards set forth in the NAIC Market Regulation Handbook. Specifically, ORS 731.302 provides, in relevant part, that "[i]n conducting the examination, each examiner shall consider the guidelines and procedures in the examiner handbook, or its successor publication, adopted by the National Association of Insurance Commissioners." ORS 731.302(1). And in recognition thereof, the Final Report states that "[t]he targeted market conduct examination of the insurer was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (NAIC) . . . ." Final Report, at p. 4.

[3] Preliminary Marketwide Compliance Report on Implementation of the Reproductive Health Equity Act (June 21, 2022) available at https://dfr.oregon.gov/healthrates/Documents/rhea-quarterly-plans/rhea-marketwide-report-2022.pdf.

> January 1, 2019, to December 31, 2020, may be forwarded to the division's enforcement unit for enforcement consideration while the insurer responds to the corrective actions identified in the examination report.

Draft Reports, each at p. 4. If the Examiners had intended to consider Aetna's response to the Draft Reports, they would not have encouraged DFR to forward the Draft Reports for enforcement consideration until *after* Aetna had filed its response and until after the Director had decided whether, and to what extent, he would adopt either of the Draft Reports.

3. Examiners' Erroneous Statements in the Draft Reports

In the Draft Reports, the Examiners stated that "[t]he targeted market conduct examination of the insurer was conducted in accordance with the standards and procedures established by the NAIC . . . ." Draft Reports, each at p. 4. This assertion was incorrect relative to the conduct of the exit conference. The NAIC Market Regulation Handbook provides, in relevant part, as follows:

> Upon completion of the field work of the examination, the EIC [*i.e.*, the Examiner-in-Charge] should offer to conduct an exit meeting with [Aetna] to discuss significant findings, explain the next steps in the examination process and allow the company to present any outstanding concerns.[4]

DFR staff conducted two exit conferences, and neither the Examiner-in-Charge nor any member of the Examination team attended those meetings, which is required by NAIC standards. As a result, Aetna was deprived of the opportunity to explain the errors in the Draft Reports to the Examiners. Had Aetna been given the opportunity to do so, the Examiners might have agreed to remove several of their findings of alleged wrongdoing.

Furthermore, the Examiners also stated in the Draft Reports that Aetna had been given the opportunity to disagree with the Examiners' preliminary findings:

> The examiners asked that the insurer provide a written response to any claims where the examiners had questions regarding the processing of such claim prior to the examiners determining if such claim was processed incorrectly and a finding of noncompliance being issued regarding that claim.

Draft Reports, each at p. 5. This statement is incorrect. Aetna was not afforded the opportunity to disagree with all of the Examiners' preliminary findings or explain Aetna's actions or positions during the Examination. In some cases, Aetna did not learn that the Examiners were even investigating certain issues until it read the findings in the first Draft Report. For example, as described in detail below, Aetna was never asked for twelve-month contraceptive refill prescription

[4] NAIC Market Regulation Handbook, Chapter 12, Section O, p. 158 (2014).

data (and therefore never provided that data during the exam), and never discussed the issue as part of the Examination.[5] The first appearance of the issue was in the first Draft Report. To the extent that such evidence actually exists, the Examiners should have identified and disclosed such evidence in the Draft Reports, or the exhibits attached in the appendices thereto. By failing to identify and disclose such evidence, the Examiners deprived Aetna of its due-process right to address the matters at the Hearing and in its written submissions to DFR.

SECTION II
RESPONSES TO THE SPECIFIC FINDINGS IN THE FINAL REPORT

As discussed below, Aetna disputes all the findings in the Final Report.

Finding 1: ***Alleged Violations in Processing Medical Claims as Required by ORS 743A.067.***

Aetna disputes the allegation that its "claims adjudication programming is not robust enough to identify all instances where a RHEA claim should be paid without member cost share" and that as a result, Aetna applied member cost share when it should not have under RHEA. Final Report, at p. 7. This finding of alleged non-compliance is not due to systemic deficiencies in Aetna's claim-adjudication programing, but rather due to how the provider chose to bill Aetna for the services using CPT and diagnosis codes that do not identify the services as subject to RHEA. In this Finding, the Examiners assert that Aetna improperly applied member cost share and/or denied claims for RHEA services based on the Examiners' vague assertion that Aetna did not "consider[] . . . the context of the claim" in order to confirm that a claim is subject to RHEA and therefore would need to be covered without member cost share. Final Report, at p. 7.

The Final Report fails to acknowledge not only that the manner in which providers bill these claims is outside the control of Aetna, but also that there is statutory ambiguity with regard to how DFR has interpreted the law. For example, the report states "[i]n some instances, the entire claim, including the physician office visit, should be paid without member cost share while in other instances only certain services . . . would need to be covered at no cost to the member." Final Report, at p. 6. This conclusion is not based on the statutory language and does not provide Aetna sufficient guidance to know when an "instance" would require the full claim to be covered at zero cost share or not. Nor can the Examiners accurately describe Aetna's claims processing as being out of compliance with the law, given that this description is a newly articulated DFR interpretation that was not known or available during the Examination period. As Aetna explained to the Examiners, Aetna did not consider certain CPT or billing codes as being subject to RHEA *due to the manner in which the CPT and diagnosis codes were billed by the provider*, not because of how claims systems are designed and operationalized. In other words, the provider, rather than Aetna, is the entity that selects the CPT and diagnosis codes, and to the extent that the provider billed Aetna for the services using CPT and diagnosis codes that do not identify the services as subject to RHEA, Aetna cannot know that such services are subject to RHEA.

[5] Aetna submitted data to DFR after the conclusion of the Examination, in response to a request for supplemental data. Aetna also presented this data during the Hearing.

Relevant state law does not mandate the use of any particular CPT or diagnosis codes, nor does it mandate that insurers treat any particular CPT or diagnosis codes as subject to RHEA. If this were the expectation, a more appropriate step would have been to issue a regulation, or even sub-regulatory guidance, clarifying the obligations of insurers relative to RHEA, particularly given the disconnect between the law and how providers bill insurers using CPT and diagnosis codes that do not necessarily inform the insurer that the services are subject to RHEA. Instead, the Examiners inappropriately sought to fill this statutory and regulatory gap by identifying CPT and diagnosis codes that the Examiners *believe* should be subject to RHEA. But the Examiners lack the authority to make such a determination—rather, that is the role of the Oregon legislature (by enacting a statute) or the DFR (by promulgating a regulation or issuing a non-binding bulletin).

Even today, if compliance with RHEA is truly the objective, the best solution is for DFR to issue a regulation clarifying which services, based on the CPT and diagnosis codes customarily used by providers, are subject to RHEA. In addition, DFR could collaborate with the Oregon Health Authority so that the latter could issue a regulation directing providers to bill insurers using CPT and diagnosis codes that would inform the insurer that the services are subject to RHEA. Aetna would support these efforts and actively participate in any rulemaking or other agency activity on the continued implementation of RHEA.

Finally, RHEA does not prohibit an insurer from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for the coverage of services, drugs, devices, products, and procedures described. Nor does RHEA require plans to cover experimental or investigational treatments, treatments that do not conform to acceptable and customary standards of medical practice, or treatments for which there is insufficient data to determine efficacy. To determine if a claim is subject to RHEA, it must be viewed in its totality and not at a line level, as the diagnosis codes and other billed services will impact processing.

Finding 2: ***Alleged Failure to Provide 12-Month Contraceptive Prescription Refills as Required by ORS 743A.066 and Noncompliance with Coverage Requirements Under ORS 743A.067.***

Aetna disputes this Finding because it processed all submitted claims for twelve-month contraceptive prescriptions properly under the law. There is no evidence in the record to support any of the conclusions related to this Finding in the Final Report. First, the Examiners did not request data relevant to this requirement as part of the Examination. Rather, it was not until after the Examination had concluded that, at DFR's request, Aetna submitted supplemental data. This data showed that Aetna had received a total of 30 twelve-month contraception prescription fill requests during the Examination's review period. Of those 30 requests, 23 were paid and seven were denied. All seven of the denied claims were appropriately denied as "refill too soon," consistent with industry-wide practices designed to prevent duplicate and fraudulent claims. Such medical management techniques are consistent with ORS 743A.066 and ORS 743A.067(12). Specifically, ORS 743A.066(2)(a) indicates that these prescriptions "[m]ay be subject to provisions of the program, plan or policy that apply equally to other prescription drugs covered by the program, plan or policy." In other words, insurers are authorized to employ reasonable medical management techniques to determine the frequency of coverage for such prescription contraceptives. Likewise, ORS 743A.067(12) states that "[t]his section does not prohibit an insurer from using reasonable

medical management techniques to determine the frequency, method, treatment or setting for the coverage of . . . drugs . . . .” Accordingly, the Oregon legislature expressly authorized insurers to employ the very medical management techniques for the coverage of contraceptive prescription drugs that Aetna used during the Examination period.

Despite the law being clear that medical management is expressly permitted, the Final Report attempts to draw a conclusion that Aetna’s policy does not adequately account for the specific refill timelines for prescription contraceptive drugs. For example, the Final Report states that “[i]n the case of oral contraceptives . . . individuals may choose or are counseled by their provider to skip the placebo week,” which would result in a need for a refill before Aetna’s policy would allow it. While this may be true, there is no evidence in the record to demonstrate that this actually occurred with Aetna’s claims. *See* Final Report, at pp. 9–10. In fact, the Final Report does not present a single example of a specific Aetna claim that was denied under the refill-too-soon policy. Instead, the Final Report draws a vague inference to something that *could* happen, but that did *not* in this case.

Furthermore, even if the “refill too soon” policy could have arguably prevented refills in violation of RHEA, three of the seven denied claims referenced above were denied on the separate, appropriate basis of being duplicate submissions (caused by the pharmacy submitting the same request on the same date multiple times). Ultimately, only four members experienced a claim denial, and all but one of them obtained a refill within a short period once their respective prescriptions were eligible to be filled when the “refill too soon” period expired. The fourth member terminated from Aetna and was therefore ineligible for coverage. Therefore, all claims were processed consistent with the established and reasonable medical management techniques and policies authorized under applicable law.

Finally, the Final Report states without evidence that Aetna denied claims for the following reasons: “the drug was not in the insurer’s formulary, the dosage amount was not consistent with the amounts in the formulary, the members [*sic*] coverage had terminated, the pharmacy was not in network or and [*sic*] the pharmacy had entered the members’ demographic information incorrectly.” Final Report, at p. 9. But even if true, none of these would be improper denials of claims that are inconsistent with the state law on twelve-month contraceptive prescription refills.

CONCLUSION

Aetna appreciates the opportunity to present our information and explanations. But for the reasons set forth above, Aetna respectfully objects to the findings in the Final Report and, pursuant to ORS 731.312(4), requests that DFR include this letter in the documentation relating to the Final Report (including without limitation by posting this letter on DFR’s website).

Aetna remains committed to working with DFR on continued implementation of RHEA. To that end, Aetna looks forward to collaborating with DFR on any forthcoming rulemaking and guidance that would help to inform insurers about DFR’s expectations and interpretation of RHEA, so as to achieve the compliance intended by the Examination.

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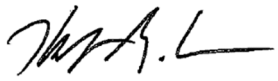
Very truly yours,



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