

BEFORE ALLAN L. MCVEY, INSURANCE COMMISSIONER
OF THE STATE OF WEST VIRGINIA

In the Matter of:

AETNA HEALTH INC. (NAIC No. 95109)
AETNA LIFE INSURANCE COMPANY (NAIC No. 60054)
AETNA HEALTH INSURANCE COMPANY (NAIC No. 72052)

Administrative Proceeding No. 25-IC-185907

**AGREED ORDER ADOPTING REPORT OF
MARKET CONDUCT EXAMINATION, DIRECTING
CORRECTIVE ACTION AND ASSESSING PENALTY**

NOW COMES, Allan L. McVey, Insurance Commissioner of the State of West Virginia (hereinafter, "Commissioner"), and Aetna Health Inc., Aetna Life Insurance Company, and Aetna Health Insurance Company (hereinafter, "Aetna") who, after consideration of the *Report of Market Conduct Examination* (hereinafter, the "*Examination Report*") of Aetna have agreed to the entry of this Order.

FINDINGS OF FACT

1. The market conduct examination was a targeted examination focusing on the statutes, rules, and regulations pertaining to mental health parity. The examination was conducted in accordance with W.Va. Code §33-2-9(c) by examiners duly appointed by the Commissioner and covered the period of January 1, 2022 through December 31, 2022.

2. On or about May 5, 2025, the examiner filed with the Commissioner, pursuant to W. Va. Code §33-2-9, the *Examination Report*.

3. A true copy of the *Examination Report* was provided to Aetna and Aetna was notified, pursuant to W.Va. Code §33-2-9(j)(2), that it had ten (10) days after receipt of the

Examination Report to file a submission or rebuttals with the Commissioner. Aetna requested additional time to respond to the *Examination Report* which was granted by the Commissioner.

4. As set forth in the *Examination Report*, the examination focused on the methods used by Aetna to manage its operations for each of the areas examined, including whether and how Aetna complies with federal and state law regarding mental health parity.

5. The *Examination Report* is a report by exception. As such, only those standards tested where violations were noted are included in the *Examination Report*.

6. The Commissioner reviewed the *Examination Report* and considered all relevant information, including Aetna's response to the final *Examination Report*. Desiring to conclude this proceeding without the necessity of a formal proceeding, and the time, trouble, and expense involved in a formal proceeding, Aetna agrees to the entry of this Order and waives notice of administrative hearing, any and all rights to an administrative hearing, and to judicial review of this matter.

CONCLUSIONS OF LAW

1. The Commissioner has jurisdiction over the subject matter and the parties to this proceeding.

2. This proceeding is conducted pursuant to and in accordance with W. Va. Code §33-2-9.

3. The Commissioner is charged with the responsibility of verifying Aetna's continued compliance with West Virginia law.

4. Violations of West Virginia law were identified in Aetna's examination as detailed in the attached *Examination Report*, a summary of which is set forth below.

- Pharmacy Formulary/Pharmacy: There were multiple issues with respect to W.Va. Code §§ 33-16-3aa(c)(2)(C), 33-16-3cc(k), 33-16-3ff(c), 33-25A-8u(c), 33-25A-8r(k), 33-25A-8o(c)(2)(C), 33-51-11(a)(5), 33-51-11(a)(10), and 33-51-11(e). Improper dispensing limitations or quantity limitations on certain drugs, such as, Buprenorphine/naloxone products, Suboxone, Zubsolv, desvenlafaxine, Pristiq, Khedezla, had quantity limitations on Narcan, naloxone products, and Kloxxado, and on all smoking cessation medications. Placed Lucemyra, and Suboxone as non-formulary; Step therapy medication policies were not operated properly. Prohibited members from filling 90 day supplies of prescription drugs at a retail pharmacy; Failed to pay all pharmacies at the state mandated NADAC plus \$10.49.
- Claims: Certain required language and information in the EOBs for denial of reimbursement for services of behavioral health, mental health and/or substance use disorders were not included as required by W.Va. Code R. §§ 114-64-6.3.2, and 114-64-6.3.3.
- Operations and Management: The company provided inaccurate and contradictory data which demonstrated the company's inability to exercise due diligence in ensuring data integrity in violation of W.Va. Code § 33-2-9(i)(2) and W.Va. Code R. § 114-15-4.4(a)(3).
- Mental Health Parity: Aetna provided one general comparative analyses for several nonquantitative treatment limitations (NQTL). After an examination of the comparative analyses, it was determined that the contents of the comparative analyses were not sufficiently specific, detailed, and reasoned to demonstrate that the processes, strategies,

evidentiary standards, and other factors used to apply the non-quantitative treatment limitations (NQTL) to mental health (MH) or substance use disorder (SUD) benefits, as written and in operation, are comparable to, and were applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical and surgical benefits in each benefits classification, as required by 42 U.S.C. § 300gg-26(a)(8)(A)(iv) and W.Va. Code R. § 114-64-1, *et. seq.* As detailed in the *Examination Report*, there were a number of ways that the company's comparative analyses were determined to be insufficient.

5. The Commissioner has determined that Aetna should be assessed a monetary penalty for violating the standards as set forth in the *Examination Report*.

ORDER

Pursuant to W.Va. Code §§ 33-2-9(j)(3)(A), following the review of the *Examination Report*, the examination work papers, and Aetna's response thereto, the Commissioner and Aetna have agreed to enter into the Agreed Order adopting the *Examination Report* and the imposition of an administrative penalty as set forth below. It is accordingly **AGREED** and **ORDERED** as follows:

1. The referenced and attached *Examination Report* is hereby **ADOPTED** and **APPROVED** and by this reference, incorporated herein and made a part hereof.

2. Aetna shall endeavor to comply with the recommendations contained in the *Examination Report*.

3. Aetna shall continue to monitor its compliance with applicable West Virginia law.

4. Aetna shall specifically cure the violations and deficiencies identified in the *Examination Report* to ensure compliance and conformity with West Virginia law, as set forth hereinabove, to the extent such has not already been completed and/or accomplished.

5. Aetna will file a Corrective Action Plan (CAP), subject to the approval of the Commissioner, which said CAP shall detail Aetna's changes to its procedures and/or internal policies to ensure compliance with West Virginia law and shall further incorporate all recommendations of the Commissioner's examiners and address all violations specifically cited in the *Examination Report*.

6. The CAP shall be submitted to the Commissioner for his approval within 30 days of the date this order is entered.

7. Aetna shall make reasonable changes to the CAP if and as directed by the Commissioner within 30 days of its receipt of the Commissioner's changes to, or disapproval of, the CAP.

8. Aetna shall, within 90 days of its receipt of notice from the Commissioner of his final approval thereof, implement the CAP.

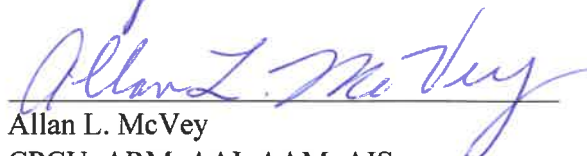
9. Pursuant to W.Va. Code § 33-2-9(j)(4) within 30 days of the date this Order is entered, Aetna shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted *Examination Report* and this Order.

10. Aetna shall pay an administrative penalty in the amount of One Hundred Thousand Dollars (\$100,000.00) for its non-compliance with West Virginia law as set forth hereinabove. the assessment of which penalty is in lieu of any other regulatory penalty. The penalty shall be proportioned as follows: Eighty-Five Thousand Dollars (\$85,000) on behalf of Aetna Life

Insurance Company, Ten Thousand Dollars (\$10,000), Aetna Health Inc., and Five Thousand Dollars (\$5,000) on behalf of Aetna Health Insurance Company. Payment shall be remitted within 30 calendar days of the date this order is entered by the Commissioner.


11. It is AGREED and ORDERED that all such statutory notices, administrative hearings and appellate rights are herein waived by Aetna concerning this Report of Market Conduct Examination and Agreed Order.

Entered this 23rd day of January, 2026.


Allan L. McVey
CPCU, ARM, AAI, AAM, AIS
Insurance Commissioner

REVIEWED AND AGREED TO BY:

On behalf of the Insurance Commissioner:


Jeffrey C. Black, Attorney Supervisor
Regulatory Compliance and Enforcement

On behalf of Aetna:

By: Edward C. Lee
Print Name

Title: Vice President and Secretary

Signature: 

Date: 1/21/26

WEST VIRGINIA OFFICES OF THE INSURANCE COMMISSIONER



REPORT OF THE MARKET CONDUCT EXAMINATION

OF

**AETNA HEALTH, INC., NAIC #95109
AETNA LIFE INSURANCE COMPANY, NAIC #60054
AETNA HEALTH INSURANCE COMPANY, NAIC #72052**

AS OF APRIL 30, 2025

MARKET CONDUCT EXAMINATION REPORT

DATE OF EXAMINATION: September 1, 2023 through April 30, 2025

EXAMINATION OF: Aetna Health, Inc.
NAIC #95109
Aetna Life Insurance Company
NAIC #60054
Aetna Health Insurance Company
NAIC #72052

LOCATION: 151 Farmington Avenue
Hartford, CT, USA 06156-9154

PERIOD COVERED: January 1, 2022 to December 31, 2022

EXAMINERS: Amanda Brandis
Art Kusserow
Tanner Qualls
Sharon Wiernik
June Coleman
Steven Gloc
Brian Stanley
Matthew Sankey
Trevor Strenchock
Marilyn Vadon
Maureen Hicks, Examiner-in-Charge
Shelly Schuman, Supervisory Insurance Examiner

TABLE OF CONTENTS

| | |
|--|----|
| SALUTATION..... | 1 |
| I. FOREWORD | 2 |
| II. SCOPE OF THE EXAMINATION..... | 3 |
| III. SUMMARY OF FINDINGS..... | 4 |
| IV. COMPANY BACKGROUND | 7 |
| V. METHODOLOGY | 8 |
| VI. FINDINGS..... | 10 |
| A. COMPANY OPERATIONS AND MANAGEMENT..... | 10 |
| B. PROVIDER CREDENTIALING AND PROVIDER RELATIONS | 10 |
| 1. Provider Credentialing..... | 10 |
| 2. Provider Relations..... | 10 |
| C. NETWORK ADEQUACY..... | 10 |
| D. CLAIMS | 10 |
| 1. Medical/Surgical Paid Claims..... | 10 |
| 2. Mental Health and Substance Use Disorder Paid Claims | 10 |
| 3. Medical/Surgical Denied Claims | 10 |
| 4. Mental Health and Substance Use Disorder Denied Claims..... | 11 |
| 5. Autism Paid and Denied Claims | 11 |
| E. COMPLAINTS, APPEALS AND EXTERNAL REVIEWS..... | 11 |
| 1. Offices of Insurance Commissioner Complaints | 11 |
| 2. Direct Consumer Complaints..... | 11 |
| 3. Mental Health and Substance Use Disorder Appeals | 11 |
| 4. Mental Health and Substance Use Disorder External Review | 11 |
| F. UTILIZATION REVIEW..... | 11 |
| 1. Medical/Surgical Approved Utilization Review | 11 |
| 2. Mental Health and Substance Use Disorder Approved Utilization Review..... | 11 |
| 3. Medical/Surgical Denied Utilization Review..... | 12 |
| 4. Mental Health and Substance Use Disorder Denied Utilization Review | 12 |
| G. PHARMACY REVIEW | 12 |
| 1. Pharmacy Paid and Denied Claims | 12 |
| 2. Pharmacy Appeals..... | 12 |
| 3. Mental Health and Substance Use Disorder Approved Drug Utilization Review | 12 |
| 4. Mental Health and Substance Use Disorder Denied Drug Utilization Review..... | 12 |
| 5. Pharmacy Formulary | 12 |
| H. MENTAL HEALTH PARITY | 16 |
| 1. Certificate of Coverage Forms | 16 |
| 2. Quantitative Treatment Limitations Assessments..... | 16 |
| 3. Nonquantitative Treatment Limitations Comparative Analysis | 16 |
| VII. SUMMARY OF EXAMINATION RECOMMENDATIONS | 18 |

SALUTATION

May 5, 2025

The Honorable Allan L. McVey, CPCU, ARM, AAI, AAM, AIS
West Virginia Insurance Commissioner
900 Pennsylvania Ave.
Charleston, West Virginia 25302

Pursuant to the authority vested in the West Virginia Offices of the Insurance Commissioner, through W.Va. Code §§33-16-3ff, 33-25A-8u, and W.Va. Rules §§114-64-7.3 and 8a, a targeted market conduct examination has been made of:

Aetna Health, Inc.,
NAIC #95109
Aetna Life Insurance Company,
NAIC #60054
Aetna Health Insurance Company,
NAIC #72052

151 Farmington Avenue
Hartford, CT, USA 06156-9154

The following examination report is respectfully submitted.

I. FOREWORD

This is a market conduct examination report (“Report”) of Aetna Health, Inc., Aetna Life Insurance Company, and Aetna Health Insurance Company (collectively “the Company”), NAIC Codes 95109, 60054 and 72052, respectively. This examination was conducted at authorized offsite locations.

This Report is generally a report by exception. However, failure to criticize specific practices, procedures or files does not constitute approval thereof by the West Virginia Offices of the Insurance Commissioner (“WVOIC”).

During this examination, the examiners cited errors made by the Company. Statutory citations were as of the examination period unless otherwise noted.

II. SCOPE OF THE EXAMINATION

The WVOIC has the authority to conduct this examination pursuant to, but not limited to, W.Va. Code §§33-16-3ff, 33-25A-8u, and W.Va. Rules §§114-64-7.3 and 8a.

The purpose of the examination was to determine if the Company complied with West Virginia and federal statutes, rules, and regulations, and to consider whether the Company's operations are consistent with the requirements of mental health parity. The examination period covered by this review was January 1, 2022 to December 31, 2022, unless otherwise noted. Errors outside of this time discovered during the examination, however, may also be included in the Report.

The scope of this examination focused on mental health parity including the following areas: company operations and management, provider credentialing, provider relations, network adequacy, claims, complaints, appeals, external review, utilization review, mental health parity (quantitative and non-quantitative treatment limitation analyses), and pharmacy review.

In performing this examination, the examiners reviewed a sample of the Company's practices, procedures, products, and files. Therefore, some noncompliant events may not have been discovered. As such, this Report may not fully reflect all the practices and procedures of the Company. As indicated previously, failure to identify or criticize improper or noncompliant business practices in this state or other jurisdictions does not constitute acceptance of such practices.

III. SUMMARY OF FINDINGS

The following table represents general findings with specific details in each section of the Report.

| TABLE OF TOTAL VIOLATIONS | | | | | | |
|---------------------------|-----------|--|--|---------|----------------------|---------|
| Finding | Finding # | Code/Rule | Description of Violation | Samples | Number of Violations | Error % |
| Pharmacy Formulary | 1 | W.Va. Code §§33-16-3ff(c) and 33-25A-8u(c) | Excluded all naloxone formulations from mail order delivery which imposed a more restrictive non-quantitative treatment limitation. | N/A | N/A | 100% |
| Pharmacy Formulary | 2 | W.Va. Code §§33-16-3ff(c) and 33-25A-8u(c) | Imposed a more restrictive dispensing limitation on Narcan and generic naloxone nasal spray on the formularies from January 1, 2022 to October 1, 2022. | N/A | N/A | 100% |
| Pharmacy Formulary | 3 | W.Va. Code §§33-16-3cc(k) and 33-25A-8r(k) | Imposed quantity limitations, a prospective utilization review requirement, on all strengths of buprenorphine tablets. Buprenorphine is indicated for treatment of opioid dependence. | N/A | N/A | 100% |
| Pharmacy Formulary | 4 | W.Va. Code §§33-16-3ff(c) and 33-25A-8u(c) | Imposed a more restrictive quantity limitation on desvenlafaxine on all formularies. The Company limited members to one tablet daily on all strengths of Pristiq, Khedezla and desvenlafaxine ER tablets. These products are indicated for the treatment of major depressive disorder ("MDD"). | 5 | 5 | 100% |
| Pharmacy Formulary | 5 | W.Va. Code §§33-16-3cc(k) and 33-25A-8r(k) | Limited access to substance use disorder ("SUD") treatment when placing Lucemyra as non-formulary on all formularies. A member would be required to obtain a prior authorization/non-formulary coverage exception for approval of the medication. | N/A | N/A | 100% |
| Pharmacy Formulary | 6 | W.Va. Code §§33-16-3cc(k) and 33-25A-8r(k) | Imposed quantity limitations, a prospective utilization management requirement, on all smoking cessation medications. The medications, bupropion SR, all nicotine replacement therapy ("NRT"), Nicotrol, and Chantix had yearly quantity limitations. | N/A | N/A | 100% |

TABLE OF TOTAL VIOLATIONS

| Finding | Finding # | Code/Rule | Description of Violation | Samples | Number of Violations | Error % |
|-------------------------------------|-----------|--|--|---------|----------------------|---------|
| Pharmacy Formulary | 7 | W.Va. Code §§33-16-3cc(k) and 33-25A-8r(k) | Imposed limited access to SUD treatment when placing Suboxone as non-formulary on all formularies. A member would be required to obtain a prior authorization/non-formulary coverage exception, a prospective utilization management requirement, for approval of the medication. | 7 | 7 | 100% |
| Pharmacy Formulary | 8 | W.Va. Code §§33-16-3cc(k) and 33-25A-8r(k) | Imposed quantity limitations, a prospective utilization management requirement, on all strengths of buprenorphine/naloxone products. The medications include Suboxone, Zubsolv, and buprenorphine/naloxone tablets/films. The medications had restrictive hard-limit quantity limitations. | N/A | N/A | 100% |
| Pharmacy Formulary | 9 | W.Va. Code §§33-16-3cc(k) and 33-25A-8r(k) | Imposed quantity limitations, a prospective utilization management requirement, on Narcan, generic naloxone nasal spray, and Kloxxado. | N/A | N/A | 100% |
| Claims - Autism Paid/Denied | 10 | W.Va. Code R. §§114-64-6.3.2 and 6.3.3 | Failed to include the email address of the Commissioner's Office and provide the required statement from W.Va. Code R. §114-64-6.3.3 on the members' explanation of benefits ("EOB") when any element of a claim was rejected. | 52 | 4 | 8% |
| Claims - Medical Denied | 11 | W.Va. Code R. §114-14-6.1 | Delayed adjudication of a claim by seeking information not reasonably required to resolve the claim. | 30 | 1 | 3% |
| Utilization Review - Medical Denied | 13 | W.Va. Code R. §114-95-7.3(a) | Failed to provide the member with a determination letter. | 30 | 1 | 3% |
| Pharmacy | 14 | W.Va. Code §§33-51-11(a)(10) and 33-51-11(e) | Prohibited members from filling 90-day supplies of prescription drugs at a retail pharmacy. | N/A | N/A | 100% |

| TABLE OF TOTAL VIOLATIONS | | | | | | |
|--|-----------|--|---|---------|----------------------|---------|
| Finding | Finding # | Code/Rule | Description of Violation | Samples | Number of Violations | Error % |
| Claims - Mental Health/Substance Use Disorder Denied | 15 | W.Va. Code R. §§114-64-6.3.2 and 6.3.3 | Failed to include the email address of the Commissioner's Office and provide the required statement from W.Va. Code R. §114-64-6.3.3 on the members' EOBs when any element of a claim was rejected. | 30 | 25 | 83% |
| Pharmacy | 16 | W.Va. Code §§33-51-11(a)(5) and 33-51-11(e) | Failed to pay all pharmacies at the state mandated National Average Drug Acquisition Cost ("NADAC") + \$10.49. | N/A | N/A | 100% |
| Pharmacy | 17 | W.Va. Code §§33-16-3aa(c)(2)(C) and 33-25A-8o(c)(2)(C) | Implemented a non-formulary exception policy with step therapy processes that are more restrictive than allowable by the W.Va. code. | N/A | N/A | 100% |
| Operations and Management | 18 | W.Va. Code §33-2-9(i)(2) and W.Va. Code R. §114-15-4.4(a)(3) | Provided inaccurate and contradictory data, demonstrating the Company's inability to exercise due diligence in ensuring data integrity. | N/A | N/A | 100% |
| Mental Health Parity | 19 | 42 U.S.C. 300gg-26(a)(8)(A), W.Va. Code §§33-16-3ff(c)(2) and (4) and 33-25A-8u(c)(2) and (4), 33-16-3ff(g)(4) and 33-25A-8u(g)(4) | Failed to provide sufficiently specific, detailed and reasoned nonquantitative treatment limitation ("NQL") comparative analysis for each separate entity. | N/A | N/A | 100% |

IV. COMPANY BACKGROUND

Aetna Life Insurance Company:

Aetna Life Insurance Company (“ALIC”) was organized in June 1853 and became a member of the insurance holding company system then controlled by Aetna Inc., a Pennsylvania corporation, in 1967. ALIC is a wholly-owned, direct subsidiary of Aetna Inc. Effective November 28, 2018, ALIC became part of the insurance holding company system currently controlled by CVS Health Corporation (“CVS Health”) as a result of a merger transaction between Aetna and a subsidiary of CVS Pharmacy, Inc., which is a direct subsidiary of CVS Health.

ALIC is licensed as a life and accident and health company in all 50 states, including the District of Columbia, Guam, Northern Mariana Islands, Puerto Rico, and Virgin Islands.

Aetna Health Insurance Company:

Aetna Health Insurance Company (“AHIC”) (formerly known as “Corporate Health Insurance Company”) is a corporation domiciled in Pennsylvania. AHIC was originally incorporated in Minnesota on July 8, 1938 as “Omaha Financial Life Insurance Company” and reincorporated in Pennsylvania on July 18, 1997. AHIC is a wholly-owned subsidiary of Aetna Inc.

AHIC is licensed to do business as a life, accident and health insurer. AHIC also writes the out-of-network portion of the Quality Point of Service product for certain HMOs, stop-loss reinsurance for certain HMOs and Medicare supplement business.

Effective November 28, 2018, AHIC became part of the insurance holding company system currently controlled by CVS Health as a result of a merger transaction between Aetna and a subsidiary of CVS Pharmacy, Inc., which is a direct subsidiary of CVS Health.

Aetna Health Inc. (PA Corp.):

Aetna Health Inc. (PA) (“AHI-PA”), formerly United States Health Care Systems of Pennsylvania, Inc. d.b.a. Aetna U.S. Healthcare, is a corporation domiciled in the State of Pennsylvania.

AHI-PA was incorporated on May 7, 1981, and is a wholly-owned subsidiary of Aetna Health Holdings, LLC, whose immediate parent is Aetna Inc. Effective November 28, 2018, AHI-PA became part of the insurance holding company system currently controlled by CVS Health as a result of a merger transaction between Aetna and a subsidiary of CVS Pharmacy, Inc., which is a direct subsidiary of CVS Health. AHI-PA is licensed to conduct business as an HMO in 24 states.

V. METHODOLOGY

The market conduct examination process places emphasis on an insurer's systems and procedures used in dealing with insureds and beneficiaries. The large commercial group, small group and HMO health insurance lines of business were reviewed in this examination. Self-funded or Medicare/Medicaid plans were not reviewed.

The scope of the examination included, but was not limited to, the following market conduct areas as they relate to mental health parity and related activities:

- Company Operations and Management
- Provider Credentialing and Provider Relations
- Network Adequacy
- Claims
- Complaints (Grievances), Appeals and External Reviews
- Utilization Review (including Case Management)
- Pharmacy (Formulary Review and some data analysis)
- Quantitative Treatment Limitation ("QTL") Testing and Reports
- NQTL Comparative Analysis, Testing and Reports

The review of these categories was accomplished through examination of material related to the business functions, as well as interviews with various Company personnel and Company responses to the coordinator's handbook, information requests, and findings. Each of the categories listed above was examined for compliance with West Virginia and federal statutes, rules, and regulations.

The following method was used to obtain the required samples and to ensure a statistically sound selection. Workpapers were developed from Company-generated Excel spreadsheets. Random statistical file selections were generated by the examiners from these spreadsheets.

Company Operations and Management

A review was conducted of the Company's guidelines and procedures, policy forms, third party vendors, internal audits, record retention policy and procedures, certificate of authority, previous market conduct examinations and annual statements. These documents were reviewed for compliance with West Virginia codes, rules, and regulations. Exceptions were noted in the Report.

Provider Credentialing and Provider Relations

The Company was requested to provide policies and procedures or other documentation demonstrating that the Company established and maintained a program for credentialing and re-credentialing during the examination period. The Company provided a list of providers that initiated the credentialing process during the examination period. A random sample of these files was made by the examiners and submitted to the Company. These files and documents were reviewed for compliance with West Virginia codes, rules, and regulations. In addition, trends related to provider relations issues were reviewed. There were no exceptions noted.

Network Adequacy

The Company was requested to provide policies and procedures that it maintained a network that is sufficient in number, files an access plan, and provides all required contracts and forms. Additionally, it submitted policies and procedures or other documentation demonstrating that the health carrier provides at enrollment a provider directory that lists all providers who participate in

its network. The network adequacy documents were received and reviewed for compliance with West Virginia codes, rules, and regulations. There were no exceptions noted.

Claims

The Company was requested to provide a list of medical/surgical (“M/S”), mental health and substance use disorder (“MH/SUD”) claims during the examination period, to include all paid and denied claims. The Company identified the universe of all paid and denied claims; random samples of the files were made by the examiners and submitted to the Company. In addition, a targeted sample of autism paid and denied claims was selected for review. The files and responses to information requests were reviewed to ensure the claims were processed in compliance with West Virginia codes, rules, and regulations, and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (“MHPAEA”) of 2008 45 C.F.R. §146 et seq. Exceptions were noted in the Report.

Complaints, Appeals and External Reviews

The Company was requested to identify all consumer and WVOIC complaints, complaint logs, appeals and external reviews received during the examination period. All complaints and appeals files and logs were received. There were no complaints or external reviews related to mental health parity reported by the Company. The appeals file was reviewed for compliance with West Virginia codes, rules, and regulations. There were no exceptions noted.

Utilization Review

The Company was requested to identify all utilization reviews. The Company identified the universe of M/S and MH/SUD utilization reviews; random samples of the files were made by the examiners and submitted to the Company. The utilization review files and responses to information requests were received and reviewed for compliance with West Virginia codes, rules, and regulations. Exceptions were noted in the Report.

Pharmacy

The Company was requested to provide a list of M/S and MH/SUD pharmacy claims, appeals, external reviews, drug utilization reviews and formularies as well as policies and procedures. The Company identified the universe of all paid and denied claims and drug utilization reviews; random samples of the files were made by the examiners and submitted to the Company. There were no appeals or external reviews related to pharmacy services. The files and responses to information requests and the coordinator’s handbook were reviewed to ensure all activities were compliant with West Virginia codes, rules, and regulations, and the MHPAEA regulations. Exceptions were noted in the Report.

Mental Health Parity

The Company was requested to provide the mental health parity QTL testing and NQTL comparative analysis for review. Also, the Company was requested to identify and provide all pharmacy policies and procedures used during the experience period for mental health parity requirements. In accordance with the requirements of the examination, the data, and responses to follow up information requests were reviewed. The parity analyses and responses to follow up information requests were reviewed for compliance with West Virginia codes, rules, and regulations, as well as MHPAEA and the Affordable Care Act regulations. Exceptions were noted in the Report.

VI. FINDINGS

A. COMPANY OPERATIONS AND MANAGEMENT

1. Data Integrity

- a. Finding #18 -The Company did not comply with W.Va. Code §33-2-9(i)(2) and W.Va. Code R. §114-15-4.4(a)(3) when it provided inaccurate and contradictory data, demonstrating the Company's inability to exercise due diligence in ensuring data integrity. During meetings, the Company stated that there were 5,697 pharmacy neutral claims associated with National Average Drug Acquisition Cost ("NADAC") implementation. However, the Company previously provided the WVOIC with a list of 5,300 claims associated with the NADAC + \$10.49 service warranty issue. The data presented to the WVOIC was inconsistent with the data presented to the examination team and required further clarification as it pertained to this examination.

B. PROVIDER CREDENTIALING AND PROVIDER RELATIONS

1. Provider Credentialing

There were no findings in the review of provider credentialing files.

2. Provider Relations

There were no findings in the review of provider relations.

C. NETWORK ADEQUACY

Any deficiency in the network was a result of a lack of available providers in a geographic area. There were no findings in the review of network adequacy.

D. CLAIMS

1. Medical/Surgical Paid Claims

There were no findings in the review of M/S paid claims.

2. Mental Health and Substance Use Disorder Paid Claims

There were no findings in the review of MH/SUD paid claims.

3. Medical/Surgical Denied Claims

- a. Finding #11 – The Company failed to comply with W.Va. Code R. §114-14-6.1 in one instance of the 30 M/S denied claim files reviewed, for an error rate of 3%, by unreasonably delaying resolution by seeking information not reasonably required to resolve the claim.

In the claim, the Company requested that the member provide coordination of benefits ("COB") information even though the member was not eligible for coverage on the date of service. The Company advised that the "system hierarchy applies COB prior to eligibility".

Due to this system set up, any claim for a member that does not have COB information on file and is not eligible for coverage will be unreasonably delayed.

4. Mental Health and Substance Use Disorder Denied Claims

- a. Finding #15 – In 25 instances of 30 MH/SUD denied claim files reviewed, for an error rate of 83%, the Company did not comply with W.Va. Code R. §114-64-6.3.2 when it failed to include the email address of the Commissioner’s Office and provide the required statement from W.Va. Code R. §114-64-6.3.3 on the members’ EOB when any element of a claim is rejected. The member was not provided with the information, as required by law.

W.Va. Code R. §114-64-6.3.3 requires a statement specifying that the covered person is entitled, upon request to the insurer or carrier, to a copy of the medical necessity criteria for any behavioral health (“BH”) and MH/SUD benefit.

5. Autism Paid and Denied Claims

- a. Finding #10 – In four instances of 52 autism claim files reviewed, for an error rate of 8%, the Company did not comply with W.Va. Code R. §114-64-6.3.2 when it failed to include the email address of the Commissioner’s Office and provide the required statement from W.Va. Code R. §114-64-6.3.3 on the members’ EOB when any element of a claim was rejected. The member was not provided with the information, as required by law.

W.Va. Code R. §114-64-6.3.3 requires a statement specifying that the covered person is entitled, upon request to the insurer or carrier, to a copy of the medical necessity criteria for any BH and MH/SUD benefit.

E. COMPLAINTS, APPEALS AND EXTERNAL REVIEWS

1. Offices of Insurance Commissioner Complaints

There were no WVOIC complaint files related to MH/SUD during the examination period.

2. Direct Consumer Complaints

The Company reported no direct consumer complaints related to MH/SUD during the examination period.

3. Mental Health and Substance Use Disorder Appeals

There were no findings in the review of the MH/SUD appeals file.

4. Mental Health and Substance Use Disorder External Review

There were no MH/SUD external reviews reported for the examination period.

F. UTILIZATION REVIEW

1. Medical/Surgical Approved Utilization Review

There were no findings in the review of M/S approved utilization review files.

2. Mental Health and Substance Use Disorder Approved Utilization Review

There were no findings in the review of MH/SUD approved utilization review files.

3. Medical/Surgical Denied Utilization Review
 - a. Finding #13 – In one instance of the 30 M/S denied utilization review files reviewed, for an error rate of 3%, the Company failed to comply with W.Va. Code R. §114-95-7.3(a) by not providing the member with a determination letter. The member was not provided with the determination of the request, the reasoning behind the determination, and additional applicable information.
4. Mental Health and Substance Use Disorder Denied Utilization Review
There were no findings in the review of MH/SUD denied utilization review files.

G. PHARMACY REVIEW

1. Pharmacy Paid and Denied Claims
There were no findings in the analysis of pharmacy paid and denied claims.
2. Pharmacy Appeals
There were no pharmacy appeals reported during the examination period.
3. Mental Health and Substance Use Disorder Approved Drug Utilization Review
There were no findings in the review of MH/SUD approved drug utilization (“DUR”) review files.
4. Mental Health and Substance Use Disorder Denied Drug Utilization Review
There were no findings in the review of MH/SUD denied DUR files.
5. Pharmacy Formulary
 - a. Finding #1 – The Company did not comply with W.Va. Code §§33-16-3ff(c) and 33-25A-8u(c) when excluding all naloxone formulations from mail order delivery, which imposed a more restrictive NQTL. Naloxone is indicated for the emergency treatment of known or suspected opioid overdose as manifested by respiratory and/or central nervous system (“CNS”) depression. The medication is intended for immediate administration as emergency therapy in settings where opioids may be present. Epinephrine, a M/S medication comparably used in an emergency had no mail order delivery exclusion during the examination period. Epinephrine is indicated for treatment of allergic reactions including anaphylactic reactions.

The Company imposed a more restrictive NQTL on naloxone, a medication used in emergencies of suspected opioid overdose. The formulary design prohibited a member from receiving any naloxone product through mail order services. The Company may not impose a NQTL with respect to MH/SUD benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to M/S benefits. As this affected written policy and there was no way to track the number of instances when a medication could have been prescribed, a number of violations could not be calculated.

After the finding was issued, the Company and its pharmacy benefits manager (“PBM”) decided to remove naloxone from the mail order exclusion list.

- b. Finding #2 – The Company did not comply with W.Va. Code §§33-16-3ff(c) and 33-25A-8u(c) by imposing more restrictive quantity limitations on Narcan and generic naloxone nasal spray on the formularies from January 1, 2022 to October 1, 2022. Naloxone is indicated for the emergency treatment of known or suspected opioid overdose as manifested by respiratory and/or CNS depression. The medication is intended for immediate administration as emergency therapy in settings where opioids may be present. Epinephrine, a M/S medication comparably used in an emergency, did not have comparable quantity limitations. Epinephrine is indicated for treatment of allergic reactions including anaphylactic reactions. The Company did not apply the same processes, strategies, evidentiary standards, or other factors to SUD overdose treatment medications compared to the same processes, strategies, evidentiary standards, or other factors both as written and in operation to M/S emergency treatment medications. As this affected written policy and there was no way to track the number of instances when a medication could have been prescribed, a number of violations could not be calculated.
- c. Finding #3 – The Company did not comply with W.Va. Code §§33-16-3cc(k) and 33-25A-8r(k) when imposing quantity limitations, a prospective utilization management requirement, on all strengths of buprenorphine tablets. Buprenorphine is indicated for treatment of opioid dependence. The policy created a barrier to treatment when a member was prescribed above label dosing on these medications for fentanyl abuse or other high dose opioid abuse. Requiring a doctor to authorize a quantity limitation on buprenorphine sublingual tablets for above label dosing when clinically appropriate is a prior authorization and is prohibited in accordance with W.Va. Code §§33-16-3cc(k) and 33-25A-8r(k). Although the Company did not reject any claims at point of sale during the examination period, the buprenorphine quantity limit policy in operation was noncompliant with state code.
- d. Finding #4 – The Company did not comply with W.Va. Code §§33-16-3ff(c) and 33-25A-8u(c) by imposing more restrictive quantity limitations on desvenlafaxine on all formularies. The Company limited members to one tablet daily on all strengths of Pristiq, Khedezla and desvenlafaxine ER tablets. These products are indicated for the treatment of MDD and are commercially available in strengths of 25mg, 50mg, and 100mg per tablet. The Food and Drug Administration (“FDA”) approved maximum dose of desvenlafaxine is 400mg/day for MDD. As a result of this quantity limitation, a provider would be required to submit a prior authorization to obtain a dose over 100mg/day, thus creating barriers to access for MH medications. The Company limited desvenlafaxine and did not allow patients to obtain its FDA approved maximum dosing for a MH indication of MDD without their healthcare professional’s override. There were no comparable M/S medications with the restrictive quantity limits. In 2022, for fully insured West Virginia members, there were five pharmacy claims for desvenlafaxine ER tablets that rejected due to “plan limitations exceeded”.

After the finding was issued, the Company decided to remove quantity limits on desvenlafaxine, meaning that the quantity limit of one tablet on all strengths of desvenlafaxine (25mg, 50mg, 100mg) no longer applies.

- e. Finding #5 – The Company did not comply with W.Va. Code §§33-16-3cc(k) and 33-25A-8r(k) by limiting access to SUD treatment when placing Lucemyra as non-formulary on all formularies. A member would be required to obtain a prior authorization/non-formulary coverage exception for approval of the medication. Lucemyra is indicated for the mitigation of opioid withdrawal symptoms to facilitate abrupt opioid discontinuation in adults. The American Society of Addiction Medicine (“ASAM”) discusses its role in treatment of managing opioid withdrawal in patients with SUDs. Lucemyra may be used for withdrawal management in an outpatient setting, where monitoring of blood pressure and management of hypotension is more difficult. Although the Company had no instances of rejections during the examination period, the policy in operation was noncompliant with state code.

After the finding was issued, the Company decided it will include Lucemyra on the formulary and remove all prospective utilization management requirements in effect during the examination.

- f. Finding #6 – The Company did not comply with W.Va. Code §§33-16-3cc(k) and 33-25A-8r(k) when imposing quantity limitations, a prospective utilization management requirement, on all smoking cessation medications. The medications, bupropion SR, all NRT, Nicotrol, and Chantix had yearly quantity limitations. In order for a patient to obtain coverage, a physician would need to submit a prior authorization. Any provider involvement after the initial prescribing process can interrupt the course of therapy. A prior authorization from the member’s provider for smoking cessation treatment is prohibited according to W.Va. Code §§33-16-3cc(k) and 33-25A-8r(k). Although the Company did not reject any claims at point of sale during the examination period, the policy in operation was noncompliant with state code. The Company did remove the quantitative limits on smoking cessation drugs during the course of the examination.
- g. Finding #7 – The Company did not comply with W.Va. Code §§33-16-3cc(k) and 33-25A-8r(k) by limiting access to SUD treatment when placing Suboxone as non-formulary on all formularies. A member would be required to obtain a prior authorization/non-formulary coverage exception, a prospective utilization management requirement, for approval of the medication. Suboxone is indicated for the treatment of opioid dependence. The coverage restriction creates a barrier for consumers and providers in the overall treatment plan of a patient diagnosed with SUD. There were seven claims rejected in 2022 for Suboxone with the reject message “product not on formulary”.
- h. Finding #8 – The Company did not comply with W.Va. Code §§33-16-3cc(k) and 33-25A-8r(k) when imposing quantity limitations, a prospective utilization management requirement, on all strengths of buprenorphine/naloxone products. The medications included Suboxone, Zubsolv, and buprenorphine/naloxone tablets/films. The medications had restrictive hard-limit quantity limitations. The buprenorphine/naloxone products are indicated for treatment of opioid dependence. This policy creates a barrier to treatment when a member is prescribed above label

dosing on these medications for fentanyl abuse or other high dose opioid abuse. Requiring a doctor to authorize a quantity limitation on a prescribed buprenorphine/naloxone combination product for above label dosing when clinically appropriate is a prior authorization and is prohibited. Although the Company had no instances of rejections during the examination period, the buprenorphine-naloxone policy in operation was noncompliant with state SUD codes.

- i. Finding #9 – The Company did not comply with W.Va. Code §§33-16-3cc(k) and 33-25A-8r(k) when imposing quantity limitations, a prospective utilization management requirement, on Narcan, generic naloxone nasal spray, and Kloxxado. Naloxone is indicated for the emergency treatment of known or suspected opioid overdose as manifested by respiratory and/or CNS. The medication is intended for immediate administration as emergency therapy in settings where opioids may be present. The policy creates a barrier to emergency treatment for patients and does not follow current ASAM guidelines. The ASAM guidelines recommend naloxone should be provided to patients being treated for, or with a history of opioid use disorder and both patients and family members/significant others should be trained in the use of naloxone in case of unexpected overdose. ASAM supports broadened accessibility to naloxone for individuals commonly in a position to initiate early response to evidence of opioid overdose. The individuals include family members, significant others, companions of people who use or are prescribed opioids, and people who use or are prescribed opioids. Although the Company did not reject any claims at point of sale during the examination period, the policy in operation was noncompliant with state SUD codes.

After the finding was issued, the Company removed quantity limits on these medications, meaning the previous quantity limit of four sprays or two packages every 25 days is no longer imposed.

- j. Finding #14 – The Company did not comply with W.Va. Code §33-51-11(a)(10) when prohibiting members from filling 90-day supplies of prescription drugs at a retail pharmacy. The policy coding error only allowed 90-day supplies to be filled when utilizing the Company’s affiliated mail order pharmacy.

The Company inappropriately coded plans to prohibit members from obtaining 90-day supplies of prescription drugs at retail pharmacies. The policy design allowed members to obtain the 90-day supplies of prescription drugs only at the Company affiliate’s mail order pharmacies. The Company violated W.Va. Code §33-51-11(a)(10) within implementation of a benefit design that favored an affiliate’s mail order pharmacy over other pharmacies in the network.

- k. Finding #16 – The Company did not comply with W.Va. Code §33-51-11(a)(5) when not paying all pharmacies at the state mandated NADAC + \$10.49. The Company’s PBM paid claims using lower of logic pricing methodology that imposed a monetary advantage or penalty under a health plan that would affect a beneficiary’s choice of pharmacies. A member’s copay for the same quantity of medication varied depending on which pharmacy was chosen for prescription drug services. The Company imposed higher copays, a reduction in reimbursement for pharmacy services, and indirectly

promoted one participating pharmacy over another by using the lower of logic pricing method for medication reimbursement to pharmacies.

- I. Finding #17 – The Company did not comply with W.Va. Code §§33-16-3aa(c)(2)(C) and 33-25A-8o(c)(2)(C) by implementing a non-formulary exception policy with step therapy processes that are more restrictive than allowable by the W.Va. code.

This policy did not allow approval when the patient had tried the required prescription drug while under their current or a previous health insurance or health benefit plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action and such prescription drug was discontinued due to a lack of efficacy or effectiveness, diminished effect, or an adverse event. Regardless of formulary status, the Company implemented step therapy processes that were more stringent than required by law.

After the finding was issued, the Company stated that it would update its exception policy to state that “the patient will not be required to try a prescription drug the patient has already tried while under their current or a previous health insurance or health benefit plan, or another prescription drug in the same pharmacologic class or with the same mechanism of action, where such prescription drug was discontinued due to a lack of efficacy or effectiveness, diminished effect, or an adverse event.”

H. MENTAL HEALTH PARITY

1. Certificate of Coverage Forms

There were no findings in the review of the certificates of coverage forms.

2. Quantitative Treatment Limitations Assessments

There were no findings in the review of the QTL assessments.

3. Nonquantitative Treatment Limitations Comparative Analysis

- a. Finding #19 - The Company did not comply with 42 U.S.C. 300gg-26(a)(8)(A), W.Va. Code §§33-16-3ff(c)(2) and (4) and 33-25A-8u(c)(2) and (4), 33-16-3ff(g)(4) and 33-25A-8u(g)(4) when it failed to provide separate NQTL comparative analyses for ALIC, AHI, and AHIC plans for each of the NQTLs requested, instead providing one general NQTL comparative analysis for each NQTL that the Company said applied to all plans and entities. Because the contents of the comparative analyses were not sufficiently specific, detailed, and reasoned to demonstrate that each of ALIC’s, AHI’s, and AHIC’s processes, strategies, evidentiary standards, and other factors used to apply an NQTL to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply an NQTL to medical or surgical benefits in the applicable benefits classification, the Company did not comply with the requirements.

The Company initially stated that it only submitted NQTL analyses for ALIC but later clarified that the NQTL analyses applied to all of the Aetna entities subject to this examination (ALIC, AHI and AHIC) and all plans issued under these entities in West Virginia. A review of the NQTL comparative analyses submitted by the Company

revealed that there were no specific references to ALIC, AHI, or AHIC or their plans and there were no differences in the explanations and analyses which would indicate that the response was specific to ALIC, AHI, or AHIC.

- b. The Company provided one general comparative analysis for the following NQTLs in one or more benefits classifications: (1) prior authorization; (2) concurrent review; (3) retrospective review; (4) medical necessity criteria; (5) participating provider reimbursement (professionals and facilities); (6) non-participating provider reimbursement (7) network adequacy; (8) provider admission standards - credentialing; (9) formulary design; and (10) Rx prior authorization.

After an examination of the comparative analyses, it was determined that the contents of the comparative analyses were not sufficiently specific, detailed, and reasoned to demonstrate that the processes, strategies, evidentiary standards, and other factors used to apply an NQTL to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply an NQTL to medical or surgical benefits in the applicable benefits classification as required by 42 U.S.C. 300gg-26(a)(8)(A)(iv) and W.Va. Code. R. §114-64-1, et seq.

There were a number of ways that the Company's comparative analyses were determined to be insufficient, which included, but were not limited to, the following:

- A. The comparative analyses did not correlate with the requirements as indicated in the coordinator's handbook and as set forth in 42 U.S.C. Section 300gg-26(a)(8)(A).
- B. The comparative analyses did not sufficiently identify what benefits or plan terms the NQTLs applied to, as required by 42 U.S.C. 300gg-26(a)(8)(A)(i).
- C. The comparative analyses did not adequately identify and describe specific plan or coverage terms of other relevant terms regarding the NQTLs, including Company policies, procedures, and processes and the policies, procedures, and processes of any vendor(s), as required by 42 U.S.C. 300gg-26(a)(8)(A)(i).
- D. There was inadequate supporting documentation or information included with the submissions or the supporting documentation was not properly referenced or integrated with the analysis provided.
- E. The comparative analysis did not specifically identify the factors used to determine that the NQTLs will apply to MH/SUD benefits and M/S benefits, as required by 42 U.S.C. § 300gg-26(a)(8)(A)(ii).
- F. The comparative analyses did not sufficiently define the factors identified, nor did they sufficiently delineate and compare the sources or evidentiary

standards for each factor used to determine that the NQTLs would apply, as required by 42 U.S.C. 300gg-26(a)(8)(A)(ii) and (iii).

- G. The comparative analyses did not demonstrate that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to MH or SUD benefits, as written and in operation, are comparable to, and were applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in each benefits classification, as required by 42 U.S.C. 300gg-26(a)(8)(A)(iv).
- H. The Company did not include data in the comparative analysis or included data without appropriate explanation or an inadequate explanation as to how the data was collected or how the data demonstrates compliance with the comparability and equitable stringency application.
- I. The comparative analyses did not provide the specific findings and conclusions reached by the Company, including any results of the analyses that indicated that the plan or coverage was or was not in compliance with MHPAEA, as required by 42 U.S.C. 300gg-26(a)(8)(A)(v).
- J. The Company did not appropriately define or explain its relationship with vendors that may have design or management responsibilities for the NQTLs and how MHPAEA compliance was assured/coordinated, including the Company's PBM.
- K. The Company did not provide a comparative analysis for every NQTL it imposed on M/S and MH/SUD benefits (e.g., quantity limits).

The Company was informed that the NQTL comparative analyses were insufficient. The Company was then asked to revise its NQTL comparative analyses, offered guidance and the opportunity to ask questions. The Company opted not to schedule a meeting to discuss comparative analyses feedback. It was asked to submit revised NQTL comparative analyses that comply with federal and state laws, regulations, and guidance as part of the WVOIC's 2024 annual data call for the 2023 plan year. Accordingly, the Company revised its NQTL comparative analyses, which are being reviewed by the WVOIC. The WVOIC will contact the Company with respect to its compliance at a later date.

VII. SUMMARY OF EXAMINATION RECOMMENDATIONS

1. The Company should continuously review and update its claims system to ensure compliance with W.Va. Code R. §114-14-6.1 and verify that claims are not unreasonably delayed by the Company pursuing information that is not reasonably required to resolve the claim.
2. The Company should ensure that all EOBs are sent and are in compliance with all mental health parity disclosure elements required in W.Va. Code R. §114-64-6.3 and its subsections.

3. The Company should complete internal audits to identify any failure to issue adverse determination letters for utilization reviews and ensure compliance with the requirements set forth in W.Va. Code R. §§114-95-7.3(a) and its subsections.
4. The Company should continuously review and update its drug policies and procedures related to dispensing limitations to comply with W.Va. Code §§33-16-3ff(c) and 33-25A-8u(c) and avoid imposing restrictive limitations.
5. The Company should complete internal evaluations to ensure compliance with W.Va. Code §§33-16-3cc(k) and 33-25A-8r(k) and avoid implementing more restrictive prior authorization processes and step therapy policies for MH/SUD medications which may create a barrier to treatment.
6. The Company should ensure formularies are in compliance with all federal and state regulations related to MHPAEA.
7. The Company should review pharmacy benefit claims reimbursement methodology to ensure compliance with W.Va. Code §33-51-11 to avoid indirectly promoting one participating pharmacy over another by implementing higher copays for the same medication at select pharmacies.
8. The Company should review pharmacy benefit claims coding to ensure compliance with W.Va. Code §33-51-11 and allow members the freedom to choose a retail pharmacy within the network without day supply restrictions.
9. The Company should complete separate NQTL comparative analyses for each entity to comply with 42 U.S.C. 300gg-26(a)(8)(A), W.Va. Code §§33-16-3ff(c)(2) and (4) and 33-25A-8u(c)(2) and (4), 33-16-3ff(g)(4) and 33-25A-8u(g)(4).

EXAMINATION REPORT SUBMISSION

The courtesy and cooperation of the officers and employees of the Company during the examination are acknowledged and appreciated.

Amanda Brandis
Art Kusserow
Tanner Qualls
Sharon Wiernik
June Coleman
Steven Gloc
Brian Stanley
Matthew Sankey
Trevor Strenchock
Marilyn Vadon

Respectfully submitted,



MAUREEN HICKS
EXAMINER-IN-CHARGE



SHELLY SCHUMAN
SUPERVISORY INSURANCE EXAMINER

EXAMINER'S AFFIDAVIT


State of South Carolina
County of Charleston

EXAMINER'S AFFIDAVIT AS TO STANDARDS AND PROCEDURES USED IN AN EXAMINATION

I, Maureen Hicks, Market Regulation Senior Examiner, being duly sworn, state as follows:

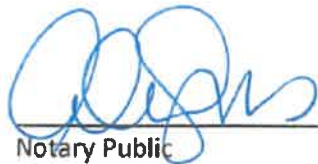
1. I have the authority to represent West Virginia in the examination of Aetna Health, Inc., Aetna Life Insurance Company and Aetna Health Insurance Company.
2. I have reviewed the examination work papers and examination report, and the examination of Aetna Health, Inc., Aetna Life Insurance Company and Aetna Health Insurance Company was performed in a manner consistent with the standards and procedures required by West Virginia.

The affiant says nothing further.



Maureen Hicks, MCM, PAHM

Subscribed and sworn before me by Maureen Hicks on this 22nd day of April, 2025.


Notary Public



My commission expires: 5/11/33