MARKET CONDUCT EXAMINATION

OF

AETNA HEALTH INC. (a NEW YORK COMPANY)

AETNA HEALTH INSURANCE COMPANY OF NEW YORK

AETNA LIFE INSURANCE COMPANY

AS OF

DECEMBER 31, 2011

DATE OF REPORT	**JUNE 9, 2014**
EXAMINER	**PEARSON GRIFFITH**

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NEW YORK STATE
DEPARTMENT *of*
FINANCIAL SERVICES

Andrew M. Cuomo
Governor

Benjamin M. Lawsky
Superintendent

June 9, 2014

Honorable Benjamin M. Lawsky
Superintendent of Financial Services
Albany, New York 12257

Sir:

Pursuant to the requirements of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Numbers 30714, 30716, and 30717 dated April 29, 2011, annexed hereto, I have made an examination into the affairs of Aetna Health Inc. (a New York Corporation), a for-profit health maintenance organization certified pursuant to the provisions of Article 44 of the New York Public Health Law, Aetna Health Insurance Company of New York, a health insurance company licensed pursuant to the provisions of Article 42 of the New York Insurance Law, and Aetna Life Insurance Company, a life and accident and health insurance company licensed under the laws of the State of New York, as of December 31, 2011, and submit the following report thereon.

The examination was conducted at the home office of Aetna Health Inc., located at 151 Farmington Avenue, West Hartford, Connecticut, and its office located at 980 Jolly Road, Blue Bell, Pennsylvania.

Wherever the designations "AHI" or the "HMO" appear herein, without qualification, they should be understood to indicate Aetna Health Inc. (a New York Corporation).

Wherever the designation, the "Parent" appears herein, without qualification, it should be understood to indicate Aetna Inc., the ultimate parent of AHI.

Wherever the designation, "AHIC" or the "Company" appears herein, without qualification, they should be understood to indicate Aetna Health Insurance Company of New York, an accident and health insurer licensed pursuant to Article 42 of the New York Insurance Law.

Wherever the term "ALIC" appears herein, without qualification, it should be understood to indicate Aetna Life Insurance Company.

Wherever the terms "Aetna" or the "Companies" appear herein, without qualification, they should be understood to indicate AHI, AHIC and ALIC, collectively.

Wherever the designation, the "Department" appears herein, without qualification, it should be understood to indicate the New York State Department of Financial Services.

1. SCOPE OF EXAMINATION

The previous market conduct examination of Aetna was conducted as of December 31, 2005. This market conduct examination was performed to review the manner in which AHI, AHIC and ALIC conducted their business practices and fulfilled their contractual obligations to policyholders and claimants and covers the six-year period January 1, 2006 to December 31, 2011. Transactions subsequent to this period were reviewed where deemed appropriate by the examiner.

This report on examination contains the significant findings of the examination and is confined to comments on those matters which involve departures from laws, regulations or rules, or which are deemed to require explanation or description.

A review was also made to ascertain what actions were taken by the Companies with regard to comments and recommendations made in the prior market conduct report on examination.

Concurrent examinations regarding the financial condition of AHI and AHIC were conducted by the Department as of December 31, 2010, and separate reports on examination will be issued thereon.

2. EXECUTIVE SUMMARY

The results of this examination revealed certain operational deficiencies that indicate areas of weakness and/or directly impacted the Companies' compliance with the New York

Insurance Law, New York Public Health Law, and Department Regulations. Significant findings relative to this examination include the following:

- During the period under examination, AHIC failed to file its utilization review report on a biennial basis with the Superintendent, as required by Section 4901(a) of the New York Insurance Law.

- AHI and ALIC did not comply with the provisions of Section 4903(b) of the New York Insurance Law when it failed to make prospective determinations for services requiring pre-authorization within three business days of receipt of the necessary information.

- ALIC did not comply with the provisions of Section 4903(c) of the New York Insurance Law when it failed to make concurrent determinations for continued services within one business day of receipt of the necessary information.

- AHI did not comply with the provisions of Section 4904(c) of the New York Insurance Law when it failed to provide written acknowledgement of the filing of the appeal to the appealing party within fifteen days of such filing.

- AHIC failed to maintain a policy record for each policy for six calendar years after the date the policy is no longer in force or until after the filing of the report on examination in which the record was subject to review, whichever is longer, in accordance with Department Regulation No. 152.

- The Companies failed to issue denial codes on their explanation of benefits statements ("EOBs") that accurately reflected the reason(s) for denial, as required by Sections 3234(b)(6) and 3234(b)(7)of the New York Insurance Law.

- The Companies failed to comply with their own policies and procedures when they improperly applied claims authorizations.

- The Companies failed to accurately apply copayments and deductibles on certain claims, in accordance with contractual provisions, and comply with their own policies and procedures for adjudicating claims.

3. DESCRIPTION OF THE COMPANIES

Aetna Health Inc., Aetna Health Insurance Company of New York and Aetna Life Insurance Company are all subsidiaries of Aetna Inc. (the Parent), a for-profit, publicly traded company.

Aetna Health Inc. was incorporated in New York on June 24, 1985, to operate as a health maintenance organization under the name, US Healthcare, Inc. The HMO was certified by the New York State Department of Health on February 3, 1986. The HMO is licensed as a for-profit independent practice association (IPA) model HMO pursuant to the provisions of Article 44 of the New York Public Health Law. In 2001, the HMO changed its name to Aetna Health Inc. AHI's primary lines of business at the time of this examination were Group HMO and point-of-service (POS).

Aetna Health Insurance Company of New York was incorporated under the laws of the State of New York on April 19, 1985, as Adirondack Life Insurance Company and was licensed to transact insurance business in the State of New York on August 29, 1986. On October 26, 1990, the Company amended its charter and removed its life and annuity powers. The Company was licensed, effective October 26, 1990, to write accident and health insurance as defined in Section 1113(a)(3) of the New York Insurance Law. The Company's name was changed to its current name, Aetna Health Insurance Company of New York, effective May 8, 2002. All business conducted by the Company at the time covered by this examination represented the out-of-network component of the point-of-service products issued by Aetna Health Inc., which covered the in-network component of such products.

Aetna Life Insurance Company is a Connecticut domestic insurer that was admitted within New York State on March 13, 1865. ALIC is licensed to conduct life, annuities, accident and health, personal injury liability and workers' compensation and employers' liability insurance, as these terms are defined within Section 1113(a) of the New York Insurance Law, within New York State. At the time of the examination period, ALIC wrote Preferred Provider Organization (PPO) and POS business within New York State.

4. UTILIZATION REVIEW

Section 4901(a) of the New York Insurance Law states:

> "Every utilization review agent shall biennially report to the superintendent of insurance, in a statement subscribed and affirmed as true under the penalties of perjury, the information required pursuant to subsection (b) of this section."

AHIC's business was derived from the out-of-network component of the point-of-service products issued by AHI. During the period under examination, AHIC failed to file its utilization review report on a biennial basis with the Superintendent, as required by Section 4901(a) of the New York Insurance Law.

It should be noted that Aetna Health Management, LLC (AHM) performs Utilization Reviews for both AHI and AHIC. AHM's comprehensive utilization program is called the Aetna Care Management Program. The Aetna Care Management Program is an innovative, member-centric approach for each covered member that incorporates health status, benefit plan design, and other information to help members understand and maintain their optimal health. The Aetna Care Management Program goals are met through the combined efforts of nurses,

social workers, medical directors, dentists, pharmacists, and other staff in multiple Aetna departments. The Aetna Care Management philosophy includes the following:

- Focusing on quality care first;
- Building collaborative relationships;
- Being a health advocate for members;
- Utilizing medical information and technology to its full effect;
- Providing superior customer service to members; and,
- Providing value to plan sponsors.

During the period under examination, AHM filed the required biennial utilization review reports on behalf of AHI, but did not file the required reports for AHIC.

It is recommended that AHIC ensure that Aetna Health Management file the required biennial utilization review reports on its behalf with the Superintendent, as required by Section 4901(a) of the New York Insurance Law.

Section 4903(b) of the New York Insurance Law states:

> "A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the insured or insured's designee and the insured's health care provider by telephone and in writing within three business days of receipt of the necessary information."

In addition, Section 4903(2) of the New York State Public Health Law states:

> "A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the enrollee or enrollee's designee and the enrollee's health care provider by telephone and in writing within three business days of receipt of the necessary information.

During the review of Utilization Review cases, the examiner noted three (3) instances of the twenty-one (21) cases the examiner reviewed where AHI failed to make prospective determinations for services requiring pre-authorization within three business days. In addition,

the examiner noted one (1) instance of the twenty-four (24) cases the examiner reviewed where ALIC failed to make a prospective determination for services requiring pre-authorization within three business days.

When this matter was brought to Aetna's attention, the examiner was informed that there were 74 AHI and 346 ALIC prospective utilization review cases that were not performed within three business days, as required by statute. Due to the volume of cases and time constraints, Aetna was not able to individually review all of the 2011 AHI and ALIC prospective utilization review cases to determine how many were out of compliance. Instead, Aetna prepared a report that identified the number of cases where the request date and the decision date were within three business days. For the remaining cases, Aetna was unable to identify when the necessary information to make a decision was received without individually reviewing each file. Consequently, Aetna reviewed a sample of twenty (20) unknown cases each for AHI and ALIC to determine the number of cases that did not meet the three business day requirement. The tables below provide the overview of Aetna's review, (as verified by the examiner):

AHI	**Prospective Reviews**
Total Number of Prospective Review Cases	2,572
Total Number of Prospective Review cases that met the three day notice of determination requirement	2,082
Total cases with unknown turnaround times	490
% of cases not meeting the statutory turnaround time based on Aetna's sampling	15%
Total estimated number of cases not meeting the statutory turnaround time, per Aetna	74

ALIC	Prospective Reviews
Total Number of Prospective Review Cases	6,597
Total Number of Prospective Review cases that met the three day notice of determination requirement	4,870
Total cases with unknown turnaround times	1,728
% of cases not meeting the statutory turnaround time based on Aetna's sampling	20%
Total estimated number of cases not meeting the statutory turnaround time, per Aetna	346

It is recommended that AHI comply with the provisions of Section 4903(2) of the New York State Public Health Law, and ALIC comply with the provisions of Section 4903(b) of the New York Insurance Law, by making prospective determinations for services requiring pre-authorization within three business days of receipt of the necessary information.

Section 4903(c) of the New York Insurance Law states:

> "A utilization review agent shall make a determination involving continued or extended health care services, additional services for an insured undergoing a course of continued treatment prescribed by a health care provider, or home health care services following an inpatient hospital admission, and shall provide notice of such determination to the insured or the insured's designee, which may be satisfied by notice to the insured's health care provider, by telephone and in writing within one business day of receipt of the necessary information except, with respect to home health care services following an inpatient hospital admission, within seventy-two hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date. Provided that a request for home health care services and all necessary information is submitted to the utilization review agent prior to discharge from an inpatient hospital admission pursuant to this subsection, a utilization review agent shall not deny, on the basis of medical necessity or lack of prior authorization, coverage for home health care services while a determination by the utilization review agent is pending."

In addition, Section 4903(d) of the New York Insurance Law states:

> "A utilization review agent shall make a utilization review determination involving health care services which have been delivered within thirty days of receipt of the necessary information."

During the review of Utilization Review cases, the examiner noted one (1) instance of the twenty-four (24) cases the examiner reviewed where ALIC failed to make a concurrent determination for continued services within one business day, as required by Section 4903(c) of the New York Insurance Law.

When this matter was brought to Aetna's attention, the examiner was informed that there were 113 ALIC concurrent utilization review cases that were not performed within one business day. Due to the volume of cases and time constraints, Aetna was not able to individually review all of the 2011 ALIC concurrent utilization review cases to determine how many were out of compliance. Instead, Aetna prepared a report that identified the number of cases where the request date and the decision date were within one business day. For the remaining cases, Aetna was unable to identify when the necessary information to make a decision was received without individually reviewing each file. Consequently, Aetna reviewed a sample of the unknown cases and determined the number of cases that did not meet the one business day requirement. The tables below provide the overview of Aetna's review, (as verified by the examiner):

ALIC	**Concurrent Reviews**
Total Number of Concurrent Review Cases	8,277
Total Number of Concurrent Review cases that met the one day notice of determination requirement	6,016
Total cases with unknown turnaround times	2,261
% of cases not meeting the statutory turnaround time based on Aetna's sampling	5%
Total estimated number of cases not meeting the statutory turnaround time, per Aetna	113

It is recommended that ALIC comply with the provisions of Section 4903(c) of the New York Insurance Law by making concurrent determinations for continued services within one business day of receipt of the necessary information.

Section 4904(3) of the New York Insurance Law states in part:

> "…The utilization review agent must provide written acknowledgement of the filing of the appeal to the appealing party within fifteen days of such filing…"

During the review of Utilization Review appeals, the examiner noted two (2) instances of the twenty (20) cases the examiner reviewed where AHI failed to provide written acknowledgements of the filing of the appeal to the appealing party within fifteen days of such filing. This matter was brought to Aetna's attention, and the Company subsequently informed the examiner that it failed, in thirteen (13) out of 349 instances, to provide written acknowledgement of the filing of the appeal to the appealing party within fifteen days of such filing.

In addition, during the review of Utilization Review appeals, the examiner noted that AHI reported two (2) grievance cases as Utilization Appeals. These grievance cases pertain to administrative or contractual denials and were also erroneously reported in Schedule M, Table 2 of the 2011 New York Annual Statement Supplement as UR appeals. This matter was brought to Aetna's attention for further review, and AHI subsequently informed the examiner that it identified a total of fourteen (14) out of 349 cases that were incorrectly classified as UR cases but should have been classified as grievances.

It is recommended that AHI comply with the provisions of Section 4904(3) of the New York Public Health Law by providing written acknowledgement of the filing of the appeal to the appealing party within fifteen days of such filing.

It is also recommended that AHI report only Utilization Review Appeals in Schedule M, Table 2 of its New York Annual Statement Supplement filings.

5. COMPLAINTS AND GRIEVANCES

Section 4802(a) of the New York Insurance Law states in part:

> "An insurer which offers a managed care product shall establish and maintain a grievance procedure with regard to such managed care product. Pursuant to such procedure, insureds shall be entitled to seek a review of determinations by the insurer with regard to such managed care product, other than determinations subject to the provisions of article forty-nine of this chapter..."

Section 4408-a(1) of the New York Public Health Law states in part:

> "A health maintenance organization licensed pursuant to article forty-three of the insurance law or certified pursuant to this article, and any other organization certified pursuant to this article shall establish and maintain a grievance procedure. Pursuant to such procedure, enrollees shall be entitled to seek a review of determinations by the organization other than determinations subject to the provisions of article forty-nine of this chapter..."

A review of Companies' complaint files was performed to determine their compliance with the grievance mandates as well as the quality of their handling of complaints. The following was noted:

A review of ALIC complaint files indicated that the company classified seventeen (17) of the twenty-four (24) files the examiner reviewed as complaints rather than grievances. In addition, a review of AHI and AHIC complaint files indicated that the companies classified five

(5) of the nine (9) files the examiner reviewed as complaints rather than grievances. This condition reduced members' appeals rights afforded them under Section 4802(a) of the New York Insurance Law and Section 4408-a(1) of the New York Public Health Law. The misclassification of grievances as complaints also resulted in the inaccurate reporting of grievances on Schedule M of the companies' filed Annual Statements. Furthermore, the examiner noted that two of the files did not contain final resolution letters.

This matter was brought to Aetna's attention for further review, whereupon the Company subsequently informed the examiner that there were fifteen (15) ALIC cases and three (3) AHI/AHIC grievance cases that were misclassified as complaints.

It is recommended that the Companies review and revise their procedures to classify members' inquiries as "complaints" and as "grievances," in accordance with the provisions of Section 4802(a) of the New York Insurance Law and Section 4408-a(1) of the New York Public Health Law.

It is also recommended that the Companies ensure that grievances are accurately classified and properly reported in Schedule M of their filed Annual Statements.

It is further recommended that the Companies include final resolution letters for complaints within the applicable case files.

6. RECORD RETENTION

During the review of policy forms in use, the examiner noted that AHIC was unable to provide a stamped approved copy of the small group policy form. Instead, the company provided a copy of the Department's approval letter dated October 7, 2011.

Department Regulation No. 152 (11 NYCRR 243.2(b)(1)) states in part:

> "Except as otherwise required by law or regulation, an insurer shall maintain:
>
> A policy record for each insurance contract or policy for six calendar years after the date the policy is no longer in force or until after the filing of the report on examination in which the record was subject to review, whichever is longer. Policy records need not be segregated from the policy records of other states as long as they are maintained in accordance with the provisions of this part. A separate copy need not be maintained in an individual policy record, provided that any data relating to a specific contract or policy can be retrieved pursuant to section 243.3(a) of this Part. A policy record shall include:
>
> (i) the policy term, basis for rating, and return premium amounts, if any;
>
> (ii) the application, including any application form or enrollment form for coverage under any insurance contract or policy;
>
> (iii) the contract or policy forms issued including the declaration pages, endorsements, riders, and termination notices of the contract or policy. Binders shall be retained if a contract or policy was not issued; and
>
> (iv) other information necessary for reconstructing the solicitation, rating, and underwriting of the contract or policy."

It is recommended that AHIC maintain a record for each policy for six calendar years after the date the policy is no longer in force or until after the filing of the report on examination in which the record was subject to review, whichever is longer, in accordance with Part 243.2(b)(1) of Department Regulation No. 152.

7. CLAIMS ATTRIBUTE REVIEW

A review of AHI's, AHIC's and ALIC's claims practices and procedures was performed covering claims paid during the period of January 1, 2011 through December 31, 2011, in order to evaluate the overall accuracy and compliance environment of their claims processing. The claim populations for the companies were divided into medical and hospital claim segments. A random statistical sample was drawn from each segment for each of the above Aetna Companies, except for the items detailed further below within this paragraph, to test for verification of compliance with certain specified areas, including: eligibility, payment adherence to appropriate fee schedules, co-payments, deductibles, treatment plan authorization, denied claims and explanation of benefits statements ("EOBs"). It should be noted for the purpose of this analysis, that those medical costs characterized as Pharmacy, Medicare/Medicaid, Dental, Capitated Payments, Federal Employees Program subscribers and HCRA bulk payments were excluded from this review.

The sample size for each population was comprised of 50 randomly selected unique claim transactions. In total, 300 claims were selected for this review (50 hospital and 50 medical for each company). Financial accuracy is defined as the percentage of times the dollar value of the claim payment was correct. Procedural accuracy is defined as the percentage of times a claim transaction was processed in accordance with Aetna's guidelines and/or Department regulations. An error in processing accuracy may or may not affect the financial accuracy. A financial error is also considered a procedural error. To ensure the completeness of the claims population being tested, the total dollars paid were accumulated and reconciled to the paid claims data reported by each Aetna entity for the period January 1, 2011 through December 31, 2011.

Section 3234(a) of the New York Insurance Law states in part:

> "Every insurer…is required to provide the insured or subscriber with an explanation of benefits form in response to the filing of any claim under a policy or certificate providing coverage for hospital or medical expenses, including policies and certificates providing nursing home expense or home care expense benefits."

In addition, Sections 3234(b) (6) and (7) of the New York Insurance Law state in part:

> (6) a specific explanation of any denial, reduction, or other reason, including any other third-party payor coverage, for not providing full reimbursement for the amount claimed; and
>
> (7) a telephone number or address where an insured or subscriber may obtain clarification of the explanation of benefits, as well as a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and a notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made.

The following represents errors identified by the examiner during the abovementioned claims review:

- The Companies failed to issue accurate denial codes on explanation of benefits statements ("EOBs") for certain denied claims, in violation of with the requirements of Sections 3234(b)(6) and 3234(b)(7) of the New York Insurance Law.

- The Companies failed to issue payments on some claims, although there were amounts owed as detailed from the adjudication process. In addition, the Companies failed to issue accurate EOBs in those instances.

- The Companies failed to pay certain claims in a timely manner in violation of the requirements of Section 3224-a(a) of the New York Insurance Law. In addition, the Companies failed to pay the requisite interest in some instances in violation of the requirements of Section 3224-a(c) of the New York Insurance Law. These claims were deemed to be financial and procedural errors.

- The Companies failed to comply with their own policies and procedures, when they improperly denied certain claims for lack of authorization. The claims were subsequently reprocessed in a timely manner. However, they were deemed to be financial and procedural errors.

- The Companies failed to accurately apply co-payments and deductibles on certain claims, in accordance with contractual provisions, and to comply with their own policies and procedures. These claims were deemed to be financial and procedural errors.

Based on the claims review that was conducted during the examination, the Companies failed to issue accurate denial codes on explanation of benefits statements ("EOBs") for two denied claims, in violation of the requirements of Sections 3234(b)(6) and 3234(b)(7) of the New York Insurance Law. In addition, the examination review indicated that the Companies improperly denied two claims for lack of authorizations. These claims were subsequently reprocessed in a timely manner. Furthermore, the Companies failed to apply co-payments and deductibles on three claims, and to comply with their own policies and procedures.

It is recommended that the Companies issue denial codes on explanation of benefits statements ("EOBs") that accurately reflect the reason(s) for denial, in compliance with the requirements of Sections 3234(b)(6) and 3234(b)(7) of the New York Insurance Law.

It is recommended that the Companies comply with policy provisions and their own policies and procedures by properly applying authorizations.

It is recommended that the Companies accurately apply co-payments and deductibles in accordance with contractual provisions and comply with their own policies and procedures.

8. STANDARDS FOR PROMPT, FAIR AND EQUITABLE SETTLEMENT OF CLAIMS FOR HEALTH CARE AND PAYMENTS FOR HEALTH CARE SERVICES ("PROMPT PAY LAW")

Section 3224-a(a) of the New York Insurance Law states:

> "(a) Except in a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law to pay a claim submitted by a policyholder or person covered under such policy ("covered person") or make a payment to a health care provider is not reasonably clear, or when there is a reasonable basis supported by specific information available for review by the superintendent that such claim or bill for health care services rendered was submitted fraudulently, such insurer or organization or corporation shall pay the claim to a policyholder or covered person or make a payment to a health care provider within thirty days of receipt of a claim or bill for services rendered that is transmitted via the internet or electronic mail, or forty-five days of receipt of a claim or bill for services rendered that is submitted by other means, such as paper or facsimile."

In addition, Section 3224-a(b) of the New York Insurance Law states:

> "(b) In a case where the obligation of an insurer or an organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law to pay a claim or make a payment for health care services rendered is not reasonably clear due to a good faith dispute regarding the eligibility of a person for coverage, the liability of another insurer or corporation or organization for all or part of the claim, the amount of the claim, the benefits covered under a contract or agreement, or the manner in which services were accessed or provided, an insurer or organization or corporation shall pay any undisputed portion of the claim in accordance with this subsection and notify the policyholder, covered person or health care provider in writing within thirty calendar days of the receipt of the claim:"
> (1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or
> (2) to request all additional information needed to determine liability to pay the claim or make the health care payment. Upon receipt of the information requested in paragraph two of this subsection or an appeal of a claim or bill for health care services denied pursuant to paragraph one of this subsection, an insurer or organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law shall comply with subsection (a) of this section.

Furthermore, Section 3224-a(c) of the New York Insurance Law states:

> "(c) (1) Except as provided in paragraph two of this subsection, each claim or bill for health care services processed in violation of this section shall constitute a separate violation. In addition to the penalties provided in this chapter, any insurer or organization or corporation that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim, in full settlement of the claim or bill for health care services, the amount of the claim or health care payment plus interest on the amount of such claim or health care payment of the greater of the rate equal to the rate set by the commissioner of taxation and finance for corporate taxes pursuant to paragraph one of subsection (e) of section one thousand ninety-six of the tax law or twelve percent per annum, to be computed from the date the claim or health care payment was required to be made. When the amount of interest due on such a claim is less then two dollars, and insurer or organization or corporation shall not be required to pay interest on such claim.
>
> (2) Where a violation of this section is determined by the superintendent as a result of the superintendent's own investigation, examination, audit or inquiry, an insurer or organization or corporation licensed or certified pursuant to article forty-three or forty-seven of this chapter or article forty-four of the public health law shall not be subject to a civil penalty prescribed in paragraph one of this subsection, if the superintendent determines that the insurer or organization or corporation has otherwise processed at least ninety-eight percent of the claims submitted in a calendar year in compliance with this section; provided, however, nothing in this paragraph shall limit, preclude or exempt an insurer or organization or corporation from payment of a claim and payment of interest pursuant to this section. This paragraph shall not apply to violations of this section determined by the superintendent resulting from individual complaints submitted to the superintendent by health care providers or policyholders."

Section 3224-a of the New York Insurance Law, "Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services" (the "Prompt Pay Law"), requires all insurers to pay undisputed electronic claims within thirty days of receipt, and undisputed paper or facsimile claims within forty-five days of receipt. If such undisputed claims are not paid within the designated timeframes, interest may be payable.

Statistical samples of claims not adjudicated within the designated timeframes by the companies were reviewed to determine whether the claims were processed in violation of the timeframe requirements of Section 3224-a(a) of the New York Insurance Law ("NYIL"), and if

interest was required, and appropriately paid, pursuant to Section 3224-a(c) of the NYIL. Accordingly, all electronic claims that were not adjudicated within 30 days, and all paper or facsimile claims that were not adjudicated within 45 days during the period January 1, 2011 through December 31, 2011, were segregated for each company. A statistical sample of this population was then selected to determine whether the claims were subject to interest, and whether such interest was properly calculated.

A "claim" is defined by Aetna as the total number of items submitted on a single claim form to which Aetna assigns a unique "claim number".

The claim populations for the companies were separated by legal entity, divided into "manual" and "electronic" submissions, and further divided into medical and hospital claim segments. A random statistical sample was drawn from each segment, for each entity. It should be noted that for the purpose of this analysis, medical costs characterized by Aetna as "Pharmacy", "Medicare", "Federal Employees Health Benefits", and "Capitated Payments", were excluded from the examiner's review.

Using ACL software, the examiner conducted an analysis of the aforementioned claims on Aetna's ACAS and HMO claim systems. The sample size for each population was comprised of 167 randomly selected unique claims, except where the population was less than 167, the entire population was selected. Additional random samples were generated for each group as "replacement items" in the event it was determined that a particular claim transaction selected in the sample was to be excluded. Accordingly, various replacement items were appropriately utilized. In total, 1,673 claims were selected for this review, 668 from AHI, 384 from AHIC and 621 from ALIC, (as detailed in the charts below).

The following charts illustrate the companies' compliance with the Prompt Pay Law, as determined by this examination:

AHI - Summary of Violations of Section 3224-a(a) of the New York Insurance Law

	Medical Claims over 30 days	Medical Claims over 45 days	Hospital Claims over 30 days	Hospital Claims over 45 days
Total population of claims	790,178	790,178	790,178	790,178
Population of claims adjudicated in violation of statute	11,487	1,091	2,429	212
Sample size	167	167	167	167
Number of claims with violations	144	132	158	130
Calculated violation rate	**86.23%**	**79.04%**	**94.61%**	**77.84%**
Upper violation limit	91.45%	85.22%	98.04%	84.14%
Lower violation limit	81.00%	72.87%	91.19%	71.55%
Calculated claims in violation	**9,905**	**862**	**2,298**	**165**
Upper limit claims in violation	10,505	930	2,381	178
Lower limit claims in violation	9,305	795	2,215	152

Note: The upper and lower violation limits represent the range of potential violation (e.g., if 100 samples were selected, the rate of violation would fall between these limits 95 times).

AHI - Summary of Violations of Section 3224-a(c) of the New York Insurance Law

	Medical Claims over 30 days	Medical Claims over 45 days	Hospital Claims over 30 days	Hospital Claims over 45 days
Total population of claims	790,178	790,178	790,178	790,178
Population of claims adjudicated in violation of statute	11,487	1,091	2,429	212
Sample size	167	167	167	167
Number of claims with violations	15	24	76	72
Calculated violation rate	**8.98%**	**14.37%**	**45.51%**	**43.11%**
Upper violation limit	13.32%	19.69%	53.06%	50.62%
Lower violation limit	4.65%	9.05%	37.96%	35.60%
Calculated claims in violation	**1,032**	**157**	**1,105**	**91**
Upper limit claims in violation	1,530	215	1,289	107
Lower limit claims in violation	534	99	922	75

Note: The upper and lower violation limits represent the range of potential violation (e.g., if 100 samples were selected, the rate of violation would fall between these limits 95 times).

AHIC - Summary of Violations of Section 3224-a(a) of the New York Insurance Law

	Medical Claims over 30 days	Medical Claims over 45 days	Hospital Claims over 30 days	Hospital Claims over 45 days
Total population of claims	30,469	30,469	30,469	30,469
Population of claims adjudicated in violation of statute	613	341	31	19
Sample size	167	167	31	19
Number of claims with violations	154	140	28	19
Calculated violation rate	**92.22%**	**83.83%**	**90.32%**	**100.0%**
Upper violation limit	96.28%	89.42%	100.0%	100.0%
Lower violation limit	88.15%	78.25%	79.91%	100.0%
Calculated claims in violation	**565**	**286**	**28**	**19**
Upper limit claims in violation	590	305	31	19
Lower limit claims in violation	540	267	25	19

Note: The upper and lower violation limits represent the range of potential violation (e.g., if 100 samples were selected, the rate of violation would fall between these limits 95 times).

AHIC - Summary of Violations of Section 3224-a(c) of the New York Insurance Law

	Medical Claims over 30 days	Medical Claims over 45 days	Hospital Claims over 30 days	Hospital Claims over 45 days
Total population of claims	30,469	30,469	30,469	30,469
Population of claims adjudicated in violation of statute	613	341	31	19
Sample size	167	167	31	19
Number of claims with violations	24	40	18	16
Calculated violation rate	**14.37%**	**23.95%**	**58.06%**	**84.21%**
Upper violation limit	19.69%	30.43%	75.44%	100.0%
Lower violation limit	9.05%	17.48%	40.69%	67.81%
Calculated claims in violation	**88**	**82**	**18**	**16**
Upper limit claims in violation	121	104	23	19
Lower limit claims in violation	55	60	13	13

Note: The upper and lower violation limits represent the range of potential violation (e.g., if 100 samples were selected, the rate of violation would fall between these limits 95 times).

ALIC - Summary of Violations of Section 3224-a(a) of the New York Insurance Law

	Medical Claims over 30 days	Medical Claims over 45 days	Hospital Claims over 30 days	Hospital Claims over 45 days
Total population of claims	1,528,926	1,528,926	1,528,926	1,528,926
Population of claims adjudicated in violation of statute	16,419	1,410	2,435	120
Sample size	167	167	167	120
Number of claims with violations	164	166	167	119
Calculated violation rate	**98.20%**	**99.40%**	**100.0%**	**99.17%**
Upper violation limit	100.0%	100.0%	100.0%	100.0%
Lower violation limit	96.19%	98.23%	100.0%	97.54%
Calculated claims in violation	**16,124**	**1,402**	**2,435**	**119**
Upper limit claims in violation	16,419	1,410	2,435	120
Lower limit claims in violation	15,793	1,385	2,435	117

Note: The upper and lower violation limits represent the range of potential violation (e.g., if 100 samples were selected, the rate of violation would fall between these limits 95 times).

ALIC - Summary of Violations of Section 3224-a(c) of the New York Insurance Law

	Medical Claims over 30 days	Medical Claims over 45 days	Hospital Claims over 30 days	Hospital Claims over 45 days
Total population of claims	1,528,926	1,528,926	1,528,926	1,528,926
Population of claims adjudicated in violation of statute	16,419	1,410	2,435	120
Sample size	167	167	167	120
Number of claims with violations	5	17	50	27
Calculated violation rate	**2.99%**	**10.18%**	**29.94%**	**22.50%**
Upper violation limit	5.58%	14.77%	36.89%	29.97%
Lower violation limit	0.41%	5.59%	22.99%	15.03%
Calculated claims in violation	**492**	**144**	**729**	**27**
Upper limit claims in violation	916	208	898	36
Lower limit claims in violation	67	79	560	18

Note: The upper and lower violation limits represent the range of potential violation (e.g., if 100 samples were selected, the rate of violation would fall between these limits 95 times).

It should be noted that the extrapolated number of violations relates to the population of claims used for the sample, which consisted of only those claims adjudicated more than thirty days (electronic claim submissions) and forty-five days (manual claim submissions) from receipt, during the period January 1, 2011 through December 31, 2011.

The Companies were not fully compliant with the provisions of Sections 3224-a(a), and (c) of the New York Insurance Law at the time of examination. It was determined that the number of claims that AHI, AHIC and ALIC processed in excess of the time limitations prescribed in Sections 3224-a(a) and (c) of the New York Insurance Law were 1.6743%, 2.9473% and 1.3133%, respectively. It should be noted that the number of claims that AHIC processed in excess of the time limitations prescribed in Sections 3224-a(a) and (c) exceeded the 2% threshold by 0.9473%.

It is recommended that AHI, AHIC and ALIC fully comply with the requirements of Section 3224-a(a) of the New York Insurance Law and make appropriate payment of all claims within the designated timeframes provided by the aforementioned section of the Insurance Law.

It is recommended that AHI, AHIC and ALIC fully comply with the requirements of Section 3224-a(c) and pay appropriate interest in those instances where the interest calculated pursuant to the aforementioned section of the Insurance Law is $2.00 or more.

A review was also performed as to determine whether Aetna processed claims (denied/requested additional information) in the time frame prescribed by Section 3224-a(b) of the New York Insurance Law.

A statistical sample of claims, processed through the Aetna HMO and ACAS claim systems, that were denied more than 30 calendar days after receipt by Aetna was reviewed to determine whether the denial was in violation of the timeframe requirements of Section 3224-a(b) of the New York Insurance Law. Accordingly, all claims on the two claim systems that were denied after 30 calendar days of receipt during the period January 1, 2011 through December 31, 2011, were segregated by legal entity. Statistical samples of these populations were then selected to determine compliance with the above mentioned statute.

The following charts illustrate AHI, AHIC and ALIC's compliance with Section 3224-a(b) of the New York Insurance Law, as determined by this examination:

AHI - Summary of Violations of Section 3224-a(b) of the New York Insurance Law

	Medical Claims	Hospital Claims
Total population of claims	790,178	790,178
Population of claims denied after 30 days of receipt	6,259	2,292
Sample size	167	167
Number of claims with violations	128	126
Calculated violation rate	**76.65%**	**75.45%**
Upper violation limit	83.06%	81.98%
Lower violation limit	70.23%	68.92%
Calculated claims in violation	**4,797**	**1,729**
Upper limit claims in violation	5,199	1,879
Lower limit claims in violation	4,396	1,580

Note: The upper and lower violation limits represent the range of potential violation (e.g., if 100 samples were selected, the rate of violation would fall between these limits 95 times).

AHIC - Summary of Violations of Section 3224-a(b) of the New York Insurance Law

	Medical Claims	Hospital Claims
Total population of claims	30,469	30,469
Population of claims denied after 30 days of receipt	957	26
Sample size	167	26
Number of claims with violations	150	16
Calculated violation rate	**89.82%**	**61.54%**
Upper violation limit	94.41%	80.24%
Lower violation limit	85.23%	42.84%
Calculated claims in violation	**860**	**16**
Upper limit claims in violation	903	21
Lower limit claims in violation	816	11

Note: The upper and lower violation limits represent the range of potential violation (e.g., if 100 samples were selected, the rate of violation would fall between these limits 95 times).

ALIC - Summary of Violations of Section 3224-a(b) of the New York Insurance Law

	Medical Claims	Hospital Claims
Total population of claims	1,528,926	1,528,926
Population of claims denied after 30 days of receipt	18,264	3,660
Sample size	167	167
Number of claims with violations	91	87
Calculated violation rate	**54.49%**	**52.10%**
Upper violation limit	62.04%	59.67%
Lower violation limit	46.94%	44.52%
Calculated claims in violation	**9,952**	**1,907**
Upper limit claims in violation	11,332	2,184
Lower limit claims in violation	8,573	1,629

Note: The upper and lower violation limits represent the range of potential violation (e.g., if 100 samples were selected, the rate of violation would fall between these limits 95 times).

It should be noted that the extrapolated number of violations relates to the population of claims used for the sample, which consisted of only those claims that were denied more than 30 calendar days after receipt during the period January 1, 2011 through December 31, 2011.

The Companies were not fully compliant with the provisions of Sections 3224-a(b) of the New York Insurance Law at the time of examination. It was determined that the number of claims that AHI, AHIC and ALIC denied more than 30 calendar days after receipt as prescribed in Section 3224-a(b) of the New York Insurance Law were 0.8259%, 2.8751% and 0.7756% respectively.

It is recommended that AHI, AHIC and ALIC fully comply with the requirements of Section 3224-a(b) of the New York Insurance Law and make appropriate denial of all claims within the designated timeframe provided by the aforementioned section of the Insurance Law.

9. COMPLIANCE WITH PRIOR MARKET CONDUCT REPORT ON EXAMINATION

The prior report on examination contained the following forty (40) comments and recommendations regarding market conduct items (The page numbers included in the table below refer to the prior report on examination).

ITEM NO.		PAGE NO.
	Circular Letter No. 9 (1999) – Adoption of Procedure Manuals	
1.	It is recommended that Aetna perform internal audit testing based on populations that are wholly derived from the New York entities to ensure that said populations are being handled in conformance with all applicable New York Insurance Laws and Regulations. *Aetna has complied with this recommendation.*	8
2.	It is recommended that the Aetna boards of directors comply with the requirements of Department Circular Letter No. 9 (1999) and adopt and maintain written procedures relative to claims operations and other key areas of Aetna's operations. While it is noted that Aetna does have written procedures in place, the numerous violations described within this report dictate that the written procedures be reviewed to ensure enhanced oversight is provided. *Aetna has complied with this recommendation.*	9
3.	It is further recommended that the Aetna boards of directors provide quarterly reports to this Department for an 18 month period, beginning 90 days after the filing date of this report, detailing what procedures / controls are (being) put in place to address the examination findings and recommendation included within this report on examination. *Aetna has complied with this recommendation.*	9

ITEM NO.		PAGE NO.
	Claims Review	
4.	It is recommended that AHI send EOBs to members in all cases in which EOBs are required to be issued pursuant to Section 3234(a) of the New York Insurance Law and Department Circular Letter No. 7 (2005). *Aetna has complied with this recommendation.*	10
5.	It is recommended that AHI modify its EOBs to comply with the requirements of New York Insurance Law §3234(b). *Aetna has complied with this recommendation.*	10
6.	It is recommended that the Company comply with the requirements of New York Insurance Law §3234(b)(5) and take steps to ensure that its EOBs are consistent, complete, and accurately describe all reductions from the billed amounts and member responsibilities. *Aetna has complied with this recommendation.*	11
7.	It is recommended that ALIC comply with the requirements of New York Insurance Law §3234(b) and ensure that each EOB clearly delineates all charges and describes in clear and concise language all reductions to the allowed amount. *Aetna has complied with this recommendation.*	11
8.	It is recommended that the HMO ensure that all of its contracted IPAs provide AHI members with EOBs that are in full compliance with Section 3234(b) of the New York Insurance Law. It is further recommended that AHI take the necessary steps to ensure that the work product of contracted IPAs complies with the requirements of all pertinent New York Insurance and Public Health Laws and Regulations of the Departments of Insurance and Health. *Aetna has complied with this recommendation.*	12

ITEM NO.		**PAGE NO.**
9.	It is recommended that Aetna comply with New York Insurance Laws §3234(b)(7), §3103(b) and §4904, and New York Public Health Law §4904, and offer New York appeal rights to members that have New York contracts, but who reside outside of New York State. *Aetna has complied with this recommendation.*	13
10.	It is recommended that Aetna's EOBs comply with the requirements of Section 3234(b)(7) of the New York Insurance Law and accurately describe Aetna's appeal process. *Aetna has complied with this recommendation.*	13
11.	It is further recommended that AHI and AHIC comply with the requirements of Section 3234 of the New York Insurance Law and issue EOBs in all cases as required. *Aetna has complied with this recommendation.*	13
12.	It is recommended that the HMO comply with its agreed upon procedure and send letters to all members whose non-participating providers are paid less than the billed amount. *Aetna has complied with this recommendation.*	15
	Prompt Pay Law	
13.	It is recommended that Aetna improve its internal claim procedures to ensure full compliance with Sections 3224-a(a), (b) and (c) of the New York Insurance Law. *Aetna has complied with this recommendation.*	17
	Utilization Review	
14.	It is recommended that Aetna comply with New York Insurance Law §4903(e) and submit written adverse determination notifications, when required, to all members. *Aetna has complied with this recommendation.*	17

ITEM NO.		PAGE NO.
15.	It is recommended that Aetna take steps to comply with the requirements of Article 49 of the New York Insurance Law, Part 98-2.9(e) of the Administrative Rules and Regulations of the New York Health Department (10 NYCRR 98-2), and Department Regulation No. 166 (11 NYCRR 410). *Aetna has complied with this recommendation.*	18
16.	It is recommended that the HMO perform audits of its utilization review cases and appeals, verifying its compliance with New York Department of Insurance and Department of Health statutes and regulations. *Aetna has complied with this recommendation.*	19
17.	It is recommended that Aetna provide expedited appeals when such are requested by a provider within the limits of Section 4903(f) of the New York Insurance Law. *Aetna has complied with this recommendation.*	19
18.	It is recommended that AHI issue final adverse determination letters that comply with the requirements of Part 98-2.9(e) of the Administrative Rules and Regulations of the New York Health Department (10 NYCRR 98-2.9(e)). *Aetna has complied with this recommendation.*	20
19.	It is recommended that Aetna notify members of the rights of their providers to receive expedited appeals for concurrent care claims of claims for prospective treatment when a provider believes an immediate appeal is warranted. *Aetna has complied with this recommendation.*	20
20.	It is recommended that the HMO change the name of its internal External Review appeal process in order to avoid confusion with the New York State mandated External Appeal process. *Aetna has complied with this recommendation.*	21
21.	It is recommended that Aetna change its on-line definition of “Adverse Determination” to include all of the conditions prescribed by Section 4904(b) of the New York Insurance Law. *Aetna has complied with this recommendation.*	21

ITEM NO.		PAGE NO.
	Complaints and Grievances	
22.	It is recommended that AHI comply with New York Public Health Law §4408-a(4) and submit acknowledgement letters for all complaints, within fifteenth business days of their receipt. *Aetna has complied with this recommendation.*	22
23.	It is recommended that AHI take steps to ensure that claims denied as not a covered benefit are in fact not eligible for the right to utilization review. *Aetna has complied with this recommendation.*	22
	Disclosure of Information	
24.	It is recommended that the AHI and AHIC Provider Directory indicate on its cover that benefit and requirement information is included within such Provider Directory. *Aetna has complied with this recommendation.*	25
25.	It is recommended that AHI and AHIC amend the language of their Certificates of Coverage to ensure that the documents describe procedures that are in compliance with Articles 44 and 49 of the New York Public Health Law for the HMO and Article 49 of the New York Insurance Law for AHIC. It is further recommended that AHI and AHIC issue letters to current members that received a version of the improperly worded contract that clarify their rights. *Aetna has complied with this recommendation.*	26
26.	It is recommended that AHI comply with the requirements of Section 4408(1)(c)(viii) of the New York Public Health Law and AHIC comply with the requirements of New York Insurance Law §3217-a and disseminate required information to all prospective, new and existing members as described within such sections of the New York Public Health Law and New York Insurance Law. *Aetna has complied with this recommendation.*	28

ITEM NO.		PAGE NO.
27.	It is recommended that AHI and AHIC review all of the documents being provided to prospective, new and existing members to ensure that each document describes processes that are in accordance with Section 4408(1)(c)(viii) of the New York Public Health Law and Sections 3217-a and 4324 of the New York Insurance Law, with its own procedures and with each respective document. *Aetna has complied with this recommendation.*	28
28.	Attaching the appeals and grievance procedures to an approved document and including the form number on the unapproved portion of the document can create confusion in the member's mind about which portion of the document is approved and which is not, thus the practice should be discontinued. *Aetna has complied with this recommendation.*	30
29.	It is recommended that ALIC comply with the requirements of Section 3217-a of the New York Insurance Law and clearly communicate Appeal and External Appeal rights to its members. *Aetna has complied with this recommendation.*	32
30.	It is recommended that Aetna comply with New York Insurance Law Section 3217-a and ensure that, upon request, each prospective subscriber is provided with the required written disclosure information in a timely manner. *Aetna has complied with this recommendation.*	32
	Agents and Brokers	
31.	It is recommended that Aetna maintains copies of the licenses of the agents and brokers with whom it conducts business, within its records, in compliance with Part 243.2(b)(5) of Department Regulation No. 152 (11 NYCRR 243.2). *Aetna has complied with this recommendation.*	33

ITEM NO.		PAGE NO.
	Independent Practice Associations / Third Party Administrators	
32.	It is recommended that AHI ensure that ACN comply with United States Department of Labor Regulation No. 29 CFR 2560.503-1(f)(2)(iii)(B) and provide forty-five day notices for members to submit additional information, or communicate that failure to provide the additional information will result in an automatic denial. It is further recommended that, for the examination period, where ACN denied claims because medical information was not filed timely, but such information had been filed within the statutory time frame, ACN retroactively reconsider the claims for payment and pay interest, where appropriate. *Aetna has complied with this recommendation.*	34
	Aetna's Website	
33.	It is recommended that Aetna provide information about the availability of and the eligibility requirements for Healthy New York on the "Buy Direct" New York section of its website. It is further recommended that Aetna correct the link within its Healthy New York brochure so that it takes members to the official Healthy New York website. *Aetna has complied with this recommendation.*	35
	Pharmacy Benefits Manager	
34.	It is recommended that Aetna comply with their member contracts and require members to pay for the cost difference between a name brand drug and an approved generic alternative when the member opts to receive the higher cost name brand alternative. *Aetna has complied with this recommendation.*	38
35.	It is recommended that Aetna revise its policy so that members can obtain a generic drug in cases where it is no more costly to them, than the drug contained in APM's formulary. *Aetna has complied with this recommendation.*	40

ITEM NO.		PAGE NO.
36.	It is recommended that the PBM require its member pharmacies to comply with the contracts and submit to the PBM the usual and customary charge for the drug being dispensed. *Aetna has complied with this recommendation.*	41
37.	It is recommended that the PBM utilize the pricing source specified in its executed contracts. *Aetna has complied with this recommendation.*	41
38.	It is recommended that APM take steps to ensure that its drug pricing is accurate. *Aetna has complied with this recommendation.*	42
39.	It is recommended that APM update its provider contracts and files to ensure they are organized and complete. *Aetna has complied with this recommendation.*	43
40.	It is recommended that APM complies with Section 243.2(b)(4) of Department Regulation No. 152 by retaining all documentation for a period of six years, or until after the filing of the report on examination, whichever is longer. It is also recommended that APM complies with the requirements of Section 216.11 of Department Regulation No. 64 retaining all aspects of its claims so that the examiner can reconstruct the complete claim transaction. *Aetna has complied with this recommendation.*	43

10. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM			PAGE NO.
A.		Utilization Review	
	i.	It is recommended that AHIC ensure that Aetna Health Management file the required biennial utilization review reports on its behalf with the Superintendent, as required by Section 4901(a) of the New York Insurance Law.	7
	ii.	It is recommended that AHI comply with the provisions of Section 4903(2) of the New York State Public Health Law, and ALIC comply with the provisions of Section 4903(b) of the New York Insurance Law, by making prospective determinations for services requiring pre-authorization within three business days of receipt of the necessary information.	9
	iii	It is recommended that ALIC comply with the provisions of Section 4903(c) of the New York Insurance Law by making concurrent determinations for continued services within one business day of receipt of the necessary information.	11
	iv.	It is recommended that AHI comply with the provisions of Section 4904(3) of the New York Public Health Law by providing written acknowledgement of the filing of the appeal to the appealing party within fifteen days of such filing.	12
	v.	It is also recommended that AHI report only Utilization Review Appeals in Schedule M, Table 2 of its New York Annual Statement Supplement filings.	12
B.		Complaints and Grievances	
	i.	It is recommended that the Companies review and revise their procedures to classify members' inquiries as "complaints" and as "grievances," in accordance with the provisions of Section 4802(a) of the New York Insurance Law and Section 4408-a(1) of the New York Public Health Law.	13
	ii.	It is also recommended that the Companies ensure that grievances are accurately classified and properly reported in Schedule M of their filed Annual Statements.	13

ITEM		PAGE NO.
iii.	It is further recommended that the Companies include final resolution letters for complaints within the applicable case files.	13
C.	Record Retention	
	It is recommended that AHIC maintain a record for each policy for six calendar years after the date the policy is no longer in force or until after the filing of the report on examination in which the record was subject to review, whichever is longer, in accordance with Part 243.2(b)(1) of Department Regulation No. 152.	14
D.	Claims Attributes Review	
i.	It is recommended that the Companies issue denial codes on explanation of benefits statements ("EOBs") that accurately reflect the reason(s) for denial, in compliance with the requirements of Sections 3234(b)(6) and 3234(b)(7) of the New York Insurance Law.	17
ii.	It is recommended that the Companies comply with policy provisions and their own policies and procedures by properly applying authorizations.	17
iii.	It is recommended that the Companies accurately apply co-payments and deductibles in accordance with contractual provisions and comply with their own policies and procedures.	17
E.	Standards for prompt, fair and equitable settlement of claims for health care and payments for Health care services ("prompt pay law")	
i.	It is recommended that AHI, AHIC and ALIC fully comply with the requirements of Section 3224-a(a) of the New York Insurance Law and make appropriate payment of all claims within the designated timeframes provided by the aforementioned section of the Insurance Law.	24
ii.	It is recommended that AHI, AHIC and ALIC fully comply with the requirements of Section 3224-a(c) and pay appropriate interest in those instances where the interest calculated pursuant to the aforementioned section of the Insurance Law is $2.00 or more.	24

ITEM		PAGE NO.
iii.	It is recommended that AHI, AHIC and ALIC fully comply with the requirements of Section 3224-a(b) of the New York Insurance Law and make appropriate denial of all claims within the designated timeframe provided by the aforementioned section of the Insurance Law.	27

Respectfully submitted,

________/P/_______________
Pearson A. Griffith
Principal Insurance Examiner

STATE OF NEW YORK)
)SS.
)
COUNTY OF NEW YORK)

PEARSON A. GRIFFITH, being duly sworn, deposes and says that the foregoing report submitted by him is true to the best of his knowledge and belief.

________/P/_______________
Pearson A. Griffith,

Subscribed and sworn to before me

this ______day of ____________________2014.

Appointment No. **30714**

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, **James J. Wrynn**, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Pearson Griffith

as a proper person to examine into the affairs of the

Aetna Health Insurance Company of New York

and to make a report to me in writing of the condition of the said

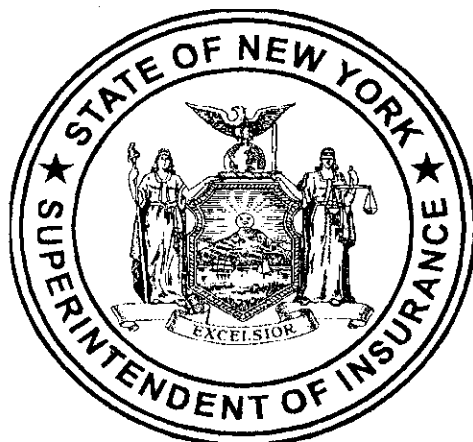
Company

with such other information as he shall deem requisite.

In Witness Whereof, I have hereunto subscribed by name and affixed the official Seal of this Department, at the City of New York.

This 29th day of April, 2011

James J. Wrynn
Superintendent of Insurance



Appointment No. **30716**

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, **James J. Wrynn**, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Pearson Griffith

as a proper person to examine into the affairs of the

Aetna Health, Inc. (a New York Corporation)

and to make a report to me in writing of the condition of the said

HMO

with such other information as he shall deem requisite.

In Witness Whereof, I have hereunto subscribed by name and affixed the official Seal of this Department, at the City of New York.

This 29th day of April, 2011

James J. Wrynn
Superintendent of Insurance

Appointment No. **30717**

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, **James J. Wrynn**, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Pearson Griffith

as a proper person to examine into the affairs of the

Aetna Life Insurance Company

and to make a report to me in writing of the condition of the said

Company

with such other information as he shall deem requisite.

In Witness Whereof, I have hereunto subscribed by name and affixed the official Seal of this Department, at the City of New York.

This 29th day of April, 2011

James J. Wrynn
Superintendent of Insurance