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, 2015

DATE OF REPORT **JANUARY 29, 2018**

EXAMINER **JEFFREY USHER, CFE**

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Andrew M. Cuomo
Governor

Maria T. Vullo
Superintendent

January 29, 2018

Honorable Maria T. Vullo
Superintendent of Financial Services
Albany, New York 12257

Madam:

Pursuant to the requirements of the New York Insurance Law and acting in accordance with the instructions contained in Appointment Numbers 31344, 31345, and 31346 dated April 17, 2015, annexed hereto, I have made an examination as of December 31, 2015, 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, an accident and 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, and submit the following report thereon.

The examination was conducted at the administrative offices of Aetna Inc., the ultimate parent company of the above three (affiliated) companies, located at 151 Farmington Avenue, Hartford, Connecticut, and 1425 Union Meeting 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 designations “AHIC” or the “Company” appear 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 refer to Aetna Life Insurance Company.

Wherever the terms “Aetna” or the “Aetna Companies” appear herein, without qualification, they should be understood to refer to the three companies under examination (AHI, AHIC and ALIC) collectively.

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

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 was conducted as of December 31, 2011. 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 covered the four-year period from January 1, 2012 to December 31, 2015. 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 Aetna 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, 2014, and separate reports on examination will be issued thereon.

2. 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 its present name, 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 of 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.

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 within New York State, as these terms are defined within Section 1113(a) of the New York Insurance Law. At the time of this examination ALIC wrote Preferred Provider Organization (PPO) and POS business within New York State.

Any reference in this report made to the New York Insurance Laws shall apply to the ALIC, AHI and AHIC entities unless reference is also made to the New York Public Health Law, which shall apply to the AHI entity only.

3. PROMPT PAY LAW

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" ("Prompt Pay Law"), requires all insurers to pay undisputed claims within 30 days of receipt of a claim that is transmitted via the internet or electronic mail or within 45 days of receipt for a claim submitted by other means such as paper or facsimile. If such undisputed claims are not paid within the respective 30 or 45 days of receipt, interest may be payable.

A review of the Aetna Companies' compliance with Section 3224-a, was conducted during the examination. Although there were instances of certain claims being paid beyond 30 or 45 days of receipt, such instances for each entity did not exceed the ninety-eight percent (98%) threshold of claims processed in compliance with Section 3224-a of the Insurance Law.

4. UNDERWRITING AND RATING

Experience Rating

Part 52.40(f) of Insurance Regulation No. 62 (11 NYCRR 52.40) states in part:

> "Experience-rated group insurance of insurers other than article 43 corporations. The following rules shall apply to the readjustment of the rate of premium for those policies rated in accordance with subsections (g), (h) and (j) of section 4235 of the Insurance Law.
>
> (1) Policies may be experience-rated in accordance with a written plan or formula approved by the board of directors of the insurer or designee thereof..."

During the examiner's review of the underwriting and rating of Aetna Companies large group policy premiums, a review of Aetna's board minutes for 2013, 2014 and 2015 for all three companies under examination showed that during 2015, the board did not approve the experience rating formulas.

It is recommended that Aetna Companies comply with Part 52.40(f) of Insurance Regulation No. 62 (11 NYCRR 52.40) and obtain pre-approval from its board of directors for its experience rating formulas prior to the implementation of such formulas.

Group Size Determination

The examiner reviewed the procedures followed by Aetna to confirm the group size of an employer. It was noted that the confirmation of a group size can be fully supported with tax documents 1094-C and 1095-C. Aetna relies on the fraud warning statement in the application and the employer's representation that group size in the application is correct. In a sample of ten (10) small group employers, Aetna was unable to provide documentation to support the group size of the employers.

It is recommended, that as a good business practice, Aetna use and maintain within it files, federal tax documents 1094-C and 1095-C as support to validate and classify the group size of employers.

5. PATIENT PROTECTION AND AFFORDABLE CARE ACT (the "PPACA")

The Patient Protection and Affordable Care Act was passed by Congress and then signed into law by the President of the United States on March 23, 2010. Key features of the PPACA include consumer protections, improvement of quality and lowering costs of health care services and increasing access to affordable health care. In this regard, existing New York laws, were revised to reflect applicable provisions of the PPACA.

Preventive Services

Section 3216(i)(17)(C) and (E) of the New York Insurance Law, "Individual accident and health insurance policy provisions," requires that certain preventive services shall not be subject to annual deductibles or coinsurance.

Section 3216(i)(17) of the New York Insurance Law states in part:

> "(17)(A) Every policy that provides medical, major-medical or similar comprehensive-type coverage shall provide coverage for the provision of preventive and primary care services.
> (B) For the purposes of subparagraphs (A), (C) and (D) of this paragraph, preventive and primary care services means the following services rendered to a covered child of an insured from the date of birth through the attainment of nineteen years;…
> **(C) Such coverage required pursuant to subparagraph (A) or (B) of this paragraph shall not be subject to annual deductibles or coinsurance.**

(D) Such coverage required pursuant to subparagraph (A) or (B) of this paragraph shall not restrict or eliminate existing coverage provided by the policy.

(E) In addition to subparagraph (A), (B), (C) or (D) of this paragraph, every policy that provides hospital, surgical or medical care coverage, except for a grandfathered health plan under subparagraph (F) of this paragraph, shall provide coverage for the following preventive care and screenings for insureds, and such coverage shall not be subject to annual deductibles or coinsurance:
(i) evidence-based items or services for preventive care and screenings that have in effect a rating of 'A' or 'B' in the current recommendations of the United States preventive services task force;
(ii) immunizations that have in effect a recommendation from the advisory committee on immunization practices of the centers for disease control and prevention with respect to the individual involved;
(iii) with respect to children, including infants and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the health resources and services administration; and
(iv) with respect to women, such additional preventive care and screenings not described in item (i) of this subparagraph and as provided for in comprehensive guidelines supported by the health resources and services administration."

Sections 3221(l)(8)(D) and (E) of the New York Insurance Law, "Group or blanket accident and health insurance policies; standard provisions," require that certain preventive services shall not be subject to annual deductibles or coinsurance.

Section 3221(l) of the New York Insurance Law states in part:

"(8)(A) Every insurer issuing a group policy for delivery in this state that provides medical, major-medical or similar comprehensive-type coverage shall provide coverage for the provision of preventive and primary care services.
(B) In subparagraphs (A), (C) and (D) of this paragraph, preventive and primary care services means the following services rendered to a covered child of an insured from the date of birth through the attainment of nineteen years of age: …
(C) Such coverage required pursuant to subparagraph (A) or (B) of this paragraph shall not be subject to annual deductibles or coinsurance.
(D) Such coverage required pursuant to subparagraph (A) or (B) of this paragraph shall not restrict or eliminate existing coverage provided by the policy.
(E) In addition to subparagraph (A), (B), (C) or (D) of this paragraph, every group policy that provides hospital, surgical or medical care coverage, except for a grandfathered health plan under subparagraph (G) of this paragraph, shall provide coverage for the following preventive care and screenings for insureds, and such coverage shall not be subject to annual deductibles or coinsurance:

> (i) evidence-based items or services for preventive care and screenings that have in effect a rating of 'A' or 'B' in the current recommendations of the United States preventive services task force;
> (ii) immunizations that have in effect a recommendation from the advisory committee on immunization practices of the centers for disease control and prevention with respect to the individual involved;
> (iii) with respect to children, including infants and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the health resources and services administration; and
> (iv) with respect to women, such additional preventive care and screenings not described in item (i) of this subparagraph and as provided for in comprehensive guidelines supported by the health resources and services administration.
> (F) The requirements of this paragraph shall also be applicable to a blanket policy of hospital, medical or surgical expense insurance covering students pursuant to subparagraph (C) of paragraph three of subsection (a) of section four thousand two hundred thirty-seven of this chapter.
> (G) For purposes of this paragraph, "grandfathered health plan" means coverage provided by an insurer in which an individual was enrolled on March twenty-third, two thousand ten for as long as the coverage maintains grandfathered status in accordance with section 1251(e) of the Affordable Care Act, 42 U.S.C. § 18011(e)."

Section 4303(j)(3) of the New York Insurance Law, "Benefits" , requires a health service corporation and a medical expense indemnity company to provide coverage to insured's for certain preventive services and shall not be subject to annual deductibles or coinsurance.

Section 4303(j)(3) of the New York Insurance Law states in part:

> "(j)(1) A health service corporation or medical expense indemnity corporation that provides medical, major-medical or similar comprehensive-type coverage shall provide coverage for the provision of preventive and primary care services.
>
> (2) For purposes of this paragraph and paragraph one of this subsection, preventive and primary care services shall mean the following services rendered to a covered child of a subscriber from the date of birth through the attainment of nineteen years of age:
>
> (A) an initial hospital check-up and well-child visits scheduled in accordance with the prevailing clinical standards of a national association of pediatric physicians designated by the commissioner of health (except for any standard that would limit the specialty or forum of licensure of the practitioner providing the service other than the limits under state law). Coverage for such services rendered shall be provided only to the extent that such services are provided by or under the supervision of a physician, or other professional licensed under article one hundred thirty-nine of the education law whose scope of practice pursuant to such law

includes the authority to provide the specified services. Coverage shall be provided for such services rendered in a hospital, as defined in section twenty-eight hundred one of the public health law, or in an office of a physician or other professional licensed under article one hundred thirty-nine of the education law whose scope of practice pursuant to such law includes the authority to provide the specified services,

(B) at each visit, services in accordance with the prevailing clinical standards of such designated association, including a medical history, a complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests which tests are ordered at the time of the visit and performed in the practitioner's office, as authorized by law, or in a clinical laboratory, and

(C) necessary immunizations, as determined by the superintendent in consultation with the commissioner of health, consisting of at least adequate dosages of vaccine against diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, haemophilus influenzae type b and hepatitis b, which meet the standards approved by the United States public health service for such biological products.

(D) Such coverage required pursuant to this paragraph and paragraph one of this subsection shall not be subject to annual deductibles or coinsurance.

(E) Such coverage required pursuant to this paragraph and paragraph one of this subsection shall not restrict or eliminate existing coverage provided by the contract.

(3) In addition to paragraph one or two of this subsection, every contract that provides hospital, surgical or medical care coverage, except for a grandfathered health plan under paragraph four of this subsection, shall provide coverage for the following preventive care and screenings for subscribers, and such coverage shall not be subject to annual deductibles or coinsurance:

(A) evidence-based items or services for preventive care and screenings that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States preventive services task force;

(B) immunizations that have in effect a recommendation from the advisory committee on immunization practices of the centers for disease control and prevention with respect to the individual involved;

(C) with respect to children, including infants and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the health resources and services administration; and

> (D) with respect to women, such additional preventive care and screenings not described in subparagraph (A) of this paragraph and as provided for in comprehensive guidelines supported by the health resources and services administration."

In addition, the following sections of the Patient Protection and Affordable Care Act also contain requirements regarding payments relative to preventive services.

42 U.S.C. § 300gg -13 states the following, in part:

> "§ 300gg–13. Coverage of preventive health services
> (a) In general a group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide coverage for and shall not impose any cost sharing requirements for—(1) evidence-based items or services that have in effect a rating of ''A'' or ''B'' in the current recommendations of the United States Preventive Services Task Force; (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and (3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, (4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph."

45 C.F.R. § 147.130 states the following, in part:

> "§ 147.130 Coverage of preventive health services.
> (a) Services—(1) In general. Beginning at the time described in paragraph (b) of this section, a group health plan, or a health insurance issuer offering group or individual health insurance coverage, must provide coverage for all of the following items and services, and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) with respect to those items or services:
> (i) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved (except as otherwise provided in paragraph (c) of this section);
> (ii) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for

routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

The Patient Protection and Affordable Care Act mandates require health plans to provide at a minimum, coverage without cost-sharing, relative to preventive services rated A or B by the U.S. Preventive Services Task Force ("USPSTF"). Such preventive services include recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women.

The examiner reviewed 70 elements of the total population of preventive services identified by the USPSTF. The examiner reviewed the claims from the aforementioned 70 elements for co-pay, deductible and coinsurance costs attributed to the member.

Upon request the company provided a preventive service claims payment policy giving instructions to providers filing preventive service claims. It was noted during the review of the claims payment policy that the "Falls Prevention" mandate, as shown below, was effective May 2012 and was not included within Aetna's payment policy instructions to the provider. This preventive service is identified by the USPSTF with a B rating and requires health plans to provide coverage without cost-sharing.

Fall prevention:

Falls prevention in older adults: exercise or physical therapy	The USPSTF recommends exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.

The examiner received separate data files by source system from the Aetna Companies. Samples were selected per source system (and separately for denied and paid claims within the source system, where appropriate). The examiner extracted from the data files all preventive service claims with cost sharing.

For 2014, in agreement with the Aetna Companies, the examiner extracted samples for review from the source systems with larger populations of preventive service claims with cost sharing, all claims with one diagnosis code. For the source systems with smaller populations of preventive service claims with cost sharing, the examiner sampled 100% of the preventive service claims with cost sharing.

For 2015, in agreement with the Aetna Companies, the examiner extracted a sample of 167 claims for review from the larger populations of preventive service claims with cost sharing. The findings from the large populations of 167 claims were extrapolated into the total populations of each system source. For the smaller populations the examiner sampled 100% of the preventive service claims with cost sharing.

For years 2014 and 2015, the examiners noted 2,345 and 2,731 claim instances, respectively, in which the Aetna Companies applied cost sharing to a preventive service claims in error or the claims were denied in error, in violation of the above mentioned sections of state and federal laws.

See the charts below for the source systems by company, sample review populations, error total and the types of errors:

2014	Source System Type	ALIC	AHI	AHIC	Total Violations
	ACAS	3,973	367	35	
	ASH	2,639			
	SRC	1,490			
	Pharmacy	11,943	2,875		
Total Reviewed		**20,045**	**3,242**	**35**	
Total Errors		**2,109**	**219**	**17**	**2,345**
Types of Errors					
Processor (Manual)		512	5	17	
Setup of Group Benefit Plan		239	78		
System Configuration		1,358	136		

2015			ALIC		
System Type	Total Population	Total reviewed	Errors	Error Rate	Total Violations
ACAS Denied	29,812	167	3	1.80%	537
ACAS Paid	30,001	167	9	5.39%	1,617
ASH	1,768	167	22	13.17%	233
Pharmacy	1,665	167	33	19.76%	329
Total Errors					**2,716**
Types of Errors					
Processor (Manual)			17		
Setup of Group Benefit Plan			4		
System Configuration			46		

2015			AHI
System Type	Total Population	Total reviewed	Total Violations
HMO	34	34	2
ACAS Paid	319	319	12
Pharmacy	37	37	1
Total Errors			**15**
Type of Errors			
Processor (Manual)			1
Setup of Group Benefit Plan			4
System Configuration			10

It was noted during the examiner's review that in some cases the Aetna Companies did not follow its established claims payment policy. The applicable claim lines data reviewed included the correct information (procedure code, diagnosis code, etc.) in accordance with Aetna's claims payment policy; however, Aetna erroneously applied cost sharing or denied the claim.

It is recommended that the Aetna Companies comply with the above stated sections of the New York Insurance Law and Federal Patient Protection and Affordable Care Act relative to preventive services.

It is recommended that the Aetna Companies update their claims payment policy procedures to include all preventive services and the associated procedure codes, including diagnosis codes and modifiers which identify such preventive services.

It is also recommended that the Aetna Companies pay claims for preventive services in accordance with their established payment policy and the above stated sections of the New York Insurance Law and Federal Patient Protection and Affordable Care Act.

It is further recommended that the Aetna Companies monitor the effectiveness of their payment policy in conjunction with actual claims paid.

The Aetna Companies indicated that a large portion of the aforementioned errors were due to configuration changes (systematic) within the claim systems including reference information (procedure code and diagnosis codes), and customer benefit plan set-up. Also, a small portion of the errors identified were manual errors made by the Aetna Companies' claims processors.

It is recommended that the Aetna Companies make the necessary configuration changes to reflect the appropriate reference information and customer benefit plans.

It is also recommended that the Aetna Companies appropriately train their claims processors.

6. UTILIZATION REVIEW

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."

Section 4903(2) of the New York Public Health Law which 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 enrollees health care provider by telephone and in writing within three business days of receipt of the necessary information.

The Aetna Companies have three third party administrators ("TPA") CareCore National, LLC, ("CareCore"), OptumHealth Care Solutions, Inc. ("Optum") and Orthonet, LLC ("Orthonet"). They are assigned as utilization review agents to conduct and provide utilization review services. This is in addition to the in-house utilization reviews by the Aetna Companies. The examiners have reviewed 2015 Utilization Review and Appeal cases of the Aetna companies and their TPA's.

The examiner noted an instance in which AHI failed to make prospective determinations for services requiring pre-authorization within three business days. The examiner also noted instances in which ALIC failed to make a prospective determination for services requiring pre-authorization within three business days. The examiner noted an instance in which AHIC failed to make a prospective determination for services requiring pre-authorization within three business days. The examiner also noted an instance in which CareCore, Aetna's utilization review TPA failed to make a prospective determination for services requiring pre-authorization within three business days.

It is recommended that AHI comply with the provisions of Section 4903(2) of the New York Public Health Law by making prospective determinations for services requiring pre-authorization within three (3) business days of receipt of the necessary information.

It is recommended that ALIC, AHIC and their TPA, CareCore 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 (3) business days of receipt of the necessary information.

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."

Section 4903(4) of the New York Public Health 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."

The examiner noted that in seven (7) instances of the thirty-one (31) utilization review cases reviewed, AHI failed to provide a determination for services within 30 days of receipt of the necessary information. The examiner also noted that in four (4) instances of the twenty (20) cases reviewed, ALIC failed to provide a determination for services within 30 days. The examiner also noted one (1) instance in which CareCore failed to provide a determination for services on ALIC's behalf within thirty (30) days.

It is recommended that AHI comply with the requirements of Section 4903(4) of the New York Public Health Law by sending the initial adverse determinations to the insured and the provider within the thirty (30) day time frame.

It is recommended that ALIC and its TPA, CareCore, comply with the requirements of Section 4903(d) of the New York Insurance Law by sending the initial adverse determinations to the insured and the provider within the thirty (30) day time frame.

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

> "In the event that a utilization review agent renders an adverse determination without attempting to discuss such matter with the insured's health care provider who specifically recommended the health care service, procedure or treatment under review, such health care provider shall have the opportunity to request a reconsideration of the adverse determination…"

Section 4903.6 of the New York Public Health Law states:

> "In the event that a utilization review agent renders an adverse determination without attempting to discuss such matter with the insured's health care provider who specifically recommended the health care service, procedure or treatment under review, such health care provider shall have the opportunity to request a reconsideration of the adverse determination…"

In eighty-six (86) of the one hundred seventy four (174) cases reviewed, the Aetna Companies and their TPAs included language in the initial adverse determination letters that limited the timeframe for providers to request a reconsideration to fourteen (14) days, in violation of the above stated laws.

It is recommended that the Aetna Companies and their TPAs comply with the requirements of Section 4903(f) of the New York Insurance Law and Section 4903(6) of the New York Public Health Law and remove the fourteen (14) day time frame from their initial adverse determination letters.

Sections 4904(c) and (c)(2) of the New York Insurance Law state 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 and shall make a determination with regard to the appeal within sixty days of the receipt of necessary information to conduct the appeal. The utilization review agent shall notify the insured, the insured's designee and, where appropriate, the insured's health care provider, in writing of the appeal determination within two business days of the rendering of such determination…"

The notice of the appeal determination shall include:

> (2) a notice of the insured's right to an external appeal together with a description, jointly promulgated by the superintendent and the commissioner of health as required pursuant to subsection (e) of section four thousand nine hundred fourteen of this article, of the external appeal process established pursuant to title two of this article and the time frames for such external appeals.

Sections 4904(3) and (3)(b) of the New York Public Health Law state 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 and shall make a determination with regard to the appeal within sixty days of the receipt of necessary information to conduct the appeal. The utilization review agent shall notify the insured, the insured's designee and, where appropriate, the insured's health care provider, in writing of the appeal determination within two business days of the rendering of such determination…"

The notice of the appeal determination shall include:

> (b) a notice of the insured's right to an external appeal together with a description, jointly promulgated by the superintendent and the commissioner of health as required pursuant to subsection (e) of section four thousand nine hundred fourteen of this article, of the external appeal process established pursuant to title two of this article and the time frames for such external appeals.

Section 4904(e) of the New York Insurance Law states:

> (e) Failure by the utilization review agent to make a determination within the applicable time periods in this section shall be deemed to be a reversal of the utilization review agent's adverse determination.

Section 4904 (5) of the New York Public Health Law states:

> (5) Failure by the utilization review agent to make a determination within the applicable time periods in this section shall be deemed to be a reversal of the utilization review agent's adverse determination.

Of fifty (50) appeal cases reviewed, there were four (4) instances where ALIC failed to provide written acknowledgement to the appealing party within fifteen (15) days. Of forty-six (46) appeal cases reviewed, there were four (4) instances where AHIC failed to provide written

acknowledgement to the appealing party within fifteen (15) days. Of fifty (50) appeal cases reviewed, there were five (5) instances where AHI failed to provide written acknowledgement to the appealing party within fifteen (15) days.

Of fifty (50) appeal cases reviewed, there were seven (7) instances where ALIC failed to make a determination within sixty (60) days of the receipt of necessary information to conduct the appeal. Of fifty (50) appeal cases reviewed, there were eleven (11) instances where Aetna Health Inc., failed to make a determination within sixty (60) days of the receipt of necessary information to conduct the appeal. In seven (7) instances Of forty-six (46) appeal cases reviewed, there were seven (7) instances where Aetna Health Insurance Company failed to make a determination within sixty (60) days of the receipt of necessary information to conduct the appeal. It was also noted of seven (7) appeal cases reviewed, there were four (4) instances for ALIC, of eleven (11) appeal cases reviewed there were three (3) instances for AHI and of nine (9) appeal cases reviewed, there were three (3) instances for AHIC, which the appeal cases were not reversed in violation of Section 4904(e) of the Insurance Law and Section 4904(5) of the New York Public Health Law.

Of fifty (50) appeal cases reviewed, there were nine (9) instances where Aetna Life Insurance Company failed to notify the insured, the insured's designee and, where appropriate, the insured's health care provider, in writing of the appeal determination within two (2) business days of the rendering of such determination. Of forty-six (46) appeal cases reviewed, there were ten (10) instances where Aetna Health Insurance Company failed to notify the insured, the insured's designee and, where appropriate, the insured's health care provider, in writing of the appeal determination within two business days of the rendering of such determination. Of fifty (50) appeal cases reviewed, there were twenty-two (22) instances where Aetna Health Inc., failed to

notify the insured, the insured's designee and, where appropriate, the insured's health care provider, in writing of the appeal determination within two (2) business days of the rendering of such determination.

It is recommended that AHIC and ALIC comply with the requirements of Section 4904(c) of the New York Insurance Law by sending acknowledgement letters within fifteen (15) days, sending the appeal determination within sixty (60) days of receiving the necessary information to conduct the appeal and sending, in writing, the appeal determination within two (2) business days after rendering a determination.

It is recommended that AHI comply with the requirements of Section 4904(3) of the New York Public Health Law by sending the acknowledgement letters within fifteen (15) days, sending the appeal determination within sixty (60) days of receiving the necessary information to conduct the appeal and sending in writing, the appeal determination within two (2) business days after rendering a determination.

It is recommended that Aetna Companies comply with the requirements of Section 4904(e) of the New York Insurance Law and Section 4904(5) of the New York Public Health Law by reversing the adverse determination if they fail to make a determination within the applicable time frame.

Of fifty (50) appeal cases reviewed, there were four (4) instances where Aetna Life Insurance Company failed to include a notice of the insured's right to an external appeal and the timeframes for such external appeal. Of forty-six (46) appeal cases reviewed, there were four (4) instances where Aetna Health Insurance Company failed to include a notice of the insured's right

to an external appeal and the timeframes for such external appeal. Of fifty (50) appeal cases reviewed, there were two (2) instances where Aetna Health Inc. failed to include a notice of the insured's right to an external appeal and the timeframes for filing such external appeal.

It is recommended that ALIC and AHIC comply with the requirements of Section 4904(c)(2) of the New York Insurance Law by including the external appeal rights (with the timeframes to request an external appeal) in all final adverse determination letters.

It is recommended that AHI comply with the requirements of Section 4904.3(b) of the New York Public Health Law by including the external appeal rights (with the timeframes to request an external appeal) in all final adverse determination letters.

Parts 410.9(e)(2) and (9) of Insurance Regulation No.166 (11 NYCRR 410.9) state in part:

> "Each notice of a final adverse determination of an expedited or standard utilization review appeal under Section 4904 of the Insurance Law shall be in writing, dated and include the following:
>
> (2) A clear statement that the notice constitutes the final adverse determination...
>
> (9) for health care plans that offer two levels of internal appeals, a clear statement written in bolded text that the 45 day time frame for requesting an external appeal begins upon receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested, and that by choosing to request a second level internal appeal, the time may expire for the insured to request an external appeal."

Parts 98-2.9(e)(2) and (9) of New York Department of Health Regulation 98.2 (10 NYCRR 98-2.9) states in part:

> "Each notice of a final adverse determination of an expedited or standard utilization review appeal under section 4904 of the Public Health Law shall be in writing, dated and include the following:
>
> (2) A clear statement that the notice constitutes the final adverse determination..."

> (9) for health care plans that offer two levels of internal appeals, a clear statement written in bolded text that the 45 day time frame for requesting an external appeal begins upon receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested, and that by choosing to request a second level internal appeal, the time may expire for the enrollee to request an external appeal."

Of fifty (50) appeal cases reviewed, there were four (4) instances where Aetna Life Insurance Company failed to include a clear statement that the notice of appeal adverse determination constitutes the final adverse determination. Of forty-six (46) appeal cases reviewed, there were four (4) instances where Aetna Health Insurance Company failed to include a clear statement that the notice of appeal adverse determination constitutes the final adverse determination. Of fifty (50) appeal cases reviewed, there were three (3) instances where Aetna Health Inc. failed to include a clear statement that the notice of appeal adverse determination constitutes the final adverse determination.

Of fifty (50) appeal cases reviewed, there were six (6) instances for Aetna Life Insurance Company, of forty-six (46) appeal cases reviewed there were fourteen (14) instances for Aetna Health Insurance Company, and of fifty (50) appeal cases reviewed, there were two (2) instances for Aetna Health Inc., which the Aetna Companies failed to include a clear statement written in bolded text, that the required time frame for requesting an external appeal begins upon receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested, and that by choosing to request a second level internal appeal, the time may expire for the insured to request an external appeal, in the final adverse or appeal determination letters. The Aetna Companies indicated that all the final adverse determination letters sent **prior** to July 2015 were missing the above statement. It was further revealed that in some cases the final adverse determination letters sent **after** July 2015 were missing the statement as well.

It is recommended that ALIC and AHIC comply with the requirements of Part 410.9(e)(2) of Insurance Regulation No. 166 (11 NYCRR 410.9) by including a clear statement that the appeal determination constitutes the final adverse determination.

It is recommended that AHI comply with the requirements of Part 98-2.9(e)(2) of New York Department of Health Regulation No. 98-2 (10 NYCRR 98-2.9) by including a clear statement that the appeal determination constitutes the final adverse determination.

It is recommended that ALIC and AHIC comply with the requirements of Part 410.9(e)(9) of Insurance Regulation No. 166 (11 NYCRR 410.9) by including a clear statement in all the final adverse or appeal determination letters that by choosing a second level internal appeal the time frame for filing an external appeal may expire.

It is recommended that AHI comply with the requirements of Part 98-2.9(e)(9) of New York Department of Health Regulation No. 98-2 (10NYCRR 98-2.9) by including a clear statement in all the final adverse or appeal determination letters that by choosing a second level internal appeal the time frame for filing an external appeal may expire.

The following language was noted within the appeal determination notice:

> "If you would like to appeal this determination directly to external review you must first waive your rights to the internal reviews that you have available, as your plan requires you to exhaust your internal appeals prior to external review."

There is no requirement for the member to exhaust the internal appeals before requesting an external review.

It is recommended that the Aetna Companies eliminate all wording that requires the member or provider to exhaust his/her rights to all internal reviews before requesting an external appeal from the appeal determinations sent to the member or provider.

The total samples and results are included within the below chart. All samples reviewed were agreed to by Aetna.

2015 ALIC, CareCore and Optum - Summary of Violations of Utilization Review & Appeals				
	Utilization Review (UR)			**Appeals**
	Prospective	**Concurrent**	**Retrospective**	
ALIC				
Total sample size	16	14	20	50
Total number of violations	2	0	4	18
Total population	1,727	2,395	49,718	9,090
CareCore				
Total sample size	5	4	4	0
Total number of violations	1	0	1	0
Total population	7,358	109	42	0
Optum				
Total sample size	0	1	0	0
Total number of violations	0	0	0	0
Total population	0	1	0	0
Grand Total including ALIC, CareCore and Optum				
Total sample size	21	19	24	50
Total number of violations	3	0	5	18
Calculated violation rate	14.28%	0%	20.83%	36%
Total population	9,085	2,505	49,760	9,090
Total estimated violations	**1,297**	**0**	**10,365**	**3,272**
Total UR violations				**11,662**
Total Appeals violations				**3,272**

It should be noted that the table below has a combined total population for the AHI and AHIC legal entities. AHI and AHIC were unable to list the total populations separately. The aforementioned sample reviews list separate errors for AHI and AHIC because each case reviewed listed the legal entity. It should also be noted that all business conducted by AHIC at the time of this examination represented the out-of-network component of the point-of-service products issued by Aetna Health Inc.

2015 AHI, AHIC, Care Core and Orthonet – Summary of Violations of Utilization Review and Appeals				
	Utilization Review (UR)			**Appeals**
	Prospective	**Concurrent**	**Retrospective**	
AHI, AHIC				
Total sample size	18	7	71	96
Total number of violations	2	0	7	53
Total population	111	57	679	250
Care Core				
Total sample size	3	0	0	0
Total number of violations	0	0	0	0
Total population	654	16	2	0
Orthonet				
Total sample size	3	11	0	0
Total number of violations	0	0	0	0
Total population	123	215	0	0
Grand Total including AHI, AHIC, CareCore and Orthonet				
Total sample size	24	18	71	96
Total number of violations	2	0	7	53
Calculated violation rate	8.33%	0%	9.85%	55.21%
Total population	888	288	681	250
Total estimated violations	74	0	67	138
Total UR violations				**141**
Total Appeals violations				**138**

7. COMPLAINTS AND GRIEVANCES

Part 216.4 of Insurance Regulation No. 64 (11 NYCRR 216) states in part:

> "(a) Every insurer, upon notification of a claim, shall, within 15 business days, acknowledge the receipt of such notice. Such acknowledgment may be in writing.
>
> (b) An appropriate reply shall be made within 15 business days on all other pertinent communications…"

Of seven (7) sampled complaints, there were two (2) instances where AHI did not acknowledge receipt of the member complaint. Of seven (7) sampled complaints, there were two (2) instances where AHIC did not acknowledge receipt of the member complaint. Of seven (7) sampled complaints, there was one (1) instance where AHI did not respond to the member complaint within fifteen (15) business days. Of seven (7) sampled complaints, there was one (1) instance where AHIC did not respond to the member complaint within fifteen (15) business days.

It is recommended that AHI and AHIC comply with Part 216.4 of Insurance Regulation No. 64 (11 NYCRR 52.40) by acknowledging and responding to member complaints within the required time frame.

By means of extrapolation the aforementioned errors are summarized in the following tables. Please note that any claim with one or more violation within the same section of the law or regulation was reflected as a single violation on the chart:

2015 AHI and AHIC – Summary of Complaint Violations	
	Complaints
AHI	
Total sample size	7
Total number of violations	2
Calculated violation rate	28.57%
Total population	24
Total estimated violations	**7**
AHIC	
Total sample size	7
Total number of violations	2
Calculated violation rate	28.57%
Total population	10
Total estimated violations	**3**
Total Complaints violations	**10**

Sections 4408-a(9) and (11)(ii) of the Public Health Law state in part:

> "(9) Within fifteen business days of receipt of the appeal, the organization shall provide written acknowledgment of the appeal…..
> (11) The organization shall seek to resolve all appeals in the most expeditious manner and shall make a determination and provide notice no more than …
> (ii) thirty business days after the receipt of all necessary information in all other instances."

Sections 4802(i) and (k)(2) of the New York Insurance Law state in part:

> "(i) within fifteen business days of receipt of the appeal, the insurer shall provide written acknowledgment of the appeal…..
> (k) The insurer shall seek to resolve all appeals in the most expeditious manner and shall make a determination and provide notice no more than;
> (2) thirty business days after the receipt of all necessary information in all other instances"

Of twenty (20) sampled grievances, there was one (1) instance where AHI did not acknowledge receipt of a grievance appeal within fifteen (15) business days. Of thirteen (13) sampled grievances, there were two (2) instances where ALIC did not acknowledge receipt of a grievance appeal within fifteen (15) business days.

Of twenty (20) sampled grievances, there were two (2) instances where AHI did not provide notice of determination within thirty (30) business days. Of thirteen (13) sampled grievances, there were two (2) instances where ALIC did not provide notice of determination within thirty (30) business days.

It is recommended that AHI comply with Sections 4408-a(9) and (11)(ii) of the New York Public Health Law by acknowledging receipt of an appeal and provide notice of determination within the required time frames.

It is recommended that ALIC comply with Sections 4802(i) and (k)(2) of the New York Insurance Law by acknowledging receipt of an appeal and provide notice of determination within the required time frames.

By means of extrapolation the aforementioned errors are summarized in the following table:

2015 ALIC and AHI – Summary of Violations of Grievances	
ALIC	
Total sample size	13
Total number of violations	2
Calculated violation rate	15.38%
Total population	5,900
Total estimated violations	**907**
AHI	
Total sample size	20
Total number of violations	2
Calculated violation rate	10%
Total population	308
Total estimated violations	**31**
Total Grievances violations	**938**

8. REPORTING OF GRIEVANCES AND UTILIZATION REVIEW APPEALS

A review of the, Exhibit of Grievances and Utilization Review Appeals for ALIC, and Schedule M for AHI as contained in their 2015 (supplement/data requirements) filings with the Department, found that both companies incorrectly reported the total number of grievances and utilization review appeals on their respective filed exhibit and/or schedule.

The Aetna Companies were unable to reconcile the grievances and appeals totals listed in the supplement/data requirements to the grievance and appeal data files given to the examiners for review. The Aetna Companies acknowledged that the 2015 Exhibit of Grievances and Utilization Review Appeals in the supplement/data requirements totals were incorrectly reported.

It is recommended that the Aetna Companies report correct data on the Exhibit of Grievances and Utilization Review Appeals and Schedule M within its supplement/data requirements filings.

9. FRAUD WARNING STATEMENTS

Part 86.4 of Insurance Regulation No. 95 (11 NYCRR 86.4) states in part:

> "(a) Applications provided to applicants for [non-automobile] commercial insurance and all claim forms for insurance, except personal automobile insurance**,** delivered to any person residing or located in this State (on and after February 2, 1994) in connection with commercial insurance policies to be issued or issued for delivery in this State shall contain the following statement.

> *Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.*
>
> (d) Location of warning statements and type size:
>
> (1) The warning statements required by subdivisions (a), (b) and (e) of this section shall be placed immediately above the space provided for the signature of the person executing the application or claim form and shall be printed in type which will produce a warning statement of conspicuous size. On claim forms which require execution by a person other than the claimant, or in addition to the claimant, the warning statements required by subdivisions (a), (b) and (e) of this section shall be placed at the top of the first page of the claim form or on the page containing instructions, either in print, by stamp or by attachment and shall be in type size which will produce a warning statement of conspicuous size…"

A review of the pharmacy claim form issued by the Aetna companies revealed that the fraud warning statement is not located above the space provided for the signature of the person executing the claim form. Aetna admitted that the pharmacy claim form was used 2,724 times between 01/01/2011 and 12/31/2016, a .12% usage rate relative to electronic claim submissions.

It is recommended that the Aetna companies comply with Part 86.4(d)(1) of Insurance Regulation No. 95 (11 NYCRR 86.4) by placing the fraud warning statement above the space provided for the signature of the person executing the claim form, relative to its pharmacy claim forms.

10. MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT ('MHPAEA")

Aetna's provider reimbursement was reviewed for purposes of MHPAEA compliance, and although we are not pursuing it at this time, we reserve the right to pursue it with Aetna in the future.

11. COMPLIANCE WITH PRIOR MARKET CONDUCT REPORT ON EXAMINATION

The prior report on examination contained the following fifteen (15) 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.
	Utilization Review	
1.	It was 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. *AHIC has complied with this recommendation.*	7
2.	It was 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. *AHI and ALIC has not complied with this recommendation.*	9
3.	It was 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. *ALIC has not complied with this recommendation.*	11
4.	It was 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. *AHI has not complied with this recommendation.*	12

ITEM NO.		PAGE NO.
	Claims Attributes Review	
10.	It was recommended that the Aetna 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. *Aetna has complied with this recommendation.*	17
11.	It was recommended that the Aetna Companies comply with policy provisions and their own policies and procedures by properly applying authorizations. *Aetna has complied with this recommendation.*	17
12.	It was recommended that the Aetna Companies accurately apply co-payments and deductibles in accordance with contractual provisions and comply with their own policies and procedures. *Aetna has not complied with this recommendation.*	17
13.	It was 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. *Aetna has complied with this recommendation.*	24
14.	It was 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. *Aetna has complied with this recommendation.*	24
15.	It was 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. *Aetna has complied with this recommendation.*	27

12. SUMMARY OF COMMENTS AND RECOMMENDATIONS

Respectfully submitted,

_____/S/_____
Jeffrey Usher, CFE
Principal Examiner

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

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

_____/S/_____
Jeffrey Usher, CFE

Subscribed and sworn to before me
this _____ day of_____

APPOINTMENT NO. 31344

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, ***BENJAMIN M. LAWSKY****, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:*

Jeffrey Usher

as a proper person to examine the affairs of

Aetna Health Insurance Company of New York

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

Company

with such other information as he shall deem requisite.

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

this 17th day of April, 2015

BENJAMIN M. LAWSKY
Superintendent of Financial Services

By: _____

Lisette Johnson
Bureau Chief
Health Bureau

APPOINTMENT NO. 31345

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, ***BENJAMIN M. LAWSKY****, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:*

Jeffrey Usher

as a proper person to examine the affairs of

Aetna Health Inc. (a New York corporation)

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

HMO

with such other information as he shall deem requisite.

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

this 17th day of April, 2015

BENJAMIN M. LAWSKY
Superintendent of Financial Services

By: _____

Lisette Johnson
Bureau Chief
Health Bureau

APPOINTMENT NO. **31346**

NEW YORK STATE

DEPARTMENT OF FINANCIAL SERVICES

I, ***BENJAMIN M. LAWSKY****, Superintendent of Financial Services of the State of New York, pursuant to the provisions of the Financial Services Law and the Insurance Law, do hereby appoint:*

Jeffrey Usher

as a proper person to examine the affairs of

Aetna Life Insurance Company

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

Company

with such other information as he shall deem requisite.

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

this 17th day of April, 2015

BENJAMIN M. LAWSKY
Superintendent of Financial Services

By: _____

Lisette Johnson
Bureau Chief
Health Bureau