

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, 2005

DATE OF REPORT

MAY 3, 2010

EXAMINER

BRUCE BOROFKY, CFE

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May 3, 2010

Sir:

Pursuant to the requirements of the New York Insurance Law, and acting in accordance with the instructions contained in Appointment Numbers 22475 and 22476, dated March 10, 2006, and Appointment Number 22495, dated April 24, 2006, annexed hereto, I have made an examination as of December 31, 2005, into the affairs of Aetna Health Inc. (a New York Corporation), a for-profit health maintenance organization licensed 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.

Aetna Pharmacy Management (APM), a subsidiary of Aetna Inc. (the Parent), serves as a pharmacy benefits manager (PBM) to the Parent's health insurance subsidiaries, including Aetna Health Inc., Aetna Health Insurance Company of New

York, and Aetna Life Insurance Company. Under the direction of the New York Insurance Department, a review of Aetna Pharmacy Management was conducted by Morgan Healthcare Audits, LLC, (MHA) for the time period January 1, 2005 through December 31, 2005. The review focused on the PBM's compliance with its requirements under member contracts. The main findings of the review by MHA are detailed in Item 13 of this report on examination.

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

Wherever the terms "AHIC" or "the Company" appear herein, without qualification, they should be understood to refer to Aetna Health Insurance Company of New York.

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 Companies" appear herein, without qualification, they should be understood to refer to all three companies (AHI, AHIC and ALIC) collectively.

Wherever the term, "the Department" appears herein, without qualification, it should be understood to refer to the New York Insurance Department.

1. SCOPE OF EXAMINATION

A previous examination was performed as of February 28, 2001, to ascertain the manner in which AHI and AHIC conducted their business practices and fulfilled their contractual obligations to policyholders and claimants. That report, which was filed on May 15, 2001, was a special “follow-up” examination to a separate market conduct examination conducted by the Department that had an effective date of March 30, 2000, and was filed on October 16, 2000. The “follow-up” examination was initiated in order to perform a more detailed statistical review of AHI’s and AHIC’s claims processing and preparation of their Schedules H (Aging Analysis of Unpaid Claims).

This examination encompassed a review of how Aetna Health Inc., Aetna Health Insurance Company of New York and Aetna Life Insurance Company conduct their business practices and fulfill their contractual obligations to policyholders and claimants. The examination period of the review was from March 1, 2001 through December 31, 2005. Events subsequent to this date were reviewed where deemed appropriate by the examiner.

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

Where this current examination establishes compliance with the recommendations of the previous reports, both reports are referenced.

Concurrent examinations regarding the financial condition of AHI and AHIC were conducted by the Department as of December 31, 2005, and separate reports on examination were 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 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.

3. 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, Regulations and Circular Letters, and the New York Public Health Law. The most significant findings relative to this examination include the following:

- Aetna Health Inc. did not consistently submit explanation of benefits forms (EOBs) to its members as required by Section 3234(a) of the New York Insurance Law. During calendar year 2005 there were 354,999 such violations.
- Explanation of benefits forms that were submitted to members of all three Aetna entities covered by this examination either were not clear or did not always contain all of the information required by Sections 3103(b) and 4904 of the New York Insurance Law and Section 4904 of the New York Public Health Law.
- In violation of Sections 4904 and 3230(b) of the New York Insurance Law and its own policy contracts, as approved by the Department, AHIC and ALIC did not grant New York statutory appeal rights to members with New York-based contracts, but who lived outside of the State of New York.
- The prior report on examination noted that Aetna Health Inc. failed to pay non-participating providers the amounts billed for claims where the member received a valid referral, as required by New York Public Health Law §4403(6)(a). AHI reached agreement with the Department that, in lieu of full payment of such claims, it would notify members to contact the HMO if they were "balance billed". However, AHI failed to comply with said agreement and did not send the aforementioned notification to its members in 17,416 such cases during calendar year 2005 alone.
- The following illustrates the total number of occurrences in which the Companies violated the various Sections of 3224-a of the New York Insurance Law (Prompt Payment Law), during the period January 1, 2005 through December 31, 2005:

AHI: 34,122	AHIC: 2,939	ALIC: 85,764
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- AHI failed to comply with New York Public Health Law §4903(5) on 5,622 occasions, while AHIC failed to comply with New York Insurance Law §4903(e) on 1,564 occasions, when they failed to send adverse determination notices to members as required by the aforementioned Laws.

- Each of the three entities violated various parts of the New York Insurance Law (AHIC and ALIC) and Public Health Law (AHI) Articles 49 by failing to properly enforce differing aspects of their utilization review programs. These include the failure to provide all of the internal and external appeal rights that are required by Law. Some of the failures were the result of systemic errors while others were the direct result of procedures and policies that were not in compliance with New York Laws and/or Regulations.
- ALIC utilized contract forms that communicated information that violated New York Insurance Laws and Regulations, such as the following:
 - Appeals were required to be in writing.
 - In one contract used for many years by both AHI and AHIC for all members, members were advised that they were not permitted to issue complaints to the Department until all internal appeals had been settled. The same contract advised members that the Department had no jurisdiction over complaints until all internal appeals had been settled.
- AHIC and ALIC violated Section 3217-a of the New York Insurance Law, while AHI violated Section 4408 of the New York Public Health Law by failing to communicate all of the information required by these Laws to prospective, new, and existing members. Additionally, some of the information that was provided contradicted New York Insurance Laws and Regulations related to utilization review, grievance procedures and record keeping.
- AHI failed to properly monitor the explanation of benefits statements (EOBs) issued by its independent practice associations (IPAs) and as a result, EOBs containing improper appeal rights and utilization review deadlines were issued by the IPAs.
- In multiple circumstances, Aetna's pharmacy benefits manager failed to comply with the terms of its pharmacy network contracts when it paid incorrect rates and dispensing fees.

The above findings are described in greater detail in the remainder of this report.

4. CIRCULAR LETTER NO. 9 (1999) - ADOPTION OF PROCEDURE MANUALS

Although Aetna conducted internal audits in many of the areas noted in the executive summary above, the testing did not consistently measure statutory compliance with New York-specific Laws and Regulations.

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.

New York Insurance Department Circular Letter No. 9 (1999) provides in part, for the board of directors to, “adopt procedures to ensure that all claims are being processed accurately, uniformly, and in accordance with applicable statutes, rules, and regulations.” As indicated in Department Circular Letter No. 9 (1999), the board has significant responsibilities in determining that health insurers and managed care companies fulfill all such responsibilities and, in the case of a controlled company, the parent company must, under long-standing principles of corporate governance, confirm that its subsidiaries are fulfilling all of its responsibilities.

Circular Letter No. 9 (1999) also notes that of equal importance to the claims adjudication process is the adoption of written procedures to enable the board to assure itself that the company’s operations in other key areas (e.g. grievance/appeal process; underwriting and rating; external appeals; and the accurate and timely reporting of all financial statement schedules and exhibits) are being conducted within applicable statutes, rules and regulations.

This report on examination details significant market conduct violations by Aetna, some of which are repeat violations as described in the prior reports on examination.

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.

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 recommendations included within this report on examination.

5. CLAIMS REVIEW

A. Explanation of Benefits Statements

Aetna Health Inc.

Between March 24, 2005 and February 9, 2007, in violation of New York Insurance Law §3234(a), the HMO failed to send explanation of benefits statements (EOBs) to its members relative to a substantial number of claims submitted by non-participating providers. The March 24, 2005 date is noted because it was on that date that the Department issued Circular Letter No. 5 (2005) to all health insurers licensed in New York State in order to clarify the circumstances under which explanation of benefits

statements (EOBs) should be sent (the February 9, 2007 date is noted because it was the approximate date of the examiner's review).

However, it was noted that there were multiple instances in which the HMO had not been in compliance with the cited Law prior to the issuance date of the Circular Letter as well, including its failure to send EOBs to non-participating providers in every case.

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).

In certain cases, in lieu of EOBs, AHI sent documents to members that contained some of the elements of an EOB, as described by New York Insurance Law §3234(b). However, other information required by §3234(b) was not included within such documents.

It is recommended that AHI modify its EOBs to comply with the requirements of New York Insurance Law §3234(b).

Aetna Health Insurance Company

Section 3234(b)(5) of the New York Insurance Law requires that each EOB issued by a company demonstrates all reductions from the amounts claimed. A review of the EOBs issued by AHIC revealed that there was little consistency in their construction and often, critical (required) parts were missing or inadequately presented. These inconsistencies and missing / inadequate wording resulted in the EOBs issued by AHIC to not be in compliance with New York Insurance Law §3234(b)(5).

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 Life Insurance Company

The examiner reviewed explanation of benefits statements distributed to members by ALIC during the examination period and noted that such EOBs did not clearly delineate all charges, and failed to describe all reductions to the allowed amount.

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.

Independent Practice Association (IPA) Issued EOBs

A sample of EOBs sent to members by AHI's IPA for in-network chiropractic claims, American Chiropractic Network (ACN), revealed that such EOBs did not comply with the requirements of Section 3234(b)(7) of the New York Insurance Law because they did not contain a notification that "failure to comply with appeals procedures could result in the forfeiture of a member's right to challenge the denial, even when a request for clarification has been made."

Several of the same violations indicated above were noted in a review of the claims handling of another IPA (since terminated by Aetna).

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.

AHI / AHIC / ALIC

When claims are submitted by or for members that have New York situs contracts, but reside outside of New York State, the EOBs did not comply with New York Insurance Law §3234(b)(7) in that, in most cases, such EOBs did not describe the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate. Nor did such EOBs include a notification that failure to comply with the 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 reason for this deficiency was that, during the examination period, Aetna erroneously provided out-of-state members with the appeal rights of the state in which they reside, instead of New York State, where the contract is domiciled.

Such omissions are violations of Sections 3103(b) and 4904 of the New York Insurance Law, Section 4904 of the New York Public Health Law and of Aetna's own contracts, as approved by the Department, and described by Aetna within its various *Summaries of Coverage* and *Certificates of Coverage*, which are provided to all new and existing members.

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.

The EOBs issued by Aetna to New York members that are residents in New York contained two separate sets of internal appeal rights. The first set described appeal rights for members with one level of internal appeal, while the other was for members with two levels of internal appeal. Members were then instructed to refer to their member cards to determine the set of rights to which they were entitled. Notwithstanding the fact that all New York members were eligible for two sets of internal appeal rights, the failure to delineate clearly the specific appeal rights to which a member is entitled, is violative of Section 3234(b)(7) of the New York Insurance Law.

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.

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.

B. Claims Processing Accuracy

A review was made of Aetna's claims handling accuracy on both a financial and procedural basis. This review was performed by using a statistical sampling methodology covering claims processed during the examination period, in order to

evaluate the overall accuracy and compliance environment of each entity's claims processing.

Such review indicated that Aetna's claims handling accuracy rate, even excluding errors associated with its EOBs as described in the previous section of this report, was significantly less than Aetna's established internal claims handling accuracy rate of 97%.

C. Payments to Members / Subscribers Regarding Referrals to Non-Participating Providers

Under certain circumstances, members of the HMO may be referred to a non-participating provider for specialist care. Since the non-participating visit is pre-certified, the subscriber is indemnified against any liability beyond the contracted co-payment, pursuant to the requirements of Section 4403(6)(a) of the New York Public Health Law.

During the previous examination, it was noted that the HMO's claims payment policy in such described instances was to pay the non-participating providers an amount less than that billed. In the event the member was "balance billed" and the HMO was advised as such, the HMO would then pay the remaining balance. As a result, a recommendation was made in the prior examination that, in such instances, the HMO comply with §4403(6)(a) of the New York Public Health Law, and provide full reimbursement beyond the contracted co-payment. In lieu of directly complying with the cited Law, the HMO reached agreement with the Department that AHI would send a letter to members advising them that if they are balance billed by the provider, the member should contact AHI to ensure that the balance is paid by the HMO.

Although the HMO took steps to comply with the agreement, during calendar year 2005 alone, the examiner determined that there were 17,416 cases where the HMO did not comply with the procedures it had agreed to with the Department. This represents nearly 35% of all instances where such letters should have been sent. Additionally, it is noted that the letters that were sent did not contain sufficient notice to members advising them of the claim's details. This information is important so that members have awareness of the amounts that may be involved and their payment responsibility. This information is especially critical since the letters are not accompanied by an explanation of benefits statement.

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.

6. PROMPT PAY LAW

New York Insurance Law §3224-a "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 forty-five days of receipt. If such undisputed claims are not paid within forty-five days of receipt, interest may be payable. Additionally, if there is a reasonable doubt on the insurer's part regarding the insurer's liability to pay, the insurer has thirty calendar days to inform the member or health care provider of the reason for denying the claim, or to request additional information.

The examiner performed a review of the Companies' compliance with Sections 3224-a(a), (b) and (c) of the New York Insurance Law. Accordingly, for each of the Companies, three separate populations of claims, one for each component of the aforementioned Law, that appeared to be violative of the respective Sections of 3224-a of the New York Insurance Law were culled from the general population of claims adjudicated during the period January 1, 2005 through December 31, 2005.

Random samples consisting of 167 claims were then drawn from each population of apparent violations using the computer software program ACL. The claims were then reviewed by the examiner in order to establish whether there were legitimate reasons for the payment / denial delays and/or failures to pay appropriate interest. After the review was performed, all of the sampled items were deemed to be Prompt Pay violations. As a result, in each case, no extrapolation was performed and the base populations were established as violations of the respective sections of the cited Law.

The number of violations derived is as follows:

<u>Statutory Reference</u>	<u>AHI</u>	<u>AHIC</u>	<u>ALIC</u>
Section 3224-a(a) of the NYIL – Claim payments made more than 45 days after receipt.	16,303	1,270	43,597
Section 3224-a(b) of the NYIL - Claims denied more than 30 days after receipt.	7,844	1,173	22,540
Section 3224-a(c) of the NYIL - Claims where interest was incorrectly calculated, or not paid at all.	9,975	496	19,627

During the period January 1, 2005 through December 31, 2005, for AHI, the claim population consisted of 2,242,487 adjudicated claims; for AHIC, the claim population consisted of 126,652 adjudicated claims and; for ALIC, the claim population consisted of 1,607,547 adjudicated claims.

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.

It is noted that the prior report on examination contained a similar recommendation.

7. UTILIZATION REVIEW

During the examination, it was noted that during calendar year 2005, in violation of New York Insurance Law §4903(e), two business units of Aetna that were not part of its core utilization review process, *Special Investigations* and *Clinical Claims Review*, did not submit adverse determination notifications in writing to members who had claims denied as being not medically necessary or experimental/investigational.

It is recommended that Aetna comply with New York Insurance Law §4903(e) and submit written adverse determination notifications, when required, to all members.

It is noted that a similar recommendation was made in a previous market conduct report on examination. In its written response to that market conduct report on examination, Aetna indicated that it had taken steps to comply with said recommendation.

A review of Aetna's appealed claims revealed several violations of various sections of Article 49 of the New York Insurance Law and Part 98 of the Administrative Rules and Regulations of the New York Health Department (10 NYCRR 98-2.9) as follows:

- As noted above, adverse determination letters as required by Section 4903(e) of the New York Insurance Law were not sent to the insured or insured's designee and insured's health care provider. These violations occurred within two business units that are not part of Aetna's core utilization review process.
- Final adverse determinations letters did not contain the appeal language required by Part 98 of the Administrative Rules and Regulations of the New York Health Department (10 NYCRR 98-2.9(e)). In some cases, this was the result of improper form letters being used. Corrected letters were sent for sampled cases during the examination.
- In one case, the initial clinical determination for services requiring pre-authorization was not reached within the three business days required by New York Insurance Law §4903(b). Upon realization that the determination was late, Aetna subsequently approved the service requested as required by the Law.
- In another case, the provider requested an expedited review for an appeal as permitted by New York Insurance Law §4904(b). The request was not acknowledged and the two business day deadline for expedited review was not met. Additionally, this action does not comply with Section 4903(f) of the New York Insurance Law.

During discussion of this last issue, Aetna indicated its belief that it has the right to make the final determination regarding whether a member's condition warrants an expedited appeal when such is requested by a provider. Aetna's conclusion is not accurate.

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).

While it is noted that the HMO does take steps to audit utilization review cases and appeals, such work is performed on a regional basis, instead of being New York specific. The quantity of errors that were noted during the examiner's review suggests that those audits are not specific enough to the individual requirements of New York State.

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.

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.

The final adverse determination letters utilized by AHI generally do not comply with Part 98 of the Administrative Rules and Regulations of the New York Health Department for the following reasons:

- AHI's final adverse determination letters do not consistently contain the requisite AHI telephone number required by Part 98-2.9(e)(3) of the Administrative Rules and Regulations of the New York Health Department (10 NYCRR 98-2.9(e)(3)).
- AHI's final adverse determination letters typically include in boldface, only the following text:

“Please be aware that if you file an internal appeal, you may not meet the 45 day time limit to file an external appeal.”

The above telephone omission and appeal language violate 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)).

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's adverse determination letters (prospective, concurrent and retrospective) state in part:

“If your claim is an Urgent Care Claim (one where delay in making a decision could seriously jeopardize your life, health or ability to regain maximum function, or could subject you to severe pain in the opinion of your physician), you or a physician on your behalf may request an expedited appeal...”

This definition does not include notification that members have automatic expedited appeal rights for concurrent treatment or that they have an uncontestable right to an expedited appeal for prospective treatment when their provider believes an immediate appeal is warranted, as permitted by New York Insurance Law §4904(b). As described earlier, it was noted during the examination that Aetna enforces this practice and has inappropriately denied expedited reviews for pre-certified services when such expedited reviews were sought by the member's provider.

It is recommended that Aetna notify members of the rights of their providers to receive expedited appeals for concurrent care claims or claims for prospective treatment when a provider believes an immediate appeal is warranted.

The HMO utilizes the term “External Review” to describe a type of internal appeal. This term can lead to member confusion, due to the fact that New York State has its own required “External Appeal” process. This confusion was noted in one utilization review case reviewed by the examiner, where a member requested one type of appeal, but

received the alternative. Additionally, the HMO cross references the two phrases in its EOBs when it notes that, “A member’s request for External Review will not affect the member’s rights to any other benefits under this plan...”

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.

The examiner reviewed the appeals policy on AHI and AHIC’s on-line system that is used by their customer service representatives (CSRs). The following was noted:

The on-line policies utilized by the CSRs define “Expedited Appeal” as an appeal of a decision not to certify urgent or ongoing services, when a delay in decision-making might seriously jeopardize the life or health of the member or jeopardize the member’s ability to regain maximum function. This definition does not include all of the conditions prescribed by Section 4904(b) of the New York Insurance Law.

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.

Additionally, the on-line instructions advise Aetna’s CSRs of the following:

“In order to help determine if the denial is clinical in nature and therefore may be expeditable, determine if the member received a denial letter. If they only received an EOB, the issue is not expeditable.”

As noted previously, Aetna does not send out adverse determination notices in all cases required under New York Insurance Law. As such, it is recommended that Aetna's on-line procedure manual instructions, which indicates that appeals may only be expedited if Aetna has received a denial letter, should be revised to allow for expedited appeals, whenever such appeals are necessary.

8. COMPLAINTS AND GRIEVANCES

New York Public Health Law §4408-a(4) establishes the requirement that the HMO provide written acknowledgement of the receipt of a grievance within fifteen business days of its receipt. A sample of complaint files was reviewed to establish the HMO's compliance with this Law, as well as with the overall quality of the complaint handling. The following was noted:

- In violation of the above cited Law, four of the files reviewed by the examiner did not include acknowledgement letters.
- In one instance noted by the examiner, a claim that was initially denied as not a covered benefit, and not given utilization review appeal rights, was in fact a medical necessity denial with the rights to utilization review.

It is recommended that AHI comply with New York Public Health Law §4408-a(4) and submit acknowledgement letters for all complaints, within fifteen business days of their receipt.

It is noted that the prior report contained a similar recommendation.

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.

One additional file was noted that was not part of this specific review. In this instance, the member wrote to complain about a claim that had been denied a year earlier. The complaint was denied by AHI as not having been filed within the HMO's timely filing deadline. While this is true, it is also noted that the member had never received an EOB statement, and as such, may have had no way of knowing there was a problem with the claim until that deadline had passed.

9. DISCLOSURE OF INFORMATION

Sections 3217-a and 4324 of the New York Insurance Law, "Disclosure of Information", and Section 4408 of the New York Public Health Law relative to the HMO, which contain similar language, enumerate various rights and responsibilities that insurers are required to communicate to all members.

Aetna's compliance with Sections 3217-a and 4324 of the New York Insurance Law and Section 4408 of the New York Public Health Law was reviewed during the examination and it was noted that for each entity, the information being provided contained incorrect information, was inconsistent, or was presented in an unclear manner as indicated below:

A. Aetna Health Inc. and Aetna Health Insurance Company

The insurance provided by AHIC consists of the "out-of-network" portion of the point-of-service (POS) product offered in conjunction with AHI, which provides coverage for the "in-network" component. As such, documents which describe AHIC member rights and responsibilities serve as supplements to the AHI contracts and

certificates that are provided to members. As a result, findings within this section of the report apply to both, AHI and AHIC.

For new and existing members, AHI and AHIC utilized three primary sources, the *Provider Directory*, the *Certificate of Coverage (COC)*, and the *Member Handbook*, to disseminate information required by Section 4408 of the New York Public Health Law and Sections 3217-a and 4324 of the New York Insurance Law. During the examination, it was noted that the appeal rights described within the Provider Directory were presented in a manner which was unclear, while the Certificate of Coverage contained information that was inaccurate and would not be in accordance with New York Law if enforced. Additionally, in some cases, the three documents contradicted each other; while taken as a whole, the documents did not communicate all of the information required under the aforementioned Disclosure of Information Laws.

For prospective members, a variety of other documents, including a stand-alone Disclosure Packet were provided in lieu of the Certificate of Coverage and the Member Handbook. That information was also incomplete and thus, not in compliance with Section 3217-a of the New York Insurance Law.

Finally, it is noted that while the AHI and AHIC Provider Directory listed many benefits and requirements for members, including those that are required by the New York Insurance Law, such Directory contained no indication on the cover that important member information was contained within.

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.

Certificate of Coverage

During the course of the examination, the HMO utilized a Certificate of Coverage that had been in effect since 2002. An amendment to that document was implemented during November 2006, subsequent to the examination date. Both are reviewed herein.

HMO/NY COC-2 (04/02)

The Certificate of Coverage, titled HMO/NY COC-2 (4/02), which was utilized until November 2006, indicated that medical necessity appeals must be in writing, a policy that would, if enforced, be in violation of Section 4904(3) of the New York Public Health Law relative to the HMO and Section 4904(c) of the New York Insurance Law relative to AHIC. Additionally, the document stated the following:

“For grievances involving other types of claims, the Member may only receive notice if the HMO upholds a claim denial in whole or in part.”

For the HMO, this policy is a violation of Section 4408-a(6) of the New York Public Health Law, which states the following:

“The notice of a determination of the grievance shall be made in writing to the enrollee or to the enrollee's designee.”

Further, the document indicated that external appeals can only be initiated by the provider with the permission of the member. For retrospective claims, enforcement of

this policy would not be in compliance with Section 4910(2) of the New York Public Health Law for the HMO and Section 4910(b) of the New York Insurance Law for AHIC, which states the following:

“...in connection with retrospective adverse determinations, an insured’s health care provider, shall have the right to request an external appeal...”

Finally, HMO/NY COC-2 (04/02) states the following:

“The foregoing procedures [in reference to appeals and complaints] are mandatory and must be exhausted prior to:

1. any investigation of a Complaint or Appeal by the Department of Insurance; or
2. the filing of a Complaint or Appeal with the Department of Insurance.”

The above cited comments are inappropriate, inaccurate and contrary to Law.

In order to correct this misinformation, Aetna submitted to the Department an amendment to the contract that provides the proper member rights. The original contract with the inappropriate wording, however, is still in circulation.

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.

Member Handbook (Handbook)

- The Handbook notes that an appeal must be in writing, which is inaccurate and not consistent with Section 4904(3) of the New York Public Health Law for the HMO and Section 4904(c) of the New York Insurance Law for AHIC.
- The document does not contain all of the External Appeal language as required by Section 4408(1)(c)(viii) of the New York Public Health Law and Section 3217-a(3)(H) of the New York Insurance Law.

It is noted that beginning in September 2007, the Company no longer utilized a Member Handbook and that disclosure information regarding external appeals was provided in the “Important Disclosure Information” section of the Provider Directory. This section of the Provider Directory advises members how to file appeals in writing or by telephone.

For prospective members, in lieu of the Member Handbook and the Certificate of Coverage, the HMO utilizes a free standing document titled, “*Important Disclosure Information*”. Thus, prospective members received, among other documents, the Provider Directory and the document, “Important Disclosure Information”.

Until March 2005, the document, “Important Disclosure Information”, contained the text of New York Public Health Law §4408(1)(c)(viii); that is, it contained the list of information that is required to be disseminated to existing and prospective members. It did not contain any of the specific information itself. After March 2005, the HMO replaced the information within the document, “Important Disclosure Information”, with the exact language from within the foreword to the Provider Directory. Thus, the only information that prospective members received contained the erroneous information described earlier within this document regarding the Provider Directory.

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.

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.

B. Aetna Life Insurance Company

For new and existing members, ALIC utilizes the Provider Directory and the Summary of Coverage (SOC) to provide the information delineated by New York Insurance Law §3217-a.

In lieu of the Summary of Coverage, which is only applicable to existing members, ALIC supplies prospective members with a stand-alone document titled “Important Disclosure Information”, to comply with the aforementioned Law.

Samples of all the required documents were reviewed by the examiner for compliance with the cited Law.

The Provider Directory for ALIC contains very basic information in a foreword titled, “*Important Disclosure Information*”, that relates to all of the states where the Company writes policies. In addition, the document contains a separate section where specific language required by various state laws is enumerated. For the State of New York, the section contains the list of items required to be disclosed by Section 3217-a of the New York Insurance Law. None of the actual information required, however, is listed there.

Between 2004 and the examination date, the language within the Summary of Coverage that related to appeal and grievance procedures was revised three times. The first set was utilized until 2005, the second was utilized during 2005, and the third was implemented during 2006.

The first set of revised procedures was attached to the Summary of Coverage as a separate unnumbered page titled, “*Additional Information Provided by Aetna Life Insurance Company*” and subtitled “*Appeals Procedure*”. As to this document, the following was noted:

- The document was not clear in that it did not delineate between a denial for medical necessity and other types of denials.
- The document established the requirement that appeals be in writing. If enforced, this requirement would be in violation of Section 4904(c) of the New York Insurance Law.
- Because the document did not delineate between the various types of grievances, the imparted deadlines did not contain sufficient detail to cover all of the circumstances under which deadlines were applied.
- The document notes that records of complaints will be held for three years, while Part 243.2(b)(8) of Department Regulation No. 152 (11 NYCRR 243.2), delineated elsewhere in this report, establishes the requirement that such documents be held for a minimum of six years.

It is noted that subsequent to the examination, the Company corrected the above deficiencies.

Similarly, the second set of revised procedures utilized by ALIC to explain appeal and grievance procedures was also attached to the Summary of Coverage. In this case, however, the pages included the form number for the Summary of Coverage.

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.

A review of that second set of appeal and grievance procedures, as distributed during 2005, revealed that this information also was not in compliance with Section 3217-a of the New York Insurance Law and Part 243.2 of Department Regulation No. 152 (11 NYCRR 243.2), as it did not provide a clear definition of a grievance that distinguished between an administrative denial and a denial involving utilization review.

The third set of revised appeal and grievance procedures utilized by Aetna since 2006 was approved by the Department as required by New York Insurance Law §3201(a). The document was given Form Number GR-9 11600. The approved document was reviewed and the following was noted:

- Under the section "Complaints", the document indicates that, "Aetna will summarize the nature of the complaint in writing. You will be required to sign a written acknowledgement of the complaint. You must sign and return the acknowledgement, with any amendments, in order to initiate the complaint."

Testing of a sample of grievances by the examiner did not reveal any cases in which Aetna enforced this requirement.

- The policy does not include a telephone number for members to contact with grievances, but instead states that members should call the Customer Service number on the member's ID card. This is inconsistent with New York Insurance Law §3217-a(a)(3), which requires, "the toll-free telephone number of the utilization review agent."
- The document does not contain all of the external appeal language required by New York Insurance Law Section 3217-a(a)(3)(H), which requires disclosure documents to include the following:

"a notice of the right to an external appeal together with a description, jointly promulgated by the superintendent and the commissioner of health... of the external appeal process established pursuant to title two of article forty-nine of this chapter..."
- The document includes a three year record retention deadline, while Part 243.2(b)(8) of Department Regulation No. 152 (11 NYCRR 243.2), as enumerated herein, establishes a requirement that such document be held a minimum of six years.

Subsequent to the examination, the Company corrected this latter deficiency.

During the examiner's review, copies of contracts containing the final appeal and grievance language were provided by Aetna. The language related to appeal and grievance procedures in that document did not correspond to the approved contract language. Where the approved document permits both verbal and written appeals, the contract specifies that appeals and complaints must be written. This omission renders this version to be not in compliance with New York Insurance Law Section 3201.

Subsequent to the examination, the Company corrected this deficiency.

When considered in tandem with the Provider Directory, the information imparted for all three sets of appeal and grievance procedures that were issued during the examination period did not comply with New York Insurance Law Section 3217-a because, at a minimum, at no time did the information clearly impart detailed appeal rights or the rights to external appeal.

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.

During the review, the examiners made three calls to a toll-free telephone number that was located on the Aetna website. In these instances, the examiners purported to be seeking small group coverage and requested information about Aetna coverage. In one case, the individual answering the telephone declined our request, while in the other two instances, the individual answering the telephone took our names and addresses and indicated such information would be forthcoming. Such information was never received.

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.

It is noted that the previous report contained a similar recommendation.

10. AGENTS AND BROKERS

Aetna uses independent insurance agents and brokers as its primary distribution system. A review of the licenses of agents and brokers utilized by Aetna during the examination period revealed that, in violation of Part 243.2(b)(5) of Department Regulation No. 152 (11 NYCRR 243.2), Aetna did not maintain copies of such licensing records. Instead, when such documents were requested, Aetna provided copies of the agents' / brokers' licenses that were downloaded from the *National Insurance Producer Registry* (NIPR). When Aetna was advised that it was insufficient to rely on electronic copies that are maintained on an external database, it cited in defense, New York Insurance Department General Counsel Opinions dated January 15, 2003 and August 1, 2003 (No. 5).

These opinions state that “[t]here is no requirement under the Insurance Law that an insurer keep a hard copy of its agents’ licenses” and that “screenprints that meet the standards contained in [Department] Regulation No. 152... would be acceptable.” While it is true that it is acceptable to maintain such licenses in an electronic format, such electronic copies should be maintained within Aetna’s own systems so that an external source need not be relied upon.

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).

11. INDEPENDENT PRACTICE ASSOCIATIONS / THIRD PARTY ADMINISTRATORS

AHI delegated claims processing for in-network chiropractic claims to an Independent Practice Association (IPA), American Chiropractic Network (ACN).

It was noted that ACN did not provide the forty-five day notice for a member to provide additional information necessary for the processing of a claim, in compliance with United States Department of Labor Regulation No. 29 CFR 2560.503-1(f)(2)(iii)(B).

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.

12. AETNA'S WEBSITE

It was noted that the only link on Aetna's website for Healthy New York is under the "Producers" section of the website. It is further noted that the link located at such site did not connect to the official Healthy New York website.

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.

13. PHARMACY BENEFITS MANAGER

Aetna Pharmacy Management (APM), a subsidiary of Aetna Inc. (the Parent), serves as a pharmacy benefits manager (PBM) to the Parent’s health insurance subsidiaries. As a pharmacy benefits manager, APM maintains a network of pharmacies and provides those pharmacies with active “on-line” information regarding member eligibility and benefits so that the pharmacies can service Aetna members. Generally, in return for servicing Aetna members, the pharmacies are compensated for the cost of the drugs provided and also receive a reimbursement for dispensing the drug.

A review of Aetna Pharmacy Management was conducted by Morgan Healthcare Audits, LLC, (MHA) for the period January 1, 2005 through December 31, 2005. The review focused on the PBM’s compliance with its requirements under Aetna’s member contracts, as well as its handling of pharmacy contracts. The objective of this review was to assist the Department in testing the PBM’s compliance with New York Laws and Regulations, as well as ensuring that the claims paying function was operating appropriately and in accordance with the member and provider contracts.

The following details the major findings of MHA's review:

A. Pharmacy Contract Compliance

When a claim is adjudicated, the basic formula is (Ingredient Cost + Dispensing Fee + Sales Tax) – Copayment = Amount Billed/Paid.

APM provided 2,475,539 claims for the period January 1, 2005 through December 31, 2005. Some of these claims were excluded from the review due to anomalous results. The claims were tested first by pharmacy contract, then against the member contracts. Where systemic errors were noted in the testing of a pharmacy's claims, an extrapolation was made to establish the potential population of claims that could have been impacted.

Ingredient Cost

For the period under review, it was noted that the PBM made retroactive adjustments to the Maximum Allowable Cost (MAC) prices in certain situations. These adjustments were made in response to complaints from network pharmacies asserting the prices were too low. Although apparently not in conflict with any New York State law or regulation, APM discontinued the practice in January 2008.

During the review of claims submitted through one pharmacy, it was noted that there were a number of pricing errors caused by a coding error. These errors accounted for 1.07% of that pharmacy's claims. Extrapolation of the error indicated the potential number of such errors could be 21,400.

Dispensing Fees

During its audit, MHA isolated a number of apparently incorrectly paid Dispensing Fees, but APM contested many of those findings, acknowledging only 498 errors out of 1,155,000 applicable claims tested. For those contested by APM, MHA was not able to confirm or refute its findings for the following reasons:

- In some cases, it appeared that APM was charging the Ingredient Cost and Dispensing Fee as “brand name”, while the co-payment charged was for “generic”. In other cases the opposite was true, and the co-payment charged was that of a brand drug but the Ingredient Cost and Dispensing Fees charged were for a generic. APM indicated that in some instances, this was intentional based upon the type of claim involved, but APM did not provide sufficiently detailed claim information to permit MHA to isolate those specific items. As a result, MHA was not able to ascertain whether the Ingredient Cost + Dispensing Fee was incorrect, whether the co-payment was incorrect, or whether both were correct.
- APM maintained that in some cases, the claims had been submitted by the members and thus, no Dispensing Fee was due. However, APM data did not allow for an identification of these specific claims, thus MHA was not able to confirm or refute this conclusion.
- APM maintained in other cases that no Dispensing Fee was due because the claims were coordination of benefit (COB) claims, meaning that APM was only responsible for a portion of those claims. Again, however, APM’s data did not sufficiently indicate which claims were involved.
- For non-New York pharmacies, it was noted that there were 1,231 claims that were overpaid and 26 that were underpaid. Some of these errors were caused by coding errors, while others were the result of inconsistent policy application.

Co-Payments

Aetna’s member contracts contain at minimum, a two-tier co-payment structure, whereby the co-payment for generic drugs is less than the co-payment for the more expensive name brand drugs. Those contracts also indicate the following:

“If a Physician prescribes, or the Member requests, a covered Brand Name Prescription Drug when a Generic Prescription Drug equivalent is available, the Member will pay the difference in cost between the Brand Name Prescription Drug and the Generic Prescription Drug equivalent, plus the applicable Copayment.”

This requirement is in place because, while a generic product is expected to provide the member with an equal benefit as the brand name alternative, the brand name drug has a higher cost to the insurer.

In practice, Aetna waives the requirement that the member pay the cost difference between the generic and brand name alternative, only requiring that the member pay the higher co-payment.

The member, the prescribing physician, and the pharmacist are all permitted to make the decision to opt for the name brand product, in lieu of the generic. In fact, APM does not have systems that allow it to know who makes the decision to opt for the higher cost name brand drug, only that a purchase was made.

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.

MHA noted instances wherein APM permitted members who are on vacation to obtain prescriptions for up to three-month periods, although the member contracts only allow for up to a two-month period. It is noted that this practice is permitted by New York State Law, and that this practice does not have any negative impact to members in terms of co-payments for extended days' supply of these medications.

In 2006, the PBM identified a discrepancy between its claims adjudication logic and the terms of its pharmacy plan contracts regarding medications packaged in "kit

form”. The PBM charged a co-payment for each kit, but this structure was not reflected in the member contracts. To remedy this situation, Aetna filed updated contract language, which was approved by the New York Insurance Department, in March 2007.

MHA identified certain claims for self-injectable drugs which adjudicated with a zero dollar co-payment. Aetna acknowledged that it had an internal policy, under its HMO plans, to apply a zero dollar co-payment for a subset of self-injectable drugs. However, the policy was not applied consistently.

MHA noted inconsistencies in the way that APM applied co-payments under the HMO plan for diabetic supplies and medications. APM’s general practice had been to apply the lowest co-payment (primary care physician co-payment) for diabetic supplies and medications, while Section 4321(c) of the New York Insurance Law requires a fixed \$15 co-payment for these items.

In some cases where it appeared that the co-payments were incorrect, APM explained that the prescriptions were only fractionally filled, and as such, the appropriate fraction of co-payment was charged. In order to illustrate this, APM noted a number of medications on the list of potential errors that could in fact be dispensed partially. However, APM did not respond to the whole list provided by MHA and it was noted that some of the co-payment differences involved drugs that could not be dispensed fractionally.

There were also a small number of additional incorrectly paid co-payments noted by MHA, to which APM did not respond.

Brand vs. Generic Designators

One instance was noted wherein APM required the member to be charged a higher co-payment for using a generic drug because the drug was not in APM's formulary. Generic drugs should be a cost savings to both the member and Aetna and their use should not be discouraged.

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.

Rounding Errors

MHA found many instances where drug prices paid to pharmacies were inaccurate, but within a small range.

Zero Balance Logic

APM permits pharmacies to utilize a "Zero Balance Logic" (ZBL) when establishing the price to charge members whose drug cost is less than the co-payment. Thus, if the cost of the drug is \$7, and the member's co-payment is \$10, the member will be charged \$10.

B. Provider Contract Compliance

APM does not consistently require its member pharmacies to submit the usual and customary charge as required by contract, when they provide a drug to a member. This failure inhibits the PBM's ability to construct an accurate and current table of charges.

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.

Many pharmacy contracts stipulated that the pricing source be *First Data Bank*, while in practice, the PBM utilized *Medispan*. No review was performed in regard to the impact this may have had on the reimbursement of pharmacy claims.

It is recommended that the PBM utilize the pricing source specified in its executed contracts.

C. Specialty Drugs

In addition to the PBM, the Parent maintains a subsidiary, Aetna Specialty Pharmacy, which provides Specialty Drugs. Specialty drugs are a category of drugs created through advances in research, technology, and design that generally target and treat specific complex conditions or illnesses and which are less commonly used and normally have a greater cost than a standard prescription drug. MHA tested claims paid through this entity.

During the testing, MHA noted a number of pricing errors. In some cases, APM disputed the conclusions, but did not provide sufficient documentation to support its contention. In other cases, APM acknowledged the errors, attributing them to incorrect prices being installed in the database.

It is recommended that APM take steps to ensure that its drug pricing is accurate.

Section 243.2(b)(4) of Department Regulation No. 152 (11 NYCRR 243.2(b)(4)) requires that:

“...an insurer shall maintain a claim file for six calendar years after all elements of the claim are resolved and the file is closed or until after the filing of the report on examination in which the claim file was subject to review, whichever is longer. A claim file shall show clearly the inception, handling and disposition of the claim, including the dates that forms and other documents were received.”

Further, Section 216.11 of Department Regulation No. 64 (11 NYCRR 216.11) states in part:

“...to enable department personnel to reconstruct an insurer’s activities, all insurers subject to the provisions of this Part must maintain within each claim file all communications, transactions, notes and work papers relating to the claim. All communications and transactions, whether written or oral, emanating from or received by the insurer shall be dated by the insurer. Claim files must be so maintained that all events relating to the claim can be reconstructed by the Insurance Department examiners. Insurers shall either make a notation in the file or retain a copy of all forms mailed to claimants.”

The problems encountered during the review of pharmacy claims were exacerbated by the fact that many of APM’s files and provider contracts were disorganized and/or incomplete.

It is recommended that APM update its provider contracts and files to ensure they are organized and complete.

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 by retaining all aspects of its claims so that the examiner can reconstruct the complete claim transaction.

14. COMPLIANCE WITH PRIOR REPORTS ON EXAMINATION

The two prior market conduct reports on examination were the result of examinations into AHI and AHIC only. Those reports contained the following comments and recommendations (the items listed below refer only to those comments and recommendations which Aetna had not fully complied with as of the date of this examination. All other prior report on examination comments and recommendations were noted as having been complied with):

The prior report on examination as of March 30, 2000, contained the following comments and recommendations (the page numbers included in the table below refer to that prior report on examination):

<u>ITEM NO.</u>	<u>PAGE NO.</u>
<u>Commissions to Agents</u>	
1.	<p>It is recommended that U.S. HealthCare comply with NYSID licensing requirements as to all U.S. HealthCare's employees who earn a commission or fee based on sales and to comply with New York Insurance Law §2114(a)(3) and §2116 to ensure that commissions are only paid to licensed agents and brokers.</p> <p><i>This report contains a similar recommendation.</i></p>
	8-13
<u>Written Disclosure of Information</u>	
2.	<p>It is recommended that U.S. HealthCare comply with the requirements of §4324 of the New York Insurance Law and ensure that each subscriber, and upon request each prospective subscriber prior to enrollment, is provided with the required written disclosure information in a timely manner.</p> <p><i>This report contains a similar recommendation.</i></p>
	15-17

ITEM NO.**PAGE NO.**Claims

3. It is recommended that USHC-NY comply with §4403(6)(a) of the New York State Public Health Law, §2601(a)(4) of the New York State Insurance Law and its member handbook and provide full reimbursement beyond the contracted co-payment to all subscribers who are properly referred to a non-participating provider. 21-24

This report contains a similar recommendation.

Prompt Pay

4. It is recommended that U.S. HealthCare implement the necessary procedures in order to ensure compliance with §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”. 24-32

This report contains a similar recommendation.

5. It is recommended that U.S. HealthCare perform a comprehensive review of all claims that were not processed within 45 days for the period 1998 through present and reprocess those claims in which interest is due pursuant to §3224-a of the New York Insurance Law. Said results should be forwarded to the Department for review. 24-32

Aetna has complied with this recommendation though a similar recommendation for a different time period is contained within this report.

6. It is recommended that U.S. HealthCare implement the necessary procedures to ensure compliance with §3224-a(b) of the New York Insurance Law and send out requisite notifications within 30 days where applicable. 24-32

This report contains a similar recommendation.

Utilization Review

7. It is recommended that USHC-NY comply with §4903(5) of the New York State Public Health Law and provide notices of adverse determinations in accordance with said statute. 38-41

A similar recommendation is contained within this report.

The prior report on examination as of February 28, 2001, contained the following comments and recommendations (the page numbers included in the table below refer to that prior report on examination):

<u>ITEM NO.</u>	<u>PAGE NO.</u>
<u>Record Retention</u>	
1.	<p>It is recommended that U.S. HealthCare comply with standards of retention of records by insurance companies as set forth in New York State Insurance Department Regulation No. 152 (11 NYCRR 243).</p> <p><i>This report contains a similar recommendation.</i></p>
2.	<p>It is recommended that U.S. HealthCare implement the necessary changes to its claims processing system to ensure that the required New York Health Care Reform Act (“HCRA”) Surcharges are paid to the State of New York. The Department will refer the issue of U.S. HealthCare’s failure to properly remit the required New York Health Care Reform Act (“HCRA”) Surcharges to the New York State Department of Health for further investigation.</p> <p><i>Similar recommendations are contained within the financial reports on examination prepared separately but concurrently for Aetna Health Inc. and Aetna Health Insurance Company of New York.</i></p>
<u>Explanation of Benefits Statements</u>	
3.	<p>It is recommended that U.S. HealthCare implement the necessary changes to the claims processing system to ensure that its EOB language clearly communicates to the subscriber and/or provider that U.S. HealthCare has processed a claim and how it was adjudicated. This includes the requisite programming that should ensure that inapplicable processing codes that result from manual overrides are not reflected on the EOB.</p> <p><i>This report contains a similar recommendation.</i></p>

15. SUMMARY OF COMMENTS AND RECOMMENDATIONS

<u>ITEM</u>	<u>PAGE NO.</u>
A. <u>Circular Letter No. 9 (1999) – Adoption of Procedure Manuals</u>	
i. 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.	8
ii. 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.	9
iii. 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 recommendations included within this report on examination.	9
B. <u>Claims Review</u>	
i. 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).	10
ii. It is recommended that AHI modify its EOBs to comply with the requirements of New York Insurance Law §3234(b).	10
iii. 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.	11
iv. 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.	11

<u>ITEM</u>	<u>PAGE NO.</u>
v. 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.	12
vi. 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.	13
vii. 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.	13
viii. 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.	13
ix. 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.	15
C. <u>Prompt Pay Law</u>	
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.	17
It is noted that the prior report on examination contained a similar recommendation.	
D. <u>Utilization Review</u>	
i. It is recommended that Aetna comply with New York Insurance Law §4903(e) and submit written adverse determination notifications, when required, to all members.	17
It is noted that a similar recommendation was made in a previous market conduct report on examination. In its written response to that market conduct report on examination, Aetna indicated that it had taken steps to comply with said recommendation.	

<u>ITEM</u>	<u>PAGE NO.</u>
ii. 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).	18
iii. 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.	19
iv. 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.	19
v. 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)).	20
vi. It is recommended that Aetna notify members of the rights of their providers to receive expedited appeals for concurrent care claims or claims for prospective treatment when a provider believes an immediate appeal is warranted.	20
vii. 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.	21
viii. 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.	21
E. <u>Complaints and Grievances</u>	
i. It is recommended that AHI comply with New York Public Health Law §4408-a(4) and submit acknowledgement letters for all complaints, within fifteen business days of their receipt.	22

It is noted that the prior report contained a similar recommendation.

<u>ITEM</u>	<u>PAGE NO.</u>
ii. 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.	22
 F. <u>Disclosure of Information</u>	
i. 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.	25
ii. 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.	26
iii. 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.	28
iv. 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.	28
v. 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.	30
vi. 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.	32

<u>ITEM</u>	<u>PAGE NO.</u>
vii. 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.	32
It is noted that the previous report contained a similar recommendation.	
G. <u>Agents And Brokers</u>	
It is recommended that Aetna maintain 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).	33
H. <u>Independent Practice Associations / Third Party Administrators</u>	
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.	34
I. <u>Aetna’s Website</u>	
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.	35
J. <u>Pharmacy Benefits Manager</u>	
i. 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.	38

<u>ITEM</u>	<u>PAGE NO.</u>
ii. 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.	40
iii. 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.	41
iv. It is recommended that the PBM utilize the pricing source specified in its executed contracts.	41
v. It is recommended that APM take steps to ensure that its drug pricing is accurate.	42
vi. It is recommended that APM update its provider contracts and files to ensure they are organized and complete.	43
vii. 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 by retaining all aspects of its claims so that the examiner can reconstruct the complete claim transaction.	43

Appointment No. 22475

**STATE OF NEW YORK
INSURANCE DEPARTMENT**

I, Howard Mills, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Bruce Borofsky

as a proper person to examine into the affairs of the

Aetna Health, Inc.

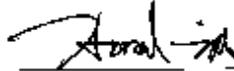
and to make a report to me in writing of the said

Company

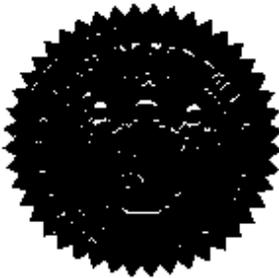
with such information as he shall deem requisite.

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

this 10th day of March 2006



Howard Mills
Superintendent of Insurance



Appointment No. 22476

**STATE OF NEW YORK
INSURANCE DEPARTMENT**

I, Howard Mills, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Bruce Borofsky

as a proper person to examine into the affairs of the

Aetna Health Insurance Company of New York.

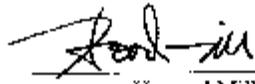
and to make a report to me in writing of the said

Company

with such information as he shall deem requisite.

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

this 10th day of March 2006



Howard Mills
Superintendent of Insurance



Appointment No. 22495

**STATE OF NEW YORK
INSURANCE DEPARTMENT**

I, Howard Mills, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:

Bruce Borofsky

as a proper person to examine into the affairs of the
Aetna Life Insurance Company

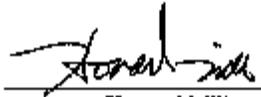
and to make a report to me in writing of the said

Company

with such information as he shall deem requisite.

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

this 24th day of April 2006



Howard Mills
Superintendent of Insurance

