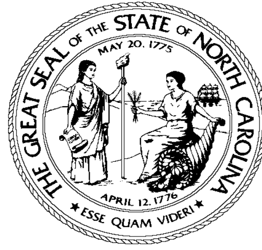

Report on

Market Conduct Examination

of

Aetna Life Insurance Company

Hartford, Connecticut

by Representatives of the

North Carolina Department of Insurance

as of

June 24, 2019

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Raleigh, North Carolina
June 24, 2019

Honorable Mike Causey
Commissioner of Insurance
Department of Insurance
State of North Carolina
Albemarle Building
325 N. Salisbury Street
Raleigh, North Carolina 27603

Honorable Andrew N. Mais
Commissioner of Insurance
Connecticut Insurance Department
153 Market Street, 7th Floor
Hartford, Connecticut 06103

Honorable Commissioners:

In accordance with the provisions of North Carolina General Statute (NCGS) 58-2-131 through 58-2-134, a target examination has been made of the market conduct activities of the following entity

Aetna Life Insurance Company
(NAIC #60054)
NAIC Exam Tracking System Exam Number: NC-NC094-5
Hartford, Connecticut
(hereinafter generally referred to as the Company)

The examination was conducted at the North Carolina Department of Insurance (Department) office located at 325 N. Salisbury Street, Raleigh, North Carolina. A report thereon is respectfully submitted.

SCOPE OF EXAMINATION

This examination commenced on March 26, 2018, and covered the period of July 1, 2016, through June 30, 2017. Analyses of certain operations of the Company were concluded during the Wrap-Up Conference which was held May 28, 2019. This action was taken due to analysis of the market conduct annual filing submission. All comments made in this report reflect conditions observed during the period of the examination.

This examination was performed in accordance with auditing standards established by the Department and procedures established by the National Association of Insurance Commissioners (NAIC). The scope of this examination was not comprehensive and consisted of an examination of the Company's practices and procedures in utilization reviews, member appeals and grievances, and provider availability/accessibility standards and monitoring. The findings and conclusions contained within the report are based on the work performed and are referenced within the appropriate sections of the examination report.

It is the Department's practice to cite companies in violation of a statute or rule when the results of a sample show errors/noncompliance that fall outside certain tolerance levels. The Department applied a 0 percent tolerance level for timeliness of utilization review, member appeal and grievance acknowledgement, and determination letters. A tolerance level of 3 percent was applied for notification letter content of utilization reviews, member appeals, and grievances. Sample sizes were generated using Audit Command Language software. The Department utilized a 95% Confidence Level to determine the error tolerance level.

EXECUTIVE SUMMARY

This market conduct target examination revealed concerns with Company procedures and practices in the following areas:

Utilization Management – Failure to conduct timely reviews for utilization review requests; failure to provide compliant written decision notification letters to covered persons for member appeals; failure to provide timely acknowledgement letters to covered persons for member appeals; failure to provide adequate notice to members of

review panel meeting dates; and failure to issue an adverse decision rendered by a North Carolina licensed Medical Doctor for one expedited appeal.

Policyholder Grievances – Failure to provide timely written acknowledgement and decision letters to covered persons; failure to notify the covered person of the review meeting at least 15 days prior to the scheduled meeting date; failure to provide compliant acknowledgement and decision letters to the member submitting the grievance; and failure to reprocess claims for out-of-network anesthesia services as in-network in order to hold the member harmless by preventing balance-billing.

Specific violations are noted in the appropriate sections of this report. All North Carolina General Statutes and rules of the North Carolina Administrative Code cited in this report may be viewed on the North Carolina Department of Insurance Web site www.ncdoi.com.

This examination identified various statutory violations, some of which may extend to other jurisdictions. The Company is directed to take immediate corrective action to demonstrate its ability and intention to conduct business in North Carolina according to its insurance laws and regulations.

All statutory violations may not have been discovered or noted in this report. Failure to identify statutory violations in North Carolina or in other jurisdictions does not constitute acceptance of such violations.

UTILIZATION MANAGEMENT

The Company's Utilization Management program and activities were reviewed to determine adherence to Company guidelines and compliance with applicable North Carolina Statutes and rules.

As required by the provisions of NCGS 58-50-61, a formal structure has been established to oversee and conduct utilization management functions. The Medical Director has ultimate responsibility for oversight and implementation of the Utilization Management Program. This program is integrated with other operational areas of the Company in adherence to the provisions of NCGS 58-50-61.

Policies and Procedures

The Company's Utilization Management Program document, as well as policies and procedures, were examined to determine compliance with appropriate North Carolina statutes. The examination revealed that these documents adhere to the provisions of NCGS 58-50-61.

Medical Necessity Reviews

The scope of utilization management services provided includes prospective review for hospital admissions and ambulatory care and services, concurrent review of inpatient health services, retrospective review, referral management, complex case management, and discharge planning. Written noncertifications are communicated to members as required by the provisions of NCGS 58-50-61.

The Company received a total of 2,449 utilization review requests during the examination period, consisting of prospective, concurrent, and retrospective requests. A random sample of 131 files was reviewed to assess the Company's compliance with the provisions of NCGS 58-50-61, as well as its own policies and procedures. The review revealed that the Company did not adhere to the provisions of NCGS 58-50-61 within six files, as the review was not completed and communicated with three business days after receiving the request.

Appeals

Members who are not satisfied with utilization review determinations have the right to appeal the Company's decision. A member is entitled to an expedited review of his or her appeal if a delay in the rendering of health care would be detrimental to the member's health.

Appeal Records Review

The Company received a total of 27 utilization review standard appeal requests during the examination period. The total population of files was reviewed to assess the Company's compliance with the provisions of NCGS 58-50-61 and 58-50-62, as well as its own policies and

procedures. The review revealed that the Company did not adhere to the provisions of NCGS 58-50-61 or NCGS 58-50-62 within six files based on the following:

- The acknowledgement letter within four files was not sent to the covered person within three business days after receiving the appeal request.

- One file for a 2nd level appeal review did not contain a determination letter to the member.

- Within one file, the written notification to the member regarding the date for the 2nd level review panel meeting was issued less than 15 days before the meeting date.

Three additional standard appeal files contained a determination letter which was issued beyond the Company's internal standard of 15 calendar days.

The Company received a total of seven expedited appeal requests during the examination period. The total population of files was reviewed to assess the Company's compliance with the provisions of NCGS 58-50-61 and 58-50-62, as well its internal policies and procedures. The review revealed that the Company did not adhere to the provisions of NCGS 58-50-61(l) within one file, as the adverse review decision was not rendered by a North Carolina licensed Medical Doctor.

The average service time to process a member appeal was 17 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
0 - 7	7	20.6
8 - 14	8	23.5
15 - 21	17	50.0
22 – 30	2	5.9
Total	**34**	**100.0**

POLICYHOLDER GRIEVANCES

The Company received a total of 134 member grievance review requests during the examination period. A random sample of 131 grievance files was reviewed to assess the Company's compliance with the provisions of NCGS 58-50-62, as well as its internal policies

and procedures. The review revealed that the Company did not adhere to the provisions of NCGS 58-50-62 within 34 files based on the following:

- The acknowledgement letter within 25 files was not sent to the member within three business days after receiving the grievance.
- No acknowledgement letter was sent to the member as reflected within two files.
- One file contained an acknowledgement letter which did not indicate the name and phone number of the grievance coordinator assigned to the review.
- One file contained an adverse decision letter which did not contain notice of the availability of assistance from the Health Insurance Smart NC program.
- Within two files, the written notification to the member regarding the date for the 2nd level review panel meeting was issued less than 15 days before the meeting date.
- Within four files, the review and decision were not completed and communicated to the member within 30 days after receiving the grievance.

Within nine additional grievance files, the Company did not adhere to the provisions of NCGS 58-3-200(d). The medically necessary anesthesia service was not provided within the carrier's network due to no fault of the member. However, the Explanation of Benefits did not contain language indicating that the member should be held harmless by not being subjected to balance billing for amounts in excess of claim payment rendered and benefits applied.

Based on these examination findings within the grievance sample review, the Company identified an additional six claims within the examination period for which processing resulted in the same balance billing issue. The Company reprocessed all 15 claims, each involving the same anesthesia provider. These 15 claims were reworked to incorporate 'member held harmless' language within the Explanation of Benefits. Reprocessing also resulted in additional payment issued to the provider totaling $6,694.02. in addition to this amount, interest was paid to the provider totaling $1,813.15 in adherence to NCGS 58-3-225. As a corrective action, the Company reprogrammed systems logic to prevent future recurrence of this issue.

The average service time to process a member grievance was 25 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
0 - 7	9	6.9
8 - 14	11	8.4
15 - 21	18	13.7
22 - 30	89	68.0
31 - 60	2	1.5
Over 60	2	1.5
Total	**131**	**100.0**

PROVIDER NETWORK AVAILABILITY AND ACCESSIBILITY

The Company's policies and standards for provider and facility availability and accessibility, as well as monitoring results showing performance against these standards were reviewed to ascertain compliance with the provisions of 11 NCAC 20.0301(3) and 20.0302(3).

The Company has established adequate standards and monitors performance results for all required provider availability and accessibility parameters. The Company met all standards during the examination period with the following exceptions:

- 2016 Urgent Care Appointment waiting times (within 24 hours).
- 2016 Primary Care – Routine Appointment waiting times (seven days or less).

COMMENTS, RECOMMENDATIONS, AND DIRECTIVES

The Company must complete and implement corrective actions as a result of this target examination. These corrective actions must include but are not limited to compliance with statutory requirements regarding timely processing of member utilization review requests; member appeal and grievance written notification decisions and acknowledgement letters (including timeliness and content of notifications); and processes to prevent the member from being balance-billed for services such as anesthesia provided by a non-contracted provider within an in-network or emergency setting (i.e. 'hold-harmless' provisions).

Upon acceptance of the Report the Company shall provide the Department with a statement of corrective action plan to address the violations identified during the examination. The Department will conduct a future investigation if warranted to determine if the Company successfully implemented its statement of corrective action.

CONCLUSION

A target examination has been conducted on the market conduct affairs of Aetna Life Insurance Company for the period July 1, 2016, through June 30, 2017, with analyses of certain operations of the Company being conducted through May 28, 2019.

This examination was conducted in accordance with the North Carolina Department of Insurance and the National Association of Insurance Commissioners Market Regulation Handbook procedures, including analyses of Company operations in the areas of utilization reviews, member appeals and grievances, and provider availability/accessibility standards and monitoring.

In addition to the undersigned, Darla Wright, MCM, North Carolina Market Conduct Senior Examiner, participated in this examination.

Respectfully submitted,

Scott D. Grindstaff, HIA, MHP, MCM
Examiner-In-Charge
Market Regulation Division
State of North Carolina

I have reviewed this examination report and it meets the provisions for such reports prescribed by this Division and the North Carolina Department of Insurance.

Teresa Knowles, ACS
Deputy Commissioner
Market Regulation Division
State of North Carolina