[IN ACCORDANCE WITH CALIFORNIA INSURANCE CODE (CIC) SECTION 12938, THIS REPORT WILL BE MADE PUBLIC AND PUBLISHED ON THE CALIFORNIA DEPARTMENT OF INSURANCE (CDI) WEBSITE]

WEBSITE PUBLISHED REPORT OF THE MARKET CONDUCT EXAMINATION OF THE CLAIMS PRACTICES OF

AETNA LIFE INSURANCE COMPANY
NAIC # 60054 CDI # 0003-4

AS OF JANUARY 31, 2017

ADOPTED JULY 14, 2020

STATE OF CALIFORNIA

CALIFORNIA DEPARTMENT OF INSURANCE
MARKET CONDUCT DIVISION
FIELD CLAIMS BUREAU
NOTICE

The provisions of Section 735.5(a) (b) and (c) of the California Insurance Code (CIC) describe the Commissioner’s authority and exercise of discretion in the use and/or publication of any final or preliminary examination report or other associated documents. The following examination report is a report that is made public pursuant to California Insurance Code Section 12938(b)(1) which requires the publication of every adopted report on an examination of unfair or deceptive practices in the business of insurance as defined in Section 790.03 that is adopted as filed, or as modified or corrected, by the Commissioner pursuant to Section 734.1.
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FOREWORD

This report is written in a “report by exception” format. The report does not present a comprehensive overview of the subject insurer’s practices. The report contains a summary of pertinent information about the lines of business examined, details of the non-compliant or problematic activities that were discovered during the course of the examination and the insurer’s proposals for correcting the deficiencies. When a violation that reflects an underpayment to the claimant is discovered and the insurer corrects the underpayment, the additional amount paid is identified as a recovery in this report.

While this report contains violations of law that were cited by the examiner, additional violations of CIC § 790.03 or other laws not cited in this report may also apply to any or all of the non-compliant or problematic activities that are described herein.

All unacceptable or non-compliant activities may not have been discovered. Failure to identify, comment upon or criticize non-compliant practices in this state or other jurisdictions does not constitute acceptance of such practices.

Alleged violations identified in this report, any criticisms of practices and the Company’s responses, if any, have not undergone a formal administrative or judicial process.

This report is made available for public inspection and is published on the California Department of Insurance website (www.insurance.ca.gov) pursuant to California Insurance Code section 12938(b)(1).
SCOPE OF THE EXAMINATION

Under the authority granted in Part 2, Chapter 1, Article 4, Sections 730, 733, and 736, and Article 6.5, Section 790.04 of the California Insurance Code; and Title 10, Chapter 5, Subchapter 7.5, Section 2695.3(a) of the California Code of Regulations, an examination was made of the claim handling practices and procedures in California of:

Aetna Life Insurance Company  
NAIC # 60054  

Group NAIC # 0001

Hereinafter, the Company listed above also will be referred to individually as Aetna, ALIC, or the Company.

This examination covered the claim handling practices of the aforementioned Company on Individual and Group Disability Health claims closed during the period from February 1, 2016 through January 31, 2017. Additionally, the examination targeted the claims handling practices on mental health claims closed under its Individual and Group Disability Health policies during the period from February 1, 2016 through January 31, 2017. The examination was made to discover, in general, if these and other operating procedures of the Company conform to the contractual obligations in the policy forms, the California Insurance Code (CIC), the California Code of Regulations (CCR), the California Mental Health Parity Act, the Mental Health Parity and Addiction Equity Act of 2008 (MHPAE), and case law.

To accomplish the foregoing, the examination included:

1. A review of the guidelines, procedures, training plans and forms adopted by the Company for use in California including any documentation maintained by the Company in support of positions or interpretations of the California Insurance Code, Fair
Claims Settlement Practices Regulations, and other related statutes, regulations and case law used by the Company to ensure fair claims settlement practices.

2. A review of the application of such guidelines, procedures, and forms, by means of an examination of a sample of individual claim files and related records.

3. A review of the California Department of Insurance’s (CDI) market analysis results; and if any, a review of consumer complaints and inquiries about this Company closed by the CDI during the period February 1, 2016 through January 31, 2017, a review of previous CDI market conduct claims examination reports on this Company; and a review of prior CDI enforcement actions.

4. A review of electronic paid claims data for timeliness of payment of claims, and the proper payment of interest if payment was issued beyond 30 working days from date of receipt.

5. A review of the Company’s response to a CDI questionnaire pertaining to Company procedures during the review period for complying with the California Mental Health Parity Act (CIC § 10144.5) and coverage for essential health benefits pursuant to the Patient Protection and Affordable Care Act (CIC § 10112.27).

The review of the sample of individual claim files was conducted at the offices of the Company in West Sacramento, California and at the offices of the California Department of Insurance in Sacramento, California.
EXECUTIVE SUMMARY

The Individual and Group Disability Health claims reviewed were closed from February 1, 2016 through January 31, 2017, referred to as the “review period”. The examination also targeted the claims handling practices of the Company on mental health claims. The mental health claims reviewed were closed from February 1, 2016 through January 31, 2017.

The examiners randomly selected 160 Individual and Group Disability Health medical claim files, 90 Individual and Group Disability Mental Health claim files, and 25 pharmacy claim files for examination. The examiners cited 179 alleged claims handling violations of the California Insurance Code, the California Code of Regulations, and other specified codes from this sample file review.

ALIC was the subject of 258 California consumer complaints and inquiries closed from February 1, 2016 through January 31, 2017 in regard to the lines of business reviewed in this examination. Of the complaints and inquiries, the CDI determined that 105 consumer complaints were justified. The CDI alleged 243 violations of law on the justified complaints including, but not limited to: the failure to include CDI information on correspondence and/or explanation of benefits (EOB); the failure to include mandated language advising of the right to an independent medical review (IMR); the failure of Aetna to use its own name on correspondence; Aetna’s misrepresentation of facts or policy provisions; the failure to acknowledge communication from the insured within 15 calendar days; the failure to provide 30-day status letters; the failure to acknowledge and act promptly upon communications; the failure to effectuate a prompt, fair, and equitable settlement of the claim; the failure to adopt and implement standards for the prompt investigation and processing of claims; the failure to process claims within 30 working days; the failure to include dispute resolution language; the failure to respond to a provider dispute within 45 working days; the failure to include interest for a contested
claim; and the failure to timely respond to the Department’s inquiries. The examiners focused on these issues during the course of the file review.

ALIC was the subject of a previous claims examination. This claims examination reviewed a sample of claims closed from June 1, 2007 through March 31, 2011. The most significant noncompliance issues identified in this previous examination report were the Company’s misrepresentation of facts or policy provisions; the failure to include mandated language advising of the right to an IMR; the failure to effectuate a prompt, fair, and equitable settlement of the claim; the failure to conduct and diligently pursue a thorough, fair and objective investigation; the failure to provide a clear explanation of the computation of benefits; and the Company’s settlement of a claim that was unreasonably low. These issues were similarly identified as problematic in the current examination.

ALIC was also the subject of a previous targeted claims examination. This targeted claims examination reviewed a sample of claims closed from June 1, 2008, through March 31, 2011. The examination targeted the claims handling practices of the aforementioned Company on health insurance claims for applied behavioral analysis (ABA) and speech therapy for the treatment of pervasive development disorder (PDD) or autism which are identified under the collective term, autism spectrum disorder (ASD). The most significant noncompliance issues identified in this previous targeted examination report were the failure to pay a claim for the treatment of ASD under the provision of the policy that affords coverage for a severe mental illness or a serious emotional disturbance of a child as mandated and defined in CIC §10144.5; the failure to include mandated language advising of the right to an IMR; the Company’s misrepresentation of facts or policy provisions; and the Company’s settlement of a claim that was unreasonably low. With the exception of the failure to pay for a claim for the treatment of ASD, these issues were similarly identified as problematic in the current examination.
Findings of this examination included the following:

- The Company failed to include in its notice of a contested or denied claim that the insured or provider may seek a review by the Department.
- The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.
- The Company failed to provide written notice of the need for additional time every 30 calendar days to the claimant or provider.
- The Company failed to include in its notice of a denied claim to the insured or provider, the portion of the claim that was denied, and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for denying the claim.
- The Company failed to advise the insured of the right to request an independent medical review (IMR) on letters of denial and on all written response to grievances in cases in which the insured believes that health care services had been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers.

The examination also included an electronic analysis of all paid claims during the review period to determine compliance with timeliness of payment of claims and payment of interest requirements in California law. The electronic data field parameters were: Date Claim Received, Date Claim Paid or Closed, and for contested claims, the Date Additional Information Received and Date Claim Paid or Closed. The electronic review initially identified 71,585 alleged violations of the California Insurance Code, which included the failure to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim, and the failure to pay interest on claims paid beyond 30 working days. In response to the findings of the electronic review, the Company provided additional claim data for the Department’s consideration. The Company demonstrated compliance with respect to 4,580 alleged violations. As a result of the Company’s additional information, the Department now alleges a total of
67,005 violations of the California Insurance Code for the electronic analysis. The final section number 37 of the report provides more details on these findings.
DETAILS OF THE CURRENT EXAMINATION

Further details with respect to the examination and alleged violations are provided in the following tables and summaries:

### AETNA SAMPLE MEDICAL FILE REVIEW

<table>
<thead>
<tr>
<th>LINE OF BUSINESS / CATEGORY</th>
<th>CLAIMS IN REVIEW PERIOD</th>
<th>SAMPLE CLAIMS REVIEWED</th>
<th>NUMBER OF ALLEGED VIOLATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability Health / Group Paid</td>
<td>2,571,792</td>
<td>20</td>
<td>9</td>
</tr>
<tr>
<td>Disability Health / Group Denied</td>
<td>228,323</td>
<td>30</td>
<td>17</td>
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<tr>
<td>Disability Health / Group Contested</td>
<td>93,264</td>
<td>20</td>
<td>42</td>
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<tr>
<td>Disability Health / Individual Paid</td>
<td>239</td>
<td>20</td>
<td>13</td>
</tr>
<tr>
<td>Disability Health / Individual Denied</td>
<td>1,165</td>
<td>30</td>
<td>5</td>
</tr>
<tr>
<td>Disability Health / Individual Contested</td>
<td>77</td>
<td>20</td>
<td>16</td>
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<tr>
<td>Disability Health / Group Member Appeals</td>
<td>2,917</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Disability Health / Group Provider Appeals</td>
<td>20,362</td>
<td>5</td>
<td>17</td>
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<tr>
<td>Disability Health / Individual Member Appeals</td>
<td>2</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Disability Health / Individual Provider Appeals</td>
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<td>0</td>
</tr>
<tr>
<td>Pharmacy / Paid</td>
<td>4,515,906</td>
<td>10</td>
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</tr>
<tr>
<td>Pharmacy / Denied - Rejected</td>
<td>1,060,150</td>
<td>15</td>
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<tr>
<td><strong>TOTALS</strong></td>
<td><strong>8,494,558</strong></td>
<td><strong>185</strong></td>
<td><strong>133</strong></td>
</tr>
<tr>
<td>LINE OF BUSINESS / CATEGORY</td>
<td>CLAIMS IN REVIEW PERIOD</td>
<td>SAMPLE CLAIMS REVIEWED</td>
<td>NUMBER OF ALLEGED VIOLATIONS</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-------------------------</td>
<td>------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Disability Health / Mental Health / Group Paid</td>
<td>100,557</td>
<td>19</td>
<td>6</td>
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<tr>
<td>Disability Health / Mental Health / Group Denied</td>
<td>5,933</td>
<td>17</td>
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<tr>
<td>Disability Health / Mental Health / Group Contested</td>
<td>2,925</td>
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<tr>
<td>Disability Health / Mental Health / Individual Denied</td>
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<td>13</td>
<td>0</td>
</tr>
<tr>
<td>Disability Health / Mental Health / Individual Contested</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Disability Health / Mental Health / Group Member Appeals</td>
<td>288</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Disability Health / Mental Health / Group Provider Appeals</td>
<td>937</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Disability Health / Mental Health / Individual Member Appeals</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Disability Health / Mental Health / Individual Provider Appeals</td>
<td>27</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>110,682</strong></td>
<td><strong>90</strong></td>
<td><strong>46</strong></td>
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</tbody>
</table>
## AETNA ELECTRONIC CLAIMS PAID REVIEW

<table>
<thead>
<tr>
<th>LINE OF BUSINESS / CATEGORY</th>
<th>NUMBER OF CLAIMS</th>
<th>NUMBER OF ALLEGED VIOLATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability Health / Group Paid (includes violations paid over 30 working days and violations related to interest owed)</td>
<td>2,571,792</td>
<td>63,857</td>
</tr>
<tr>
<td>Disability Health / Group Contested Paid (includes violations paid over 30 working days and violations related to interest owed)</td>
<td>39,275</td>
<td>5,681</td>
</tr>
<tr>
<td>Disability Health / Individual Paid (includes violations paid over 30 working days and violations related to interest owed)</td>
<td>239</td>
<td>46</td>
</tr>
<tr>
<td>Disability Health / Individual Contested Paid (includes violations paid over 30 working days and violations related to interest owed)</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td><strong>Medical Claims Subtotal</strong></td>
<td>2,611,313</td>
<td>69,588</td>
</tr>
<tr>
<td>Disability Health / Mental Health / Group Paid (includes violations paid over 30 working days and violations related to interest owed)</td>
<td>100,557</td>
<td>1,874</td>
</tr>
<tr>
<td>Disability Health / Mental Health / Group Contested Paid (includes violations paid over 30 working days and violations related to interest owed)</td>
<td>1,274</td>
<td>123</td>
</tr>
<tr>
<td>Disability Health / Mental Health / Individual Paid</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Disability Health / Mental Health / Individual Contested Paid</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Mental Health Claims Subtotal</strong></td>
<td>101,832</td>
<td>1,997</td>
</tr>
<tr>
<td><strong>Totals for Initial Analysis</strong></td>
<td>5,426,290</td>
<td>71,585</td>
</tr>
<tr>
<td><strong>Company Demonstrated Compliance</strong></td>
<td></td>
<td>4,580*</td>
</tr>
<tr>
<td><strong>Final Totals</strong></td>
<td></td>
<td>67,005</td>
</tr>
</tbody>
</table>

*The number of claims in which Aetna demonstrated compliance for the electronic analysis includes group and individual medical claims and group and individual mental health claims.*
# TABLE OF TOTAL ALLEGED VIOLATIONS

<table>
<thead>
<tr>
<th>Citation</th>
<th>Description of Allegation</th>
<th>Number of Alleged Violations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Sample Medical Claims Review</td>
</tr>
<tr>
<td>CIC §10123.13(a) *[CIC §790.03(h)(3)] Insured &amp; Provider</td>
<td>The Company failed to include in its notice of a contested or denied claim that the insured and the provider may seek a review by the Department.</td>
<td>22</td>
</tr>
<tr>
<td>CIC §790.03(h)(1)</td>
<td>The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.</td>
<td>23</td>
</tr>
<tr>
<td>CCR §2695.11(d) *[CIC §790.03(h)(3)] Insured &amp; Provider</td>
<td>The Company failed to provide written notice of the need for additional time every 30 calendar days to the claimant and the provider.</td>
<td>24</td>
</tr>
<tr>
<td>CIC §10123.13(a) *[CIC §790.03(h)(13)] Insured &amp; Provider</td>
<td>The Company failed to include in its notice of a denied claim to the insured and the provider, the portion of the claim that was denied, and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for denying the claim.</td>
<td>9</td>
</tr>
<tr>
<td>CIC §10169(i) *[CIC §790.03(h)(1)]</td>
<td>The Company failed to advise the insured of the right to request an independent medical review (IMR) on letters of denials and on all written responses to grievances in cases in which the insured believes that health care services had been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers.</td>
<td>10</td>
</tr>
<tr>
<td>CCR §2695.11(b) *[CIC §790.03(h)(3)] Insured &amp; Provider</td>
<td>The Company failed to provide a clear explanation of the computation of benefits to the claimant and the provider with each claim payment.</td>
<td>4</td>
</tr>
<tr>
<td>Citation</td>
<td>Description of Allegation</td>
<td>Number of Alleged Violations</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>CIC §790.03(h)(5)</td>
<td>The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
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<td></td>
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</tr>
<tr>
<td>CIC §10123.13(a) *[CIC §790.03(h)(5)]</td>
<td>The Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim, or after receipt of all information necessary to determine payer liability.</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
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<td></td>
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<tr>
<td>CCR §2695.7(d) *[CIC §790.03(h)(3)]</td>
<td>The Company failed to conduct and diligently pursue a thorough, fair and objective investigation. The Company persisted in seeking information not reasonably required for or material to the resolution of a claims dispute.</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
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<td></td>
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<tr>
<td>CCR §2695.7(g) *[CIC §790.03(h)(5)]</td>
<td>The Company attempted to settle a claim by making a settlement offer that was unreasonably low.</td>
<td>4</td>
</tr>
<tr>
<td></td>
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<td>1</td>
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<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td>CIC §790.03(h)(3)</td>
<td>The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
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<tr>
<td>CIC §10112.2 *[CIC §790.03(h)(5)]</td>
<td>The Company failed to comply with Section 2713 of the federal Public Health Service Act.</td>
<td>4</td>
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<tr>
<td></td>
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<td>0</td>
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<tr>
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<td></td>
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</tr>
<tr>
<td>CIC §10112.27(a)(2)(D) *[CIC §790.03(h)(5)]</td>
<td>The Company failed to comply with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) by imposing a quantitative treatment limit (QTL) with no available recourse for medical necessity.</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CIC §10123.13(a) *[CIC §790.03(h)(13)]</td>
<td>Insured The Company failed to notify the insured in writing, within 30 working days after receipt of the claim, that the claim was denied.</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Citation</td>
<td>Description of Allegation</td>
<td>Number of Alleged Violations</td>
</tr>
<tr>
<td>----------</td>
<td>----------------------------------------------------------------------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sample Medical Claims Review</td>
</tr>
<tr>
<td>CIC §10123.131(b) *[CIC §790.03(h)(3)]</td>
<td>The Company requested information that is not reasonably necessary to determine liability for payment of a claim.</td>
<td>1</td>
</tr>
<tr>
<td>CIC §10133.66(b) *[CIC §790.03(h)(3)]</td>
<td>The Company failed to send a written request to the provider within 365 days of the date of the claims overpayment with a clear explanation of the basis for the requested reimbursement.</td>
<td>3</td>
</tr>
<tr>
<td>CIC §10123.13(b) *[CIC §790.03(h)(5)]</td>
<td>The Company failed to pay interest on an uncontested claim after 30 working days.</td>
<td>0</td>
</tr>
<tr>
<td>CCR §2695.11(d) *[CIC §790.03(h)(3)]</td>
<td>The Company failed, upon contesting a claim under CIC §10123.13, to affirm or deny the claim within 30 calendar days from the original notification.</td>
<td>2</td>
</tr>
<tr>
<td>CIC §10123.13(a) *[CIC §790.03(h)(3)]</td>
<td>The Company failed to notify the insured in writing, within 30 working days after receipt of the claim, that the claim was contested.</td>
<td>1</td>
</tr>
<tr>
<td>CIC §10123.13(c) *[CIC §790.03(h)(5)]</td>
<td>The Company failed to pay interest on a contested claim after 30 working days.</td>
<td>1</td>
</tr>
<tr>
<td>CIC §10123.135(h)(4) *[CIC §790.03(h)(3)]</td>
<td>The Company failed to include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification.</td>
<td>0</td>
</tr>
<tr>
<td>CIC §10123.137(c) *[CIC §790.03(h)(3)]</td>
<td>The Company failed to resolve each provider dispute consistent with applicable law and issue a written determination within 45 working days after the date of receipt of the provider dispute.</td>
<td>1</td>
</tr>
</tbody>
</table>
**AETNA LIFE INSURANCE COMPANY**

<table>
<thead>
<tr>
<th>Citation</th>
<th>Description of Allegation</th>
<th>Sample Medical Claims Review</th>
<th>Mental Health Targeted Claims Review</th>
<th>Electronic Analysis Medical Claims Paid</th>
<th>Electronic Analysis Mental Health Claims Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCR §2695.5(b) *CIC §790.03(h)(2)]</td>
<td>The Company failed to respond to communications within 15 calendar days.</td>
<td>1</td>
<td>0</td>
<td>--</td>
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</tr>
<tr>
<td><strong>TOTAL NUMBER OF ALLEGED VIOLATIONS</strong></td>
<td></td>
<td>133</td>
<td>46</td>
<td>69,588</td>
<td>1,997</td>
</tr>
<tr>
<td><strong>Company Demonstrated Compliance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4,580**</td>
</tr>
<tr>
<td><strong>FINAL TOTAL NUMBER OF ALLEGED VIOLATIONS</strong></td>
<td></td>
<td>133</td>
<td>46</td>
<td></td>
<td>67,005</td>
</tr>
</tbody>
</table>

** The number of claims in which Aetna demonstrated compliance for the electronic analysis includes group and individual medical claims and group and individual mental health claims.

*DESCRIPTIONS OF APPLICABLE UNFAIR CLAIMS SETTLEMENT PRACTICES*

- **CIC §790.03(h)(1)**
  - The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.

- **CIC §790.03(h)(2)**
  - The Company failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

- **CIC §790.03(h)(3)**
  - The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.

- **CIC §790.03(h)(5)**
  - The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability had become reasonably clear.

- **CIC §790.03(h)(13)**
  - The Company failed to provide promptly a reasonable explanation of the bases relied upon in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.
# TABLE OF ALLEGED VIOLATIONS BY LINE OF BUSINESS
## DISABILITY HEALTH - MEDICAL

<table>
<thead>
<tr>
<th>AMOUNT OF RECOVERIES</th>
<th>NUMBER OF ALLEGED VIOLATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCR §2695.11(d) [CIC §790.03(h)(3)]</td>
<td>24</td>
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<tr>
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<td>CIC §10169(i) [CIC §790.03(h)(1)]</td>
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<td>CIC §10112.12 [CIC §790.03(h)(5)]</td>
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<td>CCR §2695.7(g) [CIC §790.03(h)(5)]</td>
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<td>CCR §2695.5(b) [CIC §790.03(h)(2)]</td>
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**SUBTOTAL** 133
# TABLE OF ALLEGED VIOLATIONS BY LINE OF BUSINESS
## DISABILITY HEALTH - MENTAL HEALTH

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<thead>
<tr>
<th>ACCIDENT AND DISABILITY (Disability Health - Mental Health)</th>
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</tr>
</tbody>
</table>

**SUBTOTAL** 46

| TOTAL | 179 |
SUMMARY OF EXAMINATION RESULTS

The following is a brief summary of the criticisms that were developed during the course of this examination related to the violations alleged in this report.

In response to each criticism, the Company is required to identify remedial or corrective action that has been or will be taken to correct the deficiency. The Company is obligated to ensure that compliance is achieved.

Any noncompliant practices identified in this report may extend to other jurisdictions. The Company should address corrective action for other jurisdictions when applicable.

Money recovered within the scope of this report was $98,410.66 as described in section numbers 7(e), 8, 13, 17, 23(a), 23(b), 28, 29, and 37 below. Following the findings of the examination, closed claims surveys as described in sections 13 and 24 below were conducted by the Company resulting in additional payments of $8,383,122.92. As a result of the examination, the total amount of money returned to claimants within the scope of this report was $8,481,533.58.

ACCIDENT AND DISABILITY (HEALTH) – SAMPLE MEDICAL FILE REVIEW

1. In 24 instances, the Company failed to provide written notice of the need for additional time every 30 calendar days to the claimant and the provider. Twelve instances apply to the claimant and twelve instances apply to the provider. When reference is made to the word “claimant” in this context, this also refers to the “member” and the “insured”. These words are used interchangeably throughout the report. The Department alleges these acts are in violation of CCR §2695.11(d) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company’s Response: The Company acknowledges these findings in all identified instances. In 18 instances on the same claim, the Company
incorrectly pended the claim for the primary carrier statement of payment or denial. The delays were associated with this incorrect pend. To ensure future compliance, the Company retrained the claim processing staff on coordination of benefits claim handling, which was completed on or before October 24, 2017. In six instances on the same claim, the Company was in possession of the operative report when the explanation of benefit (EOB) was produced. This isolated processor error was the factor that impacted the 30-day notification and additional time letters. To ensure future compliance, the Company discussed this error with the processor on July 6, 2017.

2. In 23 instances, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue. The Department alleges these acts are in violation of CIC §790.03(h)(1).

2(a). In 16 instances, the Company misrepresented the denial of claims as either not receiving requested information or not being filed within the required time limit. However, the claims should have been denied as the policies terminated prior to the services being rendered. Fifteen of these misrepresented denials involved individual policies and one involved a group policy.

Summary of the Company’s Response to 2(a): The Company acknowledges these findings in all identified instances. Due to the age of the claims, from a claim processing date perspective, the Company cannot replicate what occurred when these claims were originally processed. Eligibility, coordination of benefits, and other aspects of the plan are taken into account during claim processing. The order in which these were applied to the claims resulted in viewing coordination of benefits prior to eligibility. The Company tested these claims and if this scenario occurred today, the claims would appropriately deny as no coverage in effect. The Company completed review of the identified claims and of all claims involving individual plans during the examination period in September 2017 to identify any other impacted claims. In addition to the 16 instances, the Company identified 138 additional claims and sent the member and provider revised EOBs indicating no coverage was in effect at the time services were rendered.

2(b). In two instances, while the Company determined the service was not medically necessary and/or considered experimental or investigational upon appeal, the Company misrepresented the denials in the original EOBs to the member and the provider. The EOB to the member stated the following: “You do not have to pay this. The charge for this service is included in the overall rate your provider has agreed to accept.” The EOB to the provider stated the following: “The payment for this service is included within the negotiated rate. The patient is not responsible for this amount.”

Summary of the Company’s Response to 2(b): The Company acknowledges these findings and confirms the denial reasons were not correct. Due to processor oversight, an incorrect code was applied. As a result, the Company sent a reminder on
or around October 23, 2017 to the claim processing staff to ensure that the appropriate denial reason/denial code is applied to the claim.

2(c). In one instance, in a phone call, the provider was incorrectly informed that precertification was not required.

**Summary of the Company’s Response to 2(c):** The Company acknowledges this finding and confirms the provider was incorrectly informed that no precertification was required. To ensure future compliance, the Company provided feedback to the individual responsible for this human error to determine what went wrong and to help prevent similar errors from occurring in the future.

2(d). In one instance, the EOB message informed the insured the claim was denied as requested medical information was not received; however, the requested medical information had been received.

**Summary of the Company’s Response to 2(d):** The Company acknowledges this finding. The Company states upon receipt of the operative report, the claim should have been re-pended for review. Instead, the claim was denied for information not being received. To ensure compliance, on July 6, 2017, the Company made the analyst aware of the error and educated the analyst on future handling.

2(e). In one instance, the Company misrepresented that letters were sent to the insured when letters were only sent to the provider.

**Summary of the Company’s Response to 2(e):** Although the Company does not agree the analyst error represents a misrepresentation of pertinent facts, the Company acknowledges that the analyst made an error when she referred to letters being sent to the insured. To ensure future compliance, the Company provided feedback in a group meeting on October 30, 2017. The analyst was provided feedback the following week.

2(f). In one instance, the Company stated it asked the provider to resubmit an appropriate modifier code for a service yet the Company never asked the provider either verbally or via written correspondence.

**Summary of the Company’s Response to 2(f):** The Company acknowledges it did not send additional correspondence or contact the provider to resubmit the bill with an appropriate modifier. The Company states this isolated error was pended due to processor oversight and the processor associated with the claim is no longer with the Company. Therefore, remediation is not indicated.

2(g). In one instance, the Company’s denial to the provider included two distinct and identifiable reasons for the denial separated by an “or” in between both denial reasons. The EOB stated the following, in part: “This service is related to a service that
is excluded by the member's plan as experimental, investigational, cosmetic or not generally recognized according to professional standards of safety and effectiveness in the United States for diagnosis care or treatment; or this service is related to or provided in conjunction with a service that requires precertification where no precertification was obtained. These services are not covered under the member's plan.” These remarks mislead and misrepresent the denial to the provider since it is unclear if the denial is related to a service that is experimental or to a service that requires precertification. The “or” indicates that the denial could be one of the reasons identified, but not all. Therefore, the issue is not that the services were not covered; the issue is that one of the denial reasons indicates and implies that if precertification had been obtained, the service would have been covered.

**Summary of the Company’s Response to 2(g):** The Company disagrees that the denial reason represents a misrepresentation. The Company states the claim was for anesthesia expenses, and anesthesia is not a medical treatment in and of itself. In the case of anesthesia services, the Company further states it is a sufficient explanation to the anesthesiologist to state that the claim was denied because it is related to the surgery performed which was not covered by the member’s plan. The additional text is not needed to convey the specific reason for denial, but only provides a fuller explanation of when anesthesia services are not covered. The Company also responded that the services were denied as they were related to the surgical procedure and this surgical procedure was denied as experimental or investigational.

While the Company continues to disagree with this finding, the Company revised the language for action code N21 to clarify the denial reason(s). Effective October 29, 2018, the Company implemented new language as follows:

This service is related to a service that is excluded by the member’s plan for one or more of the following reasons: experimental, investigational, cosmetic; not generally recognized according to professional standards of safety and effectiveness in the United States for diagnosis care or treatment; service is related to or provided in conjunction with a service that requires precertification where no precertification was obtained. These related services are not covered under the member’s plan.

3. **In 22 instances, the Company failed to include in its notice of a contested or denied claim that the insured may seek a review by the Department.** The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(3).

3(a). In 21 instances, the Company failed to include reference to the CDI to its insureds who reside out-of-state. The health policies or certificates were issued in California to California employers and to their out-of-state employees. The policies in
question include California mandated benefits and the referenced Insurance Code specifically states that it applies to claims “whether in state or out of state”.

Summary of the Company’s Response to 3(a): The Company disagrees with these findings. The Company states that many of its California employers purchasing Preferred Provider Organization (PPO) and point-of-service plan type policies have employees located in other states who are covered by the policy. One of the reasons employers choose to do business with Aetna is its ability to cover employees at multiple locations. And as a multistate health insurer, Aetna encounters situations where the laws of both the state where the policy was issued (the situs state), and the laws of the state where the claim was incurred have requirements about how insurance claims are to be handled.

With regard to Department notices on EOBs, the Company generally follows the laws of the state where the policy was issued. This approach is also followed for meeting utilization review requirements, providing patient management, complaints, and grievance notices, including IMRs. However, for contracts issued in California, everyone who is covered will receive the rights of the contract state unless they live in one of the states where their managed care laws are extraterritorial and must be applied to all resident certificate holders in their states regardless of the policy situs. Aetna refers to these as the “exception states”. The Company identified the exception states as Arizona, Louisiana, Maine, Mississippi, Missouri, Nebraska, Oklahoma, Rhode Island, Texas, and Washington. If a member/insured lives in one of the exception states, the Company applies the requirements of the residence state instead of the contract state. Balancing the relative interests of the contract and member states, and the need to administer plans with members residing in multiple states, the Company considers its approach to be a practical and compliant one.

Nonetheless, with full reservation of its rights, the Company agrees to implement claims practices that use the CIC §10123.13 rules for out-of-state provider claims covered by California sitused policies on a prospective basis. Aetna completed its implementation analysis and due to the extensive necessary system enhancements, the Company expects to complete the system enhancements and implement the changes by the end of the second quarter of 2020.

3(b). In one instance, the original claim adjudication included Department of Managed Health Care (DMHC) information and failed to include reference to the CDI.

Summary of the Company’s Response to 3(b): The Company acknowledges this finding that the DMHC was an incorrect reference. This finding occurred prior to the Company’s completion of a project in 2014 to remove reference to the DMHC.

4. In 10 instances, the Company failed to advise the insured of the right to an independent medical review (IMR) on letters of denials and on all written responses to grievances in cases in which the insured believes that health care
services had been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. The Company failed to include disclosure of the insured’s right to an IMR to its insureds who reside out-of-state in one of the 10 exception states identified by the Company in section 3(a) above. The health policies or certificates were issued in California to California employers and to their out-of-state employees. Additionally, the policies in question include California mandated benefits. The Department alleges these acts are in violation of CIC §10169(i) and are unfair practices under CIC §790.03(h)(1).

**Summary of the Company’s Response:** The Company disagrees with these findings. The Company states that many of its California employers purchasing Preferred Provider Organization (PPO) and point-of-service plan type policies have employees located in other states who are covered by the policy. One of the reasons employers choose to do business with Aetna is its ability to cover employees at multiple locations. And as a multistate health insurer, Aetna encounters situations where the laws of both the state where the policy was issued (the situs state), and the laws of the state where the claim was incurred have requirements about how insurance claims are to be handled.

With regard to IMR disclosure on EOBs, the Company generally follows the laws of the state where the policy was issued. This policy is also followed for providing patient management, complaints, and grievance notices. However, for contracts issued in California, everyone who is covered will receive the rights of the contract state unless they live in one of the 10 exception states. If a member/insured lives in one of the exception states, the Company applies the requirements of the residence state instead of the contract state. The Company further states the exception states have determined that their laws are extraterritorial and govern the complaints, grievances, and appeals of members living in their states. Balancing the relative interests of the contract and member states, and the need to administer plans with members residing in multiple states, the Company considers its approach to be a practical and compliant one.

With regard to the exception states, Aetna implemented processes to apply the exception state requirements for residents of those states in the mid-2000s. This approach is a long-standing practice and the Company believes it is consistent with industry practice as well. To make changes in these processes would require extensive changes across the Company, as well as outreach to the states with extraterritorial requirements. Aetna believes that any changes of this scope are best addressed through the regulatory process so that all carriers may have input and all carriers are required to make similar changes at the same time. This would also serve as a basis for addressing this matter with other affected states.

In summary, for member EOBs and utilization review requirements, including IMRs, the Company currently uses the requirements of the situs state with the exception of 10 states that have required the Company to use its laws for insured residents in that state. These states provide comparable consumer protections, including the right to an
external review. The Company recognizes the complexity of conflicting law and extraterritoriality issues and offers to continue discussion of these matters with the Department, the industry as a whole, and/or the exception states.

**Summary of the Department’s Evaluation of the Company’s Response:** As noted above, the Aetna examination involves policies or certificates that were issued in California to California employers and to their out-of-state employees. The extraterritorial statute does not apply in the present situation. Aetna makes reference to “exception” states, states whose managed care laws are extraterritorial and must be applied to all resident certificate and policyholders in their states regardless of the policy situs. Aetna is essentially stating that these exception states have their own extraterritorial statutes that require the resident state’s laws apply to the health insurance policies and certificates, just like California’s laws could apply to a California resident even when a policy is issued to an out-of-state employer. For these states, Aetna claims that it must follow only the laws of the resident states regarding notice language on explanations of benefits (EOBs) and disregard California law. However, no evidence has been presented that these exception states’ extraterritorial laws require that only the exception state’s health insurance laws apply. In this situation, both the resident state and California’s laws would apply. Section 10169(i) requires Aetna to provide notice to insureds when their claims are denied, modified, or delayed based on medical necessity that they have the right to request an IMR from the California Department of Insurance.

Aetna does not claim that any provision of California law excuses it from complying with these California laws, rather it claims that because it may also be required to follow the laws of another “exception” state, it should be able to simply choose which state’s law to follow for the sake of “practicality.” Aetna has provided no legal justification as to the reason it is not in compliance with the referenced Insurance Code. The Department does not have discretion to simply waive an insurer’s statutory obligations.

Aetna also contends that this noncompliance with California law is a longstanding practice consistent with industry practice. Aetna requests that the Department address this issue “through the regulatory process” so that all carriers may have notice and input. However, this is not a regulatory issue. The requirements at issue are set forth in statute. The Department cannot change statutory requirements through regulation and the Department cannot excuse an insurer from compliance with selected state laws for the convenience of the insurer. Accordingly, Aetna must comply with the statutory requirements of CIC §10169. Therefore, this is an unresolved issue that may result in administrative action.

5. **In nine instances, the Company failed to include in its notice of a denied claim to the insured and the provider, the portion of the claim that was denied, and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for denying the claim.** Six instances apply to the
member and three instances apply to the provider. The Company failed to explain to the member and to the provider the specific reason(s) it determined the services were considered experimental or investigational, not medically necessary, and/or related to a procedure that is not covered. And in instances in which the denial was based upon the Company’s Clinical Policy Bulletin (CPB), the Company failed to reference the CPB upon which the denial was based. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(13).

**Summary of the Company’s Response:** The Company respectfully disagrees that it did not provide the specific reasons for the denials of the claims in all identified instances. The Company states the denial reasons convey that the services performed were related to a service that is excluded under the member's plan as not covered, not medically necessary, experimental, investigational, cosmetic, and/or not generally recognized according to professional standards of safety and effectiveness in the United States. Additionally, the Company states it appropriately denied the claims.

Nonetheless, with respect to the explanations of benefits related to all identified instances, the Company implemented text changes for the provider and member effective October 25, 2018 for action codes F13, 413, and 777 and October 29, 2018 for action codes N21, 775, and 776 respectively:

- This is not covered. Your plan covers services that are necessary. It does not cover services that are experimental or investigational. If you and your provider have been notified that a service is not covered, but you sign an agreement with your provider to pay for non-covered services, your provider may bill you. To obtain more information regarding coverage of this service, go to our website and enter the procedure code in the search field or go to NaviNet, select our plan, then "Claims", and "Code Editing, Clinical & Payment Policy Lookup. [F13]

- The member’s plan of benefits provides coverage for services or supplies that we determine are necessary. To meet this requirement the service or supply must be accepted under recognized professional standards as appropriate and effective for the diagnosis, care or treatment of the disease or injury involved. In addition, it should not be experimental or still under clinical investigation. Based on the information provided, this expense does not meet this requirement of the member's plan of benefits and is not covered. To obtain more information regarding coverage of this service, go to our website and enter the procedure code (CPT-4 or HCPCS code) in the search field. If there is additional information that should be brought to our attention, please contact us. The member is not responsible for this charge unless they agreed to be responsible for this charge in writing before the service or supply was given. [F13]
The member's plan of benefits provides coverage for services or supplies that are necessary. To meet this requirement the service or supply must be accepted under recognized professional standards as appropriate and effective for the diagnosis, care or treatment of the disease or injury involved. In addition, it should not be experimental or still under clinical investigation. Based on the information provided, this expense does not meet this requirement of the member's plan of benefits and is not covered. To obtain more information regarding coverage of this service, go to our website and enter the procedure code in the search field or go to NaviNet, select our plan, then "Claims", and "Code Editing, Clinical & Payment Policy Lookup." If there is additional information that should be brought to our attention, please contact us. [413]

Your plan provides benefits for services and supplies which are necessary for the treatment of disease or injury. The services must be broadly accepted professionally as effective, appropriate and essential to treat the disease or injury. Based on the information provided, this expense is not covered. To obtain more information regarding coverage of this service, go to our website and enter the procedure code (CPT-4 or HCPCS code) in the search field. If there is additional information that should be brought to our attention, please let us know. [413]

Charges for or in connection with services or supplies that are, as determined by us, considered to be experimental or investigational are excluded from coverage under the member's plan. The member is not responsible for this charge, unless they agreed to be responsible for this charge in writing before the service or supply was given. To obtain more information regarding coverage of this service, go to our website and enter the procedure code in the search field or go to NaviNet, select our plan, then "Claims", and "Code Editing, Clinical & Payment Policy Lookup." [777]

This is not covered. Your plan does not cover services that we find to be experimental or investigational. Or charges related to such a service. If you and your provider have been notified that a service is not covered, but you sign an agreement with your provider to pay for non-covered services, your provider may bill you. To obtain more information regarding coverage of this service, go to our website and enter the procedure code (CPT-4 or HCPCS code) in the search field. [777]

This service is related to a service that is excluded by the member's plan for one or more of the following reasons: experimental, investigational, cosmetic; not generally recognized according to professional standards of safety and effectiveness in the United States for diagnosis care or treatment; service is related to or provided in conjunction with a service
that requires precertification where no precertification was obtained. These related services are not covered under the member's plan. [N21]

This service is related to a service that is excluded by the member's plan for one or more of the following reasons: experimental, investigational, cosmetic; not generally recognized according to professional standards of safety and effectiveness in the United States for diagnosis care or treatment; service is related to or provided in conjunction with a service that requires precertification where no precertification was obtained. These related services are not covered under the member's plan. [N21]

Charges for, or in connection with services or supplies that are considered to be experimental or investigational are excluded from coverage under the member's plan. To obtain more information regarding coverage of this service, go to our website and enter the procedure code in the search field or go to NaviNet, select our plan, then "Claims", and "Code Editing, Clinical & Payment Policy Lookup." [775]

You do not have to pay this. Your plan does not cover charges or services that are experimental or investigational. To obtain more information regarding coverage of this service, go to our website and enter the procedure code (CPT-4 or HCPCS code) in the search field. [775]

Charges for or in connection with services or supplies that are, as determined by us, considered to be experimental or investigational are excluded from coverage under the member's plan. To obtain more information regarding coverage of this service, go to our website and enter the procedure code in the search field or go to NaviNet, select our plan, then "Claims", and "Code Editing, Clinical & Payment Policy Lookup." [776]

Your plan does not cover charges for, or related to, services or supplies that we consider to be experimental or investigational. To obtain more information regarding coverage of this service, go to our website and enter the procedure code (CPT-4 or HCPCS code) in the search field. [776]

6. **In seven instances, the Company failed to comply with the requirements of CCR §2695.7(d).**

   6(a). **In four instances, the Company persisted in seeking information not reasonably required for or material to the resolution of a claims dispute.** All instances involve the member. In the first instance, the Company pursued modifier information, which was not necessary to process the claim. In the second instance, the Company received the claim with other health coverage information attached; however,
the Company still pended the claim for other health coverage requested from the member. In the third instance, the Company requested medical records, which were not necessary. In the fourth instance, although one service code for a charge of $12,135.00 required medical records to determine medical necessity, the Company pended the claim and requested a letter of medical necessity and clinical records for the entire claim with submitted charges of $22,685.73 on June 7, 2016. A letter of medical necessity and clinical records were not required for the other five service codes. The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

**Summary of the Company’s Response to 6(a):** In the first instance, the Company acknowledges the claim was pended in error when it had the necessary information to process the claim at that time. This was an isolated error and the processor associated with this claim is no longer with the Company. Therefore, remediation is not indicated.

In the second instance, the Company acknowledges the claim should have resulted in a denial indicating that no coverage was in effect. The Company also states it is unusual that a claim is received for a member where the member’s coverage terminated well before the date of service on the claim. Due to the age of this claim, the Company cannot replicate what occurred during claims processing. Eligibility, coordination of benefits, and other aspects of the plan are taken into account during claim processing. The order in which these were applied to the claim resulted in viewing coordination of benefits prior to eligibility. The Company tested this claim and if this scenario occurred today, the appropriate denial for no coverage in effect would be applied.

In the third instance, the Company agrees that a request for medical records was not necessary. The request for records was based on the overpayment analyst’s misunderstanding that funds were returned by the provider as services were not rendered. The overpayment analyst is no longer with the Company; therefore, no remediation is indicated for this isolated error.

In the fourth instance, the Company acknowledges the medical records request for the entire claim was not reasonably necessary to determine liability for payment of the claim regarding the member. Records were required for one service code only; however, due to processor oversight, the entire claim was pended for medical records. This was an isolated one-time error. Therefore, remediation is not indicated.

6(b). **In three instances, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation.** In the first instance, Aetna failed to investigate whether coverage was in effect before processing and paying the claim, resulting in an overpayment situation. In the second instance, the Company delayed opening and investigating a provider appeal. The provider called on two occasions and then sent in a written appeal. Each telephone call was recorded and the
Company failed to listen to the recordings as part of its investigation. In the third instance, the member submitted an appeal disputing the denial because the provider relied on information obtained in a telephone coverage call with the Company. The Company failed to complete an investigation to determine whether or not the information given to the provider was correct. This investigation would have included reviewing notes and/or the recording of any phone calls that took place. As a result of the failure to conduct a thorough investigation, the Company incorrectly upheld the appeal stating that the previous decision was correct based on a review of the plan. The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

**Summary of the Company's Response to 6(b):** In the first instance, the Company acknowledges this finding and states that the processing of the claim was not correct. This was an isolated error and the processor associated with this claim is no longer with the Company. Therefore, remediation is not indicated.

In the second instance, customer service sent the claim for reconsideration and did not open an appeal due to human error. The Company acknowledges an individual failed to follow procedures, but believes this is an isolated occurrence. The individual responsible is no longer with the Company. Additionally, the Company did not listen to the recorded telephone call per Company policy. The Company reviewed this policy regarding listing to phone recordings and as a result of the review, the Company updated the policy. The policy change includes guidelines on when to listen to a call and how to document and maintain the call records with the appeal file. The Company rolled out the change and implemented the updated policy on August 14, 2018. The updated policy was also communicated to all applicable staff.

In the third instance, the Company acknowledges this finding and states that policies and procedures were not followed. To ensure future compliance, the representative who took the appeal call received feedback and re-education. In addition, based on exam feedback from the appeals areas, the Company conducted refresher training with the customer service team in October 2017 to document all pertinent information in the appeal request.

7. **In six instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.** The Department alleges these acts are in violation of CIC §790.03(h)(5).

7(a). In one instance, the Company denied the claim in error as the provider contract did not require certification of the services. As a result of the provider’s request and prior to the market conduct examination, the Company conducted an internal rework project and this claim and all other impacted claims were processed with payment.
**Summary of the Company’s Response 7(a):** The Company acknowledges it processed this claim in error. To ensure future compliance, the Company reprocessed all claims impacted as part of a rework project. The Company completed the rework project on November 2, 2016.

7(b). In one instance, the Company wrongfully denied the claim. Specifically, the Company denied the claim for the member’s coverage being terminated before services were provided although the member’s coverage was active at the time of the denial. Upon receipt of the denial, the member contacted the Company to inform of active coverage. The Company then issued payment with interest. This occurred prior to the market conduct examination.

**Summary of the Company’s Response 7(b):** The Company acknowledges the claim was denied in error. The Company completed a review of this claim and confirmed that this member had no lapse in coverage; however, updates to this member’s eligibility may have resulted during processing. As a result of this error, the claim was reconsidered and paid. From a remediation perspective, the Company assessed the cause of the denial and reviewed data to determine if other members covered under this group plan were impacted. Based on the Company’s analysis, the only member identified was the member associated with this claim.

7(c). In one instance, the Company incorrectly denied a procedure code for being mutually exclusive to another procedure performed on the same date of service. The Company corrected this error and issued payment in full on the same day, prior to the market conduct examination.

**Summary of the Company’s Response 7(c):** The Company acknowledges it incorrectly denied the procedure code. To ensure future compliance, the Company issued an educational notification on October 18, 2017 to the claim processing staff regarding the appropriate procedures when performing an override or splitting of the bill prior to processing the claim.

7(d). In one instance, the Company wrongfully denied the claim for reaching the plan maximum when the maximum had not yet been met. The claim was reworked as a result of a request from customer service and paid with interest. This occurred prior to the market conduct examination.

**Summary of the Company’s Response 7(d):** The Company acknowledges it incorrectly processed the original claim as the plan maximum was met. To ensure future compliance, the Company issued an educational notification to the claim processing staff on October 18, 2017 regarding the review of accumulators, deductible, and coinsurance prior to processing the claim.
7(e). In one instance, while the subject claim was denied for a duplicate, the underlying claim was denied in error for speech therapy when it is expected to restore speech function.

**Summary of the Company’s Response 7(e):** The Company acknowledges it denied the claim in error due to processor oversight. While this error is isolated, the Company provided further education to the claim processor to avoid future errors of this nature. As a result of this examination, the Company reprocessed all impacted claims and applied $72.06 to the member's deductible.

7(f). In one instance, the Company denied the claim upon initial receipt in March 2016 and then again in May 2016 even though the member and provider detrimentally relied upon information conveyed to the provider by the Company prior to services being rendered. The claim was eventually reprocessed with interest in July 2016 as a result of the provider appeal, prior to the market conduct examination. The Company failed to recognize the detrimental reliance the member and provider assumed prior to commencing treatment and in follow-up phone calls related to the denials.

**Summary of the Company’s Response 7(f):** The Company acknowledges this finding and states that policies and procedures were not followed. The Company states it received a call from the provider of service on April 11, 2016. The customer service representative advised the claim processor to deny the claim indicating that the request for reconsideration had been received and the original determination was correct. However, the claim processor did not follow the customer service representative’s instructions; the claim was incorrectly considered eligible and applied to the deductible. Due to this claim error, the claim processor re-initiated the claim for reprocessing on May 9, 2016 and it was auto denied due to no precertification. The Company states it reprocessed the claim to appropriately deny as ineligible due to no precertification. To ensure future compliance, the representative who took the appeal call received feedback and re-education. In addition, based on exam feedback from the appeals areas, the Company conducted refresher training with the customer service team in October 2017 to document all pertinent information in the appeal request.

8. **In five instances, the Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim, or after receipt of all information necessary to determine payer liability.** The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(5).

**Summary of the Company’s Response:** The Company acknowledges these findings in all identified instances. In the first instance, the Company states this delay was due to an accumulator/deductible error. As a result, the Company issued an educational notification on October 18, 2017 to the claim processing staff regarding the review of accumulators and the deductible prior to processing the claim. In the second
instance, the Company states the delay was associated with an incorrect pend. As a result, the Company completed retraining on or before October 24, 2017 regarding coordination of benefits claim handling to the claim processing staff. In the third instance, the Company overturned the provider appeal and issued payment with interest prior to the market conduct examination. Although the Company responded that the appeal was handled correctly with the information at the time, to ensure future compliance, the Company conducted refresher training with the customer service team in October 2017 on following procedures to provide accurate and detailed information in the call notes, and for the appeals area to better assess the members reason for appealing in order to avoid delays. In the fourth instance, the Company agrees it failed to reimburse the claim within 30 working days. To ensure future compliance, the Company discussed the timeliness of this claim with the claim processor on November 1, 2017 with specific emphasis on handling claim processing timely following an appeal. In the fifth instance, the Company obtained information necessary to determine payer liability on April 29, 2016; however, due to processor oversight, the claim was pended in error and never processed. As a result of this finding, the Company initiated reprocessing of this particular claim and applied $651.66 to the insured’s deductible, and paid $306.81 ($271.68 plus $35.13 interest) directly to the member for a total of $958.47.

9. **In four instances, the Company failed to comply with Section 2713 of the federal Public Health Service Act.** Specifically, the Company imposed a cost-sharing requirement for human immunodeficiency virus (HIV) preventive care services included in the bill. As a result of a rework project, all claims were paid with interest. This occurred prior to the market conduct examination. The Department alleges these acts are in violation of CIC §10112.2 and are unfair practices under CIC §790.03(h)(5).

**Summary of the Company’s Response:** The Company acknowledges these findings and agrees the original processing of these claims resulted in underpayments due to the application of cost sharing. To ensure future compliance, the Company updated its preventive care code guidelines on February 19, 2016. In addition, the Company initiated a rework project and identified all claims involving the specific Current Procedural Terminology (CPT) code and diagnosis code combinations. The project resulted in a review/reprocessing of 21,106 claims. Of these claims, 2,367 involved California contracts. All impacted claims including these four instances were reworked. The Company completed the project on March 22, 2016.

10. **In four instances, the Company attempted to settle a claim by making a settlement offer that was unreasonably low.** Three instances occurred in the same claim. In the fourth instance, the claim was underpaid as a result of an incorrect contracted rate with an in-network provider. In all instances, the claims were reprocessed and paid during the claims handling, prior to the market conduct examination. The Department alleges these acts are in violation of CCR §2695.7(g) and are unfair practices under CIC §790.03(h)(5).
Summary of the Company’s Response: The Company acknowledges the findings in all identified instances. In the three instances on the same claim, the Company issued an educational notification on October 18, 2017 to the claim processing staff regarding the appropriate procedures when performing an override or splitting of the bill, and the review of accumulators, deductible, and coinsurance prior to processing the claim. In the fourth instance, the Company corrected the contract rate and reworked all impacted claims with the incorrect contract rate. The Company completed this rework project on October 27, 2016 and noted that some impacted claims resulted in overpayments.

11. In four instances, the Company failed to provide a clear explanation of the computation of benefits to the claimant and the provider with each claim payment. Two instances apply to the insured and two instances apply to the non-participating provider. In all instances, the EOB messages to the insured and provider do not provide an explanation as to how the allowable amount was calculated pursuant to the benefit plan. The EOB messages state, in part, that the plan provides benefits for covered expenses the Company finds to be a “Recognized Charge” or a “recognized or reasonable charge”. Compliance with CCR §2695.11(b) requires the EOB provide a clear explanation of the computation of benefits with each claim payment. To presume the insured or provider knows the definition of “Recognized Charge” provided in the insurance policy does not absolve the Company from the requirements of this Regulation. The Department alleges these acts are in violation of CCR §2695.11(b) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company’s Response: The Company disagrees with these findings in all instances. The Company states the explanation references the applicable member’s plan provision and is consistent with the “Recognized Charge” definition in the plan document. The provider is also instructed in the remark section to contact the Company if there are further questions regarding the reasonable and customary charge. Additionally, the Company states the EOBs clearly reflect the “amount not payable” and explain that the amount not payable is applicable to what the Company finds to be a recognized or reasonable charge explained in the policy plan. Further, the EOBs display the name of the provider of service, dates of service, remaining balance, applicable copay, plan benefit (coinsurance), and the total amount paid.

The Company disputes that these EOB remarks are deficient. Nonetheless, the Company states that it understands improvements can be made to the recognized charge language to provide a clearer explanation of the computation of benefits to the provider and member. The Company implemented text changes effective April 1, 2019 for the provider and member regarding action codes 551 (Voluntary non par services, recognized charge geographic area), V88 (Voluntary non par services, recognized charge national advantage program preferred/in-network benefit level), and V90 (Voluntary non par services, recognized charge national advantage program non-preferred/out-of-network benefit level) respectively:
The member’s plan provides benefits for covered expenses at the prevailing charge level made for the service in the geographical area where it is provided. In determining the amount of a charge that is covered we may consider other factors including the prevailing charge in other areas. Prevailing charge is calculated based on any one of the following:

- %tile of Fair Health
- Nonparticipating Professional Fee Schedule is elected by the Member’s Plan

Our determination of the prevailing charge does not suggest your fee is not reasonable and proper. We believe our payment was fair. If there is additional information that should be brought to our attention or questions on this reduction, please contact us at the telephone number shown on this statement. [551]

This amount is over the recognized charge for this service. Recognized charge is determined based on geographic area, the Member’s plan and is calculated based on one of the following:

- %tile Fair Health
- Nonparticipating Professional Fee Schedule is elected by the Member’s Plan

We believe our payment to the provider was fair. The provider may not agree. [551]

The member’s plan provides benefits for covered expenses at what we find to be a recognized or reasonable charge. The reasonable charge determination on the claim resulted in a reduction in payment and was calculated based on one of the following:

- Cost information submitted by hospitals to the Center for Medicare and Medicaid services, plus mark-up
- Fair Health %tile elected by Member’s Plan or required by state regulations

The reduced amount may appear on one or more claim lines until the total reduction amount is achieved. Contact us at 1-877-252-4600 for questions regarding the reasonable charge determination. [V88]

Your plan provides benefits for covered expenses at what we find to be a recognized or reasonable charge. The reasonable charge determination
on the claim resulted in a reduction in payment and was calculated based
on one of the following:

- Cost information submitted by hospitals to the Center for Medicare
  and Medicaid services, plus mark-up
- Fair Health %tile elected by your Plan or required by state
  regulations

The reduced amount may appear on one or more claim lines until the total
reduction amount is achieved. The provider may not accept this amount
as payment in full. You may receive a bill for the difference between the
submitted and paid charges. If the provider bills you for an additional
amount, please contact us at 1-877-252-4600 or refer to this statement for
your appeals rights. [V88]

The member’s plan provides benefits for covered expenses at what we
find to be a recognized or reasonable charge. The reasonable charge
determination on the claim resulted in a reduction in payment and was
calculated based on one of the following:

- Cost information submitted by hospitals to the Center for Medicare
  and Medicaid services, plus mark-up
- Fair Health %tile elected by Member’s Plan or required by state
  regulations

The reduced amount may appear on one or more claim lines until the total
reduction amount is achieved. Contact us at 1-877-252-4600 for questions
regarding the reasonable charge determination. [V90]

Your plan provides benefits for covered expenses at what we find to be a
recognized or reasonable charge. The reasonable charge determination
on the claim resulted in a reduction in payment and was calculated based
on one of the following:

- Cost information submitted by hospitals to the Center for Medicare
  and Medicare services, plus mark-up
- Fair Health %tile elected by your Plan or required by state
  regulations

The reduced amount may appear on one or more claim lines until the total
reduction amount is achieved. The provider may not accept this amount
as payment in full. You may receive a bill for the difference between the
submitted and paid charges. If the provider bills you for an additional
amount, please contact us at 1-877-252-4600 or refer to this statement for
your appeals rights. [V90]
12. In three instances, the Company failed to notify the insured in writing, within 30 working days after receipt of the claim, that the claim was denied. Specifically, although these instances all involve resubmitted claims, the member was not provided with an EOB identifying the reason for the denial of the resubmission. The provider, however, was sent a denial with the following remarks: “The member’s plan provides coverage for charges that are responsible and appropriate. This procedure exceeds the maximum number of services allowed under our guidelines for a single date of service”. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(13).

**Summary of the Company’s Response:** The Company acknowledges these findings that it did not provide the member with an EOB notice of the claim denial. The Company researched these claims and noted that these claims were submitted multiple times. The Company has not determined the underlying cause regarding the absence of member EOBS on these claims; however, the Company believes the cause may be attributable to the multiple submissions of the same claim(s). While the Company states these occurrences are isolated anomalies, the Company will monitor this going forward to ensure notice of claim denials are generated on all California claim denials.

13. In three instances, the Company failed to send a written request to the provider within 365 days of the date of the claims overpayment with a clear explanation of the basis for the requested reimbursement. The Department alleges these acts are in violation of CIC §10133.66(b) and are unfair practices under CIC §790.03(h)(3).

**Summary of the Company’s Response:** The Company acknowledges these findings in all identified instances. California legislative requirements are programmed into the Company’s Overpayment Tracking System (OPT) to advise the overpayment analyst to review state legislation. This system creates an edit rule prompting review by the recovery analyst. The edit prompts the analyst to review the relevant legislation applicable to overpayment recoupment and any applicable timeframes. To support this process, in April of 2017, the Company’s OPT support area implemented a new review to monitor the compliance of the state legislation for fully insured plans. This review compares the claim paid date to the date of the first overpayment letter. If the timeframe is exceeded (12 months for California), the record is returned to the recovery savings analyst for closure. Additionally, the Company advised the Overpayment Unit of the incorrect handling in an email dated May 25, 2017 to ensure future compliance. As a result of the findings of this examination in these three instances, the Company issued payments to the providers totaling $1,189.03.

In response to a concern that the Company sought reimbursement from the provider after 365 days had passed, the Company conducted an internal survey of closed claims from January 1, 2014 through April 1, 2017. The Company voluntarily
included health maintenance organization (HMO) claims and dental claims in its internal survey of closed claims. The Company completed the survey and reported the final results to the Department on January 16, 2018. The Company reviewed 3,324 claim files and determined 2,227 were not handled correctly. Of these 2,227 claim files, the Company reissued 1,455 funds/payments back to the providers totaling $1,356,951.70.

14. In two instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies. The Department alleges these acts are in violation of CIC §790.03(h)(3).

14(a). In one instance, the processor failed to follow procedures in manually calculating the deductible and coinsurance when the accumulators were not available.

Summary of the Company’s Response to 14(a): The Company acknowledges this finding. There are multiple processes and procedures in place to ensure that deductible and coinsurance accumulators have been updated. However, the Company’s claim system holds accumulators for three years (current plus two previous years). As 2013 accumulators were not available, the processor should have performed a manual calculation of deductible and coinsurance prior to completing processing of the claim. To ensure future compliance, the Company issued an educational notification on October 18, 2017 to the claim processing staff regarding the review of accumulators, deductible, and coinsurance prior to processing the claim.

14(b). In one instance, the processor failed to follow procedures in performing an override or splitting the bill.

Summary of the Company’s Response to 14(b): The Company acknowledges this finding. There are multiple processes and procedures in place to ensure the correct contracted amount is paid. The Company’s claim system accommodates a three-position counter for units billed. The claim processor should have either performed an override or split the billing to accurately price the claim. When the oversight was discovered on this claim, it was corrected and an additional benefit was released. To ensure future compliance, the Company issued an educational notification on October 18, 2017 to the claim processing staff regarding the appropriate procedures when performing an override or splitting of the bill.

15. In two instances, the Company failed, upon contesting a claim under CIC §10123.13, to affirm or deny the claim within 30 calendar days from the original notification. The Department alleges these acts are in violation of CCR §2695.11(d) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company’s Response: The Company acknowledges the findings in both instances. In the first instance, the Company states this was an isolated processor error. The Company discussed this error with the processor on July 6, 2017.
In the second instance, the Company incorrectly pended the claim for the primary carrier statement of payment or denial. The delay was associated with this incorrect pend. The Company retrained the claim processing staff on coordination of benefits claim handling, which was completed on or before October 24, 2017.

16. **In one instance, the Company failed to notify the insured in writing, within 30 working days after receipt of the claim, that the claim was contested.** Specifically, the provider was sent a contested EOB on March 23, 2016; however, a corresponding EOB to the insured was not sent. The Department alleges this act is in violation of CIC §10123.13(a) and is an unfair practice under CIC §790.03(h)(3).

**Summary of the Company’s Response:** The Company acknowledges this finding that it did not provide the member with an EOB notice of the contested claim. The Company researched this claim and noted that this claim was submitted multiple times. The Company has not determined the underlying cause regarding the absence of the member EOB on this claim; however, the Company believes the cause may be attributable to the multiple submissions of the same claim. While the Company states this occurrence is an isolated anomaly, the Company will monitor this going forward to ensure notice of contested claims are generated on all California claims.

17. **In one instance, the Company failed to pay interest on a contested claim after 30 working days.** The Department alleges this act is in violation of CIC §10123.13(c) and is an unfair practice under CIC §790.03(h)(5).

**Summary of the Company’s Response:** The Company acknowledges this finding. As a result, the Company reprocessed the claim for interest and issued payment in the amount of $2.86.

18. **In one instance, the Company requested information that is not reasonably necessary to determine liability for payment of a claim.** This instance applies to the provider. Specifically, although one service code for a charge of $12,135.00 required medical records to determine medical necessity, the Company pended the claim and requested a letter of medical necessity and clinical records for the entire claim with submitted charges of $22,685.73 on June 7, 2016. A letter of medical necessity and clinical records were not required for the other five service codes. The Department alleges this act is in violation of CIC §10123.131(b) and is an unfair practice under CIC §790.03(h)(3).

**Summary of the Company’s Response:** The Company acknowledges the medical records request for the entire claim was not reasonably necessary to determine liability for payment of the claim. Records were required for one service code only; however, due to processor oversight, the entire claim was pended for medical records. This was an isolated one-time error. Therefore, remediation is not indicated.
19. **In one instance, the Company failed to resolve each provider dispute consistent with applicable law and issue a written determination within 45 working days after the date of receipt of the provider dispute.** The Department alleges this act is in violation of CIC §10123.137(c) and an unfair practice under CIC §790.03(h)(3).

**Summary of the Company’s Response:** The Company acknowledges this finding. To ensure future compliance, the Company implemented a procedure in March 2017. If the claim is not already reprocessed, a resolution letter for overturned appeals will need to be sent to mitigate this issue.

20. **In one instance, the Company failed to respond to communications within 15 calendar days.** Specifically, the Company failed to respond to the member’s appeal within the regulatory timeframe. The member called in an appeal on June 3, 2016 and the Company did not respond until July 1, 2016. The Department alleges this act is in violation of CCR §2695.5(b) and is an unfair practice under CIC §790.03(h)(2).

**Summary of the Company’s Response:** The Company agrees it did not acknowledge or otherwise respond within 15 calendar days. It is the Company’s process to acknowledge member appeals via a postcard. The postcard acknowledgment process began in the spring of 2012. It is initiated when the Company receives an appeal, and it is posted in review status in its Complaint and Appeal Tracking System (CATS). A file feed of these cases is forwarded daily to the distribution team that coordinates the postcards. The postcards are addressed and mailed based on the information in the file feed. Once that is completed, another file feed is sent back to CATS with the date the postcard was mailed and the mailing of the postcard is documented in the correspondence screen of CATS. This was an isolated incident due to a system glitch that prevented documentation of the mailed postcard date from being entered into the system.

**ACCIDENT AND DISABILITY (HEALTH) – TARGETED MENTAL HEALTH FILE REVIEW**

21. **In eight instances, the Company failed to provide a clear explanation of the computation of benefits to the claimant and the provider with each claim payment.** Four instances apply to the insured and four instances apply to the non-participating provider. The Department alleges these acts are in violation of CCR §2695.11(b) and are unfair practices under CIC §790.03(h)(3).

21(a). In four instances, the EOB messages to the insured and non-participating provider do not provide an explanation as to how the allowable amount was calculated pursuant to the benefit plan. In three of these instances, the EOB messages state, in part, that the plan provides benefits for covered expenses the Company finds to be a “Recognized Charge” or a “recognized or reasonable charge”. In one of these
instances, the EOB message to the insured does not include any reference to charges, only to the service codes involved in the bill. The EOB in this instance includes the following remark: “These service codes reflect the submitted codes. The service codes directly below the shaded lines indicate the service codes utilized for payment based upon our claim policies and rules.” In addition, in this claim, the provider appealed and the Company’s appeal letter provided the specific language from the member’s plan explaining how the benefits were computed. Compliance with CCR §2695.11(b) requires the EOB provide a clear explanation of the computation of benefits with each claim payment. To presume the insured or provider knows the definition of “Recognized Charge” provided in the insurance policy does not absolve the Company from the requirements of this Regulation.

**Summary of the Company’s Response to 21(a):** The Company disagrees with these findings in all four instances. The Company states the service was priced according to the member’s plan benefits and the Company referred to the plan document definition for “Recognized Charge”. As such, the Company applied the “Recognized Charge” provision of the member’s plan and this was the basis for the payable amount. The provider is also instructed in the remark section to contact the Company if there are further questions regarding the reasonable and customary charge. Additionally, the Company states the EOBs clearly provide a breakdown of each billed charge, to include the amount not payable, deductible applied (where applicable), coinsurance amount, member responsibility, and the paid amount. Furthermore, the Company states the member text is conveyed in an understandable and less complex terminology. The Company applies this approach as most often, the provider text descriptions are in detailed medical/technical descriptive terms, and the Company does not believe this level of detail is appropriate for the member message.

The Company disputes that these EOB remarks are deficient. Nonetheless, the Company states that it understands improvements can be made to the recognized charge language to provide a clearer explanation of the computation of benefits to the provider and member. The Company implemented text changes effective April 1, 2019 for the provider and member regarding action codes 551 (Voluntary non par services, recognized charge geographic area), V88 (Voluntary non par services, recognized charge national advantage program preferred/in-network benefit level), and V90 (Voluntary non par services, recognized charge national advantage program non-preferred/out-of-network benefit level) respectively:

The member’s plan provides benefits for covered expenses at the prevailing charge level made for the service in the geographical area where it is provided. In determining the amount of a charge that is covered we may consider other factors including the prevailing charge in other areas. Prevailing charge is calculated based on any one of the following:

- %tile of Fair Health
Nonparticipating Professional Fee Schedule is elected by the Member’s Plan

Our determination of the prevailing charge does not suggest your fee is not reasonable and proper. We believe our payment was fair. If there is additional information that should be brought to our attention or questions on this reduction, please contact us at the telephone number shown on this statement. [551]

This amount is over the recognized charge for this service. Recognized charge is determined based on geographic area, the Member’s plan and is calculated based on one of the following:

- %tile Fair Health
- Nonparticipating Professional Fee Schedule is elected by the Member’s Plan

We believe our payment to the provider was fair. The provider may not agree. [551]

The member’s plan provides benefits for covered expenses at what we find to be a recognized or reasonable charge. The reasonable charge determination on the claim resulted in a reduction in payment and was calculated based on one of the following:

- Cost information submitted by hospitals to the Center for Medicare and Medicaid services, plus mark-up
- Fair Health %tile elected by Member’s Plan or required by state regulations

The reduced amount may appear on one or more claim lines until the total reduction amount is achieved. Contact us at 1-877-252-4600 for questions regarding the reasonable charge determination. [V88]

Your plan provides benefits for covered expenses at what we find to be a recognized or reasonable charge. The reasonable charge determination on the claim resulted in a reduction in payment and was calculated based on one of the following:

- Cost information submitted by hospitals to the Center for Medicare and Medicare services, plus mark-up
- Fair Health %tile elected by your Plan or required by state regulations
The reduced amount may appear on one or more claim lines until the total reduction amount is achieved. The provider may not accept this amount as payment in full. You may receive a bill for the difference between the submitted and paid charges. If the provider bills you for an additional amount, please contact us at 1-877-252-4600 or refer to this statement for your appeals rights. [V88]

The member’s plan provides benefits for covered expenses at what we find to be a recognized or reasonable charge. The reasonable charge determination on the claim resulted in a reduction in payment and was calculated based on one of the following:

- Cost information submitted by hospitals to the Center for Medicare and Medicaid services, plus mark-up
- Fair Health %tile elected by Member’s Plan or required by state regulations

The reduced amount may appear on one or more claim lines until the total reduction amount is achieved. Contact us at 1-877-252-4600 for questions regarding the reasonable charge determination. [V90]

Your plan provides benefits for covered expenses at what we find to be a recognized or reasonable charge. The reasonable charge determination on the claim resulted in a reduction in payment and was calculated based on one of the following:

- Cost information submitted by hospitals to the Center for Medicare and Medicaid services, plus mark-up
- Fair Health %tile elected by your Plan or required by state regulations

The reduced amount may appear on one or more claim lines until the total reduction amount is achieved. The provider may not accept this amount as payment in full. You may receive a bill for the difference between the submitted and paid charges. If the provider bills you for an additional amount, please contact us at 1-877-252-4600 or refer to this statement for your appeals rights. [V90]

21(b). In four instances, the EOB messages to the member and provider do not provide an explanation regarding the allowance of 50% for each service based on the billed amount for out-of-network facility providers. Instead, the EOB remarks to the member in the first instance state the following: “This provider is not part of our network. This means we do not have a contract with the provider. Your provider may bill you for any amounts greater than the allowed amount shown above.” The EOB
remarks to the provider in the second instance state the following: “This payment is for services covered in accordance with the member’s benefit plan.” The EOB remarks to the insured in the third instance state the following: “Your provider may have sent diagnosis codes with your claim. You may obtain these codes and their meanings by contacting us at the number listed at the top of the first page…” The EOB remarks to the provider in the fourth instance state the following: “These service codes reflect the submitted codes. The service codes directly below the shaded lines indicate the service codes utilized for payment based upon our claim policies and rules.”

**Summary of the Company’s Response to 21(b):** In two instances on the same claim, although the Company states that most of its benefit plans now base the out-of-network benefit on a percentage of the Medicare rate, the Company recognizes the description could provide a clearer explanation of the computation of benefits to the insured and provider.

In the remaining two instances on the same claim, in which the EOB messages do not include any reference to charges, only to the service codes involved in the bill, the Company states that the provider has an indirect contract through the Company’s National Advantage Program (NAP). NAP reduces claim costs for plan sponsors and members by providing contracted rates through vendor arrangements for many hospital and physician claims. The claim was sent to the Company’s external pricing vendor who handles most NAP network claims. Because the provider on the claim was non-contracted under eligible networks, the claim was returned with no pricing. When returned from external pricing, the claim processor applied the default pricing of 50% of allowed charges per the policy. The action code to notify the provider of the pricing method was not included on the claim. The omission of this action code was the reason the “Allowed Amount” field was populated instead of the “Not Payable” field. Furthermore, the Company may also reduce the recognized charge by applying Aetna Reimbursement Policies. Aetna Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service.

To ensure future compliance, the Company evaluated the Department’s comments that the remark codes do not provide a clear explanation of the computation of benefits, which would include the reason 50% of the amount billed was allowed. The Company implemented the following text change to members on October 15, 2018 for benefits based on “reasonable and customary” charges:

We paid for these for services in accordance with your benefit plan. Allowed amount is standardly 50% of billed, however, depending on plan structure can be up to 100%. Consult your plan of benefits for additional information. Note: Your provider may bill you for amounts greater than the amount we paid.

The Company implemented the following text change to providers on October 30, 2018 for benefits based on “reasonable and customary” charges:
We paid for these services in accordance with the Member's benefit plan. Allowed amount is standardly 50% of billed, however, depending on the Member's plan; the allowed amount can be up to 100%.

22. **In five instances, the Company failed to include in its notice of a contested or denied claim that the insured and the provider may seek a review by the Department.** The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(3).

22(a). In three instances, the Company failed to include reference to the CDI to its insureds who reside out-of-state. The health policies or certificates were issued in California to California employers and to their out-of-state employees. The policies in question include California mandated benefits and the referenced Insurance Code specifically states that it applies to claims "whether in state or out of state".

**Summary of the Company’s Response to 22(a):** The Company disagrees with these findings. The Company states that many of its California employers purchasing Preferred Provider Organization (PPO) and point-of-service plan type policies have employees located in other states who are covered by the policy. One of the reasons employers choose to do business with Aetna is its ability to cover employees at multiple locations. And as a multistate health insurer, Aetna encounters situations where the laws of both the state where the policy was issued (the situs state), and the laws of the state where the claim was incurred have requirements about how insurance claims are to be handled.

With regard to Department notices on EOBs, the Company generally follows the laws of the state where the policy was issued. This approach is also followed for meeting utilization review requirements, providing patient management, complaints, and grievance notices, including IMRs. However, for contracts issued in California, everyone who is covered will receive the rights of the contract state unless they live in one of the states where their managed care laws are extraterritorial and must be applied to all resident certificate holders in their states regardless of the policy situs. Aetna refers to these as the “exception states”. The Company identified the exception states as Arizona, Louisiana, Maine, Mississippi, Missouri, Nebraska, Oklahoma, Rhode Island, Texas, and Washington. If a member/insured lives in one of the exception states, the Company applies the requirements of the residence state instead of the contract state. Balancing the relative interests of the contract and member states, and the need to administer plans with members residing in multiple states, the Company considers its approach to be a practical and compliant one.

Nonetheless, with full reservation of its rights, the Company agrees to implement claims practices that use the CIC §10123.13 rules for out-of-state provider claims covered by California sitused policies on a prospective basis. Aetna completed its implementation analysis and due to the extensive necessary system enhancements, the
Company expects to complete the system enhancements and implement the changes by the end of the second quarter of 2020.

22(b). In two instances, the Company’s correspondence to the provider included information on where to submit an appeal; however, the letters failed to include reference to the California Department of Insurance.

**Summary of the Company's Response to 22(b):** The Company agrees with these two findings. In each instance, the Company provided feedback to the individual responsible to help prevent similar errors from occurring in the future.

23. **In four instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.** The Department alleges these acts are in violation of CIC §790.03(h)(5).

23(a). In one instance, the Company incorrectly denied the plan for not being effective when the plan was in fact active for the date of service.

**Summary of the Company's Response to 23(a):** The Company acknowledges the claim was denied incorrectly. As a result of this finding, the Company reprocessed this claim and applied $122.68 to the insured’s deductible.

23(b). In one instance, the Company incorrectly denied an insured appeal on the basis that the appeal was not filed within 180 days from the denial.

**Summary of the Company's Response to 23(b):** The Company acknowledges the insured filed a timely appeal. The analyst who processed this appeal is no longer in the Company’s Complaints and Appeals area. As a result of this finding, the Company overturned the timely claim filing denial and issued a check in the amount of $153.42 including interest.

23(c). In one instance, the Company incorrectly denied charges that were previously authorized.

**Summary of the Company's Response to 23(c):** The Company acknowledges the charges were inappropriately denied due to a claim processor error. The impacted charges were reconsidered as a result of the provider contacting the Company. To ensure future compliance, the Company provided refresher training to the individuals involved on October 13, 2017.

23(d). In one instance, notwithstanding the findings below in section 24, the Company denied a presumptive drug test in error for the following: “This procedure has been billed and allowed the maximum number of times allowed by our payment policy.” Although the Company still imposed a maximum frequency of eight drug tests per rolling 12-month period, in this instance, because the drug testing for the member began in
2015 and throughout 2016, the Company systems counted all tests performed on the same day separately. As such, the Company failed to effectuate an equitable settlement and incorrectly denied the service.

**Summary of the Company’s Response to 23(d):** The Company stated it follows the Centers for Medicare & Medicaid Services (CMS) coding recommendations for drug testing. The applicable CMS codes changed from 2015 to 2016 and the Company adjusted its handling to reflect any changes. The Company’s payment policy was based on one encounter per day up to eight (8) encounters per rolling 12-month period across all providers. The Company has noted, in calendar years 2014 and 2015, its systems were counting all tests performed on the same day separately rather than one encounter. Each code was counting towards the eight encounters, which could potentially be met based on one date of service. To account for this, the Company adjusted the annual units to allow up to 64 per 365 days. This resulted in allowing, in some instances, presumptive drug testing services, exceeding eight encounters per rolling 12-month period. The Company did not initiate overpayment recovery on any impacted members nor will these be pursued. The Company resolved this issue January 1, 2016 going forward and claims were appropriately tracked based on one encounter per day rather than by the number of services. Additionally, the Company states the issue surrounding this claim and appeal were not prevalent; therefore, a rework project was not initiated.

The member associated with this appeal had presumptive drug testing in December of 2015 and throughout 2016, which required applying different sets of codes for each year. The subject claim for services was rendered in August of 2016. The rolling 12-month period for this member commenced in December of 2015 and on the applicable December 30, 2015 date of service, there were multiple presumptive drug testing services billed. The applicable CMS codes for 2015 were applied, and as noted above, each of these services was counted towards the maximum of eight. This should have been considered as one encounter. Due to this, and the change in CMS code sets, year-to-year, the Company agrees that this claim was initially denied in error. As a result of the appeal, the claim was paid.

**24. In four instances, the Company failed to comply with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) by imposing a quantitative treatment limit (QTL) with no available recourse for medical necessity.** Specifically, the Company imposed a frequency limitation of eight (8) presumptive or definitive drug test encounters per rolling 12-month period without an investigation into medical necessity or appropriateness of additional tests in individual cases. The limitation at issue is a fixed, numerical frequency cap, and constitutes a quantitative treatment limitation. To the extent this limitation was imposed on drug testing for the treatment of substance use disorder (SUD), it is a QTL that is subject to MHPAEA’s quantitative parity standard. Under MHPAEA’s implementing rule, QTLs are subject to the quantitative parity test outlined in 45 Code of Federal Regulations (CFR) 146.136(c)(3). That rule provides that a plan cannot impose a QTL on MH/SUD
benefits in a classification (or sub-classification) unless that QTL applies to substantially all (at least two-thirds) of medical/surgical benefits in the same classification, and the level of the QTL is not more restrictive than the predominant level (more than half) that applies to medical/surgical benefits that are subject to that QTL in that classification. Accordingly, the Company must submit a quantitative analysis for this QTL, for each classification in which the QTL applies to MH/SUD benefits. If the drug testing benefits are all outpatient, then Aetna must submit an analysis showing that the QTL applies to at least two-thirds of outpatient medical surgical benefits. If it also applies to inpatient drug tests, it must do the same for inpatient medical/surgical benefits.

As noted in the Company’s response below, Aetna declined to provide a quantitative analysis demonstrating that the limit complies with MHPAEA’s quantitative parity standard. In addition to being out of compliance with federal parity law, this limitation is also contrary to the terms of Aetna’s policies/contracts. Specifically, the policy language under “Requirements for Coverage” the Company pointed to as justification for imposing this quantitative treatment limit is an inappropriate interpretation of that policy provision. The policy did not impose any such limits on drug testing, and covered services that were medically necessary. As such, Aetna would be unlikely to meet the quantitative standard, unless it imposes similar frequency limits on substantially all outpatient medical/surgical services (as well as in any other classifications which imposed this limit, including inpatient, outpatient, and emergency care). Thus, Aetna’s limit on drug testing violates MHPAEA.

Additionally, while the American Society of Addiction Medicine (ASAM) Guidelines reference eight tests per year, this reference is only in the context of opioid treatment program (OTP) settings, and it is not recommended as a maximum limit. Rather, ASAM states the eight tests per year “should be viewed as a minimum”. The ASAM Guidelines also state that many patients will require more frequent testing, and determinations about optimal frequency are best made on an individualized basis. In contrast to the ASAM Guidelines, Aetna’s frequency limit on drug testing was applied indiscriminately in all settings of care and regardless of the insured’s diagnosis or medical condition. Aetna did not provide any mechanism to consider an individual insured’s medical needs and situation in determining the optimal frequency of drug testing.

The Department alleges these acts are in violation of CIC §10112.27(a)(2)(D) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company’s Response: For claims handling within the review period and in the Company’s original response, the Company indicated that limitations can be imposed. The Company also stated it can follow the rule of generally accepted standards of medical practice and the plan does not allow a richer benefit than the generally accepted standard benefit. The Company referred the Department to the plan under “Requirements for Coverage” and highlighted that the service must be in accordance with generally accepted standards of medical practice and clinically
appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease. The Company only recognizes the CMS drug screening codes; therefore, since the plan sponsor does not have an exception to pay more than industry standard, the Company follows CMS recommendations for presumptive and definitive drug testing.

As a result of the Department’s follow-up inquiries to the Company pertaining to the frequency limitation of eight (8) presumptive and definitive (confirmatory) drug tests within a rolling 12-month period, the Department provided a template for Aetna’s quantitative analysis of this quantitative treatment limit (QTL). The Company was asked to complete the inpatient tab and/or the outpatient tabs depending on whether the QTL at issue (eight tests per 12-month period limitation) applies to inpatient drug testing, outpatient drug testing, or both. The Company responded as follows:

The Company uses an edit to its claims adjudication system that denies presumptive and definitive drug testing claims if there have already been eight encounters in the last twelve month period. This edit is consistent with CMS coding standards. The Company notified its provider network about the claims policy prior to implementation and policy is accessible by participating and non-participating providers via Navinet.

The impetus for adding the presumptive and definitive drug testing claims edit was that the Company had observed patterns of significant fraud and waste by some providers that were ordering excessive numbers of tests to generate revenue, rather than because clinically indicated. In some cases, providers were ordering daily testing, using excessively broad test panels, and ordering duplicate testing to “validate” a test result.

The use of a claims edit is intended to support efficient claims operations and does not mean that there is a benefit or frequency limitation imposed on medically necessary covered services. Providers can request additional presumptive and definitive drug testing. Additional testing can be approved as part of an overall treatment program. A claim for presumptive and definitive drug testing can be resubmitted with additional information for reconsideration. Also the claims edit is not applied to an appeal that demonstrates a clinically appropriate reason for additional testing.

Nonetheless, the Company acknowledges its efforts to address this fraud problem should have been applied more narrowly. To ensure future compliance, the Company revised its handling of presumptive and definitive drug testing claims and has taken the following steps:
1. Effective December 1, 2017, the Company implemented system and procedural changes to exempt presumptive and definitive drug testing claims specific to emergency room place of service (POS ER 23) from edits, other than same day edits.

2. Effective with dates of service beginning December 1, 2017, the Company updated its presumptive and definitive drug testing policy on December 19, 2017, to exempt drug testing ordered in the emergency room from the annual frequency limitation.” The policy change removes the quantitative limit for medically necessary testing.

Based on these proposed changes that demonstrate unlimited coverage for presumptive and definitive drug tests, so long as medically necessary, the Company indicated it is not providing a quantitative analysis for a limitation pursuant to the template provided by the Department.

In an effort to remediate this issue, the Company conducted a review of denied presumptive and definitive drug screening test claims with an emergency room place of service (POS ER 23) from July 1, 2014 through November 30, 2017. The Company reviewed 456 claim files and determined 295 required reprocessing. The Company issued payments totaling $63,754.64 including interest for impacted members.

The Company also states that because additional presumptive or definitive testing can be approved when part of an overall drug treatment program, Aetna continues to believe that the noted above remediation project based on a review of “POS ER 23” claims is appropriate.

The Company continues to disagree that these claims edits violate any applicable requirements. Nonetheless, Aetna understands the Department’s concerns and also acknowledges that the fraud enforcement laws have been tightened with the recent enactment of the Eliminating Kickbacks in Recovery Act. With full reservation of rights, the Company removed claims edits for presumptive and definitive drug testing claims for California policies on a prospective basis. The system change to remove these claim edits was completed April 1, 2019 on the Aetna system and April 16, 2019 on the Aetna Student Health (ASH) claim system. With regard to a small number of claims handled by a third-party administrator (TPA), the system change was completed April 19, 2019. Therefore, in summary, and as noted in other sections of the report, effective December 1, 2017, Aetna removed the Drug Testing Limitation on medically necessary drug testing performed in the emergency room, and effective April of 2019 Aetna removed the Drug Testing Limitation on medically necessary drug testing done in inpatient and outpatient places of service.

Additionally, Aetna offers the below clarifying context regarding portions of its previously submitted responses. In portions of Aetna’s previous responses, it indicated that the Drug Testing Limitation can be imposed because it follows “the rule of generally
accepted standards of medical practice and the plan does not allow a richer benefit than the generally accepted standard benefit.” Aetna’s previous response (cited above) is in the context of its position that this limitation is properly classified as an NQTL. Insofar as the Department has concluded that the Drug Testing Limitation is a QTL, Aetna notes that the above referenced response (and any similar points made by Aetna throughout the report) is moot.

Aetna maintains that the annual frequency limitation on presumptive and definitive drug testing (Drug Testing Limitation) ordered by providers to further the treatment of members with both mental health/substance use disorder (MH/SUD) and medical/surgical conditions was reasonably classified as a non-quantitative treatment limit (NQTL) because medical necessity review is available on appeal for drug testing claims in dispute. As Aetna previously noted, the Drug Testing Limitation will not be applied upon appeal to a claim that demonstrated a clinically appropriate reason for additional drug testing. Notwithstanding Aetna’s position and with full reservation of rights, insofar as the Department has definitively concluded that the Drug Testing Limitation is a QTL, Aetna expanded the denied presumptive and definitive drug testing claims remediation project beyond claims involving the emergency room place of service to include all denied MH/SUD claims with other places of service (inpatient and outpatient) between February 1, 2016 through March 31, 2019. The Company reviewed 13,993 claim files and determined 11,217 required reprocessing. The Company issued payments totaling $6,962,416.58 including interest for impacted members.

25. In four instances, the Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(5).

**Summary of the Company’s Response:** The Company acknowledges these findings in all four instances. In the first instance, the Company states the denial and partial denials were due to processor error. To ensure future compliance, the Company provided feedback and additional training on October 13, 2017. In the second instance, the Company sent a reminder to claims processing staff on October 31, 2017 to process claims resulting from appeal decisions in a timely manner. In the third instance, a request for unnecessary information attributed to the delay. To ensure future compliance, the Company notified the processing staff to review claim submissions to avoid contesting claims in error on October 31, 2017. In the fourth instance, the Company states the claim was mishandled due to processor oversight. The claims processor is no longer with the Company; therefore, no remediation is indicated for this error.

26. In three instances, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue. In the first instance, the correspondence had an incorrect date of an appeal receipt. In the second instance, the EOB message to the provider stated the member is not responsible for
charges when the member is responsible for the charges. This EOB also informs the member that the provider’s contracted rate was reduced; however, the services were provided by a non-contracted provider. In the third instance, the overpayment recovery letter to the insured provided inaccurate information. All three instances misrepresented pertinent facts. The Department alleges these acts are in violation of CIC §790.03(h)(1).

Summary of the Company’s Response: In the first instance, the Company states there was a typographical error in the letter since it was written before the date indicated in the letter. The Company planned to do one-on-one education with the analyst to ensure correct dates are input; however, the analyst who processed the appeal is no longer in the appeals department. Therefore, one-on-one feedback was not provided. In the second instance, the Company states the claim was appropriately denied; however, the action code applied on the claim was not appropriate for this claim denial. Due to processor oversight, an incorrect code was applied on this claim. The Company reprocessed the claim with the appropriate code and re-emphasized the appropriate codes to apply with claim processing staff on October 11, 2017. In the third instance, the Company states the claim was processed on separate segments. The duplication of payment for the services was due to recording the overpayment and repayment occurring simultaneously. The Company indicates this was an isolated occurrence. To ensure future compliance, the Company re-educated the processor that handled this claim on November 6, 2017.

27. In three instances, the Company failed to include in its notice of a denied claim to the insured and the provider, the portion of the claim that was denied, and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for denying the claim. In the first two instances on the same claim, the EOB to the member states “Your plan excludes this service. Refer to your plan details for a list of exclusions” and the EOB to the provider states “The member’s plan excludes this service”. In the third instance, the Company failed to explain to the member the specific reason(s) it determined the services were considered experimental or investigational, and failed to reference the Company’s Clinical Policy Bulletin (CPB) upon which the denial is based. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(13).

Summary of the Company’s Response: In the first two instances, the Company agrees that the remark code applied was incorrect and does not provide the factual basis for the denial of the claim. As a remedial measure, the Company provided feedback and additional training on October 13, 2017 to the individuals involved to help prevent these types of errors from occurring in the future.

In the third instance, the Company respectfully disagrees that the EOB does not state the specific reason and factual and legal basis for denying the claim. The Company states it appropriately denied the service according to its CPB. A service which is not generally recognized according to professional standards of safety and
effectiveness is considered to be experimental or investigational. The Company provided an excerpt from the member’s plan which conveys the Experimental/Investigation provision of the policy and is consistent with the claim denial. Nonetheless, the Company re-evaluated the member experimental and investigational EOB text and the following text change was implemented and effective on October 29, 2018.

Your plan does not cover charges for, or related to, services or supplies that we consider to be experimental or investigational. To obtain more information regarding coverage of this service, go to our website and enter the procedure code (CPT-4 or HCPCS code) in the search field.

28. **In two instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.** In the first instance, the claims processor did not follow the Company’s procedure specific to pended claims. The processor paid a claim that should have been pended. In the second instance, the claims processor did not follow the Company’s procedure specific to retro-terminations. The Company subsequently made an error in its processing of this claim. The original processing was correct; however, it was incorrectly reprocessed with a request for an overpayment due to an incorrect retroactive termination. The Department alleges these acts are in violation of CIC §790.03(h)(3).

**Summary of the Company’s Response:** In the first instance, the Company states it appropriately pended the initial claim for a breakdown of the charge amount per CPT code; however, due to processor oversight, the subsequent claim was paid and should have been pended in the same manner as the initial claim. The Company provided feedback to the claim processor associated with the isolated processor error to determine what went wrong and to help prevent similar errors from occurring in the future. In the second instance, the Company acknowledges the retroactive termination policy was not appropriately applied in this instance. This was an isolated error due to processor oversight. As a result of this finding, the Company issued payment with interest in the amount of $79.14.

29. **In two instances, the Company failed to pay interest on an uncontested claim after 30 working days.** In the first instance, although interest was included when the claim was eventually paid, the Company used an incorrect receipt date. Therefore, the correct amount of interest was not included. In the second instance, the claim was reprocessed; however, the Company identified a claim receipt date almost three months beyond the original receipt date. The Department alleges these acts are in violation of CIC §10123.13(b) and are unfair practices under CIC §790.03(h)(5).

**Summary of the Company’s Response:** In the first instance, the Company agrees the applicable receipt date was not correct and that additional interest was owed. As a result of this finding, the Company issued an interest payment in the
amount of $104.01. In the second instance, the Company agrees late claim interest was owed. As a result of this finding, the Company issued an interest payment in the amount of $142.66. To ensure future compliance, the Company provided feedback and additional training to the individuals involved to help prevent these types of errors from occurring in the future.

30. **In two instances, the Company requested information that is not reasonably necessary to determine liability for payment of a claim.** Specifically, in both instances, the Company incorrectly sought the tax identification number and billing address from the provider, which was already on record upon receipt of the initial claim submission. The Department alleges these acts are in violation of CIC §10123.131(b) and are unfair practices under CIC §790.03(h)(3).

   **Summary of the Company's Response:** The Company acknowledges it incorrectly contested the claims in both instances. In one instance, the processor associated with the claim is no longer with the Company; therefore, no remediation is indicated for this error. In the other instance, the Company notified the claim processing staff on October 13, 2017 to review claim submissions and confirm that the required provider tax identification number and billing address is present before contesting the claim.

31. **In two instances, the Company failed to advise the insured of the right to an independent medical review (IMR) on letters of denials and on all written responses to grievances in cases in which the insured believes that health care services had been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers.** The Company failed to include disclosure of the insured’s right to an IMR to its insureds who reside out-of-state in one of the 10 exception states identified by the Company in section 3(a) above. The health policies or certificates were issued in California to California employers and to their out-of-state employees. Additionally, the policies in question include California mandated benefits. The Department alleges these acts are in violation of CIC §10169(i) and are unfair practices under CIC §790.03(h)(1).

   **Summary of the Company's Response:** The Company disagrees with these findings. The Company states that many of its California employers purchasing Preferred Provider Organization (PPO) and point-of-service plan type policies have employees located in other states who are covered by the policy. One of the reasons employers choose to do business with Aetna is its ability to cover employees at multiple locations. And as a multistate health insurer, Aetna encounters situations where the laws of both the state where the policy was issued (the situs state), and the laws of the state where the claim was incurred have requirements about how insurance claims are to be handled.

   With regard to IMR disclosure on EOBs, the Company generally follows the laws of the state where the policy was issued. This policy is also followed for providing
patient management, complaints, and grievance notices. However, for contracts issued in California, everyone who is covered will receive the rights of the contract state unless they live in one of the 10 exception states. If a member/insured lives in one of the exception states, the Company applies the requirements of the residence state instead of the contract state. The Company further states the exception states have determined that their laws are extraterritorial and govern the complaints, grievances, and appeals of members living in their states. Balancing the relative interests of the contract and member states, and the need to administer plans with members residing in multiple states, the Company considers its approach to be a practical and compliant one.

With regard to the exception states, Aetna implemented processes to apply the exception state requirements for residents of those states in the mid-2000s. This approach is a long-standing practice and the Company believes it is consistent with industry practice as well. To make changes in these processes would require extensive changes across the Company, as well as outreach to the states with extraterritorial requirements. Aetna believes that any changes of this scope are best addressed through the regulatory process so that all carriers may have input and all carriers are required to make similar changes at the same time. This would also serve as a basis for addressing this matter with other affected states.

In summary, for member EOBs and utilization review requirements, including IMRs, the Company currently uses the requirements of the situs state with the exception of 10 states that have required the Company to use its laws for insured residents in that state. These states provide comparable consumer protections, including the right to an external review. The Company recognizes the complexity of conflicting law and extraterritoriality issues and offers to continue discussion of these matters with the Department, the industry as a whole, and/or the exception states.

**Summary of the Department’s Evaluation of the Company’s Response:** As noted above, the Aetna examination involves policies or certificates that were issued in California to California employers and to their out-of-state employees. The extraterritorial statute does not apply in the present situation. Aetna makes reference to “exception” states, states whose managed care laws are extraterritorial and must be applied to all resident certificate and policyholders in their states regardless of the policy situs. Aetna is essentially stating that these exception states have their own extraterritorial statutes that require the resident state’s laws apply to the health insurance policies and certificates, just like California’s laws could apply to a California resident even when a policy is issued to an out-of-state employer. For these states, Aetna claims that it must follow only the laws of the resident states regarding notice language on explanations of benefits (EOBs) and disregard California law. However, no evidence has been presented that these exception states’ extraterritorial laws require that only the exception state’s health insurance laws apply. In this situation, both the resident state and California’s laws would apply. Section 10169(i) requires Aetna to provide notice to insureds when their claims are denied, modified, or delayed based on
medical necessity that they have the right to request an IMR from the California Department of Insurance.

Aetna does not claim that any provision of California law excuses it from complying with these California laws, rather it claims that because it may also be required to follow the laws of another “exception” state, it should be able to simply choose which state’s law to follow for the sake of “practicality.” Aetna has provided no legal justification as to the reason it is not in compliance with the referenced Insurance Code. The Department does not have discretion to simply waive an insurer’s statutory obligations.

Aetna also contends that this noncompliance with California law is a longstanding practice consistent with industry practice. Aetna requests that the Department address this issue “through the regulatory process” so that all carriers may have notice and input. However, this is not a regulatory issue. The requirements at issue are set forth in statute. The Department cannot change statutory requirements through regulation and the Department cannot excuse an insurer from compliance with selected state laws for the convenience of the insurer. Accordingly, Aetna must comply with the statutory requirements of CIC §10169. Therefore, this is an unresolved issue that may result in administrative action.

32. **In two instances, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation.** In the first instance, the utilization management (UM) clinician/nurse was of the opinion that the request for an additional seven days of inpatient care was reasonable. This was referred to an Aetna Medical Director (MD) who was of the opinion that the medical necessity for inpatient care was not met and recommended an alternative level of care. The MD did not discuss the differing opinion with the UM clinician/nurse as part of the investigation and ultimate decision to deny. As a result of the denial on October 12, 2016, an appeal was requested and the denial was overturned on October 14, 2016. Peer-to-peer discussions with the attending physician occurred both at the time of the initial denial and at the time of the appeal. It appears there was no difference in the information available to Aetna at the time of the appeal versus at the time of the initial denial.

In the second instance, the Company failed to fully investigate whether additional residential treatment was necessary prior to the denial. The UM clinician opined a claim for residential treatment to treat chemical dependency was not necessary and intensive outpatient treatment would be appropriate. The claim was sent to an Aetna MD who agreed with the UM clinician’s assessment. The MD did not communicate with either the treating physician or the member prior to rendering an adverse decision. The decision appears to have been rendered solely on the review of the patient’s condition and circumstances, and the ASAM guidelines. On appeal, additional days of residential treatment were allowed based on a call to the referring facility/provider and a review of the medical records.
The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

**Summary of the Company’s Response:** In the first instance, the Company states the UM clinician’s opinion was considered per the file notes and the MD would have reviewed the clinician’s notes. The MD discussed the case with the attending physician (AP). The MD verified the clinical in case management notes and acknowledged that over the past weekend the patient had already had a pass with her parents to test compliance with the safety contract. Continued residential treatment was advocated, but the AP acknowledged that the member was not endorsing specific intent nor plan to harm self or others, and the member was not psychotic and treatment cooperative. Without any additional clinical for needing continued 24-7 residential treatment center (RTC) monitoring and due to the conversation with the AP, the alternative level of care (ALOC) of partial hospitalization (PHP) was offered. There is no documentation that a conversation between the MD and the UM clinician took place in regard to the difference of opinion.

Clinicians are encouraged to use their clinical judgment and provide recommendations and concerns to the MD during their review process. Had the clinician continued to dispute the MD’s recommendation after the discussion with the AP occurred, she could have followed up and would have documented that discussion and the outcome. Furthermore, the Company states the AP and the MD completed a peer-to-peer discussion on October 12, 2016 prior to the denial. The appeal date in the system is noted to have been launched on October 13, 2016. Therefore, the Company states it conducted a thorough, fair and objective investigation prior to the October 12, 2016 denial.

Nonetheless, in a phased rollout with initial revisions made on August 8, 2018, Aetna Medical Directors have been educated on completing an enhanced Medical Director template with specific criteria fields including medical records reviewed and the rationale for the decision. The UM clinician/nurse receives the enhanced decision documentation template completed by the MD, which will aid and provide the UM clinician/nurse to clearly see what documentation the MD based his/her decision and assist in discussions, as applicable, should the nurse and physician recommendations differ. The UM clinician/nurse will be able to consult with the MD by phone, email, instant messaging, or in person for any questions on the denial reason. The UM clinician/nurse will then generate the appropriate approval and/or denial letters. Aetna also implemented additional enhancements to the Medical Director Decision Documentation Template. The Clinical Claim Review (CCR) template was implemented in October 2018 and is used by CCR medical directors who review post service claims. The Company had in place a Territory Medical Director Template since 2013. Additional enhancements to the Territory template were made on June 11, 2019. This is used by the Territory Medical Directors who conduct precertification, concurrent, and retrospective reviews.
In the second instance, the Company disagrees with this violation. Clinical information was provided over the phone with the request for concurrent review. Per Company policy, the case did not meet medical necessity, and therefore was sent to a Medical Director for review. A Medical Director reviewed the clinical information and determined that the Level of Care (LOC) was not appropriate and the continued stay request was denied. When the denial was verbally provided, the Company offered a peer-to-peer review pursuant to Company procedures. There is no documentation of a request from the facility for that review to occur. Instead, the facility chose to appeal the decision at which time another Aetna Medical Director handling the appeal spoke with the facility and obtained additional clinical information that resulted in an overturn of the original denial. Further, the Company states when the initial review was completed three days earlier, some of the circumstances could have changed.

**Summary of the Department's Evaluation of the Company's Response:** In the second instance, the Aetna Medical Director did not communicate with either the treating physician or the patient prior to rendering an adverse decision. Aetna procedures regarding decision making state that an MD may consult with other staff, the treating practitioner, a peer specialty reviewer and/or the member as needed during the coverage determination process. Although a peer-to-peer was offered to the facility, a thorough, fair, and objective investigation was not conducted prior to the denial. Instead, the investigation was conducted as a result of the appeal. The investigation should be proactive rather than reactive as the burden is on the Company particularly when a denial is involved. Therefore, this is an unresolved issue that may result in administrative action.

33. **In two instances, the Company failed to provide written notice of the need for additional time every 30 calendar days to the claimant and the provider.** One instance applies to the insured and one instance applies to the provider. The Department alleges these acts are in violation of CCR §2695.11(d) and are unfair practices under CIC §790.03(h)(3).

**Summary of the Company's Response:** The Company acknowledges these findings in both instances. To ensure future compliance, the Company brought this to the attention of the processors on June 28, 2017.

34. **In one instance, the Company failed to notify the insured in writing, within 30 working days after receipt of the claim, that the claim was denied.** Specifically, although this instance involves a resubmitted claim, the member was not provided with an EOB identifying the reason for the denial of the resubmission. The provider, however, was sent a denial with the following remarks: “The member's plan provides coverage for charges that are responsible and appropriate. This procedure exceeds the maximum number of services allowed under our guidelines for a single date of service”. The Department alleges this act is in violation of CIC §10123.13(a) and is an unfair practice under CIC §790.03(h)(13).
Summary of the Company’s Response: The Company acknowledges this finding that it did not provide the member with an EOB notice of the claim denial. The Company researched this claim and noted that this claim was submitted multiple times. The Company has not determined the underlying cause regarding the absence of the member EOB on this claim; however, the Company believes the cause may be attributable to the multiple submissions of the same claim. While the Company states this occurrence is an isolated anomaly, the Company will monitor this going forward to ensure notice of contested claim denials are generated on all California claims.

35. In one instance, the Company failed to include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Specifically, the Company’s letter upholding the denial did not include the name and telephone number of the health care responsible for the denial. The letter states only that a Medical Director, a complaint and appeal nurse, and a complaint and appeal analyst participated in the review of the appeal. The Department alleges this act is in violation of CIC §10123.135(h)(4) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company’s Response: The Company acknowledges the analyst reviewing the file made an error. To ensure future compliance, the Company provided feedback in a group meeting on October 30, 2017 and separately to the analyst.

36. In one instance, the Company attempted to settle a claim by making a settlement offer that was unreasonably low. Specifically, the Company originally paid the claim using an incorrect contract or fee resulting in an underpayment. As a result of the provider appeal, the Company overturned the claim. The Department alleges this act is in violation of CCR §2695.7(g) and is an unfair practice under CIC §790.03(h)(5).

Summary of the Company’s Response: The Company agrees the original claim processing was incorrect and resulted in an underpayment due to the processor selecting the incorrect provider of service. As a result of the provider’s appeal, the Company initiated a project for this error after the sample claim was reprocessed. A claims report was generated identifying impacted claims. Each claim was individually reviewed to determine applicability and corrected/reprocessed if required. To ensure future compliance, the Company reviewed this issue and discovered that due to the similarity of the provider names, the facility Provider Identification Number (PIN) was applied instead of the hospital’s PIN. The Company’s provider network area contacted the provider to discuss this issue and requested that the billing reflect the applicable hospital name. Additionally, the Company discussed this with the provider periodically between August and December of 2016.
ACCIDENT AND DISABILITY (MEDICAL CLAIMS and MENTAL HEALTH CLAIMS) - ELECTRONIC REVIEW

37. In 67,005 instances, the Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim, or after receipt of all information necessary to determine payer liability; the Company failed to pay interest on an uncontested claim after 30 working days; and the Company failed to pay interest on a contested claim after 30 working days. Utilizing the populations provided by the Company, the Department identified 2,611,313 total group and individual medical claims paid and contested claims paid within the populations, and the Department identified 101,832 total group and individual mental health claims paid and contested claims paid within the populations.

When these paid and contested paid populations were tested for the timeliness of payment, the results of the electronic analysis identified 59,548 medical claims (59,499 group paid and group contested paid; 49 individual paid and individual contested paid) and 1,759 mental health claims (1,759 group paid and group contested paid; and zero individual paid and individual contested paid) that were potentially paid beyond 30 working days from receipt of the claim, or after receipt of all information necessary to determine payer liability. The Department’s analysis included claims paid beyond 30 working days with and without interest.

The electronic review tested for “clean” medical claims and “clean” mental health claims where a payment was issued beyond 30 working days from the date of receipt, no interest was paid, and the allowed amount was not completely applied towards the deductible. A “clean” claim is an insurance claim that can be processed without the need for additional information. The analysis identified 9,034 medical claims (9,033 group and one individual) and 220 mental health claims (220 group and zero individual) which were paid late and without interest.

The electronic review tested for contested medical claims and contested mental health claims where a payment was issued beyond 30 working days after receipt of all information necessary to determine payer liability and interest was not paid. The analysis identified 1,006 medical claims (1,006 group and zero individual) and 18 mental health claims (18 group and zero individual) which were paid late and without interest.

The instances identified by the Department’s analysis included instances in which Aetna applied the time frame requirements for the state in which the claim arose in lieu of the California requirement, and insurance in which Aetna did not adhere to California required time frames when being billed by a state or federal agency for reimbursement of Medi-Cal or Medicaid payments. Aetna state it did not agree CIC section 10123.13(a) applied in such cases.
The Company provided additional data which demonstrated compliance in 4,580 claims with the details identified below in the Company’s response to this section. Because Aetna did not fully separate out the lines of business or categories in its analysis, the electronic analysis for medical and mental health claims were combined and the number of claims in which Aetna demonstrated compliance were deducted from this section (71,585-4,580=67,005).

The Department alleges these 67,005 acts are in violation of CIC §10123.13(a), CIC §10123.13(b), and CIC §10123.13(c), and are unfair practices under CIC §790.03(h)(5).

**Summary of the Company’s Response:** The Company evaluated the Department’s results of the electronic analysis. The Company notes the electronic analysis data files (claim populations) include claims representing payments to out-of-state providers and payments to members residing outside of the State of California. As a multistate carrier, Aetna encounters situations where the laws of both the state where the policy was issued (i.e., the situs state) and the laws of the state where the provider submits a claim have requirements about how claims are to be handled. Aetna follows the claim payment requirements of the state where the medical service was delivered (where the claim arose) even when the health insurance policy was issued in another state. Aetna contends this practice is consistent with its understanding of state fair claims practice laws that do not differentiate requirements for the handling of claims based on policy situs. For this reason, the Company states claims in this category would not be applicable to the California prompt pay requirements. This applies to claims in the population with and without interest paid. The Company also notes the electronic analysis populations include Medicaid Reclams. These claims represent reimbursements to Medi-Cal, California’s Medicaid program. The Company states payments to Medi-Cal pursuant to its reclamation program are not within the scope of Insurance Code section 10123.13 that apply an interest requirement to late paid insured or provider claims. Reclamation occurs when the provider claim has already been paid by the Medi-Cal program. If the Medi-Cal program discovers that there was private health care coverage available to the patient, it seeks reimbursement directly from that private plan pursuant to California Welfare and Institutions Code.

Regardless of the Company’s positions noted above, with full reservation of its rights, the Company agrees to implement claims practices that use the CIC §10123.13 rules for out-of-state provider claims covered by California sitused policies on a prospective basis regarding prompt pay requirements. In addition, with full reservation of its rights, the Company agrees to update its policies and procedures to treat Medi-Cal reimbursement requests as claims for California prompt pay purposes on a prospective basis. Aetna completed its implementation analysis and due to the extensive necessary system enhancements, the Company expects to complete the system enhancements and implement the changes by the end of the second quarter of 2020.
With respect to all other claims, the Company indicates that while every effort is made to pay claims within 30 working days from date of receipt, there are a number of factors that impact claim processing turnaround times including; but not limited to, claim complexity, medical necessity reviews, and the review of some claims to ensure that charges are appropriate. Additionally, a small number of claims are handled by a third-party administrator (TPA). This TPA experienced an influx in claims activity that overstressed their proprietary systems and staffing. This resulted in an increase in claims paid beyond 30 working days.

To remediate this issue, the Company has several mechanisms in place to monitor and ensure whenever possible that claims are paid within 30 working days. Some mechanisms include the following:

(1) Inventory Fundamentals and Site Working File Procedures
   a. Daily inventory management reports containing claims that are approaching or exceeding state timeframes for payment of interest
   b. Site working file used by Claim Operations that includes state information which is monitored with a final date for state legislation for on-hand inventory
   c. Late claim interest exposure report used by ancillary areas (Medical Case Management, Clinical Claim Review, Special Investigations Unit, etc.)

(2) Escalation Process for claims in ancillary areas approaching prompt pay timeframes

To ensure future compliance, the Company issued an educational reminder to the claim processing staff to reference existing policies regarding late claim interest and to apply the appropriate receipt date with specific emphasis on reworked claims on or before October 31, 2017. To remediate this issue for the TPA, the TPA promptly began hiring and training additional staff, which reduced its inventory by the fourth quarter of 2016. To ensure future compliance, a similar educational reminder was issued to claim processing staff for the TPA on or before November 30, 2017. Additionally, the TPA migrated to a new system that handles work much more efficiently in the first quarter of 2018.

As noted above, the Company demonstrated compliance in 4,580 claims with the details as follows: 1,038 internal adjustments/adjusted claims, 1,027 overpayments/overpayment adjustments, 731 timely adjudicated/processed claims, 644 split claim segments/split onto multiple segments for processing, 618 timely payment of claims following receipt of additional information, 486 corrected claims, 16 previously processed claims, 11 claims where additional requested information was not received, and nine claims where the Company had received additional information, but the processor failed to update the pend date in the system.
Finally, as a result of the Company’s review of claims that were not paid timely, and interest was not previously included, the Company calculated appropriate interest on uncontested and contested claims and issued payments totaling $95,586.33.