

**DELAWARE DEPARTMENT OF INSURANCE**

**MARKET CONDUCT EXAMINATION REPORT**

**AETNA HEALTH INC, PA**  
**NAIC # 95109**

151 Farmington Avenue  
Hartford, CT 06156

**As of**

**April 30, 2018**

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Honorable Trinidad Navarro  
Insurance Commissioner  
State of Delaware  
841 Silver Lake Boulevard  
Dover, Delaware 19904

Dear Commissioner Navarro:

In compliance with the instructions contained in Certificate of Examination Authority Number: 95109-18-707 and pursuant to statutory provisions including 18 Del. CODE §318-322, a market conduct examination has been conducted of the affairs and practices of:

**Aetna Health Inc, PA**  
**NAIC # 95109**

This examination was performed as of April 30, 2018. The examination consisted of two phases, an on-site phase and an off-site phase. The on-site phase of the examination was conducted at the following company location:

151 Farmington Avenue  
Hartford, CT 06156

The off-site examination phase and was performed at the offices of the Delaware Department of Insurance, hereinafter referred to as the "Department" or "DDOI," or other suitable locations.

The report of examination herein is respectfully submitted.

## EXECUTIVE SUMMARY

The main administrative offices of Aetna Health Inc., PA (Aetna Health or the Company) are located in Hartford, Connecticut. The Company's 2017 annual statement filed with the Department reported total premiums written for all states of \$3,946,998,495 of which Delaware has a market share of 3.55% or approximately \$140,219,228.

This examination focused on the Aetna Health's healthcare lines in the following areas of operation: Forms, Complaint Handling, Grievances and Appeals, and Claims. The following exceptions were noted and the details for the cited code references are included:

- **33 Exceptions**

- **18 Del. C. § 2304(16)(b) Unfair claim settlement practices.**

- *b. Failing to acknowledge and act reasonably promptly upon communication with respect to claims arising under insurance policies;*

- Aetna Health failed to acknowledge and act reasonably promptly upon communication with respect to claims.

- **26 Exceptions**

- **18 Del. C. § 2304(16)(n) Unfair claim settlement practices.**

- *n. Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.*

- Aetna Health failed to promptly provide an explanation for the denial of the claim or for the offer of a compromise settlement.

- **5 Exceptions**

- **18 Del. C. § 2712(a) Filing, approval of forms.**

- *a. No basic insurance policy or annuity contract, form, or application form where written application is required and is to be made a part of the policy or contract or printed rider or endorsement form or form of renewal certificate shall be delivered or issued for delivery in this State, unless the form has been filed with the Commissioner. This provision shall not apply to surety bonds or to specially rated inland marine risks nor to policies, riders, endorsements, or forms of unique character designed for and used with relation to insurance upon a particular subject or which relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or health insurance policies and are used at the request of the individual policyholder, contract holder, or certificate holder. With respect to group and blanket health insurance policies issued and delivered to a trust or to an association outside of this State and covering persons resident in this State, the group certificates to be delivered or issued for delivery in this State shall be filed with the Commissioner pursuant to this section provided, however, that this requirement shall not apply to an association group having received a waiver from the Commissioner upon a finding*

*that the association group meets the qualifications set forth in § 3506 of this title. In the case of forms for use in property, marine (other than wet marine and transportation insurance), casualty, surety and title insurance coverages, the filing required by this subsection may be made by rating organizations on behalf of their members and subscribers, but this provision shall not be deemed to prohibit any such member or subscriber from filing any such forms on its own behalf.*

Aetna Health failed to file forms with the Commissioner.

- **3 Exceptions**

- **18 Del. C. § 2304(17) Failure to maintain complaint handling procedures.**

- *(17) Failure to maintain complaint handling procedures. — Failure of any person to maintain a complete record of all the complaints which it has received since the date of its last examination as otherwise required in this title. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint. For purposes of this subsection, "complaint" shall mean any written communication primarily expressing a grievance.*

Aetna Health failed to include a Department complaint in the DDOI complaint registry and/or inaccurately recorded the grievance received date.

- **22 Exceptions**

- **18 Del. C. § 332(c)(4) Prompt response to written grievances.**

- *(4) Prompt response to written grievances. — The IRP shall provide that within 5 business days of receipt of a written grievance, the carrier shall provide written acknowledgement of the grievance, including the name, address and telephone number of the individual or department designated by the carrier to respond to the grievance.*

Aetna Health failed to provide written acknowledgement of the grievances that included the name, address and telephone number of the individual or department designated by the carrier to respond to the grievance within 5 business days of receipt.

- **5 Exceptions**

- **18 Del. C. § 332(c)(7) Written notice of decisions.**

- *(7) Written notice of decisions. — The IRP shall provide that within 5 days after a grievance is decided in the manner described above, the insured shall be provided with written notice of the disposition of that grievance. In cases where the grievance has been decided in a manner that does not pay the claim in its entirety, the carrier shall provide the insured with a letter fully stating the reasons for the disposition (including specific policy language relied upon and any other documents relied upon) and the clinical rationale for the determination in cases where the determination has a clinical basis. The carrier's written notice shall also inform the insured of the appropriate manner for the insured to pursue an external review of the carrier's*

*decision. Finally, the carrier's written notice shall inform the insured of the mediation services offered by the Department of Insurance, but shall clearly inform the insured in layman's terms that mediation does not change the deadlines imposed by § 6416 of this title or this section. The Department of Insurance shall inform any person with rights under § 6416 of this title or this section of those rights.*

Aetna Health did not provide written notice to the insured of mediation services offered by the Department of Insurance.

- **3 Exceptions**

- **18 Del. C. § 332(c)(5) Speedy review of grievances.**

- That IRP shall require that all grievances be decided in an expeditious manner, and in any event, no more than:

- a. 72 hours after the receipt of all necessary information relating to an emergency review;*
    - b. 30 days after the receipt of all necessary information in the case of requests for referrals or determinations concerning whether a requested benefit is covered pursuant to the contract; and*
    - c. 45 days after the receipt of all necessary information in all other instances.*

Aetna Health failed to decide grievances in an expeditious manner.

- **3 Exceptions**

- **18 Del. Admin C. § 1313-3.0 Notice.**

- 3.1 At the time a carrier provides to a health care provider written notice of a carrier's final decision regarding reimbursement for an individual claim, procedure or service, if the decision does not authorize reimbursement of the provider's charge in its entirety, the carrier shall give the provider written notice of the provider's right to arbitration. Such notice may be separate from or a part of the written notice of the carrier's decision. Any such notice given to a provider shall, at a minimum, contain the following language:*

- "You have the right to seek review of our decision regarding the amount of your reimbursement. The Delaware Insurance Department provides claim arbitration services which are in addition to, but do not replace, any other legal or equitable right you may have to review of this decision or any right of review based on your contract with us. You can contact the Delaware Insurance Department for information about arbitration by calling the Arbitration Secretary at 302-674-7322 or by sending an email to: [DOI-arbitration@state.de.us](mailto:DOI-arbitration@state.de.us). <mailto:DOI-arbitration@state.de.us> All requests for arbitration must be filed within 60 days from the date you receive this notice; otherwise, this decision will be final."*

The Company did not provide notice indicating the providers right to arbitrate.

- **9 Exceptions**

- **18 Del. C. § 2304(16)(f) Unfair claim settlement practices.**

*f. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;*

Aetna Health failed to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear.

- **2 Exceptions**

**18 Del. Admin. C. § 902-1.2.1.2 Authority for Regulation; Basis for Regulation.**

*1.2.1.2 Failing to acknowledge and respond within 15 working days, upon receipt by the insurer, to communications with respect to claims by insureds arising under insurance policies.*

Aetna Health failed to acknowledge the claims within 15 working days.

- **6 Exceptions**

**18 Del. Admin. C. § 902-1.2.1.3 Authority for Regulation; Basis for Regulation.**

*1.2.1.3 Failing to implement prompt investigation of claims arising under insurance policies within 10 working days upon receipt of the notice of loss by the insurer.*

Aetna Health failed to implement prompt investigation of the claims within 10 working days.

- **26 Exceptions**

**18 Del. Admin. C. § 902-1.2.1.5 Authority for Regulation; Basis for Regulation.**

*1.2.1.5 Failing to affirm or deny coverage or a claim or advise the person presenting the claim, in writing, or other proper legal manner, of the reason for the inability to do so, within 30 days after proof of loss statements have been received by the insurer.*

Aetna Health failed to affirm or deny the claims within 30 days.

- **25 Exceptions**

**18 Del. Admin. C. § 1310 - 6.1.1 Processing of Clean Claim.**

*6.1 No more than 30 days after receipt of a clean claim from a provider or policyholder, a carrier shall take one of the following four actions:*

*6.1.1 if the entire claim is deemed payable, pay the total allowed amount of the claim;*

*6.1.2 if a portion of the claim is deemed payable, pay the allowable portion of the claim that is deemed payable and specifically notify the provider or policyholder in writing why the remaining portion of the claim will not be paid;*

*6.1.3 if the entire claim is deemed not payable, specifically notify the provider or policyholder in writing why the claim will not be paid;*

*6.1.4 if the carrier needs additional information from a provider or policyholder who is submitting the claim to determine the propriety of payment of a claim, the carrier shall request in writing that the provider or policyholder provide documentation that is relevant and necessary for clarification of the claim.*

Aetna Health failed to pay the claims within 30 days.

- **10 Exceptions**

**18 Del. Admin. C. § 1310 - 6.2 Processing of Clean Claim.**

*6.2 The request pursuant to section 6.1.4 must describe with specificity the clinical information requested and relate only to information the carrier can demonstrate is specific to the claim or the claim's related episode of care. A provider is not required to provide information that is not contained in, or is not in the process of being incorporated into, the patient's medical or billing record maintained by the provider whose services are the subject of inquiry. A carrier may make only one request under this subsection in connection with a claim. A carrier who requests information under this subsection shall take action under sections 6.1.1 through 6.1.3 within 15 days of receiving properly requested information.*

Aetna Health failed to provide a determination of the claims within 15 days following receipt of additional requested information.

- **20 Exceptions**

**18 Del. Admin. C. § 1310 - 6.1.3 Processing of Clean Claim.**

*6.1 No more than 30 days after receipt of a clean claim from a provider or policyholder, a carrier shall take one of the following four actions:*

*6.1.1 if the entire claim is deemed payable, pay the total allowed amount of the claim;*

*6.1.2 if a portion of the claim is deemed payable, pay the allowable portion of the claim that is deemed payable and specifically notify the provider or policyholder in writing why the remaining portion of the claim will not be paid;*

*6.1.3 if the entire claim is deemed not payable, specifically notify the provider or policyholder in writing why the claim will not be paid;*

*6.1.4 if the carrier needs additional information from a provider or policyholder who is submitting the claim to determine the propriety of payment of a claim, the carrier shall request in writing that the provider or policyholder provide documentation that is relevant and necessary for clarification of the claim.*

Aetna Health failed to notify the provider or policyholder in writing of why the claim will not be paid within 30 days.

- **2 Exceptions**

**18 Del. C. § 3343(b)(1)(b) Insurance coverage for serious mental illness.**

*(b) Coverage of serious mental illnesses and drug and alcohol dependencies. — (1) a. Carriers shall provide coverage for serious mental illnesses and drug and alcohol dependencies in all health benefit plans delivered or issued for delivery in this State. Coverage for serious mental illnesses and drug and alcohol dependencies must provide all of the following:*

*1. Inpatient coverage for the diagnosis and treatment of drug and alcohol dependencies.*

*b. Subject to subsections (a), (c) through (f), and (h) of this section, no carrier may issue for delivery, or deliver, in this State any health benefit plan containing terms that place a greater financial burden on an insured for covered services provided in the diagnosis and*



*treatment of a serious mental illness and drug and alcohol dependency than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan, including terms for deductibles, co-pays, monetary limits, coinsurance factors, limits in the numbers of visits, limits in the length of inpatient stays, durational limits, or limits in the coverage of prescription medicines.*

Aetna Health required and provided prior approval with a 6-month approval period. A change to a substantially similar medication due to cost or clinically significant reasons requires an additional prior authorization approval to treat the same disease. The pre-authorization requirement includes the establishing a diagnosis of opioid dependence, proof of counselling and abstinence from all opioids monitored through drug screening. This additional prior authorization requirement causes treatment delay and is excessive and discriminatory to mental health/substance abuse members.

- **1 Exception**

- **18 Del. Admin. C. § 3350(b) Prescription medication.**

*(a) This section applies to every policy or contract of health insurance, including each policy or contract issued by a health service corporation, which is delivered or issued for delivery in this State and which provides coverage for outpatient prescription drugs.*

*(b) Every policy or contract of health insurance described in subsection (a) of this section shall provide coverage for any outpatient drug prescribed to treat a covered person for a covered chronic, disabling or life-threatening illness if the drug:*

*(1) Has been approved by the Food and Drug Administration for at least 1 indication; and*

*(2) Is recognized for treatment of the indication for which the drug is prescribed in:*

*a. A prescription drug reference compendium approved by the Insurance Commissioner for purposes of this section; or*

*b. Substantially accepted peer reviewed medical literature.*

Aetna Health improperly denied a transitional fill claim due to exceeding plan limits even though the maximum dosing meets Food and Drug Administration guidelines.

- **1 Exception**

- **18 Del. C. § 3373(a) Utilization review entity's obligations with respect to pre-authorizations in nonemergency circumstances.**

*(a) If a utilization review entity requires pre-authorization of a pharmaceutical, the utilization review entity must complete its process or render an adverse determination and notify the covered person's health-care provider within 2 business days of obtaining a clean pre-authorization or of using services described in § 3377 of this title.*

Aetna Health failed to complete its process or render an adverse determination and notify the covered person's health-care provider within 2 business days.

- **1 Exception**

**18 Del. C. § 3373(c) Utilization review entity's obligations with respect to pre-authorizations in nonemergency circumstances.**

*(c) If a utilization review entity requires pre-authorization of a health-care service, the utilization review entity must grant a pre-authorization or issue an adverse determination and notify the covered person's health-care provider of the determination within 5 business days of receipt of a clean pre-authorization through electronic pre-authorization. For purposes of this subsection, a clean pre-authorization includes the results of any face-to-face clinical evaluation or second opinion that may be required.*

Aetna Health failed to grant a pre-authorization or issue an adverse determination and notify the covered person's health-care provider of the determination within 5 business days of receipt.

- **1 Exception**

**18 Del. C. § 3373(b) Utilization review entity's obligations with respect to pre-authorizations in nonemergency circumstances.**

*(b) If a utilization review entity requires pre-authorization of a health-care service, the utilization review entity must grant a pre-authorization or issue an adverse determination and notify the covered person's health-care provider of the determination within 8 business days of receipt of a clean pre-authorization not submitted through electronic pre-authorization. For purposes of this subsection, a clean pre-authorization includes the results of any face-to-face clinical evaluation or second opinion that may be required.*

Aetna Health failed to grant a pre-authorization or issue an adverse determination within 8 business days of receipt.

- **1 Exception**

**18 Del. C. § 2304(1)(a) Misrepresentations and false advertising of insurance policies.**

*(1) Misrepresentations and false advertising of insurance policies. — No person shall make, issue, circulate or cause to be made, issued or circulated any estimate, circular, statement, sales presentation, omission or comparison which:*

*a. Misrepresents the benefits, advantages, conditions or terms of any insurance policy;*

Aetna Health misrepresented the benefits, advantages, conditions, or terms of any insurance policy. The Company had a Clinical Policy Bulletin (CPB) to ensure methadone therapy for Opioid Use Disorder (OUD) prescriptions are obtained through a SAMHSA approved program. This CPB policy would apply to outpatient prescription drug benefits, obtained at a pharmacy. The company does not have any contracts with SAMHSA community pharmacies. Currently there are no SAMHSA community pharmacies in Delaware. Due to this a member would not be able to access their pharmacy benefits in Delaware for OUD.

- **85 Exceptions**

**18 Del. C. § 3343(b)(1)(b) Insurance coverage for serious mental illness.**

*(b) Coverage of serious mental illnesses and drug and alcohol dependencies. — (1) a. Carriers shall provide coverage for serious mental illnesses and drug and alcohol dependencies in all health benefit plans delivered or issued for delivery in this State. Coverage for serious mental illnesses and drug and alcohol dependencies must provide all of the following:*

*1. Inpatient coverage for the diagnosis and treatment of drug and alcohol dependencies.*

*b. Subject to subsections (a), (c) through (f), and (h) of this section, no carrier may issue for delivery, or deliver, in this State any health benefit plan containing terms that place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan, including terms for deductibles, co-pays, monetary limits, coinsurance factors, limits in the numbers of visits, limits in the length of inpatient stays, durational limits, or limits in the coverage of prescription medicines.*

Aetna Health has imposed a Non-Quantitative Treatment Limitation (NQTL) of a prior authorization every 6 months on all buprenorphine and buprenorphine/naloxone containing medications (both brand and generic) used for the treatment of Opioid Use Disorder (OUD). When comparing to opioid medications used for pain management (MED/SURG) the Company offers Butrans (buprenorphine) transdermal patch approved for chronic pain (MED/SURG), without a prior authorization requirement, and Belbuca (buprenorphine) buccal film approved for chronic pain (MED/SURG) with a prior authorization duration of 1 year.

- **85 Exceptions**

- 45 CFR § 146.136(c)(4)(ii)(a)(b) Nonquantitative treatment limitations.**

*(i) General rule A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference, and*

*(ii) Illustrative list of nonquantitative treatment limitations. Nonquantitative treatment limitations include -*

*(A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness.*

*(B) Formulary design for prescription drugs.*

Aetna Health has imposed a Non-Quantitative Treatment Limitation (NQTL) of a prior authorization every 6 months on all buprenorphine and buprenorphine/naloxone containing medications (both brand and generic) used for the treatment of Opioid Use Disorder (OUD). When comparing to opioid medications used for pain management (MED/SURG) the Company offers Butrans (buprenorphine) transdermal patch approved for chronic pain (MED/SURG), without a prior authorization requirement, and Belbuca (buprenorphine) buccal film approved for chronic pain (MED/SURG) with a prior authorization duration of 1 year.

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*1. Inpatient coverage for the diagnosis and treatment of drug and alcohol dependencies.*

*b. Subject to subsections (a), (c) through (f), and (h) of this section, no carrier may issue for delivery, or deliver, in this State any health benefit plan containing terms that place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan, including terms for deductibles, copays, monetary limits, coinsurance factors, limits in the numbers of visits, limits in the length of inpatient stays, durational limits, or limits in the coverage of prescription medicines.*

Aetna Health has imposed higher tier placements (Tier 3) on buprenorphine hcl sublingual tablets, buprenorphine/naloxone sublingual tablets, methadone (all strengths), naltrexone tablets, Suboxone films, and Bunavail. This is a violation by placing higher tiers (Tier 3) on the substance abuse medications used to treat Opioid Use Disorder (OUD) compared to MED/SURG medications which exhibit lower tier designations (Tier 1 and Tier 2) in every medication classification throughout this formulary. Comparing these aforementioned substance abuse medications to MED/SURG medications classified in this formulary, the patient/member would be paying higher copays resulting in higher cost to treat their disease.

- **1 Exception**

**45 CFR § 146.136(c)(4)(ii)(b) Nonquantitative treatment limitations.**

*(i) General rule A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits*

*in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference, and*

*(ii) Illustrative list of nonquantitative treatment limitations. Nonquantitative treatment limitations include -*

*(A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness.*

*(B) Formulary design for prescription drugs.*

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- **33 Exceptions**

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- 1. Inpatient coverage for the diagnosis and treatment of drug and alcohol dependencies.*

- b. Subject to subsections (a), (c) through (f), and (h) of this section, no carrier may issue for delivery, or deliver, in this State any health benefit plan containing terms that place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan, including terms for deductibles, co-pays, monetary limits, coinsurance factors, limits in the numbers of visits, limits in the length of inpatient stays, durational limits, or limits in the coverage of prescription medicines.*

Aetna Health applied a NQTL (quantity limitation/dose restriction) on max dosing of duloxetine for Major Depressive Disorder (MDD) and Generalized Anxiety Disorder (GAD) that was not included on max dosing for its MED/SURG indications. The recommended maximum dose for duloxetine is 120mg per day for Major Depressive Disorder (MDD) and Generalized Anxiety Disorder (GAD) in accordance with both the

FDA and the American Psychiatric Association's (APA) recommended guidelines. Duloxetine's other indications such as Diabetic Peripheral Neuropathic Pain (DPNP), Fibromyalgia (FM), and Chronic Musculoskeletal pain all have a maximum dosage of 60mg per day. None of these MED/SURG indications require a prior authorization at their maximum dose. However, a prior authorization override is required at doses of 120mg per day for only mental health indications (MDD and GAD). This policy is discriminatory towards mental health members since the same maximum dosing criteria is not provided equally to MH/SUD and MED/SURG indications.

- **33 Exceptions**

- **45 CFR § 146.136(c)(4)(ii)(a)(b) Nonquantitative treatment limitations.**

*(i) General rule A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference, and*

*(ii) Illustrative list of nonquantitative treatment limitations. Nonquantitative treatment limitations include -*

*(A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness.*

*(B) Formulary design for prescription drugs.*

Aetna Health applied a NQTL (quantity limitation/dose restriction) on max dosing of duloxetine for Major Depressive Disorder (MDD) and Generalized Anxiety Disorder (GAD) that was not included on max dosing for its MED/SURG indications. The recommended maximum dose for duloxetine is 120mg per day for Major Depressive Disorder (MDD) and Generalized Anxiety Disorder (GAD) in accordance with both the FDA and the American Psychiatric Association's (APA) recommended guidelines. Duloxetine's other indications such as Diabetic Peripheral Neuropathic Pain (DPNP), Fibromyalgia (FM), and Chronic Musculoskeletal pain all have a maximum dosage of 60mg per day. None of these MED/SURG indications require a prior authorization at their maximum dose. However, a prior authorization override is required at doses of 120mg per day for only mental health indications (MDD and GAD). This policy is discriminatory towards mental health members since the same maximum dosing criteria is not provided equally to MH/SUD and MED/SURG indications.

- **164 Exceptions**

- **45 CFR § 146.136(c)(4)(ii)(a)(b) Nonquantitative treatment limitations.**

*(i) General rule A group health plan may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan as written and in operation, any*

*processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference, and*

*(ii) Illustrative list of nonquantitative treatment limitations. Nonquantitative treatment limitations include -*

*(A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness.*

*(B) Formulary design for prescription drugs.*

Aetna Health placed quantity limitations on ADHD stimulant-based medications. When comparing the same criteria to MED/SURG, many MED/SURG medications exceeded their FDA, manufacturer, and peer reviewed literature dosing guidelines during the scope of the exam. This resulted in many paid MED/SURG claims with no dosing restrictions on above label/off label dosing. The Company is being more stringent/restrictive on ADHD medications, prescribed under physician supervision, by holding this type of mental health medication to FDA and manufacturer recommended guidelines. Quantity limits were later adjusted and raised on various ADHD medications as a result of excessive overturn rates on appeals (74%) from the entire class of ADHD medications. The Company applied quantity limitations (off label dosing) to ADHD medications more stringently than the processes, strategies, evidentiary standards, and other factors being applied to MED/SURG medications.

## **SCOPE OF EXAMINATION**

The Market Conduct Examination was conducted pursuant to the authority granted by 18 Del. C. §§318-322 and covered the experience period of January 1, 2016, through April 30, 2018 unless otherwise noted. The purpose of the examination was to determine compliance by the Company with Delaware insurance laws and regulations related to the healthcare lines.

The examination was a targeted market conduct examination of the healthcare lines for the period of January 1, 2016, through April 30, 2018. On October 8, 2018, the examination was expanded at the request of Centers for Medicare & Medicaid Services (CMS). The examination focus is on Affordable Care Act (ACA) compliance for the period of January 1, 2016 through December 31, 2017.

## **METHODOLOGY**

This examination was performed in accordance with Market Regulation standards established by the Department and examination procedures suggested by the NAIC.

**Delaware Market Conduct Examination Report  
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While the examiners' report on the errors found in individual files, the general business practices of the Company were also a subject of the review.

Aetna Health was requested to identify the universe of files for each segment of the review. Based on the universe sizes identified, random sampling was utilized to select the files reviewed for this examination.

Delaware Market Conduct Examination Reports generally note only those items, to which the Department, after review, takes exception. An exception is any instance of Company activity that does not comply with an insurance statute or regulation. Exceptions contained in the Report may result in imposition of penalties. General practices, procedures, or files that were reviewed by Department examiners during the course of an examination may not be referred to in the Report if no improprieties were noted. However, the Examination Report may include management recommendations addressing areas of concern noted by the Department, but for which no statutory violation was identified. This enables company management to review these areas of concern in order to determine the potential impact upon Company operations or future compliance.

Throughout the course of the examination the Aetna Health's officials were provided status memoranda which referenced specific policy numbers with citation to each section of law violated. Additional information was requested to clarify apparent violations. An exit conference was conducted with the Aetna Health's officials to discuss the various types of exceptions identified during the examination and review written summaries provided on the exceptions found.

## **COMPANY HISTORY AND PROFILE**

Aetna Health is a Pennsylvania domestic for-profit health maintenance organization. The Company was incorporated on May 7, 1981 and its legal home office address and its principal executive office address is 1425 Union Meeting Road, Blue Bell, Pennsylvania, 19422. Aetna Health is a wholly owned subsidiary of Aetna Health Holdings, LLC, a Delaware limited liability company, whose ultimate parent is Aetna Inc.

Aetna Health is licensed as a health maintenance organization in 23 states. In 2017, Aetna Health reported \$3,946,998,495 premium of which \$140,219,228 was written in Delaware. In 2016, Aetna Health reported \$4,525,823,229 premium of which \$111,445,521 was written in Delaware.

## **COMPANY OPERATIONS AND MANAGEMENT**

The Company provided the following company operations and management documentation:

- Internal Control Methods.



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- Internal Audits.
- Company Overview and History.
- Third Party Administrators.
- The Company's Annual Report for 2015, 2016, and 2017.
- Overpayments.

The documents were reviewed to ensure compliance with the State of Delaware Laws and Regulations. The only exceptions are noted below:

**A. Overpayments**

Health insurers often pay claims and subsequently determine the amount paid was incorrect. If a claim is paid at a higher amount than what was appropriate an overpayment recovery must occur.

Aetna Health Inc. was requested to explain their overpayment recovery processes and procedures. They were also requested to provide written documentation of the process used to identify claim overpayments, notify providers of the overpayments, and the recovery methods used. A listing of all claim overpayments recoveries during the examination period of January 1, 2016 through April 30, 2018 was requested. The Company provided a list of 1,902 overpayment recoveries. A random sample of 113 was selected and reviewed.

The following exceptions were noted:

**1 Exception – 18 Del. C. § 2304(16)(b) Unfair claim settlement practices.**

Aetna Health failed to acknowledge and act reasonably promptly upon communication with respect to claims.

*Recommendation:* It is recommended that the Company acknowledge and act reasonably promptly upon communication with respect to claims as required by 18 Del. C. § 2304(16)(b).

**1 Exception – 18 Del. C. § 2304(16)(n) Unfair claim settlement practices.**

Aetna Health failed to promptly provide an explanation for the denial of the claim or for the offer of a compromise settlement.

*Recommendation:* It is recommended that the Company promptly provide an explanation for the denial of the claim or for the offer of a compromise settlement as required by 18 Del. C. § 2304(16)(n).

## FORMS

Aetna Health was requested to provide a list of all individual/group policy, certificate forms, conversion contracts, applications, amendments, and endorsements used during the experience period for newly issued Health Coverage in Delaware. The Company provided a list of 79 DDOI forms and certificates that were in use during the examination period. All 79 forms and certificates were reviewed.

The following exceptions were noted:

### **5 Exceptions – 18 Del. C. § 2712(a) Filing, approval of forms.**

Aetna Health failed to file forms with the Commissioner.

*Recommendation:* It is recommended that the Company file forms with the Commissioner as required by 18 Del. C. § 2712(a).

## COMPLAINT HANDLING

### **A. DDOI Complaints**

Aetna Health was requested to provide a listing of all complaints initiated through the DDOI and filed with the Company during the examination period of January 1, 2016 through April 30, 2018. The Company provided a list of 36 Department complaints that were received during the examination period. All 36 Department complaint files were reviewed.

The Department also provided a list of complaints received during the examination period. Reconciliation between Aetna Life's list and the Department list was performed, and discrepancies were addressed. All complaint files were reviewed for compliance with applicable Delaware Department of Insurance statutes.

No exceptions were noted.

### **B. NON- DDOI Complaints**

Aetna Health Inc. was requested to provide a listing of all NON-DDOI complaints filed with the Company during the examination period of January 1, 2016 through April 30, 2018. The Company provided a list of 30 consumer complaints that were received directly by the Company during the examination period. All 30 complaint files were reviewed.

In addition, the Company's policy and procedures related to the handling and processing of complaints were provided and reviewed.

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All complaint files and associated policies and procedures were reviewed for compliance with applicable Department statutes.

The following exceptions were noted:

**1 Exception - 18 Del. C. § 2304(17) Failure to maintain complaint handling procedures.**

Aetna Health failed to include a Department complaint in the DDOI complaint registry.

*Recommendation:* It is recommended that the Company accurately record all complaints as required by 18 Del. C. § 2304(17).

**4 Exceptions - 18 Del. C. § 332(c)(4) Prompt response to written grievances.**

Aetna Health failed to provide written acknowledgement of the grievances that included the name, address, and telephone number of the individual or department designated by the carrier to respond to the grievance within 5 business days of receipt.

*Recommendation:* It is recommended that the Company provide written acknowledgement of grievances including the name, address and telephone number of the individual or department designated by the carrier to respond to the grievance within 5 business days of receipt as required by 18 Del. C. § 332(c)(4).

**5 Exceptions – 18 Del. C. § 332(c)(7) Written notice of decisions.**

Aetna Health did not provide written notice to the insured of mediation services offered by the Department.

*Recommendation:* It is recommended that the Company provide written notices of grievance dispositions which should inform the insured of the mediation services by the Department as required by 18 Del. C. § 332(c)(7).

## **GRIEVANCES AND APPEALS**

### **A. Grievance and Appeals:**

Aetna Health was requested to provide a listing of all Grievances and Appeals filed with the Company during the examination period of January 1, 2016 through April 30, 2018. The Company provided a list of 84 grievances and appeals that were received by the Company during the examination period. All 84 grievance and appeal files were reviewed.

All grievance and appeal files and associated policies and procedures were reviewed for compliance with applicable DDOI statutes.

The following exceptions were noted:

**15 Exceptions – 18 Del. C. § 332(c)(4) Prompt response to written grievances.**

Aetna Health failed to provide written acknowledgement of the grievances that included the name, address and telephone number of the individual or department designated by the carrier to respond to the grievance within 5 business days of receipt.

*Recommendation:* It is recommended that the Company provide written acknowledgement of grievances including the name, address and telephone number of the individual or department designated by the carrier to respond to the grievance within 5 business days of receipt as required by 18 Del. C. § 332(c)(4).

**3 Exceptions – 18 Del. C. § 332(c)(5) Speedy review of grievances.**

Aetna Health failed to decide grievances in an expeditious manner.

*Recommendation:* It is recommended that the Company decide grievances in an expeditious manner as required by 18 Del. C. § 332(c)(5).

**28 Exceptions - 18 Del. C. § 2304(16)(b) Unfair claim settlement practices.**

Aetna Health failed to acknowledge and act reasonably promptly upon communication with respect to claims.

*Recommendation:* It is recommended that the Company acknowledge and act reasonably promptly upon communication with respect to claims as required by 18 Del. C. § 2304(16)(b).

**22 Exceptions - 18 Del. C. § 2304(16)(n) Unfair claim settlement practices.**

Aetna Health failed to promptly provide an explanation for the denial of the claim or for the offer of a compromise settlement.

*Recommendation:* It is recommended that the Company promptly provide an explanation for the denial of the claim or for the offer of a compromise settlement as required by 18 Del. C. § 2304(16)(n).

**3 Exceptions – 18 Del. Admin. C. § 1313-3.0 Notice.**

The Company did not provide notice indicating the provider's right to arbitrate.

*Recommendation:* It is recommended that the Company provide notice indicating the providers right to arbitrate as required by 18 Del. Admin. C. § 1313-3.0 Notice.

## **B. External Reviews:**

The Coordinators Handbook requested that the Company provide a list of all external review requests that were received from Delaware consumers and referred through the Department during the experience period. The Company provided a list of five external reviews and the associated files. All five external reviews were reviewed.

The grievance and appeal files related to external reviews and associated policies and procedures were reviewed for compliance with applicable DDOI statutes.

There were no exceptions noted.

## **CLAIMS**

Aetna Health was requested to provide listings of all claims that occurred during the examination period. The listings were separated by product type. The product types are HNO which are Health Network Option plans, HMO which are Health Maintenance Organization plans and CB ie Consumer Business, which are individual plans. The results of the reviews are provided below.

### **A. Claim Manuals:**

Aetna Health was requested to provide the following documentation related to Claim Manuals and procedures:

- Copies of all claim manuals and the Company's Claims procedures
- Copies of procedures and program specifications on how the Company determines if interest is due on claim payments and how such interest is calculated.
- Copies of all claims processing reports generated during the examination period which measure actual performance against standards.
- This should include any revisions or amendments to the procedures during the exam period.

The Company provided their response to the request with the following:

“The Company maintains all claims processing, alerts, directives and policy and procedures as an online reference manual for research and guidance. Claim processing alerts, directives and policy and procedure documents are accessible in an on-line format and producing copies of this entire population of documents will result in a voluminous amount of paper and/or extremely large files.

As an alternative, we propose that the Company provide the examiners with our claim processing procedures on any specific topic upon request. We have uploaded a Table of Contents document listing the various claim topics for your

reference to the Department ShareFile and a listing of Delaware specific policies (below) that can be provided upon request.”

The listing provided was a 38-page document that included only the title of the claim document lacking a description or the Company to which the document applies. The examination team based on this limited information selected a total of 108 manuals and documents for review.

There were no exceptions noted.

**B. HNO Paid Claims:**

Aetna Health was requested to provide a listing of all claims that were paid during the examination period of January 1, 2016 through April 30, 2018. The Company provided a list of 148,126 HNO claims that were paid during the examination period. A random sample of 109 HNO claims was selected for review. All 109 HNO claims were reviewed.

There were no exceptions noted.

**C. HNO Denied Claims:**

Aetna Health was requested to provide a listing of all claims that were denied during the examination period of January 1, 2016 through April 30, 2018. The Company provided a list of 14,076 HNO claims that were denied during the examination period. A random sample of 109 was selected for review.

The following exceptions were noted:

**1 Exception - 18 Del. C. § 2304(16)(f) Unfair claim settlement practices.**

Aetna Health failed to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear.

*Recommendation:* It is recommended that the Company effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear as required by 18 Del. C. § 2304(16)(f).

**D. HMO Paid:**

Aetna Health Inc. was requested to provide a listing of all claims that were paid during the examination period of January 1, 2016 through April 30, 2018. The Company provided a list of 79 HMO claims that were paid during the examination period. All 79 were selected for review.

The following exceptions were noted:

**1 Exception - 18 Del. Admin. C. § 902 – 1.2.1.2 Authority for Regulation; Basis for Regulation.**

Aetna Health failed to acknowledge the claims within 15 working days.

*Recommendation:* It is recommended that the Company acknowledge and respond within 15 working days, upon receipt by the insurer, to communications with respect to claims as required by 18 Del. Admin. C. § 902 – 1.2.1.2.

**1 Exception - 18 Del. Admin. C. § 902 – 1.2.1.3 Authority for Regulation; Basis for Regulation.**

Aetna Health failed to implement prompt investigation of the claims within 10 working days.

*Recommendation:* It is recommended that the Company implement prompt investigation of the claims within 10 working days as required by 18 Del. Admin. C. § 902 – 1.2.1.3.

**2 Exceptions - 18 Del. Admin. C. § 902 – 1.2.1.5 Authority for Regulation; Basis for Regulation.**

Aetna Health failed to affirm or deny the claims within 30 days.

*Recommendation:* It is recommended that the Company affirm or deny claims within 30 days as required by 18 Del. Admin. C. § 902 – 1.2.1.5.

**2 Exceptions - 18 Del. Admin. C. § 1310 - 6.1.1 Processing of Clean Claim.**

Aetna Health failed to pay the claims within 30 days.

*Recommendation:* It is recommended that the Company pay claims within 30 days as required by 18 Del. Admin. C. § 1310 - 6.1.1.

**7 Exceptions - 18 Del. Admin. C. § 1310 - 6.2 Processing of Clean Claim.**

Aetna Health failed to provide a determination of the claim within 15 days following receipt of additional requested information.

*Recommendation:* It is recommended that the Company provide a determination of the claim within 15 days following receipt of additional requested information as required by 18 Del. Admin. C. § 1310 - 6.2.

**1 Exception - 18 Del. C. § 2304(16)(f) Unfair claim settlement practices.**

Aetna Health failed to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear.

*Recommendation:* It is recommended that the Company effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear as required by 18 Del. C. § 2304(16)(f).

**2 Exceptions – 18 Del. C. § 2304(16)(b) Unfair claim settlement practices.**

Aetna Health failed to acknowledge and act reasonably promptly upon communication with respect to claims.

*Recommendation:* It is recommended that the Company acknowledge and act reasonably promptly upon communication with respect to claims as required by 18 Del. C. § 2304(16)(b).

**2 Exceptions – 18 Del. C. § 2304(16)(n) Unfair claim settlement practices.**

Aetna Health failed to promptly provide an explanation for the denial of the claim or for the offer of a compromise settlement.

*Recommendation:* It is recommended that the Company promptly provide an explanation for the denial of the claim or for the offer of a compromise settlement as required by 18 Del. C. § 2304(16)(n).

**2 Exceptions - 18 Del. C. § 2304(17) Failure to maintain complaint handling procedures.**

Aetna Health inaccurately recorded the grievance received date.

*Recommendation:* It is recommended that the Company accurately record all complaints as required by 18 Del. C. § 2304(17).

**E. HMO Denied Claims:**

Aetna Health was requested to provide a listing of all claims that were denied during the examination period of January 1, 2016 through April 30, 2018. The Company provided a list of 70 HMO claims that were denied during the examination period. All 70 claims were selected for review.

There were no exceptions noted.

**F. CB HMO Paid Claims:**

Aetna Health was requested to provide a listing of all claims that were paid during the examination period of January 1, 2016 through April 30, 2018. The Company provided a list of 82,659 CB HMO claims that were paid during the examination period. A random sample of 109 were selected for review.



The following exceptions were noted:

**5 Exceptions - 18 Del. Admin. C. § 902 – 1.2.1.3 Authority for Regulation; Basis for Regulation.**

Aetna Health failed to implement prompt investigation of the claims within 10 working days.

*Recommendation:* It is recommended that the Company implement prompt investigation of claims within 10 working days as required by 18 Del. Admin. C. § 902 – 1.2.1.3.

**1 Exception - 18 Del. Admin. C. § 902 – 1.2.1.5 Authority for Regulation; Basis for Regulation.**

Aetna Health failed to affirm or deny the claim within 30 days.

*Recommendation:* It is recommended that the Company affirm or deny claims within 30 days as required by 18 Del. Admin. C. § 902 – 1.2.1.5.

**3 Exceptions - 18 Del. Admin. C. § 1310 - 6.1.1 Processing of Clean Claim.**

Aetna Health failed to pay the claims within 30 days.

*Recommendation:* It is recommended that the Company pay claims within 30 days as required by 18 Del. Admin. C. § 1310 - 6.1.1.

**2 Exceptions– 18 Del. Admin. C. §1310 - 6.2 Processing of Clean Claim.**

Aetna Health failed to provide a determination of the claims within 15 days following receipt of additional requested information.

*Recommendation:* It is recommended that the Company provide a determination of the claim within 15 days following receipt of additional requested information as required by 18 Del. Admin. C. § 1310 - 6.2.

**G. CB HMO Denied Claims:**

Aetna Health was requested to provide a listing of all claims that were denied during the examination period of January 1, 2016 through April 30, 2018. The Company provided a list of 16,395 CB HMO claims that were denied during the examination period. A random sample of 109 was selected for review.

The following exceptions were noted:

**1 Exception - 18 Del. Admin. C. § 902 – 1.2.1.2 Authority for Regulation; Basis for Regulation.**

Aetna Health failed to acknowledge the claims within 15 working days.

*Recommendation:* It is recommended that the Company acknowledge claims within 15 working days as required by 18 Del. Admin. C. § 902 – 1.2.1.2.

**5 Exceptions – 18 Del. Admin. C. § 1310 - 6.1.3 Processing of Clean Claim**

Aetna Health failed to notify the provider or policyholder in writing of why the claim will not be paid within 30 days.

*Recommendation:* It is recommended that the Company provide a determination of claims within 30 days as required by 18 Del. Admin. C. § 1310 – 6.1.3.

**3 Exceptions – 18 Del. C. § 332(c)(4) Prompt response to written grievances.**

Aetna Health failed to provide written acknowledgement of the grievances that included the name, address and telephone number of the individual or department designated by the carrier to respond to the grievance within 5 business days of receipt.

*Recommendation:* It is recommended that the Company provide written acknowledgement of grievances including the name, address and telephone number of the individual or department designated by the carrier to respond to the grievance within 5 business days of receipt as required by 18 Del. C. § 332(c)(4).

**2 Exceptions – 18 Del. C. § 2304(16)(b) Unfair claim settlement practices.**

Aetna Health failed to acknowledge and act reasonably promptly upon communication with respect to claims.

*Recommendation:* It is recommended that the Company acknowledge and act reasonably promptly upon communication with respect to claims as required by 18 Del. C. § 2304(16)(b).

**H. HNO Chiropractor Paid Claims:**

Aetna Health was requested to provide a listing of all Chiropractor claims paid during the examination period of January 1, 2016 through April 30, 2018. The Company provided a list of 5,746 Chiropractor HNO claims that were paid during the examination period. A sample of 108 Chiropractor HNO paid claims was selected for review.

There were no exceptions noted.

**I. HNO Chiropractor Denied Claims:**

Aetna Health was requested to provide a listing of all Chiropractor claims denied during the examination period of January 1, 2016 through April 30, 2018. The Company provided a list of 692 Chiropractor HNO claims that were denied during the examination period. A random sample of 83 was selected for review.

There were no exceptions noted.

#### **J. CB HMO Chiropractor Paid Claims:**

Aetna Health was requested to provide a listing of all Chiropractor claims paid during the examination period of January 1, 2016 through April 30, 2018. The Company provided a list of 3,305 Chiropractor CB HMO claims that were paid during the examination period. A sample of 107 Chiropractor CB HMO paid claims was selected for review.

The following exceptions were noted:

##### **1 Exception - 18 Del. Admin. C. § 1310 - 6.1.1 Processing of Clean Claim.**

Aetna Health failed to pay the claim within 30 days.

*Recommendation:* It is recommended that the Company pay claims within 30 days as required by 18 Del. Admin. C. § 1310 - 6.1.1.

#### **K. CB HMO Chiropractor Denied Claims:**

Aetna Health was requested to provide a listing of all Chiropractor claims denied during examination period of January 1, 2016 through April 30, 2018. The Company provided a list of 546 Chiropractor CB HMO claims that were denied during the examination period. A sample of 83 Chiropractor CB HMO denied claims were selected for review.

The following exception was noted:

##### **1 Exception - 18 Del. C. § 2304(16)(n) Unfair claim settlement practices.**

Aetna Health did not provide an explanation to the insured for the denial of the claim.

*Recommendation:* It is recommended that the Company provide an explanation for a denial of a claim to the insured as required by 18 Del. C. § 2304(16)(n).

### **ACA EXPANSION**

On October 8, 2018 the examination was expanded at the request of Centers for Medicare & Medicaid Services (CMS). The examination focus is on Affordable Care Act (ACA) compliance for the period of January 1, 2016 through December 31, 2017.

This ACA Expansion focused on the Aetna Health's healthcare lines in the following areas Company Operations and Management, Provider Relations, CMS Complaint Handling, Grievance Procedures, Policyholder Services, Underwriting and Rating, Claims, Utilization Review, Pharmacy, and Mental Health Parity.

## **ACA COMPANY OPERATIONS AND MANAGEMENT**

The Company provided the following company operations and management documentation:

- Internal Control.
- Company Operations.
- Fines, Penalties, and Reports.
- Company History.
- Voluntary Accreditation.
- Privacy and Security.
- Records Retention.
- Transparency.
- NON-Discrimination Report.
- Downstream and Delegated Entities.

The documents were reviewed to ensure compliance with the CMS Compliance Review Protocols and Standards and applicable Delaware Statutes. There were no exceptions noted.

## **ACA PROVIDER RELATIONS**

Aetna Health was requested to provide the provider relations analyses, reports and summaries prepared on a regular recurring basis and identify the recipients of those reports and to provide examples of each analyses, report and/or summary documentation. The Company was also requested to provide policies and procedures related to handling provider concerns, inquiries and complaints. As well as policies and procedures, or other documentation demonstrating that the Company takes adequate steps to finalize and dispose of the provider concerns, inquiries and complaints.

The Company provided the requested documentation which was reviewed for compliance with the Centers for Medicare & Medicaid Services Compliance Review Protocols and Standards and applicable Delaware Statutes.

There were no exceptions noted.

## **ACA CMS COMPLAINTS**

Aetna Health was requested to provide a listing of all complaints that were obtained by CMS and sent to the Company through CMS's Health Insurance Casework System (HICS). The Company was also requested to provide the Company's listing which demonstrated the complaints were properly recorded in the Company's Health Insurance Exchange (HIX) complaint database during the examination period of January 1, 2016 through December 31, 2017. The Company provided a list of 86 complaints of which all 86 complaints were selected for review.

The Company was requested to provide their policies and procedures related to the monitoring and processing of HICS complaints. The complaints and procedures were reviewed for compliance with the CMS Compliance Review Protocols and Standards and applicable Delaware Statutes.

There were no exceptions noted.

## **ACA GRIEVANCE PROCEDURES**

Aetna Health was requested to provide its written definition of a grievance, policies and procedures or other documentation demonstrating how the Company has implemented grievance procedures and how this has been disclosed to covered persons in compliance with applicable statutes, rules and regulations.

The policies, procedures and documentation were reviewed for compliance with the Centers for Medicare & Medicaid Services Compliance Review Protocols and Standards and applicable Delaware Statutes.

There were no exceptions noted.

## **ACA POLICYHOLDER SERVICES**

### **A. Commission Schedules:**

Aetna Health was requested to provide copies of commission schedules for brokers and producers, for plans within the Individual Exchange as well as the outside market. A copy of the Company's standard agent/broker agreement and the compensation schedule for similar QHPs offered on and off the Exchange were reviewed. In addition, screenshots of Aetna Health's Issuer compensation for three QHPs selected for review with three similar off-Exchange plans to compare and validate compensation rates were the same.

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The commission schedules were reviewed for compliance with the Centers for Medicare & Medicaid Services Compliance Review Protocols and Standards and applicable Delaware Statutes.

There were no exceptions noted.

**B. Continuity of Care:**

Aetna Health Inc. was requested to provide a copy of their Continuity of Care Transition Plan.

The Continuity of Care Transition Plan documentation was reviewed for compliance with the Centers for Medicare & Medicaid Services Compliance Review Protocols and Standards and applicable Delaware Statutes.

There were no exceptions noted.

**C. Covered Individuals:**

Aetna Health was requested to provide a listing of all individuals that were covered during the examination period of January 1, 2016 through December 31, 2017. The Company provided a list of 9,828 individuals that were covered during the examination period. In keeping with the Medical Issuers Guidelines, a random sample of 25 Covered Individual files was selected for review. The Covered Individuals files contained enrollment data, privacy and non-discrimination notices.

The Covered Individual files were reviewed for compliance with the Centers for Medicare & Medicaid Services Compliance Review Protocols and Standards and applicable Delaware Statutes.

There were no exceptions noted.

**D. Lapsed Coverage:**

Aetna Health was requested to provide a listing of all ACA Policies that lapsed during the examination period of January 1, 2016 through December 31, 2017. The Company provided a list of 5,807 policies that lapsed during that period. In keeping with the Medical Issuers Guidelines, a random sample of 25 lapsed policies was selected for review.

The ACA lapsed policies were reviewed for compliance with the Centers for Medicare & Medicaid Services Compliance Review Protocols and Standards and applicable Delaware Statutes.

There were no exceptions noted.

### **E. Marketplace Withdrawal:**

Aetna Health was requested to provide a copy of its withdrawal from the marketplace transition plans. They were also requested to provide a list of all Delaware residents affected by the withdrawal. The Company provided a list of 4,021 Delaware residents that were terminated as a result of the withdrawal. In keeping with the Medical Issuers Guidelines, a random sample of 25 enrollee files was selected for review.

The withdrawal plans and the files were reviewed for compliance with the Centers for Medicare & Medicaid Services Compliance Review Protocols and Standards and applicable Delaware Statutes.

There were no exceptions noted.

### **ACA UNDERWRITING AND RATING**

Aetna Health Inc. provided copies of their rate filings in use during the examination period. The off-exchange and the on-exchange rates were compared using the website of <https://www.healthcare.gov/> The Company was also requested to provide a listing of all individuals who were denied coverage during the examination period. The Company indicated that it was Guaranteed Issue for the Individual Market so there were no individuals denied coverage as long as they submitted the proper documentation and effectuated their coverage.

The underwriting and rate files were reviewed for compliance with the Centers for Medicare & Medicaid Services Compliance Review Protocols and Standards and applicable Delaware Statutes.

There were no exceptions noted.

### **ACA CLAIMS**

Aetna Health was requested to provide listings of all claims that occurred during the examination period. In addition to the previous products that were in the first claims review there is also DMO which are Dental Maintenance Organization plans. The following claim types were reviewed: Medical/Surgical (Med/Surg), Mental Health/Substance Use Disorder (MH/SUD), Habilitative, Midwife, Pediatric (Pedia) Dental and Vision, and Pharmacy.

The claims were reviewed for compliance with the Centers for Medicare & Medicaid Services Compliance Review Protocols and Standards and applicable Delaware Statutes.

### **A. HNO Med/Surg Paid Claims:**

Aetna Health was requested to provide a listing of all Med/Surg claims that were paid during the examination period of January 1, 2016 through December 31, 2017. The Company provided a list of 179,543 HNO Med/Surg claims that were paid during the examination period. A sample of 109 files was reviewed.

The following exception was noted:

#### **1 Exception— 18 Del. Admin. C. § 1310 - 6.2 Processing of Clean Claim.**

Aetna Health failed to provide a determination of the claims within 15 days following receipt of additional requested information.

*Recommendation:* It is recommended that the Company provide a determination of the claim within 15 days following receipt of additional requested information as required by 18 Del. Admin. C. § 1310 - 6.2.

### **B. HNO Med/Surg Denied Claims:**

Aetna Health was requested to provide a listing of all Med/Surg claims that were denied during the examination period of January 1, 2016 through December 31, 2017. The Company provided a list of 19,913 HNO Med/Surg claims that were denied during the examination period. A random sample of 109 claims was selected for review. The Step Sampling technique was applied, and the first 25 claims sampled were reviewed and reported no exceptions.

There were no exceptions noted.

### **C. CB HMO Med/Surg Paid**

Aetna Health was requested to provide a listing of all Med/Surg claims that were paid during the examination period of January 1, 2016 through December 31, 2017. The Company provided a list of 93,595 CB HMO Med/Surg claims that were paid during the examination period. A random sample of 109 claims was selected for review.

The following exceptions were noted:

#### **1 Exception - 18 Del. Admin. C. § 902 – 1.2.1.5 Authority for Regulation; Basis for Regulation.**

Aetna Health failed to affirm or deny the claim within 30 days.

*Recommendation:* It is recommended that the Company affirm or deny claims within 30 days as required by 18 Del. Admin. C. § 902 – 1.2.1.5.



**2 Exceptions - 18 Del. Admin. C. § 1310 - 6.1.1 Processing of Clean Claim.**

Aetna Health failed to pay the claims within 30 days.

*Recommendation:* It is recommended that the Company pay claims within 30 days as required by 18 Del. Admin. C. § 1310 - 6.1.1.

**D. CB HMO Med/Surg Denied Claims:**

Aetna Health was requested to provide a listing of all Med/Surg claims that were denied during the examination period of January 1, 2016 through December 31, 2017. The Company provided a listing of 17,769 CB HMO Med/Surg claims that were denied during the examination period. A random sample of 109 claims was selected for review.

The following exceptions were noted:

**7 Exceptions - 18 Del. Admin. C. § 902 – 1.2.1.5 Authority for Regulation; Basis for Regulation.**

Aetna Health failed to affirm or deny the claims within 30 days.

*Recommendation:* It is recommended that the Company affirm or deny claims within 30 days as required by 18 Del. Admin. C. § 902 – 1.2.1.5.

**8 Exceptions – 18 Del. Admin. C. § 1310 - 6.1.3 Processing of Clean Claim**

Aetna Health failed to notify the provider or policyholder in writing of why the claim will not be paid within 30 days.

*Recommendation:* It is recommended that the Company provide a determination of claims within 30 days as required by 18 Del. Admin. C. § 1310 – 6.1.3.

**E. HMO Med/Surg Denied Claims:**

Aetna Health was requested to provide a listing of all Med/Surg claims that were denied during the examination period of January 1, 2016 through December 31, 2017. The Company provided a listing of three (3) HMO Med/Surg claims that were denied during the examination period. All three (3) claims were selected for review.

There were no exceptions noted.

**F. HNO MH/SUD Paid Claims:**

Aetna Health was requested to provide a listing of all MH/SUD claims that were paid during the examination period of January 1, 2016 through December 31, 2017. The

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Company provided a list of 13,757 HNO MH/SUD claims that were paid during the examination period. A random sample of 109 claims was selected for review.

The following exceptions were noted:

**2 Exceptions - 18 Del. Admin. C. § 1310 - 6.1.1 Processing of Clean Claim.**

Aetna Health failed to pay the claims within 30 days.

*Recommendation:* It is recommended that the Company pay claims within 30 days as required by 18 Del. Admin. C. § 1310 - 6.1.1.

**G. HNO MH/SUD Denied Claims:**

Aetna Health was requested to provide a listing of all MH/SUD claims that were denied during the examination period of January 1, 2016 through December 31, 2017. The Company provided a list of 3,346 HNO MH/SUD claims that were denied during the examination period. A random sample of 107 claims was selected for review.

There were no exceptions noted.

**H. CB MH/SUD Paid Claims:**

Aetna Health was requested to provide a listing of all MH/SUD claims that were paid during the examination period of January 1, 2016 through December 31, 2017. The Company provided a list of 3,611 CB MH/SUD claims that were paid during the examination period. A random sample of 108 claims was selected for review.

The following exceptions were noted:

**3 Exceptions - 18 Del. Admin. C. § 902 – 1.2.1.5 Authority for Regulation; Basis for Regulation.**

Aetna Health failed to affirm or deny the claims within 30 days.

*Recommendation:* It is recommended that the Company affirm or deny claims within 30 days as required by 18 Del. Admin. C. § 902 – 1.2.1.5.

**3 Exceptions - 18 Del. Admin. C. § 1310 - 6.1.1 Processing of Clean Claim.**

Aetna Health failed to pay the claims within 30 days.

*Recommendation:* It is recommended that the Company pay claims within 30 days as required by 18 Del. Admin. C. § 1310 - 6.1.1.

**I. CB MH/SUD Denied Claims:**

Aetna Health was requested to provide a listing of all MH/SUD Claims that were denied during the examination period of January 1, 2016 through December 31, 2017. The Company provided a list of 923 CB MH/SUD claims that were denied during the examination period. A random sample of 83 claims was selected for review.

The following exceptions were noted:

**4 Exceptions - 18 Del. Admin. C. § 902 – 1.2.1.5 Authority for Regulation; Basis for Regulation.**

Aetna Health failed to affirm or deny the claims within 30 days.

*Recommendation:* It is recommended that the Company affirm or deny claims within 30 days as required by 18 Del. Admin. C. § 902 – 1.2.1.5.

**4 Exceptions – 18 Del. Admin. C. § 1310 - 6.1.3 Processing of Clean Claim**

Aetna Health failed to notify the provider or policyholder in writing of why the claim will not be paid within 30 days.

*Recommendation:* It is recommended that the Company provide a determination of claims within 30 days as required by 18 Del. Admin. C. § 1310 – 6.1.3.

**J. HNO Habilitative Paid Claims:**

Aetna Health was requested to provide a listing of all Habilitative claims that were paid during the examination period of January 1, 2016 through December 31, 2017. The Company provided a list of 2,108 HNO Habilitative claims that were paid during the examination period. A random sample of 107 was selected for review. The Step Sampling technique was applied, and the first 25 claims sampled were reviewed.

There were no exceptions noted.

**K. HNO Habilitative Denied Claims:**

Aetna Health was requested to provide a listing of all Habilitative claims that were denied during this examination period of January 1, 2016 through December 31, 2017. The Company provided a list of 465 HNO Habilitative claims that were denied during the examination period. A random sample of 82 was selected for review. The Step Sampling technique was applied, and the first 25 claims sampled were reviewed.

There were no exceptions noted.

**L. CB Habilitative Paid Claims:**

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Aetna Health was requested to provide a listing of all Habilitative claims that were paid during the examination period of January 1, 2016 through December 31, 2017. The Company provided a list of 299 CB Habilitative claims that were paid during the examination period. A random sample of 76 was selected for review.

The following exceptions were noted:

**3 Exceptions - 18 Del. Admin. C. § 902 – 1.2.1.5 Authority for Regulation; Basis for Regulation.**

Aetna Health failed to affirm or deny the claims within 30 days.

*Recommendation:* It is recommended that the Company affirm or deny claims within 30 days as required by 18 Del. Admin. C. § 902 – 1.2.1.5.

**3 Exceptions - 18 Del. Admin. C. § 1310 - 6.1.1 Processing of Clean Claim.**

Aetna Health failed to pay the claims within 30 days.

*Recommendation:* It is recommended that the Company pay claims within 30 days as required by 18 Del. Admin. C. § 1310 - 6.1.1.

**M. CB Habilitative Denied Claims:**

Aetna Health was requested to provide a listing of all Habilitative claims that were denied during the examination period of January 1, 2016 through December 31, 2017. The Company provided a list of 44 CB Habilitative claims that were denied during the examination period. All 44 claims were selected for review.

The following exceptions were noted:

**6 Exceptions - 18 Del. C. § 2304(16)(f) Unfair claim settlement practices.**

Aetna Health failed to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear.

*Recommendation:* It is recommended that the Company effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear as required by 18 Del. C. § 2304(16)(f).

**N. HNO Midwife Paid Claims:**

Aetna Health was requested to provide a listing of all Midwife claims that were paid during the examination period of January 1, 2016 through December 31, 2017. The Company provided a list of 395 HNO Midwife claims that were paid during the examination period. A random sample of 76 was selected for review.

There were no exceptions noted.

**O. HNO Midwife Denied Claims:**

Aetna Health was requested to provide a listing of all Midwife claims that were denied during the examination period of January 1, 2016 through December 31, 2017. The Company provided a list of 70 HNO Midwife claims that were denied during the examination period. All 70 claims were selected for review.

There were no exceptions noted.

**P. CB Midwife Paid Claims:**

Aetna Health was requested to provide a listing of all Midwife claims that were paid during the examination period of January 1, 2016 through December 31, 2017. The Company provided a list of 101 CB Midwife Paid claims that were paid during the examination period. A random sample of 76 were selected for review.

The following exceptions were noted:

**1 Exception - 18 Del. Admin. C. § 902 – 1.2.1.5 Authority for Regulation; Basis for Regulation.**

Aetna Health failed to affirm or deny the claim within 30 days.

*Recommendation:* It is recommended that the Company affirm or deny claims within 30 days as required by 18 Del. Admin. C. § 902 – 1.2.1.5.

**5 Exceptions - 18 Del. Admin. C. § 1310 - 6.1.1 Processing of Clean Claim.**

Aetna Health failed to pay the claims within 30 days.

*Recommendation:* It is recommended that the Company pay claims within 30 days as required by 18 Del. Admin. C. § 1310 - 6.1.1.

**Q. CB Midwife Denied Claims:**

Aetna Health was requested to provide a listing of all Midwife claims that were denied during the examination period of January 1, 2016 through December 31, 2017. The Company provided a list of 22 CB Midwife claims that were denied during the examination period. All 22 CB Midwife Denied claims were selected for review.

The following exceptions were noted:

**2 Exceptions - 18 Del. Admin. C. § 902 – 1.2.1.5 Authority for Regulation; Basis for Regulation.**

Aetna Health failed to affirm or deny the claims within 30 days.

*Recommendation:* It is recommended that the Company affirm or deny claims within 30 days as required by 18 Del. Admin. C. § 902 – 1.2.1.5.

**2 Exceptions – 18 Del. Admin. C. § 1310 - 6.1.3 Processing of Clean Claim**

Aetna Health failed to notify the provider or policyholder in writing of why the claim will not be paid within 30 days.

*Recommendation:* It is recommended that the Company provide a determination of claims within 30 days as required by 18 Del. Admin. C. § 1310 – 6.1.3.

**R. DMO Pediatric Dental Paid Claims:**

Aetna Health was requested to provide a listing of all Pediatric Dental claims that were paid during the examination period of January 1, 2016 through December 31, 2017. The Company provided a list of 151 DMO Pediatric Dental claims that were paid during the examination period. A random sample of 76 was selected for review. The Step Sampling technique was applied, and the first 25 claims sampled were reviewed and reported no exceptions.

There were no exceptions noted.

**S. DMO Pediatric Dental Denied Claims:**

Aetna Health was requested to provide a listing of all Pediatric Dental claims that were denied during the examination period of January 1, 2016 through December 31, 2017. The Company provided a list of 18 DMO Pediatric Dental claims that were denied during the examination period. All 18 DMO Pediatric Dental denied claims were selected for review.

There were no exceptions noted.

**T. CB Pediatric Dental Paid Claims:**

Aetna Health was requested to provide a listing of all Pediatric Dental claims that were paid during the examination period of January 1, 2016 through December 31, 2017. The Company provided a list of 71 CB Pediatric Dental claims that were paid during the examination period. All 71 CB Pediatric Dental paid claims were selected for review.

The following exceptions were noted:

**2 Exceptions - 18 Del. Admin. C. § 902 – 1.2.1.5 Authority for Regulation; Basis for Regulation.**

Aetna Health failed to affirm or deny the claims within 30 days.

*Recommendation:* It is recommended that the Company affirm or deny claims within 30 days as required by 18 Del. Admin. C. § 902 – 1.2.1.5.

**3 Exceptions - 18 Del. Admin. C. § 1310 - 6.1.1 Processing of Clean Claim.**

Aetna Health failed to pay the claims within 30 days.

*Recommendation:* It is recommended that the Company pay claims within 30 days as required by 18 Del. Admin. C. § 1310 - 6.1.1.

**U. CB Pediatric Dental Paid Claims:**

Aetna Health was requested to provide a listing of all Pediatric Dental claims that were denied during the examination period of January 1, 2016 through December 31, 2017. The Company provided a list of 43 Pediatric Dental claims that were denied during the examination period. All 43 CB Pediatric Dental Denied claims were selected for review.

There were no exceptions noted.

**V. HNO Pediatric Vision Paid Claims:**

Aetna Health was requested to provide a listing of all Pediatric Vision claims that were paid during the examination period of January 1, 2016 through December 31, 2017. The Company provided a list of 147 HNO Pediatric Vision claims that were paid during the examination period. A random sample of 76 was selected for review. The Step Sampling technique was applied, and the first 25 claims sampled were reviewed and reported no exceptions.

There were no exceptions noted.

**W. HNO Pediatric Vision Denied Claims:**

Aetna Health was requested to provide a listing of all Pediatric Vision claims that were denied during the examination period of January 1, 2016 through December 31, 2017. The Company provided a list of eight (8) HNO Pediatric Vision claims that were denied during the examination period. All eight (8) HNO Pediatric Visions denied claims were selected for review.

There were no exceptions noted.

**X. CB Pediatric Vision Paid Claims:**

Aetna Health was requested to provide a listing of all Pediatric Vision claims that were paid during the examination period of January 1, 2016 through December 31, 2017. The Company provided a list of 199 Pediatric Vision CB claims that were paid during the examination period. A random sample of 76 was selected for review. The Step Sampling technique was applied, and the first 25 claims sampled were reviewed and reported no exceptions.

There were no exceptions noted.

**Y. CB Pediatric Vision Denied Claims:**

Aetna Health was requested to provide a listing of all Pediatric Vision claims that were denied during the examination period of January 1, 2016 through December 31, 2017. The Company provided a list of two (2) CB Pediatric Vision claims that were denied during the examination period. Both CB Pediatric Vision denied claims were selected for review.

There were no exceptions noted.

**Z. MH/SUD Pharmacy Paid Claims:**

Aetna Health was requested to provide a listing of all MH/SUD Pharmacy Claims that were paid during the examination period of January 1, 2016 through December 31, 2017. The Company provided a list of 18,033 Mental Health/Substance Use Disorder claims that were paid during the examination period. A random sample of 109 was selected for review.

The following exception was noted:

**1 Exception - 18 Del. Admin. C. § 1310 - 6.1.1 Processing of Clean Claim.**

Aetna Health failed to pay the claim within 30 days.

*Recommendation:* It is recommended that the Company pay claims within 30 days as required by 18 Del. Admin. C. § 1310 - 6.1.1.

**AA. MH/SUD Pharmacy Denied Claims:**

Aetna Health was requested to provide a listing of all MH/SUD Pharmacy Claims that were denied during the examination period of January 1, 2016 through December 31, 2017. The Company provided a list of 3,782 MH/SUD Claims that were denied during the examination period. A random sample of 108 was selected for review.

The following exceptions were noted:



**1 Exception - 18 Del. C. § 2304(16)(f) Unfair claim settlement practices.**

Aetna Health failed to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear.

*Recommendation:* It is recommended that the Company effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear as required by 18 Del. C. § 2304(16)(f).

**2 Exceptions - 18 Del. C. § 3343(b)(1)(b) Insurance coverage for serious mental illness.**

Aetna Health required and provided prior approval with a 6-month approval period. A change to a substantially similar medication due to cost or clinically significant reasons requires an additional prior authorization approval to treat the same disease. The pre-authorization requirement includes the establishing a diagnosis of opioid dependence, proof of counselling and abstinence from all opioids monitored through drug screening. This additional prior authorization requirement causes treatment delay and is excessive and discriminatory to mental health/substance abuse members.

*Recommendation:* It is recommended that the Company not issue for delivery, or deliver, in this State any health benefit plan containing terms that place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan, including terms for deductibles, co-pays, monetary limits, coinsurance factors, limits in the numbers of visits, limits in the length of inpatient stays, durational limits, or limits in the coverage of prescription medicines as required by 18 Del. C. § 3343(b)(1)(b).

**1 Exception – 18 Del. Admin. C. § 3350(b) Prescription medication.**

Aetna Health improperly denied a transitional fill claim due to exceeding plan limits even though the maximum dosing meets Food and Drug Administration guidelines.

*Recommendation:* It is recommended that the Company provide coverage for any outpatient drug prescribed to treat a covered person for a covered chronic, disabling or life-threatening illness when the drug has been approved by the Food and Drug Administration for at least 1 indication; and is recognized for treatment of the indication for which the drug is prescribed in A prescription drug reference compendium approved by the Insurance Commissioner or Substantially accepted peer reviewed medical literature as required 18 Del. Admin. C. § 3350(b).

**ACA UTILIZATION REVIEW**

**A. Utilization Review Policies and Procedures:**

Aetna Health was requested to provide documentation related to Utilization Review Policies and Procedures demonstrating the Company:

- Establishes and maintains a utilization review program in compliance with applicable statutes, rules and regulations.
- Operates its utilization review program in accordance with applicable state statutes, rules and regulations.
- Discloses information about its utilization review and benefit determination procedures to covered persons, or, if applicable, the covered person's authorized representative, in compliance with applicable statutes, rules and regulations.
- Makes standard utilization review and benefit determinations in a timely manner and as required by applicable state statutes, rules and regulations, as well as the provisions of HIPAA.
- Provides written notice of an adverse determination of standard utilization review and benefit determinations in compliance with applicable statutes, rules and regulations.
- Conducts reconsideration of an adverse determination in a timely manner and in compliance with applicable statutes, rules and regulations.
- Establishes written procedures for the expedited review of an adverse determination involving a situation where the time frame of the standard review procedures would seriously jeopardize the life or health of a covered in compliance with applicable statutes, rules and regulations.
- Conducts utilization reviews or makes benefit determinations for emergency services in compliance with applicable statutes, rules and regulations.
- Monitors the activities of the utilization review organization or entity with which the carrier contracts and ensures that the contracting organization complies with applicable state provisions equivalent to the Utilization Review and Benefit Determination Model Act (#73) and accompanying regulations.
- Establishes and maintains an external review program in compliance with applicable statutes, rules and regulations.

The policies, procedures, and documentation were reviewed for compliance with the Centers for Medicare & Medicaid Services Compliance Review Protocols and Standards and applicable Delaware Statutes.

There were no exceptions noted.

#### **B. Ambulatory Approved Utilization Review:**

Aetna Health was requested to provide a listing of all Ambulatory Approved Utilization Review files during the examination period of January 1, 2016 through December 31, 2017. The Company identified 918 Ambulatory Utilization Review files that were approved. A random sample of 86 was selected for review.

The Utilization Review files were reviewed for compliance with the Centers for Medicare & Medicaid Services, Compliance Review Protocols and Standards and applicable Delaware Statutes.

There were no exceptions noted.

### **C. Ambulatory Denied Utilization Review:**

Aetna Health was requested to provide a listing of all Ambulatory Denied Utilization Review files during the examination period of January 1, 2016 through December 31, 2017. The Company identified 159 Ambulatory Utilization Review files that were denied. A random sample of 79 was selected for review.

The Utilization Review files were reviewed for compliance with the Centers for Medicare & Medicaid Services Compliance Review Protocols and Standards and applicable Delaware Statutes.

The following exceptions were noted:

#### **1 Exception - 18 Del. C. § 3373(a) Utilization review entity's obligations with respect to pre-authorizations in nonemergency circumstances.**

Aetna Health failed to complete its process or render an adverse determination and notify the covered person's health-care provider within 2 business days.

*Recommendation:* It is recommended that the Company complete its process or render an adverse determination and notify the covered person's health-care provider within 2 business days as required by 18 Del. C. § 3373(a).

#### **1 Exception - 18 Del. C. § 3373(c) Utilization review entity's obligations with respect to pre-authorizations in nonemergency circumstances.**

Aetna Health failed to grant a pre-authorization or issue an adverse determination and notify the covered person's health-care provider of the determination within 5 business days of receipt.

*Recommendation:* It is recommended that the Company issue an adverse determination and notify the covered person's health-care provider of the determination within 5 business days of receipt as required by 18 Del. C. § 3373(c).

### **D. Inpatient Approved Utilization Review:**

Aetna Health was requested to provide a listing of all Inpatient Approved Utilization Review files during the examination period of January 1, 2016 through December 31, 2017. The Company identified 1,655 Inpatient Utilization Review files that were approved. A random sample of 113 was selected for review.

The Utilization Review files were reviewed for compliance with the Centers for Medicare & Medicaid Services, Compliance Review Protocols and Standards and applicable Delaware Statutes.

There were no exceptions noted.

#### **E. Inpatient Denied Utilization Review:**

Aetna Health was requested to provide a listing of all Inpatient Denied Utilization Review files during the examination period of January 1, 2016 through April 30, 2018. The Company identified 429 Inpatient Utilization Review files that were denied. A random sample of 84 was selected for review.

The Utilization Review files were reviewed for compliance with the Centers for Medicare & Medicaid Services Compliance Review Protocols and Standards and applicable Delaware Statutes.

The following exception was noted:

#### **1 Exception - 18 Del. C. § 3373(b) Utilization review entity's obligations with respect to pre-authorizations in nonemergency circumstances.**

Aetna Health failed to grant a pre-authorization or issue an adverse determination within 8 business days of receipt.

*Recommendation:* It is recommended that the Company grant a pre-authorization or issue an adverse determination within 8 business days of receipt as required by 18 Del. C. § 3373(b).

#### **F. Pharmacy Approved Utilization Review:**

Aetna Health was requested to provide a listing of all Pharmacy Approved Utilization Review files during the examination period of January 1, 2016 through December 31, 2017. The Company identified 813 Pharmacy Utilization Review files that were approved. A random sample of 86 was selected for review.

The Utilization Review files were reviewed for compliance with the Centers for Medicare & Medicaid Services Compliance Review Protocols and Standards and applicable Delaware Statutes.

There were no exceptions noted.

#### **G. Pharmacy Denied Utilization Review:**

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Aetna Health was requested to provide a listing of all Pharmacy Denied Utilization Review files during the examination period of January 1, 2016 through December 31, 2017. The Company provided a list of 437 Pharmacy Utilization Review files that were denied during the examination period. A random sample of 84 was selected for review.

The following exception was noted:

**1 Exception – 18 Del. Admin. C. § 1310 - 6.1.3 Processing of Clean Claim**

Aetna Health failed to notify the provider or policyholder in writing of why the claim will not be paid within 30 days.

*Recommendation:* It is recommended that the Company provide a determination of claims within 30 days as required by 18 Del. Admin. C. § 1310 – 6.1.3.

**ACA PHARMACY REVIEW**

Aetna Health Inc., was requested to provide the Essential Health Benefit (EHB) Drug Count Tool Results, Clinical Appropriateness Tool (CAT) results, Treatment Protocol Calculator (TPC) review results, Formulary Outlier Review (FOR) results, Pharmacy and Therapeutics (P&T) Committee notes, all formularies and amendments in effect, and Step Therapy Protocols.

The Company's documentation was reviewed for compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA), ACA regulations, and applicable Delaware Laws and Regulations.

The following exceptions were noted:

**1 Exception - 18 Del. C. § 2304(1)(a) Misrepresentations and false advertising of insurance policies.**

Aetna Health misrepresented the benefits, advantages, conditions, or terms of any insurance policy. The Company had a Clinical Policy Bulletin (CPB) to ensure methadone therapy for Opioid Use Disorder (OUD) prescriptions are obtained through a SAMHSA approved program. This CPB policy would apply to outpatient prescription drug benefits, obtained at a pharmacy. The company does not have any contracts with SAMHSA community pharmacies. Currently there are no SAMHSA community pharmacies in DE. Due to this a member would not be able to access their pharmacy benefits in DE for OUD.

*Recommendation:* It is recommended that the Company not make, issue, circulate or cause to be made, issued or circulated any estimate, circular, statement, sales presentation, omission or comparison which misrepresents the benefits, advantages, conditions or terms of any insurance policy as required by 18 Del. C. § 2304(1)(a).

**85 Exceptions - 18 Del. C. § 3343(b)(1)(b) Insurance coverage for serious mental illness.**

Aetna Health has imposed a Non-Quantitative Treatment Limitation (NQTL) of a prior authorization every 6 months on all buprenorphine and buprenorphine/naloxone containing medications (both brand and generic) used for the treatment of Opioid Use Disorder (OUD). When comparing to opioid medications used for pain management (MED/SURG) the Company offers Butrans (buprenorphine) transdermal patch approved for chronic pain (MED/SURG), without a prior authorization requirement, and Belbuca (buprenorphine) buccal film approved for chronic pain (MED/SURG) with a prior authorization duration of 1 year.

*Recommendation:* It is recommended that the Company not issue any health benefit plan containing terms that place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan, including terms for deductibles, co-pays, monetary limits, coinsurance factors, limits in the numbers of visits, limits in the length of inpatient stays, durational limits, or limits in the coverage of prescription medicines as required by 18 Del. C. § 3343(b)(1)(b).

**85 Exceptions - 45 CFR § 146.136(c)(4)(ii)(a)(b) Nonquantitative treatment limitations.**

Aetna Health has imposed a Non-Quantitative Treatment Limitation (NQTL) of a prior authorization every 6 months on all buprenorphine and buprenorphine/naloxone containing medications (both brand and generic) used for the treatment of Opioid Use Disorder (OUD). When comparing to opioid medications used for pain management (MED/SURG) the Company offers Butrans (buprenorphine) transdermal patch approved for chronic pain (MED/SURG), without a prior authorization requirement, and Belbuca (buprenorphine) buccal film approved for chronic pain (MED/SURG) with a prior authorization duration of 1 year.

*Recommendation:* It is recommended that the Company not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required by 45 CFR § 146.136(c)(4)(ii)(b).

**1 Exception - 18 Del. C. § 3343(b)(1)(b) Insurance coverage for serious mental illness.**

Aetna Health has imposed higher tier placements (Tier 3) on buprenorphine hcl sublingual tablets, buprenorphine/naloxone sublingual tablets, methadone (all strengths), naltrexone tablets, Suboxone films, and Bunavail. This is a violation by placing higher tiers (Tier 3) on the substance abuse medications used to treat Opioid Use Disorder (OUD) compared to MED/SURG medications which exhibit lower tier designations (Tier 1 and Tier 2) in every medication classification throughout this formulary. Comparing these aforementioned substance abuse medications to MED/SURG medications classified in this formulary, the patient/member would be paying higher copays resulting in higher cost to treat their disease.

*Recommendation:* It is recommended that the Company not issue any health benefit plan containing terms that place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan, including terms for deductibles, co-pays, monetary limits, coinsurance factors, limits in the numbers of visits, limits in the length of inpatient stays, durational limits, or limits in the coverage of prescription medicines as required by 18 *Del. C.* § 3343(b)(1)(b).

**1 Exception - 45 CFR § 146.136(c)(4)(ii)(b) Nonquantitative treatment limitations.**

Aetna Health has imposed higher tier placements (Tier 3) on buprenorphine hcl sublingual tablets, buprenorphine/naloxone sublingual tablets, methadone (all strengths), naltrexone tablets, Suboxone films, and Bunavail. This is a violation by placing higher tiers (Tier 3) on the substance abuse medications used to treat Opioid Use Disorder (OUD) compared to MED/SURG medications which exhibit lower tier designations (Tier 1 and Tier 2) in every medication classification throughout this formulary. Comparing these aforementioned substance abuse medications to MED/SURG medications classified in this formulary, the patient/member would be paying higher copays resulting in higher cost to treat their disease.

*Recommendation:* It is recommended that the Company not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required by 45 *CFR* § 146.136(c)(4)(ii)(b).

**33 Exceptions - 18 Del. C. § 3343(b)(1)(b) Insurance coverage for serious mental illness.**

Aetna applied a NQTL (quantity limitation/dose restriction) on max dosing of duloxetine for Major Depressive Disorder (MDD) and Generalized Anxiety Disorder (GAD) that

was not included on max dosing for its MED/SURG indications. The recommended maximum dose for duloxetine is 120mg per day for Major Depressive Disorder (MDD) and Generalized Anxiety Disorder (GAD) in accordance with both the FDA and the American Psychiatric Association's (APA) recommended guidelines. Duloxetine's other indications such as Diabetic Peripheral Neuropathic Pain (DPNP), Fibromyalgia (FM), and Chronic Musculoskeletal pain all have a maximum dosage of 60mg per day. None of these MED/SURG indications require a prior authorization at their maximum dose. However, a prior authorization override is required at doses of 120mg per day for only mental health indications (MDD and GAD). This policy is discriminatory towards mental health members since the same maximum dosing criteria is not provided equally to MH/SUD and MED/SURG indications.

*Recommendation:* It is recommended that the Company not issue any health benefit plan containing terms that place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan, including terms for deductibles, co-pays, monetary limits, coinsurance factors, limits in the numbers of visits, limits in the length of inpatient stays, durational limits, or limits in the coverage of prescription medicines as required by 18 Del. C. § 3343(b)(1)(b).

**33 Exceptions - 45 CFR § 146.136(c)(4)(ii)(a)(b) Nonquantitative treatment limitations.**

Aetna applied a NQTL (quantity limitation/dose restriction) on max dosing of duloxetine for Major Depressive Disorder (MDD) and Generalized Anxiety Disorder (GAD) that was not included on max dosing for its MED/SURG indications. The recommended maximum dose for duloxetine is 120mg per day for Major Depressive Disorder (MDD) and Generalized Anxiety Disorder (GAD) in accordance with both the FDA and the American Psychiatric Association's (APA) recommended guidelines. Duloxetine's other indications such as Diabetic Peripheral Neuropathic Pain (DPNP), Fibromyalgia (FM), and Chronic Musculoskeletal pain all have a maximum dosage of 60mg per day. None of these MED/SURG indications require a prior authorization at their maximum dose. However, a prior authorization override is required at doses of 120mg per day for only mental health indications (MDD and GAD). This policy is discriminatory towards mental health members since the same maximum dosing criteria is not provided equally to MH/SUD and MED/SURG indications.

*Recommendation:* It is recommended that the Company not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in



applying the limitation with respect to medical/surgical benefits in the classification as required by 45 *CFR* § 146.136(c)(4)(ii)(a)(b).

**164 Exceptions - 45 *CFR* § 146.136(c)(4)(ii)(a)(b) Nonquantitative treatment limitations.**

Aetna Health placed quantity limitations on ADHD stimulant-based medications. When comparing the same criteria to MED/SURG, many MED/SURG medications exceeded their FDA, manufacturer, and peer reviewed literature dosing guidelines during the scope of the exam. This resulted in many paid MED/SURG claims with no dosing restrictions on above label/off label dosing. The Company is being more stringent/restrictive on ADHD medications, prescribed under physician supervision, by holding this type of mental health medication to FDA and manufacturer recommended guidelines. Quantity limits were later adjusted and raised on various ADHD medications as a result of excessive overturn rates on appeals (74%) from the entire class of ADHD medications. The Company applied quantity limitations (off label dosing) to ADHD medications more stringently than the processes, strategies, evidentiary standards, and other factors being applied to MED/SURG medications.

*Recommendation:* It is recommended that the Company not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required by 45 *CFR* § 146.136(c)(4)(ii)(a)(b).

**ACA MENTAL HEALTH PARITY**

Aetna Health was requested to provide the Company's (including a third-party contractor who performed actuarial testing of health plans) analysis, the Company's project plan for implementation, the Company's definition of Mental Health Benefits and Substance Use Disorder Benefits, the classification of benefits and the standards used to create it, identification of all nonquantitative treatment limitations (NQTs). Also, documentation demonstrating that NQTs are applied no more stringently to mental health or substance disorder benefits than to medical/surgical benefits, documentation demonstrating the process used to develop or select the medical necessity criteria, and their disclosure policies and procedures were reviewed.

The Company's documentation was reviewed for compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA), ACA regulations, and 18 Del C § 3343 in terms of defining mental health or substance use disorder benefits, classifying benefits, financial requirements, quantitative treatment limitations (QTLs), and nonquantitative treatment limitations (NQTs), required disclosures, and vendor coordination.

There were no exceptions noted.

**A. Provider Reimbursements:**

Aetna Health was sent an interrogatory to identify and ensure the as written and in operation processes and factors for determining provider reimbursements are applied comparably and not more stringently for mental health providers than for those processes and factors for medical/surgical providers.

The Company's responses and supporting documentation were reviewed for compliance with the provider reimbursements and their response to the interrogatory as well as supporting documentation, as it pertains to the Mental Health Parity and Addiction Equity Act (MHPAEA), ACA regulations, and 18 *Del. C.* § 3343 Insurance coverage for serious mental illness.

There were no exceptions noted.

**ACA FORMS REVIEW**

Aetna Health was requested to provide a list of all individual/group policies, certificate forms, conversion contracts, applications, amendments, and endorsements in use during the examination period of January 1, 2016 through December 31, 2017. The Company provided a list of 79 contracts, forms and certificates that were in use during the examination period. All 79 contracts, forms and certificates were selected for review.

The contracts, forms and certificates were reviewed for compliance with the Centers for Medicare & Medicaid Services Compliance Review Protocols and Standards and applicable Delaware Statutes.

There were no exceptions noted.

## CONCLUSION

As stated in the Scope of Examination section, the purpose of the examination was to determine compliance by the Aetna Life Insurance Company with Delaware insurance laws and regulations related to the healthcare lines.

The recommendations made below identify corrective measures the Department finds necessary as a result of the exceptions noted in the Report. Location in the Report is referenced in parenthesis.

1. It is recommended that the Company acknowledge and act reasonably promptly upon communication with respect to claims as required by 18 *Del. C.* § 2304(16)(b). (Overpayments)(Grievances and Appeals)(Claims).
2. It is recommended that the Company provide an explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement as required by 18 *Del. C.* § 2304(16)(n). (Overpayments)(Grievances and Appeals)(Claims).
3. It is recommended that the Company file forms with the Commissioner as required by 18 *Del. C.* § 2712(a). (Forms).
4. It is recommended that the Company accurately record all complaints as required by 18 *Del. C.* § 2304(17). (Complaint Handling)(Claims).
5. It is recommended that the Company provide written acknowledgement of grievances including the name, address and telephone number of the individual or department designated by the carrier to respond to the grievance within 5 business days of receipt as required by 18 *Del. C.* § 332(c)(4). (Complaint Handling)(Grievances and Appeals)(Claims).
6. It is recommended that the Company provide written notices of grievance dispositions which should inform the insured of the mediation services of by the Department of Insurance as required by 18 *Del. C.* § 332(c)(7). (Complaint Handling).
7. It is recommended that the Company decide grievances in an expeditious manner as required by 18 *Del. C.* § 332(c)(5). (Grievances and Appeals).
8. It is recommended that the Company provide notice indicating the providers right to arbitrate as required by 18 *Del. Admin. C.* § 1313-3.0 Notice. (Grievances and Appeals).

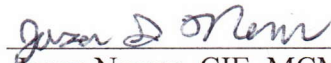
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9. It is recommended that the Company effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear as required by 18 *Del. C. § 2304(16)(f)*. (Claims)(ACA Claims).
10. It is recommended that the Company acknowledge and respond within 15 working days, upon receipt by the insurer, to communications with respect to claims as required by 18 *Del. Admin. C. § 902 – 1.2.1.2*. (Claims).
11. It is recommended that the Company implement prompt investigation of the claims within 10 working days as required by 18 *Del. Admin. C. § 902 – 1.2.1.3*. (Claims).
12. It is recommended that the Company affirm or deny claims within 30 days as required by 18 *Del. Admin. C. § 902 – 1.2.1.5*. (Claims)(ACA Claims).
13. It is recommended that the Company pay claims within 30 days as required by 18 *Del. Admin. C. § 1310 - 6.1.1*. (Claims)(ACA Claims).
14. It is recommended that the Company provide a determination of the claim within 15 days following receipt of additional requested information as required by 18 *Del. Admin. C. § 1310 - 6.2*. (Claims)(ACA Claims).
15. It is recommended that the Company provide a determination of claims within 30 days as required by 18 *Del. Admin. C. § 1310 – 6.1.3*. (Claims)(ACA Claims)(ACA Utilization Review).
16. It is recommended that the Company not issue for delivery, or deliver, in this State any health benefit plan containing terms that place a greater financial burden on an insured for covered services provided in the diagnosis and treatment of a serious mental illness and drug and alcohol dependency than for covered services provided in the diagnosis and treatment of any other illness or disease covered by the health benefit plan, including terms for deductibles, co-pays, monetary limits, coinsurance factors, limits in the numbers of visits, limits in the length of inpatient stays, durational limits, or limits in the coverage of prescription medicines as required by 18 *Del. C. § 3343(b)(1)(b)*. (ACA Claims)(ACA Pharmacy Review).
17. It is recommended that the Company provide coverage for any outpatient drug prescribed to treat a covered person for a covered chronic, disabling or life-threatening illness when the drug has been approved by the Food and Drug Administration for at least 1 indication; and is recognized for treatment of the

- indication for which the drug is prescribed in A prescription drug reference compendium approved by the Insurance Commissioner or Substantially accepted peer reviewed medical literature as required 18 *Del. Admin. C.* § 3350(b). (ACA Claims).
18. It is recommended that the Company complete its process or render an adverse determination and notify the covered person's health-care provider within 2 business days as required by 18 *Del. C.* § 3373(a). (ACA Utilization Review).
  19. It is recommended that the Company issue an adverse determination and notify the covered person's health-care provider of the determination within 5 business days of receipt as required by 18 *Del. C.* § 3373(c). (ACA Utilization Review).
  20. It is recommended that the Company grant a pre-authorization or issue an adverse determination within 8 business days of receipt as required by 18 *Del. C.* § 3373(b). (ACA Utilization Review).
  21. It is recommended that the Company not make, issue, circulate or cause to be made, issued or circulated any estimate, circular, statement, sales presentation, omission or comparison which misrepresents the benefits, advantages, conditions or terms of any insurance policy as required by 18 *Del. C.* § 2304(1)(a). (ACA Pharmacy Review).
  22. It is recommended that the Company not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification as required by 45 *CFR* § 146.136(c)(4)(ii)(b). (ACA Pharmacy Review).

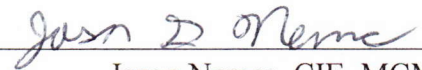
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The examination conducted by Joseph Krug, Jason Nemes, Jack Rucidlo, and Gwen Douglas is respectfully submitted.



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Jason Nemes, CIE, MCM  
Examiner-in-Charge  
Market Conduct  
Delaware Department of Insurance

I, Jason Nemes, hereby verify and attest, under penalty of perjury, that the above is a true and correct copy of the examination report and findings submitted to the Delaware Department of Insurance pursuant to examination authority 95109-18-707.



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Jason Nemes, CIE, MCM