

COMMONWEALTH OF PENNSYLVANIA INSURANCE DEPARTMENT

MARKET CONDUCT EXAMINATION REPORT

OF

AETNA HEALTH INSURANCE COMPANY (AHIC, #72052),
AETNA HEALTH INC., PA CORP. (AHI, #95109), HEALTH
AMERICA, INC. (HAPA, #15827), HEALTH ASSURANCE PA,
INC. (HASPA, #11102), AND AETNA LIFE INSURANCE
COMPANY (ALIC, #60054)

c/o Aetna Inc., Hartford, CT

As of: July 18, 2018 Issued: November 5, 2018

> BUREAU OF MARKET ACTIONS LIFE AND HEALTH DIVISION

VERIFICATION

Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. § 4903 (relating to false swearing).

Lindsi Swartz, Examiner-In-Charge

Kindsi Swarty

Sworn to and Subscribed Before me

This Day of Lovember 2018

Notary Public

COMMONWEALTH OF PENNSYLVANIA

NOTARIAL SEAL Glenda J. Ebersole, Notary Public City of Harrisburg, Dauphin County My Commission Expires Feb. 13, 2019

VERIFICATION

Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. § 4903 (relating to false swearing).

Parker W.B. Stevens, Examiner-in-Charge

Sworn to and Subscribed Before me

Day of November, 2018

Notary Public

AMANDA B SHIRLEY
Notary Public
New Hanover County
North Carolina
y Commission Evolution 17, 200

AETNA, INC.

TABLE OF CONTENTS

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I.	INTRODUCTION	1
II.	SCOPEOFEXAMINATION	4
III.	COMPANY HISTORY AND LICENSING	6
A.	Aetna Health Inc., a Pennsylvania corporation ("AHI") (NAIC #95109)	6
B.	Aetna Health Insurance Company, a Pennsylvania corp. (NAIC #72052)	6
C.	HealthAmerica Pennsylvania, Inc. (NAIC #95060)	7
D.	HealthAssurance Pennsylvania, Inc. (NAIC #11102)	9
E.	Aetna Life Insurance Company (NAIC #60054)	9
IV.	COMPANY OPERATIONS AND MANAGEMENT	11
A.	Audits Conducted	11
B.	Policies and Procedures for Information Technology Protection	11
C.	Anti-Fraud Procedures	11
D.	Disaster Recovery Plan and Procedures	12
E.	Third-Party Agreements	12
F.	Contracted-Entity Activity Monitoring	12
G.	Record Retention	13
H.	Written Overview of Operations	13
I.	Response Requests	13
J.	Privacy Policies and Procedures	14
K.	Insurance Information Security	14
L.	Security Protection of Non-Public Information	15
M.	Privacy Notices	15
N.	Opt-Out Notices	15
O.	Non-Public Personal Financial Information	16
р	Non-Public Personal Health Information Disclosure	16

Q.	Written Information Security Program	. 16
R.	Data Submission to Regulator – Policies and Procedures	. 16
S.	Management of Compliance Division	. 17
T.	External Audits and Examinations	. 17
U.	Annual Statements and Related Schedules	. 17
V.	CONSUMER COMPLAINTS	. 18
A.	Complaint Handling	. 18
B.	Complaint Handling Procedures	. 18
C.	Complaint Resolution	. 18
D.	Complaint Response Time	. 19
E.	Complaint Disposal	. 19
F.	Definition of Complaint	. 19
G.	Complaint Summaries	. 19
H.	Pennsylvania Insurance Department Complaints	. 20
VI.	PRODUCER LICENSING	. 22
A.	Active Producers	. 22
B.	Account Balances Policies and Procedures	. 22
C.	Description of Agency System	. 22
D.	Licensing and Appointment Verification	. 23
VII.	POLICYHOLDER SERVICES	. 24
A.	Collection and Billing Practices	. 24
B.	Timely Issuance and Insured-Requested Cancellations	. 24
C.	Department Correspondence	. 24
D.	Assumption Reinsurance Agreements	. 25
E.	Individual Policy Additions	. 25
F.	Individual Drops	. 25
G.	Individual ID Changes	. 26
Н.	Premium Refunds	. 26
I.	Reinstatement Policies and Procedures	. 26

J.	Unearned Premium and Refunds	27
K.	Premium and Billing Notices	27
L.	Cancellations and Non-Renewals	27
M.	Reinstatements	27
VIII.	UNDERWRITING AND RATING	29
A.	Rating Schedules	29
B.	Mandated Disclosures	29
C.	Prohibition of Illegal Rebating	29
D.	Underwriting Practices	30
E.	Form Filing	30
F.	Issue and Renewal	30
G.	Policy Rejections and Declinations	31
H.	Cancellation Notices	31
I.	Rescissions	31
J.	Cancellation Practices	32
K.	Information on Policy Forms	32
L.	COBRA and Mini-COBRA	32
M.	Genetic Information Nondiscrimination Act Compliance	32
N.	Health Information Protection	33
O.	Pre-existing Conditions	33
P.	Coverage Discrimination Based on Health Status	33
Q.	Compliance with Guaranteed Issuance	34
R.	Individual Portability	34
S.	Clinical Trials	34
T.	Dependent Coverage	35
U.	Group Health Plan Renewability	35
V.	Lifetime Limits	35
W.	Cost Sharing Requirements	36
X.	Rescissions	36

Y.	30-Day Notice	36
Z.	Group New Business Policies	37
AA.	Individual New Business Policies	37
BB.	Terminations	38
CC.	Formulary	38
IX.	CLAIMS PROCEDURES	40
A.	Claimant Contact	40
B.	Timely Investigations	40
C.	Timely Claims Resolution	40
D.	Claims Handling	41
E.	Claims Forms	41
F.	Claim Reserves	41
G.	Denied and Closed-without-Payment Claims	41
H.	Cancelled Benefit Checks	42
I.	Claims Closing Practices	42
J.	Claims Handling Practices	42
K.	Newborns' and Mother's Health Protection Act	42
L.	Compliance with Mental Health Parity and Addiction Equity Act	43
M.	Women's Health and Cancer Rights Act of 1998	43
N.	Group Coverage Replacements	43
X.	COMPLAINTS AND GRIEVANCES	45
A.	Grievances	45
B.	Complaint and Grievance Procedures	45
C.	Grievance Procedure Disclosure	46
D.	First-Level Reviews of Grievances Involving Adverse Benefit Determinations	46
E.	Grievance Reviews Not Involving Adverse Determination	46
F.	Second-Level Reviews of Complaints and Grievances	46
G.	Expedited Review of Grievances	47
H.	Complaint and Grievance Procedures Comply with Federal Law	47

I.	Expedited Reviews of Urgent Care Requests	48
J.	Appeals	48
XI.	NETWORK ADEQUACY	49
A.	Access Plan Filed	49
B.	Contract Forms Filed	49
C.	Access to Emergency Services	49
D.	Accrediting Certification	50
E.	Provider Directory	50
XII.	PROVIDER CREDENTIALING	51
A.	Credentialing and Re-credentialing Program	51
B.	Accrediting Verification	51
C.	Primary Verification	51
D.	Provider Notification of Changes in Status	52
E.	Provider Opportunity to Review	52
F.	Contractor Credentialing Monitoring	52
XIII.	QUALITY ASSESSMENT AND IMPROVEMENT	53
A.	Quality Assessment	53
B.	Quality Assessment Filing	53
C.	Quality Improvement Program	54
D.	Reports to Appropriate Licensing Authority	54
E.	Quality Assessment Program Communication	55
F.	Annual Certification of Program	55
G.	Quality Assessment and Improvement Entity Monitoring	55
XIV.	UTILIZATION REVIEW	56
A.	Utilization Review Program	56
B.	Annual Report	56
C.	Utilization Review Program Operation	56
D.	Utilization Review Disclosure	57
E.	Timely Standard Utilization Review	57

F.	Adverse Determination of Utilization Review	57
G.	Expedited Utilization Review and Benefit Determinations	58
H.	Emergency Services Utilization Reviews	58
I.	Monitoring Utilization Review Entity	58
XV.	MARKETING AND SALES	59
A.	Advertising and Sales Materials	59
XVI.	MEDICAL AND PHARMACY CLAIMS REVIEW	61
A.	Serious Mental Health Claims	62
B.	Habilitative Services Claims	62
C.	Midwifery Services Claims	62
D.	Pediatric Vision Claims	64
E.	Pediatric Dental Claims	64
F.	Mammography Claims	64
G.	Pharmacy Claims	64
H.	General Medical Claims	65
I.	Dental Anesthesia Claims	66
J.	Medical Food Claims	66
K.	Autism Spectrum Disorder Claims	67
L.	Emergency Room Claims	71
M.	Ambulance Transport Claims	73
N.	Substance Use Disorder and Chemical Recovery Claims	76
O.	Mental Health Claims	79
P.	Behavioral Health Claims	80
Q.	HIV/AIDS Claims	81
R.	Inpatient and Outpatient High Dosage Opioid Addiction Treatment Claims	82
XVII.	DATA INTEGRITY	86
XVIII.	RECOMMENDATIONS	89
XIX.	COMPANY RESPONSE	92

BEFORE THE INSURANCE COMMISSIONER OF THE COMMONWEALTH OF PENNSYLVANIA

ORDER



Jessica K. Altman
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER OF THE COMMONWEALTH OF PENNSYLVANIA

IN RE:

VIOLATIONS:

AETNA HEALTH INSURANCE

COMPANY

and

AETNA HEALTH INC., PA CORP.

and

HEALTH AMERICA, INC.

and

HEALTH ASSURANCE PA, INC.

and

AETNA LIFE INSURANCE COMPANY

C/O Aetna Inc.

151 Farmington Avenue

Hartford, Connecticut 06156

40 P.S. §323.3(a)

40 P.S. §323.4(b)

40 P.S. §477a

40 P.S. §752(A)(4)

40 P.S. §753(B)(8)

40 P.S. §761

40 P.S. §764h(a), (b), & (f)(3)

40 P.S. §§908-1 et seq.

40 P.S. §§908-11 et seq.

40 P.S. §991.2116

40 P.S. §991.2166(a), (b)

40 P.S. §1171.5(a)(1)(i)

40 P.S. §1171.5(a)(7)(ii)

40 P.S. §1171.5(a)(10)(i), (iv), (v), (vi), (x)

40 P.S. §3042

40 P.S. §3801.310

31 Pa. Code §51.4

31 Pa. Code §51.5

- 31 Pa. Code §89b.11
 - 31 Pa. Code §146.3
 - 31 Pa. Code §146.4(b)
 - 31 Pa. Code §146.5(a)
 - 31 Pa. Code §146.6
 - 31 Pa. Code §146.7(a)(1)
 - 31 Pa. Code §146.7(c)(1)
 - 31 Pa. Code §152.20
 - 31 Pa. Code §154.18(a), (c), (d)
 - 31 Pa. Code §301.82
 - 42 U.S.C. §300gg-4(a)
 - 42 U.S.C. §300gg-19(a)(1)(c)
 - 42 U.S.C. §300gg-19a(b) & (b)(1)(C)(ii)(II)
 - 45 C.F.R. §146.136(c)(2)(i) & (c)(4)
 - 45 C.F.R. §147.104
- 45 C.F.R. §147.138(b)
- 45 C.F.R. §155.310(e)
- 45 C.F.R. §156.125

Respondent. : Docket No. MC18-07-0014

CONSENT ORDER

AND NOW, this 12th day of November , 2018, this Order is hereby issued by the Insurance Department of the Commonwealth of Pennsylvania pursuant to the statutes cited above and in disposition of the matter captioned above.

- 1. Respondent hereby admits and acknowledges that it has received proper notice of its rights to a formal administrative hearing pursuant to the Administrative Agency Law, 2 Pa.C.S. §101, et seq., or other applicable law.
- 2. Respondent hereby waives all rights to a formal administrative hearing in this matter and agrees that this Consent Order shall have the full force and effect of an order duly entered in accordance with the adjudicatory procedures set forth in the Administrative Agency Law, supra, or other applicable law.

FINDINGS OF FACT

- 3. The Insurance Department finds true and correct each of the following Findings of Fact:
- (a) Respondent is Aetna Health Insurance Company, Aetna Health Inc., PA Corp., Health America, Inc., Health Assurance PA, Inc., and Aetna Life Insurance Company, collectively Aetna Inc., and maintains its address at 151 Farmington Avenue, Hartford, Connecticut 06156.
- (b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from January 1, 2015 to March 31, 2016.

- (c) On November 5, 2018, the Insurance Department issued a Market Conduct Examination Report to Respondent.
- (d) No company response was provided to the Examination Report.
- (e) The Examination Report notes violations of the following:
 - (i) 40 P.S. §§323.3(a) and 323.4(b) require that every company or person from whom information is sought must provide the examiners timely, convenient and free access to all books, records, accounts, papers, documents and any and all computer or other recording relating to the property, assets business and affairs of the company being examined;
 - (ii) 40 P.S. §§477a, 761, and 1171.5(a)(7)(ii) state that unfair discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of life, health and accident insurance, covered by this act, or in the benefits payable thereon, or in any of the terms or conditions of such policy, or in any other manner whatsoever, is prohibited. Discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of insurance covered by this act, or in the benefits payable thereon, or in any of the terms or conditions of such policy, or in any other manner whatsoever, is prohibited. Unfairly discriminating by means of:

 Making or permitting any unfair discrimination between individuals of the same class

and of essentially the same hazard in the amount of premium, policy, fees or rates charged for any policy or contract of insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever, is prohibited;

40 P.S. §752(A)(4) and 31 Pa. Code §89b.11 require that each form shall state the full (iii) corporate or legal name of the company, association, exchange or society. However, the name need appear for filing purposes only on a rider, endorsement, amendment, agreement or insert page. If added for filing purposes only, the name may be added by any legible means. If more than one insurer is using an application, a multi-company application providing for the designation of the applicable insurer and available coverages, if applicable, may be used. A policy, contract or fraternal certificate shall state a current address for the insurer, consisting of at least a city and state or province. Conditions subject to which policies are to be issued. No such policy shall be delivered or issued for delivery to any person in this Commonwealth unless: the style, arrangement and over-all appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lower-case unspaced alphabet length not less than 120-point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions;

- (iv) 40 P.S. §753(B)(8) states that the insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to his last address as shown by the records of the insurer, stating when, not less than five days thereafter such cancellation shall be effective; and after the policy has been continued beyond its original term, the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro-rata;
- (v) 40 P.S. §764h(a) & (b) state that a health insurance policy or government program covered under this section shall provide to covered individuals or recipients under 21 years of age coverage for the diagnostic assessment of autism spectrum disorders and for the treatment of autism spectrum disorders. Coverage provided under this section by an insurer shall be subject to a maximum benefit of thirty-six thousand dollars (\$36,000) per year but shall not be subject to any limits on the number of visits to an autism service provider for treatment of autism spectrum disorders;
- (vi) 40 P.S. §764h(a) & (f)(3) state that health insurance policy or government program covered under this section shall provide to covered individuals or recipients under 21 years of age coverage for the diagnostic assessment of autism spectrum disorders and for

the treatment of autism spectrum disorders. As used in this section: "Autism spectrum disorders" means any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or its successor, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified;

- (vii) 40 P.S. §§908-1 et seq. require group health insurance policies to provide coverage of inpatient detoxification, nonhospital residential and outpatient services for alcohol or other substance use and dependency, with a certification and referral by a licensed physician or psychologist controlling both the nature and duration of treatment to the extent of the mandate;
- (viii) 40 P.S. §§908-11 et seq. and 45 C.F.R. §146.136(c)(2)(i) state that licensed insurers are required to provide mental health and substance use disorder benefits in parity with medical/surgical benefits. For quantitative treatment limitations, this means that a licensed insurer may not apply any quantitative treatment limitation (QTL) to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification;
 - (ix) 40 P.S. §§908-11 et seq. and 45 C.F.R. §§146.136(c)(4) and 156.115(a)(3) state that licensed insurers are required to provide mental health and substance use disorder benefits in parity with medical/surgical benefits. For NQTLs, this means that a licensed

insurer may not apply any NQTL in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying that limitation to MH/SUD benefits within that classification are "comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the classification."

- (x) 40 P.S. §991.2116 requires that if an enrollee seeks emergency services and the emergency health care provider determines that emergency services are necessary, the emergency health care provider shall initiate necessary intervention to evaluate and, if necessary, stabilize the condition of the enrollee without seeking or receiving authorization from the managed care plan. The managed care plan shall pay all reasonably necessary costs associated with the emergency services provided during the period of the emergency;
- (xi) 40 P.S. §§991.2116 and 3042, 42 U.S.C. §300gg-19a(b), and 45 C.F.R. §147.138(b) state that if an enrollee seeks emergency services and the emergency health care provider determines that emergency services are necessary, the emergency health care provider shall initiate necessary intervention to evaluate and, if necessary, stabilize the condition of the enrollee without seeking or receiving authorization from the managed care plan. The managed care plan shall pay all reasonably necessary costs associated with the emergency services provided during the period of the emergency. When processing a reimbursement claim for emergency services, a managed care plan shall consider both the presenting symptoms and the services provided. An insurer shall reimburse an

insured or provider for medically necessary services that are provided in a hospital emergency facility due to a medical emergency. A hospital emergency facility shall provide to an insurer, with any claim for reimbursement of services, information on the presenting symptoms of the insured as well as the services provided. An insurer shall consider both the presenting symptoms and the services provided in processing a claim for reimbursement of emergency services. A plan or issuer subject to the requirements of this paragraph must provide coverage for emergency services in the following manner: without the need for any prior authorization determination, even if the emergency services are provided on an out-of-network basis; without regard to whether the health care provider furnishing the emergency services is a participating network provider with respect to the services; if the emergency services are provided out of network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from in-network providers; if the emergency services are provided out of network, by complying with the cost-sharing requirements of paragraph (b)(3) of this section;

(xii) 40 P.S. §991.2166(a) and 31 Pa. Code §154.18(a) state that a licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim. Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim under subsection (d) submitted by a health care provider for services provided on or after January 1, 1999, within 45 days of the licensed insurer's or managed care plan's receipt of the claim from the health care provider;

- (xiii) 40 P.S. §991.2166(b) and 31 Pa. Code §154.18(c) state that if a licensed insurer or a managed care plan fails to remit payment as provided under subsection (a), interest at 10% per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid;
- (xiv) 40 P.S. §§1171.5(a)(1)(i) and 1171.5(a)(10)(i) state that "unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means: making, publishing, issuing or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which: misrepresents the benefits, advantages, conditions or terms of any insurance policy. Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices: misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue;
- (xv) 40 P.S. §1171.5(a)(7)(ii) prohibits making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy, fees or rates charged for any policy or contract of insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever;

- (xvi) 40 P.S. §1171.5(a)(10)(iv) prohibits the refusal to pay claims without conducting a reasonable investigation based upon all available information, if committed or performed with such frequency as to indicate a business practice in claims settlement practices;
- (xvii) 40 P.S. §1171.5(a)(10)(v) requires an insurer to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the insurer or its representative, if committed or performed with such frequency as to indicate a business practice in claims settlement practices;
- (xviii) 40 P.S. §1171.5(a)(10)(vi) prohibits the failure to attempt in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear, if committed or performed with such frequency as to indicate a business practice in claims settlement practices;
 - (xix) 40 P.S. §1171.5(a)(10)(x) prohibits making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made, if committed or performed with such frequency as to indicate a business practice in claims settlement practices;
 - (xx) 40 P.S. §3801.310 states that upon request, the Department shall be provided a copy of any form being issued in this Commonwealth. Insurers shall maintain complete and accurate specimen or actual copies of all forms which are issued to Pennsylvania residents, including copies of all applications, certificates and endorsements used with

policies. Retention of the forms may be kept on diskette, microfiche or any other electronic method. Specimen copies shall also indicate the date the form was first issued in this Commonwealth. The records shall be maintained until at least two years after a claim can no longer be reported under the form;

- (xxi) 31 Pa. Code §51.4 states that a company shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its individual contracts and typical printed, published or prepared advertisements of its blanket, franchise and group contracts hereafter disseminated in this or another state whether or not licensed in the other state;
- (xxii) 31 Pa. Code §51.5 states that a company required to file an annual statement which is now or which hereafter becomes subject to this chapter shall file with the Department with its Annual Statement a Certificate of Compliance executed by an authorized officer of the company wherein it is stated that to the best of his knowledge, information and belief the advertisements which were disseminated by the company during the preceding statement year complied or were made to comply in all respects with the provisions of the insurance laws and regulations of this Commonwealth;
- (xxiii) 31 Pa. Code §146.3 requires an insurer's claim files to be subject to examination by the Commissioner or by her appointed designees, with the files containing notes and work papers pertaining to the claim in sufficient detail that pertinent events and the dates of the events can be reconstructed;

- (xxiv) 31 Pa. Code §146.4(b) states that an insurer or agent may not fail to fully disclose to first-party claimants benefits, coverages or other provisions of an insurance policy or insurance contract when the benefits, coverages or other provisions are pertinent to a claim;
- (xxv) 31 Pa. Code §146.5(a) states every insurer, upon receiving notification of a claim, shall acknowledge receipt of the notice or pay the claim within 10 working days;
- (xxvi) 31 Pa. Code §146.6 requires an insurer, if an investigation cannot be completed within 30 days, and if it is not completed, then every 45 days thereafter, to provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected;
- (xxvii) 31 Pa. Code §146.7(a)(1) requires the first-party claimant to be advised of the acceptance or denial of the claim by the insurer within 15 working days after receipt by the insurer of properly executed proofs of loss;
- (xxviii) 31 Pa. Code §146.7(c)(1) requires an insurer, if it cannot make a determination of acceptance or denial of a first-party claim within 15 days of receipt of a properly executed proof of loss, to notify the first-party claimant within 15 working days after receipt of the proof of loss giving the reasons;

- (xxix) 31 Pa. Code §§152.20 and 301.82 state that the Commissioner and the Secretary may investigate a preferred provider organization in order to determine whether it is complying with this chapter, and that the Commissioner or an agent shall have free access to the books, records, papers and documents that relate to the business of the HMO;
- (xxx) 31 Pa. Code §154.18(d) requires clean claims to be paid within 45 days pursuant to the interest provisions of the act, and states if a paid claim is to be re-adjudicated due to additional information, a new 45-day period for the prompt pay provision beings at the time such additional information is provided;
- (xxxi) 42 U.S.C. §300gg-19(a)(1)(c) requires a group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan shall have at a minimum:

an internal claims appeal process, provide notice to enrollees in a culturally and linguistically appropriate manner of available internal and external appeals processes, the availability of any applicable office insurance consumer assistance and allow an enrollee to review their file, to present evidence and testimony as part of the appeals process and to receive continued coverage pending the outcome of the appeals process;

- (xxxii) 40 P.S. §§477a, 761, and 1171.5(a)(7)(ii); 42 U.S.C. 300gg-4(a); and 45 C.F.R. §§147.104 and 156.125 state than an issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions;
- (xxxiii) 42 U.S.C. §300gg-19a(b)(1)(C)(ii)(II) and 45 C.F.R. §147.138 state that if a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides any benefits with respect to services in an emergency department of a hospital, the plan or issuer must cover emergency services (as defined in 45 C.F.R. §147.138(b)(4)(ii)) consistent with the rules of that paragraph (b). In general, if a group health plan, or a health insurance issuer offering group or individual health insurance issuer, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in 42 U.S.C. §300gg-19a(b)(2)(B)) —(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee— (II) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided innetwork;
- (xxxiv) 45 C.F.R. §155.310(e) states that the Exchange must determine eligibility promptly and without undue delay. The Exchange must assess the timeliness of eligibility determinations based on the period from the date of application or transfer from an

agency administering an insurance affordability program to the date the Exchange notifies the applicant of its decision or the date the Exchange transfers the application to another agency administering an insurance affordability program, when applicable.

CONCLUSIONS OF LAW

- 4. In accord with the above Findings of Fact and applicable provisions of law, the Insurance Department makes the following Conclusions of Law:
- (a) Respondent is subject to the jurisdiction of the Pennsylvania Insurance Department, violated the laws referenced in the Findings of Fact, and is subject to penalties, including those set forth in these Conclusions of Law.
- (b) Respondent's violations of Sections 40 P.S. §§752(a)(4), 753(b)(8), 761, 764h(a), (b) & (f)(3), and 31 Pa. Code §152.20 are punishable by the following under 40 P.S. §763:
 - (1) License revocation.
 - (2) Imposition of a penalty of not more than one thousand dollars (\$1,000.00) for each violation.
- (c) Respondent's violations of 40 P.S. §§991.2116, 991.2116(b), 991.2166(a), 991.2166(b), and 31 Pa. Code §154.18 are punishable by the following under 40 P.S. §991.2182:
 - (1) Imposition of a penalty of not more than five thousand dollars (\$5,000.00) for each violation.

- (2) An action in which the Commonwealth Court may impose an injunction to prohibit any activity that violates the act.
- (3) An order temporarily prohibiting respondent from enrolling new members.
- (4) A requirement to develop and adhere to a plan of correction.
- (d) Respondent's violations of 40 P.S. §§1171.5(a)(1)(i) and (10)(i), 1171.5(a)(7)(ii), 1171.5(a)(10)(iv), 1171.5(a)(10)(v), 1171.5(a)(10)(vi), and 1171.5(a)(10)(x) are punishable by the following under 40 P.S. §1171.9:
 - (1) An order to cease and desist.
 - (2) License suspension or revocation.
- In addition to any penalties imposed by the Commissioner for Respondent's violations of 40 P.S. §§1171.5(a)(1)(i) and (10)(i), 1171.5(a)(7)(ii), 1171.5(a)(10)(iv), 1171.5(a)(10)(v), 1171.5(a)(10)(vi), and1171.5(a)(10)(x) the Commissioner may, under 40 P.S. §§1171.10, 1171.11, file an action in which the Commonwealth Court may impose the following civil penalties:
 - (1) An injunction.
 - (2) For each method of competition, act or practice which the company knew or should have known was in violation of the law, a penalty of not more than five thousand dollars (\$5,000.00) for each violation but not to exceed an aggregate penalty of fifty thousand dollars (\$50,000) in any six-month period.
 - (3) For each method of competition, act or practice which the company did not know nor reasonably should have known was in violation of the law, a penalty of not

more than one thousand dollars (\$1,000.00) for each violation but not to exceed an aggregate penalty of ten thousand dollars (\$10,000) in any six-month period.

- (f) Respondent's violations of 31 Pa. Code §§51.5, 146.3, 146.4(b), 146.5(a), 146.6, 146.7(a)(1), and 146.7(c)(1) are punishable by the following under 40 P.S. §1171.9:
 - (1) An order to cease and desist.
 - (2) License suspension or revocation.
- In addition to any penalties imposed by the Commissioner for Respondent's violations of 31 Pa. Code §§51.5, 146.3, 146.4(b), 146.5(a), 146.6, 146.7(a)(1), and 146.7(c)(1), the Commissioner may, under 40 P.S. §§1171.10 and 1171.11 file an action in which the Commonwealth Court may impose the following civil penalties:
 - (1) An injunction.
 - (2) For each method of competition, act or practice which the company knew or should have known was in violation of the law, a penalty of not more than five thousand dollars (\$5,000.00) for each violation but not to exceed an aggregate penalty of fifty thousand dollars (\$50,000) in any six-month period.
 - (3) For each method of competition, act or practice which the company did not know nor reasonably should have known was in violation of the law, a penalty of not more than one thousand dollars (\$1,000.00) for each violation but not to exceed an aggregate penalty of ten thousand dollars (\$10,000) in any six-month period.
- (h) Respondent's violations of 31 Pa. Code §301.82 are punishable under 40 P.S. §1565 by imposition of a penalty of not more than one thousand dollars (\$1,000.00) for each violation.

- (i) Respondent's violations of 40 P.S. §908-11 et seq. are punishable by the following under 40 P.S. §908-15:
 - (1) License suspension, revocation, or refusal to renew.
 - (2) Imposition of a penalty of not more than five thousand dollars (\$5,000.00) for each violation.
 - (3) Imposition of a penalty of not more than ten thousand dollars (\$10,000.00) for each violation.
 - (4) Provided that the total penalty imposed thereunder shall not exceed \$500,000 in the aggregate during a single calendar year.

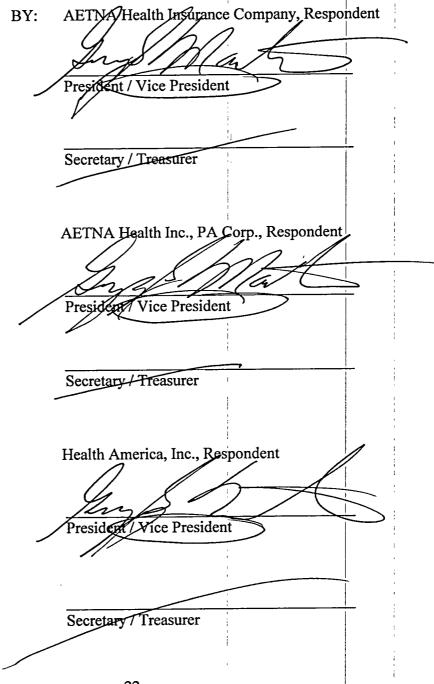
<u>ORDER</u>

- 5. In accord with the above Findings of Fact and Conclusions of Law, the Insurance Department orders and Respondent consents to the following:
- (a) Respondent shall cease and desist from engaging in the prohibited activities described herein in the Findings of Fact and Conclusions of Law.
- (b) Respondent shall file an affidavit stating under oath that it will provide each of its directors, at the next scheduled directors meeting, a copy of the adopted Report and related Orders. Such affidavit shall be submitted within thirty (30) days of the date of this Order.
- (c) Respondent shall comply with all recommendations contained in the attached Report.
- (d) Respondent shall pay One Hundred and Ninety Thousand Dollars (\$190,000.00) to the Commonwealth of Pennsylvania in settlement of the violations pertaining to, inter alia, the prompt payment of claims, the retention of records, autism spectrum disorders coverage, drug and alcohol abuse coverage and Pennsylvania's requirement for compliance with the Federal Mental Health Parity and Addiction Equity Act.
- (e) Payment of this matter shall be made by check payable to the Commonwealth of Pennsylvania. Payment should be directed to April Phelps, Bureau of Market Actions,

1227 Strawberry Square, Harrisburg, Pennsylvania 17120. Payment must be made no later than thirty (30) days after the date of this Order.

- 6. In the event the Insurance Department finds that there has been a breach of any of the provisions of this Order, based upon the Findings of Fact and Conclusions of Law contained herein may pursue any and all legal remedies available, including but not limited to the following: The Insurance Department may enforce the provisions of this Order in the Commonwealth Court of Pennsylvania or in any other court of law or equity having jurisdiction; or the Department may enforce the provisions of this Order in an administrative action pursuant to the Administrative Agency Law, <u>supra</u>, or other relevant provision of law.
- 7. Alternatively, in the event the Insurance Department finds that there has been a breach of any of the provisions of this Order, the Department may declare this Order to be null and void and, thereupon, reopen the entire matter for appropriate action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.
- 8. In any such enforcement proceeding, Respondent may contest whether a breach of the provisions of this Order has occurred but may not contest the Findings of Fact and Conclusions of Law contained herein.
- 9. Respondent hereby expressly waives any relevant statute of limitations and application of the doctrine of laches for purposes of any enforcement of this Order.
- 10. This Order constitutes the entire agreement of the parties with respect to the matters referred to herein, and it may not be amended or modified except by an amended order signed by all the parties hereto.

11. This Order shall be final upon execution by the Insurance Department. Only the Insurance Commissioner or a duly authorized delegee is authorized to bind the Insurance Department with respect to the settlement of the alleged violations of law contained herein, and this Consent Order is not effective until executed by the Insurance Commissioner or a duly authorized delegee.



Health Assurance PA Inc., Respondent President Vice President Secretary / Treasurer AETNA Life Insurance Company, Respondent President Wice President Secretary / Treasurer COMMONWEALTH OF PENNSYLVANIA Christopher R. Monahan Deputy Insurance Commissioner

I. <u>INTRODUCTION</u>

The Market Conduct Examination was conducted on Aetna Inc.'s subsidiaries Aetna Health Insurance Company (AHIC), Aetna Health Inc., PA Corp. (AHI), Health America, Inc. (HAPA), Health Assurance PA, Inc. (HASPA), and Aetna Life Insurance Company (ALIC), hereafter collectively referred to as "Company." The Company's corporate headquarters are located in Hartford, Connecticut. The examination reviews were conducted in the offices of the Pennsylvania Insurance Department and off-site locations from August of 2016 through April of 2018.

Pennsylvania Market Conduct Examination Reports generally note the items that have been reviewed and whether or not a violation of law or regulation exists. A violation is any instance of Company activity that does not comply with an insurance statute or regulation. Violations contained in the Report may result in imposition of penalties. This Examination Report also includes 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. Summaries issued to the Company throughout the examination process are included in this Examination Report; however, in some instances, the content of multiple summaries may be combined into a single report section. This only applies to sections in which no violations were found.

It is also noted that certain areas subject to examination are and will continue to be the focus of ongoing compliance emphasis by the Department. These areas reflect developments in complex areas of health insurance regulation at both the national and state levels, such as, for example, discrimination in formulary design and parity for nonquantitative treatment limitations in mental health and substance use disorder coverage. The Department anticipates providing more specific guidance to the industry with respect to these areas, and also appreciates and anticipates the continued cooperation of the Company in providing coverage consistent with the laws and regulations governing these complex areas.

Throughout the course of the examination, Company 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

Company officials to discuss the various types of violations identified during the examination and review written summaries provided on the violations found.

The courtesy and cooperation extended by the Officers and employees of the Company during the course of the examination is acknowledged.

The following examiners participated in the Examination and in the preparation of this Report:

Donna Fleischauer Market Conduct Division Chief Pennsylvania Insurance Department

Parker Stevens, FLMI, AIRC, CCP, CIE, MPM, AMCM Co-Examiner-in-Charge

Sam Binnun, LUTCF, MCM Co-Examiner-in-Charge

Lindsi Swartz, MBA Market Conduct Examiner Pennsylvania Insurance Department

Ernest L. Nickerson, FLMI, ACS, AIRC, ARM, RHU, AIE, AMCM Contract Examiner

> Marc Springer, CIE, CPCU, MCM Contract Examiner

Jo-Anne Fameree, AMCM, CIE, FLMI, AIRC, ACS Contract Examiner

Pat Lee, MCM, AIE, FLHC, AIRC, ACS, ALMI Contract Examiner

II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted pursuant to the authority granted by Sections 903 and 904 (40 P.S. §§ 323.3 and 323.4) of the Insurance Department Act and covered the experience period of January 1, 2015, through March 31, 2016, unless otherwise noted. The purpose of the examination was to ensure compliance with Pennsylvania insurance laws and regulations, as well as federal laws and regulations not superseded by state law.

The examination focused on the Company's policies and procedures in the following areas: Operations and Management, Complaints, Producer Licensing, Policyholder Services, Underwriting and Rating, Claims, Grievances, Network Adequacy, Provider Credentialing, Quality Assessment and Improvement, and Utilization Review.

Examiners requested that the Company 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 examination.

For control purposes, some of the review segments identified in this Examination Report may be broken down into various sub-categories by line of insurance or Company administration. These specific sub-categories, if not reflected individually in the Examination Report, are included and grouped within the respective categories of the Examination Report. All reviews conducted throughout the examination included consideration of company responses to examiner requests pursuant to 40 P.S. §§ 323.3 and 323.4, as well as 31 Pa. Code §§ 152.20 and 301.82. While included in all reviews completed during the examination, the Examination Report only notes when examiners found a violation of these sections in a particular area.

Within the duration of the market conduct examination, the Company provided the examiners with multiple positive process improvements from the 2015 to 2016 benefit period, including the restructure and change in formulary benefit design for certain plan types, which placed fewer restrictions on some therapeutic drug categories and classes, and the removal of potentially discriminatory language from certificates of coverage. In addition, the Company demonstrated enhanced external audit practices including on-site visits to third party administrator (TPA) locations. The Company remains dedicated to continuous improvement, which is noted throughout their policies and procedures. The Company also utilized federal and state guidance, including

FAQs released by HHS and Bulletins released by the Department, and updated their policies and processes according to the clarified interpretations of the law.

III. <u>COMPANY HISTORY AND LICENSING</u>

A. Aetna Health Inc., a Pennsylvania corporation ("AHI") (NAIC #95109)

AHI was incorporated in the Commonwealth of Pennsylvania on May 7, 1981 and acquired the net assets and operations of a prepaid health care plan, which had operated as a health maintenance organization (HMO) in southeastern Pennsylvania since 1976. The Company commenced HMO operations in Pittsburgh in 1987 and in central Pennsylvania in 1994.

In March 2002, the Company changed its name from United States Health Care Systems of Pennsylvania, Inc. to Aetna Health of Pennsylvania, Inc., and then to Aetna Health Inc., in May 2002.

AHI is a wholly-owned subsidiary of Aetna Health Holdings, LLC, whose ultimate parent is Aetna Inc.

AHI is also licensed in the following states: Arizona, Colorado, District of Columbia, Delaware, Illinois, Indiana, Kansas, Kentucky, Maryland, Massachusetts, Missouri, Nebraska, Nevada, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, Virginia, Washington and West Virginia.

In 2015, based on the annual statements submitted for business in the state of Pennsylvania, AHI had health premiums written in the amount of \$1,087,587,631, under comprehensive (hospital and medical) for individual and group, Federal Employees Health Benefits plan, and Title XIX Medicare lines of business. In 2016, for business in the state of Pennsylvania, AHI had health premiums written in the amount of \$1,712,246,768, under comprehensive (hospital and medical) for individual and group, Federal Employees Health Benefits plan, and Title XIX Medicare lines of business.

B. Aetna Health Insurance Company, a Pennsylvania corp. (NAIC #72052)

This entity was incorporated in 1938 and commenced business in 1956. Previous names of the Company included St. Paul Health & Accident Company, St. Paul Hospital and Casualty Company and, in 1977, Omaha Financial Life Insurance Company.

In 1989, this entity entered into an assumption agreement and transferred and assigned all its inforce credit life business and mortgage policies to its former parent company, United Omaha Life Insurance Company and two unaffiliated companies. This entity ceased writing business prior to the transfer and remained inactive until its purchase by U.S Healthcare, Inc., on January 6, 1993.

This entity adopted a new name, Corporate Health Insurance Company, on February 4, 1993.

This entity was a Minnesota domiciled insurer until July 20, 1997, when it became a Pennsylvania domiciled insurer pursuant to an order of the Pennsylvania Insurance Commissioner, based on an application received April 9, 1997.

The ultimate parent of this entity was U.S. Healthcare, Inc., from January 6, 1993 until July 18, 1996 when U.S. Healthcare, Inc. merged with Aetna Inc. in 1996. The surviving company was Aetna Inc.

Effective January 1, 2008, this entity adopted its present name, Aetna Health Insurance Company (AHIC).

AHIC is also licensed in the following states: Alabama, Alaska, Arizona, Arkansas, Colorado, District of Columbia, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming.

In 2015, based on the annual statements submitted for business in the state of Pennsylvania, AHIC had health premiums written in the amount of \$3,161,093, under comprehensive (hospital and medical) for group lines of business. In 2016, for business in the state of Pennsylvania, AHIC had health premiums written in the amount of \$5,837,060, under comprehensive (hospital and medical) for group lines of business.

C. HealthAmerica Pennsylvania, Inc. (NAIC #95060)

On October 1, 1988, Penn Group Corporation purchased all of the stock (five shares) of Maxicare/HealthAmerica Pennsylvania, Inc., from Maxicare Health Plans, Inc. Penn Group Corporation, a Delaware corporation, was 80% (800 shares) owned by Coventry Corporation and 20% (200 shares) owned by Montefiore Hospital Association of Western Pennsylvania.

On November 21, 1988, this entity changed its name from Maxicare/HealthAmerica Pennsylvania, Inc., to HealthAmerica Pennsylvania, Inc. (HAPA). On October 31, 1994, Coventry Corporation purchased the 20% ownership of Penn Group Corporation from University of Pittsburgh Medical Center, formerly, Montefiore Hospital Association of Western Pennsylvania.

On December 18, 1997, and effective December 31, 1997, HAPA's direct parent, Penn Group Corporation, entered into a plan of merger with Coventry Corporation, leaving Coventry Corporation the surviving entity and ceased the existence of Penn Group Corporation. As of December 31, 1997, HAPA's direct parent was Coventry Corporation. Coventry Corporation was merged into Coventry Health Care, Inc. (CHC), on June 30, 2000.

On April 5, 1999, The Medical Center HPJV, Inc. was merged into HAPA, with HAPA as the surviving corporation.

On May 1, 2002, HAPA purchased New Alliance Health Plan, a managed care organization that services members in Pennsylvania and Ohio. All of New Alliance Health Plan's HMO business was retained by HAPA, and the POS and PPO business was merged into HAPA's affiliate, HealthAssurance Pennsylvania, Inc. (HASPA). After the merger, New Alliance Health Plan ceased to exist.

HAPA was authorized to transact business under 40 P.S. §§1551 et seq. and under Ohio Revised Code §1751. HAPA operated as an HMO serving Pennsylvania and Ohio. HAPA stopped writing new business in Ohio in January 1, 2014 and surrendered its Ohio license.

HAPA was wholly owned by its direct parent, CHC.

CHC was acquired by Aetna Inc. May 7, 2013. CHC was later merged into Aetna Inc.'s subsidiary Aetna Health Holdings, LLC (AHH) January 1, 2014. HAPA became the wholly owned subsidiary of AHH. HAPA was later merged into AHH's subsidiary Aetna Health Inc. (AHI-PA), a Pennsylvania corporation, January 1, 2016. AHI-PA is the surviving entity and HAPA ceased to exist after the merger.

In 2015, based on the annual statements submitted for business in the state of Pennsylvania, HAPA had direct premiums written in the amount \$837,846,074 for comprehensive health coverage (individual, small group, and large group) and Medicare Advantage Part C and Medicare Part D

Stand-Alone Subject to ACA lines of business.

D. HealthAssurance Pennsylvania, Inc. (NAIC #11102)

HealthAssurance PA, Inc. (HASPA) was incorporated on September 10, 1985. HASPA became a part of the CHC insurance holding company system on May 14, 2001 upon receipt of the Pennsylvania Department of Insurance Certificate of Authority to Operate a Risk-Assuming Preferred Provider Organization Not a Licensed Insurer (RANLI).

On May 7, 2013, Aetna Inc. (Aetna) a Pennsylvania corporation, acquired CHC, and, as a result, transferred CHC and its subsidiaries under AHH, a wholly-owned subsidiary of Aetna. Aetna is the Ultimate Parent Company and owns 100% of the outstanding common stock of HASPA.

On January 1, 2014, CHC merged with and into AHH and as a result, Coventry Health Care, Inc. was eliminated as a legal entity and AHH is the direct parent and owns 100% of the outstanding common stock of HASPA.

In 2015, based on the annual statements submitted for business in the state of Pennsylvania, HASPA had health premiums written in the amount of \$1,249,233,601, under comprehensive (hospital and medical) for group employers and Title XVIII Medicare lines of business. In 2016, for business in the state of Pennsylvania, HASPA had health premiums written in the amount of \$1,032,647,329, under comprehensive (hospital and medical) for group employers and Title XVIII Medicare lines of business.

E. Aetna Life Insurance Company (NAIC #60054)

Aetna Life Insurance Company (ALIC) was incorporated in Connecticut on June 14, 1853. In 1951, ALIC introduced major medical coverage. ALIC is licensed in all 50 states, the District of Columbia, Canada, Guam, Northern Mariana Islands, Puerto Rico, and Virgin Islands. All Aetna products are sold by licensed agents.

In 2015, based on the annual statements submitted for business in the state of Pennsylvania, ALIC had premiums written in the amount of \$16,440,818,014 for group accident and health and other individual contract(s) lines of business. In 2016, for business in the state of Pennsylvania, ALIC had premiums written in the amount of \$17,931,462,260 for group accident and health and other

individual contract(s) lines of business.

IV. COMPANY OPERATIONS AND MANAGEMENT

Examiners requested documentation relating to internal audit and compliance procedures. The audits and procedures were reviewed to assure best practices. Documents requested dealt with information technology protection, anti-fraud policies and procedures, disaster recovery plans, monitoring business functions, record retention policies and procedures, company management and governance, privacy protections and notices, and standards for handling non-public personal information. Unless noted, all documents identified in the universe by the Company were requested, received and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review.

A. Audits Conducted

Examiners requested a list of audits performed during the experience period. The Company identified a universe of 23 audits performed. In accordance with the requirements of the examination, the information provided by the Company was reviewed to ensure compliance with applicable state law using the guidelines set forth in Chapter 16, Section B, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Policies and Procedures for Information Technology Protection

Examiners requested documentation demonstrating that the Company had controls, safeguards and procedures for protecting the integrity of computer information in place during the experience period. The Company identified a universe of three documents, which were reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code Ch. 146a, 146b, 146c, using the guidelines set forth in Chapter 16, Section A, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Anti-Fraud Procedures

Examiners requested documentation demonstrating that the Company had anti-fraud initiatives in place during the experience period that were reasonably calculated to detect, prosecute and prevent fraudulent insurance acts. The Company identified a universe of three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with Page 11 of 101

applicable state laws and regulations using the guidelines set forth in Chapter 16, Section A, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

D. Disaster Recovery Plan and Procedures

Examiners requested documentation demonstrating that the Company had a valid disaster recovery plan in place during the experience period. The Company identified a universe of three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section A, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

E. Third-Party Agreements

Examiners requested copies of contracts between the Company and any third-party entity, including managing general agents, general agents, third-party administrators, and vendors that conducted activities on behalf of the Company during the experience period. The Company provided four vendor contracts including CVS Pharmacy (CVS), Express Scripts (ESI), Eye Med and Group Dental Service (GDS), which were used to process Pharmacy, Prescription Drug Program, Pediatric Vision and Group Dental benefits. In accordance with the requirements of the examination, the contracts were reviewed to ensure compliance with state and federal laws and regulations, including 45 C.F.R. § 156.340, using the guidelines set forth in Chapter 16, Section A, Standard 5 of the NAIC Market Regulation Handbook. The Company explained that it conducts on-site external audits with all vendors to ensure compliance with contract provisions and state requirements. The Company supplied examples of audits conducted on two vendors, CVS and Eye Med. The audits demonstrated the comprehensive and detailed oversight the Company conducts on vendors with delegated services. It was further noted that GDS is an Aetna affiliate; all employees of GDS are Aetna employees, and no delegated audits are deemed necessary by the Company. Additionally, the Company represented the same type of oversight conducted for CVS was also exercised for ESI. No violations were noted.

F. Contracted-Entity Activity Monitoring

Examiners requested documentation demonstrating that the Company adequately monitored the

activities of entities that contractually assumed a business function or acted on behalf of the Company during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. § 156.340, using the guidelines set forth in Chapter 16, Section A, Standard 6 of the *NAIC Market Regulation Handbook*. No violations were noted.

G. Record Retention

Examiners requested copies of the records retention policies and procedures for assurance that Company records are adequate, accessible, consistent and orderly, and comply with state retention requirements for the experience period. The Company identified a universe of three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section A, Standard 7 of the *NAIC Market Regulation Handbook*. No violations were noted.

H. Written Overview of Operations

Examiners requested a written overview of the Company's operations including management structure, type of carrier, states where the Company is licensed and the major lines of business the Company had written for the experience period, including information if a regional office handled any portion of the Pennsylvania business. The Company identified a universe of 12 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code §§ 152.3 and 301.42, using the guidelines set forth in Chapter 16, Section A, Standard 8 of the *NAIC Market Regulation Handbook*. No violations were noted.

I. Response Requests

Examiners requested documentation demonstrating that the Company recognized it was required to respond to requests from the examiners in a timely manner during the experience period. The Company identified a universe of three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code §§ 152.3 and 301.42, using the guidelines set forth in Chapter

16, Section A, Standard 9 of the *NAIC Market Regulation Handbook*. In addition to the review of policies and procedures, the Department analyzed the Company's timeliness of responses for items requested by the Department during the market conduct examination. One general data integrity violation was noted for the Company's failure to provide timely access to all requests made by the Department during the course of the examination. In addition to the data integrity violation, the following violation was noted:

1 Violation – 31 Pa. Code §§ 152.20 and 301.82

The Commissioner and the Secretary may investigate a preferred provider organization in order to determine whether it is complying with this chapter. The Commissioner or an agent shall have free access to the books, records, papers and documents that relate to the business of the HMO. The Company provided policies and procedures for the Regulatory Compliance Unit on examination management. Examiners noted, however, that during the course of the examination, the Company requested numerous extensions or failed to provide requested documentation in a timely manner.

J. Privacy Policies and Procedures

Examiners requested documentation demonstrating that the Company assured that the collection, use and disclosure of information gathered in connection with insurance transactions was performed in a manner that minimizes any improper intrusion into the privacy of applicants and policyholders during the experience period. The Company identified a universe of 16 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code Ch. 146a, 146b, 146c, using the guidelines set forth in Chapter 16, Section A, Standard 10 of the *NAIC Market Regulation Handbook*. No violations were noted.

K. Insurance Information Security

Examiners requested documentation demonstrating that the Company developed and implemented written policies, standards and procedures for the management of insurance information for the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state laws and regulations, including and 31 Pa. Code Ch. 146a, 146b, 146c, using the guidelines

set forth in Chapter 16, Section A, Standard 11 of the *NAIC Market Regulation Handbook*. No violations were noted.

L. Security Protection of Non-Public Information

Examiners requested documentation indicating that, for the experience period, the Company had policies and procedures in place to protect the privacy of non-public personal information relating to its customers, former customers, and consumers that were not customers. The Company identified a universe of nine documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code Ch. 146a, 146b, and 146c, using the guidelines set forth in Chapter 16, Section A, Standard 12 of the *NAIC Market Regulation Handbook*. No violations were noted.

M. Privacy Notices

Examiners requested documentation demonstrating that the Company provided privacy notices to its customers and, if applicable, to its consumers who are not customers regarding treatment of non-public personal financial information. The Company identified a universe of five documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code Ch. 146a, 146b, and 146c, using the guidelines set forth in Chapter 16, Section A, Standard 13 of the *NAIC Market Regulation Handbook*. No violations were noted.

N. Opt-Out Notices

Examiners requested documentation demonstrating that the Company disclosed information subject to an opt-out right, that the Company had policies and procedures in place so that non-public personal financial information would not be disclosed when a consumer who was not a customer had opted out, and that the Company provided opt-out notices to its customers and other affected consumers during the experience period. The Company identified a universe of five documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code Ch. 146a, using the guidelines set forth in Chapter 16, Section A, Standard 14 of the *NAIC Market Regulation Handbook*. No violations were noted.

O. Non-Public Personal Financial Information

Examiners requested documentation demonstrating that the Company's collection, use and disclosure of non-public personal financial information were in compliance with policy provisions, and state and federal laws and regulations applicable during the experience period. The Company identified a universe of two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code Ch. 146a, using the guidelines set forth in Chapter 16, Section A, Standard 15 of the *NAIC Market Regulation Handbook*. No violations were noted.

P. Non-Public Personal Health Information Disclosure

Examiners requested documentation that the Company had policies and procedures in place during the experience period so that non-public personal health information would not be disclosed, except as permitted by law, unless a customer or a consumer who is not a customer has authorized the disclosure. The Company identified a universe of nine documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code Ch. 146a and 146b, using the guidelines set forth in Chapter 16, Section A, Standard 16 of the *NAIC Market Regulation Handbook*. No violations were noted.

Q. Written Information Security Program

Examiners requested documentation demonstrating that, during the experience period, the Company implemented a comprehensive written information security program for the protection of non-public customer information. The Company provided a copy of the Company's Security Policies document for review by the examiners. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code Ch. 146c, using the guidelines set forth in Chapter 16, Section A, Standard 17 of the *NAIC Market Regulation Handbook*. No violations were noted.

R. Data Submission to Regulator – Policies and Procedures

Examiners requested documentation demonstrating that the Company's data that was required to be reported to the Pennsylvania Insurance Department were complete and accurate for the Page 16 of 101

experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state laws and regulations, including 40 P.S. § 1171.5(a)(5) and 31 Pa. Code §§ 146.1 et seq., using standards set forth in Chapter 16, Section A, Standard 18 of the *NAIC Market Regulation Handbook*. Examiners also analyzed the Company's timeliness and completeness of responses for items requested by the Department. As noted above, one general data integrity violation was noted for the Company's failure to submit complete responses in a timely manner and failure to provide timely access to data and documentation for all requests made by the Department during the course of the examination.

S. Management of Compliance Division

Examiners requested a description of the management structure of the Company as it relates to Major Medical Health insurance, including the management structure that handled compliance issues during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code §§ 152.3 and 301.42. No violations were noted.

T. External Audits and Examinations

Examiners requested a list of all examination fines, penalties, and recommendations from any state for the last five years, as well as copies of all Financial and Market Conduct Examination reports issued during the last five years. The Company identified a universe of six documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

U. Annual Statements and Related Schedules

Examiners requested copies of the annual statements for the prior three years and any Accident and Health related schedules or statements for the experience period. The Company identified a universe of 54 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations. No violations were noted.

V. CONSUMER COMPLAINTS

Examiners requested documentation relating to consumer complaints. Unless noted, all documents identified in the universe by the Company were requested, received, and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with 40 P.S. §§ 1171.5, and 991.2141 through 991.2143, as well as 42 U.S.C. § 300gg-19 and 45 C.F.R. § 147.136.

A. Complaint Handling

Examiners requested all consumer complaints and copies of consumer complaint logs for the experience period. The Company provided all requested materials including the complaint handling policies and procedures and the complaint log. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 16, Section B, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Complaint Handling Procedures

Examiners requested documentation demonstrating that the Company had adequate complaint handling procedures in place and communicated such procedures to policyholders. The Company identified a universe of three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. § 156.1010, using the guidelines set forth in Chapter 16, Section B, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Complaint Resolution

Examiners requested documentation demonstrating that the Company took adequate steps to finalize and resolve complaints in accordance with contract language, and state and federal laws and regulations applicable during the experience period. The Company identified a universe of 12 documents. In accordance with the requirements of the examination, the documents were reviewed

to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 16, Section B, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

D. Complaint Response Time

Examiners requested documentation demonstrating that the timeframe within which the Company responded to complaints during the experience period was in accordance with applicable state and federal laws and regulations. The Company identified a universe of 12 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 16, Section B, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

E. Complaint Disposal

Examiners requested documentation demonstrating that the Company took adequate steps to finalize and dispose of complaints in accordance with policy provisions, and state and federal laws and regulations applicable during the experience period. The Company provided 12 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 16, Section B, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

F. Definition of Complaint

Examiners requested documentation regarding complaint handling policies, including the Company's definition of what constitutes a complaint. The Company provided 12 documents. In accordance with requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations. No violations were noted.

G. Complaint Summaries

The Company was asked to describe the complaint reports and summaries prepared on a recurring basis and identify the recipients of those reports. The Company identified a universe of 12 Page 19 of 101

documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations. No violations were noted.

H. Pennsylvania Insurance Department Complaints

Examiners requested that the Company identify all complaints received from the Insurance Department during the experience period. The Company identified 158 consumer complaints received during the experience period. A random sample of 50 complaint files was requested. The documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 31 Pa. Code § 146.5. The following substantive violations of state law were noted in the universe of complaints to the Insurance Department:

1 Violation – 40 P.S. § 753(B)(8)

The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to his last address as shown by the records of the insurer, stating when, not less than five days thereafter such cancellation shall be effective; and after the policy has been continued beyond its original term, the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro-rata. The Company failed to retain records to demonstrate prompt notification to the member of the policy cancellation.

2 Violations – 45 C.F.R. § 155.310(e)

The Exchange must determine eligibility promptly and without undue delay. The Exchange must assess the timeliness of eligibility determinations based on the period from the date of application or transfer from an agency administering an insurance affordability program to the date the Exchange notifies the applicant of its decision or the date the Exchange transfers the application

to another agency administering an insurance affordability program, when applicable. The Company failed to promptly notify the members of the eligibility determination.

VI. PRODUCER LICENSING

Examiners requested documentation relating to producer licensing. Unless noted, all documents identified in the universe by the Company were requested, received and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with the Producer Licensing Act, 40 P.S. §§ 310.1 et seq.

A. Active Producers

Examiners requested a list of all producers active during the experience period. The Company identified a universe of 62,035 active producers during the experience period. A random sample of 50 producers was selected, and a subsample of 20 producers from the new business underwriting sample, were reviewed. The records were compared to Department records of producers to verify appointments, terminations, and licensing, as well as the Federally-facilitated Marketplace Registration Status List. In accordance with the requirements of the examination, the records were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. § 310.71(f), 31 Pa. Code §§ 152.20 and 301.82, and 45 C.F.R. §155.220, using the guidelines set forth in Chapter 16, Section D, Standard 1 of the *NAIC Market Regulation Handbook*,. No violations were noted.

B. Account Balances Policies and Procedures

Examiners requested policies and procedures requiring that producer contracts' account balances were in accordance with producer contracts for the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section D, Standard 6 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Description of Agency System

Examiners requested a description of the type of agency system utilized by the Company during the experience period, e.g., independent, direct or exclusive. The Company responded that the type

of agency system utilized for their group sponsored business is an independent agency. The direct to consumer system is used for the Company's Individual business. No violations were noted.

D. Licensing and Appointment Verification

Examiners requested a description of how the Company verified that all business accepted from producers was written by individuals who were duly licensed and appointed to represent the Company during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state laws and regulations using standards set forth in Chapter 16, Section D, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

VII. POLICYHOLDER SERVICES

Examiners requested documentation relating to policyholder services. Specifically, the documents were reviewed to ensure policyholder service guidelines were in place and being followed in a uniform and consistent manner, and that no policyholder service practices or procedures were in place that could be considered discriminatory in nature, or specifically prohibited by statute or regulation. Unless noted, all documents identified in the universe by the Company were requested, received and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with 40 P.S. §§ 477a, 753, 761, 991.2152, and 1171.5; 42 U.S.C. § 300gg-4(a); and 45 C.F.R. §§ 146.121, 147.110, and 155.430.

A. Collection and Billing Practices

Examiners requested policies and procedures used for collection/billing practices describing requirements for issuances of notices with required advance notice. The Company identified a universe of eight documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section E, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Timely Issuance and Insured-Requested Cancellations

Examiners requested documentation describing requirements for timely policy issuance, insured-requested cancellations, and all correspondence directed to the Company during the experience period. The Company identified a universe of seven documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section E, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Department Correspondence

Examiners requested documentation describing the requirements for timely and responsive Page 24 of 101

answers by appropriate Company departments to all correspondence directed to the Company during the experience period. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section E, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

D. Assumption Reinsurance Agreements

Examiners requested documentation demonstrating that, whenever the Company transferred the obligation of its contracts to another regulated entity pursuant to an assumption reinsurance agreement during the experience period, the Company had sent required notices to affected policyholders. The Company did not identify any pertinent documents and stated "the Company had no such arrangements in place during the examination timeframe. While the Company has no written policy, the PID has created "Guidelines" to be followed in the event of a withdrawal or transition [and] that the Company follows [those Guidelines]." Chapter 16, Section E, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

E. Individual Policy Additions

Examiners requested a list of individual policy addition requests received during the experience period to verify that policy transactions are processed accurately and completely. The Company identified a universe of 209 transactions. A random sample of 25 transaction files was requested. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, including 40 P.S. §§ 477a and 761, 42 U.S.C. § 300gg-4(a), and 45 C.F.R. §§ 146.121 and 147.110, using the guidelines set forth in Chapter 16, Section E, Standard 5 of the *NAIC Market Regulation Handbook*, and. No violations were noted.

F. Individual Drops

The Company was asked to provide a list of all dropped policy transactions during the experience period to verify that policy issuance and insured-requested cancellations were timely. The Company identified a universe of 243 dropped transactions. A random sample of 25 transaction files was requested. In accordance with the requirements of the examination, the files were

reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 477a and 761; 42 U.S.C. § 300gg-4(a)(1), and 45 C.F.R. §§ 146.121 and 147.110, using the guidelines set forth in Chapter 16, Section E, Standard 5 of the *NAIC Market Regulation Handbook*. No violations were noted.

G. Individual ID Changes

Examiners requested a list of all Individual ID Change transactions for the experience period to verify that policy transactions were processed accurately and completely. The Company identified a universe of 4,345 Individual ID Change transactions. A sample of 25 transaction files was requested. In accordance with the requirements of the examination, the files were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 16, Section E, Standard 5 of the *NAIC Market Regulation Handbook*. No violations were noted.

H. Premium Refunds

Examiners requested a list of policies for which premium refunds were issued during the experience period to verify that unearned premiums were correctly calculated and returned to the appropriate party in a timely manner and in accordance with policy provisions and applicable state and federal laws and regulations. The Company identified a universe of 1,494 refund transactions. A random sample of 60 files was requested. In accordance with the requirements of the examination, the files were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. § 753(B)(8), using the guidelines set forth in Chapter 16, Section E, Standard 7 of the *NAIC Market Regulation Handbook*. No violations were noted.

I. Reinstatement Policies and Procedures

Examiners requested documentation demonstrating how the Company monitored and assured that reinstatement was applied consistently and in accordance with policy provisions. The Company identified a universe of 17 documents. The Company subsequently located and provided one additional document specifically for the purpose of explaining reinstatement and how it was applied consistently and in accordance with policy provisions. In accordance with the requirements of the examination, all 18 documents were reviewed to ensure compliance applicable

state laws and regulations, including 40 P.S. § 753(A)(4), using guidelines set forth in Chapter 16, Section E, Standard 5 of the *NAIC Market Regulation Handbook*. No violations were noted.

J. Unearned Premium and Refunds

Examiners requested documentation demonstrating how the Company handled unearned premium calculation and refunds during the experience period. The Company identified a universe of five documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section E, Standard 7 of the *NAIC Market Regulation Handbook*. No violations were noted.

K. Premium and Billing Notices

Examiners requested a sample of premium and billing notices used during the experience period. The Company identified a universe of 19 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 16, Section E, Standard 1 of the *NAIC Market Regulation Handbook*. Examiners noted that the Company's Policyholder Services policies and procedures were easily accessed by Examiners. No violations were noted.

L. Cancellations and Non-Renewals

Examiners requested a list of cancellations and non-renewals for the experience period to verify that policy issuance and insured-requested cancellations were processed timely. The Company identified a universe of 2,684 cancellation and non-renewal transactions. A random sample of 114 files was requested. In accordance with the requirements of the examination, the policies were reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. § 155.430, using guidelines set forth in Chapter 16, Section E, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

M. Reinstatements

Examiners requested a list of reinstatements requested during the experience period. The Company identified a universe of 2,518 reinstatement transactions. A random sample of 70 files was

requested. In accordance with the requirements of the examination, the files were reviewed to ensure compliance with applicable state and federal laws and regulations. No violations were noted.

VIII. UNDERWRITING AND RATING

Examiners requested documentation relating to underwriting and rating. Specifically, the documents were reviewed to ensure underwriting and rating guidelines were in place and being followed in a uniform and consistent manner, and that no underwriting practices or procedures were in place that could be considered discriminatory in nature, or specifically prohibited by statute or regulation. Unless noted, all documents identified in the universe by the Company were requested, received and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with 40 P.S. §§ 3801.301 et seq., as well as 42 U.S.C. § 300gg and 45 C.F.R. § 147.102.

A. Rating Schedules

Examiners requested rating schedules for Affordable Care Act Major Medical Health Individual, Small Group and Large Group plans effective during the experience period. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 16, Section F, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Mandated Disclosures

Examiners requested documentation demonstrating how the Company assured that all mandated disclosures were issued in accordance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using guidelines set forth in Chapter 16, Section F, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Prohibition of Illegal Rebating

Examiners requested documentation demonstrating how the Company assured that it did not permit illegal rebating, commission cutting or inducements during the experience period. The

Company identified a universe of two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 310.45, 310.46, and 471, using the guidelines set forth in Chapter 16, Section F, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

D. Underwriting Practices

Examiners requested documentation demonstrating that the Company's underwriting practices were not unfairly discriminatory and that the Company adhered to state and federal laws and regulations applicable during the experience period. Examiners also reviewed Company guidelines relating to the selection of risks. The Company identified a universe of 43 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. §§ 146.121 and 147.110, using the guidelines set forth in Chapter 16, Section F, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

E. Form Filing

Examiners requested documentation establishing the Company's processes to assure that all forms, including policies, contracts, riders, amendments, endorsement forms and certificates, were filed with the Department for the experience period. The Company provided 105 sample forms of individual, small group, and large group filings. Of the 105 sample forms provided, 12 forms (individual market) were selected and reviewed to ensure compliance with applicable state and federal laws and regulations, including 31 Pa. Code §§ 152.3 and 301.42, using the guidelines set forth in Chapter 16, Section F, Standard 5 of the *NAIC Market Regulation Handbook*. No violations were noted.

F. Issue and Renewal

Examiners requested documentation demonstrating that policies, contracts, riders, amendments and endorsements were issued or renewed accurately, timely and completely during the experience period. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and

federal laws and regulations, including 45 C.F.R. §§ 147.104 and 147.106, using the guidelines set forth in Chapter 16, Section F, Standard 6 of the *NAIC Market Regulation Handbook*. No violations were noted.

G. Policy Rejections and Declinations

Examiners requested documentation demonstrating the Company's rejections and declinations during the experience period were not unfairly discriminatory. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. §§ 146.121 and 147.110, using the guidelines set forth in Chapter 16, Section F, Standard 7 of the *NAIC Market Regulation Handbook*. No violations were noted.

Examiners requested a list of all declinations issued during the experience period. The Company identified a universe of 17 declination transactions. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with 42 U.S.C. § 300gg-4(a)(1), and 45 C.F.R. §§ 146.121 and 147.110. No violations were noted.

H. Cancellation Notices

Examiners requested documentation demonstrating that cancellation/nonrenewal, discontinuance and declination notices complied with policy and contract provisions, Company guidelines, and state and federal laws and regulations applicable during the experience period. The Company identified a universe of two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. § 155.230, using the guidelines set forth in Chapter 16, Section F, Standard 8 of the *NAIC Market Regulation Handbook*. No violations were noted.

I. Rescissions

Examiners requested documentation demonstrating that rescissions were not made for non-material misrepresentation during the experience period. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. § 147.128, using the guidelines set forth in Chapter 16, Section F, Standard 9 of the

NAIC Market Regulation Handbook. No violations were noted.

J. Cancellation Practices

Examiners requested documentation demonstrating that cancellation practices complied with policy provisions, and state and federal laws and regulations applicable during the experience period. The Company identified a universe of two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. § 147.128, using the guidelines set forth in Chapter 20, Section F, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

K. Information on Policy Forms

Examiners requested documentation demonstrating that pertinent information on applications that formed a part of the policy in use during the experience period were complete and accurate. The Company provided one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with state and federal laws and regulations, including 40 P.S. § 753(A), using the guidelines set forth in Chapter 20, Section F, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

L. COBRA and Mini-COBRA

Examiners requested documentation demonstrating that the Company complied with the provisions of COBRA and/or continuation of benefits procedures contained in policy forms and state and federal laws and regulations applicable during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. § 764j, as well as 29 U.S.C. §§ 1161 et seq., using the guidelines set forth in Chapter 20, Section F, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

M. Genetic Information Nondiscrimination Act Compliance

Examiners requested documentation demonstrating that the Company complied with the Genetic

Information Nondiscrimination Act of 2008 and Pennsylvania law. The Company identified a universe of three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 908-11 et seq., as well as 45 C.F.R. §§ 146.121 and 146.122, using the guidelines set forth in Chapter 20, Section F, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

N. Health Information Protection

Examiners requested documentation demonstrating that the Company complied with proper use and protection of health information in accordance with state laws and regulations applicable during the experience period. The Company identified a universe of seven documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 31 Pa. Code Ch. 146b, using the guidelines set forth in Chapter 20, Section F, Standard 5 of the *NAIC Market Regulation Handbook*. No violations were noted.

O. Pre-existing Conditions

Examiners requested documentation demonstrating that the Company complied with state and federal laws and regulations regarding limits on the use of pre-existing exclusions during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. §§ 146.111 and 147.108, using the guidelines set forth in Chapter 20, Section F, Standard 6 and Chapter 20A, Prohibitions on Preexisting Condition Exclusions for Individuals under 19 Years of Age, Standards 1 and 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

P. Coverage Discrimination Based on Health Status

Examiners requested documentation demonstrating that the Company did not improperly deny coverage or discriminate based on health status in the group market or against eligible individuals in the individual market in conflict with the requirements of state and federal laws and regulations applicable during the experience period. The Company identified a universe of one document. In

accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 908-11 et seq., as well as 45 C.F.R. §§ 146.121 and 147.110, using the guidelines set forth in Chapter 20, Section F, Standard 7 of the *NAIC Market Regulation Handbook*. No violations were noted.

Q. Compliance with Guaranteed Issuance

Examiners requested documentation demonstrating that the Company issued coverage that complied with the guaranteed-issue requirements of state and federal laws and regulations applicable during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 1302.1 et seq., as well as 42 U.S.C. § 300gg-1 and 45 C.F.R. § 147.104, using the guidelines set forth in Chapter 20, Section F, Standard 8 and Chapter 20A, Guaranteed Availability of Coverage, Standards 1 and 2, of the *NAIC Market Regulation Handbook*. No violations were noted.

R. Individual Portability

Examiners requested documentation demonstrating that the Company, when issuing individual insurance coverage to eligible individuals, entitled enrollees to portability under the provisions of federal laws and regulations and in compliance with state laws and regulations applicable during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. § 147.104, using the guidelines set forth in Chapter 20, Section F, Standard 9, and Chapter 20A, Guaranteed Availability of Coverage of the *NAIC Market Regulation Handbook*. No violations were noted.

S. Clinical Trials

Examiners requested documentation demonstrating that the Company did not deny or restrict coverage for qualified individuals, as defined in state and federal laws and regulations, who participated in approved clinical trials during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations,

including 42 U.S.C. § 300gg-8, using the guidelines set forth in Chapter 20A, Coverage for Individuals Participating in Approved Clinical Trials, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

T. Dependent Coverage

Examiners requested documentation demonstrating that the Company made available dependent coverage for children until attainment of 26 years of age during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations, including 42 U.S.C. § 300gg-14, and 45 C.F.R. § 147.120, using the guidelines set forth in Chapter 20A, Extension of Dependent Coverage to Age 26, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

U. Group Health Plan Renewability

Examiners requested documentation demonstrating that, during the experience period, the Company renewed or continued in force coverage, at the option of the policyholder, in accord with final regulations established by the United States Department of Labor (DOL), the United States Department of Health and Human Services (HHS), and the United States Department of the Treasury (Treasury). The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. § 147.106, using the guidelines set forth in Chapter 20A, Guaranteed Renewability of Coverage, Standards 1 and 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

V. Lifetime Limits

Examiners requested documentation demonstrating that the Company did not establish lifetime or annual limits on the dollar amount of essential health benefits (EHBs) for any individual, in accordance with the final regulations established by HHS, DOL, and Treasury during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations, including 42 U.S.C. § 300gg-11 and 45 C.F.R. § 147.126,

using the guidelines set forth in Chapter 20A, Lifetime/Annual Benefits Limits, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

W. Cost Sharing Requirements

Examiners requested documentation demonstrating that, during the experience period, the Company did not impose cost-sharing requirements upon preventive services, as defined in, and in accordance with, final regulations established by HHS, DOL, and Treasury. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations, including 42 U.S.C. § 300gg-13 and 45 C.F.R. § 147.130, using the guidelines set forth in Chapter 20A, Preventive Health Services, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

X. Rescissions

Examiners requested documentation demonstrating that the Company did not retrospectively rescind coverage unless the individual (or a person seeking coverage on behalf of the individual) performed an act, practice or omission that constitutes fraud, or made an intentional misrepresentation of material fact during the experience period. The Company identified a universe of three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. § 147.128, using the guidelines set forth in Chapter 20A, Rescissions, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

Y. 30-Day Notice

Examiners requested documentation that showed that, before coverage was rescinded during the experience period, the Company provided at least 30 days' advance written notice to each plan enrollee (or, in the individual market, primary subscriber) who would be affected. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. § 147.128, using the guidelines set forth in Chapter 20A, Rescissions, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

Z. Group New Business Policies

Examiners requested a list of group new business policies issued during the experience period. The Company identified a universe of 1,978 small and large group policies. A random sample of 113 underwriting files was requested. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 908-11 et seq. and 3801.310; 42 U.S.C. §§ 300gg-1, 300gg-3(a) and (d), 300gg-4, 300gg-7, 300gg-26, and 300gg-53; 45 C.F.R. §§ 146.111, 146.121, 146.122, 147.104, 147.108, 147.110, and 147.116. The following violation and concern were noted:

1 Violation – 40 P.S. § 3801.310

Upon request, the Department shall be provided a copy of any form being issued in this Commonwealth. Insurers shall maintain complete and accurate specimen or actual copies of all forms which are issued to Pennsylvania residents, including copies of all applications, certificates and endorsements used with policies. Retention of the forms may be kept on diskette, microfiche or any other electronic method. Specimen copies shall also indicate the date the form was first issued in this Commonwealth. The records shall be maintained until at least two years after a claim can no longer be reported under the form. The Company failed to provide policy issue records including the original rate approval form.

Concern: The Company was unable to provide one of the requested files' group applications. Examiners were unable to review the application for compliance with 40 P.S. §§ 908-11 et seq. and 3801.310; 42 U.S.C. §§ 300gg-1, 300gg-3, 300gg-4, 300gg-7, 300gg-26, and 300gg-53; and 45 C.F.R. §§ 146.121, 147.104, 147.108, 147.110, 146.111, 147.116, and 146.122.

AA. Individual New Business Policies

Examiners requested a list of all individual new business policies issued during the experience period. The Company identified a universe of 63,015 individual new business policies. A random sample of 116 new business underwriting files was requested. Of the 116 new business underwriting files provided, 20 files were not considered new business. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws, including 40 P.S. §§ 908-11 et seq., 3801.310; 31 Pa. Code §§

152.15 and 301.62(c); 42 U.S.C. §§ 300gg-1, 300gg-3, 300gg-4, 300gg-7, 300gg-26, 300gg-53; and 45 C.F.R. §§ 146.111, 146.121, 146.122, 147.104, 147.108, 147.110, and 147.116. No violations were noted.

BB. Terminations

Examiners requested a list of on- and off-exchange terminations during the experience period. The Company identified a universe of 24,701 terminations. A random sample of 10 on-exchange and 10 off-exchange termination transactions were requested. Of the 20 sample files selected for review, two files were not terminations. In accordance with the requirements of the examination, the files were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. § 753(B)(8); and 45 C.F.R. § 156.270. No violations were noted.

CC. Formulary

Examiners requested all commercial formularies utilized during the experience period. The Company identified 14 formularies applicable to the experience period: six formulary designs during the 2015 benefit period and eight formulary designs during the 2016 benefit period. In accordance with the requirements of the examination, all 14 formularies were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 477a, 761, and 1171.5; 42 U.S.C. §§ 300gg-4(a) and 18022; and 45 C.F.R §§ 147.104, 147.150 and 156.125. The following violations and concern were noted:

2 Violations – 40 P.S. §§ 477a, 761, & 1171.5(a)(7)(ii); 42 U.S.C. §300gg-4(a); and 45 C.F.R. §§ 147.104(e) & 156.125

An issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. While the Department did not see evidence of discriminatory intent, it did appear that the formulary benefit package the Company designed nevertheless resulted in discrimination against certain individuals based on health status, medical/health condition, and degree of medical dependency. The potentially discriminatory benefit design may have also discouraged certain individuals from participation in the plan.

Concern: Examiners have concerns regarding the practices of (1) failing to place widely used and preferred drug agents intended for treatment on Tier 1 and 2: and (2) placing an excessive amount of drug agents that are clinically appropriate and considered preferred treatment on Tier 3 or Tier 4 Non-Preferred and Specialty Tiers, and (3) implementing stringent step therapy and reauthorization requirements. The specific therapeutic drug categories affected were Antipsychotics/Antimanic, Analgesics-Opioid, Antianxiety Agents, Anticonvulsants, Antidepressants, ADHD/Anti-Narcolepsy/Anti-Obesity/Anorexiants, Antidotes and Hypnotics. The Department is continuing to review this issue through other initiatives and more guidance will be forthcoming.

IX. CLAIMS PROCEDURES

Examiners requested documentation relating to claims procedures. Unless noted, all documents identified in the universe by the Company were requested, received and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documentation in this section was reviewed to ensure compliance with the Unfair Insurance Practices Act (40 P.S. § 1171.5), 31 Pa. Code Ch. 146.

A. Claimant Contact

Examiners requested documentation demonstrating that the initial contact with the claimant occurred within the required timeframe applicable during the experience period. The Company identified a universe of two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. § 155.230, using the guidelines set forth in Chapter 16, Section G, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Timely Investigations

Examiners requested documentation demonstrating that investigations were conducted timely during the experience period. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. §§ 147.136 and 156.1010, using the guidelines set forth in Chapter 16, Section G, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Timely Claims Resolution

Examiners requested documentation demonstrating that claims were resolved in a timely manner during the experience period. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. §§ 147.136 and 156.1010, using the guidelines set forth in Chapter 16, Section G, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

D. Claims Handling

Examiners requested a brief description of how claims were handled during the experience period from the date received through closure, including timeliness requirements. Further, examiners requested documentation demonstrating that claims were handled in accordance with policy provisions, and state and federal laws and regulations applicable during the experience period. The Company identified a universe of five documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations using guidelines set forth in Chapter 16, Section G, Standard 6 and Chapter 20, Section G, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

E. Claims Forms

Examiners requested documentation demonstrating that the Company's claims forms were appropriate for the type of product for which they were used during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section G, Standard 7 of the *NAIC Market Regulation Handbook*. No violations were noted.

F. Claim Reserves

Examiners requested documentation demonstrating files were reserved in accordance with the Company's established procedures during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section G, Standard 8 of the *NAIC Market Regulation Handbook*. No violations were noted.

G. Denied and Closed-without-Payment Claims

Examiners requested documentation demonstrating how denied and closed-without-payment claims were handled during the experience period in accordance with policy provisions and state and federal laws and regulations. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure

compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 16, Section G, Standard 8 of the *NAIC Market Regulation Handbook*. No violations were noted.

H. Cancelled Benefit Checks

Examiners requested documentation demonstrating that cancelled benefit checks and drafts from the experience period reflected appropriate claims handling practices. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state laws and regulations, using the guidelines set forth in Chapter 16, Section G, Standard 10 of the *NAIC Market Regulation Handbook*. No violations were noted.

I. Claims Closing Practices

Examiners requested documentation demonstrating that claims handling practices did not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than was due under the policy during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section G, Standard 11 of the *NAIC Market Regulation Handbook*. No violations were noted.

J. Claims Handling Practices

Examiners requested documentation demonstrating that claim files were handled in accordance with policy provisions, and state and federal laws and regulations applicable during the experience period. The Company identified a universe of six documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section G, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

K. Newborns' and Mother's Health Protection Act

Examiners requested documentation demonstrating that the Company complied with the

requirement of the federal Newborns' and Mothers' Health Protection Act of 1996 and the Pennsylvania Health Security Act. The Company identified a universe of five documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 1581 through 1584, as well as 42 U.S.C. § 300gg-25, using the guidelines set forth in Chapter 20, Section G, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

L. Compliance with Mental Health Parity and Addiction Equity Act

Examiners requested documentation demonstrating that the Company complied with the requirements of the federal Mental Health Parity and Addiction Equity Act of 2008 and the Pennsylvania Health Insurance Coverage Parity and Nondiscrimination Act. The Company identified a universe of two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 908-11 et seq., 42 U.S.C. § 300gg-26, and 45 C.F.R § 146.136, using standards set forth in Chapter 20, Section G, Standard 3 of the *NAIC Market Regulation Handbook*. Violations relating to compliance with mental health parity provisions were noted; however, those violations and concerns relating to the processing and payment of mental health and substance use disorder claims have been addressed in other sections of this report.

M. Women's Health and Cancer Rights Act of 1998

Examiners requested documentation demonstrating that group health plans complied with the requirements of the federal Women's Health and Cancer Rights Act of 1998 and corresponding state law during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 764d and 1571.5 and 42 U.S.C. §300gg-27, using the guidelines set forth in Chapter 20, Section G, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

N. Group Coverage Replacements

Examiners requested documentation demonstrating that the Company complied with state laws and regulations for group coverage replacement applicable during the experience period. The Company identified a universe of 10 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations, including 31 Pa. Code § 89.93, using the guidelines set forth in Chapter 20, Section G, Standard 5 of the *NAIC Market Regulation Handbook*. No violations were noted.

X. COMPLAINTS AND GRIEVANCES

Examiners requested documentation relating to complaints and grievances filed during the experience period. Unless noted, all documents identified in the universe by the Company were requested, received and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with 40 P.S. §§ 1171.5 and 991.2101 et seq., and 31 Pa. Code § 154.13, as well as 42 U.S.C. § 300gg-19 and 45 C.F.R. § 147.136, incorporating 29 C.F.R. § 2560.503-1.

A. Grievances

Examiners requested documentation demonstrating that the Company treated as a grievance any written complaint, or any oral complaint that involved an urgent care request, submitted by or on behalf of a covered person regarding: 1) the availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; 2) claims payment, handling or reimbursement for health care services; or 3) matters pertaining to the contractual relationship between a covered person and the health carrier during the experience period. The Company identified a universe of three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using guidelines set forth in Chapter 20, Section H, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Complaint and Grievance Procedures

Examiners requested documentation demonstrating that the Company documented, maintained, and reported complaints and grievances, and established and maintained complaint and grievance procedures in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of five documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using guidelines set forth in Chapter 20, Section H, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Grievance Procedure Disclosure

Examiners requested documentation demonstrating how the Company implemented complaint and grievance procedures and how these procedures were disclosed to covered persons in compliance with state and federal laws and regulations applicable during the experience period. Examiners requested copies of files showing the Company's complaint and grievance procedures, including all forms used to process grievances during the experience period, that were filed with the Department. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws using the guidelines set forth in Chapter 20, Section H, Standard 3 of the NAIC Market Regulation Handbook. No violations were noted.

D. First-Level Reviews of Grievances Involving Adverse Benefit Determinations

Examiners requested documentation demonstrating that the Company had procedures for and conducted first-level reviews of grievances involving adverse determinations in compliance with state and federal rules and regulations applicable during the experience period. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section H, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

E. Grievance Reviews Not Involving Adverse Determination

Examiners requested documentation demonstrating the Company had procedures for and conducted standard reviews of grievances not involving adverse determinations in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section H, Standard 5 of the *NAIC Market Regulation Handbook*. No violations were noted.

F. Second-Level Reviews of Complaints and Grievances

Examiners requested documentation demonstrating the Company had procedures for second-level

reviews of complaints and grievances, and that the Company conducted voluntary reviews of complaints and grievances in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws using the guidelines set forth in Chapter 20, Section H, Standard 6 of the *NAIC Market Regulation Handbook*. No violations were noted.

G. Expedited Review of Grievances

Examiners requested documentation demonstrating the Company had procedures for and conducted expedited reviews of grievances involving adverse determinations in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws using guidelines set forth in Chapter 20, Section H, Standard 7 and Chapter 20A, Grievance Procedures Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

H. Complaint and Grievance Procedures Comply with Federal Law

Examiners requested documentation demonstrating that the Company's complaint and grievance procedures were properly handled in accordance with policy provisions and federal laws and regulations applicable during the experience period. The Company identified a universe of three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable federal laws and regulations. No violations were noted.

Examiners also requested documentation demonstrating that the Company's grievance procedures were properly handled in accordance with federal laws and regulations requiring a health carrier to conduct first-level reviews of grievances involving adverse determinations in accordance with the final regulations promulgated under the Affordable Care Act (ACA) by HHS, DOL and Treasury. The Company identified a universe of three documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable federal laws and regulations using the guidelines set forth in Chapter 20A, Grievance Procedures, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

I. Expedited Reviews of Urgent Care Requests

Examiners requested documentation demonstrating that grievance procedures were properly handled in accordance with federal laws and regulations requiring a health carrier to conduct expedited reviews of urgent care requests for grievances involving adverse determinations and in compliance with the final regulations promulgated under the ACA by HHS, DOL, and Treasury. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws using guidelines set forth in Chapter 20, Section H, Standard 7 and Chapter 20A, Grievance Procedures Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

J. Appeals

Examiners requested all appeals received during the experience period. The Company identified a universe of 114 appeals received during the experience period. In accordance with the requirements of the examination, the appeals files were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in, Chapter 20A, Grievance Procedures Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

XI. NETWORK ADEQUACY

Examiners requested documentation relating to network adequacy. Unless noted, all documents identified in the universe by the Company were requested, received and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with 40 P.S. § 991.2111, 31 Pa. Code §§ 152.1 et seq. and 301.42, and 45 C.F.R. § 156.230.

A. Access Plan Filed

Examiners requested documentation demonstrating that the Company filed an access plan for each managed care plan that the Company offered in the state and filed updates whenever it made a material change to an existing managed care plan during the experience period. The Company must make the access plans available: 1) on its business premises; 2) to regulators; and 3) to interested parties, absent proprietary information, upon request. The Company identified a universe of documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section I, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Contract Forms Filed

Examiners requested documentation demonstrating that the Company filed all required contract forms and any material changes to a contract proposed for use with its participating providers and intermediaries during the experience period. The Company identified a universe of two documents. In accordance with the examination, the documents were reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 20, Section I, Standards 3, 5, 6, and 7 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Access to Emergency Services

Examiners requested documentation demonstrating that, during the experience period, the Company ensured covered persons had access to emergency services 24 hours per day, seven

days per week within its network and provided coverage for emergency services outside of its network, pursuant to state and federal laws and regulations applicable during the experience period. The Company identified a universe of six documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations, including 31 Pa. Code § 152.15 and 301.62(c), and 45 C.F.R. § 147.138, using the guidelines set forth in Chapter 20, Section I, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

D. Accrediting Certification

Examiners requested a copy of the Company's HHS-recognized accrediting entity certification. The Company provided a National Committee for Quality Assurance certificate of accreditation. In accordance with the requirements of the examination, the certificate was reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. § 156.275. No violations were noted.

E. Provider Directory

Examiners requested documentation demonstrating that the Company provided at enrollment a provider directory that listed all providers who participated in its network during the experience period and that it provided updates to its directory during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section I, Standard 8 of the *NAIC Market Regulation Handbook*. No violations were noted.

XII. PROVIDER CREDENTIALING

Examiners requested documentation relating to provider credentialing. Unless noted, all documents identified in the universe by the Company were requested, received and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with 40 P.S. § 991.2121, 28 Pa. Code § 9.761, and 45 C.F.R. § 156.275.

A. Credentialing and Re-credentialing Program

Examiners requested documentation demonstrating that the Company established and maintained a program for credentialing and re-credentialing in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section J, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Accrediting Verification

Examiners requested documentation demonstrating that the Company verified the credentials of health care professionals before entering into a contract with the health care professionals during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section J, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Primary Verification

Examiners requested documentation demonstrating that the Company obtained primary or secondary verification of the information required by state laws and regulations applicable during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with

applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section J, Standards 3 and 5 of the *NAIC Market Regulation Handbook*. No violations were noted.

D. Provider Notification of Changes in Status

Examiners requested documentation demonstrating that the Company required all participating providers to notify the Company's designated individual of any changes in the status of information that is required to be verified by the Company for the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 991.2117 and 1171.5; 31 Pa. Code §§ 154.15, 152.6 and 301.42, using the guidelines set forth in Chapter 20, Section J, Standard 6 of the *NAIC Market Regulation Handbook*. No violations were noted.

E. Provider Opportunity to Review

Examiners requested documentation demonstrating that the Company provided to health care professionals the opportunity to review and correct information submitted in support of their credentialing verification for the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section J, Standard 7 of the *NAIC Market Regulation Handbook*. No violations were noted.

F. Contractor Credentialing Monitoring

Examiners requested documentation demonstrating that the Company monitored the activities of any entity with which it contracted to perform credentialing functions and ensured the requirements of state laws and regulations applicable during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section J, Standard 8 of the *NAIC Market Regulation Handbook*. No violations were noted.

XIII. QUALITY ASSESSMENT AND IMPROVEMENT

Examiners requested documentation relating to quality assessment and improvement. Unless noted, all documents identified in the universe by the Company were requested, received and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with 42 U.S.C. § 18031 and 45 C.F.R. §§ 155.200(d) and 156.1105 et seq.

A. Quality Assessment

Examiners requested documentation demonstrating that the Company developed and maintained a quality assessment program in compliance with state and federal rules and regulations applicable during the experience period. The Company identified a universe of two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable federal laws and regulations using the guidelines set forth in Chapter 20, Section K, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Quality Assessment Filing

Examiners requested documentation demonstrating that the Company filed a written description of the quality assessment program in the prescribed format, which included a signed certification by a corporate officer of the Company that the filing met federal requirements applicable during the experience period. The Company identified a universe of two documents.

The Company also verified the following: for HAPA/HAPSA, regulatory reviews were performed in the Northeast Region. State regulatory reviews were performed in March 2015, PA Coventry Annual Status Report (included HealthAmerica, HealthAssurance and Coventry Cares); in April 2015, Pennsylvania HMO Annual QM Policy Listing Filing; and on a monthly basis, Pennsylvania QM Credentialing Policy Filings. In addition, UR license/accreditation filings and/or reports were submitted for the following states: Pennsylvania and West Virginia. The Company submitted a copy of the Annual Quality Assurance Report documenting it was reviewed and signed by the Chief Medical Officer along with members of the Board of Directors who are ultimately

responsible for its validity. 2015 QM Work Plan includes Commercial (including Exchanges), Medicare (including Special Needs Plans [SNPs]) and Medicaid Business. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable federal laws and regulations using the guidelines set forth in Chapter 20, Section K, Standard 2 of the *NAIC Market Regulation Handbook*. No violations were noted.

C. Quality Improvement Program

Examiners requested documentation demonstrating that the Company developed and maintained a quality improvement program in compliance with state and federal laws and regulations applicable during the experience period.

The Company's quality management improvement manual, titled HAPA-HASPA Quality Management Program, states, "The organization utilizes continuous quality improvement (CQI) techniques and tools to improve the quality and safety of clinical care and service delivered to members. This includes systematic and periodic follow-up on the effect of interventions which allows for correction of problems identified through internal surveillance, analysis of complaints or other mechanisms. Quality improvement is implemented through a cross functional team approach, as evidenced by multidisciplinary committees. Quality reports are used to monitor, communicate and compare key indicators. The QM Program is designed to comply with all applicable state laws and regulations and with Centers for Medicare & Medicaid Services (CMS) requirements. The QM department, in collaboration with the Medicare Compliance department and the Business Integrity Unit, monitors CMS/ Federal laws and regulations specific to quality. QM and business units are accountable for implementation of actions needed to assure compliance." The Company identified a universe of two documents. In accordance with the requirements of the examination, the documentation provided was reviewed to ensure compliance with applicable federal laws and regulations using the guidelines set forth in Chapter 20, Section K, Standard 3 of the NAIC Market Regulation Handbook. No violations were noted.

D. Reports to Appropriate Licensing Authority

Examiners requested documentation demonstrating that the Company reported to the appropriate licensing authority any persistent pattern of problematic care provided by a provider that was sufficient to cause the Company to terminate or suspend contractual arrangements with the

Page 54 of 101

provider during the experience period. The Company identified a universe of one document. In accordance with the requirements of the examination, the document was reviewed to ensure compliance with applicable federal laws and regulations using the guidelines set forth in Chapter 20, Section K, Standard 4 of *the NAIC Market Regulation Handbook*. No violations were noted.

E. Quality Assessment Program Communication

Examiners requested documentation that the Company documented and communicated information about its quality assessment improvement program and its quality improvement program to covered persons and providers. The Company identified a universe of two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable federal laws and regulations using the guidelines set forth in Chapter 20, Section K, Standard 5 of the *NAIC Market Regulation Handbook*. No violations were noted.

F. Annual Certification of Program

Examiners requested documentation demonstrating that the Company annually certified that its quality assessment and quality improvement program, along with the materials provided to providers and consumers, met federal requirements applicable during the experience period. The Company identified a universe of 19 documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable federal laws and regulations using the guidelines set forth in Chapter 20, Section K, Standard 6 of the *NAIC Market Regulation Handbook*. No violations were noted.

G. Quality Assessment and Improvement Entity Monitoring

Examiners requested documentation demonstrating that the Company monitored the activities of the entity with which it contracted to perform quality assessment or quality improvement functions and ensured they met federal requirements applicable during the experience period were met. The Company identified a universe of two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable federal laws and regulations using the guidelines set forth in Chapter 20, Section K, Standard 7 of the *NAIC Market Regulation Handbook*. No violations were noted.

XIV. UTILIZATION REVIEW

Examiners requested documentation relating to utilization review. Unless noted, all documents identified in the universe by the Company were requested, received and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with 40 P.S. §§ 991.2136, 991.2151, and 991.2152, as well as federal standards found at 45 C.F.R. § 156.275.

A. Utilization Review Program

Examiners requested documentation demonstrating that the Company established and maintained a utilization review program in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section L, Standard 1 of the *NAIC Market Regulation Handbook*. No violations were noted.

B. Annual Report

Examiners requested documentation demonstrating that the Company filed an annual summary report of its utilization review activities and maintained records of all benefit requests, claims and notices associated with utilization review and benefit determinations in accordance with state and federal laws and regulations applicable during the experience period. The Company provided four documents. The documents were reviewed to ensure compliance with applicable state and federal laws and regulations. No violations were noted.

C. Utilization Review Program Operation

Examiners requested documentation demonstrating the Company operated its utilization review program in accordance with state and federal laws and regulations applicable during the experience period. The Company provided four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with the applicable state and

federal laws and regulations, including 40 P.S. § 991.2152 and 45 C.F.R. § 147.136, using the guidelines set forth in Chapter 20, Section L, Standard 2 of the *NAIC Market Regulations Handbook*. No violations were noted.

D. Utilization Review Disclosure

Examiners requested documentation demonstrating the Company disclosed information about its utilization review and benefit determination procedures to covered persons or, if applicable, to the covered person's authorized representative, in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section L, Standard 3 of the *NAIC Market Regulation Handbook*. No violations were noted.

E. Timely Standard Utilization Review

Examiners requested documentation demonstrating that the Company made standard utilization review and benefit determinations in a timely manner and as required by state and federal laws and regulations applicable during the experience period. The Company identified a universe of two documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section L, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

F. Adverse Determination of Utilization Review

Examiners requested documentation demonstrating the Company provided written notice of adverse determinations of standard utilization review and benefit determinations in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section L, Standard 5 of the *NAIC Market Regulation Handbook*. No violations were noted.

G. Expedited Utilization Review and Benefit Determinations

Examiners requested documentation demonstrating that the Company conducted expedited utilization review and benefit determinations in a timely manner and in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of four documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section L, Standard 6 of the *NAIC Market Regulation Handbook*. No violations were noted.

H. Emergency Services Utilization Reviews

Examiners requested documentation demonstrating the Company conducted utilization reviews or made benefit determinations for emergency services in compliance with state and federal laws and regulations applicable during the experience period. The Company identified a universe of two documents. The documents were reviewed for compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20A, Utilization Review, Standard 4 of the *NAIC Market Regulation Handbook*. No violations were noted.

I. Monitoring Utilization Review Entity

Examiners requested documentation demonstrating that the Company monitored the activities of the utilization review organization or entity with which the Company contracted and ensured that the contracting organization complied with state and federal laws and regulations applicable during the experience period. The Company identified a universe of six documents. In accordance with the requirements of the examination, the documents were reviewed to ensure compliance with applicable state and federal laws and regulations using the guidelines set forth in Chapter 20, Section L, Standard 7 of the *NAIC Market Regulation Handbook*. No violations were noted.

XV. MARKETING AND SALES

Examiners requested documentation relating to marketing and sales. Unless noted, all documents identified in the universe by the Company were requested, received and reviewed by the examiners. In the event the initial documents provided by the Company did not provide enough information, examiners issued information requests, which resulted in additional documents that were included in the review. Documents provided pursuant to examiner requests under this section were reviewed to ensure compliance with 40 P.S. § 1171.5 and 31 Pa. Code §§ 51.4 and 51.5.

A. Advertising and Sales Materials

Examiners requested copies of the 2015 and 2016 Annual Statement Advertising Certificate of Compliance for each company being examined. Additionally, Examiners requested a list of all marketing and sales materials for the Company. The Company identified a universe of 578 pieces of marketing and sales material. A random sample of 50 pieces of marketing and sales material was requested. For each of the 50 sample files, a copy of the advertising file annotations and control sheets denoting the manner and extent of distribution was requested along with the form number of the contract advertised. The Company also provided three documents in response to the request for the 2015 and 2016 Annual Statement Advertising Certificate of Compliance for each company being examined. In accordance with the requirements of the examination, the sample files were reviewed to ensure compliance with applicable state laws and regulations using the guidelines set forth in Chapter 16, Section C, Standard 1 of the NAIC Market Regulation Handbook. The following violations were noted:

5 Violations – 31 Pa. Code § 51.5

A company required to file an annual statement which is now or which hereafter becomes subject to this chapter shall file with the Department with its Annual Statement a Certificate of Compliance executed by an authorized officer of the company wherein it is stated that to the best of his knowledge, information and belief the advertisements which were disseminated by the company during the preceding statement year complied or were made to comply in all respects with the provisions of the insurance laws and regulations of this Commonwealth. The Company failed to provide proof that the 2015 Annual Statement Advertising Certificate of Compliance was filed on behalf of Aetna Health Inc., Health America, Inc., Aetna Health Insurance Company and Health

Assurance PA, Inc. Additionally, the Company failed to provide proof that the 2016 Annual Statement Advertising Certificate of Compliance was filed on behalf of Health America, Inc.

1 Violation – 31 Pa. Code § 51.4

A company shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its individual contracts and typical printed, published or prepared advertisements of its blanket, franchise and group contracts hereafter disseminated in this or another state whether or not licensed in the other state. An advertisement included in this advertising file shall be annotated as to the manner and extent of distribution and the form number of the contract advertised. The Company failed to maintain the appropriate file documentation.

XVI. MEDICAL AND PHARMACY CLAIMS REVIEW

Examiners requested a list of all medical and pharmacy claims paid, denied, and partially paid during the experience period. The Company identified a universe of 9,326,788 medical and pharmacy claims. For each of the sections listed below, a random sample was requested, received and reviewed.

- A. Serious Mental Health Claims
- B. Habilitative Services Claims
- C. Midwifery Services Claims
- D. Pediatric Vision Claims
- E. Pediatric Dental Claims
- F. Mammography Claims
- G. Pharmacy Claims
- H. General Medical Claims
- I. Dental Anesthesia Claims
- J. Medical Food Claims
- K. Autism Spectrum Disorder Claims
- L. Emergency Room Claims
- M. Ambulance Transport Claims
- N. Substance Use Disorder and Chemical Recovery Claims
- O. Mental Health Claims
- P. Behavioral Health Claims
- Q. HIV/AIDS Claims
- R. Inpatient and Outpatient High Dosage Opioid Addiction Treatment Claims

In accordance with the requirements of the examination, all claims files were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 991.2166 and 1171.5; 31 Pa. Code §§ 146.3, 146.4, 146.5, 146.6, 146.7, and 154.18; 18 Pa. C.S. § 4117; 42 U.S.C. § 300gg-6, 300gg-13, and 18022; and 45 C.F.R. §§ 147.130, 147.150, and 156.110. Claims files were also reviewed to ensure compliance with topic-specific laws and regulations. To the extent unfair trade practice violations were identified across multiple types of claims, the Department determined that there was evidence of such frequency as to constitute a business practice.

A. Serious Mental Health Claims

Examiners requested a list of all serious mental health claims (as defined in 40 P.S. § 764g(a)(1)) received during the experience period. The Company identified a universe of 299,616 serious mental health claims. A random sample of 100 claim files was requested. In accordance with the requirements of the examination, the claims files were reviewed to ensure compliance with 40 P.S. §§ 477a, 761, 764g, and 1171.5; 31 Pa. Code Ch. 146 and 154; 45 CFR §§ 146.136 and 156.110. No violations were noted.

B. Habilitative Services Claims

Examiners requested a list of all habilitative service claims received during the experience period. The Company identified a universe of 155,902 habilitative service claims. A random sample of 150 claim files was requested. In accordance with the requirements of the examination, the claim files were reviewed to ensure compliance with applicable state and federal laws and regulations, including 45 C.F.R. § 147.150. No violations were noted.

C. Midwifery Services Claims

Examiners requested a list of all midwifery service claims received during the experience period. The Company identified a universe of 2,596 midwifery service claims. A random sample of 50 claim files was requested. In accordance with the requirements of the examination, the claim files were reviewed to ensure compliance with applicable state and federal laws and regulations. The following violations were noted:

4 Violations – 40 P.S. § 991.2166(a) and 31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim under subsection (d) submitted by a health care provider for services, within 45 days of the licensed insurer's or managed care plan's receipt of the claim from the health care provider. The four claims noted were not paid within 45 days of the licensed insurer's or managed care plan's receipt of the claim.

1 Violation – 40 P.S. § 991.2166(b) and 31 Pa. Code § 154.18(c)

If a licensed insurer or a managed care plan fails to remit payment as provided under subsection (a), interest at 10% per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer or managed care plan shall not be required to pay any interest calculated to be less than \$2. The interest due of \$2 or more on the one claim was not paid.

4 Violations – 40 P.S. § 1171.5(a)(10)(vi)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear. The Company improperly denied the claims noted when the Company's liability under the policy was reasonably clear. The Company later paid the overdue claims.

4 Violations – 31 Pa. Code § 154.18(d)

Claims paid by a licensed insurer or managed care plan are considered clean claims and are subject to the interest provisions of the act. If a paid claim is re-adjudicated by the licensed insurer or managed care plan, a new 45-day period for the prompt payment provision begins again at the time additional information prompting the re-adjudication is provided to the plan.

Additional moneys which are owed or paid to the health care provider are subject to the prompt payment provisions of the act and this chapter. The prompt payment requirement of the act also

applies to the uncontested portion of a contested claim. A contested claim is a claim for which required substantiating documentation for the entire claim has been supplied to the licensed insurer or managed care plan, but the licensed insurer or managed care plan has determined that it is not obligated to make payment. Uncontested claims were adjudicated then reprocessed after initial adjudication due to Company error. The delay in payment is subject to prompt pay requirements of state law and regulation.

D. Pediatric Vision Claims

Examiners requested a list of all pediatric vision claims paid and denied during the experience period. In accordance with the requirements of the examination, the claim files were reviewed to ensure compliance with applicable state and federal laws and regulations.

The Company identified a universe of 8,065 paid claims and 137 denied claims. A random sample of 50 paid claims and all denied claims were requested. The Company determined there were no reviewable denied pediatric vision claims available from the experience period. The paid claim files were reviewed, and no violations were noted.

E. Pediatric Dental Claims

Examiners requested a list of all pediatric dental claims received during the experience period. The Company identified a universe of 5,230 claims. A random sample of 50 claims was requested. In accordance with the requirements of the examination, the claim files were reviewed to ensure compliance with applicable state and federal laws and regulations. No violations were noted.

F. Mammography Claims

Examiners requested a list of all mammography claims received during the experience period. The Company identified a universe of 3,957 mammography claims. A random sample of 150 claims was requested. The claim files were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. § 764c. No violations were noted.

G. Pharmacy Claims

Examiners requested a list of all pharmacy claims received during the experience period. The Company identified a universe of 1,915,203 paid claims and a universe of 867,127 denied claims.

A random sample of 50 paid claims and 50 denied claims was requested. In accordance with the requirements of the examination, the claim files were reviewed to ensure compliance with applicable state and federal laws and regulations. No violations were noted.

H. General Medical Claims

Examiners requested a list of all medical claims received during the experience period. The Company identified a universe of 1,003,930 paid medical claims, a universe of 1,818,296 denied medical claims, and a universe of 1,016,766 partially paid medical claims. A random sample of 150 paid claims was requested in each section. In accordance with the requirements of the examination, the claim files were reviewed to ensure compliance with applicable state and federal laws and regulations. The examiners found the following violations:

3 Violations – 40 P.S. § 1171.5(a)(10)(vi)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear. For two of the violations noted, the Company improperly denied a portion of the claim when the liability under the policy should have been reasonably clear based on its agreement with the provider. For one of the violations noted, the Company incorrectly applied the coverage to the out-of-network benefit, when it should have been processed as in-network. In two cases, the Company was not prompt in their payment even though the liability under the policy should have been reasonably clear on the original claim submission date and based on its agreement with the provider. In a third case, the Company improperly applied the coverage to an out-of-network benefit, when it should have been processed as in-network, resulting in the Company not promptly paying the claim.

1 Violation – 40 P.S. § 991.2166(a) and 31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim under subsection (d) submitted by a health care provider for services, within 45 days of the licensed insurer's or managed care plan's receipt of the claim from the health care

provider. The one claim noted was not paid within 45 days of the licensed insurer's or managed care plan's receipt of the claim.

1 Violation – 40 P.S. § 991.2166(b) and 31 Pa. Code § 154.18(c)

If a licensed insurer or a managed care plan fails to remit payment as provided under subsection (a), interest at 10% per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer or managed care plan shall not be required to pay any interest calculated to be less than \$2. The interest due of \$2 or more on the one claim was not paid.

1 Violation – 31 Pa. Code § 146.5(a)

Failure to acknowledge pertinent communications. Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice. The Company failed to acknowledge the claim submitted by the claimant within 10 working days.

I. Dental Anesthesia Claims

Examiners requested a list of all dental anesthesia claims received during the experience period. The Company identified a universe of 429 paid claims, a universe of 527 denied claims, and a universe of 168 partially-paid claims. A random sample of 10 claim files was requested for each section. In accordance with the requirements of the examination, the claim files were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. § 3510.3. No violations were noted.

J. Medical Food Claims

Examiners requested a list of all medical food claims received during the experience period. The Company identified a universe of 2,414 paid claims, a universe of 1,027 denied claims, and a universe of 258 partially paid claims. A random sample of 10 claim files was requested for each

section. In accordance with the requirements of the examination, the claim files were reviewed to ensure compliance with 40 P.S. §§ 991.2166 and 1171.5, 31 Pa. Code §§ 146.7, 154.18, 42 U.S.C. § 18022, and 45 C.F.R. § 146, 147 and 156. The following violations and concern were noted:

1 Violation – 40 P.S. § 991.2166(a) and 31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim under subsection (d) submitted by a health care provider for services, within 45 days of the licensed insurer's or managed care plan's receipt of the claim from the health care provider. The claim noted was not paid within 45 days of the licensed insurer's or managed care plan's receipt of the claim.

1 Violation – 31 Pa. Code § 146.7(c)(1)

The following provisions govern acceptance or denial of a claim where additional time is needed to make a determination: If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the proof of loss giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the date of the initial notification and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation and state when a decision on the claim may be expected. The Company failed to send a written explanation within 15 working days after receipt giving the reason more time was needed.

Concern: The Company failed to fully disclose to the member within the Certificate of Coverage and/or Schedule of Benefits that coverage was available under the policy for infants and children for Amino acid-based elemental medical formula ordered by a physician as medically necessary and administered orally or enterally for food protein allergies, food protein-induced enterocolitis syndrome, eosinophilic disorders and short-bowel syndrome as mandated by 40 P.S. § 3904(b). Additionally, the Certificate of Coverage Limitations and Exclusions may have caused confusion for members relating to the coverage available for Amino acid-based elemental medical formula.

K. Autism Spectrum Disorder Claims

Examiners requested a list of all autism claims received during the experience period. The Company identified a universe of 39,861 paid claims, a universe of 3,358 denied claims, and 1,203

partially paid claims. A random sample of 10 claims was requested for each section. In accordance with the requirements of the examination, the files were reviewed to ensure compliance with 40 P.S. §§ 477a, 761, 764h, 908-11 et seq., and 1171.5; and 45 C.F.R § 146.136. The examiners found the following violations and concerns:

8 Violations – 40 P.S. §§ 477a, 761, and 1171.5(a)(7)(ii)

Unfair discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of life, health and accident insurance, covered by this act, or in the benefits payable thereon, or in any of the terms or conditions of such policy, or in any other manner whatsoever, is prohibited. Discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of insurance covered by this act, or in the benefits payable thereon, or in any of the terms or conditions of such policy, or in any other manner whatsoever, is prohibited. Unfairly discriminating by means of: Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy, fees or rates charged for any policy or contract of insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever. According to policy documents, the Company excludes coverage of Autism Spectrum Disorders unless the "child is diagnosed with Autism Spectrum Disorder with onset prior to age three." Members with a diagnosis of Asperger's Disorder, Childhood Disintegrative Disorder or Pervasive Developmental Disorder, Not Otherwise Specified are unfairly discriminated against and may not have coverage under the plan based on the noted policy provision and exclusion because they could have onset after age three. While the Department did not see evidence of discriminatory intent, the benefit design for the plans noted appeared to be discriminatory toward those insureds who may have relied on this policy language, especially when applied to services that have been found clinically effective for members with onset of the condition beyond the age of three. To the extent the Company demonstrated that, despite the noted policy language, the Company did not impose this limitation when adjudicating claims, the Department recognizes that this discrimination was unintentional.

2 Violations – 40 P.S. § 764h(a) and (b)

A health insurance policy or government program covered under this section shall provide to

covered individuals or recipients under 21 years of age coverage for the diagnostic assessment of autism spectrum disorders and for the treatment of autism spectrum disorders. Coverage provided under this section by an insurer shall be subject to a maximum benefit of \$36,000 per year (as adjusted) but shall not be subject to any limits on the number of visits to an autism service provider for treatment of autism spectrum disorders. The Company failed to provide coverage without limits for the assessment and treatment of Autism Spectrum Disorders.

8 Violations – 40 P.S. \S 764h(a) and (f)(3)

A health insurance policy or government program covered under this section shall provide to covered individuals or recipients under 21 years of age coverage for the diagnostic assessment of autism spectrum disorders and for the treatment of autism spectrum disorders. As used in this section: "Autism spectrum disorders" means any of the pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or its successor, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified. According to policy documents, the Company excludes coverage of Autism Spectrum Disorders unless the "child is diagnosed with Autism Spectrum Disorder with onset prior to age three." Members with a diagnosis of Asperger's Disorder, Childhood Disintegrative Disorder or Pervasive Developmental Disorder, Not Otherwise Specified may not have coverage under the plan based on the noted policy provision and exclusion because they could have onset after age three. While the language noted may have caused confusion for some enrollees, it appears that the Company did not impose this limitation when adjudicating claims, i.e., no claims were denied due to this age restriction.

1 Violation – 40 P.S. §§ 908-11 et seq. and 45 C.F.R. § 146.136(c)(2)(i)

Licensed insurers are required to provide mental health and substance use disorder benefits in parity with medical/surgical benefits. For quantitative treatment limitations, this means that a licensed insurer may not apply any quantitative treatment limitation (QTL) to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. Examiners requested the Company to provide proof of compliance for each plan type affected, each classification of benefits and for each type

of QTL separately. The Company imposed a QTL with respect to mental health benefits not in parity with medical/surgical benefits. It was noted that the Company did not demonstrate compliance with the substantially all or predominant level tests within the specified classifications of benefits; however, this appears to have been due to the Company's mis-classification of the benefit as a medical benefit, for which no parity test would have been required.

13 Violations – 40 P.S. §§ 908-11 et seq. and 45 C.F.R. § 146.136(c)(4)

Licensed insurers are required to provide mental health and substance use disorder benefits in parity with medical/surgical benefits. For nonquantitative treatment limitations (NQTL), this means that a licensed insurer may not apply any NQTL in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying that limitation to MH/SUD benefits within that classification are "comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the classification." The Company imposed a nonquantitative treatment limitation with respect to mental health benefits not in parity with medical/surgical benefits. The Company is limiting the scope and duration of treatment for the noted claims in a manner that was applied more stringently than medical/surgical benefits within the classification.

3 Violations – 40 P.S. § 991.2166(a) and 31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim under subsection (d) submitted by a health care provider for services, within 45 days of the licensed insurer's or managed care plan's receipt of the claim from the health care provider. The noted claims were not paid within 45 days of the licensed insurer's or managed care plan's receipt of the claim.

2 Violations – 40 P.S. § 991.2166(b) and 31 Pa. Code § 154.18(c)

If a licensed insurer or a managed care plan fails to remit payment as provided under subsection (a), interest at 10% per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer or managed care plan shall not be required to pay any interest calculated to be less than \$2. The interest due of \$2 or more on the two claims was not paid.

1 Violation – 40 P.S. § 1171.5(a)(10)(vi)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear. The Company improperly denied a portion of the claim when the liability under the policy should have been reasonably clear based on its agreement with the provider.

L. Emergency Room Claims

Examiners requested a list of all emergency room claims received during the experience period. The Company identified a universe of 253,118 paid claims, a universe of 232,285 denied claims, and a universe of 333,770 partially paid claims. A random sample of 10 claims was requested for each section. In accordance with the requirements of the examination, the claim files were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. § 3042, 31 Pa. Code §§ 152.15 and 301.62(c), 42 U.S.C. § 300gg-19, and 45 C.F.R. § 147.138. The following violations and concern were noted:

2 Violations – 31 Pa. Code § 146.4(b)

An insurer or agent may not fail to fully disclose to first-party claimants benefits, coverages or other provisions of an insurance policy or insurance contract when the benefits, coverages or other provisions are pertinent to a claim. The Company mailed out an explanations of benefits (EOB) that misrepresented the activity of the claim.

1 Violation – 40 P.S. §§ 991.2116 & 3042, 42 U.S.C. § 300gg-19a(b), & 45 C.F.R. § 147.138(b)

An insurer shall reimburse an insured or provider for medically necessary services that are provided in a hospital emergency facility due to a medical emergency. An insurer shall consider both the presenting symptoms and the services provided in processing a claim for reimbursement of emergency services. The Company failed to pay all reasonably necessary costs associated with the emergency services provided during the period of an emergency, based on both presenting symptoms of the insured as well as the services provided.

1 Violation – 40 P.S. § 991.2166(a) and 31 Pa. Code § 154.18(a)

A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of the clean claim. Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim under subsection (d) submitted by a health care provider for services provided on or after January 1, 1999, within 45 days of the licensed insurer's or managed care plan's receipt of the claim from the health care provider. The noted clean claim was not paid within 45 days of receipt.

1 Violation – 40 P.S. § 1171.5(a)(10)(v)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative. The Company failed to affirm or deny coverage of the claim within a reasonable time after proof of loss for the claim listed.

1 Violation – 31 Pa. Code § 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to complete the investigation of the claim within 30 days after notification of the claim

1 Violation – 31 Pa. Code § 146.7(c)(1)

If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the proofs of loss giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the date of the initial notification and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation and state when

a decision on the claim may be expected. The Company failed to complete the investigation of the claim within 30 days after notification of the claim and status letters were not timely mailed to notify the member and provider of the pending status.

Concern: The Company applied two different cost-sharing requirements for Emergency Services based on designated network provider status and non-designated network provider status. During the period of an emergency, a member may not be able to determine whether an Emergency facility is designated or non-designated. A member should not be penalized, i.e., pay more out-of-pocket, when receiving services during the period of an emergency from a non-designated network provider.

M. Ambulance Transport Claims

Examiners requested a list of all ambulance transport claims received during the experience period. The Company identified a universe of 28,163 paid claims, a universe of 12,235 denied claims, and a universe of 4,890 partially paid claims. A random sample of 10 claims was requested for each section. In accordance with the requirements of the examination, the claim files were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. § 3042, 42 U.S.C. § 300gg-19a, and 45 C.F.R. § 147.138. The following violations were noted:

1 Violation – 40 P.S. § 991.2116

If an enrollee seeks emergency services and the emergency health care provider determines that emergency services are necessary, the emergency health care provider shall initiate necessary intervention to evaluate and, if necessary, stabilize the condition of the enrollee without seeking or receiving authorization from the managed care plan. The managed care plan shall pay all reasonably necessary costs associated with the emergency services provided during the period of the emergency. When processing a reimbursement claim for emergency services, a managed care plan shall consider both the presenting symptoms and the services provided. The Company failed to pay all reasonably necessary costs associated with the emergency services provided during the period of the emergency.

1 Violation – 40 P.S. §§ 1171.5(a)(1)(i) and 1171.5(a)(10)(i)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of Page 73 of 101

insurance means: Making, publishing, issuing or circulating any estimate, illustration, circular, statement, sales presentation, omission comparison which: Misrepresents the benefits, advantages, conditions or terms of any insurance policy. Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue. The Company misrepresented pertinent facts or policy or contract provisions for the claim noted, including the failure to treat this emergency ambulance transportation as innetwork and the failure to apply out-of-pocket amounts for essential health benefits to the deductible and maximum out-of-pocket accumulators.

1 Violation -40 P.S. § 1171.5(a)(10)(v)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative. The Company failed to affirm or deny coverage of the claim within a reasonable time after proof of loss for the claim listed.

1 Violation – 31 Pa. Code § 146.6

Standards for prompt investigation of claims. Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected.

1 Violation – 31 Pa. Code § 146.7(a)(1)

Acceptance or denial of a claim shall comply with the following: Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to the provision,

condition or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial. The Company failed to advise the acceptance or denial of the claim by the insurer within 15 working days after receipt of properly executed proofs of loss.

1 Violation – 31 Pa. Code § 146.7(c)(1)

The following provisions govern acceptance or denial of a claim where additional time is needed to make a determination: If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the proofs of loss giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the date of the initial notification and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation and state when a decision on the claim may be expected. The Company failed to complete the investigation of the claim within 30 days after notification of the claim and status letters were not timely mailed to notify the member/provider of the pending status.

2 Violations – 42 U.S.C. § 300gg-19a(b) and 45 C.F.R. § 147.138(b)

If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides any benefits with respect to services in an emergency department of a hospital, the plan or issuer must cover emergency services (as defined in paragraph (b)(4)(ii) of this section) consistent with the rules of this paragraph (b). In general, if a group health plan, or a health insurance issuer offering group or individual health insurance issuer, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee— (II) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network. The Company failed to pay an out-of-network claim for emergency services at the in-network level of benefits.

N. Substance Use Disorder and Chemical Recovery Claims

Examiners requested a list of all substance use disorder and chemical recovery received during the experience period. The Company identified a universe of 61,661 paid claims, a universe of 48,155 denied claims, and a universe of 52,259 partially paid claims. A random sample of 10 paid claims was requested for section. In accordance with the requirements of the examination, the claim files were reviewed to ensure compliance with applicable state and federal law, including 40 P.S. §§ 752, 908-1 et seq., and 908-11 et seq.; 31 Pa. Code § 89b.11; 42 U.S.C. § 300gg-26; and 45 C.F.R § 146.136. The following violations were noted:

2 Violations – 40 P.S. § 752(a)(4) and 31 Pa. Code § 89b.11

Each form shall state the full corporate or legal name of the company, association, exchange or society. However, the name need appear for filing purposes only on a rider, endorsement, amendment, agreement or insert page. If added for filing purposes only, the name may be added by any legible means. If more than one insurer is using an application, a multi-company application providing for the designation of the applicable insurer and available coverages, if applicable, may be used. A policy, contract or fraternal certificate shall state a current address for the insurer, consisting of at least a city and state or province. Conditions subject to which policies are to be issued. No such policy shall be delivered or issued for delivery to any person in this Commonwealth unless: the style, arrangement and over-all appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lower-case unspaced alphabet length not less than 120-point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions. The Company gave undue prominence to Aetna Life Insurance Company when the member had coverage under Aetna Health Inc. The Company was inconsistent with the labeling of the legal entity providing coverage on its policy forms, provider remittance and/or explanation of benefits.

8 Violations – 40 P.S. §§ 908-1 et seq.

Licensed insurers are required to provide, in group policies, inpatient detoxification, nonhospital Page 76 of 101

residential and outpatient services for alcohol or other substance use and dependency. A certification and referral by a licensed physician or psychologist controls both the nature and duration of treatment to the extent of the mandate. Based on the noted policy provisions, the Company failed to provide coverage for substance use disorder benefits that met the requirements of the Act; however, for certain categories of claims noted herein, despite policy language to the contrary, based on claims files provided, it appears that the Company did not impose this limitation when adjudicating claims.

21 Violations – 40 P.S. §§ 908-11 et seq., 45 C.F.R. §§ 146.136(c)(4) & 156.115(a)(3)

Licensed insurers are required to provide mental health and substance use disorder benefits in parity with medical/surgical benefits. For NQTLs, this means that a licensed insurer may not apply any NQTL in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying that limitation to MH/SUD benefits within that classification are "comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the classification." The Company imposed a nonquantitative treatment limitation with respect to mental health and substance use disorder benefits not in parity with medical/surgical benefits. It was noted that the Company limited the scope and duration of treatment for the claims listed in a manner that was applied more stringently than medical/surgical benefits within the classification in the claims noted. For certain categories of claims noted herein, however, despite policy language to the contrary, based on claims files provided, it appears that the Company did not impose this limitation when adjudicating claims.

3 Violations – 40 P.S. § 991.2166(a) and 31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim under subsection (d) submitted by a health care provider for services, within 45 days of the licensed insurer's or managed care plan's receipt of the claim from the health care provider. The claims noted were not paid within 45 days of the licensed insurer's or managed care plan's receipt of the claim.

3 Violations – 40 P.S. § 991.2166(b) and 31 Pa. Code § 154.18(c)

If a licensed insurer or a managed care plan fails to remit payment as provided under subsection (a), interest at 10% per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer or managed care plan shall not be required to pay any interest calculated to be less than \$2. The interest due of \$2 or more on the three claims was not paid.

1 Violation – 40 P.S. § 1171.5(a)(10)(iv)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. Refusing to pay claims without conducting a reasonable investigation based upon all available information. The Company failed to conduct a reasonable investigation, which resulted in an improper denial of services.

1 Violation – 40 P.S. § 1171.5(a)(10)(vi)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear. The Company improperly denied the claim noted when the Company's liability under the policy was reasonably clear. The Company later paid the overdue claim based on additional information supplied by the provider (which was consistent with the original claim submission), indicating coverage was available when the claim originally denied. Additionally, once the information was received by the Company and liability was again reasonably clear, the Company did not promptly issue payment to the provider for the services rendered.

1 Violation -40 P.S. § 1171.5(a)(10)(x)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices.

Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made. The final processing of the claim did not include a statement setting forth the coverage under which payments were made, as the claim originally denied on 10/29/2015, then reprocessed to pay on 4/25/2016 permitting balance billing of amounts not covered, and then reprocessed again on 10/1/2016 allowing payment for one-hundred percent of the billed charges without balance billing the member. There was nothing included in the explanation of benefits that explained the reprocessing of this claim.

O. Mental Health Claims

Examiners requested a list of all mental health claims received during the experience period. The Company identified a universe of 509,608 paid mental health claims, a universe of 272,055 denied mental health claims, and a universe of 258,728 mental health partially paid claims. A random sample of 10 files was requested for each section. In accordance with the requirements of the examination, the claim files were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 908-1 et seq., 908-11 et seq., and 1171.5, 31 Pa. Code Ch. 146 and 154, 42 U.S.C. § 300gg-26, and 45 C.F.R §§ 146.136. The following violations were noted:

4 Violations – 40 P.S. §§ 908-11 et seq. and 45 C.F.R. §§ 146.136(c)(2)(i) & 156.115(a)(3)

Licensed insurers are required to provide mental health and substance use disorder benefits in parity with medical/surgical benefits. For quantitative treatment limitations, this means that a licensed insurer may not apply any quantitative treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification. Examiners requested the Company to provide proof of compliance for each plan type affected, each classification of benefits and for each type of quantitative treatment limitation separately. The Company imposed a QTL with respect to mental health and substance use disorder benefits not in parity with medical/surgical benefits. It was noted that the Company did not demonstrate compliance with the substantially all or predominant level tests within the specified classifications of benefits. For certain categories of claims noted herein, despite policy language to the contrary, based on claims files provided, it appears that the Company

did not impose this limitation when adjudicating claims.

1 Violation – 40 P.S. § 1171.5(a)(10)(vi)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear. The Company improperly denied the claim noted when the Company's liability under the policy was reasonably clear.

1 Violation – 31 Pa. Code § 146.3

The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in the detail that pertinent events and the dates of the events can be reconstructed. Failure to maintain a complete claim file.

1 Violation – 31 Pa. Code § 146.5(a)

Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice. The Company failed to acknowledge the claim submitted by the claimant within 10 working days.

P. Behavioral Health Claims

Examiners requested a list of all behavioral health claims received during the experience period. The Company identified a universe of 464,055 paid claims, a universe of 219,212 denied claims, and a universe of 263,197 partially paid claims. A random sample of 10 claims was requested for each section. In accordance with the requirements of the examination, the claims were reviewed to ensure compliance with applicable state and federal laws and guidance, including 40 P.S. §§ 991.2166, 908-11 et seq., and 1171.5, 31 Pa. Code Ch. 146 and 154, 42 U.S.C. § 300gg-26, and

45 C.F.R. § 146.136. The following violations were noted:

1 Violation – 40 P.S. § 991.2166(a) and 31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim under subsection (d) submitted by a health care provider for services, within 45 days of the licensed insurer's or managed care plan's receipt of the claim from the health care provider. The noted claim was not paid within 45 days of the licensed insurer's or managed care plan's receipt of the claim.

1 Violation – 40 P.S. § 991.2166(b) and 31 Pa. Code § 154.18(d)

If a licensed insurer or a managed care plan fails to remit payment as provided under subsection (a), interest at 10% per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer or managed care plan shall not be required to pay any interest calculated to be less than \$2. The interest due of \$2 or more on the one claim was not paid.

1 Violation – 31 Pa. Code § 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to send a written explanation of the reason for delay at the end of 30 days and every 45 days thereafter until completed.

O. HIV/AIDS Claims

Examiners requested a list of all HIV/AIDS claims received during the experience period. The Company identified a universe of 6,829 paid claims, a universe of 2,265 denied claims, and a universe of 2,845 partially paid claims. A random sample of 10 files was requested for each section. In accordance with the requirements of the examination, the claims were reviewed to ensure compliance with applicable state and federal laws and regulations. The following violation was noted:

1 Violation – 31 Pa. Code § 146.5(a)

Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice. The Company failed to issue a 10-day acknowledgement notice for one claim.

R. Inpatient and Outpatient High Dosage Opioid Addiction Treatment Claims

Examiners requested a list of all inpatient and outpatient high dosage opioid addiction treatment claims received during the experience period. The Company identified a universe of 30,219 paid claims, a universe of 28,704 denied claims, and a universe of 19,559 partially paid claims. A random sample of 10 claims was requested for each section. In accordance with the requirements of the examination, the claims were reviewed to ensure compliance with applicable state and federal laws and regulations, including 40 P.S. §§ 752(a), 991.2166, 908-1 et seq., 908-11 et seq., and 1171.5, 31 Pa. Code Ch. 146 and 154 and § 89b.11, 42 U.S.C. § 300gg-26, and 45 C.F.R § 146.136. The following violations were noted:

3 Violations – 40 P.S. § 752(a)(4) and 31 Pa. Code § 89b.11

Each form shall state the full corporate or legal name of the company, association, exchange or society. However, the name need appear for filing purposes only on a rider, endorsement, amendment, agreement or insert page. If added for filing purposes only, the name may be added by any legible means. If more than one insurer is using an application, a multi-company application providing for the designation of the applicable insurer and available coverages, if applicable, may be used. A policy, contract or fraternal certificate shall state a current address for the insurer, consisting of at least a city and state or province. Conditions subject to which policies are to be issued. No such policy shall be delivered or issued for delivery to any person in this Commonwealth unless: the style, arrangement and over-all appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lower-case unspaced

alphabet length not less than 120-point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions. The Company gave undue prominence to Aetna Life Insurance Company when the member has coverage under Aetna Health Inc. The Company was inconsistent with the labeling of the legal entity providing coverage on its policy forms, provider remittance and/or explanation of benefits.

7 Violations – 40 P.S. §§ 908-1 et seq.

Licensed insurers are required to provide, in group policies, inpatient detoxification, nonhospital residential and outpatient services for alcohol or other substance use and dependency. A certification and referral by a licensed physician or psychologist controls both the nature and duration of treatment to the extent of the mandate. Based on the noted policy provision, the Company failed to provide coverage for substance use disorder benefits that met the requirements of the Act.

13 Violations – 40 P.S. §§ 908-11 et seq. and 45 C.F.R. § 146.136(c)(4)

Licensed insurers are required to provide mental health and substance use disorder benefits in parity with medical/surgical benefits. For NQTLs, this means that a licensed insurer may not apply any NQTL in any classification unless the processes, strategies, evidentiary standards, or other factors used in applying that limitation to MH/SUD benefits within that classification are "comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the classification." The Company imposed a nonquantitative treatment limitation with respect to mental health and substance use disorder benefits not in parity with medical/surgical benefits. It was noted that the Company limited the scope and duration of treatment for the claims listed in a manner that is applied more stringently than medical/surgical benefits within the classification in the claims noted. For certain categories of claims noted herein, despite policy language to the contrary, based on claims files provided, it appears that the Company did not impose this limitation when adjudicating claims.

2 Violations – 40 P.S. § 991.2166(a) and 31 Pa. Code § 154.18(a)

Licensed insurers and managed care plans shall pay clean claims and the uncontested portions of a contested claim under subsection (d) submitted by a health care provider for services, within 45 days of the licensed insurer's or managed care plan's receipt of the claim from the health care provider. The claim noted was not paid within 45 days of the licensed insurer's or managed care plan's receipt of the claim.

2 Violations -40 P.S. § 1171.5(a)(10)(v)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative. The Company failed to affirm or deny coverage of the claim within a reasonable time after proof of loss for the claim listed.

1 Violation – 40 P.S. § 1171.5(a)(10)(vi)

"Unfair methods of competition" and "unfair or deceptive acts or practices" in the business of insurance means: Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear. The Company denied the claim in which the Company's liability under the policy was reasonably clear.

1 Violation – 31 Pa. Code § 146.5(a)

Failure to acknowledge pertinent communications. (a) Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice. The Company failed to acknowledge the receipt of the claim within 10 days.

2 Violations – 31 Pa. Code § 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to complete the investigation of the claim within 30 days after notification of the claim.

2 Violations – 31 Pa. Code § 146.7(c)(1)

The following provisions govern acceptance or denial of a claim where additional time is needed to make a determination: If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the proofs of loss giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the date of the initial notification and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation and state when a decision on the claim may be expected. The Company failed to complete the investigation of the two noted claims within 30 days after notification of the claim and status letters were not mailed out on the 30th day to notify the claimant of the pending status.

XVII. DATA INTEGRITY

As part of the examination, the Company was sent a preliminary examination packet in accordance with National Association of Insurance Commissioners uniformity standards. The purpose of the packet was to provide certain basic examination information, identify preliminary requirements, and to provide specific requirements for requested data call information. Once the Company provided all requested information and data contained within the data call, the Department reviewed and validated the data to ensure accuracy and completeness, and to determine compliance with The Insurance Department Act of 1921, Section 904 (40 P.S. §323.4). Several data integrity issues were found during the examination. The data integrity issues from each area of review are identified below.

Data Submission to the PID During the Course of the Examination

Situation: Examiners requested documentation demonstrating the intent to respond to all requests from the examiners in a timely manner during the relevant experience period. In addition to the review of policies and procedures, the Department analyzed the Company's timeliness of responses for items requested by the Department during the market conduct examination. The Department recorded the length of time for Company responses to Information Requests (IR), Initial Summaries (IS) and Exit Summaries (ES) and took into account any extension requests made by the Company throughout the course of the examination.

Finding One: During the examination, a total of 194 IRs were issued to the Company. Of those, a total of 50 IRs were responded to on-time or within three business days. The Company provided a late response to 144 IRs. Therefore, 74% of the IRs were not responded to in a timely manner. Of the 144 IRs that were submitted after the due date, the Company averaged 29 days to reply.

Finding Two: During the examination, a total of 180 ISs were issued to the Company. Of those, 116 ISs were responded to on-time or within 10 business days. The Company provided a late response to 64 ISs. Therefore, 36% of the ISs were not responded to in a timely manner. Of the 64 ISs that were submitted after the due date, the Company averaged 12 days to reply.

Finding Three: During the examination, a total of 180 ESs were issued to the Company. Of those, a total of 162 ESs were responded to on-time or within five business days. The Company provided

a late response to 18 ESs. Therefore, 10% of the ESs were not responded to in a timely manner. Of the 18 ESs that were submitted after the due date the Company averaged 11 days to reply.

Policies/Procedures for Data Submission to the PID

Situation: Examiners requested documentation demonstrating that the Company's data reported to the Department was complete and accurate. In addition to the review of policies and procedures, the Department analyzed the Company's timeliness and completeness of responses for items requested by the Department during the market conduct examination.

Finding: Throughout the course of the market conduct examination, the Company failed to provide to the Department complete responses in a timely manner and timely access to data and documentation. For some of the items noted, the Company failed to supply the requested data until the Exit Summary phase of the examination, although it was requested in earlier phases.

Group New Business Underwriting

Situation: As the examiners reviewed the Group New Business Underwriting files, it was noted that not all of the 113 files were complete.

Finding: Of the 113 group new business underwriting files reviewed, 11 files were missing the underwriting approval form, the approved rates of the policy, or the new business application.

Pediatric Vision Paid Claims

Situation: As the examiners reviewed the Pediatric Vision Paid Claims, it was noted that 20 of the files were incomplete, were not associated with pediatric patients, and may have been associated with coverage other than pediatric vision coverage under a comprehensive health insurance policy.

Finding: Upon discussion with the Company, the Company confirmed that the original denied pediatric vision claim population was invalid. The script used to identify the population neglected to filter claims based on diagnosis and patient age. The Company provided a revised population that contained only a single claim, which was for an Aetna Vision Preferred plan (vision only plan) issued by Aetna Life Insurance Company. Since the Vision Preferred plan is a vision only plan, it was not within the scope of the examination.

Marketing and Advertising Sample

Situation: As the examiners reviewed the Marketing and Advertising Sample, not all of the 50 files were provided or the files that were provided did not contain all of the components of a complete file.

Finding: Of the 50 sample files reviewed, 11 files were missing the 2015 or 2016 Annual Statement Advertising Certificate of Compliance a copy of the advertisement, a copy of the quote form, or the referenced website URL.

The following violation was noted:

General Violation 40 P.S. §§ 323.3(a) and 323.4(b)

Requires every company or person from whom information is sought must provide the examiners timely, convenient and free access to all books, records, accounts, papers, documents and any and all computer or other recording relating to the property, assets business and affairs of the company being examined. The violation was the result of a failure to exercise sufficient due diligence to ensure compliance with the Insurance Department Act of 1921.

XVIII. <u>RECOMMENDATIONS</u>

The recommendations below identify corrective measures the Department finds necessary as a result of the number of some violations, or the nature and severity of other violations, noted in the Examination Report.

- 1. The Company must review and revise internal control procedures to ensure compliance with the mental health and substance use disorder parity requirements of 40 P.S. §§ 908-11 et seq. and 45 C.F.R. §§ 146.136(c)(4) and 156.115(a)(3) relating to nonquantitative treatment limitations.
- 2. The Company must review and revise internal control procedures to ensure compliance with the mental health and substance use disorder parity requirements of 40 P.S. §§ 908-11 et seq. and 45 C.F.R. §§ 146.136(c)(2)(i) and 156.115(a)(3) relating to quantitative treatment limitations.
- 3. The Company must implement procedures to ensure compliance with the requirements of 40 P.S. §§ 1171.5(a)(1)(i) and 1171.5(a)(10)(i). The Company must not misrepresent pertinent facts or policy or contract provisions.
- 4. The Company must review and revise internal control procedures to ensure compliance with anti-discrimination requirements of 40 P.S. §§ 477a, 761, and 1171.5(a)(7)(ii); 42 U.S.C. § 300gg–4(a); and 45 C.F.R. §§ 147.104 and 156.125.
- 5. The Company must review and revise its internal controls to ensure that all records and documents are maintained in accordance with 40 P.S. § 323.4 so that the violation noted in the Examination Report does not occur in the future.
- 6. The Company must implement procedures to ensure compliance with the requirements of 40 P.S. § 1171.5(a)(10)(v). The Company must affirm or deny coverage of claims within 45 days after proof of loss for the claims is received.
- 7. The Company must comply with 40 P.S. § 1171.5(a)(10)(vi) and ensure prompt, fair and equitable settlements are being provided to claimants.
- 8. The Company must implement procedures to ensure compliance with the requirements

- of 40 P.S. § 1171.5(a)(10)(x). The Company must include a statement setting forth the coverage under which payments are being made to accompany claim payments to insureds or beneficiaries.
- 9. The Company must implement procedures to ensure compliance with the requirements of 31 Pa. Code § 146.3 to maintain complete claim files and documentation.
- 10. The Company must review and revise internal control procedures to ensure compliance with the claims handling requirements of 31 Pa. Code, Chapter 146, so that the violations relating to claim acknowledgement, status letters, and acceptance or denials, as noted in the Examination Report, do not occur in the future.
- 11. The Company must comply with 40 P.S. § 991.2166(a) and 31 Pa. Code § 154.18(a), and ensure that all clean claims are paid within 45 days of receipt. The Company shall also provide documentation to the Department within 30 days demonstrating that all claims found in violation during the examination were processed and paid including due interest and restitution.
- 12. The Company must comply with 40 P.S. § 991.2166(b) and 31 Pa. Code § 154.18(c), and ensure all requirements are met related to interest payments. The Company shall also provide documentation to the Department within 30 days demonstrating that all claims found in violation during the examination were processed and paid including due interest and restitution.
- 13. The Company must comply with 31 Pa. Code § 154.18(d) and ensure clean claims are paid according to timelines outlined in state laws and regulations.
- 14. The Company must review and revise internal control procedures to ensure compliance with 40 P.S. § 752(A)(4) and 31 Pa. Code § 89b.11 relative to undue prominence and form requirements.
- 15. The Company must comply with 40 P.S. § 753(B)(8) and ensure prompt notifications to the member of policy cancellations.
- 16. The Company must comply with 45 C.F.R. § 155.310(e) and ensure prompt notifications

to the member regarding eligibility determinations.

- 17. The Company must comply with 40 P.S. §§ 908-1 et seq. and ensure substance use disorder benefits claims are paid in accordance with state and federal laws and regulations. The Company shall also provide documentation to the Department within 30 days demonstrating that all claims found in violation during the examination were processed and paid including due interest and restitution.
- 18. The Company must comply with 40 P.S. § 764h and ensure diagnostic assessment of autism spectrum disorders and treatment of autism spectrum disorders are covered for covered individuals under 21 years of age. The Company shall also provide documentation to the Department within 30 days demonstrating that all claims found in violation during the examination were processed and paid including due interest and restitution.
- 19. The Company must comply with 40 P.S. §§ 991.2116 and 3042, 42 U.S.C. § 300gg-19a(b), 45 C.F.R. § 147.138(b) and ensure emergency services are covered in accordance with state and federal laws and regulations. The Company shall also provide documentation to the Department within 30 days demonstrating that all claims found in violation during the examination were processed and paid including due interest and restitution.
- 20. The Company must comply with 42 U.S.C. § 300gg-19a(b)(1)(C)(ii)(II) and 45 C.F.R. § 147.138 and ensure that ambulance and emergency services are covered in accordance with federal laws and regulations. The Company shall also provide documentation to the Department within 30 days demonstrating that all claims found in violation during the examination were processed and paid including due interest and restitution.
- 21. The Company must comply with 40 P.S. § 3801.310 and ensure policy issue records are compliant with state laws and regulations.
- 22. The Company must implement procedures to ensure compliance with 31 Pa. Code § 51.4 and maintain appropriate file documentation.

XIX. <u>COMPANY RESPONSE</u>