Market Conduct Report

Aetna Health Inc
Aetna Life Insurance Company

June 5, 2023

Connecticut Insurance Department

TABLE OF CONTENTS

I. INTRODUCTION

An Examination of Aetna Health Inc. and Aetna Life Insurance Company, (hereinafter referred to as the "Companies") were conducted by Market Conduct examiners of the State of Connecticut Insurance Department at the Department's offices, and remotely.

II. SCOPE OF EXAMINATION

From October 15, 2021 through July 13, 2022, the Market Conduct Division of the Connecticut Insurance Department examined the market conduct practices of the Companies using a sample period of January 1, 2018 through September 30, 2020.The examination was limited to Connecticut business.

The purpose of the examination was to evaluate the Companies' market conduct practices and treatment of policyholders in the State of Connecticut. The examination focused on the solicitation of new business, marketing and sales, agent licensing and appointment, underwriting and rating, policyholder service, complaint handling, network adequacy, provider credentialing, claim processing and company operations.

The Market Conduct examination was conducted pursuant to Connecticut Insurance Department policies and procedures, and the standards proposed in the NAIC Market Regulation Handbook.

III. COMPANY PROFILE

The Companies are wholly owned subsidiaries of Aetna Inc. (the Parent Company). Aetna Health Inc. is domiciled in the State of Connecticut and commenced business on June 1, 1987. Aetna Life Insurance Company is domiciled in the State of Connecticut and commenced business on December 31, 1850. Aetna Health Inc. is licensed in Connecticut as a health care center and Aetna Life Insurance Company is licensed to write life, accident and health insurance.

Direct premiums written as of December 30, 2021 were as follows:

Aetna Health Inc

	Connecticut	Total (All States)
Health Care Center	524,288	524,288

Aetna Life Insurance Company

	Connecticut	Total (All States)
Life	2,575,886	52,631,838
Annuity	9,318,346	27,261,796
Accident & Health	875,297,285	26,155,051,859

IV. MARKET CONDUCT REPORTS

The examiners reviewed copies of all market conduct examination reports that had been issued to the Companies by other state insurance departments during the examination period. The reports were reviewed to ensure that corrective actions were taken regarding all recommendations made by the respective Insurance Departments.

V. AGENCY ORGANIZATION

The Companies market new business through the offices of independent agents as well as direct sales staff.

The Companies maintain ongoing training programs for their agents. The Companies supply new agents with a product portfolio, which provides detailed descriptions of products and coverages. Changes in coverage are mandated by statute or the Companies' policies and are communicated through written notices as they occur. In addition, the Companies host periodic training seminars for agents.

VI. RECORDS SELECTED FOR REVIEW

The Companies supplied a listing of all individual and group health new business produced, terminations, declinations, complaints/appeals, and claims denied during the period under review. The examiners selected a random sample of files using a sampling methodology described in the NAIC Market Regulation Handbook. A sample of four hundred twenty-eight (428) new business contracts, terminations and declinations and seven hundred forty-six (746) claims were selected for review.

The new health business files were reviewed to evaluate the solicitation and sales practices of producers and agents. In general, applications were examined for completeness, appropriate signatures and dates of application. The application process was reviewed to assure that medical underwriting was applied equitably and to verify that adverse selection had not occurred.

In addition, the producer licensing history and the application date for each policy in the samples were noted in order to identify any individuals or organizations that were not licensed or appointed at the time of sale. The licensing and appointment review is described in more detail in Section VII. Producer Licensing and Appointment.

VII. PRODUCER LICENSING AND APPOINTMENT

The lists of the new business written during the sample period, identifying the producer for each policy, were compared to the Department's licensing records to determine whether each producer was licensed in the State of Connecticut and whether each agent was appointed by the Companies.

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: Companies' records of licensed and appointed producers agree with Insurance Department's records.

Standard 2: Producers are properly licensed and appointed in the jurisdiction where the application was taken.

The following information was noted in conjunction with the review of these standards:

- The Companies maintain an automated producer database that interfaces with new group health business processing, policy maintenance and producer compensation.
- The Companies perform due diligence procedures on individuals prior to contracting with them.
- The Companies' appointment procedures are designed to comply with the Department's requirements, which mandate that an agent must be appointed within 15 days from the date that the Company receives the application.

Findings:

Comparisons were made between the Companies' records of licensed and appointed producers and the Insurance Department's records. A review of the Companies' records revealed one (1) instance of an individual acting as an agent who was not appointed by the Companies within the timeframe required by statute.

Standard 3: Termination of producers complies with applicable standards, rules and regulations regarding notification to the producer and notification to the state, if applicable.

The Companies have procedures to provide notification of termination to the Department.

Findings:

The examiners reviewed the Companies' termination lists and verified that no producers were terminated for cause during the examination period.

Standard 4: The Companies' policies of producer appointments and terminations do not result in unfair discrimination against policyholders.

Findings:

The examiners noted no evidence of unfair discrimination against policyholders as a result of producer appointments and terminations.

Standard 5: Records of terminated producers adequately document reasons for terminations.

The examiners reviewed the Companies' terminated producer files to ensure that records are documented sufficiently.

Findings:

The examiners verified the listing of terminated agents and reviewed the reasons for termination for each agent.

In Summary:
It is recommended that the Company review its licensing and appointment system to ensure that no new business is accepted from, nor commissions paid to,individuals acting as agents of the Company who were not appointed within the time frame required by statute.

VIII. UNDERWRITING AND RATING

The new group health business underwriting files were reviewed to determine the use and accuracy of rating methodology, accuracy of issuance, consistent (non-discriminatory) practices and use of proper forms. The Companies' policies, forms and rates were reviewed for proper filing with the Insurance Department and compliance with applicable statutes and regulations.

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: The rates charged for the policy coverages are in accordance with filed rates, if applicable, or the Companies' rating plans.

The following information was noted in conjunction with the review of this standard:

- Rates are systematically computed based on applicant information and rating classification assigned.
- The Companies have written underwriting policies and procedures.
- The Companies provided copies of Department approved rates for the new group health business submissions reviewed during the examination period.

Findings:

The examiners reviewed four (4) small group rating files and no exceptions were noted.

Standard 2: The Companies do not permit illegal rebating, commission cutting or inducements.

The following information was noted in conjunction with the review of this standard:

- The Companies have procedures to pay producers' commissions in accordance with Companies' approved written contracts.

Findings:

The examiners reviewed the Companies' policies and procedures and verified that controls are in place to monitor and prevent illegal rebating, commission cutting and inducements.

Standard 3: All forms, including contracts, riders, endorsement forms and certificates, are filed with the Insurance Department, if applicable.

The following information was noted in conjunction with the review of this standard:

- The Companies have compliance policies and procedures in place to review and track all forms, rates, contract riders and endorsements.
- The Companies have a process to log and document Department approved forms, rates, contract riders, endorsements and content of summary of benefits

and coverage (SBC) in accordance with Connecticut requirements.

Findings:

The examiners reviewed the Companies' policy forms through a review of the new group health business files and no exceptions were noted.

Standard 4: The Companies' underwriting practices are not to be unfairly discriminatory. The Companies adhere to applicable statutes, rules and regulations and Companies' guidelines in selection of risks.

The following information was noted in conjunction with the review of this standard:

- The Companies' policies and procedures prohibit unfair discrimination.
- Written underwriting guidelines are designed to reasonably assure consistency in rating of policies.
- The Companies have policies and procedures in place for the prohibition of denial and restriction of coverage for qualified individuals participating in approved clinical trials, dependent coverage for individuals to age 26, lifetime/annual limits on the dollar amounts of essential health benefits and PPACA-related restrictions on the assessment of cost-sharing upon insureds for preventative items and services.
- The Companies have established policies and procedures to ensure compliance with restrictions on establishing lifetime/annual limits on the dollar amounts of essential health benefits for any individual.
- The Companies have established policies and procedures regarding compliance with PPACA-related restrictions on the assessment of cost-sharing upon insureds for preventative items and services.

Findings:

The Companies' underwriting practices do not appear discriminatory.

Standard 5: File documentation adequately supports decisions made.

Findings:

No exceptions noted.

Standard 6: Policies and endorsements are issued or renewed accurately, timely and completely.

The examiners reviewed the sample new group health business and renewal files to ensure that the Companies' underwriting policies and procedures were consistently applied for each sample file reviewed.

Findings:

The Companies' practices for the issuance of policies and endorsements had no exceptions noted.

Standard 7: Applications rejected and not issued are not found to be discriminatory.

The Companies' underwriting policies and procedures prohibit unfair discrimination.

Findings:

No exceptions were noted.

Standard 8: Cancellation/non-renewal notices comply with policy provisions and state laws, including the amount of advance notice provided to the insured and other parties to the contract.

The Companies have procedures in place for the issuance of cancellation and renewal notices.

Findings:

The examiners selected one hundred sixty-three (163) cancellation files for review. The examiners reviewed sample files selected and no exceptions were noted.

Standard 9: Pertinent information on applications that form a part of the policies is complete and accurate.

Findings:

The examiners reviewed the Companies' sample new health business files, and no exceptions were noted.

Standard 10: Companies comply with the provisions of COBRA and/or

continuation of benefits procedures contained in policy forms, statutes, rules and regulations.

The examiners reviewed the Companies' procedures for providing information pertaining to continuation of benefits, for processing applications and for notification to policyholders of the beginning and termination of benefit periods and premium notices.

Findings:

The examiners reviewed the Companies' underwriting procedures and sample new business files and no exceptions were noted.

Standard 11: The Companies comply with the provisions of HIPAA regarding limits on the use of pre-existing exclusions.

The Examiners reviewed the Companies' policies and procedures for provisions related to applicants/proposed insured under the age of 19 to verify that coverage is not denied based on a pre-existing condition.

Findings:

The Companies' pre-existing conditions were found to be in compliance with the requirements of HIPAA and Connecticut statutes and regulations, and no exceptions noted.

Standard 12: The Companies issue coverage that complies with guaranteed issue requirements of HIPAA and related state laws for groups of 1 to 50.

The Examiners reviewed the Companies' policies and procedures regarding guaranteed availability and renewability of individual and small group health insurance coverage in accordance with statutes and regulations.

Findings:

The Companies' small group business appears to comply with Connecticut requirements.

Standard 13: The Companies refer eligible individuals entitled to portability under the provisions to HRA.

Findings:

The examiners verified that the Companies have procedures in place for

individuals eligible for HRA. No exceptions were found for the small group new health business sample files reviewed.

IX. POLICYHOLDER SERVICE

New business, underwriting files and policy transactions were reviewed for accuracy and timeliness of handling.

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: Premium notices and billing notices are sent out with an adequate amount of advance notice.

The following information was noted in conjunction with the review of this standard:

- Verification that billing notices are generated automatically based on contract renewal dates and payment cycles.
- If premiums are not received, as required, an overdue premium notice is mailed, noting that non-payment will cause the policy to lapse.

Findings:

No exceptions noted.

Standard 2: Policy issuance and insured requested cancellations are timely.

The following information was noted in conjunction with the review of this standard:

- When the policyholder requests cancellation, the cancellation is processed and any premium due is provided to the policyholder.
- The Companies provide written notice to the policyholders when a policy cancels.

Findings:

No exceptions noted.

Standard 3: All communication directed to the Companies is answered in a timely and responsive manner by the appropriate department.

The following information was noted in conjunction with the review of this standard:

- The Companies have a customer call center to respond to policyholder and member concerns.

Findings:

The examiners reviewed the Companies' policies and procedures and no exceptions were noted.

Standard 4: Reinstatement is applied consistently and in accordance with policy provisions.

The Companies have standardized reinstatement guidelines in place to ensure that requests are reviewed and either approved or denied by underwriting.

Findings:

The examiners reviewed the Companies' policies and procedures and sample underwriting files. No exceptions were noted.

Standard 5: Policy transactions are processed accurately and completely.

The Companies have policies and procedures in place for processing policyholder transactions including conversions, plan changes and enrollment updates.

Findings:

The examiners reviewed the Companies' policies and procedures and sampling of new business files. No exceptions were noted.

Standard 6: Evidence of creditable coverage is provided in accordance with the requirements of HIPAA and/or statutes, rules and regulations.

The Companies have policies and procedures in place for tracking and issuing evidence of creditable coverage.

Findings:

The examiners reviewed the Companies' policies and procedures and no exceptions were noted.

Additional Findings:

X. MARKETING AND SALES

The Companies provided samples of all marketing and sales materials used in Connecticut during the period under examination. The marketing and sales materials were analyzed to identify any pieces that had a tendency to mislead or misrepresent any aspect of the Companies' products or benefits to policyholders. In addition, the marketing and sales materials were reviewed to verify compliance with statutes and regulations related to the disclosure of certain information regarding the Companies' identity, financial standing and organization.

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: All advertising and sales materials are in compliance with applicable statutes, rules and regulations.

The following information was noted in conjunction with the review of this standard:

- Written policies and procedures govern the advertising and sales material process.
- All advertising and sales materials are reviewed in a consistent format through an online submission and tracking process.
- All advertising and producer generated material is subject to compliance review.
- Prior to final approval, all advertising and sales materials are reviewed to ensure that any necessary changes identified during the initial review were made.
- Approved submissions are endorsed for use for a specific period, which is incorporated into the approval number on the piece.

Findings:

The companies were found to be in compliance.

Standard 2: The Companies' internal producer training materials are in compliance with applicable statutes, rules and regulations.

The Companies have developed training programs for their producers.

Findings:

The examiners reviewed the Companies' training programs and established policies and procedures. The Companies' internal producer training materials appear to be adequate and in compliance.

Standard 3: The Companies' communications to producers are in compliance with applicable statutes, rules and regulations.

The Companies maintain an extensive on-going training program. Written policies and procedures govern that all communications are reviewed and approved by the Companies' compliance units.

Findings:

The examiners verified that the Companies have communication procedures in place for all producers.

Standard 4: Outline of coverage is in compliance with applicable statutes, rules and regulations.

Findings:

The examiners reviewed the Companies' outlines of coverage and no exceptions were noted.

XI. COMPLAINTS

The examiners reviewed all ninety-two (92) Department complaint files and two hundred seventeen (217) sample Non-Department Complaints, Grievances and Appeal files during the examination period. Included in our review were grievances and appeals involving mental health and substance abuse disorders.

Department Complaint Handling

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: All complaints or grievances are recorded in the required format on the Companies' complaint registers.

The following information was noted in conjunction with the review of this standard:

- Written policies and procedures govern the complaint handling process.
- All complaints are recorded in a consistent format in the complaint log.
- An automated tracking database is used to record and maintain complaint information.

Findings:

The examiners reviewed the Companies Complaint log and the Department's records. No exceptions were noted.

Standard 2: The Companies have adequate complaint handling procedures in place and communicate such procedures to policyholders.

The following information was noted in conjunction with the review of this standard:

- The Companies' Plan Descriptions have been reviewed and approved by the Department's Life and Health Division.
- The complaint handling procedures are included in the Plan Descriptions.

Findings:

The examiners verified that the Companies' Plan Descriptions include all complaint handling procedures as required by statute.

Standard 3: The Companies should take adequate steps to finalize and dispose of Department complaints in accordance with applicable statutes, rules and regulations and contract language.

Findings:

- The examiners noted during a review of the Aetna Companies Insurance Department Complaints, the Companies responded to the Department in a timely manner.

Non-Department Complaints (Grievance/Appeal/Concerns)

The Companies have established the following complaint and appeal policies that are available to members and providers as outlined in the Plan Descriptions:

A. Complaints:

A member can contact Member Services for assistance with questions or complaints. The Member Services Representative will attempt to resolve the complaint. If the member remains dissatisfied, the member may file an appeal.

B. Appeal/Grievance Procedure for Benefit/Administrative (Non-Medical Necessity) Issues

Members have one level of appeal available if they disagree with an administrative decision. A member can initiate an appeal orally, electronically, or by mail by calling, faxing or writing to the Companies.

- If a member chooses to appeal, the appeal must be filed within 180 calendar days. The Companies will acknowledge receipt of the appeal in writing within three (3) business days.
- The member will receive written notice of the Companies' decision within twenty (20) business days.

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 4: The time frame within which the Companies respond to complaints, grievances and appeals is in accordance with applicable statutes, rules and regulations.

Findings:

The examiners verified that the Companies responded to complaints, grievances and appeals in a timely manner.

Standard 5: The health carriers document complaints, grievances and appeals and establish and maintain grievance/appeal procedures in compliance with statutes, rules and regulations.

Findings:

No exceptions noted.

Standard 6: The health carriers file, with the Commissioner, a copy of their complaints, grievances and appeals, including all forms.

Findings:

The examiners verified that the plan descriptions filed with the Department

appear to be in compliance.

XII. CLAIMS

The Companies provided a listing of all claims submitted during the period under examination. The review consisted of a sampling of seven hundred forty-six (746) claims. The files were reviewed to determine the accuracy and timeliness of claim and interest payments.

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: The initial contact by the Companies with the claimant is within the required time frame and claims are settled in a timely manner.

The following information was noted in conjunction with the review of this standard:

- Written policies and procedures govern the claim handling process.
- All claim notifications are logged into the claim system.
- Claim management monitors claim accuracy and timeliness.

Findings:

Pursuant to §38a-816(15) of the Connecticut General Statutes, the Companies are required to pay clean claims within twenty (20) days for claims filed electronically and sixty (60) days for claims filed in paper format. The Department requested that the Companies provide a listing of all clean claims paid in excess of twenty (20) and sixty (60) days for the examination period. The examiners one hundred-five (105) claims that were not paid within twenty (20) and sixty (60) days, and failed to include interest.

It is recommended that the Companies review their claim handling procedures to ensure that all claims are investigated and resolved pursuant to required claim settlement practices.

Standard 2: Claim files are adequately documented.

The following information was noted in conjunction with the review of this standard:

- copy of the HCFA form or electronic proof of loss

- applicable clinical/other investigative correspondence
- written communication, telephone or other communication
- proof of payment

Findings:

See concerns identified through a review of claims in Section XII Claims.

Standard 3: The Companies have appropriate policies in place for the archival and disposal of claim forms.

Findings:

The examiners reviewed the policies and procedures and no exceptions were found.

Standard 4: The Companies' claim forms are appropriate for the type of product.

Findings:

The examiners noted that the claim forms were appropriate and in accordance with the Companies' policies and procedures.

Standard 5: Canceled benefit checks and drafts reflect appropriate claim handling practices.

The following information was noted in conjunction with the review of this standard:

- Claim procedures were verified to ensure that the check/draft claim process was handled accurately and was appropriate.

Findings:

The examiners verified that processes were in place and no exceptions were noted.

Standard 6: Claim handling practices do not compel claimants to institute litigation, in cases of clear liability and coverage, to recover amounts due under policies by offering substantially less than is due under the policy.

The following information was noted in conjunction with the review of this standard:

- All litigated claims were reviewed for the examination period.

Findings:

The examiners reviewed the policies and procedures and no exceptions were found. Specific claim errors are identified below.

Standard 7: The group health plan complies with the requirements of Federal and State law for Mental Health Parity, (including PPACA and HIPAA).

The following information was noted in conjunction with the review of this standard:

- A review of the Companies' responses to the Mental Health Parity Annual Compliance Survey for the period under review.

- A review of the Companies' responses to Consumer Report Cards on Health Insurance Carriers in Connecticut for the period under review.

- A review of the Companies MCAS (Market Conduct Annual Statement) Health Data submission to I-Site for 2017 and 2018.

Findings:

The examiners reviewed the Companies' Mental Health Parity Annual Compliance Survey, which included the Companies' responses to the analysis and testing for any cost share features, penalties and benefit limitations and classifications (inpatient in and out-of-network, outpatient in and out-of-network, emergency and prescription drugs) that apply to mental health and substance abuse disorders vs. medical/surgical conditions. In addition, the examiners reviewed the Companies' responses in the Survey regarding non-quantitative treatment limitations (medical management, prior authorization and step therapy). Also, the examiners reviewed the Companies MCAS Health Data submissions. Finally, the examiners also reviewed the Companies' response to the Consumer Report Card on Health Insurance Carriers in Connecticut, for the period under review. No exceptions were noted.

Specific claim errors are identified below.

- The Examiners noted through a review of Aetna Life Insurance Company's small group denied claims, one (1) instance where a claim was denied in error. The Company reprocessed the claim for a total of $86, which was applied to the members deductible. The Examiners recommend that the Companies review its policies and procedures to ensure that claims are properly investigated and paid.

- The Examiners noted through a review of Aetna Life Insurance Company's Emergency Room denied claims, one (1) instance where a claim was denied in error, as a result of the Company miscoding the eligibility age for a dependent. The claim was reprocessed for a total of $666, including interest. The Examiners recommend that the Companies review its policies and procedures to ensure that claims are properly investigated and paid.

- The Examiners noted through a review of Aetna Life Insurance Company's Substance Abuse denied claims, that it was noted that when procedure code H0020 was implemented, that the Company incorrectly loaded a code which was intended to impact Medicare business only, however, commercial claims were also impacted. The Company identified all impacted claims through data and initiated the reprocessing to correct the impacted claims. The reprocessing was finalized on 12/31/20. A total of 30 claims were reprocessed for a total of $3,717 including interest. The Examiners recommend that the Companies review its policies and procedures to ensure that claims are properly investigated and paid.

In Summary:

It is recommended that the Companies review their policies and procedures to ensure that claims are all properly investigated and resolved pursuant to required claim handling requirements.

XIII. NETWORK ADEQUACY

Standard 1: The health carrier demonstrates, using reasonable criteria that it maintains a network that is sufficient in number and types of providers to ensure that all services to covered persons will be accessible without unreasonable delay.

The following information was noted in conjunction with the review of this standard:

- ratios of providers, both primary care providers and specialty providers, to covered persons

- geographic accessibility, as measured by the reasonable proximity of participating providers to the business or personal residence of covered persons

- waiting times for appointments, hours of operation, and volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care

The examiners reviewed the Connecticut Insurance Department Network Adequacy

Survey, which included the Companies' responses to the ratio of providers, both primary care and specialty care to members. In addition, the examiners reviewed geographic accessibility of participating providers to the business or members personal residences and wait times for scheduling in-network appointments for the period under review.

Findings:

The Companies submitted the 2018 and 2019 Network Adequacy Survey. No exceptions were noted.

Standard 2: The health carrier files a quality assurance plan with the Commissioner for each managed care plan that the carrier offers in the state, and files updates whenever it makes a material change to an existing managed care plan. The carrier makes the quality assurance plans available to regulators.

The following information was noted in conjunction with the review of this standard:

- the health carrier's procedures for making referrals within and outside its network
- the health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services
- the health carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning

Standard 3: The carrier has provided documentation to the Commissioner that it is currently NCQA accredited.

Standard 4: The health carrier files, with the Commissioner, all required contract forms and any material changes to a contract proposed for use with its participating providers and intermediaries.

Standard 5: The health carrier ensures covered persons have access to emergency services 24 hours per day, 7 days per week, within its network and provides coverage for emergency services outside of its network, pursuant to the appropriate section of state law that corresponds to the Managed Care Plan Network Adequacy Model Act.

Standard 6: The health carrier executes written agreements with each participating provider that are in compliance with statutes rules and regulations.

Standard 7: The health carrier's contracts with intermediaries are in compliance with statutes, rules and regulations.

The following information was noted in conjunction with the review of this standard:

- Intermediaries and participating providers, with whom they contract, shall comply with all applicable Requirements for Health Carriers and Participating Providers as indicated in the Managed Care Plan Network Adequacy Model Act and accompanying regulations.

- A health carrier's statutory responsibility to monitor the offering of covered benefits to covered persons shall not be delegated or assigned to the intermediary.

- A health carrier shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons.

- A health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon twenty (20) days prior written notice from the health carrier.

- Each contract between a health carrier and participating provider or provider group shall contain a "hold harmless" provision specifying protection for covered persons from being billed by providers. The language of the "hold harmless" provision shall be substantially similar to the language of the Managed Care Plan Network Adequacy Model Act.

Standard 8: The health carrier provides notice to members advising them of Primary Care Physicians who have terminated with the plan as required by Connecticut Statute.

The following information was noted in conjunction with the review of this standard:

- The health carrier shall develop selection standards for primary care professionals and each health care professional specialty.

- The standards shall be used in determining the selection of health care professionals by the health carrier, its intermediaries, and any provider networks

with which it contracts.

Standard 9: The health carrier provides, at enrollment, a Provider Directory listing of all providers participating in its network. It also makes available, on a timely and reasonable basis, updates to its directory.

Findings:

The examiners noted that guidelines in place appear to be appropriate and no exceptions were noted.

XIV. PROVIDER CREDENTIALING

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: The health carriers establish and maintain programs for credentialing and re-credentialing in compliance with statutes, rules and regulations.

The following information was noted in conjunction with the review of this standard:

- The Companies have established written policies and procedures for credentialing and re-credentialing verification of all health care professionals with whom the health carriers contract and shall apply those standards consistently.
- The Companies have assured that the carriers' medical director or other designated health care professional shall have responsibility for, and shall participate in, the health care professional credentialing verification.
- The Companies have established a credentialing verification committee consisting of licensed physicians and other health care professionals to review credentialing verification information and supporting documentation.

Findings:

The examiners noted that procedures in place appear to be appropriate and no exceptions were noted.

Standard 2: The health carriers verify the credentials of a health care professional before entering into a contract with that health care professional.

The following information was noted to ensure providers are properly credentialed prior to appearing in the provider directory:

Findings:

The examiners noted that procedures in place appear to be appropriate and no exceptions were noted.

Standard 3: The health carriers require all participating providers to notify the health carriers' designated individual of changes in the status of any information that is required to be verified by the health carriers.

Findings:

The examiners noted that guidelines in place appear to be appropriate and no exceptions were noted.

Standard 4: The health carriers provide a health care professional the opportunity to review and correct information submitted in support of that health care professional's credentialing verification.

Findings:

The examiners noted that guidelines in place appear to be appropriate and no exceptions were noted.

XV. COMPANY OPERATIONS

Evaluation included, but was not limited to, an assessment based on the following specific standards:

Standard 1: The Companies have up-to-date, valid internal or external audit programs.

The following information was noted in conjunction with the review of this standard:

- The Companies have an internal audit department that has performed reviews of a variety of operational functions.
- Audit reports are distributed to all relevant operational and management personnel.

- External audits are performed on a regular basis.

Findings:

The Companies have performed a number of audits during the examination period. The examiners reviewed the audit reports provided and found no exceptions during the examination period.

Standard 2: The Companies have appropriate controls, safeguards and procedures for protecting the integrity of computer information.

The following information was noted in conjunction with the review of this standard:

- The Companies have procedures in place for all operational functions.
- System tests are performed on a regular basis.

Findings:

The examiners reviewed and verified that the Companies have programs in place to protect the integrity of computer information and appear to be in compliance.

Standard 3: The companies have anti-fraud plans in place.

The following information was noted in conjunction with the review of this standard:

- The Companies have written anti-fraud plans.
- The Companies have a Special Investigative Unit (SIU) dedicated to the prevention and handling of fraud.
- Potential fraud activity is tracked by the SIU and investigated. Activity is reported to the regulator, as necessary.

Findings:

The examiners reviewed the written anti-fraud plans and investigative policies and procedures. For the examination period, the Companies had no reportable incidents.

Standard 4: The Companies have valid disaster recovery plans.

Findings:

The examiners reviewed and verified that the Companies have valid disaster

recovery programs in place and no incidences were reported during the examination period.

Standard 5: Records are adequate, accessible, consistent and orderly and comply with record retention requirements.

Findings:

The Companies appear in compliance.

Standard 6: The Companies are licensed for the lines of business that are being written.

The examiners reviewed the Certificates of Authority for the Companies and compared them to the lines of business that the Companies write in the State of Connecticut.

Findings:

The examiners verified that the Companies are duly authorized for the lines of business being written.

Standard 7: The Companies have procedures for the collection, use and disclosure of information gathered in connection with insurance transactions so as to minimize any improper intrusion into the privacy of applicants and policyholders.

The following information was noted in conjunction with the review of this standard:

- The Companies' policies allow for sharing customer and personal information with affiliates, but do not share such information with non-affiliates.
- The Companies' policies require a consumer privacy notice to be provided to policyholders on an annual basis.
- The Companies have developed and implemented information technology security practices to safeguard the customer's personal and health information.
- The Companies' internal audit function conducts reviews of privacy policies and procedure.
- The Companies' use of Artificial Intelligence with regard to underwriting, rating/pricing and claims. Describe how the models and algorithms developed are tested to ensure they are not biased or discriminatory, and in addition who is responsible for the monitoring and testing of the processes developed.

- The Companies advise and describe any use of Biometric Data including but not limited to: Retinal Scans, Finger Prints, Voice Prints, Hand and Face Geometry.

Findings:

The examiners reviewed and verified that the Companies have valid programs inplace. In addition, the examiners verified that the Companies do not use Artificial Intelligence with regard to underwriting of risks, pricing/rating/classifications and claims for its insured business.

No incidences were reported during the examination period.

Standard 8: The Companies have a comprehensive written information security program for the protection of non-public customer information.

The examiners reviewed and verified that the Companies have a written security program in place for the protection of non-public customer information. In addition, the examiners verified that the Companies have proper cyber security policies and procedures in the areas of breach notification, administrative, physical and technical safeguards to protect consumer information and security incident response procedures.

Standard 9: The Companies cooperate on a timely basis with examiners performing the examinations.

Findings:

The Department received cooperation during the examination process.

XVI. SUMMARY OF RECOMMENDATIONS

Report
Section

VII. Producer Licensing and Appointment

The Department is concerned that the Companies failed to establish proper procedures are in place to ensure that individuals acting as agents of the Companies are properly appointed according to Connecticut requirements.

XI. Claims:

It is recommended that the Companies review their policies and procedures to ensure that claims are all properly investigated and resolved pursuant to required claim handling requirements.

XVII. ACKNOWLEDGMENT

Stephen DeAngelis, Meg Salamone, Karen Mayer and Shannon Gonska participated in the preparation of this report.

STATE OF CONNECTICUT

INSURANCE DEPARTMENT

----------x

IN THE MATTER OF: DOCKET MC 23-21

AETNA HEALTH INC.:

----------x

STIPULATION AND CONSENT ORDER

It is hereby stipulated and agreed between Aetna Health Inc., and the State of Connecticut Insurance Department by and through Andrew N. Mais, Insurance Commissioner, to wit:

I

WHEREAS, pursuant to a Market Conduct examination, the Commissioner alleges the following with respect to Aetna Health Inc.:

1. Aetna Health Inc, hereinafter referred to as Respondent, is domiciled in the State of Connecticut and is licensed to transact the business of a healthcare center in the State of Connecticut under license number 95935.

2. From October 15, 2021 through July 13, 2022, the Department conducted an examination of Respondent's market conduct practices in the State of Connecticut covering the period from January 1, 2018 through September 30, 2020.

3. During the period under examination, Respondent, failed to follow established practices and procedures to ensure compliance with statutory requirements, resulting in instances of:

   a. failure to pay claims in a timely manner

   b. failure to pay interest on claims not paid in a timely manner

1. The conduct as described above violates § 38a-816 of the Connecticut General Statutes, and constitutes cause for the imposition of a fine or other administrative penalty under §§38a-2, 38a-41 and 38a-817 of the Connecticut General Statutes.

II

1. WHEREAS, Respondent admits to the allegations contained in paragraphs three and four of Article I of this Stipulation; and

2. WHEREAS, Respondent agrees to undertake a complete review of its practices and procedures to enhance compliance with Connecticut statutes in the areas of concern, as described in the Market Conduct Report and this Stipulation; and

3. WHEREAS, Respondent agrees to provide the Insurance Commissioner with a summary of actions taken to comply with the Recommendations in the Market Conduct Report within ninety (90) days of the date of this document; and

4. WHEREAS, Respondent agrees to pay a fine in the amount of $5,000 for the violations described herein; and

5. WHEREAS, Respondent, being desirous of terminating this proceeding without the necessity of a formal proceeding or further litigation, does consent to the making of this Consent Order and voluntarily waives:

   a. any right to a hearing; and

   b. any requirement that the Insurance Commissioner's decision contain a statement of findings of fact and conclusions of law; and

   c. any and all rights to object to or challenge before the Insurance Commissioner or in any judicial proceeding any aspect, provision or requirement of this Stipulation

NOW THEREFORE, upon the consent of the parties, it is hereby ordered and adjudged:

1. That the Insurance Commissioner has jurisdiction of the subject matter of this administrative proceeding.

2. That Respondent is fined the sum of Five Thousand Dollars ($5,000) for the violations herein above described.

AETNA HEALTH INC

By: _____
(Representative of Insurance Company)

Gregory Martin

CERTIFICATION

The undersigned deposes and says that he/she has duly executed this Stipulation and Consent Order on this 14th day of June 2023 for and on behalf of Aetna Health Inc., that he/she is the Vice Pres. of such company, and he/she has authority to execute and file such instrument.

By: _____

State of PA

County of Dauphin

Personally appeared on this 14th day of June 2023 Gregory Martino signer and sealer of the foregoing Stipulation and Consent Order, acknowledged same to be his/her free act and deed before me.

_____
Notary Public/Commissioner of the Superior Court

Commonwealth of Pennsylvania - Notary Seal
Kristie L. Shirk, Notary Public
Dauphin County
My commission expires May 20, 2025
Commission number 1151402

Section Below To Be Completed by State of Connecticut Insurance Department

---

Dated at Hartford, Connecticut this 12th day of July 2023.

_____
Andrew N. Mais
Insurance Commissioner