

# **OHIO DEPARTMENT OF INSURANCE**

**A**

**TARGETED**

**MARKET CONDUCT EXAMINATION**

**OF**

**AETNA HEALTH INC.**

**NAIC #96518**

**As Of**

**December 31, 2003**



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(NOTE: Print this page of final report on OH-DOI letterhead)

The Honorable Ann Womer Benjamin  
Director of Insurance  
Ohio Department of Insurance  
2100 Stella Court  
Columbus, OH 43215-1067

Dear Director Womer Benjamin:

Pursuant to your authority delegated under the provisions of R.C. 3901.011 and in accordance with your instructions, a target market conduct examination of the business practices and affairs has been conducted on:

Aetna Health Inc.  
4059 Kinross Lakes Parkway  
Richfield, OH 44286

The Company is an Ohio domiciled Health Maintenance Organization (HMO), hereinafter referred to as "AHI" or the "Company." The examination was performed as of December 31, 2003, at the office located in New Albany, OH.

The report of examination is herewith respectfully submitted.

## SCOPE OF EXAMINATION

This Target Market Conduct Examination was performed to determine Aetna Health Inc.'s (hereinafter referred to as "Company" or "AHI") compliance with the Health Insurance Portability and Accountability Act ("HIPAA"), the Women's Health and Cancer Rights Act ("WHCRA"), the Newborns' and Mothers' Health Protection Act ("NMHPA"), and the statutes and rules of the State of Ohio.

The examination process is governed by, and performed in accordance with, the procedures developed by the National Association of Insurance Commissioners, Centers for Medicare and Medicaid Services, the Ohio Department of Insurance ("Department"), and the Insurance Regulatory Examiners' Society. Examiners rely primarily on records and materials maintained and provided by the Company. The examination covers the period of January 1, 2002 through December 31, 2003.

The Department regarded the function of the Examiner-In-Charge to be a determining factor in the expeditious conduct of this examination. A company's responses to the examiners' requests will not only affect the quality of the final report, but will also determine the time required to complete the examination and, ultimately, the cost to the company.

The examination includes, but is not limited to, review of the following phases:

1. Company Operations and Management
2. Marketing and Sales
3. Complaints and Grievances
4. Contract/Policy Language
5. Underwriting: Policies Issued, Declined and Terminated, Certificates of Creditable Coverage
6. Claims Paid and Denied
7. Association Coverage

The Target Market Conduct Examination consisted of a review of information, materials, documents and files requested by the examiners and supplied by the Company. Upon review of the documents, any concerns, discrepancies or questions were noted and the Company was notified in writing with an "inquiry form." The inquiry form provided space for the Company to respond in writing, either in agreement with the findings or to explain or justify the Company's action regarding the issue raised by the examiners. After consideration of the Company's responses, any invalid or non-issue comments were eliminated from the final report findings.

The Report of Examination contains an explanation of the procedures performed and the findings and conclusions reached in each phase of the examination. Examination report recommendations that do not reference specific insurance laws, rules and bulletins are presented to encourage improvement of company practices and operations and to ensure consumer protection. Examination findings may result in administrative action by the Ohio Department of Insurance.

Not all unacceptable or non-complying practices may have been discovered during the course of the examination. Failure to identify specific Company practices does not constitute acceptance of such practices. Additionally, this Report of Examination should not be construed to endorse or discredit any insurance company or insurance product.

## **COMPANY OPERATIONS AND MANAGEMENT**

### Company History and Profile

The health maintenance organization (“HMO”) became operational in 1983 as Western Reserve Health Plan in Cleveland, Ohio. In 1987, Western Reserve Health Plan became Partners; in 1992, Aetna acquired Partners.

In 1993, the organization expanded to Southern Ohio and in 1994, expanded to Central Ohio. In 1994, a Medicare product was introduced in Northeast Ohio. In 1996, the plan expanded to northwest Ohio; the same year that Aetna merged with U.S. Healthcare.

In 1997, the HMO changed its name to Aetna U.S. Healthcare Inc. and expanded the Medicare product to include the Cincinnati area. The Quality Point of Service (“QPOS”) and U.S. Access were added to the HMO’s product offerings in 1998.

In 1999, Aetna Inc. purchased the health business of Prudential. In 2001, the HMO introduced the Open Access product and exited Medicare in all the Ohio markets.

The name was changed to Aetna Health Inc. (“AHI”) in 2002. AHI, an Ohio corporation, is a for-profit HMO owned by Aetna Inc..

AHI provides healthcare services to an enrolled population through contracted providers. The products referred to above are described below:

- 1) The HMO is a pre-paid medical plan that uses a network of participating providers. Members select a primary care physician (“PCP”) that participates in the network. The PCP provides routine and preventative care and helps coordinate the member’s total health care. The PCP refers members to participating specialists or facilities for medically necessary specialty care.
- 2) USAccess is a three-tiered HMO based product that allows members to access care in three ways:
  - a) In-network referred (lowest co-pay)
  - b) In-network self-referred (higher co-pay/possible coinsurance)
  - c) Out-of-Network (subject to deductible and coinsurance)
- 3) QPOS is a “stepping stone” between the HMO and PPO plans. It is a 2-tiered product that allows members to access care in two ways:
  - a) Referred in-network (subject to co-pay)
  - b) Self-referred in or out of network (subject to deductible and coinsurance)

- 4) Open Access is an HMO based plan that does not require referrals. The member may self-refer but must go to a network provider in order to receive benefits.

The 2003 Annual Statement indicated the Company earned \$271,661,904 in health premiums in the State of Ohio. It also indicated there were 98,172 members (including 9,192 members of Federal Employee and Health Benefit Plans) utilizing an HMO plan at year-end December 31, 2003.

Cooperation with Examiners

Other than the delays in providing populations of data, sampled files, and responses to inquiries and memorandum requests, the Company personnel were cooperative throughout the examination.

**MARKETING AND SALES**

*Marketing and Sales Standard #1 – Test all sales (including producer materials) and advertising to determine compliance with HIPAA, NMHPA, WHCRA and Ohio statutes and rules.*

The Company was requested to provide all its marketing, solicitation, sales, agency training, and solicitation materials. The Company provided a total of 349 items. Of the 349 items provided, all were tested. The files could Pass, Fail, or be found not to have an issue related to WHCRA, NMHPA HIPAA or associated Ohio Law (N/A). The results of the testing are located in the table below:

	HIPAA	WHCRA	NMHPA	Ohio Law
Pass	0	0	0	0
Fail	8	2	0	10
N/A	341	347	349	339
Items failed with an issue related to law	100%	100%	0%	100%
# of Items	349	349	349	349

At this point, it is important to emphasize that the examiners were reviewing these materials for content only to see if these materials complied with the applicable federal and state laws. The Company, in several of its responses, indicated that, while a form’s content may be contrary to the applicable federal and state laws, its implementation of HIPAA, NMHPA, WHCRA, and Ohio statutes and rules was compliance with those provisions. Whether this is, in fact, the case is not the purpose behind these tests.

“Disclosure Notice” and “Request for New Business Proposal” Forms

The Company provided its “Disclosure Notice,” which indicates rating factors, renewability information and pre-existing condition information. In addition, the

Company provided its “Request for New Business Proposal” for small groups. The Company indicated that the two documents are provided to small group employers to fulfill the requirements of Public Law, Part A—Group Market Reforms, Section 2713, “Disclosure of Information,” 45 CFR § 146.160, “Disclosure of Information,” and R.C. 3924.033(A), “Information available to employer.” While the content of the “Disclosure Notice” complied with applicable federal and state laws, the “Request for New Business Proposal” did not.

Specifically, the “Request for New Business Proposal” provides, “PLAN OPTIONS (Limit Four quotes).” There are five AHI PPO plans and four AHI HMO plans offered on the request. The employer may be qualified for all nine and, at the very least, may be qualified for all five of the AHI PPO plans. Therefore, AHI is not providing a reasonable disclosure to a small employer (if qualified for more than four), as part of its solicitation and sales materials. Therefore, the form is in violation of Public Law, Part A—Group Market Reforms, Section 2713, “Disclosure of Information,” 45 CFR § 146.160, “Disclosure of Information,” and R.C. 3924.033(A), “Information available to employer,” which requires the insurer to provide information about the benefits and premiums available under all health insurance coverage for which the employer is qualified). In its response, the Company stated, “*We will remove ‘(limit four quotes)’ from our Request for New Business Proposal.*”<sup>1</sup>

Subsequent to the conclusion of the on-site portion of the examination, the Company removed this language and submitted a new “Request for New Business Proposal” form, which content now complies with the applicable federal and state laws.

**COMPANY RESPONSE: The Company agrees with Recommendations 1 and 2 and advises that it has made these changes to the New Business Proposal Forms.**

“Website Enrollment Packet”

A website enrollment packet was requested, which contained an application in the packet. The packet, however, did not contain the “Request for New Business Proposal” or the “Disclosure Notice,” which the Company stated are provided to all Ohio small employers during the enrollment process. Therefore, the website packet does/did not comply with the requirements of Public Law, Part A—Group Market Reforms, Section 2713, “Disclosure of Information,” 45 CFR § 146.160, “Disclosure of Information,” and R.C. 3924.033(A), “Information available to employer.” These laws require insurers, in connection with offering of a health benefit plan to a small employer, to disclose to the employer, as part of its solicitation and sales materials, the following information about coverage:

- (1) The provisions concerning issuer’s right to change premium rates and the factors that may affect changes in premium rates;
- (2) The provisions relating to renewability of coverage;
- (3) The provisions relating to any preexisting condition exclusion; and

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<sup>1</sup> In addition, the “Request for New Business Proposal,” which limited the number of quotes, would violate R.C. 3923.16 and Ohio Adm. Code 3901-1-16(E).

- (4) The benefits and premiums available under all health insurance coverage for which the employer is qualified.

Further, by failing to include the “Request for New Business Proposal” and/or the “Disclosure Notice” in its website enrollment packet, which is distributed to its sales force and, in turn, to small employers during the enrollment process, the Company violated R.C. 1751.20, R.C. 3923.16 and Ohio Adm. Code 3901-1-16(E).

“Small Business Solutions,” “Total Solution (7/02),” and “Total Solution (6/01)” Packets  
Upon review, the examiners could not determine if the Company agents are supplying the “Request for New Business Proposal” or its “Disclosure Notice” in conjunction with these packets. Since the Company did not provide the documents in any of its solicitation materials provided to the small employer, these packets were failed as violation of Public Law, Part A—Group Market Reforms, Section 2713, “Disclosure of Information,” 45 CFR § 146.160, “Disclosure of Information,” and R.C. 3924.033(A), “Information available to employer.”

In addition, by failing to include the “Request for New Business Proposal” and/or the “Disclosure Notice” in its “Small Business” and “Total Solutions” packets, which were distributed to its sales force and, in turn, to small employers during the enrollment process, the Company violated R.C.1751.20, R.C. 3923.16, and Ohio Adm. Code 3901-1-16(E).

Subsequent to the on-site conclusion of this examination, the Company indicated that these materials are not sales or marketing materials in that the Company’s producers use these materials and that they were not given to potential insureds. While the Company may be correct in its characterization of these materials, these briefings are disseminated to its agent workforce as a resource tool. Thus, the Company should ensure content accuracy before dissemination.

#### “Broker Briefings”

Three marketing documents were failed for indicating the Company does not provide certificates of creditable coverage (“CCC”) for every member terminated from a group, which is a violation of R.C. 1751.58, which references R.C. 3924.03(A)(3), and HIPAA, at Public Law, Section 2701(e)(1)(A)(i), and 45 CFR § 146.115. These laws provide that a CCC must be provided at the time an individual ceases to be covered under the plan or otherwise becomes covered under a COBRA continuation provision. Therefore, the materials were misleading in violation of R.C. 1751.20. In its response, the Company indicated that the language in its “Broker Briefings” would be corrected in the 2<sup>nd</sup> quarter 2004. The Company also indicated that its practice was to issue certificates whenever there a termination is processed. This practice was not confirmed before closing of the “Marketing and Sales Phase” of the examination.

Subsequent to the on-site conclusion of this examination, the Company indicated that these “Broker Briefings,” were *“not sales or marketing materials and they are not materials that producers present to employers or use to solicit, market or sell products.*

*Briefings are not training materials. Producers/brokers do not have any role in the administration of issuance of Certificates of Credible Coverage.” While the Company may be correct in its characterization of these “broker briefings,” these briefings are disseminated to its agent workforce as a resource tool. Thus, the Company should ensure content accuracy before dissemination.*

**COMPANY RESPONSE: The Company agrees with Recommendation 3 and advises that it has made the changes to the Broker Briefings.**

- Nine of the HMO brochures provide either, *“What’s Not Covered . . . Services and supplies that are generally not covered include, but are not limited to:” three state “Cosmetic Surgery,”* and six provide, *“Cosmetic Surgery including breast reduction.”* The brochures/advertisements are deceptive and misleading because the Company HMO policies include coverage for WHCRA benefits other than including Prosthesis, and therefore, the brochures are a violation of R.C. 1751.20. Breast reconstruction is always cosmetic, and is a mandated benefit of WHCRA and Insurance Bulletin 2001-1.

The Company responded, *“The Brochures that the examiners refer to in this request are no longer in production or circulation. As of 7/1/04 the Brochures no longer contain a list of “what’s not covered. . . .” Attached for review are copies of the Brochures currently used in marketing the Company’s HMO based plans.”* Regardless of subsequent changes, all nine brochures were failed, because the Company provided them during the period under examination.

**COMPANY RESPONSE: The Company agrees with Recommendation 4 and advises that as of 7/1/04, this form is no longer in use.**

## COMPLAINTS AND GRIEVANCES

*Complaints and Grievances Standard #1 – Test all Ohio Department of Insurance & Department of Health complaints to determine if the Company actions, which developed the Complaint, and the resolved the Complaint, complied with HIPAA, WHCRA and Ohio statutes and rules.*

The Company was requested to supply all the AHI Department complaints and all the Ohio Department of Health (“DOH”) complaints. The Company indicated there was a total of 105 Department and DOH complaint files. However, when the Company provided the complaints, it indicated five of the 2003 complaints and seven of the 2002, complaints were ASO (self-insured members were excluded from testing) files, and another file was a duplicate file. Therefore, there was a total of 92 files (105 - 5 - 7 - 1 = 92) initially tested.

After completing a comparison of the AHI listing of Department complaints with the 92 files provided, it was discovered that the Company failed to provide 28 AHI Department complaint files for testing. In addition, the Department complaint files were compared with the Department supplied COSMOS listing of complaints. The comparison indicated

there were 13 HMO member Department complaints omitted. The omitted files were requested and a total of (92 + 28 + 13 = 133) 133 Department and DOH complaint files were tested. The results of the testing are indicated in the table below:

Total # of Files	Failed HIPAA	Failed WHCRA	Failed NMHPA	Failed Ohio	% Failed Ohio
133	2	0	1	12	9%

**Department Complaints**

- Nine files did not have all the documentation associated with the file presented for testing. In response, the Company stated, *“I agree with the above . . . .”* Therefore, the nine files were failed because the Company failed to maintain complaint records in compliance with R.C. 1751.19(C)(1), which provides: *“Copies of complaints and responses, including medical records related to those complaints, shall be available to the superintendent and the director of health for inspection for three years.”*

The Company response also indicated it has taken corrective measures to try to improve its complaint retention procedures. The Company stated, *“In late 2003, Company transitioned to an online system (Complaint and Appeals Tracking System) to improve overall tracking, storage and reporting of all complaints and appeals including Department of Insurance complaints. In early 2004, Company implemented a Quality Audit Program that samples the complaint analysts’ files to insure that files have been appropriately and adequately imaged, to include the complaint, response(s) to member, provider and/or DOI, and all other pertinent documentation. Continual reminders to reinforce with complaint analysts across the country the need to insure that each complaint and appeal file must contain the following:*

- 1) *the original complaint or appeal*
- 2) *company’s responses*
- 3) *any and all supporting documentation*

**COMPANY RESPONSE: The Company agrees with Recommendation 5 and advises that it has implemented the Company’s document retention policy.**

- The Company indicated that claims for a newborn were first denied in 1998 because the provider billed using the father’s ID number, not the mother’s, and there was no pre-authorization under the father’s ID number. The members had copies of collection notices and bills from 1999, and hired an attorney to write letters to get the insurers to pay the bills it owed. Thus, the Company had ample time to determine if it was primary, and to determine if the claims had been filed under the correct ID number. In addition, the member’s letter indicates the other insurer paid its responsibilities. Therefore, the Company should have been able to locate the provider and adjudicate the

claims on the member's behalf. The claims had not been paid at the time of the Department Complaint, June 1, 2003.

The Company's failure to pay the claims was a violation of R.C. 3923.63(A) and (A)(1), "Maternity benefits for include inpatient and follow-up care minimums; early discharge decisions; prohibitions," and 45 CFR § 146.130 "Standards relating to benefits for mothers and newborns." R.C. 3923.63(A) states in part, "each individual or group policy . . . that provides maternity benefits shall provide coverage of inpatient care and follow-up care for a mother and her newborn as follows: . . ." Federal Regulation § 146.130 states in part, ". . . a group health plan . . . that provides benefits for a hospital length of stay in connection with childbirth for a mother or her newborn may not restrict benefits for the stay to less than – (i) 48 hours following a vaginal delivery; or (ii) 96 hours following a delivery by cesarean section. (2) When stay begins . . ." Federal Regulation § 146.117(b)(5), "Special enrollment periods," states in part, ". . . if the individual is a dependent of a participant and the individual becomes a dependent of such participant through marriage, birth, or adoption . . ." (b) (7) states in part, "The special enrollment under paragraph (b)(1) of this section is a period of not less than 30 days and begins on the date of marriage, birth, or adoption . . ."

The Company stated, "*The Company is investigating whether the member has paid any of these charges and if so, Company intends to reimburse covered charges to the member.*"

**COMPANY RESPONSE: The Company agrees with Recommendation 6.**

*Complaints and Grievances Standard #2 – Sample internal complaint files by complaint reason, to determine if Company actions, which developed the complaint and the resolution, were in compliance with HIPAA, WHCRA, NMHPA and Ohio statutes and rules.*

The Company provided a listing of 1,693 Internal Complaints/Appeals for 2002 and 1,369 for 2003. A total of 123 files were judgmentally sampled for testing based on the member reason for the Complaint/Appeal. During testing, it was discovered that five files were duplicates. Therefore, a total of 118 Internal Complaints/Appeals were tested.

The Appeal/Internal Complaint files were tested to determine if there had an issue related to HIPAA, WHCRA, NMHPA or Ohio statutes and rules. If the file contained a related issue, testing was to determine if the Company acted in compliance with those laws. The results of the testing are indicated in the table below:

# of Files	Failed HIPAA	Failed WHCRA	Failed NMHPA	Failed Ohio	% Failed
118	0	0	0	0	0%

There were no exceptions noted during the testing of Internal Complaints/Appeals.

**COMPANY RESPONSE: The Company agrees.**

*Complaints and Grievances Standard #3 – Sample grievance/appeals files by complaint reason for testing, to determine if Company actions which developed the complaint and the resolution was in compliance with HIPAA, WHCRA, NMPHA and Ohio Statutes and Rules.*

The Company's appeal files were provided, sampled, and tested with the Internal Complaints and was included in the testing for Standard #2 above.

The Company has indicated that it now utilizes an on-line company-wide tracking system for the management of complaints, grievances and appeals which will help eliminate the possibility that a manually managed file could inadvertently be misfiled and, therefore, unaccounted.

**COMPANY RESPONSE: The Company agrees.**

**CONTRACT/POLICY LANGUAGE**

*Contract/Policy Language #1 – Test all contracts/policies, applications, riders and endorsements to determine if the contractual language is in compliance with HIPAA, WHCRA and Ohio statutes and rules, e.g. benefits, pre-ex, guaranteed issue, guaranteed renewable, etc.*

All the contract/policy forms (including applications, riders and endorsements) issued or renewed during the period under examination were tested to determine if the forms were in compliance with Ohio and/or federal law(s).

At this point, it is important to emphasize that the examiners were reviewing the contract and policy language for content only to see if these materials complied with the applicable federal and state laws. The Company, in several of its responses, indicated that while a contract and policy language's content may be contrary to the applicable federal and state laws, its implementation of HIPAA, NMPHA, WHCRA, and Ohio statutes and rules were in compliance with those provisions. Whether this is, in fact, the case, is not the purpose behind these tests.

Ohio Small Group Business Employer Application

The Company's "Ohio Small Group Business Employer Application" provided Waiting Period options for small employers of 90, 120, and 180 days with the benefit period starting on the first day of the month following the Waiting Period. To provide Waiting Period options in excess of 90 days contravenes R.C. 3924.03(E)(2), "Conditions applicable to small employer health benefit plans." The Company disagreed, stating, "The employer application has been amended to remove the 120 and 180 day waiting

*period options. It was filed on 7/6/04 with the Ohio Department of Insurance.*” However, the Application was used throughout the examination period.

**COMPANY RESPONSE: The Company agrees with Recommendation 7 and advises that it has already made this change to the small group application.**

The Company’s “Ohio Small Group Business Employer Application” provided, *“I understand that Aetna may choose not to accept this application at its sole discretion.”* The Company cannot choose or exercise discretion, sole or otherwise, concerning the acceptance of a Small Employer’s application for insurance. An “exercise of discretion,” as this application suggests, contravenes the requirements of the following laws which require an issuer to accept every small employer in the state that applies for such coverage: R.C. 3924.03(3)(1) “Conditions applicable to small employer health benefit plans,” Public Law, 104-191, Part A-Group Market Reforms, Section 2711, “Guaranteed Availability of Coverage for Employers in the Group Market,” subsection (a)(1)(A), and 45 CFR § 146.150 “Guaranteed availability of coverage for employers in the small group market.”

The Company disagreed, stating that it *“has not declined to offer and quote any of its small employer plans to any interested small employer and did not decline any small employer group that submitted an application and met contribution and participation criteria for coverage,”* and *“A copy of the Small Group Application that was filed in early July, 2004 with the Ohio Department of Insurance is attached for your reference. Please note that the application no longer contains the following phrase: “choose not to accept this application at its sole discretion.”* Again, the Application in question was used throughout the examination period.

**COMPANY RESPONSE: The Company agrees with Recommendation 8 and advises that it has already made this change to the small group application.**

The Company’s Group Agreement provided for termination of the group contract if the Contract Holder did not confirm an intent to renew within a specified period before renewal. Neither federal nor state law permits termination of the group contract for this reason. The statement contravenes R.C. 3924.03(B)(1), “Conditions applicable to small employer health benefit plans,” which defers to Section 2712(b) to (e) of the “Health Insurance Portability and Accountability Act of 1996” for the exceptions to the requirement for guaranteed renewability. The Group Agreement is, therefore, also in contravention of Public Law 104-191, Part A-Group Market Reforms, Section 2712(b) to (e), “Guaranteed renewability of coverage for employers in the group market,” and 45 CFR § 146.152(a) and (b)(2), “Guaranteed renewability of coverage for employers in the group market.” The Company responded, *“The Company will remove Section 6.2 from the Group Agreement.”*

**COMPANY RESPONSE: The Company agrees with Recommendation 9.**

The Company's "Service Agreement" for small groups covered under a Contract Holder's plan (e.g. Association groups or similar entities), provided for Small Employer Groups with a *history* of fraud to be ineligible for coverage. Exhibit A of the Service Agreement stated, "In order for a Group to be eligible through the Contract Holder under this Agreement, the Group must have *no history* of fraud or *misrepresentation*." The Company must accept every small group that is a Member Employer of the Contract Holder if that small group applies for coverage through the Association or similar entity, whether or not the group has a history of fraud or misrepresentation. The only reasons for denying coverage to a small group are specified in R.C. 3924.031(B)(2)(a), and R.C. 3924.032(a)(1), "Options of carrier offering network plan" and "Conditions for refusal to issue plans in small employer market" respectively (capacity and financial reserves). In the case of fraud or intentional misrepresentation of material fact under the plan, the Company may discontinue or nonrenew the small group plan, but may not refuse to issue due to the small group's history. To refuse to issue coverage because of a small groups history is a violation of R.C. 3924.03(E)(1), "Conditions applicable to small employer health benefit plans," Public Law 104-191, Subtitle C-Definitions, Section 2711(a)(1)(A), "Guaranteed availability of coverage for employers in the group market," and 45 CFR § 144.150(a)(1), "Guaranteed availability of coverage for employers in the small group market."

The Company disagreed, stating, "*Public policy strongly supports the concept that insurers should not have to insure groups that have a repeated history of fraudulent insurance activity. As fraudulent activity in the health insurance area drives up premium costs for everyone and allows fraudulent groups to perpetuate their fraud by switching carriers is not the purpose of the above-referenced statutes.*"

However, while the law permits cancellation for fraud, it does not permit refusal to issue based on *previous* fraudulent activity by the Contract Holder.

**COMPANY RESPONSE: The Company agrees with Recommendation 10.**

The group Certificate of Coverage ("COC") and the Open Enrollment Certificate of Coverage provided for the benefits required by the WHCRA, except for benefits for prostheses. When the Company's COC describes the benefits provided by WHCRA, it should not omit any benefit for which the Act requires coverage. Failure to include prostheses contravenes Ohio Bulletin 2001-1, "The mental health parity act of 1996 and the women's health and cancer rights act of 1998," and WHCRA, at Section 2706 of the Public Health Service Act (PHS Act) which further incorporates by reference, Section 713 of the Employee Retirement Income Security Act of 1974 (ERISA 713), "Required Coverage for Reconstructive Surgery Following Mastectomies," and 2752 of the PHS Act, which indicates that Section 2706 requirements also apply to the individual market. The Company response concerning the group COC by stating it would "*amend Section R. of the Certificate of Coverage to include benefits for prostheses. The amended Certificate will be filed with the Department.*"

In response to the Open Enrollment Certificate of Coverage, the Company stated, *“Company agrees to amend and file the Open Enrollment Certificate of Coverage to include coverage for prosthetic devices related to breast reconstruction surgery required by WHCRA. Despite the fact that the verbiage regarding this benefit is not currently found in the Certificate, prosthetic devices related to breast reconstruction required by WHCRA are covered.”*

**COMPANY RESPONSE: The Company agrees with Recommendation 11.**

The Company’s group and individual COC, including the “Conversion Certificate” and “Open Enrollment Certificate of Coverage,” contained a provision that provided for a newborn child, including an adopted newborn, and a newborn placed for adoption, to be covered from the date of birth, *but only for injury and sickness*. Notwithstanding the coverage described elsewhere in the Certificates, which does include well newborn care, the COCs should not state that a newborn’s coverage is restricted to coverage for injury and sickness. Such a statement contravenes the following laws, which require coverage for a newborn, whether sick or well, from the moment of birth: R.C. 1751.61(A) and R.C. 1751.67(A), “Coverage for newly born child,” and “Maternity benefits to include inpatient and follow-up care minimums; early discharge decisions; prohibitions” respectively. For the group Certificate, the wording also contravenes 45 CFR § 146.130(a)(1), “Standards relating to benefits for mothers and newborns.” For the Open Enrollment and Conversion Certificates, the wording also contravenes 45 CFR § 148.170(a), “Standards relating to benefits for mothers and newborns.”

**COMPANY RESPONSE: The Company agrees with Recommendation 13.**

The Company, when asked to amend and refile its subsection concerning enrollment of newborn children to remove the statement that coverage consists of coverage of injury and sickness, responded: (1) For the group Certificate, *“We agree to remove the wording in the Eligibility and Enrollment section of the Certificate so as not to confuse members. However, the Covered benefits section of the Certificate does provide coverage for preventative and well baby care.”* (Note: The Company did *not* state it would re-file the provision without the restrictive wording); (2) for the “Conversion Certificate,” *“The Company will amend the language in the Newborn Children provision of the Eligibility and Enrollment section to remove the statement that coverage consists of coverage of injury and sickness. The amended Conversion Certificate of Coverage will then be filed with the Ohio Department of Insurance”*; and (3) for the “Open Enrollment Certificate,” *“Company respectfully disagrees. The language in the Enrollment and Eligibility section is not intended to be such a limitation on newborn coverage. . . . However, we have no objection to deleting the words ‘illness and injury’ in the eligibility section.”*

**COMPANY RESPONSE: The Company agrees with Recommendation 12.**

The group COC provided that a Member must have been continuously enrolled under the HMO for three months in order to be eligible for conversion coverage. The COC stated,

“In the event a Member ceases to be eligible for coverage under this Certificate and has been continuously enrolled for 3 months under HMO, such person may . . . convert to individual coverage with HMO . . . .” The law does not provide for a Member to have been continuously enrolled for three months in order to be eligible for conversion coverage. This statement contravenes R.C. 1751.16(A), “Option for conversion from group to individual contract,” which provides for the conversion option to be available to any subscriber covered under the group contract upon termination of employment or membership in the group. The Certificate also stated that a Federally Eligible Individual *may* have the right to convert. The term “may” should not be used when referring to a Federally Eligible Individual’s right to a conversion contract. A Federally Eligible Individual has the right to convert. This right is granted under R.C. 1751.16(A), “Option for conversion from group to individual contract,” and supported by 45 CFR § 148.120, “Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage.”

The Company agreed and stated it would “*remove the 3 months of continuous enrollment requirement,*” “*change the language from “may also have the right” to “has the right,”*” and “*file the amended form with the Ohio Department of Insurance.*”

**COMPANY RESPONSE: The Company agrees with Recommendation 14.**

The Company’s “Group Agreement, Services Agreement and Employer Verification” Form provided for differing termination dates, none of which correctly described the date on which a small group may be terminated if participation falls from two to one eligible employee. The different termination dates each contravened R.C. 3924.01(N)(2), “Definitions,” which is supported by HCFA Bulletin, (Transmittal No. 99-03 (V), September 1999) “Group size issues under Title XXVII of the Public Health Service Act,” Public Law 104-191, Part A—Group Market Reforms, Section 2721(a), “Exclusion of certain plans,” and 45 CFR § 146.145(a), “Special rules relating to group health plans.” The Transmittal provides that coverage cannot be terminated until the first renewal date following the beginning of a new plan year, even if the issuer knows at the beginning of the plan year that the employer no longer has at least two participants who are current employees.

Regarding the date on which the Company terminates a small group that falls from two to one, the Company stated, “*Company does not have a policy that specifically addresses the issue of when an existing small group may be terminated for falling below 1 enrollee. In addition, we have found no such plans during the time period covered by this review that Company terminated because the number of enrolled employees decreased to 1.*” The Company was informed that it should amend its “Service Agreement and Employer Verification” form to provide consistent termination dates that comply with law, particularly for a group that falls to one eligible employee. The Company responded, “*Company agrees that it will amend its forms as needed to be expressly consistent with CMS Transmittal No. 99-03. Company’s intent is not to term a group “any time” for any reason but only as permitted by HIPAA. The exact text of the language will need to be developed and then submitted to the department pursuant to the Department’s normal form filing procedures. For example, Company will need to determine how much prior*

*notice to provide for termination based on a group falling to one employee. As a future practice, Company will not terminate a group' until the first renewal date following the beginning of a new plan year, even if the Company knows as of the beginning of the plan year that the employer no longer has at least two participants who are current employees. As stated previously, however, during the time period of this exam, the Company did not terminate any group for this reason."*

**COMPANY RESPONSE: The Company agrees with Recommendation 15.**

The Company's "Conversion Certificate" provided that only Federally Eligible Individuals were eligible for coverage under the Conversion Certificate. The Company advised that the "Conversion Certificate" that it provided for examination, is the Certificate issued to all Members wishing to convert their coverage to either the Basic or Standard Plan, even though the Certificate denies eligibility to any individual who is not federally eligible. With some exceptions, R.C. 1751.16(A), "Option for conversion from group to individual contract," requires the issuance of an individual conversion contract to all individuals who have terminated employment or membership in the group. To issue a Certificate to a non-federally eligible individual, when the Certificate provides that the individual is not eligible for coverage under that Certificate, contravenes the requirements of R.C. 1751.16(A) and R.C. 3901.21(A), "Option for conversion from group to individual contract" and "Unfair and deceptive acts defined," respectively. The Company responded, "*The Company does offer an HMO Conversion policy to all federally and non-federally eligible individuals. However, to avoid confusion, the form will be amended to remove the reference to federally eligible Individual.*"

**COMPANY REPSONSE: The Company agrees with Recommendation 16.**

The Company's Ohio Basic and Standard Conversion Certificate, which is Ohio's alternative mechanism, provided for the exclusion of surgery to correct the results of injuries unless the surgery is performed within 2 years of the injury, or the surgery is a continuation of a staged reconstruction procedure. This Certificate exclusion imposes a preexisting conditions limitation on surgery for an injury that would otherwise be covered under the plan if treated promptly by providing in the Exclusions, "*This exclusion does not apply to surgery to correct the results of injuries when performed within 2 years of the event causing the impairment, or as a continuation of a staged reconstruction procedure.*"

- (1) The Company cannot impose a pre-existing condition exclusion on surgery that is otherwise covered for an injury, due simply to prior non-treatment of the injury, regardless of the reason for non-treatment, unless the injury occurred before coverage under the contract. In such a circumstance, credit towards satisfaction of the pre-existing condition limitation must be given for any time the individual was covered under prior coverage. Coverage cannot be excluded.
- (2) The Company cannot impose any preexisting condition limitation on a federally eligible individual.

- (3) The Company cannot require in the case of reconstructive breast surgery, the surgery to be a *continuation* of a staged reconstruction procedure. Such a restriction would deny coverage for reconstructive breast surgery if reconstruction had not already begun.

The Company's provision contravenes R.C. 3924.03(A)(2), "Conditions applicable to small employer health benefit plans," Public Law 104-191, Part A—Group Market Reforms, Sections 2701(c)(1) and 2706, "Increased portability through limitation on preexisting condition exclusions," and "Required Coverage for reconstructive surgery following mastectomies" respectively, Public Law 104-191, Subtitle B-Individual Market Rules, Section 2744(a)(1)(B), "State flexibility in individual market reforms," 45 CFR §§ 146.111(a)(1), 146.115(d)(2) and 148.120(a)(2), "Limitations on preexisting condition exclusion period," "Certification and disclosure of previous coverage," and "Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage" respectively, Ohio Bulletin 2001-1, "The mental health parity act of 1996 and the women's health and cancer rights act of 1998," and WHCRA, at Section 2706 of the Public Health Service Act, which further incorporates by reference, Section 713 of the Employee Retirement Income Security Act of 1974 (ERISA 713), "Required Coverage for Reconstructive Surgery Following Mastectomies," and 2752 of the PHS Act, which indicates that Section 2706 requirements also apply to the individual market. The Company responded, "*Re: Surgery to repair an injury to be performed with 2 years of the injury. Company agrees to amend the certificate to remove the restriction on surgeries performed to correct the result of injuries if the surgery is not performed within 2 years of the event causing the impairment. The amended Conversion Certificate of Coverage will be filed with the Ohio Department of Insurance.*" In response to item (3) above, the Company stated, "*The Company agrees to amend the Conversion Certificate to include the Reconstructive Breast Surgery benefits required under WHCRA. Despite the fact that the verbiage regarding this benefit is not currently found in the Certificate, breast reconstruction benefits are covered for Conversion policy members. These services require pre-certification and if approval is given for these services, the claim is paid.*"

**COMPANY RESPONSE: The Company agrees with Recommendation 17.**

The Company's Basic and Standard Plan Conversion Certificate, which is Ohio's alternative mechanism, excluded coverage for prosthetic devices, and reconstructive surgery unless the surgery is deemed Medically Necessary to restore normal physiological functioning. Coverage for prostheses and reconstructive surgery following a mastectomy is required under the WHCRA. To deny coverage for prostheses and reconstructive breast surgery contravenes Ohio Bulletin 2001-1, "The mental health parity act of 1996 and the women's health and cancer rights act of 1998," WHCRA, at Section 2706 of the Public Health Service Act, which further incorporates by reference, Section 713 of the Employee Retirement Income Security Act of 1974 (ERISA 713), "Required Coverage for Reconstructive Surgery Following Mastectomies," and 2752 of the PHS Act, which indicates that Section 2706 requirements also apply to the individual market (includes the requirement for conversion policies to comply with the Act). Any

requirement for restoration of normal physiological functioning is moot to the provision of this benefit.

The Company responded, "*Company agrees to amend and file the Conversion Certificate of Coverage to include coverage for prosthetic devices related to breast reconstruction surgery required by WHCRA. Despite the fact that the verbiage regarding this benefit is not currently found in the Certificate, prosthetic devices related to breast reconstruction required by WHCRA are covered. See attached clinical policy bulletin which provides guidance to claim processors.*"

The review of the clinical policy bulletin, which is used by claim processors, showed that the Company covers reconstructive breast surgery following a mastectomy and also covers prostheses. However, wording in the contract that excludes these benefits may deter claims. The contract should specifically state that the benefits specified in WHCRA are covered.

The Company was also asked to comply with R.C. 3924.10, "Design, adoption and contents of OHC plans; renewal of coverage," which states that the board of directors of the Ohio Health Reinsurance Program will establish the form and level of coverage to be made available by carriers in their OHC plans. The Benefits Outline prepared by the board includes in the Schedule of Benefits, the requirements for coverage of reconstructive breast surgery. This is not included in the Company's Schedule of Benefits for its conversion plans. The Company responded, "*Company agrees to file the amended Schedule of Benefits as noted above.*" However, the Company did not state it would remove or amend the *exclusion* of "reconstructive surgery unless deemed medically necessary to restore normal physiological functioning." The contract, therefore, remains out of compliance with Ohio Bulletin 2001-1, "The mental health parity act of 1996 and the women's health and cancer rights act of 1998," and WHCRA.

**COMPANY RESPONSE: The Company agrees with Recommendation 18.**

The Company's Basic and Standard Plan Conversion Certificate, which is Ohio's alternative mechanism, provided for the termination of the Certificate if there is (1) a change in the eligibility or participation requirements of the Contract Holder (the Subscriber), or (2) if the HMO ceases to offer coverage in the individual market.

With regard to (1) above, a change in the eligibility or participation requirements of the Subscriber (such as termination by the Subscriber of coverage for his or her spouse or child) is not a reason for termination of the conversion contract under either Ohio or federal law. Termination for such a reason contravenes R.C. 1751.57(A)(1), "Conditions applicable to individual contracts; group contracts unrelated to employment," and Public Law 104-191, Subtitle B—Individual Market Rules, Section 2742(a) & (b), "Guaranteed renewability of individual health insurance coverage." With some exceptions, these laws require the issuer to renew the coverage at the option of the Contract Holder. The Company responded, "*Company agrees to remove the statement that coverage may be*

*terminated due to a change in the eligibility or participation requirements of the contract holder.”*

**COMPANY RESPONSE: The Company agrees with Recommendation 19.**

With regard to (2) above, the Company is not in the individual market in Ohio, and therefore, to provide for termination due to an exit from a market in which the Company is not a participant, is not a valid reason for termination. The Company responded, “. . . *the Company will amend the referenced section as follows: HMO ceases to offer coverage in the Service Area in accordance with state law. The amended Conversion Certificate of Coverage will be filed with the Ohio Department of Insurance.*”

**COMPANY RESPONSE: The Company agrees with Recommendation 20.**

The Company’s Basic and Standard Plan Conversion Certificate, which is Ohio’s alternative mechanism, and the “Open Enrollment Certificate of Coverage” provided for termination of the Member’s coverage upon eligibility for Medicare. The Open Enrollment COC is the Certificate issued to individuals accepted for coverage during the Annual Open Enrollment Period required under R.C. 1751.15, “Annual open enrollment period; transplant coverage; reinsurance program.” Both Certificates provided for termination of the contract or a Member’s coverage under the contract upon eligibility of the Member for Medicare. The Company cannot terminate a conversion or any other individual contract because a person becomes *eligible for* Medicare. The contract, by law, is unaffected by the Medicare *eligibility* of an individual. Neither can the Company terminate a conversion contract when a person becomes *entitled to* Medicare. HCFA Bulletin (Transmittal No. 01-01, March 2001), “Guaranteed Renewability of Conversion Policies,” in the section “Guaranteed Renewability,” clearly provides that conversion policies are renewable at the option of the individual, subject to the exceptions noted in section 2742(b) to (e) of the “Health Insurance Portability and Accountability Act of 1996.” To terminate a conversion or other individual contract due to Medicare eligibility contravenes R.C. 1751.57(A), “Conditions applicable to individual contracts; group contracts unrelated to unemployment,” respectively, Public Law 104-191, Subtitle B-Individual Market Rules, Section 2742(a) & (b), “Guaranteed renewability of individual health insurance coverage,” 45 CFR § 148.122(b)(2), “Guaranteed renewability of individual health insurance coverage,” and HCFA Bulletin (Transmittal No. 01-01, March 2001), “Guaranteed Renewability of Conversion Policies,”

In response to termination of a conversion contract due to Medicare eligibility, the Company disagreed, stating, “*According to O.R.C. § 1751.16(B)(2) the converted policy may contain provisions for avoiding duplication of benefits as approved by the superintendent. The conversion language above was approved by the Department. However given the position of the examiner, we will modify the language consistent with this inquiry.*” The Company responded to the Open Enrollment contract by stating, “*According to O.R.C. § 1751.16(B)(2) the policy may contain provisions for avoiding duplication of benefits as approved by the superintendent . . . . However given the position of the examiner, we will modify the language consistent with this inquiry.*”

R.C. 1751.16(B)(2) permits coordination of benefits *with those of Medicare to the extent that Medicare pays*, if a person becomes entitled to Medicare *after* becoming insured under a conversion or other individual contract. However, the contract cannot be terminated due to Medicare entitlement.

**COMPANY RESPONSE: The Company agrees with Recommendation 21.**

The Company's "Open Enrollment Certificate of Coverage" provided for termination of the Subscriber's and his or her dependents' coverage upon eligibility for or coverage under an employer-sponsored health care plan, or availability of such coverage during an Open Enrollment Period. The "Open Enrollment Certificate of Coverage" is the COC issued to individuals accepted for coverage during the Annual Open Enrollment Period required under R.C. 1751.15, "Annual open enrollment period; transplant coverage; reinsurance program." The Open Enrollment Certificate provided for termination of the contract or a Member's coverage under the contract upon eligibility for or coverage under an employer-sponsored health plan or the availability of such coverage during an Open Enrollment Period. The Company cannot terminate an individual contract for these reasons. The contract is guaranteed renewable at the option of the insured except for the specific reasons set forth in law. A person who becomes covered under other coverage may have his or her benefits coordinated with the other coverage as permitted by state law, but the contract cannot be terminated due to other coverage and coverage cannot be coordinated with other coverage for which an insured is merely eligible. To terminate an Open Enrollment contract for such reasons contravenes R.C. 1751.57(A), "Conditions applicable to individual contracts; group contracts unrelated to unemployment," Public Law 104-191, Subtitle B-Individual Market Rules, Section 2742(a) & (b), "Guaranteed renewability of individual health insurance coverage," and 45 CFR § 148.122(c), "Guaranteed renewability of individual health insurance coverage," which prohibit termination of an individual contract for other than specific reasons. Eligibility for, entitlement to, or availability of other coverage are not among the specified reasons.

The Company response to the Open Enrollment contract by stating, "*According to O.R.C. § 1751.16(B)(2) the policy may contain provisions for avoiding duplication of benefits as approved by the superintendent. . . . However given the position of the examiner, we will modify the language consistent with this inquiry.*" While R.C. 1751.16(B)(2) permits coordination of benefits, it does not permit termination of the contract.

The "Open Enrollment Certificate of Coverage" (HMO/OH DIRPAYCOC-2 08-02) provided for termination of the Member's coverage immediately upon discovering a material misrepresentation in obtaining coverage or benefits under the Certificate. This may include furnishing incorrect or misleading information. The Company also reserves the right at its discretion, to rescind a Member's coverage (e.g., to void the coverage back to its effective date) on and after the date such misrepresentation occurred, and recover from the member the reasonable and recognized charges for covered benefits.

The law does not permit termination or rescission of a Member's coverage for other than fraud or intentional misrepresentation of material fact and then only if the fraud or

intentional misrepresentation of material fact is not related to health status. Intent is the overriding factor when a material misrepresentation occurs. In the absence of intent by the Member to misrepresent material facts, the Company (1) cannot terminate the Member's coverage; or (2) rescind the Member's coverage, or (3) recover charges before the date the act causing the termination occurred. It may only rescind coverage if the intentional misrepresentation of material fact occurs at the time of application, terminate the Member's coverage on the date the act occurs, non-renew the coverage on or after that date, and recover charges that resulted from or were incurred after the act. To terminate or rescind coverage otherwise, contravenes R.C. 1751.18(B), "Restrictions on canceling or failing to renew coverage; discrimination prohibited; appeals" and 45 CFR § 148.122(b) and (c), "Guaranteed renewability of individual health insurance coverage."

The Company agreed, but responded, "*The section of the Open Enrollment Contract noted in this Inquiry will be changed to read: 'Any intentional misrepresentation sufficiently material could result in the termination or rescission of this plan.' The amended form will then be filed for approval with the Ohio Department of Insurance.*"

**COMPANY RESPONSE: The Company agrees with Recommendation 22.**

Notwithstanding the use of the word "could," the Company's revision to the contract provides for rescission or termination of the plan, not just the offending Member's coverage under the plan for "any" intentional misrepresentation sufficiently material. Intentional misrepresentations of material fact related to health status cannot be used to rescind or terminate the plan, nor can such misrepresentations by any Member other than the Subscriber. This provision would permit the Company to *rescind* the entire family's coverage and recover all monies paid for claims, due to the actions of one Member, even if the contract had been in force for some time. It would also permit the Company to *terminate* the plan due to the actions of one Member. Only the actions of the Subscriber may result in the rescission of the plan and then only if the fraudulent act or intentional misrepresentation of material fact occurred in writing at the time of application. Otherwise, any such act may only result in the termination of the plan at the time the act occurred. An act by any other Member may only result in the termination of that Member's coverage at the time of the act. To do otherwise would contravene R.C. 1751.18(B) and R.C. 1751.57(A), "Restrictions on canceling or failing to renew coverage; discrimination prohibited; appeals," and "Conditions applicable to individual contracts; group contracts unrelated to employment," respectively. R.C. 1751.57 defers to section 2742(b) to (e) of Public Law 104-191, Subtitle B-Individual Market Rules, "Guaranteed Availability of individual health insurance coverage," which states that the issuer may nonrenew or discontinue an *individual's* coverage based on an *individual's* fraud or intentional misrepresentation of material fact under the terms of the coverage. The law does not permit the coverage of other individuals covered by the plan to be nonrenewed or discontinued unless the offending individual is the Subscriber.

## UNDERWRITING

**Underwriting Standard #1** – Test a sample of small group policies issued to determine if the Company actions are in compliance with HIPAA, WHCRA, NMPHA and Ohio statutes and rules.

The Company supplied listings of Small Group Contracts Issued indicating there were 91 issued during 2002 and 14 during 2003. The entire population for 2003 was judgmentally selected for sampling and 25 contracts were sampled for 2002. Therefore, there were 39 files originally sampled for testing. Upon testing it was revealed that two of the files sampled were small groups converted from an ALIC PPO plan to an AHI HMO plan. Therefore, the two files were omitted, and a total of 37 files were tested.

The table below indicates the results of testing the sampled small groups issued for the period under examination:

# of Files	Failed HIPAA	Failed Ohio	% Failed
37	24	24	65%

Four files evidenced the issuance of a contract to a small group despite the Employer's failure to meet the Company's contribution standards. The Company required an Employer with 2 – 9 Employees to contribute 100% of the cost of employee-only coverage or 50% of the cost of employee and dependent coverage, and for Employers with 10-50 Employees, 75% of the cost of employee-only coverage or 50% of the cost of employee and dependent coverage. The Company's "Small Group Participation/Contribution Requirements" provided, "Effective with the January 2002 New Business and February 2002 renewals, we will begin enforcing our participation and contribution guidelines in addition to adding more stringent guidelines for the 2 – 9 life segment." When asked why the Company did not enforce its contribution requirements for each of the above groups, it responded, "After a thorough review, it cannot be determined why the contribution guidelines were not enforced."

The rules of the issuer must be imposed uniformly and without discrimination. To issue contracts that do not comply with the Company's contribution rules contravenes R.C. 3924.03(E)(1), "Conditions applicable to small employer health benefit plans," which is supported by Public Law 104-191, Part A – Group Market Reforms, Section 2711(e), "Guaranteed availability of coverage for employers in the group market," and 45 CFR 146.150(e), "Guaranteed availability of coverage for employers in the small group market." Any such actions on the part of the issuer could imply that the Company may discriminate against some groups with poor health status by denying coverage based on the Employers' non-complying contribution percentages, while accepting others with superior health status, although those Employers' contributions were also non-complying. The rules of the health insurance issuer must be uniformly applied to small employers.

The Company responded, *“The Company agrees to uniformly apply its small group participation contribution percentages according to its underwriting guidelines. As of 11/01/02, the New Business Small Group Underwriting Unit in Jacksonville Florida implemented the rollout and training of documented Ohio Underwriting Guidelines including contribution percentage requirements. Additionally, the New Business Small Group Underwriting Unit performs a monthly Quality Review Audit on a random sampling of new business cases. This audit includes a review to insure the enforcement of its small group contribution percentage rules.”*

**COMPANY RESPONSE: The Company agrees with Recommendation 23.**

The Company’s “Small Group Proposal” sheet provided for a minimum 3 months and maximum 6 months Waiting Period or a match with the incumbent carrier’s Waiting Period up to a maximum of 6 months. The “Ohio Small Group Business Employer Application” (GR-96241-OH (1/03)) provided Waiting Period options of 0, 30, 60, 90, 120, and 180 days. In response to the Waiting Period options of 120 and 180 days in the “Small Group Business Employer Application,” the Company responded, *“The employer application has been amended to remove the 120 and 180 day waiting period options. It was filed on 7/6//04 with the Ohio Department of Insurance.”*

**COMPANY RESPONSE: The Company agrees with Recommendation 25.**

The “Small Group Business Employer Application” also provided that the benefit period would start “on the first day of the policy month following the waiting period.” To delay coverage until the first day of the following contract month results in a Waiting Period longer than the specified number of days. Waiting Periods in excess of 90 days are not permitted under R.C. 3924.03(E)(2), “Conditions applicable to small employer health benefit plans.” The federal law supporting state law is found at Public Law 104-191, Part A – Group Market Reforms, Section 2702(a)(3), “Prohibiting discrimination against individual participants and beneficiaries based on health status,” 45 CFR §§ 146.143(a), 144.103, and 146.121(b)(1)(ii)(C), “Preemption; state flexibility; construction,” “Definitions applicable to both group (45 CFR part 146) and individual (45 CFR 148) markets,” and “Prohibiting discrimination against participants and beneficiaries based on a health status-related factor,” respectively. The Company responded, *“I agree with the factual findings. Please note that the forms mentioned in this Inquiry have already been amended, filed and approved to insure that no Small Employer Group will choose a BWP that exceeds 90 days.”*

**COMPANY RESPONSE: The Company agrees with Recommendation 24 and advises that the change to small group application has already been implemented.**

Eight files reflected Waiting Periods in excess of 90 days. Of these eight small groups, six had a Waiting Period of 90 days, one had selected 3 months and another, 180 days. By providing for benefit eligibility to start on the first day of the contract month following the Waiting Period, each of these groups had a Waiting Period in excess of the

maximum permitted under state law, thereby contravening R.C. 3924.03(E)(2), “Conditions applicable to small employer health benefit plans.” Federal law supports the state law’s definition of the maximum Waiting Period. Thus, to permit a Waiting Period greater than 90 days also contravenes Public Law 104-191, Part A – Group Market Reforms, Section 2702(a)(3), “Prohibiting discrimination against individual participants and beneficiaries based on health status,” 45 CFR §§ 146.143(a), 144.103, and 146.121(b)(1)(ii)(C), “Preemption; state flexibility; construction,” “Definitions applicable to both group (45CFR part 146) and individual (45 CFR 148) markets,” and “Prohibiting discrimination against participants and beneficiaries based on a health status-related factor,” respectively. The Company agreed with the factual findings and stated, *“Please note that the forms mentioned in this Inquiry have already been amended, filed and approved to insure that no Small Employer Group will choose a BWP that exceeds 90 days.”*

**Underwriting Standard #2** - *Test a sample of small group policies discontinued/terminated to determine if discontinued in compliance with HIPAA, and Ohio Statutes, Rules and Regulations. Determine if Certificates of Creditable Coverage were issued to terminated members in compliance with HIPAA and Ohio statutes and rules.*

The Company supplied a 2002 and 2003 listing of Small Group contracts discontinued. After the converted ALIC PPO contracts were excluded, there were 344 small group contracts discontinued during 2002, and 202 terminated during 2003. Twenty-five files were sampled for 2002 and 2003. Therefore, a total of 50 files were sampled for testing.

The results of testing small groups discontinued during the period under examination are indicated in the table below:

# of Files	Failed HIPAA	Failed Ohio	% Failed
50	11	11	22%

Two files evidenced Waiting Periods of 90 days with benefit eligibility starting on the first day of the contract month following the Waiting Period. In one other file, a Waiting Period of 180 days had been selected. These Waiting Periods are in excess of the 90 day maximum permitted by R.C. 3924.03(E)(2), “Conditions applicable to small employer health benefit plans,” which is supported by 45 CFR, §§ 146.150(b)(3) 146.143(a), 144.103, and 146.121(b)(1)(ii)(C), “Guaranteed availability of coverage for employers in the small group market,” “Preemption; state flexibility; construction,” “Definitions applicable to both group (45 CFR part 146) and individual (45 CFR 148) markets,” and “Prohibiting discrimination against participants and beneficiaries based on a health status-related factor,” respectively. The Company responded, *“I agree with the factual findings. . . .”*

Eight files did not contain information sufficient to determine whether the Company cancelled the plan or the Plan Sponsor requested the cancellation. When asked to document the source of the cancellation, the Company responded, “*After an extensive and thorough search, additional documentation could not be located.*” The files were failed because the Company was unable to provide evidence that the health plans were terminated in compliance with R.C. 3924.03(B)(1), “Conditions applicable to small employer health benefit plans,” which defers to Public Law 104-191, Part A – Group Market Reforms, Section 2712(b) to (e), “Guaranteed renewability of coverage for employers in the group market.” To contravene these laws would also be a contravention of 45 CFR, § 146.152, “Guaranteed renewability of coverage for employers in the group market.”

**COMPANY RESPONSE: Company agrees with Recommendation 26.**

**Underwriting Standard #3** – *Test a sample of small group declinations to determine if declined in compliance with HIPAA, and Ohio Statutes and Rules.*

The Company stated there were no small groups declined that applied for coverage during the period under examination.

**Underwriting Standard #4** – *Test a sample of conversion policies issued to determine if the policies are issued in compliance with HIPAA, NMHPA, WHCRA and Ohio Statutes and Rules.*

The Company supplied listings of 159 Conversion Policies issued during 2002 and 22 during 2003. The entire population for 2003 was judgmentally sampled and 28 files were sampled for 2002. Therefore, a total of 50 files were sampled for testing.

The results of testing Conversion Policies issued, during the period under examination, are indicated in the table below:

# of Files	Failed HIPAA	Failed Ohio	% Failed
50	0	8	16%

The Company indicated it could not provide the applications for four of the conversion policies issued, and could not determine how four applicants selected the plan they received. Therefore, a total of eight files were failed during testing of conversion policies issued.

The files were failed because the Company could not produce evidence that the applicant received the conversion plan for which they applied. The Company offers the Ohio Basic and Standard Plans as its only conversion plans. Because all the applicants failed were federally eligible individuals, the Company should have offered both the Basic and Standard plans to each individual. Without documentation to support it offered both plans, the Company may have only offered one plan in violation of R.C.

1751.16(B)(1)(b), “Option for conversions from group to individual contract,” which is supported by Public Law 104-191, Subtitle B-Individual Market Rules, Section 2744, “State Flexibility in individual market reforms.” and 45 CFR 148.128 “State Flexibility in individual market reforms-alternative mechanism.”

The Company responses to requests concerning files, which did not have documentation to support what plan the applicant selected, indicated that the applications did not confirm what plan the member selected, but the member should have been contacted by the conversion staff to verify which plan the member had chosen. In addition, the Company stated it could not produce notes from the account files for verification that this had occurred.

**COMPANY RESPONSE: The Company agrees with Recommendation 27 and advises that it has already implemented a company document retention policy.**

***Underwriting Standard #5** – When Conversion policies are discontinued/terminated, determine if discontinued in compliance with HIPAA, and Ohio Statutes and Regulations. Determine if Certificates of Creditable Coverage were issued to terminated members in compliance with HIPAA and Ohio statutes and rules.*

The Company supplied listings indicating there were 112 Conversion Policies discontinued during 2002 and 131 during 2003. An initial sample of 25 files was selected for both 2002 and 2003. However, testing of the sampled files revealed there were 17 files, which were never issued, or terminated in error. Therefore, the 17 files were replaced.

Of the 17 files added, four of the 2002 added files were never issued. Due to time constraints the four files were not replaced. In addition, during testing, it was discovered that three of the 17 files eliminated had previous Prudential coverage, and were converted to an AHI plan. Therefore, those three contracts originally eliminated were included back for testing, bringing the total to 49 files sampled for testing.

The results of testing Conversion Termination Files, for the period under examination, are indicated in the table below:

# of Files	Failed HIPAA	Failed Ohio	% Failed
49	49	49	100%

The Company did not issue certificates of creditable coverage (“CCC”) to any of its members terminated from a conversion plan. Therefore, all files tested were failed, and the Company practice has been a violation of R.C. 1751.57, “Conditions applicable to individual contracts; group contracts unrelated to employment,” (which references Public

Law 104-191, Section 2743), 45 CFR § 148.124, “Certification and disclosure of Coverage,” Public Law 104-191, Subtitle B – Individual Market Rules, Section 2743, “Certification of coverage,” (which references Section 2701(e)).

45 CFR § 148.124(b) states in part,

“General Rules—(1) Individuals for whom a certificate must be provided; timing of issuance. A certificate must be provided without charge, for individuals and dependents, who are or were covered under an individual health insurance policy for the following:

- (i) Issuance of automatic certificates. An automatic certificate must be provided within a reasonable time period consistent with State law after the individual ceases to be covered under the policy.”

The Company indicated CCCs were not issued to members terminated from its conversion products when it responded, *“I agree with the above. Copy of corrective action taken is attached.”*

*The Company agrees to:*

- 1) Issue Certificates of Creditable Coverage (CCCs) in compliance with HIPAA*
- 2) Provide access to copies of all CCCs for a period of 3 years as required by Ohio law*
- 3) Issue CCCs timely – subject to receipt of timely notice to Company by member of termination.”*

**COMPANY RESPONSE: The Company agrees with Recommendation 28 and advises it has corrected the COCC production.**

**Underwriting Standard #6** – *Determine if Conversion policies declined are declined in compliance with HIPAA, and Ohio Statutes and Rules.*

The Company was requested to provide a listing of all conversion applicants declined coverage during the period under examination. The Company response to the request was provided in an email, *“During the period of the exam (2002 and 2003), the AHI conversion unit did not keep documentation on the declined conversion requests. Beginning in the 3rd quarter of 2004, the conversion unit will keep appropriate documentation on all declined conversion requests. Despite the lack of documentation maintained during the exam period, the Company declined conversion coverage only in one or more of the following situations: 1) Requesting member had not been covered under an employer group policy 2) Requesting member did not exhaust all COBRA and state continuation benefits available to them 3) Requesting member did not make the request for coverage within the permitted time frame 4) Requesting member was eligible for Medicare.”* Therefore, testing could not be completed on the declined applications because the Company indicated it cannot determine if there were declined conversion applicants during the period under examination.

**COMPANY RESPONSE: The Company agrees with Recommendation 29 and advises it has already implemented the company document retention policy.**

**CLAIMS PAID AND DENIED**

***Claims Paid and Denied Standard #1 – Sample and test Paid Claim files, as determined from CPT codes selected, to determine if breast reconstruction benefits are provided in compliance with WHCRA and Ohio Bulletin 2001-1.***

The Company provided a listing with 2,793 mastectomy and breast reconstruction, “Claims Paid and Denied.” Because of the volume, the claims were sorted and the Denied Mastectomies and Breast Reconstruction files were eliminated leaving a total of 364 Paid Mastectomy files. It was judgmentally determined to delete all files with excision codes for procedures involving biopsies and/or lesion removals, which left a total of 172 files. A judgmental decision was made to extract and test all names, which appeared to be males (eight members), which left a total of 164 files. Forty-two files were sampled from the remaining 164. Therefore, a total of 50 files were sampled for testing.

Testing indicated nine files passed, 41 files did not have a claim associated with the benefits of WHCRA (N/A), and none of the files were failed. The failure results are shown in the table below:

# of Files	Failed WHCRA	Failed Ohio	% Failed
50	0	0	0%

***Claims Paid and Denied Standard #2 – Sample and test Denied Claims files, as determined from CPT codes selected, to determine if breast reconstruction benefits are provided in compliance with WHCRA and Ohio Bulletin 2001-1.***

The Company provided a listing with 2,793 mastectomy and breast reconstruction, “Claims Paid and Denied.” Because of the volume, the claims were sorted and the Mastectomy and Paid Breast Reconstruction files were eliminated. After that process, duplicate procedure files were eliminated leaving a total of 124 Denied Breast Reconstruction files. From the remaining 124 files, all the claims denied for CPT code 19318 were eliminated. CPT code 19318 (Reduction Mammoplasty) is generally assigned for procedures that do not involve a mastectomy. After exclusion of these files, there were a total of 65 Denied Claims remaining, and all were sampled for testing.

Testing indicated 19 files were passed, and 46 files did not have a claim associated with the benefits of WHCRA (N/A), and none of the files were failed. The failure results are shown in the table below:

# of Files	Failed WHCRA	Failed Ohio	% Failed
65	0	0	0%

***Claims Paid and Denied Standard #3 - Sample and test policy/certificate holders denied requests for Pre-Certification of Breast Reconstruction and/or prosthesis to determine if the denial was completed in compliance with WHCRA and Ohio Bulletin 2001-1.***

The Company provided a listing of 39 pre-certification denials for 2002 and 22 during 2003. The 61 files were sampled for testing. One file was for a member of an ASO, therefore, the file was withdrawn from testing, leaving a total of 60 files tested.

The results of the testing indicate there was one file failed, none passed, and 59 files did not contain requested benefits related to WHCRA (N/A). The failure results are indicated in the table below:

# of Files	Failed WHCRA	Failed Ohio	% Failed
60	1	1	2%

## ASSOCIATIONS

***Associations Standard #1 – Determine if Association products are issued and terminated in compliance with HIPAA and Ohio Statutes and Rules.***

Company responses indicated there were no certificates of coverage or memberships issued through an Association. There was only business sold through a Washington D.C. Multiple Employer Welfare Arrangement for the employees of two Associations located in Ohio. Therefore, further review of Associations, for the period under examination, was not deemed necessary.

## SUMMARY OF RECOMMENDATIONS

1. It is recommended the Company implement a process to guarantee all solicitations include the required information dictated in HIPAA as part of the solicitation process. *See Marketing and Sales Standard #1, Pages 4 & 5.*
2. The Company indicated it no longer limits the group market to four quotes. The Company indicated it will remove the limit of four quotes from its New Business Proposal. *See Marketing and Sales Standard #1, Page 5.*

3. The Company stated it will correct the language in its Broker Briefings in the 2<sup>nd</sup> quarter of 2004 due to the examination. It will issue certificates at termination and termination of COBRA. *See Marketing & Sales Standard #1, Pages 6 & 7.*
4. The Company indicated it no longer uses nine brochures, which noted, "What's not covered." The forms were misleading in referencing what was not a covered procedure. The Company indicated its new brochures have been revised without the wording. *See Marketing and Sales Standard #1, Pages 7.*
5. The Company agreed it had failed to maintain complete complaint records, and provided a corrective course of action to maintain complete complaint records. *See Complaints and Grievances Standard #1, Pages 8.*
6. The Company indicated it pays claims in compliance with NMHPA. In addition, it indicated it would investigate claims for one member to determine why a newborn's claims were not paid, and reimburse the covered charges if paid by the member. *See Complaints and Grievances Standard #1, Pages 8 & 9.*
7. The Company indicated it has changed its Employer Application and removed the 120 and 180 day waiting period options. In addition, it re-filed the application with the Department, July 6, 2004. *See Contract/Policy Language Standard #1, Page 10 & 11.*
8. The Company indicated its small group application has been amended and no longer contains the phrase, "choose not to accept this application at its sole discretion." *See Contract/Policy Language Standard #1, Page 11.*
9. The Company stated it would remove language from its Group Agreement, which allowed for termination if a group did not confirm intent to renew within a specified time frame prior to renewal. *See Contract/Policy Language Standard #1, Page 11.*
10. It is recommended the Company remove language, which allows it to decline coverage if the small group has a history of fraud or misrepresentation. This is not a valid reason for declination in the small group market. *See Contract/Policy Language Standard #1, Pages 12.*
11. The Company stated it would amend and file the Open Enrollment Certificate of Coverage to include coverage for prosthetic devices related to breast reconstruction surgery required by WHCRA. *See Contract/Policy Language Standard #1, Pages 12 & 13.*
12. The Company agreed to remove wording from the Eligibility and Enrollment section of its group Certificates of Coverage (COC). However, it did not agree to re-file the COCs. Therefore, it is recommended the COCs be re-filed. *See Contract/Policy Language Standard #1, Page 13.*

13. The Company stated it would amend the language in the Newborn Children provision of the Eligibility and Enrollment section of the Conversion COC. In addition, it agreed to remove a statement from the same form, which provides that coverage consists of coverage of injury and sickness. It also indicated the revised Conversion COC would be re-filed. *See Contract/Policy Language Standard #1, Page 13.*
14. The Company agreed to remove the 3 months of continuous enrollment requirement for conversion applicants, and change language to indicate a federally eligible individual has the right to conversion in its group COC. *See Contract/Policy Language Standard #1, Pages 13 & 14.*
15. The Company stated it would amend its Group Agreement, Services Agreement and Employer Verification form language regarding terminating groups when participation falls to less than two members. The Company intent in amending the forms is not to terminate a group “any time” for any reason but only as permitted by HIPAA. However, the Company indicated it had not developed the language for the forms. *See Contract/Policy Language Standard #1, Page 14 & 15.*
16. The Company agreed to amend its Basic and Standard Conversion policies by eliminating the reference to federally eligible individuals because the Company provides both plans to non-federally eligible individuals. *See Contract/Policy Language Standard #1, Pages 15.*
17. The Company agreed to amend the Standard and Basic Conversion COC to remove the restriction on surgeries performed to correct the result of injuries, if the surgery is not performed within 2 years of the event causing the impairment. *See Contract/Policy Language Standard #1, Pages 15 & 16.*
18. It is recommended the Company remove or amend the exclusion of reconstructive surgery unless deemed medically necessary to restore normal physiological functioning. The current provision is not in compliance with WHCRA and Ohio Bulletin 2001-1. *See Contract/Policy Language Standard #1, Page 16 & 17.*
19. The Company stated it would remove a statement from its Basic and Standard Conversion COCs, which indicates coverage may be terminated due to a change in the eligibility or participation requirements of the contract holder. *See Contract/Policy Language Standard #1, Page 17 & 18.*
20. The Company stated it would re-file its Basic and Standard Conversion COCs, to indicate that a member can be terminated if the Company ceases to offer coverage in a service area in accordance with state law. *See Contract/Policy Language Standard #1, Page 18.*
21. The Company first stated it could terminate members under its duplication of benefit standards (if Medicare Eligible) in its Conversion and Open Enrollment COCs, as

approved by the superintendent. However, it later indicated it would delete the provision, because to terminate a member for reason of duplication of benefits, or Medicare eligibility, is a violation of HIPPA's guaranteed renewability requirements in the individual market. *See Contract/Policy Language Standard #1, Page 15 & 19.*

22. The Company stated it would amend language in its Open Enrollment COC to allow any intentional misrepresentation sufficiently material could result in the termination or rescission of a plan. In addition, the Company stated it would re-file the COC with the amended changes. However, the corrected language allows for rescission of the entire plan, not just the member that committed the fraudulent act. It is recommended the Company amend the language to only allow for termination or rescission of a member that commits a fraudulent act. *See Contract/Policy Language Standard #1, Pages 19 & 20.*

23. The Company stated it could not determine, for six files, why its contribution guidelines were not enforced. In addition, it stated the Company agrees to uniformly apply its small group participation contribution percentages according to its underwriting guidelines, and agreed to perform monthly quality review audits on a random sampling of new business cases to insure enforcement. *See Underwriting Standard #1, Pages 21 & 22.*

24. The Company indicated it has amended and re-filed its Employer Application with the Department, allowing for only for waiting periods of 90 days or less. The form was re-filed July 6, 2004. *See Underwriting Standard #1, Pages 22.*

25. The Company indicated it has changed its Small Group Proposal form and removed a statement, which allowed it to match waiting periods up to a six-month maximum. In addition, it stated the Form was amended and re-filed with the Department, indicating waiting periods of only 90 days or less. *See Underwriting Standard #1, Pages 22.*

26. The Company indicated it could not find information for eight small groups to determine whether the Company cancelled the plan, or if the plan sponsor requested the cancellation. It is recommended the Company maintain all records to determine how small groups are terminated. *See Underwriting Standard #2, Page 23 & 24.*

27. It is recommended the Company maintain applications for all members who apply for conversion policies. The Company indicated it could not provide applications for four conversion policies issued to members. *See Underwriting Standard #4, Page 24 & 25.*

28. The Company indicated Certificates of Creditable Coverage (CCCs) were not issued to any members terminated from conversion coverage. In addition, it indicated it had taken corrective action to ensure CCCs would be issued to all future members terminated from a conversion policy. *See Underwriting Standard #5, Page 25 & 26.*

29. The Company stated it did not maintain files for determining if conversion applicants were declined during the period under examination. In addition, it indicated it was

enacting procedures to maintain records for all declined conversion applicants. *See Underwriting Standard #6, Pages 26.*

### **ACKNOWLEDGEMENT**

In addition to the undersigned, Yvonne Sainsbury, AIE, AIRC, participated in this examination.

Respectfully submitted,

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Thomas D. McIntyre, CIE, CPCU, FLMI, AIRC, APA  
Examiner-In-Charge  
For the State of Ohio  
Department of Insurance



**APPENDIX A – MANAGEMENT LETTER OF REPRESENTATION**



100 N. Riverside Plaza, F643  
Chicago, IL 60606-1518

**Maureen Weldon, MA, MBA, MHP**  
North Central Region Compliance Director  
PH 312-928-3156  
FAX 312-928-3840  
WeldonM@aetna.com

December 5, 2006

Melissa Hull  
Market Conduct Division  
Ohio Department of Insurance  
2100 Stella Court  
Columbus, OH 43215

Re: Targeted Market Conduct Examinations of Aetna Health Inc.

Dear Melissa:

In response to the Department's Report Re: Targeted Market Conduct Examination of Aetna Health Inc., Aetna's response is in the body of the report attached. Aetna also respectfully submits the following:

**Issues Identified**

The Marketing and Sales section of the report identified only a 2.9 % error rate, which is well within the NAIC guideline of a 5% tolerance. The Complaint and Grievance section of the report for internal complaints identified a 100% compliance rate. In addition, the examiners' review of claims payment practices also identified a 100% compliance rate. The results noted from these three areas, the cornerstones of most regulatory reviews, confirm that Aetna has established strong processes and controls to address these key areas of concern. The Company is committed to full compliance with all Ohio and federal laws and regulations.

While there were a number of issues identified in the Contract/Policy section of the report, the language concerns were of minor impact and did not result in practices that harmed a member.

Similarly, the Underwriting section of the report also identified a number of conversion policy language issues of minor impact that did not result in practices that harmed a member. We have corrected many of the languages changes noted in the report and have filed them with the Department. The remaining changes are in draft and will be submitted to the Department as soon as possible.

**Consumer Impact**

As stated above, the examiners did not look for or uncover evidence that any of the language issues identified in the report had resulted in significant consumer impact.

**Provision of Records**

Since the completion of these exams, the Company has adopted a formal, company-wide document retention initiative that will result in even stronger procedures and controls to retain and retrieve records as required by law and regulation and in support of business needs. In future exams, where the examiner provides consistent and timely direction on the records to be provided, the Company is confident that we will be able to respond timely and accurately to those requests.

We again want to emphasize that the Company has already made many of the changes recommended by the Department during the course of the exam as the Company is committed to full compliance with state and federal laws and regulations.

Sincerely,



Maureen Weldon  
North Central Regional Compliance Director

cc: Gerald Connor, Regional Counsel  
Janet S. Mann, Vice President, Counsel and Chief Compliance Officer  
Gregory Martino, Head of Government Relations  
Mary Taylor, Head of Regional Compliance

Attachments:

Draft Report with Company Response

STATE OF OHIO

DEPARTMENT OF INSURANCE

IN THE MATTER OF:

AETNA HEALTH INCORPORATED  
TARGETED MARKET CONDUCT  
EXAMINATION

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)

CONSENT ORDER

The Superintendent of the Ohio Department of Insurance (hereinafter the "Superintendent") is responsible for administering Ohio insurance laws pursuant to Ohio Revised Code § 3901.011. Aetna Health Inc. (the Company), an Ohio-domiciled health insuring corporation, is authorized to engage in the business of insurance in the State of Ohio and, as such, is under the jurisdiction of the Superintendent. The Superintendent conducted a targeted market conduct examination of the Company covering the period January 1, 2002, through December 31, 2003 (Examination).

The focus of the Examination was to determine the Company's compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the Women's Health and Cancer Rights Act (WHCRA); the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA); and the statutes (Ohio Revised Code, hereinafter "R.C."), and regulations, Ohio Administrative Code (hereinafter, "O.A.C.") of the State of Ohio, as published by Anderson, and as amended through September 2005.

The details of the Examination are contained in *The Ohio Department of Insurance, A Targeted Market Conduct Examination of Aetna Health Inc., NAIC #96518 as of December 31, 2003* (Report), which is incorporated by reference herein. After the Consent Order is executed by all parties, the Consent Order and Report will become a public record.

SECTION I

BASED UPON THE EXAMINATION THE SUPERINTENDENT DETERMINED:

In general, as provided in more detail in the Report, some of the Company's forms, documents, applications, and marketing and advertising materials failed to provide all of the information required by HIPAA or failed to accurately explain benefits or how the law applied; some of the Company's forms and documents failed to comply with both federal and Ohio law, e.g., the Company failed to properly issue COBRA certificates of coverage at the termination of coverage; the Company failed to maintain complete consumer complaint files and an accurate tracking system; the Company failed to maintain records of conversion policies; and the Company failed to issue certificates of coverage to individuals terminated from conversion coverage.

## SECTION II

IT IS HEREBY AGREED AND CONSENTED TO BY THE PARTIES THAT:

- A) The Superintendent and the Company enter into this Consent Order to resolve the allegations as set forth in Section I of this Consent Order. Further, the Company admits to the allegations set forth in Section I of this Consent Order.
- B) The Company has been advised that it has a right to a hearing before the Superintendent pursuant to R.C. Chapter 119; that, at a hearing, it would be entitled to appear in person, to be represented by an attorney or other representative who is permitted to practice before the agency; and that, at a hearing, it would be entitled to present its position, arguments or contentions in writing and to present evidence and examine witnesses appearing for and against it. The Company hereby waives all such rights.
- C) The Company consents to the jurisdiction of the Superintendent and the Ohio Department of Insurance (Department) to determine the issues set forth herein. The Company waives any prerequisites to jurisdiction that may exist.
- D) The Company hereby waives all rights to challenge or to contest this Consent Order, in any forum now available to it or in the future, including the right to any administrative appeal, or an action or appeal filed in state or federal court.
- E) The Company has reviewed this Consent Order with counsel and knowingly and voluntarily enters into this Consent Order.
- F) The Company agrees that the failure to adhere to one or more of the terms and conditions of this Consent Order shall constitute a violation of a lawful order of the Superintendent and the Department, and may subject the Company to all administrative action available to the Superintendent.
- G) By filing the Consent Order in this cause, the parties intend to and do resolve all issues arising out of actual or alleged violations of the laws and regulations of the State of Ohio that are the subject matter of Section I of this Consent Order.
- H) The Company agrees that upon the signing of this Consent Order by its authorized representative, it shall be subject to the following additional terms and conditions:
  - 1. The Company shall pay Fifty Thousand Dollars (\$50,000) civil penalty, with Twenty Thousand Dollars (\$20,000) suspended pending the outcome of the Self-Audit described in subparagraph H) 5, herein. All payments required to be made herein shall be sent within thirty (30) days of Company's receipt of an invoice from the Department and shall be paid by check or money order made payable to the "Ohio Department of Insurance."
  - 2. The Company shall henceforth comply with those provisions of the laws and regulations of the State of Ohio that are the subject matter of this Consent Order.
  - 3. The Company shall, on or before the 45<sup>th</sup> day after the Company signs this Consent Order, submit a Corrective Plan of Action (Plan) for approval by the

Superintendent within thirty (30) days of receipt. The Company's goal in preparing and implementing the Plan shall be the immediate correction of all violations identified in Section I of this Consent Order, as more fully set forth in the Report. The Plan will provide, at minimum, the following, for each item in the Plan that remains to be completed at the time the Company submits the Plan:

- (a) Identification of each corrective action to be taken in response to each violation cited in the Report, including the section of law to which each action relates;
  - (b) How each corrective action is to be addressed, including, without limitation, what will be done, by whom it will be done and the date it will be completed;
  - (c) The Company's corrective actions with regard to providing timely and complete data, files, responses to inquiries and memoranda during a market conduct examination or other inquiry by the Department; and
  - (d) The name of the Company officer, including his/her title, office location, and telephone number, who is responsible for assuring that all the corrective action necessary is documented in the Plan, and that each corrective action is undertaken and completed in a timely manner and in full compliance with the terms and conditions of this Consent Order and the Plan, as approved by the Superintendent.
4. The Company shall begin immediately, if it has not already done so, in good faith, to correct the problems identified in Section I of this Consent Order. Any corrective action taken before the Plan's formal approval by the Superintendent can be noted in the Plan when submitted.
  5. One hundred-eighty days (180) following the Company's execution of this Consent Order, the Company shall begin a self audit of up to thirty (30) days duration to determine whether it has successfully implemented the Plan (Self-Audit). The detailed results of the Self-Audit shall be provided to the Superintendent within fifteen (15) business days following the end of the self-audit period.
  6. At anytime after eighteen (18) months from the date the Superintendent signed this Consent Order, the Superintendent may initiate a targeted examination of the Company. This examination will cover the business areas reviewed in the Examination to determine whether the Company is in compliance with federal and Ohio laws and regulations that are the subject matter of Section I of this Consent Order. Any violations found may require the payment of up to the remainder of the civil penalty, as set forth in Section II, herein.
  7. If, pursuant to the terms of this Consent Order, the Superintendent has not initiated a targeted examination of the Company on or before December 1, 2007, in lieu of the examination and possible fine of up to Twenty Thousand Dollars

(\$20,000), the Company may advise the Superintendent, in writing, that it has elected to:

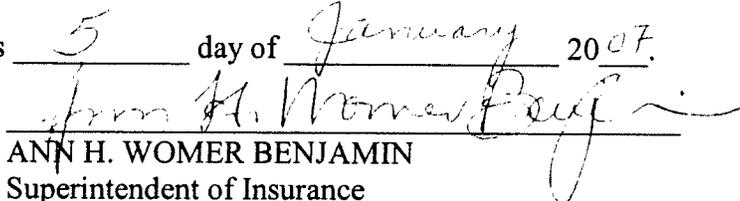
(a) pay one-half of the pending fine (Ten Thousand Dollars [\$10,000]); and

(b) certify to the Superintendent, in a writing signed by an authorized officer of Company, that the Company is in compliance with the requirements of this Consent Order and have corrected the violations set forth in Section I, herein.

**NOW, THEREFORE**, the agreement by and between Aetna Life Insurance Company, the Superintendent and the Department, consisting of the terms and conditions set forth above, is approved.

**FURTHER**, all terms and conditions are hereby ORDERED.

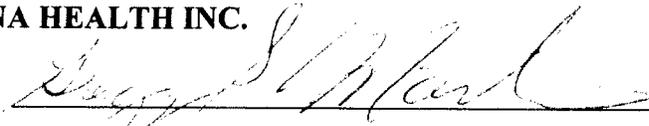
**APPROVED AND ORDERED** this 5 day of January 2007.

  
ANN H. WOMER BENJAMIN  
Superintendent of Insurance

**AETNA HEALTH INC.  
ACKNOWLEDGEMENT AND ACCEPTANCE**

**By execution hereof, Aetna Health Inc., consents to entry of this Consent Order, agrees without reservation to all of the above terms and conditions, and shall be bound by all provisions herein. The undersigned represents that he/she has the authority to bind Aetna Health Inc. to the terms and conditions of this Consent Order.**

**AETNA HEALTH INC.**

By: 

Print or type name: Gregory S. Martino

Title: Vice President

Date: 1-4-07