# PRESS RELEASE

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## Arizona Insurance Department Fines Aetna U.S. Healthcare for Violations of Health Care Appeals Law

The Arizona Department of Insurance has found that Aetna U.S. Healthcare, Inc., violated numerous elements of the state's Health Care Appeals law and has fined the HMO $10,000.

The Department of Insurance is auditing a number of health insurers to assess compliance with the health care appeals laws, which first went into effect in 1998. The settlement with Aetna U.S. Healthcare is the first resolution of such an audit. Aetna U.S. Healthcare agreed with the findings and terms of a consent order that was issued by Arizona Insurance Director Charles R. Cohen, on June 26. In addition to the fine, the company agreed to correct their procedures and reopen some appeals.

At the time that health insurance policies are issued or renewed, health insurers are required to provide consumers with information packages describing the appeals process. To start the process, the consumer must appeal directly to his or her insurance company. The appeals law requires four levels of review:

- Expedited Medical Review for urgent medical cases, to be completed within one business day.
- Informal Reconsideration for non-urgent medical cases, to be completed within 30 days.
- Formal Appeal, to be completed within 30 days of the request for a review, or 60 days in cases of denied claims for services already received.
- External Independent Review, generally completed within 30 days, but with no statutory time limit.

"We are in the process of conducting audits of other health insurers to determine whether they are complying with the law that created the Health Care Appeals program," Cohen said. "This is an important consumer-protection law, and the public must have confidence that health insurers are living up to their legal obligations."

Cohen said Insurance Department examiners found a broad range of violations by Aetna U.S. Healthcare in virtually every aspect of the program. For example:

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- Of 158 informal reconsideration appeals audited, 151 contained at least one deficiency.
- Of 15 formal appeals, 13 contained at least one deficiency.
- All three external independent reviews contained deficiencies.

In addition, examiners found problems with the Aetna U.S. Healthcare Complaint, Grievance and Appeal Resolution Procedures Manual and its health care appeals information packet given to enrollees.

- Many of the violations involved Aetna's failure to properly notify the member, provider or the Insurance Department of pending appeals. Aetna also failed to meet prescribed deadlines for handling appeals.

- After Aetna upheld its own denial of appeals in four cases, the insurer failed to properly notify those members that they had the right to request an external independent review.

- Aetna failed to include the criteria and clinical reasons for its decisions in all formal appeal decision letters to members.

- All expedited medical reviews were not completed within the required one business day of receiving the request and a physician's certification.

The Aetna U.S. Healthcare audit covered the period from July 1, 1998, to Aug. 31, 1999.

"Because this is a relatively new law, we are not surprised to find less than perfect compliance," Cohen said. "That's why we are doing these audits. Our objective at this point is to assess the level of compliance throughout the industry, identify problem companies and areas, and be proactive about bringing health insurers into full compliance."

The Insurance Department conducted a training session and seminar for the industry last September to apprise health insurers of their obligations under the law and to answer their questions. Approximately 70 representatives of health insurers, including all of the HMOs active in Arizona, attended.

From July 1, 1998, to June 21, 2000, health insurers received a total of 455 appeals that were subject to the External Independent Review process, with 164 of those involving determinations of medical necessity referred directly by insurers to external medical reviewers. Of the 164 appeals, 96 were upheld in favor of insurers, 51 were overturned in favor of consumers, seven were partially overturned, three were overturned by insurers before external reviewers reached decisions, and seven are pending.

The remaining 291 cases were submitted to the Insurance Department for review regarding questions of coverage. In 79 of those cases the Insurance Department referred the appeals to external independent medical reviewers. Of the 79 appeals, 39 were upheld, 35 were overturned, one was partially overturned, two were overturned by insurers before external reviewers reached decisions, and two are pending.

Of the 212 cases at the Insurance Department reviewed regarding coverage, 149 were upheld, 37 were overturned in favor of consumers, six were partially overturned, five were overturned by insurers, two are pending, and 13 were withdrawn because they did not meet the statutory definition of an appealable issue.

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