

1 SONIA R. FERNANDES
Deputy Director | Chief Counsel, Bar Number 232932
2 KYLE C. MONSON
Assistant Chief Counsel, Bar Number 251166
3 ROBERT L. WAINESS
Attorney IV, Bar Number 121137
4 CALIFORNIA DEPARTMENT OF
MANAGED HEALTH CARE
5 980 9th Street, Suite 500
Sacramento, CA 95814-2725
6 916-323-0435 - Phone
916-323-0438 - Fax
7

8 Attorneys for the Department of Managed Health Care

9 BEFORE THE DEPARTMENT OF MANAGED HEALTH CARE
10 OF THE STATE OF CALIFORNIA

11 IN THE MATTER OF:

12 **AETNA HEALTH OF CALIFORNIA INC.,**
13 *Department License Number 933 0313*

14 Respondent.

Enforcement Matter Number: 19-268 plus
three associated matters

ORDER TO CEASE AND DESIST

(Health & Saf. Code, §§ 1344, 1386,
subd. (b)(1), & 1391.)

15
16 The Director of the Department of Managed Health Care, by and through her
17 designee, Deputy Director and Chief Counsel Sonia R. Fernandes (Complainant), after
18 investigation, determines as follows:

19 **I.**

20 **PARTIES**

21 1. The Department of Managed Health Care (Department) is the state regulatory
22 agency charged with administering and enforcing the Knox-Keene Health Care Service Plan
23 Act of 1975 (Knox-Keene Act) (Health & Saf. Code, § 1340, et seq.), and title 28 of the
24 California Code of Regulations. The Department's jurisdiction includes the execution of the
25 laws of this state relating to a health care service plan (health plan) and the health plan
26 business. (Health & Saf. Code, § 1341, subd. (a).)

27 2. Aetna Health of California Inc. (Respondent), is now, and has been since
28 August 6, 1981, a full service plan (License Number 933 0313) licensed pursuant to Health

1 and Safety Code section 1349. Its principal place of business is located at 1401 Willow Pass
2 Road, Suite 600, Concord, California 94520.. Respondent is subject to the Knox-Keene Act
3 and California Code of Regulations, title 28, promulgated pursuant to the Knox-Keene Act.

4 **II.**

5 **JURISDICTION**

6 3. As a licensee with the Department, Respondent is subject to the Department's
7 jurisdiction. (Health & Saf. Code, §§ 1341, subd. (a), 1343, subdivision (a).)

8 **III.**

9 **STATUTORY AUTHORITY**

10 4. The Director may adopt orders as are necessary to carry out the provisions of
11 the Knox-Keene Act. (Health & Saf. Code, § 1344, subd. (a).) This includes an order
12 directing a health plan to cease and desist from engaging in any act or practice in violation
13 of the Knox-Keene Act or title 28 of the California Code of Regulations. (Health & Saf. Code,
14 § 1391, subd. (a)(1).)

15 5. A health plan may be subject to disciplinary action by the Director if the health
16 plan is operating at variance with the basic organizational documents as filed pursuant to
17 Health and Safety Code section 1351 or in a manner contrary to a material modification of
18 its plan or operations approved by the Director pursuant to Health and Safety Code section
19 1352, subdivision (b). (Health & Saf. Code, § 1386, subd. (b)(1).)

20 6. A health plan may be subject to disciplinary action by the Director if the health
21 plan is violating any provision of the Knox-Keene Act, the Department's regulations, or any
22 order issued by the Director. (Health & Saf. Code, § 1386, subd. (b)(6).)

23 7. "Basic health care services" include "emergency medical services." (Health &
24 Saf. Code, § 1345, subd. (b)(6).)

25 8. Health care service plans such as Respondent shall provide "all of the basic
26 health care services included in subdivision (b) of Health and Safety Code section 1345."
27 (Health & Saf. Code § 1367, subd. (i).)

1 9. A health plan may be subject to disciplinary action by the Director where the
2 plan does not provide basic health care services to its enrollees and subscribers as set forth
3 in the evidence of coverage. (Health & Saf. Code, § 1386, subd. (b)(3).)

4 10. A health plan that delegates “any services it is required to perform to its
5 medical groups, independent practice associations, or other contracting entities” cannot
6 waive its legal obligations under the Knox-Keene Act and/or regulations. (Health & Saf.
7 Code, § 1367, subd. (j).)

8 11. A health care service plan or its contracting medical providers shall reimburse
9 providers for emergency services and care provided to its enrollees except as provided in
10 Health and Safety Code section 1371.4, subdivision (c). (Health & Saf. Code, § 1371.4,
11 subd. (b).)

12 12. A health care service plan or its contracting medical providers may only deny
13 coverage for emergency medical services where it has reasonably determined that the
14 emergency medical services were never performed or that both of the following conditions
15 exist: a) the enrollee did not require emergency medical services; and b) the enrollee
16 reasonably should have known that an emergency did not exist. (Health & Saf. Code,
17 § 1371.4, subd. (c).)

18 13. Health care service plans are prohibited from engaging in an unfair payment
19 pattern including engaging in a “demonstrable and unjust pattern” of denying complete and
20 accurate claims. (Health & Saf. Code, § 1371.37, subd. (c)(2).) A demonstrable and unjust
21 pattern means “any practice, policy or procedure that results in repeated delays in the
22 adjudication and correct reimbursement of provider claims.” (Cal. Code Regs., tit. 28, §
23 1300.71 subd. (a)(8).)

24 14. The Department is required to periodically conduct an onsite medical survey of
25 each plan’s health delivery system including a review of the procedures for obtaining health
26 services and the overall performance of the plan in providing health care benefits and
27 meeting the health needs of the subscribers and enrollees. (Health & Saf. Code, § 1380,
28 subd. (a).)

1 15. A "person" includes any business entity. (Health & Saf. Code, § 1345, subd.
2 (j).)

3 **IV.**

4 **STATEMENT OF FACTS**

5 16. Respondent independently, and through its delegates, operates full service
6 health maintenance organization (HMO) plans throughout California that cover, among other
7 things, emergency medical services.

8 17. Respondent and its delegate medical groups and independent practice
9 associations routinely receive requests from its enrollees and/or emergency room (ER)
10 providers seeking payment and/or reimbursement for enrollees' emergency medical
11 services.

12 18. In 2010, Respondent agreed with the Department that it had improperly
13 applied its national "prudent layperson" standard in denying coverage for emergency
14 medical services in approximately 23 cases. Respondent's national standard provides that:
15 "We cover health care services provided in a hospital emergency room in compliance with
16 the 'Prudent Layperson' emergency policy set forth in the federal Balanced Budget Act of
17 1997 and applicable state law standards. The federal law defines an emergency medical
18 condition as 'a medical condition manifesting itself by acute symptoms of sufficient severity
19 (including severe pain) such that a prudent layperson, who possesses an average
20 knowledge of health and medicine, could reasonably expect the absence of immediate
21 medical attention to result in: placing the health of the individual (or, with respect to a
22 pregnant woman, the health of the woman and her unborn child) in serious jeopardy; serious
23 impairment to bodily functions, or serious dysfunction of any bodily organ or part."

24 19. Respondent agreed in 2010 that it had not applied the California standard,
25 Health and Safety Code section 1371.4, subdivisions (b) and (c), to adjudicate claims for
26 emergency medical services. As a result, it agreed to implement an informal corrective
27 action plan (CAP), as documented in emails from Respondent's then West Region Counsel,
28 dated December 13, 2010, and February 17, 2011, to reform its procedures for adjudicating

1 claims for payment of emergency medical services in several specific ways that would assist
2 Respondent in obtaining evidence that the enrollee reasonably should have known that an
3 emergency did *not* exist as required by Section 1371.4, subdivision (c).

4 20. In 2015, in Enforcement Matter 14-296, after having improperly denied
5 coverage for an enrollee's emergency medical services, Respondent entered into a Letter of
6 Agreement with the Department and agreed to pay a \$10,000 administrative penalty and
7 enter into a CAP that required Respondent to train employees handling claims for
8 emergency medical services to apply Section 1371.4, subdivisions (b) and (c).

9 21. In 2016, in Enforcement Matters 12-048 and 15-383, which concerned
10 Respondent's denial of eight claims for emergency medical services in which it failed to
11 properly apply Section 1371.4, Respondent entered into a Letter of Agreement with the
12 Department and agreed to pay a \$125,000 administrative penalty and implement a CAP to
13 reimburse for emergency medical services based on the California standard instead of its
14 national prudent layperson standard.

15 22. As documented in four separate complaints from the Department's Help
16 Center (Help Center), Respondent wrongfully denied coverage for emergency medical
17 services on four occasions in 2017 and 2018 based on Respondent's or its delegate's use of
18 its national prudent layperson standard.

19 23. From August 14 to August 16, 2018, a survey team from the Department's
20 Office of Plan Monitoring's (OPM), Division of Plan Surveys, conducted an onsite medical
21 survey and reviewed a sample of the Plan's denials of emergency medical services
22 adjudicated on or after February 1, 2017. The Department's August 23, 2019, Non-Routine
23 Survey Final Report found, as Deficiency Number 10, that "[Respondent] does not account
24 for the enrollee's subjective belief that he or she had experienced a medical emergency
25 when evaluating the medical necessity of emergency services" in violation of Health and
26 Safety Code section 1371.4, subdivision (c). emergency medical services

27 24. In 2019, the Department reviewed Respondent's commercial emergency
28 medical services denial template for HMOs, and each of its delegates' templates for denial

1 of emergency medical services, and found that each of Respondent's templates used the
2 national prudent layperson standard, or a standard substantially similar thereto, to
3 adjudicate claims for emergency medical services and that none of the templates conformed
4 to the requirements of Health and Safety Code section 1371.4, subdivision (c).

5 **V.**

6 **FINDINGS**

7 25. Complainant hereby incorporates by reference paragraphs 1 through 24.

8 26. Respondent is a person within the meaning of Health and Safety Code
9 sections 1391, and 1345, subdivision (o), subject to the requirements of the Knox-Keene
10 Act.

11 27. Respondent and its delegates continue to deny enrollees' claims for
12 emergency medical services unless the enrollee's medical record shows that a prudent
13 layperson with an average knowledge of health and medicine should have known that he or
14 she was in an emergent condition. This is the Plan's national standard and is improper
15 under California law, which requires a health plan to pay for emergency medical services
16 unless it is in possession of evidence to show either that the emergency medical services
17 were never performed or that both of the following conditions exist: a) the enrollee did not
18 require emergency medical services; and b) the enrollee reasonably should have known that
19 an emergency did not exist. (Health & Saf. Code, § 1371.4, subd. (c).) These improper
20 denials of emergency medical services subject the Respondent to discipline under Health
21 and Safety Code section 1386, subdivision (b)(6).

22 28. Respondent's and its delegates' emergency treatment denial templates fail to
23 follow the requirements of Health and Safety Code section 1371.4, subdivisions (b) and (c),
24 subjecting Respondent to discipline under Health and Safety Code section 1386, subdivision
25 (b)(6).

26 29. Based on Respondent's ongoing practice of denying claims for emergency
27 medical services in a manner inconsistent with Health and Safety Code section 1371.4,
28 subdivisions (b) and (c), and its ongoing failure to follow the CAPs to which it had agreed in

1 prior enforcement matters, Respondent is engaging in an unfair payment pattern in violation
2 of Health and Safety Code section 1371.37, subdivision (c)(2), which forces enrollees to file
3 grievances with the Respondent, and then with the Help Center, to force the Respondent to
4 pay for emergency medical services.

5 30. By its ongoing denial of coverage for emergency medical services based on
6 Respondent's national standard, Respondent is in violation of Health and Safety Code
7 sections 1371.4, subdivisions (b) and (c), and is denying a basic health care service
8 required by Health and Safety Code section 1367, subdivision (i). These violations make
9 Respondent subject to discipline under Health and Safety Code section 1386, subdivisions
10 (b)(3) and (b)(6).

11 **VI.**

12 **ORDER**

13 **THEREFORE**, the Director of the Department, by and through her designee,
14 Deputy Director and Chief Counsel Sonia R. Fernandes, **ORDERS AS FOLLOWS:**

15 1. Respondent shall immediately Cease and Desist from denying claims for
16 enrollees' emergency medical screening examinations in California on the basis of
17 Respondent's national prudent layperson standard, or any standard other than that set
18 forth in the Knox-Keene Act and its regulations.

19 2. Respondent shall immediately comply with Health and Safety Code section
20 1371.4, subdivisions (b) and (c), by adjudicating claims for emergency medical services so
21 that Respondent provides coverage for such claims unless it is in possession of evidence
22 to reasonably determine that:

- 23 a. the emergency services and care were never performed; or
- 24 b. both the following two conditions are met:
 - 25 i. the health plan enrollee did not require emergency medical
 - 26 services; and
 - 27 ii. the enrollee reasonably should have known that an emergency did
 - 28 not exist.

1 3. Respondent shall immediately conduct a review of all claims for emergency
2 medical services denied subject to Section 1371.4, subdivision (c) since February 1, 2017,
3 and readjudicate and overturn each such denial unless it is in possession of evidence in
4 each case to reasonably determine that:

- 5 a. the emergency services and care were never performed; or
- 6 b. both the following two conditions are met:
 - 7 i. the plan enrollee did not require emergency medical services; and
 - 8 ii. the enrollee reasonably should have known that an emergency did
9 not exist.

10 4. On or before thirty-five (35) days from the date of this **ORDER**, the
11 Respondent shall provide a report (Initial Report) to the Office of Enforcement of the
12 Department detailing how it intends to comply with this cease and desist order. The Initial
13 Report shall

- 14 a. describe the process the Plan will use to readjudicate each claim for
15 emergency medical services denied since February 1, 2017, as well
16 as the anticipated time period for completion;
- 17 b. identify each claim reviewed, the billed amount, the amount paid or to
18 be paid by the Plan, and the documents that provide evidence of all
19 readjudications;
- 20 c. describe the process the Plan will use to identify overpayments made
21 by enrollees for such claims, or payments due to providers; and
- 22 d. for each claim upheld, describe the evidence in the Plan's possession
23 showing that the enrollee reasonably should have known that an
24 emergency did not exist.

25 ///

26 ///

27 ///

28

1 5. Respondent shall file a final proof of compliance (Final Report) with this
2 **ORDER** with the Office of Enforcement within sixty (60) days of the filing of this **ORDER**.
3 The Final Report shall detail and affirm Respondent’s practice of providing coverage for all
4 claims for emergency medical services unless it is in possession of evidence to
5 reasonably determine that:

- 6 a. the emergency services and care were never performed; or
- 7 b. both the following two conditions are met:
 - 8 i. the health plan enrollee did not require emergency medical
 - 9 services; and
 - 10 ii. the enrollee reasonably should have known that an emergency did
 - 11 not exist.

12 6. The Final Report shall:

- 13 a. confirm that the Plan readjudicated each claim for emergency medical
- 14 services improperly denied since February 1, 2017;
- 15 b. describe each action the Plan used to readjudicate each such claim;
- 16 c. identify each claim readjudicated, the billed amount, the amount paid
- 17 or to be paid by the Plan, and the documents that provide evidence of
- 18 readjudication;
- 19 d. describe the process the Plan used to identify overpayments made by
- 20 enrollees for such claims, or payments due to providers; and

21 ///

22 ///

23 ///

24 ///

25 ///

26 ///

27 ///

28 ///

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

e. for each claim upheld, describe the evidence in the Plan's possession that the enrollee reasonably should have known that an emergency did not exist.

MARY WATANABE
Acting Director
Department of Managed Health Care

Dated: August 25, 2020

By: /Original Signed/
SONIA R. FERNANDES
Deputy Director | Chief Counsel
Office of Enforcement
Department of Managed Health Care