BECOME THE DEPARTMENT OF MANAGED HEALTH CARE
OF THE STATE OF CALIFORNIA

IN THE MATTER OF:
Aetna Health of California Inc.,
Respondent.

ACCUSATION
(Health & Safety Code section 1340 et seq.)

INTRODUCTION
The California Department of Managed Health Care (Department) brings the present action to assess administrative penalties against Aetna Health of California Inc. (Respondent) pursuant to the provisions of the Knox-Keene Health Care Service Plan Act of 1975, as amended (the Act) (Health and Safety Code section 1340 et seq.) Respondent is a health care service plan licensed under and regulated by the Act.

PARTIES
1. Sonia R. Fernandes (Complainant) is the Deputy Director and Chief Counsel of the Department’s Office of Enforcement. Complainant brings this Accusation

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solely in her official capacity as Deputy Director and Chief Counsel of the Office of
Enforcement for the Department.

2. At all times pertinent to the allegations herein, Respondent has been a full-
service health care service plan as defined by Health and Safety Code section 1345,
subdivision (f),¹ and is subject to the regulatory provisions of the Act. Respondent is the
holder of health care service plan license number 933 0176 which was issued on August
6, 1981, by the Commissioner of the Department of Corporations, predecessor to the
Director of the Department. Respondent’s principal corporate office is located at 1401
Willow Pass Road, Suite 600, Concord, California 94520.

III. JURISDICTION

3. This Accusation is brought before the Director of the Department (Director)
under the authority conferred in the Act and Title 28 of the California Code of Regulations,
as specified below.

4. The Department is charged with the task of regulating managed care in the
State of California and ensuring that the entities which sell managed care products in
California, known as health care service plans, are in compliance with their obligations
under the Act. (Health & Saf. Code, §§ 1341, subd. (a) and 1345, subd. (f).)

5. The Director is responsible for the performance of all duties and
responsibilities vested by law in the Department, including the administration and
enforcement of the Act and the rules and regulations adopted thereunder. (Health & Saf.
Code, §§ 1341, subd. (c).)

6. Section 1386, subdivision (a), authorizes the Director to take disciplinary
action against a health care service plan under the appropriate circumstances. The
Director is authorized to assess administrative penalties against Respondent if the

¹ For convenience, a section of the Health and Safety Code is hereinafter referred
to as “Section,” followed by the section number unless otherwise indicated.
Director determines, after appropriate notice and opportunity for a hearing, that Respondent has committed any of the acts or omissions enumerated in Section 1386, subdivision (b), which constitute grounds for disciplinary action.

7. Section 1386, subdivision (b)(6), states that the grounds for disciplinary action include instances where “The plan has violated or attempted to violate, or conspired to violate, directly or indirectly, or assisted in or abetted a violation or conspiracy to violate any provision of this chapter, any rule or regulation adopted by the director pursuant to this chapter, or any order issued by the director pursuant to this chapter.”

8. As set forth more specifically below, disciplinary action is appropriate in this case because Respondent and its delegates denied enrollees' claims for emergency medical services in violation of Section 1371.4, subdivisions (b) and (c), engaged in an unfair payment pattern in violation of Section 1371.37, subdivision (c)(2), acted at variance with its Evidence of Coverage (EOC) in violation of Section 1386, subdivision (b)(1), and denied a basic health care service required by Section 1367, subdivision (i), in violation of Section 1386, subdivisions (b)(3) and (b)(6).

9. All hearings before the Director are to be held in accordance with the Administrative Procedure Act, and the Director has all of the powers granted under that act. (Health & Saf. Code § 1397, subd. (a).) The factors for determining an appropriate penalty for violations of the Knox-Keene Act are set forth in California Code of Regulations, title 28, section 1300.86.²

² For convenience, a section of California Code of Regulations, title 28, is hereinafter referred to as “Rule,” followed by the section number, unless otherwise indicated.
IV.

FACTUAL ALLEGATIONS

10. Respondent independently, and through its delegates, operates full-service health maintenance organization (HMO) plans throughout California that provide coverage for, among other things, emergency medical services.

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

Respondent’s past history of using the wrong standard.

12. In 2010, Respondent agreed with the Department that it improperly applied its national “prudent layperson” standard in denying coverage for emergency medical services in approximately 23 cases. Respondent’s national standard provides that:

“We cover health care services provided in a hospital emergency room in compliance with the ‘Prudent Layperson’ emergency policy set forth in the federal Balanced Budget Act of 1997 and applicable state law standards. Federal law defines an emergency medical condition as ‘a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.’

13. Respondent agreed in 2010 that it had not applied the California standard for adjudicating claims for emergency medical services which is found in Section 1371.4, subdivisions (b) and (c). As a result, it agreed to implement an informal corrective action plan (CAP), as documented in emails dated December 13, 2010, and February 17, 2011, to reform its procedures for adjudicating claims for payment of emergency medical services in several specific ways that would assist Respondent in obtaining evidence that
the enrollee reasonably should have known that an emergency did not exist as required by Health and Safety Code section 1371.4, subdivision (c).

14. In 2015, in Enforcement Matter 14-296, after having improperly denied coverage for an enrollee's emergency medical services, Respondent entered into an agreement with the Department to pay a $10,000 administrative penalty and enter into a CAP that required Respondent to train employees adjudicating claims for emergency medical services to apply the California standard for adjudicating claims for emergency medical services which is found in Health and Safety Code, section 1371.4, subdivisions (b) and (c).

15. In 2016, in Enforcement Matters 12-048 and 15-383, Respondent denied coverage for eight claims for emergency medical services in which it failed to properly apply the standards found in Section 1371.4, subdivision (c). To resolve these matters, Respondent entered into an agreement with the Department to pay a $125,000 administrative penalty and implement a CAP to reimburse emergency medical services based on the California standard instead of its national prudent layperson standard.

**The current cases and the medical survey.**

16. In 2017, in Enforcement Matter 19-1151, the Plan's delegate, Sharp Community Medical Group, denied coverage for emergency medical services provided to a 61-year-old HMO enrollee who complained of left upper quadrant abdominal and flank pain for the past three days. This enrollee also had a history of diabetes, hypertension, and heart disease. The denial letter stated that the clinical facts "do not support a reasonable belief that an emergency existed, therefore, the emergency claim is denied." Respondent did not provide evidence to show that the enrollee reasonably should have known that an emergency did not exist as required by California law.

17. In 2018, in Enforcement Matter 19-268, the Plan's delegate, Desert Oasis Healthcare, denied coverage for emergency medical services provided to a 25-year-old HMO enrollee complaining of cough, congestion, phlegm and vomiting, stating that "the clinical facts referenced do not support a reasonable belief that an emergency existed."
under its national standard. Respondent did not provide evidence to show that the enrollee reasonably should have known that an emergency did not exist as required by California law.

18. In 2018, in Enforcement Matter 19-766, the Plan’s delegate, St. Mary Choice Medical Group, denied coverage for emergency medical services provided to a 10-year-old HMO enrollee being treated for severe open leg wounds caused by a golf cart accident. The family had been instructed on the importance of changing the bandage twice daily to prevent infection. Their pediatrician’s office recommended that they go to the emergency room because they could not find an appropriate wound care specialist covered by Respondent. Respondent denied coverage on the grounds that the enrollee did not meet Respondent’s national “prudent layperson” standard but failed to determine that the enrollee reasonably should have known that an emergency did not exist as required by California law.

19. In 2018, in Enforcement Matter 19-977, the Plan’s delegate, Hill Physicians Medical Group, San Joaquin County, denied coverage for emergency medical services provided to a 37-year-old HMO enrollee referred to the emergency room by her OB-GYN because she was experiencing “excruciating and debilitating” leg pain and, based on her medical and family history, feared she might have a deep vein thrombosis. Respondent denied coverage because her condition did not meet its national “prudent layperson” standard but failed to show that the enrollee reasonably should have known that an emergency did not exist as required by California law.

20. From August 14 to August 16, 2018, a survey team from the Department’s Office of Plan Monitoring’s (OPM), Division of Plan Surveys, conducted an onsite medical survey and reviewed a sample of Respondent’s denials of emergency medical services adjudicated on or after February 1, 2017. The Department’s August 23, 2019, Non-Routine Survey Final Report found that ninety-three percent of the sampled emergency room claims were wrongfully denied and concluded as Deficiency Number 10, that “[Respondent] does not account for the enrollee’s subjective belief that he or she had
experienced a medical emergency when evaluating the medical necessity of emergency services" in violation of Section 1371.4, subdivision (c).

21. In 2019, the Department reviewed Respondent’s and its delegates’ commercial emergency medical services denial template for cases involving its HMO products, and found that each template used Respondent’s national prudent layperson standard, or a standard substantially similar thereto, to adjudicate claims for emergency medical services. None of the templates conformed to the requirements of Section 1371.4, subdivision (c).

V.
FIRST CAUSE FOR DISCIPLINE
(Respondent Failed to Pay Emergency Room Claims)
[Section 1386, subdivision (a), Section 1386, subdivision (b)(6),
Section 1367, subdivision (j), Section 1371.4, subdivisions (b) and (c)]

22. Complainant hereby realleges and incorporates paragraphs 1 through 21 as though fully set forth herein.

23. The Department may, after appropriate notice and the opportunity for a hearing, assess administrative penalties against licensees that have committed acts or omissions that constitute grounds for disciplinary action. (Health & Saf. Code, § 1386, subd. (a).)

24. The grounds for disciplinary action include acts or omissions by Respondent which violated (or attempted to violate, or conspired to violate), directly or indirectly (or assisted in or abetted a violation or conspiracy to violate), any provision of the Knox-Keene Act, any rule or regulation promulgated thereunder, or any order issued by the Director thereunder. (Health & Saf. Code, § 1386. subd. (b)(6).)

25. The Act provides that, “The obligation of the plan to comply with this chapter shall not be waived when the plan delegates any services that it is required to perform to its medical groups, independent practice associations, or other contracting entities.” (Health & Saf. Code § 1367, subd. (j).)
26. Here, since 2017, Respondent violated the Knox-Keene Act when it or its delegates failed to follow the requirements of Section 1371.4, subdivision (c), in its denial of ER claims. Section 1371.4, subdivisions (b) and (c), provides as follows:

“(b) A health care service plan, or its contracting medical providers, shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires that emergency services and care be provided without first questioning the patient’s ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee’s emergency medical condition.

“(c) Payment for emergency services and care may be denied only if the health care service plan, or its contracting medical providers, reasonably determines that the emergency services and care were never performed; provided that a health care service plan, or its contracting medical providers, may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.”

27. The key difference between Respondent’s national standard and California law is that the national “prudent layperson” standard allows Respondent to deny payment for an emergency room visit unless the medical record shows that “a prudent layperson” with “an average knowledge of health and medicine” would have known that his or her condition was truly emergent. The California standard, by contrast, requires a plan to pay for the emergency room visit unless it has evidence to show that: 1) no emergency services were performed; or 2) the enrollee did not require emergency health care services and reasonably should have known that an emergency did not exist. (Emphasis added.) (Health & Saf. Code, § 1371.4, subd. (b) & (c).)

28. As shown by the factual history above, since 2017, Respondent has denied coverage for emergency medical services unless the medical record shows that the enrollee presented with an emergent condition. This business practice failed to follow the
requirements of Section 1371.4, subdivision (c), which requires Respondent to provide coverage for an ER visit unless it can show that the enrollee reasonably knew or should have known that an emergency did not exist. This failure to utilize the lawful standard to adjudicate emergency services claims subjects Respondent to discipline under Section 1386, subdivisions (a) and (b)(6).

VI.

SECOND CAUSE FOR DISCIPLINE
(Respondent Engaged in an Unfair Payment Pattern Regarding Emergency Claims)
[Section 1386, subdivision (b)(6), Section 1371.37, subd. (c)(2), Rule 1300.71, subdivision (a)(8)]

29. Complainant hereby realleges and incorporates paragraphs 1 through 28 as though fully set forth herein.

30. The grounds for disciplinary action include acts or omissions by Respondent which violated (or attempted to violate, or conspired to violate), directly or indirectly (or assisted in or abetted a violation or conspiracy to violate), any provision of the Knox-Keene Act, any rule or regulation promulgated thereunder, or any order issued by the Director thereunder. (Health & Saf. Code, § 1386. subd. (b)(6).)

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

32. Here, since 2017, Respondent’s business practice of denying coverage for ER claims in a manner inconsistent with Section 1371.4, subdivision (c), resulted in repeated delays in the correct reimbursement of emergency claims. This business practice forced enrollees to file grievances with Respondent in an effort to have their ER treatment claims correctly adjudicated. While Respondent could have caught and
corrected these errors at the internal grievance level, it failed to do so, forcing enrollees to file complaints with the Department’s Help Center in order to compel Respondent to pay for their ER treatment in accord with the Act. These repeated delays in the correct reimbursement of emergency claims are an unfair payment pattern pursuant to Rule 1300.71, subdivision (a)(8). Engaging in an unfair payment pattern is a violation of Section 1371.37, subdivision (c)(2), for which the Plan is subject to discipline pursuant to Section 1386, subdivision (b)(6).

VII.

THIRD CAUSE FOR DISCIPLINE
(Respondent Acted at Variance with the EOC)

[Section 1386, subdivision (a), Section 1386, subdivision (b)(1)]

33. Complainant hereby realleges and incorporates paragraphs 1 through 32 as though fully set forth herein.

34. Section 1386, subdivision (a), provides that the Director may assess administrative penalties after appropriate notice and opportunity for a hearing if the Director determines that the licensee has committed any of the acts or omissions constituting grounds for disciplinary action. Section 1386, subdivision (b)(1), provides that grounds for disciplinary action includes operating at variance with the plan contained in its application for licensure. The EOC is the plan filed with the Department as part of the Plan’s application for licensure. (Health & Saf. Code, § 1351, subd. (f).)

35. Statutory coverage mandates are incorporated into the terms and conditions of an EOC. (Samson v. Transamerica Ins. Co. (1981) 30 Cal.3d 220, 231.) Any failure by Respondent to cover statutorily mandated services is also an act at variance with the EOC. (Id.) Thus, the statutory mandate of Section 1371.4, subdivisions (b) and (c), is incorporated into Respondent’s EOC as a matter of law.

36. Here, each time the Plan failed to apply the standards listed in Section 1371.4, subdivision (c), in denying an emergency room claim, it was operating at variance
with the terms of the EOC and is subject to discipline pursuant to Section 1386, subdivision (b)(1).

VIII.

FOURTH CAUSE FOR DISCIPLINE

(Respondent Failed to Provide a Basic Health Care Service)

[Section 1386, subdivision (b)(6),
Section 1367, subdivision (i), 1386, subdivision (b)(3)]

37. Complainant hereby realleges and incorporates paragraphs 1 through 36 as though fully set forth herein.

38. The grounds for disciplinary action include acts or omissions by the plan which violated (or attempted to violate, or conspired to violate), directly or indirectly (or assisted in or abetted a violation or conspiracy to violate), any provision of the Knox-Keene Act, any rule or regulation promulgated thereunder, or any order issued by the Director thereunder. (Health & Saf. Code, § 1386, subd. (b)(6).)

39. Section 1367, subdivision (i), states, “A health care service plan contract shall provide to subscribers and enrollees all of the basic health care services included in subdivision (b) of Section 1345.” Section 1345 subdivision (b) defines, “Basic health care services” to include “Emergency health care services.” Thus, the requirement that plans provide coverage for emergency health care services is codified in Section 1367, subdivision (i), as well as in Section 1371.4, subdivisions (b) and (c).

40. The Plan’s repeated failure since 2017 to adjudicate emergency room claims under Section 1371.4, subdivision (c), constitutes a denial of emergency health care services, a basic health care service mandated by Section 1367 subdivision (i), subjecting the Plan to discipline under Section 1386, subdivision (b)(6).

41. Section 1386, subdivision (b)(3), states that it is a separate ground for discipline where “The plan does not provide basic health care services to its enrollees and subscribers as set forth in the evidence of coverage.” Statutory coverage mandates are incorporated into the terms and conditions of an EOC as a matter of law and the Plan

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unlawfully denies coverage for emergency medical services claims by using the wrong standard to evaluate such claims. Thus, its failure to cover emergency medical services also constitutes a failure to include in its EOC coverage for this basic health care service. Thus, the Plan is also subject to discipline under Section 1386, subdivision (b)(3).

**PRAYER**

WHEREFORE, Complainant prays that a decision be rendered by the Director of the Department of Managed Health Care assessing an administrative penalty against the Respondent, in the amount of $500,000 for the violations of the Knox-Keene Act and the accompanying rules and regulations it has committed as alleged in this Accusation.

WHEREFORE, Complainant also prays for such other and further relief, as the Director deems proper.

Dated: August 25, 2020

/Original Signed/

SONIA R. FERNANDES
Deputy Director | Chief Counsel
Office of Enforcement