United States Senate

WASHINGTON, DC 20510

February 27, 2018

Mark T. Bertolini
Chairman and Chief Executive Officer
Aetna Inc.
151 Farmington Avenue
Hartford, CT 06156

Dear Mr. Bertolini:

We write to you in regards to recent news reports concerning Aetna's procedures for reviewing health insurance claims for critical medical treatment.[1] This episode raises broader questions about the adequacy of Aetna's claims review process, the steps the company takes when evaluating patients' medical histories, and its compliance with federal law.

Most troubling was the description of Aetna's claims review process described by a former medical director, Dr. Jay Iinuma. According to a sworn deposition, Dr. Iinuma, said he did not personally review the medical record of Aetna enrollee Gillen Washington or Mr. Washington's subsequent appeals. Instead, Dr. Iinuma relied exclusively on the recommendation of a nurse employed by the insurer. [2] Dr. Iinuma further stated that he had no experience treating Mr. Washington's condition, Chronic Variable Immunodeficiency Disease, or any knowledge about the disease, its symptoms, treatment or the requested therapy, intravenous immunoglobulin infusions.[3] Dr. Iinuma, who estimated that he was responsible for coverage decisions affecting more than a million beneficiaries, stated that Aetna did not train him to review medical records when he joined the company, adding that he might only consult with nurses regarding their recommendations once a month, even though he considered 20-to-30 claims every day.[4] Dr. Iinuma stated that while he was employed as an Aetna medical director, he had never personally reviewed the medical records of <u>any</u> claimant when making claims determinations.[5]

In addition, Aetna's appeals process may not have been in compliance with federal law. According to court documents reviewed by our staff, "[Mr.] Gillen called Aetna to obtain a copy of the denial letter. Aetna advised him that Aetna had denied coverage based on Aetna's medical criteria. Aetna also told him that it could not provide him with a copy of the denial letter, and

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[1] Wayne Drash, "California launches investigation following stunning admission by Aetna medical director," *CNN*, February 11, 2017, https://www.cnn.com/2018/02/11/health/aetna-california-investigation/index.html.
[2] Deposition of Jay Ken Iinuma, M.D., October 13, 2016.
[3] *Id.*
[4] *Id.*
[5] *Id.*

that he would have to obtain the letter from his doctor."[6] Aetna's alleged decision to bar Mr. Gillen access to his denial letter appears to violate safeguards put in place by the Affordable Care Act that require insurers offering group or individual plans to "allow an enrollee to review their file,"[7] a critical consumer protection when a patient appeals an adverse insurance decision.

The practices described by court documents and Dr. Iinuma's deposition have led California's two insurance regulators to launch investigations into Aetna's medical claims practices.[8] Such issues are apparently not new for Aetna. In 2009, Aetna Health, Inc., and Aetna Life Insurance paid a $256,500 fine to Arizona insurance regulators for, among other things, "denying health care provider payments without requesting additional information that could prove the claim valid," and failing "to advise policyholders about the criteria and reason for the company's appeal decision on their claims."[9] Four years later, Arizona regulators determined that Aetna Life Insurance failed one-third of the audit standards the state examined, including failing "to perform a reasonable investigation before denying claims," and denying claims "without performing a reasonable investigation to determine whether the patient met the medical criteria" established by the company's own clinical policies.[10]

In order to better understand the issues related to Aetna's claim approval processes, please answer the questions below and provide the requested information by close of business on March 20th:

1. Dr. Iinuma's sworn deposition in the Washington case suggests that Aetna's medical directors are not expected—or trained—to review beneficiaries' medical records during the insurance claim determination process. Please provide a written description of Aetna's claims review process, including the specific responsibilities of medical directors, nurses and chief medical officers, as well as any other company employees who are involved in such decisions. Please also provide supporting documents related to Aetna's medical claims determination process, including but not limited to those establishing the steps medical directors are expected to take during consideration of insurance claims and appeals.

2. Please provide a description of the medical claims determination and patient appeal processes specific to Aetna's Medicare Advantage and Medicare Part D plans and detail any differences, including any review required by medical directors, in such processes compared to other non-Medicare Aetna plans.

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[6] Opposition motion filed by Gillen Washington, *Washington v. Aetna, Inc.*, (Case No. 30-2015-00811734-CU-BC-CJC), Superior Court for the State of California for Orange County, March 28, 2017.
[7] 42 U.S.C. 300gg-19
[8] Barbara Feder Ostrov, "California's Regulators To Investigate Aetna's Medical Coverage Decisions," *Kaiser Health News*, February 13, 2018, https://khn.org/news/californias-two-health-insurance-regulators-to-investigate-aetnas-medical-coverage-decisions.
[9] Arizona Department of Insurance, "Aetna to Correct Violations and Pay $256,500 Penalties," November 2, 2009, https://insurance.az.gov/press-release-2009-05-arizona-department-insurance-orders-aetna-correct-violations-and-pay-256500.
[10] Arizona Department of Insurance, "Report of Targeted Examination of Aetna Life Insurance Company as of December 31, 2009," November 18, 2013, https://insurance.az.gov/sites/default/files/documents/files/60054M20131118.pdf.

3. Please provide the total number of medical claims Dr. Iinuma reviewed, and the number for which he made determinations, during his tenure as medical director, and note how many were approved and how many were denied.

4. Please provide (a) the total number of medical directors employed by Aetna to review and evaluate medical insurance claims for each of the past five years, and (b) the total number of such claims they have reviewed, noting how many were approved and how many were denied, for each of the past five years.

5. Please describe all duties and responsibilities of Aetna's medical directors, including corporate activities other than claims review, and the performance evaluation criteria and procedures for all such duties and responsibilities.

6. Dr. Iinuma's sworn deposition states that he primarily reviewed beneficiaries' claims in Aetna's online system, processing 20-to-30 such claims daily, but spoke to nurses who prepared the claims no more than "zero to one" time a month. He further states he did not speak with nurses regarding Mr. Washington's claim.

    a. Please provide guidelines and training materials that demonstrate how medical directors should communicate and consult with the nurse examiners.
    b. Please provide guidelines and training materials regarding how medical directors are expected to handle claims when they lack expertise about the condition.
    c. What is the process medical directors should use when the medical director lacks expertise with regard to a beneficiary's condition or treatment?

7. Mr. Washington's attorney informed our staff that he could not provide Dr. Iinuma's full deposition because of confidentiality claims by Aetna. Please either provide the full deposition, or release Mr. Washington's attorney to do so.

8. Aetna has informed staff that after the CNN press report occurred, Dr. Iinuma prepared a sworn statement "clarifying" his earlier deposition. Please provide a copy of this sworn statement and a detailed timeline and explanation of how this statement came to be, e.g. did Aetna solicit this statement, if so by whom and when? What, if any, legal, financial or contractual relationship between Aetna and Dr. Iinuma (a) existed at the time this statement was made, and (b) exists today?

9. Court documents show that Mr. Washington requested a denial letter from Aetna, which the company refused to provide, in apparent violation of federal law that allows consumers to access their insurance records.

    a. Does Aetna routinely deny such requests from beneficiaries?
    b. Please state how many claimant requests for denial letters Aetna refused in each of the years 2014-2017.
    c. Please also provide supporting documents related to Aetna's policies and procedures governing claimants' access to their insurance records.

10. When benefits are denied because Aetna lacks information it deems necessary to process or pre-approve a claim, i.e. Denial for Insufficient Information, what steps does Aetna take to ensure that the patient's health and medical treatment will not be compromised? Please describe the procedures for, and provide supporting documentation, for issuing such denials.

Thank you for your attention to this important matter. Please direct any questions that you or your staff may have to Peter Gartrell at (202) 224-4515 on the Senate Finance Committee or Elizabeth Letter at (202) 224-0767 on the Senate Health, Education, Labor, and Pensions Committee.

Sincerely,

Ron Wyden
Ranking Member
Senate Committee on Finance

Patty Murray
Ranking Member
Senate Committee on Health, Education, Labor, and Pensions