STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
BUREAU OF INSURANCE
34 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0034

ANGUS S. KING, JR.
GOVERNOR

ALESSANDRO A. IUPPA
SUPERINTENDENT

IN RE :	)	
	)	
AETNA U.S. HEALTHCARE, INC.	)	**CONSENT AGREEMENT**
	)	**Docket No. INS 00-3035**
	)	
	)	

This Consent Agreement is authorized by 5 M.R.S.A. § 9053(2) and 24-A M.R.S.A. § 12-A(1)(A), and is entered into by Aetna U.S. Healthcare, Inc. (hereafter also *Aetna)* and the Superintendent of the Maine Bureau of Insurance (hereafter also the *Superintendent*). Its purpose is to resolve, without resort to an adjudicatory proceeding, violations of 24-A M.R.S.A. § 220(2), as follows.

FACTS

1. The Superintendent of Insurance is the official charged with administering and enforcing Maine's insurance laws and regulations.

2. Since April 10, 1996, Aetna has been a Maine licensed health maintenance organization (HMO), License No. HMD45749.

3. Title 24-A M.R.S.A. § 220(1) authorizes the Superintendent to "conduct investigations ... upon reasonable cause to determine whether any person has violated any provision of [Title 24-A, also known as the Insurance Code] or to secure information useful in the lawful administration of any such provision." The Superintendent routinely and regularly exercises this authority upon receiving complaints from consumers against Bureau licensees.

4. Section 220(2) requires licensees who are the objects of consumer complaints to respond, if the Bureau so instructs the carrier, as follows:

> *All insurers and other persons required to be licensed pursuant to this Title shall respond to all lawful inquiries of the superintendent that relate to resolution of consumer complaints involving the licensee within 14 days of receipt of the inquiry....If a substantive response can not [sic] in good faith be made within the time period, the person required to respond shall so advise the superintendent and provide the reason for the inability to respond.*

5. During the period covered in this Agreement, the Bureau has used a uniform letter of inquiry to inform carriers of complaints; to elicit the carrier's response to the issues

raised by the complainant; and to request from the carrier documents relevant to these issues. The letter states in full (emphasis in original):

> *Enclosed please find a photocopy of a complaint letter recently received by this office. Please review the complaint and provide a detailed, substantive response to all issues raised. Your response must be supplemented by documentation in support of all representations, including, as applicable, all relevant notices, internal memos, file notes, phone logs or correspondence.*
>
> *In addition, please provide a copy of the policy at issue along with all relevant policy amendments and riders.*
>
> *Pursuant to Title 24-A M.R.S.A §220(2), you must respond within 14 days after your receipt of this letter. Failure to provide a timely response that both meaningfully addresses all issues raised in the complaint and provides supporting documentation may result in disciplinary action. If you have any questions please do not hesitate to call me.*

6. On April 18, 2000, the Bureau received complaint #2000507717, in which an Aetna health plan enrollee complained that Aetna wrongfully refused to pay benefits for the enrollee's last three days of mental health hospitalization. Aetna's denial of inpatient benefits turned on the carrier's determination that the services were not medically necessary.

7. On April 20, 2000, the Bureau mailed a copy of the enrollee's complaint to Aetna, together with the standard letter of inquiry quoted in Paragraph 5.

8. Aetna's May 5, 2000 response to the Bureau's inquiry failed to explain the company's reason for initially denying hospital benefits for the three days at issue. Aetna further did not provide the Bureau with any hospital record or other contemporaneous documents it relied on when it rejected Consumer's benefit claim.

9. A single document was enclosed with the response, a copy of a letter dated May 5, 2000 from an Aetna regional quality medical director to the enrollee. The director acknowledges that his letter is in response to the Bureau's intervention on behalf of the enrollee. He further notes that Aetna recently reversed the benefit denial "[b]ased on the information provided and review of your particular circumstances...," which information and circumstances are not specified, nor is any explanation offered as to why the claim was not paid when initially received.

10. On May 19, 2000, the Bureau received complaint #2000508189 from an Aetna enrollee who complained that the company, after having made a medical necessity assessment and having paid for her daily dosage of two Prilosec pills, would no longer pay for more than one pill per day.

11. On May 23, 2000, the Bureau mailed a copy of the enrollee's complaint to Aetna, together with the standard letter of inquiry quoted in Paragraph 5.

12. In its response letter dated June 19, 2000, Aetna informed the Bureau that: "This rejection was based upon the fact that on April 1, 2000 a quantity limitation was put in place for Prilosec which only allowed 1 pill per day. A letter had been system generated to our members who were taking this medication informing them of that change." The letter explains that Aetna reversed its denial because the enrollee's physician, on April 28th, asked Aetna to authorize two pills per day, and Aetna approved the request.

13. Also enclosed in Aetna's response was a letter dated June 19, 2000 from its Medical Director, in which he stated that he was answering the Bureau's inquiry and that the reason for Aetna's reversal was because of medical necessity. But he failed to address the enrollee's assertion that Aetna had made a medical necessity assessment *before* Aetna's April 1 formulary change regarding Prilosec. The Medical Director also failed to provide any supporting documentation, either for Aetna's initial denial or for its subsequent reversal approving the larger dosage.

14. On August 8, 2000, the Bureau received complaint #2000509329 from an enrollee. She complained that Aetna denied her claim for hospital maternity benefits because it had not pre-authorized the hospitalization. The enrollee had obtained such pre-authorization from another carrier with whom she was insured at the time. The authorized hospital stay, however, occurred when the Aetna plan replacing the enrollee's prior coverage was in effect.

15. On August 9, 2000, the Bureau mailed a copy of the enrollee's complaint to Aetna, together with the standard letter of inquiry quoted in Paragraph 5.

16. Aetna's August 24, 2000 response, written by a deputy medical director, acknowledged it was in answer to the Bureau's inquiry. The letter stated that, when the enrollee began her maternity stay, she presented her *prior* carrier's identification card rather than her Aetna I.D. The Aetna medical director explained that the wrong identification led Aetna to deny hospital benefits. No documentation was enclosed to support this assertion, nor was any explanation provided as to why Aetna failed to pay the enrollee's claim until the Bureau intervened.

17. On August 15, 2000, the Bureau received complaint #2000509456 from an Aetna enrollee. She wrote that Aetna and its behavioral health utilization review entity (URE) incorrectly informed her that her claim for mental health hospitalization payment could not be processed, because the hospital had not sent a billing to the URE. The complaint asserted that the hospital repeatedly resubmitted the billing to Aetna's URE, but the latter told her as late as August 10, 2000 it could not find the claim. Pursuant to Bureau Rule Chapter 850(8)(A), Aetna is responsible for the acts and omissions of its URE.

18. On August 17, 2000, the Bureau mailed a copy of the enrollee's complaint to Aetna, together with the standard letter of inquiry quoted in Paragraph 5.

19. Aetna's September 8, 2000 response, although acknowledging the Bureau's inquiry, failed to address the complaint of unjustified delay in payment. In its September 8th letter, Aetna suggested the claim was not lost at all and a *different* cause was responsible for the delay. Aetna explained the cause was an insufficiently itemized bill from the hospital. Aetna made no attempt to reconcile the disparate explanations for its failure to timely pay the claim, and provided no documentation in support of either explanation for the delay.

CONCLUSION OF LAW

20. As described in paragraphs 5 through 19, Aetna violated 24-A M.R.S.A. § 220(2) by failing to substantively respond to the Superintendent's inquiries made to Aetna in Bureau complaint files 2000507717, 2000508189, 2000509329 and 2000509456, and in three of the files by initially not responding at all within 14 days of its receipt of such inquiries.

COVENANTS

21. A formal hearing in this complaint proceeding is waived and no appeal will be taken. This Consent Agreement is an enforceable agency action within the meaning of the Maine Administrative Procedure Act.

22. At the time of executing this Agreement, Aetna shall pay to the Maine Bureau of Insurance a penalty in the amount of $8,000 drawn to the Maine State Treasurer.

23. In consideration of Aetna's execution of and compliance with the terms of this Agreement, the Superintendent agrees to forgo pursuing any disciplinary measure or other civil sanction for the violations described above, other than those agreed to herein.

MISCELLANEOUS

24. Aetna understands and acknowledges that this Agreement will constitute a public record within the meaning of 1 M.R.S.A. § 402, will be available for public inspection and copying as provided by 1 M.R.S.A. § 408, and will be reported to the NAIC "RIRS" database.

25. The parties understand that nothing herein shall affect any right or interest of any person who is not a party to this Agreement.

26. This Agreement may be modified only by the written consent of the parties.

27. Aetna was informed of its right to consult with counsel of its own choice before executing this Agreement.

28. Nothing herein shall prohibit the Superintendent from seeking an order to enforce this Agreement, or from seeking additional sanctions in the event Aetna does not comply with the above terms, or in the event the Superintendent receives evidence that further legal action is necessary for the protection of Maine consumers.

29. The Superintendent reserves the right under 24-A M.R.S.A. §§ 2151-2187 to pursue additional action against Aetna in connection with the within-referenced complaints.

FOR AETNA U.S. HEALTHCARE, INC.

Dated: 3/2, 2001

By: _____
Signature

DANIEL FISHBEIN, GENERAL MANAGER
Typed Name and Title

Subscribed and sworn to before me
this 2nd day of MARCH, 2001

_____
Notary Public
Joanne R. Nappi
Notary Public
My Commission Expires
August 23, 2004

FOR THE BUREAU OF INSURANCE

Dated: 3-15, 2001

_____
Alessandro A. Iuppa
Superintendent of Insurance

STATE OF MAINE
KENNEBEC ss.

Subscribed and sworn to before me
this 15th day of March, 2001

_____
Notary Public/Attorney at Law
LYNDY P. MORGAN
NOTARY PUBLIC, MAINE
MY COMMISSION EXPIRES NOVEMBER 14, 2005

FOR THE MAINE ATTORNEY GENERAL

Dated: March 14, 2001

_____
Carolyn A. Silsby
Assistant Attorney General

STATE OF MAINE
KENNEBEC ss.

Subscribed and sworn to before me
this 14th day of MARCH, 2001

_____
Notary Public/~~Attorney at Law~~
GAYLE L. MICHAUD
Notary Public, Maine
My Commission Expires December 3, 2002