Market Conduct Examination
Aetna Health Inc.

NAIC Company Code #95517
NAIC Exam Tracking System #ME008-M6

One Monument Square
Portland, Maine 04101

Examination Period:
4/01/02 thru 6/30/02

Contents

October 7, 2003

Alessandro A. Iuppa
Superintendent of Insurance
State of Maine
Bureau of Insurance
State House Station #34
Augusta, Maine 04333

Dear Sir:

Pursuant to the provisions of 24-A M.R.S.A. § 221 and in conformity with your instructions, a targeted market conduct examination has been made of:

Aetna Health Inc.

hereinafter collectively referred to as the "Company". The Company is organized and incorporated under the laws of the State of Maine. The examination reviewed only the operations of the Company as they impact residents and policyholders residing in the State of Maine or claimants involved in losses in, or related to, Maine claims. The on-site phase of the examination was conducted at the offices of the Company servicing Maine business located at:

One Monument Square
Portland, Maine 04101

The following report is respectfully submitted.

SCOPE OF EXAMINATION

Prompt payment of claims has become a national issue. Many states are conducting or have conducted market conduct examinations regarding the issue of prompt payment of claims. On the state level, the Maine Bureau of Insurance (hereinafter the "Bureau") has received inquiries from the provider and legislative communities of the payment practices of the insurance industry. Based on the national spotlight coupled with concern at the state level, the Superintendent has decided that targeted market conduct examinations regarding the prompt payment of claims will be performed on all managed-care organizations operating in the State of Maine over the course of 2002 and 2003.

This examination includes claims paid during the 2nd quarter 2002, (April 1, 2002 through June 30, 2002). This examination period has been utilized consistently for all managed-care organizations examined in this cycle. This was a targeted examination limited in scope to the examination of prompt payment issues as outlined in 24-A M.R.S.A. § 2436 (1) (2) and (3) and the documentation standards outlined in 24-A M.R.S.A. § 3408.

The examination was performed in accordance with examination standards and guidelines as set forth in the National Association of Insurance Commissioners (NAIC) Market Conduct Examiners Handbook (hereinafter the "Handbook") and the rules and regulations prescribed by the State of Maine through tests developed by the Bureau. Sampling was used in accordance with Handbook standards.

Readers of this report must recognize that due to the targeted focus of the examination, only matters pertaining to prompt payment of claims have been reviewed in the course of this examination. However, failure to comment on specific products, procedures or files does not constitute approval thereof by the Maine Bureau of Insurance. Statutory cites and regulation references are as of the period under examination unless otherwise noted.

HISTORY AND PROFILE

Company History

The Company was incorporated in the State of Maine on October 3, 1995. In accordance with 24-A M.R.S.A. § 4203, the Company was organized as a for-profit, privately held, health maintenance organization (HMO) to provide health care benefits and managed care services. The Company was licensed to conduct business as an HMO on April 10, 1996.

The Company was established as a direct subsidiary of NYLCare Health Plans, Inc. with the ultimate parent being New York Life Insurance Company.

Aetna, Inc. acquired all the outstanding common stock of the Company's immediate parent, NYLCare Health Plans, Inc., on July 15, 1998 and transferred ownership to Aetna U.S. Healthcare Inc. Effective December 28, 1998, the Company's name was changed from NYLCare Health Plans of Maine, Inc. to Aetna U.S. Healthcare Inc. (ME). The Company is now indirectly

a wholly owned subsidiary of Aetna U.S. Healthcare Inc. (PA), which is a wholly owned subsidiary of Aetna, Inc.

AFFILIATED COMPANIES

The Company is a member of an insurance holding company system and has filed annual Form B registration statements, as required under 24-A M.R.S.A. § 222 (8) (B). The following is an abbreviated organizational chart as of December 31, 2002.

Subsidiaries shown are 100% owned by their respective parent. Due to the number of entities within the insurance holding company system, this report's organizational chart has presented only the Company's immediate and ultimate parents, which control the Company's operations.

METHODOLOGY

This examination is based on the Standards and Tests for a Market Conduct Examination of a health insurance company as found in Chapter XVII of the Handbook, specifically as it relates to claims payment practices. The standards were tested through detailed review of a random sample of 100 claim files paid during the 2nd quarter 2002 using sampling methodology described in the Handbook.

Standards were evaluated using tests designed to adequately measure how the examinee met the standard and legal requirements of 24-A M.R.S.A. § 2436. Each test applied is described and the result of testing is provided in the "STANDARDS" section of this report. The standard, its statutory authority under Maine law, and its source in the Handbook are stated and contained within a bold border.

STANDARDS

The specific Handbook standards and tests developed by the examiners are outlined in this section.

Standard L-3 Claims are settled in a timely manner as required by statues, rules and regulations. *NAIC Market Conduct Examiners Handbook – Chapter XVII, § L, Standard 3; and 24-A M.R.S.A. § 2436*
Standard L-4 The Company responds to claim correspondence in a timely manner. *NAIC Market Conduct Examiners Handbook – Chapter XVII, § L, Standard 4; and 24-A M.R.S.A. § 2436*
Standard L-5 Claim files are adequately documented.

NAIC Market Conduct Examiners Handbook – Chapter XVII, § L, Standard 5; and 24-A M.R.S.A. § 2436 & 3408 (1)

This examination was designed to determine the compliance of the Company with 24-A M.R.S.A. § 2436 (1), (2) and (3) by applying specific tests to the sampled items based on Standards L-3, L-4 and L-5 of the Handbook. The results of the testing reflect compliance or noncompliance with the standards and statute.

TEST 1: Standard L-3 establishes a general framework for the timely settlement of claims. The corresponding Maine statute, 24-A M.R.S.A. § 2436 (1), states in part:

"A claim for payment of benefits under a policy or certificate of insurance delivered or issued for delivery in this State is payable within 30 days after proof of loss is received by the insurer and ascertainment of the loss is made either by written agreement between the insurer and the insured or beneficiary or by filing with the insured or beneficiary of an award by arbitrators as provided for in the policy. For purposes of this section, "insured" or "beneficiary"; includes a person to whom benefits have been assigned. A claim that is neither disputed nor paid within 30 days is overdue."

TEST 1: Based on 24-A M.R.S.A. § 2436 subsection (1), a claim must be paid within 30 days after proof of loss is received and ascertainment of the loss is made by the insurer, otherwise it is considered overdue.

TEST 2: In addition to the standards outlined in Test 1, 24-A M.R.S.A. § 2436 (1) outlines the standards to apply when additional information is needed by the Company in order to process an undisputed claim as contemplated in Standard L-4. The subsection continues as follows:

"If, during the 30 days, the insurer, in writing, notifies the insured or beneficiary that reasonable additional information is required, the undisputed claim is not overdue until 30 days following receipt by the insurer of the additional required information;"

The standards of documentation outlined in Standard L-5 are further solidified by 24-A M.R.S.A. § 2436 (2) which states:

"An insurer may dispute a claim by furnishing to the insured or beneficiary, or a representative of the insured or beneficiary, a written statement that the claim is disputed with a statement of the grounds upon which it is disputed. The statement must be based upon a reasonable investigation of the claim and must include sufficient detail to permit the insured or beneficiary to understand and respond to the insurer's position."

TEST 2: Based on 24-A M.R.S.A. § 2436 (1) and (2), a claim file must contain adequate documentation of the claims process including written notification to the claimant of reasonable additional or disputed information is required by law.

TEST 3: If the Company fails to pay an undisputed claim within the 30 day timeframe required by law, there is a late payment interest penalty assessed. This is a further testing requirement of Standard L-3. The application of the interest penalty is addressed in 24-A M.R.S.A. § 2436 (3) which states:

"If an insurer fails to pay an undisputed claim or any undisputed part of the claim when due, the amount of the overdue claim or part of the claim bears interest at the rate of 1 1/2% per month after the due date."

TEST 3: 24-A M.R.S.A § 2436 (3) requires an insurer to pay an interest penalty to the claimant if the insurer fails to pay undisputed claims within 30 days of proof of loss.

APPLICATION OF TESTS

This section outlines the application of the tests to the random sample of 100 items selected from the population of paid claims items during the 2nd quarter 2002. The results of applying the criteria outlined in the tests are as follows:

TABLE 1:

Test #	*Type*	*Sampled*	*N/A*	*Pass*	*Fail*	*% Pass*
TEST 1 ***Paid < 30 days***	Paid Items	100	0	96	4	96
TEST 2 ***Adequate Documentation***	Paid Items	100	0	100	0	100
TEST 3 ***Interest on Claims > 30 days***	Paid Items	100	96	1	3	25

The four paid items that were not paid within 30 days and; therefore, failed Test 1 were then subjected to Test 3 to determine Company compliance with the interest penalty portion of 24-A M.R.S.A § 2436 (3). Of the four items that were not paid within 30 days:

- 3 items were adjustments to claims processed incorrectly, which resulted in additional payments for two items and payment of an originally denied claim. No penalty interest was paid on any of the 3 items.
- 1 item had penalty interest paid but calculated incorrectly

It should be noted that for a period of time, Aetna's formula used to calculate late payment penalty interest exceeded the Bureau's interpretation of the statute by one day. While this technically would cause an item to fail Test 3, these items were not considered as errors and are not reflected in the tables of this report.

An additional random sample of 100 items was selected from the Aetna population where payment was not made within 30 days after proof of loss. This population totaled 4,839 line items or 1.7% of the total paid claims population provided by Aetna. The results are shown in Table 2.

TABLE 2:						
Test #	***Type***	***Sampled***	***N/A***	***Pass***	***Fail***	***% Pass***
TEST 2 ***Adequate Documentation***	Paid Items	100	0	100	0	100
TEST 3 ***Interest on Claims > 30 days***	Paid Items	100	0	82	18	82

The 18 items that failed Test 3 were grouped as follows:

- 11 items had no interest paid
- 7 items had interest paid but calculated incorrectly

As with many health carriers, Aetna Health Inc. contracts out the administration of their mental health care contract provisions. Magellan Behavioral Health Systems, LLC, hereinafter referred to as Magellan, is the licensed Third Party Administrator contracted by Aetna. As this area tends to be problematic within the industry, a random sample of 50 items was selected from the Magellan population where payment was not made within 30 days after proof of loss (2.1% of Magellan's total population or 165 items). Results of which are shown in Table 3.

TABLE 3:

Test #	***Type***	***Sampled***	***N/A***	***Pass***	***Fail***	***% Pass***
TEST 2 ***Adequate Documentation***	Paid Items	50	0	50	0	100
TEST 3 ***Interest on Claims > 30 days***	Paid Items	50	8	42	0	100

Of the 50 sample items tested, 32 exceeded the allowable 30-day period. In all cases where penalty interest was due, it was calculated and paid correctly. The eight items that were deemed not applicable under Test 3 in Table 3 were administrative modifications to the claim files. These modifications were primarily demographic data such as addresses and did not impact the original processing of the claims. The eight items were considered a material amount of the sample (16%) and justified an expansion of the original sample. An additional random sample of 31

items was selected from the same population as the sample reported in Table 3. The results of this expanded sample are shown in Table 4.

TABLE 4:

Test #	*Type*	*Sampled*	*N/A*	*Pass*	*Fail*	*% Pass*
TEST 2 ***Adequate Documentation***	Paid Items	31	0	31	0	100
TEST 3 ***Interest on Claims > 30 days***	Paid Items	31	2	29	0	100

There were 29 out of 31 sample items that exceeded the allowable 30-day period. In all cases where penalty interest was due, it was calculated and paid correctly.

COMMENTS & RECOMMENDATIONS

1. **Comment:** If a claim requires re-processing or recalculation, the current process creates a new claim file by copying data from the original claim. This process is referred to as a "copied" claim and is treated as a new claim. There were process errors noted in applying the appropriate "receipt date" resulting in occasions when the application of additional late payment interest did not occur.

   Recommendation: It is recommended that these types of claims be given special review to recognize potential penalty interest situations.

2. **Comment:** As with many Companies, Aetna has a quality control program whereby processed claims are randomly selected for review. Although Aetna's quality control program does have processes to assure that interest be calculated for the period during which the claim is in quality review, in one instance, the examiner found that the processor did not pick up on the claim as being due late payment penalty interest. The processor did not properly incorporate the days used in the quality review to calculate the proper late payment interest penalty.

   Recommendation: Aetna's processes and claims processing staff should recognize any claim that takes longer than 30 days from receipt to payment as being due late payment interest penalty.

3. **Comment:** During claim file reviews, it was noted that Aetna received demands for payment from the Department of Health and Human Services, Third Party Liability Unit for claims that had been paid by Maine Medicaid for qualified individuals who also had primary coverage in place with Aetna at the time medical services were rendered. Both Federal and State law establish Medicaid as the payor of last resort. Federal law requires that a state submit a claim paid by Medicaid to a primary carrier for adjudication by the

carrier. These requests for adjudication by the primary carrier are often issued after extensive periods of time after the actual services were rendered. These requests for adjudication do not typically contain the data that Aetna or its subcontractors would expect or require to receive from a traditional care provider. As a result, these requests to adjudicate a claim for payment resulted in the claims being denied for a variety of reasons.

Recommendation: Through dialog with Department of Health and Human Services, Aetna should develop and institute procedures that process these demands for payment submitted by the Department of Health and Human Services, Third Party Liability Unit according to the appropriate statutes, Title XIX of the Social Security Act § 1902 (a) (25), 42 CFR 433.135-139 and Title 22 M.R.S.A. § 14. Specialized treatment is warranted since these are not claims per se and require special handling and accommodations.

STATE OF MAINE
COUNTY OF KENNEBEC, SS

Van E. Sullivan, being duly sworn according to law, deposes and says that in accordance with the authority vested in him by Alessandro A. Iuppa, Superintendent of Insurance, pursuant to the Insurance Laws of the State of Maine, he has made an examination of the condition and affairs of the

Aetna Health Inc.

of Portland, Maine as of 2nd quarter 2002, and that the foregoing report of examination subscribed to by him is true to the best of his knowledge and belief.

The following examiners from the Bureau of Insurance assisted:

Carolee B. Nichols, AIRC
Paul C. Greenier

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Van E. Sullivan, Supervisor
Market Conduct Division

Subscribed and sworn to before me this day _____of _____, 2005

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Notary Public My Commission Expires:

I hereby certify that the attached report of examination dated October 7, 2003 shows the condition and affairs of the Aetna Health Inc., Portland, Maine as of 2nd quarter 2002 and has been filed in the Bureau of Insurance as a public document.

This report has been reviewed.

_____
Eric A. Cioppa
Deputy Superintendent

This _____ day of _____, 2005