

REPORT OF
NEW HAMPSHIRE INSURANCE DEPARTMENT
MARKET CONDUCT TARGETED EXAMINATION

OF

AETNA U.S. HEALTHCARE, INC.
A NEW HAMPSHIRE HEALTH MAINTENANCE
ORGANIZATION
980 JOLLY ROAD
P.O. BOX 1109
BLUE BELL, PENNSYLVANIA 19422

NAIC#0001-95237

FOR COMPLIANCE WITH
STIPULATION AND CONSENT AGREEMENT
ISSUED 11/22/99 DOCKET No. INS. 99-005-EP
AS OF AUGUST 28, 2002

ADOPTED

AUGUST 28, 2002

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ATTACHMENT I – Copy of Stipulation and Consent Agreement

APPENDIX 1 – Press Release

APPENDIX 2 – Company Memo Explanation of Benefit compliance

APPENDIX 3 – Explanation of Benefit Availability

APPENDIX 4 - Explanation of Denial Letter Compliance

Executive Summary

This report represents the findings and recommendations associated with a desk review and targeted examination of Aetna U.S. Healthcare, Inc. (AUSHC) conducted as a follow-up of the Stipulation and Consent Agreement issued to AUSHC (AUSHC). The stipulation and consent agreement is based on AUSHC failure, during the period from January, 1995 through March, 1999, to pay certain claims in the manner required by New Hampshire insurance law, R.S.A., § 417:4,XV and department rules, Ins 1001.02 Claims Settlement.

The targeted examination consisted of a desk review evaluation of required reports received by the New Hampshire Insurance Department as mandated within the stipulation and consent agreement, and the completion of an on-site examination in Portland, Maine to determine compliance with said stipulation and consent agreement. **(See Attachment 1 - Stipulation and Consent Agreement).**

The examination was called to determine compliance with the agreement prior to AUSHC's exit from the New Hampshire marketplace. **(See Appendix 1 – Press Release regarding AUSHC withdrawing its HMO based health insurance products from the small and large employer market in New Hampshire.)**

In summary, the examiners found AUSHC in compliance with RSA 420-J:8,1 (a) which requires all contracts between the health carrier and participating providers to contain a hold harmless provision specifying protection for covered persons. In addition, the agreement required a complaint/claims inquiry tracking system be established to address consumer inquiries received on unpaid claims for both members and providers. Examiners determined that the tracking system was established and in compliance with the agreement.

A sample of member-submitted claims reviewed during the on-site portion of the examination documented non-compliance with the agreement. Member submitted claims constitute approximately .5% of all claims submitted:

1. Date of receipt documentation on claims, required by stipulation # 8 of the agreement, was not in compliance with the order. Examiners found that 93.4% of the 274 claims reviewed did not have a date stamped on the claim.
2. All denied claims (full and partial) must include documentation of member notification in order to comply with Ins. 1001.04, 1001.06 and 1001.14. Only 27 of 136 denied claims reviewed had documentation of denial notification.

3. All denied claims within the representative samples reviewed for HMO and POS plans did not include an explanation of benefits form, furnished to members, that was compliant with Ins. 1001.01(f), 1001.04 (a), 1001.06 and 1001.14.

Content and Structure of Report

The remaining sections in the report outline the scope of the stipulation provide an overview of the targeted examination and summarize the findings relating to the documentation provided by the company to support compliance with said Stipulation and Consent Agreement.

Section I

This section is an overview of the total Stipulation and Consent Agreement that identifies statues and regulations relevant to the Agreement.

Section II

Section II includes findings from the examiners' review of a representative sampling of member submitted claims. The purpose of the review was to measure the timeliness of processing member claims submitted since issuance of said Agreement. The following Managed Care lines of business were evaluated:

- Member Paid Point of Service
- Member Denied Point of Service
- Member Paid HMO
- Member Denied HMO

Section III

This section covers compliance with RSA 420-J:8 1 (a) Hold harmless provisions relating to the contractual arrangement requirements for network providers.

Section IV

This section contains findings relevant to the Company Complaint/Claims Inquiry Tracking System, mandated in the Stipulation by the New Hampshire Insurance Department.

Section V

Section V addresses denial letter compliance with Ins. 1001.06 and 1001.14.

Section VI

This section addresses Explanation of Benefit Forms (POS and HMO) and compliance with RSA 420:H.

Section VII

The last section contains:

- a summary statement and the language of RSA 400-A:15, III, and
- company written responses, provided in the following appendices, to examination findings concerning unavailability of documentation pertinent to compliance determination:

Appendix 2 – Memo - Embossed date of receipt documentation explanation

Appendix 3 – Memo - Member Reimbursements Explanation of Benefits availability

Appendix 4 – Memo - Denial Letter procedures and availability

SECTION I

Overview of the Stipulation and Consent Agreement

The Stipulation & Consent Agreement with AUSHC was entered 11/8/99 in response to consumer complaints alleging untimely claim payments. The Department issued twenty-two stipulations in the Agreement, summarized below. Following each stipulation, shown in boldfaced italicized type, is a brief summary of findings, if any, and examiners' notes related to the stipulation.

1. Company acknowledges failure to pay certain claims, during the period from January 1995 through March 1999, in accordance with RSA 417:4,XV and Ins. 1001 and waives its right to further notice and hearing in this matter.

No examiner testing required.

2. Department concluded if a hearing was held, said conduct would be in violation of Insurance Laws and Department Rules.

No examiner testing required.

3. Company consents to the imposition of a civil penalty consisting of a fine in the sum of \$60,000. Such penalties represent an administrative fine in the amount of \$500 for each fifty-four (54) consumer complaint alleging untimely claim payments and an additional administrative fine of \$1500 for each of the twenty-two (22) instances where the consumer complaint was referred to a collection agency.

No examiner testing required.

4. Company agrees to take steps necessary to ensure full compliance for prompt, fair and equitable settlement of claims.

The Company prepared and forwarded to the Department monthly TAT Reports that consist of aged inventory for the region, monthly claim turnaround results and event tracking information. Reports were received from 11/99 through 5/01.

Company compliance with prompt, fair and equitable settlement of claims was confirmed by timeliness testing of claims selected in a random sample taken from the claim population.

5. Company agrees to provide *monthly aging reports* to the Department for Period covering November 1999 through November 2001. Reports shall be based on

the date claims are received (indicated by date stamp) and show claims inventory, as of date certain, by the number of days since the claim was received. Company agrees that if it is able to produce state – specific aging reports during the reporting period contemplated by this Agreement, monthly aging reports supplied to the Department thereafter will be New Hampshire specific.

The examiners' desk review of required reports revealed: TAT reports consisting of aged inventory of the region and monthly claim turnaround results would demonstrate processed claims inventory for a specific timeframe. State specific detail was provided until 5/01.

6. Company shall provide monthly TAT data, NH specific, from November 1999 through November 2001.

The examiners' desk review found that the company was in compliance with the Agreement from 11/99 through 5/31/01. Company reports were received by the department monthly as required (noted in Item #4). The Examiners requested, as part of the desk review, the remaining reports not received from June, 2001 through August, 2001. Upon receipt of those reports, it was noted that they were in a new format. Follow-up with the company documented that the company consolidated NH inventory with MASS01 entries due to a decrease in overall inventory and to make inventory management more efficient. Minimal concern was placed on this stipulation by examiners due to the announcement that Aetna U.S Healthcare, Inc. is withdrawing its HMO based health insurance products from the small and large employer market in New Hampshire..

7. Company shall submit monthly progress reports on the number of claims pended, the length of time in pended status, and follow-up efforts for pended claims, for the period of November 1999 through November 2001. Separate report not required if the Department determines sufficient information in these areas is included in TAT reports pursuant to #5 above. Aging reports were included with the monthly TAT reports.

Examiners were able to determine all pended claims information from the aging reports except follow-up efforts for pending claims or monthly progress reports. No documented procedures were provided to the examiners on follow-up procedures.

8. Company shall date stamp all claims to reflect the date of initial claim receipt by Company. TAT shall be calculated using the period from this date stamp indicating time of receipt through the date of the claim check.

See Appendix #2 (explanation from company).

The examiners' review of random samples of claims for verification of documentation of date of claim receipt was completed. The following reflects the results, by line of business:

POS PAID (52 claims reviewed) 94.2% did not have the receipt date on the claim.

HMO PAID (86 claims reviewed) 100% did not have receipt date on the claim.

POS DENIED (49 claims reviewed) 97.6% did not have receipt date on the claim.

HMO DENIED (87 claims reviewed) 93.3% did not have receipt date on the claim.

Based upon the above findings, the examiners determined that the company was not in compliance with the Agreement.

9. Company shall timely send and maintain record of accurate Explanation of Benefits to members for all claims involving reimbursement and remittance advice to providers indicating payment or denial. Copies to be readily available to Department upon request.

During the review of paid claim files, examiners found the explanation of benefits form being used to inform members for all member paid claims (POS and HMO) when no deductible or coinsurance explanation is required, was the Explanation of Provider Payment (EPP) forms. All other claims paid received a full member Explanation of Benefits. The EPP forms do not contain New Hampshire Insurance Department language requirements, namely, the grievance/appeals directive and the company's customer service toll free telephone number. Discussion relating to the wording in Ins.1001.02 (f) would have allowed this EOB for HMO and POS paid claims only.

All HMO and POS denied claims are in violation of Ins.1001.02 (f), 1001.04 (a), 1001.06 and 1001.14 as denied claims require the above language. (See Appendix #3 – Explanation from Company regarding availability of Documentation.)

10. Company shall provide to the department any supplementation updates or changes to internal policies and procedures for monitoring claims processing and follow-up. Such documentation shall be provided to Department no later than thirty (30) days after implementation.

The company established an Event Tracking Manual and updated its grievance procedure in November 1999, however, that was not provided to the Department until the information was requested by examiners in July of 2001. The company did not comply with the 30-day implementation stipulation in the Agreement. The tracking system was created to provide a

method of tracking all member inquiries, complaints and their resolution as required by the Agreement. The procedural manual explaining the new Event Tracking System was also tested by examiners for effectiveness during their on-site review of random samples of claims. The examiners found that the system enhancements effectively documented tracking of member inquiries, complaints and resolution. The new system was found to be compliant with the intent of the Agreement.

The examiners found exception only to the timeliness of the filing of the new procedures.

11. Company shall send timely notices for full or partial denials to members in compliance with Ins 1001.05 and 1001.07. (Regulation was changed 05/99 to Ins. 1001.04, 1001, 06 and 1001.14).

All denied claims were reviewed for member notification on full and partial denials. See responses to Item # 8 and #9.

POS Denied Claims Sample

7 of the 49 claims reviewed (14.3%) documented the letter # identifier in the system that a denial letter was sent.

HMO Denied Claims Sample

20 of 87 claims reviewed (23%) documented the letter # identifier in the system that a denial letter was sent.

Examiners did not receive copies of the denial letters, since they are not maintained by the company. This did not allow the examiners to verify the actual content of each denial letter or verify appropriate references to Ins. 1001.04, 1001.06 and 1001.14.

12. Company shall draft or revise and implement internal policies and procedures for effective member call tracking and updating claim history to reflect member communications and follow-up response on claim status. Evidence of these changes shall be made available to the Department no later than March 1, 2001.

The HMO event tracking manual established in November 1999 for member inquiry tracking was provided to the Department upon request by the examiners in July of 2001.

Clarification of Procedures – The procedure manual was received and reviewed prior to the actual testing of the tracking system. The examiners verified the audit trail of claims and inquiry documentation. The event tracking system includes all call tracking and updates all claim history to reflect member communication.

The examiners comment is relative to availability to the Department by March 1, 2001. See Response to Stipulation #10.

13. Company shall submit its event tracking report monthly addressing the number of consumer inquiries received on unpaid claims by both members and providers. Company provided monthly inquiry event tracking broken down by product.

The reports do not identify "unpaid claims". The company is not in compliance with the Agreement.

14. Company was required to submit reports to Department by 15th of the month following the end of the period to which reports relate.

The Company was in compliance through May 2001.

15. Company will meet with the Department quarterly for years 2000 and 2001, on mutually agreed upon dates, as to the status of the Company's claims processing statistics, results and procedures.

An examiner attended all meetings. No examiner testing required.

16. Company will send letter of apology, content pre-approved by Department, to each of the claimants whose names were identified on lists dated April 1999 and May 1999. Letter shall state claimant may file letter with appropriate credit reporting entity and claimant can request additional explanatory letter from Aetna, also to be approved by the Department.

Stipulation #3 cited AUSHC on 54 untimely consumer complaints and 22 instances where the consumer was referred to (or the complainant was informed referral was imminent to) a collection entity.

Examiners reviewed all available supporting documentation in Company records and filed with the New Hampshire Insurance Department to identify the claimants and make a determination whether claimants received the letter of apology required for compliance with the Agreement. The examiners were unable to determine why 36 of the letters were not sent or documented as sent for all complainants cited in the Stipulation and Consent Agreement.

17. Company shall designate an individual within the Company as a special point of contact for members relating to untimely claims payment.

The company designated a special point of contact as required within the Agreement to address and resolve untimely claim issues. The designated coordinator was Vickie Ross –Compliance Coordinator. Vickie Ross was also the coordinator and major contact person for the examiners during the targeted examination.

18. Company shall ensure “hold harmless” provisions are in place on all provider contracts or other provider agreements to ensure that members are not held financially liable by providers for payments that are the obligation of the Company. Company shall certify with the Department compliance on or before November 30, 2001.

The hold harmless provision required by the Agreement was omitted in a contract with St. Joseph’s Hospital, resulting in several complaints whereby the HMO member was balance billed. The Department required a new contract be written between AUSHC and St. Joseph’s Hospital. The revised copy of the provider contract between Aetna and St. Joseph’s Hospital was filed with the Department, reviewed by examiners and documented as being in compliance to RSA 420-J:8, I (a) which requires all contracts between the health carrier and participating providers shall contain a hold harmless provision specifying protection for covered persons. Examiners requested and reviewed all participating provider contracts (5 hospital contracts) in the New Hampshire network to assure that the “hold harmless” clause was evident in all AUSHC provider contracts (hospital contracts). Examiners received and reviewed copies of all five provider contracts to test for compliance with RSA 420-J: 8, I (a). No exceptions found by examiners.

19. The Department acknowledges the terms and conditions of this Agreement addresses the Department’s concerns and that no additional disciplinary action shall be imposed on the Company with respect to untimely claims processing and payment. This Agreement shall not prohibit any disciplinary action, sanction or other enforcement action based upon any finding or recommendation unrelated to the complaints. Nor shall this Agreement prohibit action or sanction based on the targeted examination. Nor shall Agreement have any effect upon any future action by the Department based upon additional or subsequent consumer complaints received by the Department.

Examiners reference RSA 400-A:15, III based on findings within the targeted exam:

RSA 400-A:15, III –

“Any person who knowingly violates any rule or regulation, or order of the commissioner may, upon hearing, except where other penalty is expressly provided, be subject to such suspension or revocation of certificate of authority or license, or administrative fine not to exceed \$2,500 in lieu of such suspension or revocation, as may be applicable under this title for violation of the provision to which such rule, regulation, or order relates”.

20. Company acknowledges that this Agreement may be used in a future proceeding if there is reason to believe the terms of this Agreement have been violated or if the Department institutes action against the Company for any reason other than

the specific acts considered herein. This Agreement shall not prohibit future action based upon further complaints to the Department relative to untimely claims payment by Aetna or subsequent examination findings.

Examiners reference RSA 400-A:15, III based on findings within the targeted exam: "Any person who knowingly violates any rule or regulation, or order of the commissioner may, upon hearing, except where other penalty is expressly provided, be subject to such suspension or revocation of certificate of authority or license, or administrative fine not to exceed \$2,500 in lieu of such suspension or revocation, as may be applicable under this title for violation of the provision to which such rule, regulation, or order relates."

21. The Department shall, in its discretion, conduct a targeted examination to ascertain Aetna's compliance with the terms of this Agreement. If an examination reveals noncompliance or violation of any of the terms and conditions of this Agreement the Department may impose an additional administrative fine and other penalties, after appropriate notice, hearing and findings. Such additional remedy or penalty may include revocation of Aetna's licensure to operate and offer coverage in New Hampshire.

The examiners found Aetna US Healthcare in violation of certain of the stipulations in the Agreement. The majority of the violations related to availability of information due to the record retention policies of the company and available date of receipt documentation on claim samples (no date stamp).

See Appendix #2 for explanation from Company.

22. This Stipulation and Agreement shall have no effect as to the rights or claims of any individuals except the State of New Hampshire.

No examiner follow-up required.

Section II

Member Paid & Denied Claim Summary

Findings are summarized relative to a review of member submitted claims conducted to measure timeliness of member submitted claims processed since issuance of the Stipulation and Consent Agreement and compliance with Ins. 1001.

A representative sample¹ of member paid and denied claims for HMO and POS plans was selected for member submitted claims for the following managed care claim types:

**Member Submitted HMO Denied Claims
Workpaper Ref #s HMO-D#1 through HMO-D#90 -**

The total universe of member submitted, denied claims (determined by member payment designation) were requested by examiners for the targeted examination review period, 11/99 through 11/01. The claims were retrieved to review for compliance with the Agreement. The following results are reported from the review of those member submitted, denied HMO claims:

Three of the 90 claims selected were eliminated from the sample (2 were duplicates and 1 claim could not be found). A total of 87 claims was reviewed for proper audit trail associated with the stipulations cited in the Stipulation and Consent Agreement, namely, timeliness of the process measured by the provided date of receipt (date stamp) on the claims, appropriate denial letter documentation and proper explanation of benefits to members. From the review of those 87 claims, examiners found the following:

- 84 of 87 (96.6%) claims did not have stamped received dates on the claims.
- For 87 of 87 (100%) claims, the company could not provide a copy of denial letter. (See Appendix #4 for company explanation).
- 67 of 87 (77.0%) claims had no documentation in the Claims Inquiry Screen that a denial letter was ever sent to the member.
- For 100% of the claims, the company did not have a member Explanation of Benefit form to provide to the examiner. An EPP (Provider EOB) was provided in a few cases. A memorandum was requested from Vicki Ross, Compliance Consultant, to document Aetna US HealthCare's explanation for the supporting documentation received. (See Appendix #3).
- Violation of Ins.1001 Claims Settlement 1001.04 (a) "If a claim is denied in whole or in part the insured, claimant or authorized representative of either shall be given the reason for the denial. In any case where coverage is denied the insurer shall notify the insured, claimant or authorized representative of either of the applicable policy provisions upon which denial is based."
(b) "Statements setting forth benefits included within claim payments shall be in writing and in sufficient detail so that the insured, claimant or authorized

¹ Representative samples are determined by total universe during exam period, divided by total number of selection desired with a random starting point.

representative of either can reasonably understand the benefits included in the claims payment.”

- HMO Denied Claims Timeliness measure – The review was incomplete due to lack of supporting documentation available (date stamp) on claims. Lack of such documentation violates the Stipulation and Consent Agreement.

**Member Submitted, POS Denied Claims
Workpaper Ref #s POS-D#1 through POS-D#49 -**

The following results from the review of member submitted, denied POS claims are reported:

- 1 of 49 claims was not legible and was eliminated from sample.
- 48 of 48 (100%) claims did not have date of receipt (date stamp) on the claim.
- 42 OF 48 (85.7%) of the POS denied claims did not document the denial letter sent to the member in the Claims Inquiry Screen.
- 15 of 48 (31.3%) claims did document notice to members by providing an EPP (Explanation of Provider Payment).
- Non compliance with Ins. 1001.04 (a), (b).
- POS Denied Claims Timeliness measure – The review was incomplete due to lack of supporting documentation available (date stamp) on claims. This violates the Stipulation and Consent Agreement.

**Member Submitted HMO Paid Claims
Workpaper Ref #s HMO-P#1 through HMO-P#86 –**

The following reports the results from the review of member submitted paid HMO claims are reported:

- 7 of 86 (8.1%) claims were not available for review and were eliminated from the sample.
- 4 of 79 (5%) claims had available date stamp on claims.
- 75 of 79 (95%) claims did not have the date of receipt (date stamp) on the claim.
- 86 of 86 (100%) claims did not have a documented notice to member (EOB) with which to determine compliance to RSA Part Ins. 1001. Only the first page of the EOB was provided to the examiners.

- HMO Paid Claims Timeliness measure – The review was incomplete due to lack of supporting documentation available (date stamp) on claims. This violates the Stipulation and Consent Agreement.

Member Submitted POS paid Claims

Workpaper Ref #s POS-P#1 through POS-P# 52 –

The following results from the review of member submitted paid POS claims are reported:

- 3 of 52 claims were eliminated from sample due to incomplete documentation.
- 49 of 49 (100%) claims did not have a date of receipt (date stamp) on the claim.
- 10 of 49 (20.4%) claims did not have an EOB with which to determine compliance with Ins. 1001.
- POS Paid Claims Timeliness Measure - The review was incomplete due to lack of supporting documentation available (date stamp) on claims. The company is in violation of the Stipulation and Consent Agreement.

Section III

Compliance with RSA 420-J:8

RSA 420-J:8 provides in part: “Every contract between a health carrier and a participating provider shall set forth a hold harmless provision specifying protection for covered persons.” The hold harmless provision was omitted from a contract with St. Joseph’s Hospital. Lack of such a provision facilitated “balance billing” of the HMO member, a practice that formed the basis of several complaints to the department. The Department stipulated that a new contract be written between AUSHC and St. Joseph’s Hospital as part of the Stipulation and Consent Agreement.

A copy of the newly negotiated provider contract between AUSHC and St. Joseph’s Hospital was filed with the Department, reviewed by examiners and documented as being in compliance to **RSA 420-J:8, I (a)**.

Examiners also requested and reviewed, all AUSHC participating provider contracts (5 hospital contracts) in their New Hampshire network to assure that the “hold harmless” provision was contained in all of them. Examiners received and reviewed copies of all five provider contracts and confirmed the presence of the hold harmless provision and compliance with **RSA 420-J: 8, I (a)**.

Section IV

Compliance with Complaint/Claims Inquiry Tracking

Examiners tested for compliance with the Stipulation and Consent Agreement relevant to the Company's newly established Tracking System for Complaints and Claims. The examiners determined that AUSHC established an Event Tracking Manual and an updated Grievance Procedure in November, 1999. The documentation was not provided to the Department until examiners requested the information in July of 2001. That did not comply with the 30-day notification of implementation stipulation in the Agreement.

The tracking system was created to provide a method of tracking all member inquiries, complaints and their resolution as required in the Agreement. The examiners prior to the on-site examination completed a desk review of the procedural manual outlining the new Event Tracking System. The examiners also tested the procedural manual process on-site for effective audit trail within the tracking system, utilizing the ²representative claims samples to verify compliance. The examiners confirmed that the system enhancements effectively documented the tracking of member inquiries, complaints and their resolution. The examiners found that the newly developed system is in compliance with the intent of the Agreement.

The examiners found exception to the Agreement only as to the timeliness of the filing of the new procedures, that such was not filed as required within 30 days of implementation of the Agreement.

Section V

Compliance with Ins. 1001.06 and Ins. 1001.14

The examiners tested for denial letter compliance with Ins. 1001.05 and 1001.07, a requirement cited in the Stipulation and Consent Agreement (Changed 5/99 to 1001.04, 1001.06 and 1001.14). The examiners documented the following findings in their review of the representative samples of HMO and POS denied claims. (See Memo #4-b.)

Point of Service Denied Claims Sample

- 7 of the 49 (14.3%) claims were documented with a letter # identifier in the system indicating that a denial letter was sent.

² Ibid

HMO Denied Claims Sample

- 20 of 87 (23%) claims were documented with a letter # identifier in the system that a denial letter was sent.

Examiners did not receive copies of the denial letters, since the company does not maintain them. This did not allow examiners to verify the actual content of denial letter or verify the appropriate references to Ins. 1001.04, 1001.06 and 1001.14.

Section VI

Explanation of Benefit Forms

See the memorandum dated January 31, 2002 from Vickie Ross, Regional Compliance Consultant, regarding the availability of member reimbursement Explanation of Benefits Forms. The examiners' review of paid claim files found, for all Member Paid claims (POS and HMO), the explanation of benefits form used to inform members of benefits, when no deductible or coinsurance explanation is required, was the Explanation of Provider Payment (EPP) forms which is in compliance with Ins 1001.02 (f) and would have allowed for **HMO and POS paid claims only**. All other claims paid received a full member Explanation of Benefits form.

The EPP forms do not contain the New Hampshire Insurance Department language requirements concerning the appeals directive or the company customer service toll free telephone number requirements. **HMO and POS Denied Claims** are in violation of 1001.02 (f), 1001.04 (a), 1001.06 and 1001.14.

Section VII

Summary

As stated in Item # 21 of the Stipulation and Consent Agreement, the Department shall, in its discretion, conduct a targeted examination to ascertain AUSHC compliance with the terms of the Agreement. If an examination reveals noncompliance or violation of any of the terms and conditions of the Agreement, the Department may impose additional administrative fine and other penalties, after appropriate notice, hearing and findings. Such additional remedy or penalty may include revocation of AUSHC's licensure to operate and offer coverage in New Hampshire.

cy-11-11
Ms. Fine 1432
Complaint
Date 12/21/99
Amount 60,000.00
152272
2

In the Matter of

AETNA U.S. HEALTHCARE INC.
AGREEMENT

STIPULATION AND CONSENT

Respondent

DOCKET NO. INS 99-005-EP

WHEREAS, Aetna U.S. Healthcare Inc. ("Respondent") is a domestic health maintenance organization licensed to conduct business as such in the State of New Hampshire pursuant to the provisions of the New Hampshire Insurance Law ("Insurance Law"); and

WHEREAS, an investigation of Respondent conducted by the New Hampshire Insurance Department ("Department") has revealed possible violations of the Insurance Law; and

WHEREAS, the Department initiated enforcement action in response to seventy-six consumer complaints alleging untimely claims payment for claims ultimately paid by Respondent, and

WHEREAS, twenty-two of the aforementioned complainants were referred to, or were informed that referral was immanent to, a collections agency as a result of the Respondent's untimely claims payment, and

WHEREAS, the maximum statutory administrative fine the Department may impose per violation of the above Insurance Laws is \$2,500, and

WHEREAS, the Department considers each complaint alleging untimely claims payment by Respondent to be a separate violation; and

WHEREAS, Respondent has been advised and is aware of its statutory right to notice and a hearing on any such violation; and

WHEREAS, Respondent will implement a significant quality effort to enhance and improve timeliness and accuracy of claims processing, claims payment, claims tracking, including tracking and follow-up procedures for unpaid claims referred internally or interdepartmentally to other areas such as medical review and unpaid claims pending for any reason; and

WHEREAS, Respondent desires to resolve any such violations by entering into a stipulation and consent agreement ("Agreement") on the terms and conditions hereinafter set forth in lieu of proceeding with a formal hearing on the matter;

NOW THEREFORE, IT IS STIPULATED AND AGREED by and between the Respondent and the Department, subject to the approval of the Commissioner of Insurance, as follows:

1. Respondent waives its right to further notice and hearing in this matter and stipulates that during the period from January, 1995 through March 1999 Respondent failed to pay certain claims in the manner required by Insurance Law, R.S.A., § 417:4, XV and Department Rules, Part Ins 1001, Claim Settlement.

2. The Department has concluded that, if a hearing were held in this matter, such conduct would be found violative of such provisions of the Insurance Law and Department Rules.

3. Respondent consents to the imposition of a civil penalty in the sum of \$60,000. Such penalty represents an administrative fine in the amount of \$500 for each of fifty-four consumer complaints alleging untimely claims payment by Respondent and an additional administrative fine in the amount of \$1500 for each of the twenty-two instances wherein the consumer complainant was referred to, or the complainant was informed referral was imminent to, a collections entity

4. Respondent agrees to take all reasonable steps necessary to ensure full compliance with the standards for prompt, fair and equitable settlement of claims as set forth in the Insurance Law, Department Rules and this Agreement.

5. Respondent agrees to provide monthly regional aging reports to the Department for the period November 1999 through November 2001. Such reports shall be based on the date claims are received (as indicated by the date stamp) and show claims inventory, as of a date certain, by the number of days since the claim was received. Respondent agrees that if it is able to produce state-specific aging reports during the reporting period contemplated by this Agreement, monthly aging reports supplied to the Department thereafter will be New Hampshire specific.

6. The Respondent shall provide the Department monthly TAT data in the form of monthly New Hampshire specific reports for the months beginning November 1, 1999 through November 30, 2001.

7. The Respondent shall submit monthly progress reports to the Department on the number of claims pended, the length of time in pended status, and follow-up efforts for pended claims, for the period November 1999 through November 2001. Separate reporting of this information shall not be required if, in the Department's determination, sufficient information in these areas is included in the aging reports submitted pursuant to 5 above.

8. Respondent shall date stamp all claims. Such stamp shall reflect and continue to reflect the date of initial claim receipt by Respondent. The Respondent shall not alter this date at any time. For purposes of this Agreement, turn around time (TAT) shall be calculated using the period from this date stamp indicating time of receipt through the date of the claim check.

the lists attached to correspondence to Respondent from the Department dated April 21, 1999 and May 17, 1999. The letter which is sent shall note that the claimant may file such letter with the appropriate credit reporting entity, with copy to the provider, and shall invite claimants to request an additional explanatory letter from Aetna. The Department shall also approve the contents of this additional letter. The Respondent shall report to the Department the number of complainants who request this additional letter.

17. Respondent shall designate an individual within the company as a special point of contact for members and the Department in connection with consumer complaints relating to untimely claims payment. This person shall be empowered by Aetna and given the necessary tools to address and expeditiously resolve consumer concerns related to untimely claims payment.

18. Respondent shall ensure that "hold harmless" provisions are in place in compliance with RSA 420-J:8, I for all provider contracts or other provider agreements. Such provision shall ensure that members are not held financially liable by providers for payments that are the financial obligation of Respondent. The Respondent shall provide certify to the Department compliance with this part on or before November 30, 2001.

19. The Department acknowledges that the terms and conditions of this Agreement address the Department's concerns with respect to the issues addressed herein, and that no additional disciplinary action shall be imposed on Respondent with respect to untimely claims processing and payment in the aforementioned seventy-six complaints. This Agreement shall not prohibit any disciplinary action, sanction or other enforcement action based upon any finding or recommendation unrelated to the seventy-six complaints referenced herein. Nor shall this Agreement prohibit action or sanction based on the targeted examination referenced in paragraph 21 below. Nor shall this Agreement have any effect upon any future action by the Department based upon additional or subsequent consumer complaints received by the Department after the initiation of the enforcement action that is the subject of this Agreement.

20. Respondent acknowledges that this Agreement may be used in a future proceeding if there is reason to believe the terms of the Agreement have been violated by Respondent, or if the Department institutes action against the Respondent for any reason other than the specific acts considered herein. This Agreement shall not prohibit future action based upon further complaints to the Department relative to untimely claims payment by Aetna or subsequent examination findings

21. The Department shall, in its discretion, conduct a targeted examination to ascertain Aetna's compliance with the terms of this Agreement. If an examination reveals noncompliance or violation of any of the terms and conditions of this Agreement, the Department may impose an additional administrative fine and other penalties, after

appropriate notice, hearing and findings. Such additional remedy or penalty may include revocation of Aetna's licensure to operate and offer coverage in New Hampshire.

22. This Stipulation and Agreement shall have no effect as to the rights or claims of any individuals except the State of New Hampshire.

INSURANCE

NEW HAMPSHIRE DEPARTMENT OF

By:



Title:

Life, Accident + Health Counsel

Date:

11/22/99

AETNA U.S. HEALTHCARE INC.

By:


Sal J. Uglietta

Title: President

Date:

11/8/99

STATE OF NY

COUNTY OF NY

On this the 8th day of Nov, 1999, Sal J. Uglietta personally appeared before me and acknowledged himself to be the President of Aetna U.S. Healthcare, Inc., a corporation, and that he, being authorized to do so, executed the foregoing instrument for the purposes therein contained.


Notary Public

PHYLLIS A. MADDALONI
Notary Public, State of New York
No. 24-4908430
Qualified in Kings County
Commission Expires 10/10/01

The foregoing Stipulation is hereby approved.

Paula T. Rogers
Commissioner

By: 

Title: _____

Date: _____

State of New Hampshire Insurance Department
56 Old Suncook Road
Concord, New Hampshire 03301

Paula T. Rogers
Commissioner

FOR IMMEDIATE RELEASE
September 25, 2001

Concord, NH

Insurance Commissioner Paula Rogers announced today that Aetna U.S. Healthcare Inc. is withdrawing its HMO based health insurance products from the small and large employer markets in New Hampshire. Currently, Aetna has just under 10,000 HMO members in New Hampshire's small employer market and an equal number in the large employer market.

Aetna's withdrawal from the small group market will be transitioned over a 6 month period, beginning on April 1 and continuing through August, 2002. Withdrawal from the large group market will be transitioned over a year, beginning on April 1, 2002. Aetna has worked with the New Hampshire Insurance Department to ensure that employers and employees are given sufficient advance notice of this market withdrawal and information for employers to evaluate coverage options. Aetna is mailing affected employers and employees notice letters prior to October 1, 2001. Employers and employees will have between 6 and 12 months, depending upon their renewal date and group size, to make arrangements for alternative health coverage.

Aetna is working with the New Hampshire Insurance Department in mailing additional notices to providers and insurance producers. Producers were notified by Aetna via email on September 25 and participating providers will be notified shortly.

Aetna will continue to offer its Preferred Provider Organization (PPO) products and indemnity products in both markets in New Hampshire. These products have different benefit structures from the HMO products being discontinued. Employers will have the option to continue coverage with Aetna by switching to the PPO product, in the event those benefits suit their needs, or they may wish to explore another carrier's products. Aetna's New Hampshire PPO membership is 10,000. Its indemnity membership is 7,000.

Aetna has been reviewing its competitive position in HMO markets across the country. It is attempting to strengthen overall profitability by withdrawing its HMO products from markets where it is not competitive. As a result, in addition to the New Hampshire markets, Aetna is withdrawing its HMO products from the

small and large group markets in Louisiana, Rhode Island, South Carolina, and certain geographic areas in California, Georgia, Indiana, Missouri and Pennsylvania.

Aetna has attributed the lack of competitiveness of their HMO products in the New Hampshire market to their relatively small market share. Without market share, Aetna has been unable to negotiate competitive contracts with health care providers. This in turn, has had a negative impact on profitability. Aetna has not turned a profit on its New Hampshire HMO business since 1996. Aetna's HMO enrollment in New Hampshire has never exceeded 20,000, whereas its HMO enrollment in Massachusetts is 91,000 and enrollment in Maine is 89,000.

Aetna's withdrawal of its HMO products and continuation of its PPO products is consistent with the national trend of decreasing HMO enrollment and increasing PPO enrollment.

Of the approximately 20,000 New Hampshire insureds whose Aetna HMO coverage will terminate, approximately 4,500 commute to a Massachusetts or Maine employer. These persons will be eligible to continue with an Aetna HMO product that is licensed in Massachusetts or Maine. New Hampshire residents who commute will be able to continue their relationship with their New Hampshire Primary Care Physician and receive referred care from other New Hampshire providers participating in the Aetna New Hampshire PPO network.

For additional information, please contact: Alex Feldvebel, Deputy Commissioner at 603-271-2261.

On-Site (Oct-2001)

Appendix #2 LHC 10-24-01

99a

from Peter Salk

(Mike Migliore) Non-standard HMO claims are currently imaged through desktop scanners/ ODL process and don't reflect the embossment date on the Image, however the received date is systemically contained in the system for the life of the claim and cannot be altered. The claim examples reviewed indicated the claims sampled were processed on non-standard claim scanners through the desktop and ODL process thus not displaying the embossed date on the claim. On an annual basis an excess of 23,000,000 HMO claims are imaged on our High speed Integrated Key from Image system (IKFI environment,) and all of these claims contained the received date embossed on the Image

Technology is underway to implement a new claim Image capture system for non-standard claims which is on target to be implemented in early 2002 whereby the received date will be embossed on all images. Design of the system and coding is nearing completion with testing on target for December. This new scanning technology will include the embossed received date on each image and will be in compliance with the DOI recommendation.

EOB language termed July 2000 - S10

Peter Salk



January 31, 2002

Joelien,

Currently there is a limitation for the Remit Retrieval Process within Aetna US Healthcare claims system. This limitation does not allow a re-print request for member reimbursements Explanation of Benefits, which generated a zero remit-check number 00000000. This system fix has been submitted to the claims IT Team for analysis as a System Enhancement. And is currently on the HMO Claims Top Priority Problem Log list. The system fix is currently targeted for a May 2002 claims release.

Regards,

A handwritten signature in black ink, appearing to read "Vicki L. Ross", written over a large, sweeping flourish that starts under the word "Regards" and extends to the right.

Vicki L. Ross
Northeast and Mid-Atlantic Regional
Compliance Consultant

Memorandum

To: Joellen Atwater, NH DOI
From: Peter Soifer, Compliance Manager - Aetna
Date: 02/05/02
Re: NH MCE - Denials

Joellen,

We have spoken with our HMO Systems Support team to clarify the issue surrounding denied claims and associated denial letters.

For a Quality Point of Service (QPOS) claim, the member will receive an Explanation of Benefits (EOB). The EOB will state if the claim was denied and the reason why. For an HMO claim processed as a member reimbursement, the member will receive the Statement of Payment and this will indicate the determination of the claim as well.

There are many denial codes used when processing a claim and for some of these codes, a denial letter is connected to a particular denial remit code. For example, D33- (Denied as a Non-Covered Service), this particular denial remit code would generate a member denial letter. A system generated denial letter automatically sends a claim processor to a letter writer after claim processing is complete. It prompts the processor to complete the description of the service being denied and the billed amount of the same. Once the letter is complete, a denial letter is sent to the member. Once a letter is generated, a history of the claim will indicate what type of letter denial was sent. Due to systematic constraints, it is not possible to drop a copy of the actual denial letter to paper.

At the same time, there are various denial remit codes that do not generate a denial letter to the member. Some examples would include D06 (duplicate claim) and D34 (non-billable). It depends upon the nature of the denial.

We have requested a complete listing of denial codes with an indication as to whether or not a member denial letter would be generated for that code. We will forward upon receipt.



February 12, 2001

Joelien Atwater
New Hampshire DOI
56 Old Suncook Road
Concord, NH 03301-7317

Dear Joelien,

After a thorough review for letter-generated denial remit codes, we have narrowed down the denial remit codes that do generate a letter to a member. The following is a list of letter-generated denial codes and the definition of these codes when member reimbursements are involved. For the denial codes outside of this list below, a system generated Explanation of Benefits (EOB) sent to a member would provide the member detail of claim denials or payments.

D28 – We are not responsible for these charges; the primary physician did not issue a referral for this service;

D07 – Please bill primary carrier; submit balance, if applicable, with referral from patient's primary physician;

D27 – Member was not effective at the time of service; member is responsible for these charges;

D61 – The information received is insufficient for claim processing;

D33 – This is a non-covered service; member is responsible for the charges;

DE1 – The information received is insufficient for claims processing; this code will be used for eyewear reimbursement only. Aetna U.S. Healthcare has sent a letter to the member detailing what is necessary to process the claim; and

D20 – This bill has been forwarded to the proper provider for payment consideration. If the member did not coordinate the care or was not approved by the mental health provider, the claim will be the members' responsibility.

Peter Soifer

FACSIMILE TRANSMITTAL SHEET

TO:	Joelien Atwater	FROM:	Peter Soifer
COMPANY:	NH DOI	DATE:	02/12/02
FAX NUMBER:	603-271-1406	TOTAL NO. OF PAGES INCLUDING COVER:	2
PHONE NUMBER:	[Click here and type phone number]	SENDER'S REFERENCE NUMBER:	860-952-8150
RE:	[Click here and type subject of fax]	YOUR REFERENCE NUMBER:	[Click here and type reference number]

URGENT
 FOR REVIEW
 PLEASE COMMENT
 PLEASE REPLY
 PLEASE RECYCLE

NOTES/COMMENTS:

Joelien,

Attached is a listing of those denial codes where denial letters are generated. Any denial codes outside of this listing would not necessarily generate a denial letter and the EOB would serve as the denial letter listing any reason why a claim was denied.

Memo # 4b

1

Dewey, Laura A

Denial

From: Sheaffer, Linda
Sent: Monday, November 30, 1998 4:11 PM
To: Dewey, Laura A
Subject: RE: NH claims question

Yes. In the CLI screen that displays the claim itself, at the bottom right portion of the screen are two fields: MBRLTR and PRVLTR. MBRLTR will show the name of the letter that was sent to the member, if one was sent. PRVLTR will show the name of the letter that was sent to the provider, if one was sent. From that screen, you can also press the F17 key which will take you to another screen which will tell you the date that the letter was sent. If you need more detailed instructions on how to pull up the claim in CLI, let me know.

Denial letter memo copied from initial exam '99.