Market Conduct Examination

AETNA U.S. HEALTHCARE, INC

Blue Bell, Pennsylvania

STATE OF NEW JERSEY

DEPARTEMENT OF BANKING AND INSURANCE

Division of Insurance, Office of Consumer Protection Services

Market Conduct Examination Unit

Report Adopted: July 9, 2004

CONFIDENTIAL

MARKET CONDUCT EXAMINATION

of

AETNA U.S. HEALTHCARE, INC.

(A Health Maintenance Organization)

located in

BLUE BELL, PENNSYLVANIA

as of
March 5, 2003

BY EXAMINERS

of the

STATE OF NEW JERSEY

DEPARTMENT OF BANKING AND INSURANCE

DIVISION OF INSURANCE
OFFICE OF CONSUMER PROTECTION SERVICES
MARKET CONDUCT EXAMINATION UNIT

DATE REPORT ADOPTED:

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I. INTRODUCTION

This is a report of the Market Conduct activities of Aetna U.S. Healthcare, Inc. (hereinafter referred to as "Aetna" or the "Company"). Authority for this examination is found under **N.J.S.A. 26:2J-18.1** and **N.J.S.A. 17B: 30-16**, made applicable to the operations of a health maintenance organization (hereinafter "HMO") **by N.J.S.A. 26:2J-15b, N.J.S.A. 26:2J-18b** and **N.J.A.C. 8:38-2.12(a)**. In this report, examiners of the New Jersey Department of Banking and Insurance (DOBI or the Department) present their findings, conclusions and recommendations as a result of their market conduct examination. The Market Conduct Examiners included Examiner-in-Charge Laurence J. Kievit, who passed away during the report writing phase of this exam, and Clifton J. Day, who assumed Examiner-In-Charge duties thereafter, and examiners Robert Guice and Rosalyn Benitez.

A. SCOPE OF EXAMINATION

The scope of the examination included HMO coverage sold in New Jersey. The examiners evaluated the Company's compliance with certain market conduct-related provisions of Health Maintenance Organization laws and regulations. The emphasis of this examination was to determine whether the Company was in compliance with laws that impose time constraints on HMO claims processing operations. **N.J.S.A. 26:2J-8.1** and **N.J.A.C. 11:22-1** define these limits. Additional emphasis included compliance with **N.J.A.C. 8:38-1** et seq. and **N.J.A.C. 11:22-1** et seq., as well as **N.J.S.A. 17B: 30-13.1** et seq. (Trade Practices and Discrimination), **N.J.A.C. 11:2-17.1** (Unfair Claims Settlement Act), **N.J.S.A. 26:2S-1** (Health Care Quality Act of 1997), **N.J.S.A. 17B:27-46.1** (provisions regarding Group Life, Group Health Insurance and Blanket Insurance), and **N.J.S.A. 26:2J-4.2** (Mental Health Parity Law, P.L. 1999, c. 106). The examiners conducted their fieldwork at the Company's Blue Bell, Pennsylvania office between July 2, 2001 and September 7, 2001. On various dates thereafter, the examiners completed additional review work and the writing of this report. Medicare/Medicaid, self-funded plans, federal employee health benefit plans (FEHBP), automobile PIP payments and claims covered under capitation were excluded from this review.

The examiners randomly selected files and records from computer listings and documents provided by the Company. The random selection process is in accordance with the National Association of Insurance Commissioner's Market Conduct Examiners Handbook. In addition, the examiners used the NAIC Market Conduct Examiners Handbook, Chapter VIII-Conducting the Health Examination, as a guide to write this report.

B. ERROR RATIOS

Error ratios are the percentage of files which the examiners found to be handled in error. Each file either mishandled or not handled in accordance with applicable state statutes or regulations is an error. Even though a file may contain multiple errors, the examiners

counted the file only once in calculating the error ratios; however, any file that contains more than one error will be cited more than once in the report. In the event that the Company corrected an error as a result of a consumer complaint or due to the examiners' findings, the error is included in the error ratio. If the Company corrects an error independent of a complaint or NJDOBI intervention, the error is not included in the error ratios.

For the purpose of the database computer analyses conducted during this review period, the examiners define an exception as a file or record in a database that does not meet specified criteria as set forth in electronic queries. The file or record has not been reviewed in depth by an examiner. However, the frequency, type or severity of these exceptions may result in the examiners extracting sub-populations and review samples for further, detailed analysis.

Some of the errors cited in this report define unfair practices or practices in general as specific acts that a carrier commits so frequently that it constitutes an improper general business practice. Whenever the examiners found that the errors cited constitute an improper general business practice, they have stated this in the report that follows.

The examiners sometimes find business practices or errors of a carrier that may be technical in nature or which did not have an impact on a consumer. Even though such errors or practices would not be in compliance with law, the examiners do not count each of these files as an error in determining error ratios. Whenever such business practices or errors do have an impact on an enrollee or provider, each of the files in error will be counted in the error ratio.

The examiners submitted written inquiries to Company representatives on the errors cited in this report. This provided Aetna with the opportunity to respond to the examiners' findings and to provide exception to the statutory and/or regulatory errors or mishandling of files reported herein. In response to these inquiries, Aetna agreed with some of the errors cited in this report. On those errors with which the Company disagreed, the examiners evaluated the individual merits of each response and gave due consideration to all comments. In some instances, the examiners did not cite the files due to the Company's explanatory responses. In others, the errors remained as cited in the examiners' inquiries. For the most part, this is a report by exception.

C. COMPANY PROFILE

The Company was incorporated in New Jersey on May 18, 1982, under the name Garden State HMO, Inc. During the same year, the New Jersey Department of Banking and Insurance issued the Company a Certificate of Authority to operate as a health maintenance organization. Effective January 1983, the Company changed its name to HMO of New Jersey, Inc. Effective February 1983, HMO of New Jersey, Inc., was acquired by and became a wholly owned subsidiary of the United States Healthcare Systems, Inc. In 1986, the United States Healthcare System, Inc. was renamed to U.S. Healthcare, Inc. On July 1, 1996, U.S. Healthcare, Inc. merged with Aetna to become Aetna U.S. Healthcare Inc.

As of August 2001, the Company had 14,859 participating physicians and providers in New Jersey and 670,236 enrollees.

During the review period of April 1, 2000 to March 31, 2001, the Company utilized one contracted vendor, Human Affairs International, Inc., which is an affiliate of Magellan Behavioral Health. HAII, hereinafter referred to as Magellan, contracted with Aetna to provide behavioral health care services to individuals entitled to receive these services through or from an Aetna plan.

II. CLAIM HANDLING

A. INTRODUCTION

The examiners manually reviewed 332 randomly selected mailed and electronic claims submitted under health insurance policies during the period April 1, 2000 through March 31, 2001. During this period, Aetna processed 3,563,934 claims; this number included 2,664,419 paid claims and 800,946 denied claims. Of these, 1,513,119 were electronic claims and 1,934,246 were mailed claims. In addition, Aetna's vendor, Magellan, processed 98,569 mental health mailed claims for its members; this number included 77,161 paid claims and 21,408 denied claims. Magellan did not process any electronically submitted claims. The distribution of errors from these samples is reflected in chart number 3 below.

The examiners also conducted database analyses of the entire claim population for both Aetna and Magellan to verify compliance with statutory and regulatory guidelines regarding prompt payment of claims. This analysis also reflects totals of claims closed in the examining period April 1, 2000 to March 31, 2001.

In reviewing claims, the examiners checked for compliance with statutes and regulations which govern the handling of claims, particularly **N.J.S.A. 26:2J-1** et seq. (the Health Maintenance Organization Act), **N.J.A.C. 8:38-1** et seq. (Health Maintenance Organizations), **N.J.A.C. 11:22** et seq., the regulation that implements Health Information Electronic Interchange Technology (H.I.N.T. legislation), **N.J.S.A. 17B: 30-13.1** (Unfair Trade Practices Act), **N.J.A.C. 11:2-17** et seq. (Unfair Claim Settlement Practices), the New Jersey Mental Health Parity Law, P.L. 1999, c. 106 and guidelines and procedures outlined in the NAIC Market Conduct Examiners Handbook, Chapter VIII, Conducting the Health Examination, which now includes the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

B. ERROR RATIOS

The examiners calculated the error ratios by applying the procedure outlined in the introduction of this report. The following four charts summarize the examiners' findings based on several different review types. The first chart, identified as Random Sample Review, is a summary of errors of the entire scope of this review including prompt pay, interest payments where applicable, improper claim denials, etc. The overall random sample error ratio is 17% as indicated in chart 1 (Random Sample Review). The second chart, identified as Random Sample Review – Prompt Pay and Denial Review Only, is a summary of the examiners' random review of prompt pay and settlement errors exclusively, which yielded an overall error ratio of 12%. The third chart in this error ratio section, Database Population Review (Prompt Pay and Settlement), which yielded an overall exception ratio of 2.1%, itemizes the examiners' findings based solely on prompt-pay database reviews of Aetna's and Magellan's entire population of claims. It should be noted that Aetna was unable to provide the examiners with a database that contained only clean claims as defined in **N.J.A.C. 26:2J-8.1(d)1(a)** through **(e).** This regulation specifies that a clean claim is one that is free of coding errors, missing information, suspected fraud and other variables. Therefore, the

exception ratios for this chart may include claims that are not clean. The examiners did, however, request that Aetna construct a second dataset that included specific claim detail that would permit Aetna to exclude non-clean, paid and denied claims. This dataset included only four months of paid and denied clean claim data (the last month of four quarters, which included June 2000, September 2000, December 2000 and March 2001), and was designed to compare exception ratios between the four-month dataset of clean claims and the 12-month dataset (chart 3) that contained clean and non-clean claims. Magellan was not included in this supplemental review (chart 4) because this vendor was able to extract non-clean claims from the claim population that appears in chart 3. The examiners extrapolated this four-month dataset to a 12-month period and reported an overall exception ratio of 2.84%. Each of the four charts appear below:

1. Random Sample Review – All Areas of Review

Type of Claim	Files Reviewed	Files in Error	Error Ratio
Paid Claims:			
In-House – Aetna			
Electronic	55	0	0%
Mailed	56	2	4%
Vendor – Magellan			
Mailed	55	19	35%
Total Paid Random Claims	**166**	**21**	**13%**
Denied Claims:			
In-House – Aetna			
Electronic	56	1	2%
Mailed	55	4	7%
Vendor – Magellan			
Mailed	55	29	53%
Total Denied Random Claims	**166**	**34**	**20%**
Overall Random Totals	**332**	**55**	**17%**

2. Random Sample Review – Prompt Pay and Denial Review Only

Type of Claim	Files Reviewed	Files in Error	Error Ratio
Paid Claims:			
In-House – Aetna			
Electronic	55	0	0%
Mailed	56	0	0%
Vendor – Magellan			
Mailed*	55	18	32%
Total Paid Claims	166	18	11%

Type of Claim	Files Reviewed	Files in Error	Error Ratio
Denied Claims:			
In-House – Aetna			
Electronic	56	0	0%
Mailed	55	0	0%
Vendor – Magellan			
Mailed*	55	23	42%
Total Denied Claims	166	23	14%
Overall Random Totals	**332**	**41**	**12%**

* Magellan processed mailed claims only.

3. Database Population Review (Prompt Pay and Settlement)

Type of Claim	Records Reviewed	Number of Exceptions	Exception Ratios
A. In-House – Aetna:			
Paid Claims:			
Mailed	1,404,907	17,666	1.2%
Electronic	1,259,512	12,980	1.0%
Subtotal In-House Paid Claims	2,664,419	30,646	1.1%
Denied Claims:			
Mailed	529,339	11,044	2.0%
Electronic	271,607	3,734	1.3%
Subtotal In-House Denied Claims	800,946	14,778	1.8%
Total In-House Claims	**3,465,365**	**45,424**	**1.3%**
B. Vendor – Magellan Mailed			
Paid Mailed Claims	77,161	21,765	28%
Denied Mailed Claims	21,408	8,145	38%
Total Magellan Claims	**98,569**	**29,910**	**30%**
Overall Totals	**3,563,934**	**75,334**	**2.1%**

As the above chart indicates, the examiners found that Aetna settled 1.1% of all electronic and mailed paid claims beyond the maximum settlement period specified by regulation. However, Magellan's error ratio for paid claims was significantly higher, at 28%. The examiners also found that Aetna settled 1.8% of all denied electronic and mailed claims beyond the maximum period specified by regulation. Once again, Magellan's error ratio for denied claims was significantly higher, at 38%. The overall error ratio between paid and denied claims processed by Aetna and Magellan is 2.1%, with Magellan accounting for most of these errors. Specific findings for electronic and mailed claim payments and denials are highlighted below.

Population Review – Mailed and Electronic Paid Claims (Prompt Pay)

a. Mailed Claims Paid (Aetna and Magellan)

The examiners queried the entire population of paid mailed claims for the examination period (April 1, 2000 to March 31, 2001) on Aetna's in-house system and on that of its vendor, Magellan. As noted in the following chart, the exception rate on Aetna's in-house paid claim-processing system on mailed paid claims was 1.2%. However, the Magellan error ratio for paid claims that were mailed was significantly higher, at 28%. The overall prompt pay exception ratio for paid claims that were mailed to the Company is 2.6%, with Magellan accounting for the majority of these exceptions.

Mailed Paid – Aetna and Magellan

Type of Claim (Mailed)	Records Reviewed	Exceptions Discovered	Exception Ratio
Paid Aetna	1,404,907	17,666	1.2%
Paid Magellan	77,161	21,765	28%
Category Total	1,482,068	39,431	2.6%

b. Electronic Claims Paid (Aetna Only)

The examiners queried the entire population of electronically submitted paid claims that Aetna processed during the review period (April 1, 2000 to March 31, 2001). As noted in the following chart, Aetna's electronic paid claims processing exception ratio was 1%.

Notably, Aetna's mailed paid exception ratio was 1.2%, while the electronic paid exception rate was 1.0%. This represents a percentage difference of only 0.2 between Aetna's mailed and electronic claims. The results of this review indicate that Aetna processes mailed and electronic claims in a uniform manner. These errors are discussed in Section II.C of this report.

Electronic Paid – Aetna Only

Type of Claim (Mailed)	Records Reviewed	Exceptions Discovered	Exception Ratio
Paid Electronic	1,259,512	12,980	1.0%

Population Review – Mailed and Electronic Denied Claims (Prompt Pay)

The examiners queried the entire population of denied mailed claims for the examination period (April 1, 2000 to March 31, 2001) on Aetna's in-house system and on that of its vendor, Magellan. As noted in the following chart, the exception rate on Aetna's in-house denied claim-processing system on mailed claims was 2.0%. However, the Magellan error ratio on denied claims that were mailed was significantly higher, at 38%. The overall exception ratio for denied claims that were mailed to the company is 3.4%, with Magellan accounting for the majority of these exceptions.

a. Mailed Claims Denied – Aetna and Magellan

Type of Claim (Mailed)	Records Reviewed	Exceptions Discovered	Exception Ratio
Denied Aetna	529,339	11,044	2.0%
Denied Magellan	21,408	8,145	38%
Category Total	550,747	19,189	3.4%

The examiners queried the entire population of electronically submitted denied claims that Aetna processed during the review period (April 1, 2000 to March 31, 2001). As noted in the following chart, Aetna's electronic denied claims processing exception ratio was 1.3%.

Notably, Aetna's mailed denied exception ratio was 2.0%, while the electronic denied exception rate was 1.3%. This represents a percentage difference of only 0.7 between Aetna's mailed and electronic claims. The results of this review indicate that Aetna processes mailed and electronic claims in a uniform manner. These findings are discussed in Section II.C of this report.

b. Electronic Claims Denied (Aetna Only)

Type of Claim (Mailed)	Records Reviewed	Exceptions Discovered	Exception Ratio
Denied Aetna	271,607	3,734	1.3%

4. Quarterly Month-End Clean Claim Prompt Pay Review (Aetna Only)

A. Paid and Denied Electronic

Claim Month	Claim Population	Claim Exceptions	Exception Ratio
June 2000	135,409*	1,485	1.10%
September 2000	135,409*	3,427	4.63%
December 2000	135,409*	1,978	1.46%
March 2001	135,409*	2,060	1.52%
Claims Extrapolated To 12-Month period	1,624,908**	26,850***	1.65%

B. Paid and Denied Mailed

Claim Month	Claim Population*	Claim Exceptions	Exception Ratio
June 2000	175,140*	8,115	4.63%
September 2000	175,140	9,653	5.51%
December 2000	175,140	4,747	2.71%
March 2001	175,140	3,853	2.20%
Claims Extrapolated To 12-Month Period	2,101,680**	79,104***	3.76%
Overall 12-Month Paid and Denied Claim Extrapolation	3,726,588	105,954	2.84

*Derived by using 1/12 of annual claim population. Aetna was unable to provide the exact population.
**Derived by multiplying monthly value by 12 to extrapolate annualized values.
***Derived by adding all known exceptions indicated and multiplying by 3 to extrapolate annualized values.

C. EXAMINERS' FINDINGS – PROMPT PAY AND PAID CLAIMS

1. Failure to Conform with Prompt Pay Laws – 18 Random Files in Error and 75,334 Database Exceptions (Improper General Business Practice)

N.J.S.A. 26:2J-8.1d(1) and **N.J.A.C. 11:22-1.5(a)** require a company to pay clean mailed claims within 40 days and electronically submitted claims within 30 days. In addition, **N.J.A.C. 8:38-16.4(b)** requires a company to pay clean claims submitted prior to the year 2000 within 60 days. **N.J.S.A. 26:2J-8.1(d)1(a)** through **(e)** define a clean claim as one which must be free of coding errors, missing information, suspected fraud, and other disputes. Additionally, the NAIC Market Conduct Examiners' Handbook Claims Section contains

Standard three, which states that examiners should verify whether a company settles claims in a timely manner.

The examiners reviewed the random sample and the general population database to determine if the Company and its vendor, Magellan, paid claims within required time frames. In the prompt pay random sample of 166 paid files itemized in chart 2 above, the examiners found that Aetna paid all mailed and electronically received claims within the maximum time periods specified above, resulting in an error ratio of 0%. However, Aetna's vendor, Magellan, failed to comply with prompt pay requirements on 18 out of 55 paid mailed claims, for an error ratio of 32%. The combined in-house and vendor prompt pay error ratio for paid mailed claims is 16%, which includes 18 total errors (0 in-house mailed errors + 18 vendor/Magellan errors) with a population of 111 claims (56 in-house + 55 vendor/Magellan). Combined error ratios for electronic claims are unavailable, as Magellan processed only mailed claims during the review period. The overall paid claim error ratio (Aetna mailed and electronic claims and Magellan mailed claims combined) is 11%, with Magellan accounting for all errors reported.

PLEASE SEE APPENDIX A.1 FOR THE 18 FILES IN ERROR

The examiners queried the general population databases containing claims that Aetna processed during the period April 1, 2000 to March 31, 2001 and found that the Company failed to promptly pay 17,666 mailed claims out of a population of 1,404,907 paid mailed claims for an exception ratio of 1.2%. In addition, Aetna failed to promptly pay 12,980 out of 1,259,512 electronically submitted paid claims, resulting in an exception ratio of 1.0%. During a database review of Magellan paid claims that were mailed, the examiners determined that the Company failed to promptly pay 21,765 claims out of a population of 77,161 behavior health claims, resulting in an exception ratio of 28%. These findings are highlighted in chart 3 above.

2. Failure to Pay Interest on Delayed Paid Claims – 3 Random Magellan Files in Error, 21 Select Aetna Files in Error (from four-month end-quarter dataset), 55 Supplemental Review Aetna Exceptions (from four-month end-quarter dataset) and 3,300 Magellan Exceptions (from General Population Dataset) – Improper General Business Practice

N.J.S.A. 26:2J-8.1d(7) and **N.J.A.C. 11:22-1.6 (c)** require insurers to pay interest on mailed clean claims if not paid within 40 days, and on electronically submitted clean claims if not paid within 30 days. Effective January 2, 2001, **N.J.A.C. 11:22-1.6(c)** requires a carrier to pay interest on overdue claim payments at the time claim payment is made, or within 14 days of the payment of the claim. Standard Number Six of the NAIC Market Conduct Examiners Handbook states that examiners should verify whether companies handle claim files in accordance with policy provisions and state laws.

The examiners found three claims from the random sample in which Magellan failed to pay interest on delayed payments. These claims are as follows:

Claim Number	Claim Type	Date Received	Date Paid	Days Over 40
1113728	Mailed-Magellan	4/3/2000	5/31/2000	18
1134219	Mailed-Magellan	4/10/2000	5/29/2000	9
1235607	Mailed-Magellan	4/18/2000	6/26/2000	29

The examiners also queried the general population database that contained clean Magellan claims and found a total of 3,300 out of 21,765 clean delayed claims in which interest was owed but not paid. This represents an exception ratio of 15%. In response to an inquiry, Aetna agreed with this finding.

In addition to the general population database referenced above, the examiners queried the four-month quarter-end Aetna dataset to determine compliance with interest payments on a system-wide basis. Upon review, the examiners noted that this database did not differentiate interest in the total paid column; the total amount paid included the indemnity payment and interest, if any, as one value. In response, the examiners randomly selected 50 claims from this dataset and found 21 that were delayed settlements in which interest was owed but apparently not paid. The examiners submitted inquiries to Aetna on all 21 delayed claims; in response, Aetna confirmed that interest was not paid on any of these claims (100% rate of error), contrary to **N.J.S.A. 26:2J-8.1d(7)** and **N.J.A.C. 11:22-1.6 (c)**.

PLEASE SEE APPENDIX A.2 FOR THE 21 FILES IN ERROR

The examiners then queried the entire four-month dataset and found a total of 20,401 clean claims in which settlement was delayed. Based on data contained in this database, and the 100% rate of error on the select sample, the examiners tentatively concluded that Aetna would not have paid interest on any of these 20,401 clean delayed claims. The examiners tested this conclusion by providing Aetna the opportunity to comment on each of the 20,401 files considered to be in error. Aetna randomly selected 88 of these claims and confirmed that interest was not paid on 55, for an error rate of 62.5%. On the remaining 33 claims, Aetna advised that the initial settlement delay was caused by the need to reissue previously released claim checks for which interest would not be applicable. Although this explains inapplicability of interest on these 33 claims, the examiners once again found that Aetna failed at a rate of 100% to issue interest where interest was due. Specifically, Aetna's sample of 88 clean claims revealed 55 that qualified for, but did not result in, interest payments to the provider. Since this error always occurred where the examiners and the Company had sufficient information to determine applicability of interest, this error constitutes an improper general business practice. Although Aetna did not specifically agree with this error, the results of the Company's review of 88 select claim delays confirm the examiners' findings.

3. Continuing Failure to Fully Correct a Prior Improper General Business Practice on Non-Participating Provider Claims (1,525 Select Database Exceptions, 46 Select Files in Error

In 1997, the Department of Banking and Insurance conducted a market conduct examination on U.S. Healthcare (now Aetna U.S. Healthcare and the subject of this examination). In the report that was adopted on March 12, 1998, the examiners cited U.S. Healthcare for failure to settle non-participating provider claims in a fair and equitable manner. This error constituted an improper general business practice. Specifically, the company submitted payment that was less than the reasonable and customary amount for a particular service. These payments were coded as P17- REF in the company's claim systems. If the provider appealed or otherwise disputed the amount paid, U.S. Healthcare would automatically issue a supplemental payment in an amount that more accurately reflected reasonable and customary standards. A provider that did not submit an appeal would not receive any further payment.

During the recommendation compliance phase of the 1997 examination, U.S. Healthcare agreed to discontinue this practice effective January 1, 2001, with an implementation date of January 20, 2001. The company further advised the Department that revised policy to reflect this change was communicated to pertinent staff on December 22, 2000. In order to determine compliance with this recommendation in the current review, the examiners extracted a list of 27,753 paid, non-participating provider claims from the period January 20, 2001 to March 31, 2001 and found a total of 1,525 claims, or 5.4% of the total, that were coded as "P17" transactions in which payment would be based on the reduced settlement methodology that was cited in the prior examination. The examiners cited these exceptions in the current examination as a violation of **N.J.S.A. 17B:30-13.1(f)**, which requires insurers to settle claims in a fair and equitable manner.

The examiners provided the Company with a list of all 1,525 exceptions for comment. In response, Aetna randomly reviewed 86 of these claims and agreed that 53 were indeed paid based on the reduced REF rate. Of these, 36 were not resubmitted on appeal by the provider; these claims remained underpaid. An additional 8 claims were paid in full after the first appeal and resubmission, and two others were paid in full only after a second appeal and resubmission. The remaining 7 claims were paid on an out-of-network basis and excluded from this review. Aetna's response confirmed that 46 claims (36 reduced REF settlements and 10 adjusted REF settlements based on provider appeals) out of a test population of 85 claims, or 53% of the total, were paid based on the unfair settlement methodology described above. Thus, Aetna's response at the time of the examination confirmed that the Company did not fully implement measures to correct this error.

In response to the draft report, however, Aetna advised that these errors were attributed to a phase-in and training period for the corrective action that was implemented on January 20, 2001. The Company further advised that the appropriate payment methodology was fully implemented during the post-examination period beginning April 1, 2001. The examiners were unable to independently confirm the Company's response because the period April 1, 2001 forward is beyond the examination review period of April 1, 2000 through March 31, 2001.

4. Improper Deduction of Multiple Co-Payments for Same Date of Service - 1 Random Error

On claim number 000520K1191400 from Aetna's 12-month paid claims database, the physician submitted three separate chiropractic care procedures performed on the same date of service. The company applied three separate member co-payments when only one should have applied. This error, which is contrary to **N.J.S.A. 17B:30-13.1(f)**, resulted in an underpayment of $21.00 ($13.00 for procedure 97014 and $9.00 for procedure 97010).

In response to the examiner's inquiry, the Company stated that the claim was "processed incorrectly, a co-payment should not be taken on each procedure for the same date of service. Claim will be reprocessed and paid according to the providers contracted case rate for chiropractic care."

5. Failure to Forward Claim to Magellan for Claim Handling - 1 Random Error

Aetna received claim number 2461858 on January 17, 2001. The claim was for nine individual psychotherapy sessions for dates of service between July 5, 2000 and September 28, 2000. Aetna's vendor, Magellan, is responsible for the processing all mental health claims for its' members. Aetna, which processes only medical claims, appropriately denied these benefits on 1/30/01. The statement of benefits that Aetna sent to the provider as a denial included a message stating that "this bill has been forwarded to the proper provider for payment consideration." Nevertheless, upon receipt of the denial, the provider re-submitted the claim to Magellan, which was received on 3/19/01. Magellan processed and paid the claim nine days later, on 3/28/01.

However, when the examiners questioned the Company as to whether the claim was forwarded to the proper company for payment consideration, Aetna responded that "…its policy is to forward claims to Magellan for handling…(Claim) Examiners are trained to send claims to Magellan as appropriate…In this case, Aetna's process is to send this type of claim to Magellan for handling and Magellan has no record of receiving it. We cannot say with certainty where the process failed."

D. EXAMINERS' FINDINGS – DENIED CLAIMS

1. Failure to Deny Claims Promptly – 23 Random Files in Error, 22,923 Database Exceptions

N.J.S.A. 17B:30-13.1(e) requires a company to issue a claim denial within a reasonable time after the company receives the claim. **N.J.S.A. 26:2J-8.1d(2)e** defines that period of time as 30 days for claims received in the year 2000. For claims received after January 2, 2001, **N.J.A.C. 11:22-1.6(a)** requires a carrier to deny electronic claims within 30 days and all other claims within 40 days. Standard nine of the NAIC Market Conduct Examiner's Handbook Claims Section advises examiners to verify that companies deny claims in accordance with state law.

The examiners reviewed the random sample and the general population database to determine if the Company and its vendor, Magellan, denied claims within required time

frames. In the prompt pay random sample of 166 denied files itemized in chart 2 above, the examiners found that Aetna denied all mailed and electronically received claims within the maximum time periods specified above, resulting in an error ratio of 0%. However, Aetna's vendor, Magellan, failed to comply with prompt settlement requirements on 23 out of 55 denied mailed claims, for significantly higher error ratio of 42%. The combined in-house and vendor error ratio for denied mailed claims is 14%, which includes 23 total errors (0 in-house mailed errors + 23 vendor/Magellan errors) with a population of 166 claims (56 in-house electronic + 55 in-house mailed + 55 vendor/Magellan mailed claims). Combined error ratios for electronic claims are unavailable, as Magellan processed only mailed claims during the review period. The overall denied claim error ratio (Aetna mailed and electronic claims and Magellan mailed claims combined) is 14%, with Magellan accounting for all errors reported.

The examiners queried the general population databases containing claims that Aetna processed during the period April 1, 2000 to March 31, 2001 and found that the Company failed to promptly process 11,044 mailed claims out of an overall population of 529,339 denied mailed claims for an exception ratio of 2.0%. In addition, Aetna failed to promptly deny 3,734 out of 271,607 electronically submitted denied claims, resulting in an exception ratio of 1.3%. During a database review of Magellan mailed claims that were denied, the examiners determined that the Company failed to promptly deny 8,145 claims out of a population of 21,408 behavior health claims, resulting in an exception ratio of 38%. These findings are itemized in chart 3 above.

PLEASE SEE APPENDIX A.3 FOR RANDOM CLAIMS IN ERROR

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2. **<u>Mandated Benefit Denial Errors – N.J. Mental Health Parity Law, P.L. 1999. C. 106 – 31 Select Sample Files in Error</u>**

The New Jersey Mental Health Parity Law, which became effective August 11, 1999, requires that all health contracts, policies and enrollee agreements provide coverage for biologically-based mental illness under the same terms and conditions as provided for any other illness covered by the contract, policy or agreement. Co-payments, deductibles and benefit limits cannot be different from those applied to other medical or surgical benefits. These mandated benefits must be included under new policies and contracts issued after the effective date and by endorsement on all inforce policies and contracts upon renewal.

The purpose of this select review was to specifically focus on reasons for denying any claims that are defined as biologically-based mental illnesses covered by this act, compliance with **New Jersey Department of Banking and Insurance Bulletin No. 01-06 and <u>N.J.A.C.</u> 8:38-5.2(a) 11** and **16**. The examiners also checked for compliance with **<u>N.J.A.C.</u> 11:22-1.6(a)1**, which requires a company to provide members with a reason for claim denials.

The examiners randomly selected five mental health-related ICD-9 (International Classification of Diseases) codes that appeared in the Magellan denied claim dataset. These included obsessive-compulsive disorder, schizophrenia, paranoia with systematized delusions and anorexia nervosa. These codes resulted in a select sample population of 508 claims. Upon review, the examiners found a total of 29 improper denials, for an error ratio of 5.7%. The Company agreed with these errors in response to the examiners' inquiries.

On 23 of these errors (ICD-9 code 307.1 – anorexia nervosa), Magellan assigned remit code “DS”, which designated denial because the provider is deemed to be unqualified for this type of treatment. In response to the examiners’ request that the Company provide examples of the criteria used to disqualify provider claims, Aetna responded that these claims were denied in error. Aetna further advised that these claims should have been designated as remit code “AS”. This code is used to notify a provider that a mental health claim was denied because it was submitted to Aetna and not Magellan, and that the claim should be resubmitted to Aetna’s vendor, Magellan.

PLEASE SEE APPENDIX A.4 FOR CLAIMS IN ERROR

In addition to the 23 errors outlined above, the examiners found seven additional claim denial errors as describe below:

a. Magellan improperly denied claim number 1488636, incorrectly indicating that treatment for Obsessive-Compulsive Disorder (ICD-9 code 300.3) was obtained outside of the member’s contract period. The examiners noted that the treatments, which occurred between 2/8/00 and 4/4/00, were indeed within the enrollment period. In response to an inquiry, Magellan agreed with the examiners’ determination that this claim was invalidly denied.

b. Magellan denied claim number 1815483 (Obsessive-Compulsive Disorder - ICD-9 code 300.3) on the basis that it was received beyond the maximum filing time to submit a claim. Magellan's time limit for claim submissions from providers is 12 months from the last date of service. In this case, the last date of service was 9/1/99 and the claim was received by Magellan on 8/2/2000; the claim was filed within the 12 month filing limit. In response to an inquiry, Magellan stated that "we concur that this denial was incorrect. The claim has been reprocessed."

c. Magellan denied claim number 1819551, using denial code "EG". This code stated that the date of service was “…beyond the time allowed to file a claim." The date of service was 10/23/99. The provider signed the appropriate claim form on 11/8/99. The examiners noticed three stamped receipt dates on the form; 001901808 representing 1/19/2000, 017124521 representing 6/19/2000 and lastly, 03040837? (? = last digit illegible) representing 10/30/2000. The later date of 10/30/2000 was recorded as the receipt date and used to improperly deny this claim on the basis of an untimely submission. In response to the examiner's inquiry, the vendor stated that "…the claim was denied in error and is being reprocessed. Magellan’s procedures are to use the original received date for determining compliance with timely filing standards."

d. Magellan denied claim number 2220708 (Obsessive-Compulsive Disorder - ICD-9 code 300.3) on the basis that this treatment for this disorder is not covered. In response to an inquiry regarding identification of the contract language that justified denial of this claim, Magellan stated "At the time of the denial, certain benefit codes for the plan were not in the system, causing the examiner to deny this claim as not covered. When the benefit codes were updated, the claim was paid." Even though the claim was ultimately paid when the benefit codes were updated, it was improperly denied at the time of the initial submission. However, the examiners did not include this error in the error ratios because

Magellan reprocessed the claim independent of the member's, provider's or DOBI's intervention.

e. Magellan denied claim number 2257176 as a result of a claim processor's misinterpreting the meaning of the code "E1", which was established as a means to place a claim in pend status while a claim is under consideration. In response to the examiners' inquiry, the Company stated "this claim was denied in error and is being reprocessed. The code E1 is reserved for internal pend review by a claims supervisor. The processor erroneously entered a deny status instead of a pend. Magellan has since reprogrammed our system to restrict this code to pend status only."

f. On denied Claim Number 2257788, the provider used a handwritten diagnosis code on the bill for services. Magellan erroneously denied for lack of a diagnosis code. In response to an inquiry, Aetna stated that "we concur that this claim was denied in error and is being reprocessed. The handwritten diagnosis code on the claim form submitted by the provider should have been applied."

g. On claim number 2302196, Magellan utilized denial code "DY", which indicated that the provider's services were performed outside of the authorization period. However, the examiners requested the dates of the member's authorization period and discovered from the Company's response that "…this claim was denied in error and is being reprocessed. A review of the authorization records revealed that outpatient services were authorized between 12/11/99 and 2/24/01, which encompasses this date of service (1/2/2001); however this information was not passed to the system used by the claim examiner..."

3. <u>Miscellaneous Denial Errors (Random Sample, 6 Files in Error)</u>

The examiners found the following six improper denials on claims processed by Aetna

a. On claim number 000513K16530, Aetna improperly denied the claim using code "D39", which indicated that the policy's benefit limits were exceeded. Since the claim was for a new diagnostic procedure and not a continuation of the benefit under which the claim was made, Aetna agreed this claim was denied in error and issued payment to the provider on 9/13/01.

b. On claim number 000517J21653, Aetna denied the payable benefit amount of $1.46 for an injectable medication, under denial code "D15". The file indicated that this amount was denied because it was under the member's co-payment; however, co-pays do not apply to this benefit. Aetna reprocessed this claim and issued payment on 9/13/01.

c. In reviewing claim number 000526G07561, the claim for procedure code 99283 was initially denied using code "D34". This denial code indicates that the procedure was for a non-billable service. This denial was incorrect. The claim was resubmitted and was later paid according to the agreement with the provider.

d. After reviewing Claim Number 000814E76429, the examiner submitted an inquiry to the Company questioning the reason for denial on this claim. Aetna responded that "…the primary physician was billing for services covered under capitation. The denial code of

"D73" used to deny this claim did not reflect this. It wasn't until approximately six months later, when the bill was re-submitted, that the claim was reprocessed using a corrected denial code.

e. The examiners noted that claim number 000816J28787 was originally processed and paid under Claim Number 000724G09247 with an incorrect billed amount of $38.00. On second submission, the Company received a corrected billing of $3,800.00 for total obstetric care. It was improperly denied on the basis of the limits exceeding the benefits, which was not the case. Subsequently, Aetna reprocessed this claim and issued payment on 9/7/00 for the balance owed.

f. The examiners found that Aetna denied claim number 000829E23019 with code "D08", which indicates that the requested procedure was not on the referral. However, the examiners note that the file did indeed reference existence of a referral to an OB/GYN specialist. In response to an inquiry, the Company discovered that the claim was improperly denied based on the wrong reason; Aetna then reprocessed the claim on 9/13/01 using a correct denial code "D32" that states "The fee for this service is included in the global rate paid to the delivering doctor for prenatal, delivery and postpartum care."

E. MISCELLANEOUS CLAIM HANDLING ERRORS

1. Failure to Properly Document One Paid and One Denied Vendor Claim Files - 2 Random Errors

N.J.S.A. 26:2J-18.1 requires a Health Maintenance Organization to submit or make available relevant records for an examination. **N.J.A.C. 11:2-17.12(b)** requires an HMO to maintain detailed documentation and/or evidence in each claim file to permit the examiners to reconstruct the Company's activities relative to claim settlements. In addition, Standard Number Five in the Claims Section of the NAIC Market Conduct Examiner's Handbook calls upon the examiners to review for adequate claim documentation. Magellan was unable to provide the requested copies of the images on each of two claims from the random sample. These include claim number 1683548 from the paid random sample and claim number 2172736 from the denied random sample.

The Company concurred that the original claim documentation for these two claims could not be located. Its failure to properly maintain detailed documentation on each of the two claims files is contrary to both the aforementioned statute and regulation.

2. Claim Processed with Incorrect Receipt Date

N.J.A.C. 11:22-1.5(a)2 states that written claims are considered received based on the US mail postmark date. Upon reviewing Magellan claim number 1279149, the vendor's receipt date was recorded as 5/22/00, although the DCN (document control number) stamped on the claim indicated a receipt date of 1/13/00. Also, the DLN (Document Locator Number), which incorporates the date received by the company, indicated a receipt date of 12/4/99. The Company stated in response to an inquiry that, "…the AUSHC (Aetna) claim receipt date was

inadvertently overlooked and the Magellan receipt date (5/22/00) was used to process the claim.

3. Incorrect Claim Data due to Data Entry Keying Error

In reviewing Claim Number 000505J51345, the examiner's noted that there were two charges, one for $7,000 for a vaccine and another for $2,000 for immunization administration with a benefit paid of $56.00 total. The correct billing charges should have been $70.00 and $20.00 respectively. This error occurred when the billed amount was incorrectly keyed in at the data entry stage.

F. MANDATED BENEFITS

N.J.S.A. 26:2J-4.6, N.J.S.A. 17B: 27-46.1(h) and **N.J.A.C. 8:38-5.5** require that HMOs cover expenses in a health promotion program through health wellness examinations and counseling that include annual blood tests to determine hemoglobin, blood pressure, glucose levels and cholesterol (LDL) and (HDL) levels. Also offered are eye tests for glaucoma, pap smears, colon examinations, mammograms, and an annual consultation to discuss lifestyle behaviors that promote health and well-being including smoking control, nutrition, diets and weight control, lower back protection, breast and testicular self-exams, and seat belt usage in motor vehicles.

All of the Company's offered plans include provisions for this program for its members in accordance with the aforementioned statutes and regulation and the **Health Wellness Promotion Act, PL 1993, c.327**, with amendments approved January 10, 2000 under **PL 1999, c. 339**.

G. SUMMARY AND COMPARISON TO THE 1997 REPORT

The examiners checked for continued compliance with the recommendations that were included in a 1997 examination report found some of the same claim errors in the current examination. These include failure to pay and deny claims promptly, failure to pay interest on delayed claims, and failure to pay interest on delayed claims and failure to pay a reasonable fee for the purposes of avoiding the necessity of provider appeals.

Findings outlined in this report include three improper general business practices: failure to comply with prompt settlement requirements on paid and denied claims, failure to pay interest on delayed claim payments and failure to pay reasonable and customary rates on non-participating provider claims. The latter error remained uncorrected from the prior examination.

Of the 332 randomly selected files reviewed, the examiners found an overall error ratio of 17%, with Magellan accounting for the majority of these errors. In the random sample review of prompt settlement only, the examiners found an overall error ratio of 12%, with Magellan accounting for all errors in this review sample. From the population of 3,563,934 paid and denied claims that the examiners reviewed electronically for prompt settlements

(payments and denials), the examiners found an exception ratio of 2.1%, with Magellan again accounting for the majority of these errors.

In response to the draft report, Aetna stated that it has implemented several oversight measures designed to improve on Magellan's compliance with prompt pay laws. The examiners were unable to independently confirm the Company's response since such corrective actions would have been implemented beyond the examination review period.

III. MAIL REVIEW

On July 31, 2001 the examiners performed a mail review at Aetna's mailroom and claim processing facility located in Blue Bell, P.A. On a daily basis, this facility processes approximately 110,000 of Aetna's incoming paper claims daily. These paper claims are electronically scanned into the Company's claim processing system. Date received is the date the claim was received in the mail room and not the date that appears on the envelope. Aetna also receives approximately 300-400 certified mailings which are scanned separately under individual batches. All envelopes from the incoming mail are discarded, unless addressed to a specific party. The mailroom operates seven days a week with four mail sorts daily: 7:30AM, 9:30AM, 10:30AM and 3:45PM.

The examiners did not visit the Magellan mail facility, which is responsible for handling all behavioral health and substance abuse claims for Aetna. However, the examiners did submit an inquiry to the Magellan, asking for procedures that are used to process in-coming paper claims. Magellan responded that it too, discards all mailing envelopes. The date of receipt is established by the date the claim was received in Magellan's mailroom.

Based on the above, the examiners report the following findings.

1. <u>Failure to Enter the Postmark on the Claims Processing System as the Date of Receipt</u>

Effective January 2, 2001, **<u>N.J.A.C.</u> 11:22-1.5(a)2** required that "... written claims are considered received based on the U.S. Mail postmark date." **<u>N.J.A.C.</u> 11:2-17.12(b)** requires detailed documentation and/or evidence be contained in each claim file in order to permit the examiners to reconstruct the company's activities relative to the claims settlement. As stated above and unless an envelope is addressed to a specific party, Aetna advised the examiners that all mailing envelopes are discarded when received, which is contrary to the regulations.

In response to this finding, both Aetna and Magellan disagreed with this error, stating that they could not differentiate New Jersey from other State mail for the purpose of manually recording envelope postmark dates, and that it is "…faced with imaging envelopes for every claim it receive(s) nationwide for its (approximate) 190 million claims (received) annually…Aetna has been researching various ways to comply with this aspect of the regulations and analyze the methods of compliance for feasibility." Notwithstanding the company's position, Aetna's and Magellan's practices were not in conformity with the regulatory requirement that was in effect during the review period. The U.S. Mail postmark receipt date requirement has since been repealed.

IV. RECOMMENDATIONS

Aetna should inform all responsible personnel and third party entities who handle the files and records cited as errors in this report of the remedial measures which follow in the report sections indicated. The examiners also recommend that the Company establish procedures to monitor compliance with these measures.

Throughout this report, the examiners cited all errors found. If the report cites a single error, the examiners often include a "reminder" recommendation because if a single error is found, more errors may have occurred.

The examiners acknowledge that during the examination, the Company agreed and had already complied with, either in whole or in part, some of the recommendations that are outlined in this report. For the purpose of obtaining proof of compliance and for the Company to provide its personnel with a document they can use for future reference, the examiners have listed all recommendations below.

A. GENERAL INSTRUCTIONS

All items requested for the Commissioner and copies of all written instructions, procedures, recommended forms, etc., should be sent to the Commissioner, c/o Clifton J. Day, Manager of Market Conduct Examinations and Anti Fraud Compliance, 20 West State Street, PO Box 329, Trenton, NJ 08625, within thirty (30) days of the date of the adopted report.

On claims reopened as recommended, the claim payment should be sent to the insured after a pre-mailed cover letter containing the following first paragraph (variable language is included in parentheses):

"During a recent review of our claim files by market conduct examiners of the New Jersey Department of Banking and Insurance, they have determined that you are owed (payment of a claim or claims) (interest relating to a previously submitted claim or claims) (additional payment due to underpayment of a claim) on a previously submitted claim or claims. Details regarding the claim or claims in question are provided in the enclosed Explanation of Benefits. The check associated with this amount has been mailed separately. If you have any questions regarding this payment, please contact us at (toll free number) or write us at the address listed on the Explanation of Benefits."

B. CLAIMS

1. Aetna must issue written instructions to its claim handling personnel that explain New Jersey's prompt payment laws. The Company must advise such personnel, including its contracted vendor Magellan, that **N.J.S.A. 26:2J-8.1d(1)** and **N.J.A.C. 11:22-1.5(a)1** and 2 require a company to pay clean mailed claims within 40 days and clean electronically submitted claims within 30 days of receipt. **N.J.S.A. 17B: 30-13.1(f)** requires the Company to settle claims when liability is reasonably clear.

2. Aetna must inform all claim-handling personnel in writing that:

   a. **<u>N.J.S.A.</u> 26:2J-8.1d(7)** and **<u>N.J.A.C.</u> 11: 22-1.6(c)** require a company to pay simple interest of 10% on mailed claims not paid within 40 days and on electronically submitted claims not paid within 30 days;
   b. **<u>N.J.A.C.</u> 11: 22-1.6(c)** requires that the carrier shall either add the interest amount to the claim amount when paying the claim, or pay interest within 14 days after payment of the claim.

3. Aetna must issue interest payments for the three claims cited by the examiners in Section II.C.2 of this report, the 55 claims identified by Aetna as referenced in Section II.C.2, the 3,300 Magellan errors referenced in the same section, and the 21 claims identified in Appendix A.2. Aetna and Magellan should also review its entire claim population to identify and open all delayed claims that were closed during the review period and issue interest to the appropriate provider. The Company must provide the examiners with a computer run that identifies claim number, date of service, claim receipt date, claim paid date, amount paid, interest amount paid and date Company paid interest.

4. Aetna must adhere to its December 22, 2000 compliance agreement with the New Jersey Department of Banking and Insurance with respect to the 1997 examination report. This agreement specified that, as of January 1, 2001, Aetna would pay reasonable and customary fees on initial claim submissions from all non-participating providers to avoid the necessity of provider appeals to achieve fair payment of claims. Aetna should also:

   a) provide a written notice to all appropriate claims handling personnel stating that claims may not be settled based on the Reasonable Equitable Fee methodology;

   b) provide a copy of this written notice to the Commissioner.

5. For the period January 1, 2002 to March 30, 2002, Aetna must research its system records to identify all claims that were paid under the REF code P17 to determine if reasonable and customary payment was issued to the provider. The company should provide a list of all claims reviewed, as well as an indicator that identifies any claim that was paid at the REF level. This list should also include member's name, claim number, date paid, amount paid and payee's name. Aetna should also review the 46 claims cited in Section II.C.3 and issue payment in the amount that equals the difference between Aetna's REF payment and the appropriate, reasonable and customary payment, plus interest. See General Instructions for the appropriate cover letter to be sent with any payment issued.

6. Aetna should remind all claims handling personnel that multiple co-payments should not be applied for multiple procedures performed by the same provider on the same

date of service. Aetna should issue payment of $21 to the appropriate party on claim number 000520K1191400.

7. Aetna should inform all appropriate claims personnel in writing that **N.J.S.A. 17B: 30-13.1(b)** requires the Company to acknowledge and act reasonably promptly upon receipt of claims communications. Aetna should remind all claims handling personnel that claims involving mental health/chemical dependency benefits shall be forwarded promptly to Magellan for processing.

8. Aetna must advise all claim personnel in writing that **N.J.S.A. 17B: 30-13.1(e)** requires a company to issue a claim denial within a reasonable timeframe. **N.JS.A. 26:2J-8.1d(2)e** and **N.J.A.C. 11:22-1.6(a)** define that period of time as 30 days for claims submitted by electronic means and 40 days for all other claims.

9. Aetna should inform all appropriate personnel that **N.J.A.C. 11:2-17.12(b)** requires the Company and its vendor to maintain detailed documentation and/or evidence, which includes all remit, pend or denial codes and all claim documents in each claim file to permit the examiners to reconstruct the company's activities relative to claim settlements.

10. Aetna must issue written instructions to all in-house and vendor claim handlers stating that **N.J.S.A. 17B: 30-13.1(d)** requires insurers to perform reasonable investigations based upon all available information before denying a claim. These instructions should also state that **N.J.S.A. 17B: 30-13.1(f)** prohibits unfair and inequitable claim settlements in which liability has become reasonably clear, and that **N.J.A.C. 11:22-1.6(a), N.J.S.A. 17B:30-13.1(n)1** and **N.J.A.C. 11:2-17.8(a)** require explanations of the reasons why a claim is denied, including the language in the policy that provides the basis for claim denials.

11. Aetna and Magellan should issue written reminders on the following:
    a. The Company and Magellan must actively verify the member's dates of active membership on each claim before improperly denying a member's expenses on the basis that the expenses fell outside of the member's date of eligibility and/or enrollment.
    b. Any non-mental health related medical claims received erroneously by Magellan should be promptly forwarded to Aetna for payment consideration under the member's medical portion of coverage. Conversely, any mental-health claim received by Aetna should be promptly referred to Magellan for handling.
    c. Aetna and Magellan should establish procedures to ensure that they establish the member’s correct authorization period prior to denying a claim where services are believed to be performed outside of the authorization period.

d. The Company should remind all claims personnel that, where applicable, co-payments may not be duplicated for multiple procedures that occur on the same date and by the same provider.

e. Claims data entry processors should be reminded to accurately enter the claim data when keying in billed amounts.

12. Aetna must re-open the 37 denied claims that are discussed in Section II.C2 and 3 of this report in order to remit all payments that are still owed either to the provider or the member. Aetna should provide the Commissioner with a list of all claims re-opened, as well as the amount paid.

13. Aetna must issue written instructions to all of its vendor-liaison personnel in writing that the Company is responsible for complying with prompt pay laws even though vendors may process claims. The Company must also advise its vendor-liaison personnel in writing that **N.J.A.C. 8:38-16.5** states, "An HMO's use of subcontractors, secondary contractors or primary contractors to perform one of more of the HMO's claims handling functions shall not in any way mitigate an HMO's responsibility to comply with all of the terms of this subchapter."

14. Aetna should implement measures to exercise control over Magellan's claim processing operations. It should consider including in its vendor contracts that failure to comply with prompt pay laws is a condition for termination for cause. The Company should effectively utilize internal audits to improve vendor compliance with prompt pay laws.

C. MAIL REVIEW

15. In order to comply with **N.J.A.C. 11:2-17.12(b),** Aetna must inform all personnel who are employed in the Company's mailing operations that they must maintain and accurately document the date that a claim is received by mail.

APPENDIX A

1. Failure to Promptly Pay Clean Paper Claims within 40 Days - 18 Errors

CLAIM NUMBER	DATE RECEIVED	DATE PAID	DAYS OVER 40
1113728	4/3/2000	5/31/2000	18
1134219	4/10/2000	5/29/2000	9
1235607	4/18/2000	6/26/2000	29
1270148	12/4/99*	6/22/2000	161
1454077	7/17/2000	9/28/2000	33
1514112	6/30/2000	8/24/2000	15
1552476	7/10/2000	9/6/2000	18
1597058	6/7/2000	9/19/2000	64
1614151	8/15/2000	9/25/2000	1
1681437	10/2/2000	12/1/2000	20
1683548	7/11/2000	10/11/2000	52
1705811	10/4/2000	1/19/2001	67
1727848	7/5/2000	10/24/2000	71
1734411	9/11/2000	10/25/2000	4
1821640	10/23/2000	1/4/2001	33
1842709	9/18/2000	1/8/2001	72
1883530	10/2/2000	11/28/2000	17
2078757	12/26/2000	7/25/2001	171

*Magellan Paid Claim, Aetna Receipt Date

2. Failure to pay interest on Clean Late Paid Claims - 21 Errors

CLAIM NUMBER	CLAIM NUMBER	CLAIM NUMBER
000407J2864100	000721E1927600	000829E1208900
000419E9204800	000724V1904200	001012J1283101
000421K0283100	000803M0630201	001015J0133001
00050302308500	000804J2977300	010126J1125000/01
000513E1867100	000808J2233300	010131E9181500/01
000525E8473700	000810J3105800	010212T2970900
000720V1321100	000810J4445800	010214E5540800

3. Failure to Deny Year 2000 Claims within 30 Days - 23 Errors

CLAIM NUMBER	DATE RECEIVED	DATE DENIED	DAYS OVER 30
1143684	4/14/2000	5/22/2000	8
1233207	4/7/2000	5/19/2000	12
1308416	5/10/2000	6/19/2000	10
1314826	5/31/2000	8/30/2000	61
1319439	5/31/2000	8/30/2000	61
1533984	4/24/2000	8/31/2000	99
1583790	8/8/2000	9/14/2000	7
1628002	8/21/2000	9/27/2000	7
1654810	9/25/2000	11/7/2000	13
1690971	7/10/2000	10/12/2000	64
1691207	7/11/2000	10/12/2000	63
1693404	7/19/2000	10/13/2000	56
1697236	9/15/2000	10/16/2000	1
1768758	10/2/2000	11/29/2000	28
1769413	9/18/2000	11/15/2000	28
1788514	7/10/2000	11/6/2000	89
1811064	10/17/2000	11/22/2000	6
1940588	11/6/2000	1/10/2001	35
1970343	12/5/2000	1/15/2001	11
2016250	11/8/2000	12/29/2000	21
2034593	11/13/2000	1/11/2001	29
2055087	11/27/2000	1/9/2001	13
2234171	12/18/2000	2/9/2001	23

4. Improper Denials on Mandated Biologically-Based Mental Health Illnesses - 23 Errors

CLAIM NUMBER	DATE OF SERVICE	CPT CODE
2235921	7/05/00	90804
2270531	7/05/00	90804
2270581	7/12/00	90804
2270623	8/09/00	90804
2270668	8/23/00	90804
2270685	8/30/00	90804
2270705	9/06/00	90804
2270723	9/27/00	90804
2270742	10/11/00	90804
2270898	10/18/00	90804
2270927	10/25/00	90804
2270974	11/01/00	90804
2270997	11/08/00	90804
2271012	11/22/00	90804
2271655	11/29/00	90804
2271790	12/06/00	90804
2271826	12/13/00	90804
2271845	12/20/00	90804
2271860	1/03/01	90804
2271878	1/10/01	90804
2271891	1/17/01	90804
2271911	1/24/01	90804
2271924	1/31/01	90804

V. VERIFICATION

I, Clifton J. Day, am Manager of the Market Conduct Examination of the Aetna U.S. Healthcare, Inc. conducted by the examiners of the New Jersey Department of Banking and Insurance. This verification is based on my personal knowledge as acquired in my official capacity.

The findings, conclusions and recommendations contained in the foregoing report represent, to the best of my knowledge, a full and true statement of the Market Conduct Examination of the Aetna U.S. Healthcare as of March 5, 2003.

I certify that the foregoing statements are true. I am aware that if any of the foregoing statements made by me is willfully false, I am subject to punishment.

_____________________   ____________________________

Date

Clifton J. Day

Manager, Market Conduct Examinations/Anti-Fraud Compliance

State of New Jersey Department of Banking and Insurance