

STATE OF MAINE BUREAU OF INSURANCE

MARKET CONDUCT EXAMINATION REPORT

For the Period January 1, 2005 through December 31, 2008

Aetna Health Incorporated

**151 Farmington Avenue
Hartford, CT 06156**

NAIC Number: 95517

April 22, 2011

**EXAMINATION REPORT PREPARED BY INDEPENDENT
CONTRACTORS FOR THE MAINE BUREAU OF INSURANCE**

Pursuant to Title 24-A M.R.S.A. § 221, I have caused a Targeted Market Conduct Examination to be conducted of Aetna Health Incorporated. I hereby accept this Report of Examination and make it an official record of the Bureau of Insurance.


Eric A. Cioppa
Acting Superintendent of Insurance
Maine Bureau of Insurance

6/21/11
Date

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June 13, 2011

Eric A. Cioppa
Acting Superintendent Insurance
State of Maine Bureau of Insurance
34 State House Station
Augusta, ME 04333

Dear Acting Superintendent Cioppa:

Pursuant to Title 24-A M.R.S.A. § 221(5), a targeted Market Conduct examination (the Examination) of selected focus areas including behavioral health-related complaint handling, appeals, policyholder services, provider network, utilization review and pre-authorization practices, company operations and claims practices has been conducted of:

Aetna Health Incorporated (the Company)

The Company's records were examined at the Company's offices located in Hartford, Connecticut.

The Examination covered the period from January 1, 2005 to December 31, 2008.

A Report of the Examination of Aetna Health Incorporated is, herewith, respectfully submitted.

A handwritten signature in cursive script, appearing to read "Barry Cukels", is written above a horizontal line.

RSM McGladrey
Independent Market Conduct Examiner

SECTION I – EXECUTIVE SUMMARY

Background and Examination Objectives

The Maine Bureau of Insurance (the Bureau) conducted a targeted market conduct Examination of the Company to assess the behavioral health services provided by the Company. The Bureau's primary objective in conducting the Examination is to evaluate whether mental health and substance abuse benefits are at least equal to those received by a person receiving medical treatment. More specifically, the Bureau's goals and objectives in conducting the Examination include but not limited to the following:

1. Test the Company's processes to ensure the Company is providing accurate and timely information to both enrollees and health care providers.
2. Evaluate the Company's compliance with applicable statutes and regulations as well as timeliness and accuracy of claim payments.
3. Determine the Company's compliance with applicable statutes and regulations concerning complaint handling, appeals and grievance procedures, policyholder service, claims handling, and pre-authorization and utilization review procedures.
4. Determine the timeliness of the Company's pre-authorization process and the appropriateness of the decisions. Determine the reasonableness of the Company's process for obtaining and documenting receipt and disposition of treatment plans from providers, including both participating and non-participating providers.
5. Determine the accuracy and completeness of the Company's provider directory.

Examination Approach

RSM McGladrey, Inc. (McGladrey or the Examiners) relied primarily on the review and testing of records and information maintained by the Company concerning certain of their operations included within the scope of the Examination. Where appropriate, the Examiners tendered follow-up inquiries to the Company for response. Interviews with the Company's representative were also conducted. Targeted attribute testing was performed consistent with examination processes and sampling methodologies of the Bureau in concert with the applicable State of Maine insurance statutes, rules and regulations and the NAIC Market Regulation Handbook (the Handbook), which was used as a guide. The Examiners reviewed and tested, where applicable, the following areas:

1. Company Operations and Management
2. Claims Handling and Settlement
3. Utilization Review (UR) and Pre-Authorization
4. Complaints, Appeals and Grievance Handling
5. Policyholder Services and Provider Network

The Examination scope, workplan and testing was developed consistent with the requirements of the Bureau's Rider A - Specification of Work to Be Performed, of the Agreement to Purchase Services (the Agreement). Rider A also established the Company's operational areas to be tested. In consultation with the Bureau, certain tests conducted during the Examination may have been modified from that set out in Rider A to meet the needs of the Bureau and to reflect statutes, rules and regulations referenced herein.

In testing the above referenced areas, the Examiners were directed to evaluate whether mental health and substance abuse benefits were at least equal to those for physical illnesses for a person receiving medical treatment. In so doing, the Examiners used statistically valid random samples where appropriate for the areas tested. Also, where applicable and

consistent with the requirements of the Bureau, the Examiners utilized qualified clinical professionals, approved by the Bureau, to conduct peer reviews to perform the following:

- Review medical records to determine whether an adverse decision was appropriately rendered.
- Determine whether the Company conducted a fair review of medical necessity before issuing a denial; for example, they determined that medical records were reviewed or there was a substantive collection of medical information (written or verbal) before determining the lack of medical necessity.
- Review the Company's utilization review peer reviewers' qualifications for appropriateness.
- Review that the Company's reviewer had the appropriate expertise (personally or through a qualified consultant) in cases involving experimental/investigational treatment denials; for example, they determined that denials were appropriate and based upon scientific evidence or lack thereof.
- Determine that the Company's reviewer had knowledge or familiarity with neuropsychological testing and other cognitive-related issues, if applicable.

Findings

The Examiners noted findings regarding the Company's claims and appeals handling practices. The issues identified during the Examination are noted below in order of priority:

Finding # 1

The Examiners identified a potential violation of the Maine Mental Health Parity Law, 24-A M.R.S.A. § 2843 of the Maine Insurance Code, wherein the Company failed to include one hundred ninety one (191) behavioral health diagnosis codes as covered by parity laws within their claim adjudication system. The error involved claims adjudicated between January 1, 2006 and March 13, 2007 involving six hundred seventy two (672) claims identified by the Company at the

direction of the Bureau. Six (6) of the 672 claims involving diagnosis code 314.01 were underpaid. An additional 6,038 claims involving one hundred ninety (190) other diagnosis codes were identified as not being covered by parity laws within their claim adjudication system. The Company performed a detailed review of this issue and the additional details regarding this finding and the results of the additional review performed by the Company can be found in Section V of this Report.

Finding # 2

The Examiners identified a potential violation of 24-A M.R.S.A. § 4303(4)(A)(1) and Insurance Rule Chapter 850, § 8(5), involving four (4) claims wherein the Company's HMO claims processing system did not generate an Explanation of Benefits (EOB) and the member had associated financial responsibility related to the claim. Further review of the issue by the Company at the direction of the Bureau revealed 2,668 claims and 756 members were impacted. The Company has advised they undertook remediation of this matter through a system solution on March 26, 2010. The Bureau will monitor this matter directly with the Company. The company provided comments to this finding. See attached comments.

Finding # 3

The Examiners identified four (4) of 130 denied and zero paid claims which may represent possible violations of 24-A M.R.S.A. § 2164D(3)(B)(D), wherein the Company failed to develop and maintain claims documentation supporting the Company's decisions regarding member liability. Specifically, documentation confirming the member was advised of their liability was not maintained.

Finding # 4

The Examiners identified three (3) of 130 denied and zero-paid claims as possible violations of 24-A M.R.S.A. § 2436(1-A), regarding Interest on Overdue Payments, wherein the Company failed to affirm or deny coverage for three (3) claims within a reasonable period of time. The referenced Maine insurance statute stipulates that payment or denial of a claim by a carrier must be made within 30 calendar days after the carrier has received all information needed to pay or deny

the claim. Specifically, processing the claims was not completed nor was interest paid until February 2010. The company provided comments to this finding. See attached comments.

Finding #5

The Examiners identified ten (10) of forty three (43) appeal files as possible violations of Insurance Rule Chapter 850, § 9C(1). The Company did not send the required acknowledgement letters for four (4) of the sampled files. Additionally, the Company failed to send acknowledgement letters within three (3) working days as required by statute for six (6) of the sampled files. The company provided comments to this finding. See attached comments.

Finding #6

The Examiners identified three (3) of forty three (43) appeal files as possible violations of Insurance Rule Chapter 850, § 9C(1)(a), wherein the Company did not issue decisions within 20 days as required. The company provided comments to this finding. See attached comments.

Finding #7

The Examiners identified two (2) of forty three (43) appeal files as possible violations of Insurance Rule Chapter 191, § 10(B), regarding record retention. Specifically, two (2) of the Company's appeal files did not contain a copy of the appeal decision letter sent to the member. One of those files was also missing the appeal acknowledgement letter required by this statute. The company provided comments to this finding. See attached comments.

Finding #8

The Examiners identified one (1) of forty three (43) denied and zero-paid claims included in the utilization review (UR) as possible violations of 24-A M.R.S.A. § 2164-D(3)(D and J), wherein the Company failed to develop and maintain UR documentation supporting the Company's decision regarding member liability. Specifically, the UR denial documentation confirming that the member was advised of their liability was not maintained. The company provided comments to this finding. See attached comments.

Finding #9

The Examiners identified a general business practice where the First Level adverse determination notices did not comply with Insurance Rule Chapter 850, § 9C(1)(b). Specifically, the Company's First Level appeals decision letter did not reveal the names of all of the reviewers involved in the appeal, as required by statute. The company provided comments to this finding. See attached comments.

Finding #10

The Examiners identified a possible violation of 24-A M.R.S.A. § 4303(4C), wherein the Company's appeal procedures do not provide for auxiliary telecommunication devices or qualified interpreter services by a person proficient in American Sign Language when requested by an enrollee who is deaf or hard-of-hearing, or printed materials in an accessible format, including Braille, large-print materials, computer diskette, audio cassette or a reader when requested by an enrollee who is visually impaired to allow the enrollee to exercise the enrollee's right to an appeal under this subsection. The company provided comments to this finding. See attached comments.

Finding #11

The Examiners identified a potential general business practice related to a possible violation of Insurance Rule Chapter 850, § 9(C)(1)(a). Specifically, the Examiners noted that the First Level appeal acknowledgement letter used for administrative appeals does not mention that the member can submit information to the reviewer or that they do not have the right to attend the First Level grievance review. In addition, eight (8) of 24 of the notices reviewed indicated that the appeal would be reviewed in 30 or 60 days, and not the 20 business day timeframe as required by rule. The company provided comments to this finding. See attached comments.

The details for each of the above referenced findings are discussed in Section V of this Report. Additionally, the Examiners have included Additional Observations where applicable in each relevant area of the Examination.

SECTION II – SCOPE OF EXAMINATION

The scope of the Bureau's Examination was to determine the Company's compliance with applicable mental health parity provisions of 24-A M.R.S.A. §§ 2842-2844, 4234-A and 4303 as well as Maine's Health Plan Improvement Act, Insurance Rule Chapter 191 and Insurance Chapter 850 for the period of the Examination (the Period), January 1, 2005 through December 31, 2008. The Examination was conducted under the supervision of the Bureau's Director of Consumer Health Care Division and the Director of Financial Analysis.

The Report of Examination (the Report) is a report by exception with modification, as references to practices, procedures or files that did not contain exceptions are limited. All unacceptable or non-complying practices may not have been identified. The failure to identify specific Company practices does not constitute acceptance of these practices.

McGladrey personnel participated in this Examination in their capacity as market conduct examiners. McGladrey provides no representations regarding questions of legal interpretation or opinion. Determination of findings constituting violations or potential violations is the sole responsibility of the Bureau.

SECTION III – COMPANY PROFILE

AHI is a wholly-owned subsidiary of Aetna Inc and a for profit stock corporation. AHI offers and issues HMO policies to both small and large group employers in Maine. During the Period, based on statistics reported by the Bureau in its brochure titled, "*2008 Financial Results for Health Insurance Companies in Maine*", AHI and its affiliate, Aetna Life Insurance Company (ALIC), collectively insured 71,837 enrollees. Additionally, ALIC and AHI collectively accounted for 37% of the small group market and 15% of the large group market.

AHI arranges for the provision of behavioral health care services to individuals through its network of participating behavioral health care providers, offers behavioral health care management services, employee assistance programs and work/life programs to employer sponsored benefit plans. AHI contracts with mental health and substance abuse facilities and licensed, independent providers to complete its network. Providers include psychiatrists, psychologists, masters level social workers, marriage, family and child counselors and substance abuse specialists. During 2005, AHI outsourced the behavioral health care management functions, including utilization management and claims processing, to Magellan Health Services. AHI assumed these functions for the remainder of the Period.

SECTION IV – EXAMINERS METHODOLOGY

In accordance with the Bureau's requirements, the Examiners developed random samples, where applicable, to review and test specific attributes associated with the Company's HMO policies that were marketed and sold to state of Maine residents. The policies sold and managed in the state of Maine during the Period were limited to large group policies and small group policies with 20 or fewer employees. The Examiner's sampling methodology was reviewed and approved by the Bureau.

Company Operations and Management

Testing of this focus area included the Examiners requesting certain operational data along with policies and procedures from the Company in effect during the Period. The requested information included:

- An overview of relevant Company systems.
- The Company's corporate legal entity and functional organization charts.
- The Company's policies and procedures for oversight of behavioral health vendors, service providers, and other companies that provide insurance-related services.
- Functional organizational charts for all areas responsible for handling and overseeing behavioral health claims, complaints, appeals and grievances, utilization reviews, pre-authorizations, enrollee inquiries and policyholder services.

Upon receipt of the above requested information, the Examiners evaluated the Company's responses for compliance with Maine's mental health parity laws as may be applicable and other related rules and regulations. The results are summarized in Section V.

Claims Handling and Settlement

Testing of this focus area included requesting a population of mental health claim data and the supporting policies and procedures for the Period. The information requested included:

- A printed copy of the claims processing manual.
- A schematic process flow for processing behavioral health claims.
- The population of denied and zero-paid claims which had a primary, secondary or tertiary behavioral health diagnosis.

In response to the Examiner's requests, the Company provided their claim processing guidelines and a population of 74,163 denied and zero-paid claim lines which had a behavioral health diagnosis as outlined above. The population included data from three (3) claims systems (HMO, HNO and Magellan).

Testing was conducted by sampling certain populations of Company data specific to the Period. The Examiners developed samples approved in consultation with the Bureau and utilized Audit Control Language (ACL) to select a weighted random sample of 130 denied and zero-paid claims using a 95% confidence level.

The Examiners also conducted interviews with Company representatives, reviewed the Company's claims processing manual and received training from the Company related to the Company's systems to which the Examiners would need access. The results of the claims review are summarized in Section V.

Utilization Review and Pre-Authorization

Testing of this focus area involved requesting a population of UR and pre-authorization denials and the policies and procedures the Company had in place during the Period. The information requested included:

Utilization Review

- The Company's policies and procedures related to the Company's UR program in effect during the Period.
- A listing of all behavioral health-related claims having had a UR performed, as well as the disposition of the claim as a result of the UR.
- A listing of all UR requests that were denied during the Period.
- A listing of all behavioral health utilization review peer reviewers, including authorization areas or limitations, as well as documentation to support each reviewer's qualifications.
- An overview of the process utilized to determine whether a reviewer's qualifications are appropriate, including any written policies or procedures for evaluating qualifications.

In response to the Examiner's data requests, the Company provided documentation and a population of 224 URs performed for behavioral health services that had a partial or a full denial of coverage. The Examiners developed samples approved in consultation with the Bureau and utilized ACL to select a random sample of forty three (43) UR files using a 95% confidence level.

Pre-Authorization

- The Company's policies and procedures for obtaining and documenting the receipt and disposition of treatment plans from providers (both participating and non-participating) in a timely manner.
- Written policies and procedures used by specialists in the review and documentation of pre-authorization requests, including denied pre-authorizations.

- A listing of all pre-authorization requests that were denied during the Period.
- A listing of all provider network specialists in the Company and their authorization levels for approving behavioral health-related services.

In response to the Examiner's data requests, the Company provided documentation and a population of 116 denied pre-authorization requests. The Examiners developed samples approved in consultation with the Bureau and utilized ACL to select a random sample of forty three (43) requests using a 95% confidence level.

The Examiners also conducted interviews with Company representatives and reviewed the Company's responses to information requests. In addition, all requests denied for medical necessity were reviewed by an independent clinical peer reviewer. The results are summarized in Section V below.

Complaints, Appeals and Grievances

Testing of this focus area commenced with the Examiners requesting separate populations of complaints, appeals and grievances from the records or logs maintained by the Company and which only involved behavioral health matters. The Examiners also requested the related policies and procedures the Company had in place for the Period.

Information requested from the Company to conduct the review of these areas included:

Complaints

- A copy of the written policy and procedures for processing complaints relating to residents of the state of Maine.
- A listing of training materials to assist in educating the Examiners regarding the Company's policies and procedures.

- The Company's general complaint log which included both complaints received from the Bureau and complaints from members and/or providers related to behavioral health.
- A listing of behavioral health pharmacy-related complaints received from the Bureau, members or providers.
- Complaint management reports.
- The Company's definition of a complaint as applied to complaints relating to residents of the state of Maine.
- A detailed explanation of the escalation/tiering process for complaints established by the Company.
- The description and composition of an established formal committee, which reviewed complaints specific to behavioral health services on a routine basis.

In response to the Examiner's data request, the Company provided documentation along with a listing of thirteen (13) complaints that were received during the Period related to behavioral health issues. Testing was conducted by reviewing each of the thirteen (13) complaints specific to the Period.

Also included in the scope of the Examination was testing of complaints to identify any matters related to pharmacy benefits. The Company confirmed there was no pharmacy complaints received during the Period.

Appeals and Grievances

- Written policy and procedures for processing First and Second Level appeals and grievances for residents of the state of Maine.
- A complete log of all appeals and grievances related to behavioral health received from members and providers.

- The Company's definition of appeals and grievances as applied to those received in connection with residents of the state of Maine.
- A detailed explanation of the escalation/tiering process for appeals and grievances established by the Company.
- The description and composition of an established formal committee, which reviewed appeals and grievances specific to behavioral health services on a routine basis.

In response to the Examiner's data requests, the Company provided documentation and a listing of 61 appeals (including Administrative and Clinical Levels I and II). The Examiners developed samples approved in consultation with the Bureau and utilized ACL to select a random sample of forty three (43) appeals using a 95% confidence level.

The Examiners also conducted interviews with Company representatives and reviewed the Company's responses to information requests. In addition, complaints and appeals relating to claims or requests for authorization for services denied for medical necessity were reviewed by an independent clinical peer reviewer. The results are summarized in Section V below.

Policyholder Services and Provider Network

Testing of this focus area involved requesting information related to policyholder services and provider network and the policies and procedures applicable during the Period. The information requested included:

Policyholder Services

- Written policies and procedures in place to ensure compliance with the new mental health parity requirements (Federal and State of Maine).

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- Written policies and procedures provided to, and used by, the policyholder service representatives when responding to and documenting instances when an enrollee contacts the Company (verbally or in writing) for information on behavioral health matters.
- The Company's process, including the levels of review or escalation, for handling behavioral health inquiries (verbal or written).
- The number of inquiries (verbal or written) received per year related to behavioral health.
- A listing of all insurance policies (and certificates of coverage, where applicable) that were marketed to Maine residents.

Provider Network

- Copies of the provider directories (hard copy and electronic) for each year of the Examination.
- A description of the process used by the Company to ensure that the provider directory is accurate and up-to-date, including timelines for updating, adding and deleting providers from the directory.
- A listing of all provider contracts in effect during the Period.
- Policies and procedures for claims filing and any additional requirements applicable to providers filing behavioral health claims.
- A description of the methodology used by the Company (or an external vendor) to ascertain the Maximum Allowable Charges ("the Charges").
- A description of any differences in the determination of the Charges (in the calculation factors or percentages) for behavioral health services compared to those for general medical services and the rationale for differences, if any.
- Policies and procedures in place to verify whether the methodology for determining the Charges considered relevant information specific to the state of Maine such as whether there was sufficient data to constitute a representative sample of Charges for the same or comparable service.
- The process for updating the Charges in the Company's claims system and the frequency of the updates.

- The process used by the Company to audit whether the appropriate Charges were loaded into the system.

To review and test the accuracy of a provider's network status on the date of service, the Examiners reviewed a random sample of forty three (43) claims from the 130 denied and zero-paid claim sample and compared the network status on the date of service to the Company's listing of providers contracted at any time during the Period.

The Examiners also determined the Company's compliance with the state of Maine's mental health parity laws and other applicable rules and regulations. The results are summarized in Section V.

As previously noted, in addition to reviewing the documentation and performing the testing discussed above, the Examiners also conducted interviews with Company representatives responsible for certain Aetna functional areas, including claims, complaints, appeals, pre-authorizations, UR, policyholder services and provider network.

SECTION V – RESULTS OF THE EXAMINATION

The Examination identified six (6) potential business practice violations and twenty (20) potential individual violations of Maine insurance laws. In addition, other findings were noted regarding inconsistencies with the Company's policies and procedures or represent the Examiner's observations for possible improvements in the Company's practices. The following summarizes the results of the Examination:

Company Operations and Management

No exceptions were noted.

Claims Handling and Settlement

The HMO policies that AHI underwrote, marketed and sold in the state of Maine during the period of the Examination were large group and small group policies.

The Examiners reviewed the Company's claims processing manual to assess whether the Company's procedures for processing claims appear to be in compliance with Maine's mental health parity laws and other applicable rules and regulations. The review did not identify any processing procedures that would result in the Company's non-compliance with Maine's mental health parity laws and other applicable rules and regulations. However, two (2) areas of non-compliance were identified through individual file review, which are described as follows:

1. The Examiners identified a potential violation of the Maine Mental Health Parity Law, 24-A M.R.S.A. § 2843, wherein the Company failed to include one hundred ninety one (191) behavioral health diagnosis codes as covered by parity laws within their claim adjudication system. The error involved claims adjudicated between January 1, 2006 and March 13, 2007 involving 672 claims identified by the Company at the direction of the Bureau. Six (6) of the 672 claims involving diagnosis code 314.01 were underpaid.

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As a result of the determination that they had failed to include one hundred ninety one (191) behavioral health diagnosis codes correctly in their claims adjudicated system, the Company reviewed the additional 6,038 claims involving the non-included codes. The Company's review indicated that 217 claims were underpaid in error due to the error involving the 191 codes. These 217 claims were reprocessed to issue additional benefits due and the payment included interest as required by 24-A M.R.S.A. § 2436.

2. The Examiners identified a potential violation of 24-A M.R.S.A. § 4304(4)(A)(1) Insurance Rule Chapter 850, § 8(5), involving four (4) claims wherein the Company's claims processing system (ACAS) did not generate an Explanation of Benefits (EOB) and the member had associated financial responsibility related to the claim. Further review of the issue by the Company at the direction of the Bureau revealed 2,668 claims and 756 members were impacted. The Company has advised they undertook remediation of this matter through a system solution on March 26, 2010. The Bureau has noted they will monitor this matter directly with the Company.

The testing of a sample of one hundred thirty (130) denied and zero-paid claims included assessing the Company's compliance with applicable Maine statutes in addition to testing the Company's general claim processing.

In addition to the three (3) potential general business practices, claims testing identified seven (7) potential violations regarding two (2) Maine statutes. The Maine statutes and the exceptions noted are as follows:

1. Title 24-A M.R.S.A. § 2164-D reads in part:
 2. *Prohibited activities. It is an unfair claims practice for any domestic, foreign or alien insurer transacting business in this State to commit any act under subsection 3 if: ...*
 3. *Unfair practices. Any of the following acts by an insurer, if committed in violation of subsection 2, constitutes an unfair claims practice:*
 - B. *Failing to acknowledge with reasonable promptness pertinent written communications with respect to claims arising under its policies;*

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- D. Failing to develop and maintain documented claim files supporting decisions made regarding liability;*
F. Failing to affirm coverage or deny coverage, reserving any appropriate defenses, within a reasonable time after having completed its investigation related to a claim;
J. Failing, in the case of claims denials or offers of compromise settlement, to promptly provide an accurate written explanation of the basis for those actions;

The Company failed to maintain claim documentation for four (4) of the 130 denied and zero-paid claims, or 3.1%. The errors are explained below:

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
24-A M.R.S.A. § 2164-D	Four (4) claim files were determined to be absent claim notification letters or EOB's.	4	3.1%
TOTALS		4	3.1%

2. Title 24-A M.R.S.A. § 2436 reads in part:

(1) A claim for payment of benefits under a policy or certificate of insurance delivered or issued for delivery in this State is payable within 30 days after proof of loss is received by the insurer and ascertainment of the loss is made either by written agreement between the insurer and the insured or beneficiary or by filing with the insured or beneficiary of an award by arbitrators as provided for in the policy. For purposes of this section, "insured or beneficiary" includes a person to whom benefits have been assigned. A claim that is neither disputed nor paid within 30 days is overdue. If, during the 30 days, the insurer, in writing, notifies the insured or beneficiary that reasonable additional information is required, the undisputed claim is not overdue until 30 days following receipt by the insurer of the additional required information; except that the time period applicable to a standard fire policy and to that portion of a policy providing a combination of coverage's, as described in section 3003, insuring against the peril of fire must be 60 days, as provided in section 3002.

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The Company failed to adjudicate in a timely manner three (3) of the 130 denied and zero-paid claims, or 2.3%. The errors are explained below:

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
24-A M.R.S.A. § 2436 (1)	The Company failed to properly adjudicate three (3) claims within 30 days of receipt. Proper adjudication was made as a result of this claims review and interest was paid on all three claims.	3	2.3%
TOTALS		3	2.3%

Utilization Review and Pre-Authorization

Utilization Review

The testing of forty three (43) UR denials included assessing the Company's compliance with applicable Maine statutes in addition to testing the Company's general processing.

The Examiner's testing identified one (1) potential violation regarding one (1) Maine Insurance Code. The exception is noted as follows:

Title 24-A M.R.S.A. § 2164-D(3)(D) and (3)(J) provide:

- 3. *Unfair practices. Any of the following acts by an insurer, if committed in violation of subsection 2, constitutes an unfair claims practice:*
 - D. *Failing to develop and maintain documented claim files supporting decisions made regarding liability;*
 - J. *Failing, in the case of claims denials or offers of compromise settlement, to promptly provide an accurate written explanation of the basis for those actions;*

The Examiners identified one (1) instance, or 2.3%, involving a UR file wherein the Company failed to retain all necessary documentation. The error is explained below:

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Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
24A M.R.S.A. § 2164-D(3)(D and J)	The Company did not maintain a copy of the decision letter sent to the member.	1	2.3%
TOTALS		1	2.3%

Additional Observations

The Company had policies and procedures in place requiring that UR denials be made by a qualified peer. With respect to behavioral health issues, a qualified peer, depending upon the situation, is described by the Bureau in Rider A as one that is in the provider's discipline and is equally qualified as the provider ordering the treatment or service. This would include but not be limited to a mental health professional (e.g., psychologist, psychiatrist or psychiatric nurse practitioner) or physician (e.g. M.D., D.O.).

As part of the Examiner's review and at the request of the Bureau, the Examiners referred certain files that the Company denied for medical necessity to an Independent Peer Reviewer. The Examiners identified seventeen (17) UR files that were denied by the Company for not meeting the medical necessity criteria as defined by the Company, and not overturned through the Company's appeal process. The complete files provided by the Company were reviewed and referred for peer-to-peer review.

In one (1) of the seventeen (17) UR files referred or 5.9%, the Independent Peer Reviewer was unable to conclude as to the appropriateness of the denial based on the medical information included in the file. Additionally, in one (1), or 5.9% of the files, the Independent Peer Reviewer disagreed with the Company's denial.

Pre-Authorization

The testing of a sample of forty three (43) Pre-Authorization requests that were denied included assessing the Company's compliance with applicable Maine statutes in addition to testing the Company's policies and procedures. No exceptions were noted.

Additional Observations

The Company had policies and procedures in place requiring that Pre-Authorization denials be made by a qualified peer. With respect to behavioral health issues, a qualified peer, depending upon the situation, is described by the Bureau in Rider A as one that is in the provider's discipline and is equally qualified as the provider ordering the treatment or service. This would include but not be limited to a mental health professional (e.g., psychologist, psychiatrist or psychiatric nurse practitioner) or physician (e.g. M.D., D.O.).

As part of the Examiner's review and at the request of the Bureau, the Examiners referred certain files that the Company denied for medical necessity to an Independent Peer Reviewer. The Examiners identified ten (10) Pre-Authorization files that were denied by the Company for not meeting the medical necessity criteria as defined by the Company, and not overturned through the Company's appeal process. The complete files provided by the Company were reviewed and referred for peer-to-peer review. In one (1) of ten (10), or 10%, of the Pre-Authorizations referred for Peer Review, the Independent Peer Reviewer was not able to conclude as to the appropriateness of the denial regarding the request for treatment based on the medical information in the file.

Complaints, Appeals and Grievance Handling

Complaints

The Examiners tested a sample of forty three (43) complaints, which included assessing the Company's compliance with applicable Maine statutes in addition to testing the Company's general processing. No exceptions were noted.

Pharmacy Complaints

The Examiners confirmed with the Company that no pharmacy complaints were received during the Period.

Appeals

The testing of forty three (43) appeals included assessing the Company's compliance with applicable Maine statutes and testing the Company's appeals processing procedures.

The Company's appeal procedures do not provide auxiliary telecommunications devices or qualified interpreter services by a person proficient in American Sign Language when requested by an enrollee who is deaf or hard-of-hearing, or printed materials in an accessible format, including Braille, large-print materials, computer diskette, audio cassette or a reader when requested by an enrollee who is visually impaired to allow the enrollee to exercise the enrollee's right to an appeal under this subsection. This is a general business practice in violation of:

Title 24-A M.R.S.A. § 4303(4)(C)

4. Grievance procedure for enrollees. A carrier offering or renewing a health plan in this State shall establish and maintain a grievance procedure that meets standards developed by the superintendent to provide for the resolution of claims denials or other matters by which enrollees are aggrieved.

C. In any appeal under the grievance procedure, the carrier shall provide auxiliary telecommunications devices or qualified interpreter services by a person proficient in American Sign Language when requested by an enrollee who is deaf or hard-of-hearing or printed materials in an accessible format, including Braille, large-print materials, computer diskette, audio cassette or a reader when requested by an enrollee who is visually impaired to allow the enrollee to exercise the enrollee's right to an appeal under this subsection.

The Examiners identified a possible violation of Insurance Rule Chapter 850, § Section 9C(1)(a). Specifically, the Examiners noted that the First Level Acknowledgement Letter does not mention that the member can submit information to the reviewer or that they do not have the right to attend the First Level grievance review. In addition, eight (8) of 24 of the notices reviewed indicated that the appeal would be reviewed in 30 or 60 days, and not the twenty (20) business day timeframe as required by statute. This matter may be deemed as a general business practice.

The Examiners identified a potential general business practice where the Company's First Level appeal adverse decision notice did not include the names of all reviewers involved in the appeal as required under Insurance Rule Chapter 850, § 9C(1) that states in part:

- 1) A grievance concerning any matter except an adverse utilization review determination may be submitted by a covered person or a covered person's representative. First level appeals of adverse health care treatment decisions are subject to the requirements of section 8(G) of this rule. A covered person does not have the right to attend, or to have a representative in attendance, at the first level grievance review, but is entitled to submit written material to the reviewer. The health carrier shall provide the covered person the name, address and telephone number of a person designated to coordinate the grievance review on behalf of the health carrier. The health carrier shall make these rights known to the covered person within 3 working days of receiving a grievance.*
- b) If the decision is adverse to the covered person, the written decision shall contain:*
 - i) The names, titles and qualifying credentials of the person or persons participating in the first level grievance review process (the reviewers).*

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In addition to the three (3) potential general business practices, testing identified fifteen (15) potential violations regarding three (3) Maine statutes. The Maine statutes and the exceptions noted are as follows:

1. Insurance Rule Chapter 191, § 10(B).

“HMOs shall retain records of their affairs and transactions for a period of at least six (6) years, and shall require any person or entity under contract with the HMO, either directly or indirectly, to retain records of their affairs and transactions relating to the HMO, for a period of at least six (6) years.”

The Examiners identified two (2) instances, or 4.7%, involving an appeal wherein the Company did not retain a copy of the appeal decision letter. The errors are explained below:

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
Rule 191, § 10(B)	Two of the files provided by the Company did not contain a copy of the appeal decision letter sent to the member; one of those files was also missing the appeal acknowledgement letter.	2	4.7%
TOTALS		2	4.7%

2. Insurance Rule Chapter 850, § 9C(1)(a) reads in part:

“A health carrier shall issue a written decision to the covered person within 20 working days after receiving a grievance. Additional time is permitted where the carrier can establish the 20 day timeframe cannot reasonably be met due to the carrier’s inability to obtain necessary information from a person or entity not affiliated with or under contract with the carrier.”

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The carrier shall provide written notice of the delay to the covered person. The notice shall explain the reasons for the delay. In such instances, decisions must be issued within 20 days of the carrier's receipt of all necessary information. The person or persons reviewing the grievance shall not be the same person or persons who made the initial determination denying a claim or handling the matter that is the subject of the grievance.

The Examiners identified three (3) instances, or 7.0%, involving a First Level appeal wherein the Company's letter failed to issue a determination within 20 days. The errors are explained below:

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
Rule 850, § 9C(1)(a)	The Company did not issue a decision within 20 days for three (3) of the files sampled, as required by this statute.	3	7.0%
TOTALS		3	7.0%

3. Insurance Rule Chapter 850, § 9C(1) reads in part:

"A grievance concerning any matter except an adverse utilization review determination may be submitted by a covered person or a covered person's representative. First level appeals of adverse health care treatment decisions are subject to the requirements of section 8(G) of this rule. A covered person does not have the right to attend, or to have a representative in attendance, at the first level grievance review, but is entitled to submit written material to the reviewer. The health carrier shall provide the covered person the name, address and telephone number of a person designated to coordinate the grievance review on behalf of the health carrier. The health carrier shall make these rights known to the covered person within 3 working days of receiving a grievance."

The Examiners identified ten (10) instances, or 23.3%, involving a First Level appeal wherein the Company failed to issue a First Level Administrative appeal acknowledgement letter within three (3) business days. The errors are explained below:

Maine Statute	Description of Error	Number of Errors	Percentage of Errors to Total Sample
Rule 850, § 9C(1)	The Company did not send any acknowledgement letters for four (4) of the sampled files. Since the letters were never sent, they did not meet the three (3) working day requirement of the rule.	4	9.3%
Rule 850, § 9C(1)	The Company did not send acknowledgment letters within three (3) working days for six (6) of the sampled files.	6	14%
TOTALS		10	23.3%

Additional Observations

The Examiners identified one (1) instance in which incorrect information was given to a member regarding where the member may send an appeal. Additionally, the Company's form letter incorrectly advised members that if they did not respond to an appeal within 30 days, the matter would be closed, when in fact the correct timeframe is 180 days per AHI's policies.

As part of the Examiner's review and at the request of the Bureau, the Examiners referred certain files that the Company denied for medical necessity to an Independent Peer Reviewer. The Examiners identified nine (9) appeals that were denied by the Company for not meeting the medical necessity criteria as defined by the Company, and not overturned through the

Company's appeal process. The complete files provided by the Company were reviewed and then referred for peer-to-peer review.

Of the nine (9) appeals sent for review, the independent reviewer did not disagree with any of the Company's decisions.

Policyholder Services and Provider Network

Policyholder Services

The testing of policyholder services involved assessing the Company's compliance with applicable Maine statutes. Maine mental health parity requirements are mandated benefits and are administered pursuant to the Company's standard policies and procedures applicable to mandated benefit processing. No exceptions were noted.

Provider Network

The accuracy of a provider's network status on the date of service was tested through a review of forty three (43) claim files. No exceptions were noted.

ADDENDUM – COMPANY’S RESPONSE



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December 16, 2010

Ms. Kendra Godbout
Mr. Glen Griswold
State of Maine Department of Professional
and Financial Regulation
Bureau of Insurance
34 State House Station
Augusta, Maine 04333-0034

**RE: Aetna Health Inc. and Aetna Life Insurance Company Draft Report of Findings –
Maine Behavioral Health Market Conduct Examination 2005-2008**

Dear Ms. Godbout and Mr. Griswold:

This letter is in response to the draft reports we received on November 22, 2010 for the behavioral health examination conducted by RSM McGladrey of Aetna Health Inc. and Aetna Life Insurance Company. Below we have listed the findings and our responses for your consideration.



Finding # 1

The Examiners identified a potential violation of the Maine Mental Health Parity Law, Title 24-A, Section 2843 of the Maine Insurance Rule, wherein the Company failed to include one hundred ninety one (191) behavioral health diagnosis codes as covered by parity laws within their claim adjudication system. The error involved claims adjudicated between January 1, 2006 and March 13, 2007 involving six hundred seventy two (672) claims identified by the Company at the direction of the Bureau. Six (6) of the 672 claims involving diagnosis code 314.01 were underpaid. An additional 6,038 claims involving one hundred ninety (191) other diagnosis codes are currently being reviewed by the Company. The failure to include the one hundred ninety one

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(191) diagnosis codes may be deemed as a general business practice that is non-compliant with Maine statutes. The Bureau has noted they will monitor this matter directly with the Company.

Company Response: *The Company agrees with this finding recognizing that the error pertaining to diagnosis code 314.01 impacts less than one percent of claims reviewed. The failure to include one hundred ninety one (191) other diagnosis codes was an inadvertent procedural error. As such, we respectfully request that the finding be revised to remove reference to a general business practice.*

The Company completed remediation and provided supporting documentation as of 11/11/10. We have enhanced our internal workflow and business controls to ensure the accuracy and timeliness of diagnosis codes being added to the Legislative Rule Table.

Finding # 2

The Examiners identified a potential violation of Title 24-A § 4304- 4(A)(1) of the Maine Insurance Code and Chapter 850, section 8 (5), involving four (4) claims wherein the Company's claims processing system (ACAS) did not generate an Explanation of Benefits (EOB) and the member had associated financial responsibility related to the claim. Further review of the issue by the Company at the direction of the Bureau revealed 2,668 claims and 756 members were impacted. The Company has advised they undertook remediation of this matter through a system solution on March 26, 2010. The Bureau has noted they will monitor this matter directly with the Company.

Company Response: *The Company agrees with this finding; however we respectfully request that the language be updated to correct (ACAS) to "the Company's HMO claims processing system." The Company completed remediation of this system issue on 3/26/10.*

Finding # 3

The Examiners identified a potential violation of Title 24-A M.R.S.A §2843 §§5-D (B)(1)(2), §2749-C §§1 (B)(1)(2) and §4234-A §§ 6 B (1), which based upon information provided by the Company, it was determined that prior to January 1, 2006, the amount of time allowed for participating behavioral health providers to submit a claim for payment was 60 days which is less than the 90 day time period permitted for non-behavioral health participating providers. The

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more restrictive claim submission timeframe may be deemed as a general business practice that is non-compliant with Maine statutes.

Company Response: *The Company disagrees with this finding originally disputed in our response to Concern #2. The Company agrees with the factual statements provided in the finding concerning its contracts and the contracts of a third-party delegated entity (Magellan) in 2005. The Company disagrees with this finding to the extent it refers to improper provider contracting under Maine's mental health parity laws. The Company is not aware of any requirements, including requirements set forth under Maine mental health parity statutes, that mandate administrative parity between a carrier and participating provider or establish specific timeframes within which a carrier must allow participating providers to submit claims for reimbursement. Contractual terms between the Company and its participating providers do not impact a member's receipt of mental health benefits at parity with other covered services. Members suffer no disadvantage and are held harmless in the event that a provider fails to meet its contractual requirements for payment.*

Finding # 4

The Examiners identified four (4) of 130 denied and zero paid claims which may represent possible violations of Title 24-A §2164D(3)(B)(D) of the Maine Insurance Rule, wherein the Company failed to develop and maintain claims documentation supporting the Company's decisions regarding member liability. Specifically, documentation confirming the member was advised of their liability was not maintained.

Company Response: *The Company agrees with this finding.*

Finding # 5

The Examiners identified three (3) of 130 denied and zero-paid claims as possible violations of Title 24-A §2436-1A of the Maine Insurance Rule, regarding Interest on Overdue Payments, wherein the Company failed to affirm or deny coverage for three (3) claims within a reasonable period of time. The referenced Maine Insurance Rule stipulates that payment or denial of a claim by a carrier must be made within 30 calendar days after the carrier has received all information needed to pay or deny the claim. Specifically, processing the claims was not completed nor was interest paid until February 2010.

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Company Response: *The Company agrees with this finding. The Company completed reprocessing of all claims with required interest as of 3/12/10.*

Finding #6

The Examiners identified ten (10) of forty three (43) appeal files as possible violations of Chapter 850, §9C(1) of the Maine Insurance Rule. The Company did not send the required acknowledgement letters for four (4) of the sampled files. Additionally, the Company failed to send acknowledgement letters within three (3) working days as required by statute for six (6) of the sampled files.

Company Response: *The Company agrees with this finding. Daily monitoring of internal reporting is conducted to ensure acknowledgement letter completion and timeliness. The Company will also provide additional training to member appeal staff on the Complaint Grievance & Appeal policies and procedures and the Member Maine Amendment.*

Finding #7

The Examiners identified three (3) of forty three (43) appeal files as possible violations of Chapter 850, §9C(1)(a) of the Maine Insurance Rule, wherein the Company did not issue decisions within 20 days, as required by this statute.

Company Response: *The Company agrees with this finding. Daily monitoring of internal reporting is conducted to ensure acknowledgement letter completion and timeliness. The Company will also provide additional training to member appeal staff on the Complaint Grievance & Appeal policies and procedures and the Member Maine Amendment.*

Finding #8

The Examiners identified two (2) of forty three (43) appeal files as possible violations of Chapter 191, §10(B) of the Maine Insurance Rule, regarding record retention. Specifically, two (2) of the Company's appeal files did not contain a copy of the appeal decision letter sent to the member. One of those files was also missing the appeal acknowledgement letter required by this statute.

Company Response: *The Company agrees with this finding. Aetna has made significant changes to our imaging processes since 2006. We have instituted the use of the Electronic (E2I) imaging process for our appeal correspondence which allows electronic imaging of documents rather than mailing directly to an imaging vendor. The Behavioral Health Medical Resolution Team (BH MRT) has held and will continue to hold E2I trainings, refreshers and*

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reminders at our weekly Policy and Procedure meetings of the importance of making sure that all appeal correspondence is successfully imaged to each case.

Finding #9

The Examiners identified one (1) of forty three (43) denied and zero-paid claims included in the utilization review (UR) as possible violations of Title 24-A §2164D(3)(J)(D) of the Maine Insurance Rule, wherein the Company failed to develop and maintain UR documentation supporting the Company's decision regarding member liability. Specifically, the UR denial documentation confirming that the member was advised of their liability was not maintained.

Company Response: *The Company agrees with this finding. A formal Aetna Record Retention process is in place and updated annually to ensure proper retention of business records.*

Finding #10

The Examiners identified a general business practice where the First Level adverse determination notices did not comply with Chapter 850, §9C(1)(b) of the Maine Insurance Rule. Specifically, the Company's First Level appeals decision letter did not reveal the names of all of the reviewers involved in the appeal, as required by statute. Follow up with the Company determined that this issue pertains to the Maine First Level adverse determination notice in use. Consequently, because this notice is utilized for all of the Company's First Level adverse determinations involving Maine members, this matter is deemed to be a general business practice that is non-compliant with Maine statutes.

Company Response: *The Company agrees with this finding. A training reminder will be sent to appeal staff regarding this requirement.*

Finding #11

The Examiners identified a possible violation of Title 24-A, Chapter 56-A, Section 4303, 4C, wherein the Company's appeal procedures do not provide for auxiliary telecommunication devices or qualified interpreter services by a person proficient in American Sign Language when requested by an enrollee who is deaf or hard-of-hearing, or printed materials in an accessible format, including Braille, large-print materials, computer diskette, audio cassette or a reader when requested by an enrollee who is visually impaired to allow the enrollee to exercise the enrollee's

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right to an appeal under this subsection. This matter is deemed as a general business practice that is non-compliant with Maine statutes.

Company Response: *The Company agrees with this finding. The Company completed remediation of the appeal procedures and provided supporting documentation as of 5/25/10.*

Finding #12

The Examiners identified a potential general business practice related to a possible violation of Chapter 850, Section 9 C(1). Specifically, the Examiners noted that the First Level appeal acknowledgement letter used for Administrative appeals does not mention that the member can submit information to the reviewer or that they do not have the right to attend the First Level grievance review. Follow up with the Company determined that this issue pertains to the Maine first level appeal acknowledgement letter in use. Consequently, because the acknowledgement letter is utilized for all of the Company's first level administrative appeals involving Maine members, this matter is deemed to be a general business practice that is non-compliant with Maine statutes. In addition, eight (8) of 24 of the notices reviewed indicated that the appeal would be reviewed in 30 or 60 days, and not the 20 business day timeframe as required by statute.

Company Response: *The Company agrees with this finding. The Company completed remediation of the First Level Appeal Acknowledgement and provided supporting documentation as of 6/16/10.*



Finding # 1

The Examiners identified a potential violation of the Maine Mental Health Parity Law, Title 24-A, Section 2843 of the Maine Insurance Rule, wherein the Company failed to include one hundred ninety one (191) behavioral health diagnosis codes as covered by parity within their claim adjudication system. The error involved claims adjudicated between January 1, 2005 and March 17, 2007 involving 1,167 claims identified by the Company at the direction of the Bureau, of which two (2) of the 1,167 claims involved payment errors. The failure to include the one hundred ninety one (191) diagnosis codes may be deemed as a general business practice that is non-compliant with Maine statutes. The Bureau has noted they will monitor this matter directly with the Company.

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Company Response: *The Company agrees with this finding recognizing that the error pertaining to the 190 diagnosis codes (as there were no claims impacted by the 314.01 code omission) was less than one percent of claims reviewed. The failure to include one hundred ninety one (191) other diagnosis codes was an inadvertent procedural error. As such, we respectfully request that the finding be revised to remove reference to a general business practice.*

The Company completed remediation and provided supporting documentation as of 11/11/10. We have enhanced our internal workflow and business controls to ensure the accuracy and timeliness of diagnosis codes being added to the Legislative Rule Table.

Finding # 2

The Examiners identified an area of potential non-compliance with Maine Mental Health Parity Laws including Title 24-A, Sections 2835 and 2843. Specifically, certain mental health claims regarding non-physician providers were not adjudicated in parity with medical benefits as a deductible and co-pay were applied to such claims. The error involved 1,199 claims, 210 of which were matters adjudicated after December 31, 2008 and therefore outside the Period. Of the remaining 989 claims, 137 had payment errors. Twelve (12) of the 137 claims had already been reprocessed. This failure to correctly adjudicate claims from non-physician providers may be deemed as a general business practice that is non-compliant with Maine statutes.

Company Response: *The Company agrees with this finding. The failure to correctly adjudicate claims for non-participating providers was an inadvertent procedural error. As such, we respectfully request that the finding be revised to remove reference to a general business practice.*

The Company completed remediation and provided supporting documentation as of 8/12/10.

Finding # 3

The Examiners identified thirteen (13) of 130 denied and zero-paid claims as possible violations of Title 24-A §2164D(3)(B)(D), failing to develop and maintain claim file documentation to support the Company's decision regarding member liability. Specifically, the Company could not provide the Explanation of Provider Payments (EPP).

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Company Response: *The Company agrees with this finding.*

Finding # 4

The Examiners identified a potential violation of Title 24-A M.R.S.A §2843 §§5-D (B)(1)(2), §2749-C §§1 (B)(1)(2) and §4234-A §§ 6 B (1), which based on information provided by the Company, it was determined that prior to January 1, 2006, the amount of time allowed for participating behavioral health providers to submit a claim for payment was 60 days which is less than the 90-day time period permitted for non-behavioral health participating providers. The more restrictive claim submission timeframe may be deemed as a general business practice that is non-compliant with Maine statutes.

Company Response: *The Company disagrees with this finding originally disputed in our response to Concern #1. The Company agrees with the factual statements provided in the finding concerning its contracts and the contracts of a third-party delegated entity (Magellan) in 2005. The Company disagrees with this finding to the extent it refers to improper provider contracting under Maine's mental health parity laws. The Company is not aware of any requirements, including requirements set forth under Maine mental health parity statutes, that mandate administrative parity between a carrier and participating provider or establish specific timeframes within which a carrier must allow participating providers to submit claims for reimbursement. Contractual terms between the Company and its participating providers do not impact a member's receipt of mental health benefits at parity with other covered services. Members suffer no disadvantage and are held harmless in the event that a provider fails to meet its contractual requirements for payment.*

Finding #5

The Examiners identified four (4) of 130 denied and zero-paid claims which were tested as potential violations of Title 24-A §2164-D of the Maine Insurance Rule, concerning Unfair Claim Practices. The Company incorrectly denied the four (4) behavioral health claims for which benefits were available on the member's policy. All four (4) claims involved payment errors.

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Company Response: The Company agrees with this finding. The Company completed remediation and provided supporting documentation as of 3/25/10.

Finding #6

The Examiners identified one (1) of 130 denied and zero-paid claims as a potential violation of Title 24-A §2436-1A of the Maine Insurance Rule concerning interest on overdue payments, wherein the Company failed to affirm or deny coverage within a reasonable period of time. The referenced Maine Insurance Rule stipulates that payment or denial of a claim by a carrier must be made within 30 calendar days after the carrier has received all information needed to pay or deny the claim.

Company Response: The Company agrees with this finding. The Company completed remediation and provided supporting documentation as of 3/25/10.

Finding #7

The Examiners identified four (4) of forty three (43) appeal files as possible violations of Chapter 850, §9C(1)(b) of the Maine Insurance Rule. In these instances, the Company's First Level adverse determination notices do not identify the names of all of the reviewers involved in the appeal process, as required by statute.

Company Response: The Company agrees with this finding. A training reminder will be sent to appeal staff regarding this requirement.

Finding #8

The Examiners identified three (3) of forty three (43) appeals as possible violations of Chapter 850, §9C(1)(a) of the Maine Insurance Rule. The Company did not issue decisions within 20 days, as required by statute.

Company Response: The Company agrees with this finding. Daily monitoring of internal reporting is conducted to ensure acknowledgement letter completion and timeliness. The Company will also provide additional training to member appeal staff on the Complaint Grievance & Appeal policies and procedures and the Member Maine Amendment.

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Finding #9

The Examiners identified two (2) of forty three (43) appeal files as possible violations of Chapter 850, §9C(1) of the Maine Insurance Rule. In these instances, the Company did not send Acknowledgement Letters in three (3) business days as required by statute.

Company Response: *The Company agrees with this finding. Daily monitoring of internal reporting is conducted to ensure acknowledgement letter completion and timeliness. The Company will also provide additional training to member appeal staff on the Complaint Grievance & Appeal policies and procedures and the Member Maine Amendment.*

Finding #10

The Examiners identified a potential general business practice related to a possible violation of Chapter 850, Section 9 C(1). Specifically, the Examiners noted that the First Level appeal acknowledgement letter used for Administrative appeals does not mention that the member can submit information to the reviewer or that they do not have the right to attend the First Level grievance review. Follow up with the Company determined that this issue pertains to the Maine first level appeal acknowledgement letter in use. Consequently, because the acknowledgement letter is utilized for all of the Company's first level administrative appeals involving Maine members, this matter is deemed to be a general business practice that is non-compliant with Maine statutes. In addition, four (4) of the eleven (11) notices reviewed indicated that the appeal would be reviewed in 30 or 60 days, and not the 20 business day timeframe as required by statute.

Company Response: *The Company agrees with this finding. The Company completed remediation of the First Level Appeal Acknowledgement and provided supporting documentation as of 6/16/10.*

Finding #11

The Examiners identified a possible violation of Title 24-A, Chapter 56-A, Section 4303, 4C, wherein the Company's appeal procedures do not provide for auxiliary telecommunication devices or qualified interpreter services by a person proficient in American Sign Language when requested by an enrollee who is deaf or hard-of-hearing, or printed materials in an accessible format, including Braille, large-print materials, computer diskette, audio cassette or a reader when

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requested by an enrollee who is visually impaired, to allow the enrollee to exercise the enrollee's right to an appeal under this subsection. This may be deemed as a general business practice that is non-compliant with Maine statutes.

Company Response: *The Company agrees with this finding. The Company completed remediation of the appeal procedures and provided supporting documentation as of 5/25/10.*

Finding # 12

The Examiners identified a possible violation of Title 24-A, Chapter 27, §2412 regarding requirements for the prior filing and approval of forms with the Bureau. Specifically, PPO Conversion rider (GR-96683-ME-Mental Health Parity), which addresses the state parity legislation, had not been filed with the Bureau. In follow-up with the Company, a copy of the form was provided to the Examiners noting the form had been approved on March 5, 2010. However, based on the information reviewed by the Examiners, the form appears to have been in use by the Company since October 1, 2003.

Company Response: *The Company agrees with this finding. The rider was approved by the Department as of 3/15/10.*

Please contact me at (860) 273-2730 if you have any further questions regarding this information.

Sincerely,

Karen J. Carty

Karen J. Carty
Regulatory Compliance Manager
(860) 273-3730

cc: Barry L. Wells, CCLA, MCM
Director, Regulatory Insurance Consulting Practice
RSM McGladrey Inc.