STATE OF ARIZONA

DEPARTMENT OF INSURANCE

In the Matter of:	)	Docket No. 09A-129-INS
AETNA HEALTH, Inc., NAIC #95003	)	**CONSENT ORDER**
Respondent.	)	

On March 22, 2006, the Arizona Department of Insurance ("Department") called a compliance examination ("Examination") of Aetna Health, Inc., ("AHI"), covering the time period from July 1, 2004 through June 30, 2006 ("Examination Period"). The Department divided the Examination Period into four six-month periods ("Partial Examination Periods" or "PEPs") as follows:

PEP 1: July 1, 2004 – December 31, 2004

PEP 2: January 1, 2005 – June 30, 2005

PEP 3: July 1, 2005 – December 31, 2005

PEP 4: January 1, 2006 – June 30, 2006

The Report of the Compliance Examination of AHI dated May 10, 2007 ("Report") alleges that AHI violated A.R.S. § 20-1054, A.R.S. § 20-1057.03, A.R.S. § 20-1074, A.R.S. § 20-1077, A.R.S. §§ 20-2533 through 20-2536, A.R.S. § 20-3102, A.A.C R20-6-1904, and A.A.C R20-6-1914. AHI wishes to resolve this matter without formal proceedings. AHI admits the following Findings of Fact are true and consents to the entry of the following Conclusions of Law solely for the purposes of resolving the allegations contained in the Report. AHI consents to the entry of the following Order.

FINDINGS OF FACT

I. Jurisdiction

AHI is, and throughout the Examination Period was, authorized to operate as a health care services organization pursuant to a Certificate of Authority issued by the Arizona Insurance Director ("Director").

II. Utilization Review and Health Care Appeals

A. During PEPs 1, 2, and 3, in eight out of 34 (24% of) appeals, AHI failed to provide a health care appeals information packet to members within five business days of the members initiating an appeal.

B. During PEPs 1 and 3, in three out of four (75% of) requests for expedited medical reviews, AHI failed to inform the member and the member's treating provider of the expedited decision within one business day. In the files the Department reviewed for PEP 2, the Department did not find a significant number of files with this violation.

C. During PEPs 1, 2, and 3, in 11 out of 34 (32% of) requests for informal reconsideration, AHI failed to mail a written acknowledgment to the member within five business days after receiving the request, or failed to mail a written acknowledgment to the member's treating provider within five business days after receiving the request or failed to do either.

D. During PEPs 1 and 3, in two out of 20 (10% of) informal reconsiderations, AHI failed to mail notice of its decision to the member within thirty days after receiving a request for informal reconsideration, or to mail notice of its decision to the member's treating provider within thirty days after receiving a request for informal reconsideration, or to include the criteria used and the clinical reasons for the decision. In the files the Department reviewed for PEP 2, the Department did not find a significant number of files with this violation.

E. During PEPs 1 and 2, in 13 out of 23 (57% of) formal appeals, AHI failed to mail a written acknowledgment letter to the member and the member's treating provider within five business days after receiving the formal appeal. In the files the Department reviewed for PEP 3, the Department did not find a significant number of files with this violation.

III. Timely Pay and Grievance

A. During the Examination Period, in 5,153 out of 29,415 (18% of) clean claims that AHI paid late, AHI failed to pay interest or paid too little interest.

B. During the Examination Period, in 51,087 out of 51,087 (100% of) claims that required additional information, AHI failed to request information prior to denying the claim.

C. During the Examination Period, AHI delayed the payment of clean claims without reasonable justification by paying an inaccurate amount in 2,378 out of 3,963 (60% of) clean claims from non-contracted ambulance-providers.

D. During the Examination Period, AHI failed to establish or have an effective internal system for resolving payment disputes and contractual grievances, as follows.

1. AHI failed to have an accurate grievance type in 29 out of 156 (19% of) grievance records.
2. AHI did not accurately report grievances in its statutory semi-annual grievance reports to the Department.

IV. Health Care Services Organization Requirements

A. During the Examination Period, an AHI certificate of coverage did not provide for self-referral for a minimum of twelve visits in an annual contract period for chiropractic services.

B. During the Examination Period, AHI failed to credential freestanding urgent care providers.

C. During the Examination Period, in 183 out of 266 (69% of) provider contracts, AHI failed to include the statement described in A.R.S. § 20-1074(B) requiring the provider to provide services to enrollees under certain circumstances if AHI were to become insolvent.

D. During the Examination Period, AHI failed in 230 out of 356 (65% of) cases to adequately assure that if an enrollee was admitted to a contracted hospital directly from the hospital's emergency department and obtained post-admission covered services from a non-contracted specialty physician, the enrollee was not liable for any cost that should be borne by AHI.

E. During the Examination Period, AHI failed in 958 out of 1687 (57% of) cases to adequately assure that if an enrollee obtained covered emergency care from a non-network provider, the enrollee was not liable for any cost that should be bome by AHI.

CONCLUSIONS OF LAW

I. Jurisdiction

The Director has the authority to enter and enforce this order. A.R.S. § 20-142.

II. Utilization Review and Health Care Appeals

B. During PEPs 1, 2, and 3, AHI violated A.R.S. § 20-2533(C) by failing in eight out of 34 (24% of) appeals to provide a health care appeals information packet to members within five business days of the members initiating an appeal.

B. During PEPs 1 and 3, AHI violated A.R.S. § 20-2534(B) by failing in three out of four (75% of) requests for expedited medical reviews to inform the member and the member's treating provider of the expedited decision within one business day.

C. During PEPs 1, 2, and 3, AHI violated A.R.S. § 20-2535(B) by failing in 11 out of 34 (32% of) requests for informal reconsideration to mail a written acknowledgment to the member within five business days after receiving the request, or failing to mail a written acknowledgment to the member's treating provider within five business days after receiving the request or failing to do either.

D. During PEPs 1 and 3, AHI violated A.R.S. § 20-2535(D) by failing in two out of 20 (10% of) informal reconsiderations to failing to mail notice of its decision to the member within thirty days after receiving a request for informal reconsideration, or to mail notice of its decision to the member's treating provider within thirty days after receiving a request for informal reconsideration, or to include the criteria used and the clinical reasons for the decision.

E. During PEPs 1 and 2, AHI violated A.R.S. § 20-2536(B) by failing in 13 out of 23 (57% of) formal appeals to mail a written acknowledgment letter to the member and the member's treating provider within five business days after receiving the formal appeal.

IV. Timely Pay and Grievance

A. During the Examination Period, AHI violated A.R.S. § 20-3102(A) by failing to pay interest or paying too little interest in 5,153 out of 29,415 (18% of) clean claims that AHI paid late.

B. During the Examination Period, AHI violated A.R.S. § 20-3102(B) by failing in 51,087 out of 51,087 (100% of) claims that required additional information to request information before denying the claim.

C. During the Examination Period, AHI violated A.R.S. § 20-3102(C) by delaying the payment of clean claims without reasonable justification when it paid an inaccurate

amount in 2,378 out of 3,963 (60% of) clean claims from noncontracted ambulance providers.

E. During the Examination Period, AHI violated A.R.S. § 20-3102(F) by failing to establish or have an effective internal system for resolving payment disputes and contractual grievances, as follows:

3. AHI failed to have an accurate grievance type in 29 out of 156 (19% of) grievance records.

2. AHI failed to accurately report grievances in its statutory semi-annual grievance reports to the Department.

V. Health Care Services Organization Requirements

A. During the Examination Period, AHI violated A.R.S. § 20-1057.03 because one of its certificates of coverage did not provide for self-referral for a minimum of twelve visits in an annual contract period for chiropractic services.

B. During the Examination Period, AHI violated A.R.S. § 20-1077 by failing to credential freestanding urgent care providers.

C. During the Examination Period, AHI violated A.R.S. § 20-1074(B) by failing in 183 out of 266 (69% of) provider contracts to include a statement requiring the provider to provide services to enrollees under certain circumstances if AHI were to become insolvent.

D. During the Examination Period, AHI violated A.A.C. R20-6-1906(E) and A.A.C. R20-6-1906(F)(3) during PEP1 thru PEP 3, as well as A.A.C. R20-6-1904(D)(3) and A.A.C. R20-6-1914(6) during PEP 4 by failing in 230 out of 356 (65% of) cases to adequately assure that if an enrollee was admitted to a contracted hospital directly from the hospital's emergency department and obtained post-admission covered

services from a non-contracted specialty physician, the enrollee was not liable for any cost that should be borne by AHI.

E. During the Examination Period, AHI violated A.A.C. R20-6-1906(E) and A.A.C. R20-6-1906(F)(1) during PEP1 thru PEP 3, and violated A.A.C. R20-6-1904(D)(1) during PEP 4 by failing in 958 out of 1687 (57% of) cases to adequately assure that if an enrollee obtained covered emergency care from a non-network provider, the enrollee was not liable for any cost that should be borne by AHI.

ORDER

IT IS HEREBY ORDERED THAT:

1. Health Care Appeals Practices. Within 90 days of the filed date of this Order, AHI shall submit for the Director's approval a Corrective Action Plan (CAP 1) that provides specific steps AHI already has taken or will take by certain dates to assure that by a designated implementation date, AHI is:

    a. Providing a health care appeals information packet to the member and the member's treating provider within five business days of a member initiating an appeal.

    b. Informing the member and the member's treating provider of an expedited medical review decision by mail within one business day of receiving a member's request for expedited medical review.

    c. Mailing a written acknowledgment to the member and to the member's treating provider within five business days after receiving a member's request for informal reconsideration.

    d. Mailing notice of an informal reconsideration decision to the member and to the member's treating provider within thirty days after receiving a request for informal reconsideration and including the criteria used and the clinical reasons for the decision.

    e. Mailing a written acknowledgment letter to the member and the member's treating provider within five business days after receiving a member's formal appeal.

2. Provider Timely Pay. Within 90 days of the filed date of this Order, AHI shall submit for the Director's approval a Corrective Action Plan (CAP 2) that provides specific steps AHI already has taken or will take by certain dates to assure that by a designated implementation date, AHI is:

    a. Paying the correct amount of interest on clean claims that it approves and pays late,

including claims it approves and pays late after receiving additional information.

b. Pending rather than denying unclean claims before it requests additional information from the provider.

c. Accurately identifying, approving in the correct amount, and paying clean claims it is obligated to pay non-contracted ambulance providers.

3. Provider Grievances. Within 90 days of the filed date of this Order, AHI shall submit for the Director's approval a Corrective Action Plan (CAP 3) that provides specific steps AHI already has taken or will take by certain dates to assure that by a specified implementation date, AHI is:

a. Categorizing grievances accurately.

b. Submitting accurate statutory, semi-annual grievances reports to ADOI.

4. Changes to Certificates of Coverage. Within 90 days of the filed date of this Order, AHI shall submit for the Director's approval a Corrective Action Plan (CAP 4) that provides specific steps AHI already has taken or will take by certain dates to assure that by a designated implementation date all of AHI's certificates of coverage provide for self-referral for a minimum of twelve visits in an annual contract period for chiropractic services.

5. Credentialing Freestanding Urgent Care Centers. Within 90 days of the filed date of this Order, AHI shall submit for the Director's approval a Corrective Action Plan (CAP 5) that provides specific steps AHI already has taken or will take by certain dates to assure that by a designated implementation date AHI is credentialing its freestanding urgent care centers.

6. Insolvency Provisions in Provider Contracts. Within 90 days of the filed date of this Order, AHI shall submit for the Director's approval a Corrective Action Plan (CAP 6) that provides specific steps AHI already has taken or will take by certain dates to assure that by a designated implementation date all of AHI's provider contracts will include the statement

described in A.R.S. § 20-1074(B) requiring the provider to provide services to enrollees under certain circumstances if AHI were to become insolvent.

7. Basic Health Services - Specialty Care. Within 90 days of the filed date of this Order, AHI shall submit to the Department for the Director's approval a Corrective Action Plan (CAP 7) that provides specific steps AHI already has taken or will take by certain dates to assure that by a designated implementation date, if an enrollee is admitted to a contracted hospital directly from the hospital's emergency department and obtains post-admission covered services from a non-contracted specialty physician, the enrollee is not liable for any cost that should be borne by AHI.

8. Basic Health Service – Emergency Care. Within 90 days of the filed date of this Order, AHI shall submit to the Department for the Director's approval a Corrective Action Plan (CAP 8) that provides specific steps AHI already has taken or will take by certain dates to assure that by a designated implementation date, if an enrollee obtains covered emergency care from a non-network provider, the enrollee is not liable for any cost that should be borne by AHI.

9. Progress in Development of the CAPs. Until the Director approves a CAP, AHI shall report to the Director each month on its progress in development of that CAP. Each such monthly report shall include a current draft of the CAP. The first monthly CAP development report for each CAP is due to the Director 30 days from the filed date of this Order.

10. Corrective Action Plan Requirements.

Each CAP described above shall:

a. Contain enough detail to allow the Director to determine whether the CAP will accomplish its purpose.

b. Include testing before final implementation of the CAP.

c. Include quality improvement review and follow-up.

d. Identify one individual responsible and accountable for implementation of the CAP.

e. Provide for AHI to report to the Director each month starting thirty days from the date the Director approves the CAP regarding implementation of the CAP, in a form that includes documentation and is approved by the Director.

f. Provide that within 10 business days of receiving notice that the Director has approved the CAP, AHI shall submit to the Director evidence that AHI has communicated the CAP to the appropriate personnel and begun implementation. Evidence of communication and implementation includes, without limitation, memos, e-mails, correspondence, procedure manuals, print screens and training materials.

11. Civil Penalty.

AHI shall pay a civil penalty of $199, 250 to the Director for deposit in the State General Fund for violations cited above as Conclusions of Law. AHI shall remit this civil penalty to the Life & Health Division of the Department prior to the Department filing of this Order.

The Department will file the Report when it files this order.

DATED at Phoenix, Arizona this 30th day of Oct, 2009.

Christina Urias
Director of Insurance

CONSENT TO ORDER

1. AHI has reviewed the foregoing Order and carefully considered it in conjunction with its other business and regulatory requirements. AHI is prepared to comply fully with the Order, notwithstanding any of its other business and regulatory requirements.
2. AHI admits the jurisdiction of the Director of Insurance, State of Arizona, admits the Findings of Fact, consents to entry of the Conclusions of Law solely for the purposes of resolving the allegations contained in the Report and consents to entry of the Order.
3. AHI is aware of the right to a hearing, at which it may be represented by counsel, present evidence and cross-examine witnesses. AHI irrevocably waives the right to such notice and hearing and to any court appeals related to this Order.
4. AHI states that no promise of any kind or nature whatsoever was made to it to induce it to enter into this Consent Order and that it has entered into this Consent Order voluntarily.
5. AHI acknowledges that the acceptance of this Order by the Director of the Arizona Department of Insurance is solely for the purpose of settling this matter. This Order does not preclude any other agency or officer of this state or its subdivisions or any other person from instituting proceedings, whether civil, criminal, or administrative, as may be appropriate now or in the future and does not preclude the Department from instituting proceedings as may be appropriate on other matters now or in the future.
6. Kay Thompson, who holds the office of Chief Executive Officer of AHI, is authorized to enter into this Order for AHI and on its behalf.

AETNA HEALTH, INC.

10/19/09
Date

By Kay Thomp
Kay Thompson
Chief Executive Officer
Aetna Health, Inc.

COPY of the foregoing mailed/delivered
This 30th day of Oct., 2009 to:

Gerrie Marks
Deputy Director
Mary Butterfield
Assistant Director
Consumer Affairs Division
Market Oversight Division Chief
Dean Ehler
Assistant Director
Rates & Regulations Division
Steve Ferguson
Assistant Director
Financial Affairs Division
David Lee
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