



CITY AUDITOR'S OFFICE

Medical Benefit Plans: Claims Processing

June 1, 2011

AUDIT REPORT NO. 1113

CITY COUNCIL

Mayor W.J. "Jim" Lane

Lisa Borowsky

Suzanne Klapp

Vice Mayor Robert Littlefield

Ron McCullagh

Linda Milhaven

Dennis Robbins



June 1, 2011

Honorable Mayor and Members of the City Council:

This audit of *Medical Benefit Plans: Claims Processing* included reviewing both the Plan Administrator's claims processing and the City's benefit enrollment and change processes, which are critical to proper claims determinations. We contracted with a firm, Wolcott and Associates, Inc. (Wolcott), to test medical and prescription benefit claims processing, and we tested the processing of medical benefit enrollments and changes.

Wolcott concluded that the Plan Administrator (Aetna) processes medical plan claims with a high degree of accuracy, generally in line with industry standards. However, Wolcott identified areas where claims processing and the City's Summary Plan Description document can be improved.

Similarly, our tests found no errors in medical benefit enrollment and change processing, but concluded that controls can be improved to lessen the risk they will occur.

If you need additional information or have any questions, please contact me at (480) 312-7867.

Sincerely,

Sharron Walker, CPA, CFE
City Auditor

Audit Team:

Joanna Munar, Senior Auditor

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EXECUTIVE SUMMARY

This audit of *Medical Benefit Plans: Claims Processing* was included on the Council-approved FY 2010/11 Audit Plan. A third-party Plan Administrator (Aetna) processes medical and prescription benefit claims for the City's self-insured medical plans. The City's Human Resources Division oversees employee and retiree benefit eligibility and enrollment.¹

This audit of *Medical Benefit Plans: Claims Processing* included both the Plan Administrator's claims processing and the City's benefit enrollment and change processes, which are critical to proper claim determinations. We contracted with a firm, Wolcott and Associates, Inc. (Wolcott), to test medical and prescription benefit claims processed during calendar years 2009 and 2010, and we tested the related benefit enrollments and changes made during fiscal years 2008/09 through 2010/11.

Wolcott concluded that Aetna processes medical plan claims with a high degree of accuracy, generally in line with industry standards. However, Wolcott identified areas where claims processing and the City's Summary Plan Description document can be improved. For example, some errors related to certain copayments, coordination of benefits, or computer system issues, while others were not clearly addressed in the Plan documents. Aetna agreed with five of the nine identified errors, disagreed with two due to delayed City guidance and indicated it will be consulting with the City to determine appropriate action for the other two.

Similarly, our tests found no errors in medical benefit enrollment and change processing, but concluded that certain controls can be improved to lessen the risk they will occur. For example, Human Resources staff can verify the TotalHR® system Audit Trail Log to the health benefit enrollment and change forms. In addition, Human Resources staff should retain Aetna's confirmation for receipt of the weekly membership updates.

In addition, the Administrative Services Agreement terms related to audit authority and performance guarantees can be improved.

¹ This includes former employees who are eligible under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) provisions and choose to continue medical insurance through the City's self-insured plans during the allowable time period.

BACKGROUND

The City of Scottsdale has three self-funded medical plans, each of which includes prescription benefit coverage. As Plan Administrator, Aetna provides medical and pharmaceutical networks, customer support and administrative services to implement the City's medical and prescription benefits.² The City's Administrative Services Agreement with Aetna includes nine optional 1-year extensions which continue through June 30, 2014.

This audit did not include the City's dental benefits, which are provided through separate networks, currently Assurant and Delta Dental of Arizona.

Approximately 2,700 employees and retirees are enrolled in the three medical plans, and about 3,700 dependents are covered through the primary enrollees. As shown in Table 1, 2,350 enrollees, or 87 percent, chose the EPO Plan, Aetna Open Access Elect Choice. This plan provides members with access to a network of doctors and specialists without the added cost or wait for a physician referral.

Table 1. Estimated Enrollment by Medical Plan as of January 2011

City of Scottsdale Medical Plans	Employees	Retirees	COBRA ^d	Total
EPO Plan – Aetna Elect Choice ^a	2,100	200	50	2,350
High Level PPO Plan - Aetna CPOS II ^b	200	50	0	250
Basic PPO Plan - Aetna Open Choice ^c	50	50	-	100
Total	2,350	300	50	2,700

^a Aetna Elect Choice is an exclusive provider organization (EPO) medical plan providing members access to a network of doctors and specialists without the added cost or requirement for a physician referral.

^b Aetna CPOS II is a preferred provider organization (PPO) medical plan offering an enhanced network of physicians and other health care providers. Members have access to Mayo Clinic providers.

^c Aetna Open Choice is a preferred provider organization (PPO) medical plan offering two tiers of coverage. Members have the choice of using a contracted network of providers at a lower out-of-pocket expense or a provider from outside the network for a higher out-of-pocket expense.

^d The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) allows temporary continuation of group health coverage after leaving employment. The former employee pays the total premium plus a 2% administrative fee.

SOURCE: Human Resources Division's Employee Benefits report.

² Effective since January 1, 2004, Aetna Life Insurance Company is the Plan Administrator for medical benefits and Aetna Pharmacy Management is the pharmacy benefit manager. They are referenced as 'Aetna' throughout this report.

Medical and Prescription Benefit Claims

The City's Healthcare Trust Fund (Fund) accounts for both the self-insured medical and dental benefit plans.³ Fund revenues are derived from health insurance premiums paid by the City and employees, retirees and COBRA participants. Fund expenses include healthcare costs (medical, prescription and dental), short-term disability claims and administrative costs, such as Aetna's administrative fees.⁴

Medical and prescription benefit claims totaled approximately \$19.9 million and \$19.7 million in fiscal years 2008/09 and 2009/10 respectively, as shown in Table 2. The Fund's fiscal year 2010/11 budget is \$25.8 million, of which \$20.4 million is allocated for medical and prescription claims and \$1.7 million for administration fees.

Table 2. Medical and Prescription Benefit Claims
(\$ in Millions)

Medical Plans	FY 2008/09	FY 2009/10
EPO Plan – Aetna Elect Choice	\$ 15.2	\$ 16.4
High Level PPO Plan - Aetna CPOS II	0	0
Basic PPO Plan - Aetna Open Choice	0.6	3.1
Total Aetna	\$ 15.8	\$ 19.5
MMSI PPO Plan - Health Tradition ^a	\$ 4.2	\$ 0.2
Total Medical Claims	\$ 19.9	\$ 19.7
^a MMSI PPO is a health benefits management company. <i>Health Tradition</i> , a preferred provider organization (PPO) medical plan, was the City's only plan to provide network access to Mayo Clinic providers until July 1, 2009. This plan was then replaced with the Aetna High Level PPO Plan, which now provides Mayo Clinic access.		

SOURCE: Finance & Accounting Division's SmartStream reports and Human Resources Division's Employee Benefits report.

According to the Administrative Services Agreement, the City is responsible for determining eligibility of plan participants and is required to provide Aetna with participant eligibility updates, including new hires, terminations and qualified benefit changes. Aetna relies upon this eligibility information and has no responsibility for determining its accuracy. Aetna is responsible for receiving benefit claims and reviewing them for accuracy, tracking deductibles, and paying service providers or reimbursing the covered enrollee, as applicable. Three to four times a week, Aetna notifies the City of claims paid; the City wires monies to the account that has been established for Aetna to process payments. Additionally, Aetna provides a statement of claims activity to the enrollee and a monthly claims fund activity report to the City.

³ The City offers two dental plans. The City's self-insured dental plan is administered by Delta Dental of Arizona, while a separate dental insurance plan is offered through Assurant.

⁴ The Short-Term Disability (STD) plan was previously self-funded and accounted for in the City's Healthcare Trust Fund. As of fiscal year 2010/11, STD is offered through Standard Insurance.

Audit Provisions

The Administrative Services Agreement specifies the City's right to perform an audit covering the two preceding years of claims. The City is also allowed to conduct a final audit within three years following termination of the Agreement. The City's Benefits staff last obtained an audit of medical and pharmacy claims in January 2008 with the contract audit costing approximately \$42,000.

In December 2010, the City Auditor's office issued a request for proposals for an audit of the City's medical benefit plans. Because the Administrative Services Agreement limits audit samples to 250 claims, we defined the scope of work as two separate audits covering the most recent 24-month period. One audit consisted of testing the City's medical benefit claims and the second tested prescription benefit claims, with the audit sample for each not to exceed the allowed 250 claims.

We used an Evaluation Committee, including staff from the Finance & Accounting Division, Human Resources Division and the City Auditor's Office, to rate the nine submitted proposals on firm qualifications, key project areas identified and project schedule. We awarded the contract to Wolcott & Associates, Inc. (Wolcott) on January 5, 2011. Wolcott agreed to complete the medical and prescription benefit claims audits and prepare a final report by May 8, 2011, which would include:

- Quantifying the dollar impact of any identified eligibility-based errors and identifying the root causes, such as claims paid after termination of benefits or for individuals not shown as eligible in the administrator's claims system.
- Quantifying payment errors related to any identified ineligible services, such as cosmetic surgery.
- Reviewing the effectiveness of coordination of benefits and subrogation efforts.
- Determining whether the City receives the benefit of the Plan administrator's contracted discounts and/or rates with vendors and health providers.
- Facilitating recovery of any identified vendor overpayments.

In accordance with the federal Health Insurance Portability and Accountability Act (HIPAA) requirements, we required Wolcott to sign a Business Associate Agreement to appropriately protect confidential and sensitive Plan participant information.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objective of this audit was to assess the accuracy of the City's Plan Administrator (Aetna) in processing benefit claims and to review the City's processes for determining member eligibility and communicating that to the Plan Administrator.

To gain an understanding of the City's self-funded medical benefit plans (Plans), we interviewed the Benefits Manager and Senior Benefits Analyst of the Human Resources (HR) Division's Benefits Management department. In addition, we reviewed the general conditions established in the Administrative Services Agreement between the City and Aetna, the Plan Administrator. In particular, certain specifications relate to the City's right to audit the Administrator and require the Administrator to make good faith efforts to recover any overpayments identified by this audit. We also reviewed the City Auditor's 2004 audit report on the City's self-insured medical and dental plans, and contracted audits of the City's medical and pharmacy claims performed in January 2008.⁵

To review the process of determining member eligibility, we interviewed and observed HR staff responsible for entering member information into the TotalHR® system and sending the updated member eligibility file to providers timely.⁶ For a randomly selected sample, we compared member records in TotalHR to supporting documentation, and verified that Aetna received updated member eligibility files from the City on a timely basis. In addition, we analyzed Aetna's paid claims data for the period of fiscal years 2008/09 and 2009/10 and compared it to the City's SmartStream accounting records of medical claims expenditures.

The City Auditor's Office developed a request for proposals (RFP) for two separate audits of the City's medical and prescription benefit claims. Although the City's medical plans include prescription benefits, separate audits of medical and prescription benefit claims were necessary as the City's Administrative Services Agreement with Aetna limited the audit sample to 250 claims per audit. With separate audits, a more sufficient sample size of 500 total claims was obtained. We used an Evaluation Committee, including staff from the Finance & Accounting Division, Human Resources Division and the City Auditor's Office, to rate the nine submitted proposals on firm qualifications, key project areas identified and project schedule. After evaluation and scoring of the proposals, we awarded the contract to Wolcott & Associates, Inc. (Wolcott). The firm demonstrated the qualifications, experience and technical competence required to conduct the benefit claims processing audit.

As required by Government Auditing Standards, we evaluated the qualifications and independence of the specialist (Wolcott) and documented the nature and scope of the specialist's work, including the objectives and scope of work, intended use of the specialist's work to support the audit objectives, assumptions and methods used by the specialist, and the specialist's procedures and findings in relation to other audit procedures we performed.

Wolcott concluded that Aetna achieved a 98% to 99.97% accuracy rate for medical and prescription claims processing. While Aetna's performance fell within the range of industry

⁵ City Auditor's Audit Report No. 0207, *Self Insured Medical & Dental Plans*, dated March 2004. The report recommended an annual external audit of the Self-Insured Benefits Fund and management concurred that the external auditors engaged to audit the City's annual financial statements would increase scrutiny of the Fund.

⁶ The TotalHR® application is used by the Human Resources Division to maintain employment and benefit information.

standards, errors of the medical and prescription claims resulted in some overpayments. Identified errors related to certain copayments, coordination of benefits, and computer system issues, as well as the City's need to clarify the Summary Plan Description document.

We found no errors in tests of enrollment changes, but the Human Resources Division can implement better controls to lessen the risk that errors will occur. Also, terms of the Administrative Services Agreement can be strengthened.

We conducted this audit in accordance with generally accepted government auditing standards as required by Article III, Scottsdale Revised Code, §2-117 et seq. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Audit work took place from November 2010 through May 2011, with Wolcott & Associates, Inc. conducting the benefit claims processing analysis and Joanna Munar conducting the audit work related to benefit enrollment and change processing.

FINDINGS AND ANALYSIS

1. Wolcott & Associates, Inc. identified a high degree of accuracy, but also noted a few areas for improvement.

As required by our contract, Wolcott & Associates, Inc. (Wolcott) selected for testing 250 medical benefit claims and 250 prescription benefit claims processed by Aetna, the City's Plan Administrator. For the 2-year test period, Aetna processed approximately 153,000 medical claims and 61,000 prescription claims. Summarized below, Wolcott's complete results are included in this report as Appendix A, beginning on page 15, and Aetna's response is included as Appendix B, beginning on page 33.

- A. For medical claims processing, Wolcott determined that Aetna achieved a high degree of accuracy, ranging from 98% (count) to 99.94% (value) for the tested sample. For prescription claims processing, Aetna achieved 98.4% (count) to 99.97% (value) accuracy. Wolcott indicated these rates fall within industry standards as well as the ranges that Wolcott has observed previously in other audits of third party administrators.

Aetna agreed with five of the nine identified errors. For the remaining four errors, Aetna disagreed with two due to delayed City guidance and has indicated it will be consulting with the City to determine appropriate action for the other two.

- B. Wolcott identified that the City's Summary Plan Description document does not sufficiently address the following policies:

1. *Allowability of certain behavioral health services.* In the tested sample, Aetna paid a claim for intervention and counseling services provided when the eligible patient was not present. Wolcott noted that, while the City's Plan document is not specific, claims for such services are typically excluded from coverage. This paid claim was not included as an error in part A above.
2. *Handling of certain copayments.* Aetna has made business decisions in certain situations that may not reflect the City's preferred approach.
 - a. In the tested prescription benefit sample, Aetna charged only one copayment for a 90-day medication supply. Wolcott noted that the City's Plan clearly indicates retail prescriptions are limited to a 30-day supply, and normally obtaining a 90-day supply would result in the enrollee paying 3 copayments. Aetna indicated it had previously made a business decision to charge one copayment for medications packed in a 90-day supply. However, during the audit, the City's Benefits staff agreed with Wolcott's analysis. Aetna disagreed with correcting this error.
 - b. For another prescription claim, Wolcott noted the prescription's discounted cost was less than the copayment, but Aetna charged the participant the full copayment. This practice penalizes the enrollee who typically should get the advantage of paying the lower cost. Aetna disagreed with correcting this error.

3. *Performance targets for timeliness of processing medical claims.* Wolcott's testing indicated Aetna processes 80.4% of medical claims within 14 calendar days. This result falls just within a typical target of 80 to 85%. However, the City has not specified an acceptable level of performance for the Plan Administrator.
4. *Durable medical equipment (DME) limits.* The City's Plan indicates that DME requires advance authorization. However, according to the Human Resources Benefits Manager, the City's intent is to only require authorization for "big ticket" DME items. This clarification is not specified in the City's Summary Plan Description document.

Recommendation:

The Human Resources Benefits Manager should ensure that identified errors are corrected and clarify the Summary Plan Description document to address the identified gaps.

2. Controls can be improved to ensure benefit enrollment changes are properly effected.

The City's Human Resources Benefits staff is responsible for ensuring benefit enrollments and changes are timely and properly transmitted to Aetna. We tested selected changes that were submitted during the period of fiscal years 2008/09 through 2010/11.

- A. Benefits staff enters initial health benefit enrollments for new hires and retirees as well as any other benefit changes. The submitted paper forms are shredded after being scanned into the Document Management system and electronically filed by name. However, the forms are not first compared to the TotalHR® system's Audit Trail Log to ensure changes have been accurately and completely entered.
- B. The member eligibility file is electronically transmitted to Aetna's system weekly to provide Aetna with current benefit enrollment data. An Aetna email confirms receipt of this file. However, the Benefits staff does not retain the Aetna email as documentation that the City transferred the file and Aetna's system received it.

Recommendation:

Human Resources Benefits staff should:

- A. Verify benefit enrollments/changes to the Audit Trail Log before the original records are destroyed.
- B. Retain Aetna's confirmation email as verification of the eligibility file transfer.

3. Terms of the Administrative Services Agreement can be strengthened.

While the City's Administrative Services Agreement with Aetna covers a ten-year period, it is subject to annual renewal. Certain terms of the agreement can be improved.

- A. The Agreement is very prescriptive about allowable audit samples and use of audit results. For example, the City is allowed to select only 250 claims per audit for testing,

and cannot expand testing unless the City pays Aetna for the additional testing.⁷ In addition, the results cannot be projected to the entire claims population for purposes of cost recovery.⁸ For example, for Wolcott's testing, the sample errors totaled \$970 in absolute value, but the projected error was estimated to be approximately \$690,000.

- B. Performance guarantees have not been included in recent renewals of the Agreement. Previous provisions measured performance in the areas of account management, claims administration and telephone response time. For example, Aetna previously guaranteed that 80% of claims would be processed within 12 calendar days, and financial and coding accuracy would be 99% or higher. As well, Aetna's failure to meet the performance guarantees would have resulted in a mutually agreed upon penalty. However, according to the Human Resources Benefits Manager, performance guarantees were last effective for the period of July 1, 2005, through June 30, 2006. The performance guarantees being considered for the fiscal year 2011/12 agreement do not currently include timeliness standards.

Recommendation:

Human Resources Benefits staff should:

- A. Seek to amend the terms related to audit authority to allow the City to determine appropriate sampling techniques.
- B. Ensure appropriate performance guarantees are reinstated when the Agreement is considered for renewal for fiscal year 2011/12.

⁷ Section 11 – Audit Rights, “...customer shall pay Aetna’s administrative costs for ... sample size in excess of 250 claims...”

⁸ Section 11 – Audit Rights, limits Aetna’s liability when an audit discloses overcharges, and Section 12 – Recovery of Overpayments, limits liability to those determined by direct proof of specific claims.

ACTION PLAN

1. Wolcott & Associates, Inc. identified a high degree of accuracy, but also noted a few areas for improvement.

Recommendation:

The Human Resources Benefits Manager should ensure that identified errors are corrected and clarify the Summary Plan Description document to address the identified gaps.

MANAGEMENT RESPONSE: Agree. It is not possible to address all possible medical services and claim possibilities in the Summary Plan Description (SPD) Documents. However, the City does reissue SPDs as changes are made to the medical plans and this is used as an opportunity to make other clarification and technical changes.

PROPOSED RESOLUTION: The City will work with Aetna to ensure that identified errors are corrected and suggested clarifications will be included in the 2011 Summary Plan Description Documents.

RESPONSIBLE PARTY: Human Resources Division–Benefits

COMPLETED BY: September 2011

2. Controls can be improved to ensure benefit enrollment changes are properly effected.

Recommendation:

Human Resources Benefits staff should:

- A. Verify benefit enrollments/changes to the Audit Trail Log before the original records are destroyed.
- B. Retain Aetna's confirmation emails as verification of the eligibility file transfer.

MANAGEMENT RESPONSE: Agree. Benefits staff is aware of the importance of processing enrollment changes in an accurate and timely manner. As part this effort, our current process includes an audit of change forms by a staff member other than the staff member who initially processed the form. However, we agree with the additional process improvements suggested in the report.

PROPOSED RESOLUTION: Benefits staff will verify enrollments/changes to the audit trail log before the original records are destroyed. Additionally, Aetna's confirmation emails will be kept for one year.

RESPONSIBLE PARTY: Human Resources Division–Benefits

COMPLETED BY: July 1, 2011

3. Terms of the Administrative Services Agreement can be strengthened.

Recommendation:

Human Resources Benefits staff should:

- A. Seek to amend the terms related to audit authority to allow the City to determine appropriate sampling techniques.
- B. Ensure appropriate performance guarantees are reinstated when the Agreement is considered for renewal for fiscal year 2011/12.

MANAGEMENT RESPONSE: Agree. The City has been operating under the terms of the Administrative Services Agreement with Aetna since January 1, 2004. It is this Agreement that covers the principal provisions of our relationship including the term of the contract, termination clauses, responsibilities of Aetna and the City, audit rights and other legal issues. It is felt that the provisions of this agreement are fairly typical of what was offered by medical plan administrators at that time. However, we agree with the recommendation that we should seek to strengthen the audit provision of the agreement.

PROPOSED RESOLUTION: With the help of Wolcott & Associates and our benefits consultant we will revisit the audit provision of the Aetna agreement and attempt to strengthen its terms. Additionally, the City has already taken action to include performance guarantees for FY 2011/12.

RESPONSIBLE PARTY: Human Resources Division–Benefits

COMPLETED BY: July 1, 2012

APPENDIX A – REPORT BY WOLCOTT & ASSOCIATES, INC.

CITY OF SCOTTSDALE, ARIZONA

ANALYSIS AND EVALUATION OF
CLAIMS PROCESSING

FOR THE PERIOD
JANUARY 1, 2009 THROUGH DECEMBER 31, 2010

ADMINISTERED BY
AETNA LIFE INSURANCE COMPANY

FINAL REPORT
MAY, 2011

PRESENTED BY
WOLCOTT & ASSOCIATES, INC.
12120 STATE LINE ROAD, #297
LEAWOOD, KANSAS 66209

**WOLCOTT &
ASSOCIATES, INC.**

April 18, 2011

Sharron Walker, City Auditor
City of Scottsdale, AZ
4021 North 75th Street, Suite 105
Scottsdale, Arizona 85251

Dear Ms. Walker:

We have completed our review and test procedures related to the operations of Aetna Life Insurance Company, Inc. (Aetna) as they relate to the City of Scottsdale, Arizona's health care plan (the City) for the period of January 1, 2009 through December 31, 2010.

As requested by the City, the scope of our services was limited and does not constitute a financial statement audit or an audit of the system of internal controls made in accordance with generally accepted auditing standards. As a result, we do not express an opinion on any of the financial statement elements or system of internal controls relating to the City or the health care benefits portion thereof. Projection of any evaluation of the system of internal controls to future periods may produce inaccurate results due to changes in conditions and/or the degree of compliance with procedures.

We have appreciated the opportunity to be of service to the City of Scottsdale, Arizona.

Yours truly,

WOLCOTT & ASSOCIATES, INC.

12120 State Line Road, Suite 297 Leawood, Kansas 66209 (913) 661-9400 (913) 327-7308

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I - EXECUTIVE SUMMARY

We have completed our audit of the City's health care and prescription drug plans. The plans are administered by Aetna. The objectives of this audit included the following:

- To assess the effectiveness of the claim processing procedures at Aetna.
- To audit and quantify the dollar impact of errors and measure claim processing accuracy at Aetna. We audited 250 healthcare and 250 prescription drug claims processed by Aetna.

Claim Audit Results - Medical

We identified 5 errors in the sample of 250 claims processed by Aetna. This is a 2.0% error rate or a 98.0% accuracy rate. This error rate is superior to the range of 95% to 97% accuracy rate normally observed by Wolcott & Associates, Inc. in audits of 75 similar systems for 2009 and 2010. This error rate is superior to the range of 95% to 97% accuracy rate that is considered industry standard.

The financial magnitude of payment error (overpayments plus underpayments) in our sample of 250 claims was \$970.00 or 0.06% of the payments in the sample. This is a financial accuracy rate of 99.94%. This rate is more favorable than the 99% accuracy rate established by other claim processors with which we are familiar.

The calculation of error magnitude is performed to estimate the true value of paid claims during the period. As a result, payment errors have been adjusted by corrections performed by Aetna prior to our audit.

The sample's error magnitude, extended to the population, produces a projected net underpayment of \$690,278 (2.21% of \$31,297,774). The error magnitude rate in the sample differs from the error magnitude rate when extended to the population due to the weighting of the samples.

As a result, we are 95 percent confident that the true value of the medical paid claims during the period ranges from \$32,926,985 (the \$31,297,774 recorded claims, plus the \$690,278 projected overpayment error, plus the \$938,933 value of the 3.0% precision) and \$31,049,119 (the \$31,297,774 recorded claims, plus the \$690,278 projected overpayment error, minus the \$938,933 value of the 3.0% precision).

The overpayment percentage plus underpayment percentage from our results total 2.21%. This equals a payment accuracy rate of 97.79%. This rate is less favorable than the 99% accuracy rate standards established by the industry.

Claim Processing Timeliness - Medical

We measured the elapsed time between the dates of receipt and the processed date for each of the 250 medical claims in our sample.

The results are within the range of 80% to 85% of claims processed within 14 calendar days standard established by other claim processors with which we are familiar.

Claim Audit Results - Prescription Drug

The observed error frequency in our sample was 1.6% (4 errors divided by 250 claims in our sample). These results were extended to the population of claims by calculating the frequency of error in each stratum and weighting the results by the number of claims in each stratum. This error rate is within the range of 98% to 99% accuracy rate normally observed by Wolcott & Associates, Inc. in audits of 75 similar systems for 2009 and 2010. This error rate is within the range of 98% to 99% accuracy rate that is considered industry standard.

The magnitude of payment error in our sample of 250 claims was an overpayment of \$142.58 or .027% of the payments in the sample. This error rate is superior to the range of 99% to 99.5% accuracy rate normally observed by Wolcott & Associates, Inc. in audits of similar prescription drug claim processing systems.

DISCUSSION ITEMS

Please review pages III - 3 and V - 4 for discussion items and recommendations.

II - INTRODUCTION

The City of Scottsdale, Arizona provides medical and prescription drug benefits for their employees. Eligible employees may select coverage under the plan, which is administered by Aetna.

AUDIT TIMING

We were notified by the City that our audit contract had been approved in January, 2011. Preliminary work was completed and the on-site services began, in Aetna's Fresno office, on April 4, 2011.

SCOPE OF AUDIT

The scope of the services covered health care and prescription drug claims processed during the period from January 1, 2009 through December 31, 2010. The sample was 250 claims each for medical and prescription drug claims.

Scope elements included:

- Audit and quantify the dollar impact of eligibility-based errors and identify ineligibility root causes such as claims paid after termination of benefits or for individuals not shown as eligible in the administrator's claim system.
- Identify and quantify payment errors related to ineligible services such as cosmetic surgery.
- Review the effectiveness of coordination of benefits and subrogation efforts.
- Determine whether the City receives the benefit of the Plan administrator's contracted discounts and/or rates with vendors and health providers.

III - HEALTH CLAIM PROCESSING ACCURACY

Our test work to determine payment accuracy of health claims processed during the period of January 1, 2009 through December 31, 2010 was performed on 250 claims previously processed by Aetna. Information regarding the sample selection, tests performed and results is presented below.

SAMPLE SELECTION

Computer data containing paid claim information was received from Aetna.

Claims were then selected from the population of approximately 153,000 claims on a stratified random basis using a proprietary selection software.

This methodology produced an estimated sampling precision of 3.0%.

Each selected claim was the original submission. We did not treat any correcting entries as the selected claim. If a correcting entry was selected we audited the original processed claim and the correcting claim.

INDIVIDUAL TESTS

The following tests were performed on sample claims selected:

- Review of previously processed claims to determine if a selected claim is a duplicate of a previously processed claim.
- Review to determine that Aetna is following all procedures necessary to obtain a reasonable level of coordination of benefits (COB) recoveries.
- Recomputation of each claim selected for testing to determine its accuracy, including analysis of any refunds due and/or payable.
- Review of the nature of the claim to ascertain the allowability of costs as defined in the contract (e.g., processed within the proper allowance and medical necessity guidelines, pre-certification requirements and other benefit limitation guidelines).
- Comparison of each claim to supporting documentation submitted by the member or the provider of services to ensure that the claim reflects the documentation and that it is properly authorized for payment.
- Comparison of each claim to other claims for that individual with the same date of service to ensure congruency of payment with all claims for that date of service.
- Review of the claim copies and source documents, when appropriate, to determine if there are any indications of fraud.

ADJUDICATION ACCURACY

An error was defined as any incorrect payment, incorrect amount charged to the deductible or payment to the wrong party or on behalf of the wrong patient. For purposes of determining the frequency of payment error, the above definition has been applied without considering adjustments made by Aetna. However, for the purposes of calculating the magnitude of payment error, the gross payment errors were modified by adjustments made by Aetna. The result is to produce an estimate of the claim liability for the plan year.

Information presented below describes the payment errors identified during our test work performed on the 250 sample claims.

CLAIM AUDIT RESULTS

We identified 5 errors in the sample of 250 claims processed by Aetna. This is a 2.0% error rate or a 98.0% accuracy rate. This error rate is superior to the range of 95% to 97% accuracy rate normally observed by Wolcott & Associates, Inc. in audits of 75 similar systems for 2009 and 2010. This error rate is superior to the range of 95% to 97% accuracy rate that is considered industry standard.

The financial magnitude of payment error (overpayments plus underpayments) in our sample of 250 claims was \$970.00 or 0.06% of the payments in the sample. This is a financial accuracy rate of 99.94%. This rate is more favorable than the 99% accuracy rate established by other claim processors with which we are familiar.

Analysis of Errors By Type

Each of the identified errors was analyzed to determine the reason for the error. The results of this analysis are presented in the following table.

<u>Description</u>	<u>Frequency</u>	<u>Magnitude</u>
Incorrect non-application of Copay	3	\$600.00
Incorrect application of mammogram Benefit	1	(341.00)
Incorrect COB Application	<u>1</u>	<u>29.00</u>
Total	<u>5</u>	\$ <u>970.00 (absolute value)</u>

Corrective Action

We have discussed each of the above identified payment errors with Aetna. Their comments will be added to our final report as **Exhibit C**. For those errors with which Wolcott and Aetna agree, they have assured us that corrective action either has been or will be taken for each identified error and that steps will be taken to reduce the frequency of the types of errors observed.

Conclusion – Error Magnitude

The calculation of error magnitude is performed to estimate the true value of paid claims during the period. As a result, payment errors have been adjusted by corrections performed by Aetna prior to our audit.

The sample's error magnitude, extended to the population, produces a projected net underpayment of \$690,278 (2.21% of \$31,297,774). The error magnitude rate in the sample differs from the error magnitude rate when extended to the population due to the weighting of the samples.

As a result, we are 95 percent confident that the true value of the medical paid claims during the period ranges from \$32,926,985 (the \$31,297,774 recorded claims, plus the \$690,278 projected overpayment error, plus the \$938,933 value of the 3.0% precision) and \$31,049,119 (the \$31,297,774 recorded claims, plus the \$690,278 projected overpayment error, minus the \$938,933 value of the 3.0% precision).

The overpayment percentage plus underpayment percentage from our results total 2.21%. This equals a payment accuracy rate of 97.79%. This rate is less favorable than the 99% accuracy rate standards established by the industry.

DISCUSSION ISSUES

We identified 4 issues that we believe warrant further discussion.

- We identified 2 claims for outpatient surgery and the \$150 copay was not applied. Aetna agreed that this is a systemic issue and will make the appropriate changes to their system.

In addition, we identified one inpatient hospital claim for a newborn and the inpatient copay of \$300 was not applied. The City has confirmed that the copay should apply for newborns.

We recommend Aetna review all claims that are affected by these copay issues and make the appropriate adjustments to the claims and modify the claims system, in order to correctly process these claims in the future. In addition, we recommend Aetna establish the magnitude of payment error and reimburse the City for this issue.

- We identified 2 claims for durable medical equipment (DME). We inquired as to whether or not the \$10,000 limit had been exceeded. Aetna provided information indicating that neither claimant had exceeded the \$10,000 limit. However, Aetna also confirmed that their system is not set-up to limit DME charges to \$10,000.

We recommend Aetna make the appropriate changes to their system to process these types of claims correctly. In addition, we recommend Aetna review the City's DME claims and establish the magnitude of payment error and reimburse the City for this issue.

- We identified 1 claim for a mammogram for a patient that was 38 years old. Aetna denied this claim due to the fact that their system was set-up to only allow for patients over 40 years old. The issue was discussed with the City and determined that their intent is to allow this routine service for patients over 35 years old. Therefore, we assigned an error to this claim since the patient was 38 years old and services were denied incorrectly.

We recommend Aetna make the appropriate changes to their system to process these types of claims correctly. In addition, we recommend Aetna review the City's claims and make the appropriate adjustments to the claims.

PLAN DOCUMENT DISCUSSION ITEM

- We identified 1 claim for services related to intervention and family counseling (without the presence of the patient). Aetna made payment for these services as there is no specific exclusion in the plan document for these types of services. Therefore, we did not assign an error.

It should be noted that, in most plan documents we review, this exclusion is standard. Therefore, we recommend the City make the appropriate modifications to their plan document, in order to reflect that services provided without the patient present would be excluded from payment of services.

IV - CLAIM PROCESSING TIME - MEDICAL CLAIMS

The administrative agreement defined the claim processing time measurement period to be from (1) the date the claim was received to (2) the date determination is made to pay, deny or request additional information.

PROCEDURE

Prior to our arrival in Aetna's offices, Aetna staff had provided us with access to their claim processing system. The claim history in the system contains the date the claim was received, processed and date the check and/or explanation of benefits (EOB) was issued.

RESULTS - PROCESSING

We measured the elapsed time between the date of receipt and the determination date for each of the 250 claims in our sample.

Claim Processing Timeliness

Of the 250 claims in our sample, 187 or 74.8% were processed within 7 calendar days, 14 or 5.6% were processed between 8 and 14 calendar days, 39 or 15.6% were processed between 15 and 30 calendar days, and 10 or 4% were processed in excess of 30 days.

CONCLUSION

These results are within the range of 80% to 85% of claims processed within 14 calendar days standard established by other claim processors with which we are familiar.

V - PRESCRIPTION DRUG CLAIM PROCESSING ACCURACY

Our test work to determine payment accuracy of prescription drug claims processed during the period of January 1, 2009 through December 31, 2010 was performed on 250 claims previously processed by Aetna. Information regarding the sample selection, tests performed and results is presented below.

SAMPLE SIZE AND METHODOLOGY

Computer data containing paid claim information was received from Aetna.

Claims were then selected from the population of approximately 61,000 on a stratified random basis using a proprietary selection software.

This methodology produced an estimated sampling precision of 4.4%.

Each selected claim was the original submission. We did not treat any correcting entries as the selected claim. If a correcting entry was selected we audited the original processed claim and the correcting claim.

AUDIT PROCEDURE

Each sample claim was manually reprocessed based on the plan's provisions in force as of the date the prescription was dispensed. For electronic and paper (including out-of-network) claims ingredient costs were calculated based on Average Wholesale Prices (AWP) on the package size submitted or other applicable prices in effect on the date the prescription was dispensed. Ingredient costs for mail order claims were calculated based on AWP on package sizes of 100 units or 16 oz. quantities, or smaller quantities, if such quantities are not available.

The percentage discounts, dispensing fees, and copayment amounts were compared to the plan's agreed upon provisions as of the date the prescription was dispensed.

Each sample claim's medication was identified and compared to the plan's requirements for:

- Exclusions,
- Pricing used at the time the prescription was dispensed,
- Recalculating payment amount,
- Appropriate copayment (generic, branded, etc.),
- Compliance with pre-approval requirements,
- Maximum number of days supply,
- Refill timing,
- Formulary limitations,
- Eligibility of participant and
- Differential payment on prescriptions for "Dispensed as Written".

DEFINITION OF ERROR

All network pharmacy claim (electronic claims) payments were paid to the retail pharmacy. All mail order initial and refilled claim payments were paid to Aetna mail order pharmacy.

We defined an error to be any claim where the payment to the participant or the pharmacy did not agree with the plan document provisions.

Pricing Accuracy

Manual recalculation of the 250 sample claims selected for the audit period was performed using the most current pricing in effect at the time the prescription was dispensed. To determine pricing accuracy of Aetna's calculations, we used industry standard unit price publications for AWP and Health Care Finance Administration (HCFA) and Medicare Approved Charge (MAC) pricing.

Copayment Accuracy

The plan requires the member to pay the cost differential when a generic substitute is available but the doctor writes "dispensed as written" (DAW) on the prescription for a brand name drug.

Within the 250 sample claims, all DAWs were manually recalculated based on current cost to determine copayment accuracy.

Our findings are presented in **Exhibit B**.

Duplications of Claim Payments

Our fieldwork included reviewing claim history of a selected participant in our 250 selected claims for possible duplication of prescriptions and claim payments. During our review of the selected participant's claim history we did not identify any duplicate claim payment.

CONCLUSION - ERROR FREQUENCY

The observed error frequency in our sample was 1.6 percent (4 errors divided by 250 claims in our sample). These results were extended to the population of claims by calculating the frequency of error in each stratum and weighting the results by the number of claims in each stratum. This error rate is within the range of 98% to 99% percent accuracy rate normally observed by Wolcott & Associates, Inc. in audits of 75 similar systems for 2009 and 2010. This error rate is within the range of 98% to 99% accuracy rate that is considered industry standard.

CONCLUSION - ERROR MAGNITUDE

The calculation of error magnitude is performed to estimate the true value of paid claims during the period.

The magnitude of payment error in our sample of 250 claims was an overpayment of \$142.58 or .027% of the payments in the sample. This error rate is superior to the range of 99 to 99.5 percent accuracy rate normally observed by Wolcott & Associates, Inc. in audits of similar prescription drug systems.

The sample's error magnitude, extended to the population, produces a projected overpayment of \$26,346 (0.40% of \$6,573,155). The error magnitude rate in the sample differs from the error magnitude rate when extended to the population due to the weighting of the sample strata.

As a result, we are 95 percent confident that the true value of the prescription paid claims during the period ranges from \$6,888,720 (the \$6,573,155 recorded claims, plus the \$26,346 projected overpayment error, plus the \$289,219 value of the 4.4% precision) and \$6,310,282 (the \$6,573,155 recorded claims, plus the \$26,346 projected net error, less the \$289,219 value of the 4.4% precision).

The Aetna standard accuracy rate is 99% or more of the gross dollar payments should be paid accurately. We understand the measurement is made by summing the overpayments and underpayments, and dividing the result by the total dollars and subtracting from 100%.

The overpayments/ underpayments percentage from our results (extended to the population) total 0.03%. This equals a payment accuracy rate of 99.97%. These results are superior to the Aetna standard accuracy rate. They are also superior to the 99% accuracy standard established by other claim processors with which we are familiar.

TYPES OF ERRORS

Each of the errors identified in our sample is listed in **Exhibit B**. A discussion of error types is presented below.

AETNA PHARMACY CLAIMS JANUARY 1, 2009 THROUGH DECEMBER 31, 2010 SUMMARY OF ERRORS BY TYPE

<u>ERROR TYPE</u>	<u>NUMBER</u>	<u>NET PAYMENT ERROR</u>
90 days supply from retail pharmacy.	1	\$122.58
Incorrect discount applied. (member overpayment)		0
No copayment applied.	2	20.00
Total	4	\$ 142.58

Corrective Action

We have discussed each of the above identified payment errors with Aetna. Their comments will be added to our final report as **Exhibit C**. For those errors with which Wolcott and Aetna agree, they have assured us that corrective action either has been or will be taken for each identified error and that steps will be taken to reduce the frequency of the types of errors observed.

DISCUSSION ISSUES

We identified 3 issues that we believe warrant further discussion.

- A prescription for Seasonique (birth control) indicated 90 pills for a 90 day supply from a retail pharmacy. Only 1 copay had been applied. Therefore, we presented Aetna with this discrepancy. The response, from Aetna, indicated that Aetna made a business decision to charge only one retail copayment for this product and others that come in 90 day supply packaging. This business decision is inconsistent with the City's plan document, which clearly indicates that retail prescriptions are limited to 30 days supply.

We believe that Aetna should have charged 3 copays for this prescription drug and for all prescription drugs that are packaged in this manner. Aetna's business decision has negatively impacted all self-funded plans for whom they administer. We recommend that Aetna calculate the magnitude of overpayment resulting from this business decision and reimburse the City.

- During our review, we identified 2 retail claims that did not have a copayment applied. Aetna is currently working on their response to this issue. As of the date of this draft, the response was not prepared. Therefore, we are citing this as an error.

We recommend that Aetna investigate this issue and report provide a full response to this report and to the City as to the reason(s) for the failure to apply copayments for these 2 claims. Furthermore, we recommend Aetna calculate the magnitude of overpayment resulting from this issue and reimburse the City.

- We identified one claim in our sample where the ingredient cost, minus the discount was less than the member's copayment. However, the member was charged the U&C price, which was higher than the discounted amount presented above. Aetna responded to us that when this situation occurs, the U&C logic is utilized, which resulted in a higher payment on behalf of the member. In the U&C logic, if the calculated cost (ingredient cost less the discount) is less than the member's copay, Aetna will charge the member the full copayment or the U&C price, whichever is less. Therefore, the member is "penalized" and required to pay their full copayment amount or the U&C amount which is higher than the calculated discounted amount.

V – 4

We believe that this methodology is contradictory to the City's contract and intention of how the plan should be administered. It is not typical in the industry for members to be "penalized" for prescriptions that are less than the copay amount. The members should only be charged the lesser of the copayment or the discounted ingredient cost plus the dispensing fee.

We recommend the City and Aetna discuss this issue and agree upon the methodology that would not "penalize" the member for these types of situations.

Exhibit A

**THE CITY OF SCOTTSDALE, ARIZONA
HEALTHCARE CLAIMS
CLAIMS PROCESSED FROM JANUARY 1, 2009 THROUGH DECEMBER 31, 2010
SUMMARY OF FINDINGS**

SAMPLE #	PAID AMOUNT	AUDITED AMOUNT	DOLLAR VALUE OF ERROR	TYPE
201	44.00	15.00	29.00	Incorrect coordination of benefits. Other carrier's payment data entered incorrectly. agree
77	2,215.00	2,065.00	150.00	Should have applied \$150 outpatient surgery copay. agree
22	23,851.25	23,701.25	150.00	Should have applied \$150 outpatient surgery copay. agree
2	75,000.00	74,700.00	300.00	Should have applied \$300 inpatient copay for newborn. agreed by the plan.
166	-	341.00	(341.00)	Should have allowed mammogram for 38 year old participant. Plan agrees to age 35, but Aetna system is built for age 40.

EXHIBIT B

**CITY OF
SCOTTSDALE
PRESCRIPTION DRUG CLAIM AUDIT
CLAIMS PROCESSED FROM JANUARY 1, 2009 THROUGH DECEMBER 31, 2010
SUMMARY OF FINDINGS**

Claim No.	Amount Paid	Audited Amount	Dollar Value of Error	Type
6748767	\$163.45	\$ 40.87	\$122.58	Retail prescription for 90 days supply. Member should have been charged 3 copays for prescription that is only packaged for 90 days supply.
1489006	24.41	14.41	10.00	No copayment was applied.
1641529	10.45	0.45	10.00	No copayment was applied.
6386858	-	-	-	Incorrect discount was applied. Member overpaid by \$5.07.
Totals	\$ 198.31	\$ 55.73	\$ 142.58	

APPENDIX B – AETNA’S RESPONSE

City of Scottsdale

**WOLCOTT & ASSOCIATES, Inc.
MEDICAL & PRESCRIPTION DRUG
CLAIM AUDIT RESPONSE**

**Aetna
Fresno Service Center**

Audit Finding Summary
04/21/2011
Audit Conducted April 4 – 8, 2011
Audit period January 1, 2009 through December 31, 2010

Summary of audit findings:

We appreciate the approach Wolcott & Associates has taken in addressing the issues identified during the audit. Aetna is committed to the relationship with The City of Scottsdale and is taking steps to continue to improve the level of service we are providing. We view customer audits as an opportunity to gain additional insights for training and educational opportunities. Aetna's action plan for improved service levels is attached.

We are very proud that the audit results for Financial Payment and Claims Processing Accuracy for both the medical and prescription drug audits exceed the industry standards and Wolcott & Associates' best practice standards. From a medical sample of 250 claims, there were 5 errors on 5 claims, consisting of four overpayments and one underpayment for a total mispayment of \$970.00.

Category	Audit Result	Industry Standard
Financial Payment Accuracy	99.94%	99%
Total Claim Accuracy	98.0%	95-97%

From a prescription drug sample of 250 claims, there were 4 errors on 4 claims, consisting of 4 overpayments for a total mispayment of \$142.58.

Category	Audit Result	Industry Standard
Financial Payment Accuracy	99.97%	99-99.5%
Total Claim Accuracy	98.4%	98-99%

Wolcott & Associates, Inc. timeliness results below are based on the claim sample of 250 claims, not on the total claim population. Aetna's results are within the range of 80-85% of claims processed within the 14 calendar day standard established by the TPA industry.

Turnaround Time (Of the 250 claim sample)	Audit Results
Percentage processed within 7 calendar days	74%
Percentage processed within 8-14 calendar days	6%
Percentage processed within 15-30 calendar days or less	16%
Percentage processed in excess of 30 calendar days	4%

Medical Claim Errors and Response

Claim Sample	Value	Error Description	Aetna Response and Action	Status	Completion Date
COS2	\$300 OP	Should have applied \$300 inpatient copayment for newborn.	Aetna initially agreed to this error during the onsite audit; however, after further discussion, Aetna disagrees with the error. The City writes their own SPD and in writing confirmed that their SPD is silent on whether separate inpatient copayments should apply for the mother and one for the newborn. Furthermore, Aetna has received confirmation from The City that the inpatient copayment will apply to newborns effective 7/01/2011. Aetna will update our systems to support this change and The City will also update their SPD and Benefits Guide to reflect this benefit change.	Open	
COS22	\$150 OP	Should have applied \$150 outpatient surgery copayment.	Aetna agrees with these errors. It appears that in both instances the processors used an override that bypassed the outpatient surgery logic. When these claims are recalled today, they do apply the outpatient surgery copayment correctly. Therefore, we feel that these are processor errors and not systemic. These claims will be handled pending The City's decision on pursuing overpayments that will leave the member with financial liability. The processors have been coached on the errors and refresher training has been provided to the team.	Open	
COS77	\$150 OP				

Claim Sample	Value	Error Description	Aetna Response and Action	Status	Completion Date
COS165	\$341 UP	Should have allowed mammogram for 38 year old participant.	Aetna disagrees with this error. The City has confirmed in writing that their SPD is silent in regards to the eligible age for routine mammograms and therefore, the plan was initially set up to follow Aetna standard which is age 40 and older. In 2010, The City confirmed their intent was to cover mammograms for women at age 35 and Aetna updated the system effective 07/01/2010 to reflect this change. The date of service on the audit claim was 11/18/2009 which was prior to the change.	Closed	
COS201	\$29 OP	Incorrect coordination of benefits. Other carrier's payment data entered incorrectly.	Aetna agrees with this error. The claim has been reprocessed and referred for overpayment recovery. The processor has been coached on the error and refresher training has been provided to the team.	Closed	05/03/2011

<i>Wolcott & Associates Discussion Issues</i>	<i>Aetna's Response</i>
We identified 2 claims for outpatient surgery and the \$150 copayment was not applied. Aetna agreed that this is a systemic issue and will make the appropriate changes to their system. In addition, we identified one inpatient hospital claim for a newborn and the inpatient copayment of \$300 was not applied. The City has confirmed that the copayment should apply for newborns. We recommend Aetna review all claims that are affected by these copayment issues and make the appropriate adjustment to the claims and modify the claims system, in order to correctly process these claims in the future. In addition, we recommend Aetna establish the magnitude of payment error and reimburse The City for this issue.	Aetna agrees with these errors. It appears that in both instances the processors used an override that bypassed the outpatient surgery logic. When these claims are recalled today, they do apply the outpatient surgery copayment correctly. Therefore, we feel that these are processor errors and not systemic. The City writes their own SPD and in writing confirmed that their SPD is silent on whether separate inpatient copayments should apply for the mother and one for the newborn. Furthermore, Aetna has received confirmation from The City that the inpatient copayment will apply to newborns effective 7/01/2011. Aetna will update our systems to support this change and The City will also update their SPD and Benefits Guide to reflect this benefit change.
We identified 2 claims for durable medical equipment (DME). We inquired as to whether or not the \$10,000 limit had been exceeded. Aetna provided information indicating that neither claimant had exceeded the \$10,000 limit. However, Aetna also confirmed that their system is not set-up to limit DME charges to \$10,000. We recommend Aetna make the appropriate changes to their system to process these types of claims correctly. In addition, we recommend Aetna review The City's DME claims and establish the magnitude of payment error and reimburse The City for this issue.	Aetna will update the system to track DME expenses towards the \$10,000 calendar year maximum.

<i>Wolcott & Associates Plan Discussion Item</i>	<i>Aetna's Response</i>
We identified 1 claim for a mammogram for a patient that was 38 years old. Aetna denied this claim due to the fact that their system was set-up to only allow for patients over 40 years old. The issue was discussed with The City and determined that their intent is to allow this routine service for patients over 35 years old. Therefore, we assigned an error to this claim since the patient was 38 years old and services were denied. We recommend Aetna make the appropriate changes to their system to process these types of claims correctly. In addition, we recommend Aetna review The City's claims and make the appropriate adjustments to the claims.	The City has confirmed in writing that their SPD is silent in regards to the eligible age for routine mammograms and therefore, the plan was initially set up to follow Aetna standard which is age 40 and older. In 2010, The City confirmed their intent was to cover mammograms for women at age 35 and Aetna updated the system effective 07/01/2010 to reflect this change. The date of service on the audit claim was 11/18/2009 which was prior to the change.
We identified 1 claim for services related to intervention and family counseling (without the presence of the patient). Aetna made payment for these services as there is no specific exclusion in the plan document for these types of services. Therefore, no error was assigned. It should be noted that, in most plan documents we review, this exclusion is standard. Therefore, we recommend The City make the appropriate modifications to their plan document, in order to reflect that services provided without the patient present would be excluded from payment of services.	Aetna administers the behavioral health benefit for the PPO and CPOS plans only; the behavioral health benefits for the EPO plan are carved out through Cigna. The utilization of the Aetna behavioral health plans is very low due to the catastrophic-like benefits. Aetna is open to discussions with The City regarding any modifications they wish to make to the Aetna behavioral health plans.

Prescription Drug Errors and Response

Claim Sample	Value	Error Description	Aetna Response and Action	Status	Completion Date
COS# 6748767	\$122.58 OP	Retail prescription for 90 days supply. Member should have been charged 3 copayments for prescription that is only packaged for 90 days supply.	Aetna disagrees with this error. This claim is for Seasonique, a birth control pill. This product comes packaged ONLY in a 90 day supply. Because of the packing, Aetna made a business decision to allow the purchase of this and other birth control medications packaged in 90 day supplies, at retail pharmacies. Part of that business decision included only charging one retail copayment for this medication and others that come in a 90 day package. This is consistent across all of our products and customers.	Closed	
COS# 1489006	\$10.00 OP	No copayment was applied.	Aetna agrees with these errors. Both claims have been referred to our helpdesk area for review and are being researched. The Rx system appears to be set up correctly. Since the lifetime max is integrated with the medical plan, the pharmacy system sends the claim information to the medical system. The response that was sent back to the Rx system stated a \$0 copayment. At this time, we are waiting on response from the helpdesk area.	Open	
COS# 1641529	\$10.00 OP				
COS# 6386858	\$0 NP	Incorrect discount was applied. Member overpaid by \$5.07.	Aetna disagrees with this error. Our provider contracts required us that we pay the pharmacy the lesser of copayment or the cash (U&C) price. In this case, the copayment would be \$50 for a brand non-formulary drug or \$42.69 (U&C). The member was charged U&C; therefore, the claim adjudicated correctly.	Closed	

<i>Wolcott & Associates Discussion Issues</i>	<i>Aetna's Response</i>
A prescription for Seasonique (birth control) indicated 90 pills for a 90 days supply from a retail pharmacy. Only 1 copayment had been applied. Therefore, we presented Aetna with this discrepancy. The response from Aetna indicated that Aetna made a business decision to charge only one retail copayment for this product and others that come in 90 day supply packaging. This business decision is inconsistent with The City's plan document, which clearly indicates that retail prescriptions are limited to 30 days supply. We believe that Aetna should have charged 3 copayments for this prescription drug and for all prescription drugs that are packaged in this manner. Aetna's business decision has negatively impacted all self-funded plans for which they administer. We recommend that Aetna calculate the magnitude of overpayment resulting from this business decision and reimburse The City.	This claim is for Seasonique, a birth control pill. This product comes packaged ONLY in a 90 day supply. Because of the packing, Aetna made a business decision to allow the purchase of this and other birth control medications packaged in 90 day supplies, at retail pharmacies. Part of that business decision included only charging one retail copayment for this medication and others that come in a 90 day package. This is consistent across all of our products and customers.
During our review, we identified 2 retail claims that did not have a copayment applied. Aetna is currently working on their response to this issue. As of the date of this draft, the response was not prepared. Therefore, we are citing this as an error. We recommend that Aetna investigate this issue and report provide a full response to this report and to The City as to the reasons(s) for the failure to apply copayments for these 2 claims. Furthermore, we recommend Aetna calculate the magnitude of overpayment resulting from this issue and reimburse The City.	Both claims have been referred to our helpdesk area for review and are being researched. The Rx system appears to be set up correctly. Since the lifetime max is integrated with the medical plan, the pharmacy system sends the claim information to the medical system. The response that was sent back to the Rx system stated a \$0 copayment. At this time, we are waiting on response from the helpdesk area. Once a root cause and resolution have been determined, Aetna will run a report to measure the financial impact to The City.

<i>Wolcott & Associates Discussion Issues</i>	<i>Aetna's Response</i>
We identified one claim in our sample where the ingredient cost minus the discount was less than the member's copayment. However, the member was charged the U&C price, which was higher than the discounted amount presented above. Aetna responded to us that when this situation occurs, the U&C logic is utilized, which resulted in a higher payment on behalf of the member. In the U&C logic, if the calculated cost (ingredient cost less the discount) is less than the member's copayment, Aetna will charge the member the full copayment or the U&C price whichever is less. Therefore, the member is "penalized" and required to pay their full copayment amount or the U&C amount which is higher than the calculated discounted amount. We believe that this methodology is contradictory to The City's contract and intention of how the plan should be administered. It is not typical in the industry for members to be "penalized" for prescriptions that are less than the copayment amount. The members should only be charged the lesser of the copayment or the discounted ingredient cost plus the dispensing fee.	Our provider contracts require us to pay the pharmacy the lesser of copayment or the cash (U&C) price. In this case, the copayment would be \$50 for a brand non-formulary drug or \$42.69 (U&C); therefore, the member was charged U&C. It's Aetna's position that the claim adjudicated correctly. Aetna is open to discussions with The City to further explain this policy.

City Auditor's Office

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