

**REPORT OF
MARKET CONDUCT EXAMINATION
OF**

**AETNA HEALTH INC.
Blue Bell, Pennsylvania**

**AS OF
June 22, 2009**

COMMONWEALTH OF PENNSYLVANIA



**INSURANCE DEPARTMENT
BUREAU OF MARKET CONDUCT**

Issued: August 14, 2009

AETNA HEALTH INCORPORATED

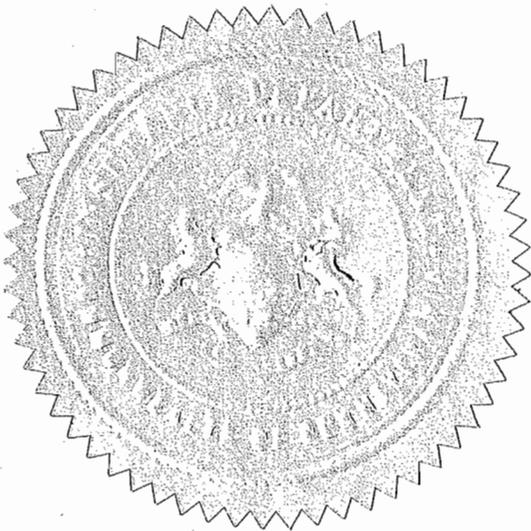
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BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

ORDER

AND NOW, this 22ND day of July, 2008, in accordance with Section 905(c) of the Pennsylvania Insurance Department Act, Act of May 17, 1921, P.L. 789, as amended, P.S. § 323.5, I hereby designate Ronald A. Gallagher, Deputy Insurance Commissioner, to consider and review all documents relating to the market conduct examination of any company and person who is the subject of a market conduct examination and to have all powers set forth in said statute including the power to enter an Order based on the review of said documents. This designation of authority shall continue in effect until otherwise terminated by a later Order of the Insurance Commissioner.





Joel S. Ario
Insurance Commissioner

BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

IN RE: : VIOLATIONS:
: :
AETNA HEALTH INCORPORATED : Sections 2166(A) and (B) of the Act of
980 Jolly Road, U13N : June 17, 1998, P.L. 464, No. 68 (40 P.S.
Blue Bell, PA 19422 : §§991.2166)
: :
: Section 2 of the Insurance Company Law,
: No. 112 (40 P.S. §3042)
: :
: Section 2116 of the Insurance Company
: Law, No. 284 (40 P.S. §991.2116)
: :
: Section 602-A of the Insurance Company
: Law, Act of May 17, 1921, P.L. 682 (40
: P.S. § 908-2)
: :
: Sections 5(a)(10)(i), (ii), (iii), (iv), (v) and
: (vi) of the Unfair Insurance Practices Act,
: Act of July 22, 1974, P.L. 589, No. 205
: (40 P.S. §§1171.5(a)(10)(i), (ii), (iii), (iv),
: (v) and (vi))
: :
: Title 31, Pennsylvania Code, Section
: 154.18(c)
: :
Respondent. : Docket No. MC09-07-031

CONSENT ORDER

AND NOW, this *14th* day of *AUGUST*, 2009, this Order is hereby
issued by the Insurance Department of the Commonwealth of Pennsylvania pursuant
to the statutes cited above and in disposition of the matter captioned above.

1. Respondent hereby admits and acknowledges that it has received proper notice of its rights to a formal administrative hearing pursuant to the Administrative Agency Law, 2 Pa.C.S. § 101, et seq., or other applicable law.

2. Respondent hereby waives all rights to a formal administrative hearing in this matter, and agrees that this Consent Order shall have the full force and effect of an order duly entered in accordance with the adjudicatory procedures set forth in the Administrative Agency Law, supra, or other applicable law.

FINDINGS OF FACT

3. The Insurance Department finds true and correct each of the following Findings of Fact:

- (a) Respondent is Aetna Health Incorporated, and maintains its address at 980 Jolly Road, U13N, Blue Bell, Pennsylvania 19422.
- (b) A market conduct examination of Respondent was conducted by the Insurance Department covering the period from January 1, 2007 through December 31, 2007.
- (c) On June 22, 2009, the Insurance Department issued a Market Conduct Examination Report to Respondent.
- (d) A response to the Examination Report was provided by Respondent on July 21, 2009.

- (e) The Examination Report notes violations of the following:
- (i) Sections 2166(A) and (B) of Insurance Company Law, No. 284 (40 P.S. § 991.2166), which provides: (A) A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within 45 days of receipt of a clean claim, and (B) If a licensed insurer or a managed care plan fails to remit the payment as provided under subsection (A), interest at 10% per annum shall be added to the amount owed on the clean claim. Interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed insurer shall not be required to pay any interest calculated to be less than two dollars;
 - (ii) Section 2 of the Insurance Company Law, No. 112 (40 P.S. §3042), and Section 2116 of the Insurance Company Law, No. 284 (40 P.S. §991.2116), which require an insurer to reimburse an insured or provider for medically necessary services that are provided in a hospital emergency facility due to a medical emergency. (b) Information - A hospital emergency facility shall provide to an insurer, with any claim for reimbursement of services, information on the presenting symptoms of the insured as well as the services provided. (c) Factors considered – An insurer shall consider both the presenting symptoms and the service provided in processing a claim for reimbursement of emergency services. Emergency transportation and related emergency service provided by a licensed ambulance constitutes an emergency service.

(iii) Section 602-A of the Insurance Company Law (40 P.S. § 908-2), which states all group health or sickness and accident insurance policies providing hospital or medical/surgical coverage and all group subscriber contracts or certificates issued by any entity subject to this act shall, in addition to other provisions required by this act, include within the coverage, those benefits for alcohol or other drug abuse and dependency as provided;

(iv) Sections 5(a)(10)(i), (ii), (iii), (iv), (v) and (vi) of the Unfair Insurance Practices Act (40 P.S. §§1171.5(a)(10)(i), (ii), (iii), (iv), (v) and (vi) states any of the following acts, if committed or performed with such frequency as to indicate a business practice, shall constitute unfair claim settlement or compromise practices:

- (i) Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue;
- (ii) Failing to acknowledge and act promptly upon written or oral communications with respect to claims arising under insurable policies;
- (iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurable policies;
- (iv) Refusing to pay claims without conducting a reasonable investigation based upon all available information;
- (v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative;

- (vi) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company's liability under the policy has become reasonably clear; and

- (v) Title 31, Pennsylvania Code, Section 154.18(c), which states interest due to a health care provider on a clean claim shall be calculated and paid by the licensed insurer or managed care plan to the health care provider and shall be added to the amount owed on the clean claim. The interest shall be paid within 30 days of the payment of the claim.

CONCLUSIONS OF LAW

4. In accord with the above Findings of Fact and applicable provisions of law, the Insurance Department makes the following Conclusions of Law:

- (a) Respondent is subject to the jurisdiction of the Pennsylvania Insurance Department.

- (b) Respondent's violations of Sections 2166(A) and 2166(B) of Act 68 (40 P.S. §§ 991.2166) are punishable under Section 2182 of Act 68 (40 P.S. § 91.2182), which states the Department may impose a penalty of up to five thousand dollars (\$5,000.00) for a violation of this article.

(c) Respondent's violations of Sections 5(a)(10)(i), (ii), (iii), (iv), (v) and (vi) of the Unfair Insurance Practices Act, No. 205 (40 P.S. §§ 1171.5) are punishable by the following, under Section 9 of the Unfair Insurance Practices Act (40 P.S. § 1171.9):

- (i) cease and desist from engaging in the prohibited activity;
- (ii) suspension or revocation of the license(s) of Respondent.

(d) In addition to any penalties imposed by the Commissioner for Respondent's violations of the Unfair Insurance Practices Act (40 P.S. §§ 1171.1 – 1171.5), the Commissioner may, under Sections 10 and 11 of the Unfair Insurance Practices Act (40 P.S. §§ 1171.10, 1171.11) file an action in which the Commonwealth Court may impose the following civil penalties:

- (i) for each method of competition, act or practice which the company knew or should have known was in violation of the law, a penalty of not more than five thousand dollars (\$5,000.00);
- (ii) for each method of competition, act or practice which the company did not know nor reasonably should have known was in violation of the law, a penalty of not more than one thousand dollars (\$1,000.00).

ORDER

5. In accord with the above Findings of Fact and Conclusions of Law, the Insurance Department orders and Respondent consents to the following:

- (a) Respondent shall cease and desist from engaging in the activities described herein in the Findings of Fact and Conclusions of Law.
- (b) Respondent shall file an affidavit stating under oath that it will provide each of its directors, at the next scheduled directors meeting, a copy of the adopted Report and related Orders. Such affidavit shall be submitted within thirty (30) days of the date of this Order.
- (c) Respondent shall comply with all recommendations contained in the attached Report.
- (d) Respondent shall pay Thirty Thousand Dollars (\$30,000.00) to the Commonwealth of Pennsylvania in settlement of all exceptions contained in this Report.
- (e) Payment of this matter shall be made by check payable to the Commonwealth of Pennsylvania. Payment should be directed to Sharon L. Fraser, Bureau of

Market Conduct, 1227 Strawberry Square, Harrisburg, Pennsylvania 17120.

Payment must be made no later than thirty (30) days after the date of this Order.

6. In the event the Insurance Department finds that there has been a breach of any of the provisions of this Order, based upon the Findings of Fact and Conclusions of Law contained herein may pursue any and all legal remedies available, including but not limited to the following: The Insurance Department may enforce the provisions of this Order in the Commonwealth Court of Pennsylvania or in any other court of law or equity having jurisdiction; or the Department may enforce the provisions of this Order in an administrative action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

7. Alternatively, in the event the Insurance Department finds that there has been a breach of any of the provisions of this Order, the Department may declare this Order to be null and void and, thereupon, reopen the entire matter for appropriate action pursuant to the Administrative Agency Law, supra, or other relevant provision of law.

8. In any such enforcement proceeding, Respondent may contest whether a breach of the provisions of this Order has occurred but may not contest the Findings of Fact and Conclusions of Law contained herein.

9. Respondent hereby expressly waives any relevant statute of limitations and application of the doctrine of laches for purposes of any enforcement of this Order.

10. This Order constitutes the entire agreement of the parties with respect to the matters referred to herein, and it may not be amended or modified except by an amended order signed by all the parties hereto.

11. This Order shall be final upon execution by the Insurance Department. Only the Insurance Commissioner or a duly authorized delegee is authorized to bind the Insurance Department with respect to the settlement of the alleged violations of law contained herein, and this Consent Order is not effective until executed by the Insurance Commissioner or a duly authorized delegee.

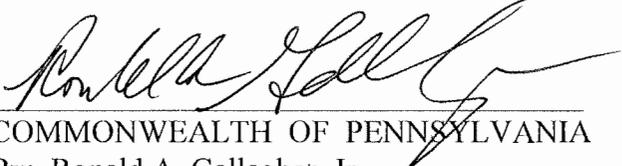
BY: AETNA HEALTH INCORPORATED,
Respondent



President / Vice President



Secretary / Treasurer



COMMONWEALTH OF PENNSYLVANIA
By: Ronald A. Gallagher, Jr.
Deputy Insurance Commissioner

I. INTRODUCTION

The Market Conduct Examination was conducted on Aetna Health Incorporated; hereafter referred to as “Company,” at the Company’s office located in Blue Bell, Pennsylvania, June 23, 2008, through August 8, 2008. Subsequent review and follow-up was conducted in the office of the Pennsylvania Insurance Department.

Pennsylvania Market Conduct Examination Reports generally note only those items, to which the Department, after review, takes exception. A violation is any instance of Company activity that does not comply with an insurance statute or regulation. Violations contained in the Report may result in imposition of penalties. Generally, practices, procedures, or files that were reviewed by Department examiners during the course of an examination may not be referred to in the Report if no improprieties were noted. However, the Examination Report may include management recommendations addressing areas of concern noted by the Department, but for which no statutory violation was identified. This enables Company management to review these areas of concern in order to determine the potential impact upon Company operations or future compliance.

Throughout the course of the examination, Company officials were provided status memoranda, which referenced specific policy numbers with citation to each section of law violated. Additional information was requested to clarify apparent violations. An exit conference was conducted with Company officials to discuss the various types of violations identified during the examination and review written summaries provided on the violations found.

The courtesy and cooperation extended by the Officers and Employees of the Company during the course of the examination is acknowledged.

The following examiners participated in the Examination and in the preparation of this Report.

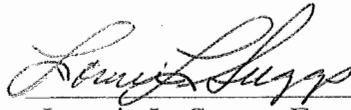
Daniel Stemcosky, AIE, FLMI
Market Conduct Division Chief

Lonnie L. Suggs
Market Conduct Examiner

Gary L. Boose, MCM
Market Conduct Examiner

Verification

Having been duly sworn, I hereby verify that the statements made in the within document are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa. C.S. §4903 (relating to false swearing).



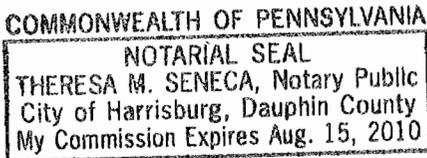
Lonnie L. Suggs, Examiner in Charge

Sworn to and Subscribed Before me

This *22* Day of *June*, 2009



Notary Public



II. SCOPE OF EXAMINATION

The Market Conduct Examination was conducted pursuant to the authority granted by Sections 903 and 904 (40 P.S. §§323.3 and 323.4) of the Insurance Department Act and covered the experience period of January 1, 2007, through December 31, 2007, unless otherwise noted. The purpose of the examination was to ensure compliance with Pennsylvania insurance laws and regulations.

The examination focused on the Company's claim handling practices and procedures related to alcohol and substance abuse and mental illness coverage.

The Company was requested to identify the universe of files for each segment of the review. Based on the universe sizes identified, random sampling was utilized to select the files reviewed for this examination.

During the course of the examination, for control purposes, some of the review segments identified in this Report may have been broken down into various sub-categories by line of insurance or Company administration. These specific sub-categories, if not reflected individually in the Report, would be included and grouped within the respective general categories of the Examination Report.

III. COMPANY HISTORY AND LICENSING

Aetna Health Inc. ("AHI-PA") was incorporated on May 7, 1981, as United States Health Care System, Inc. and changed its name to United States Health Care Systems, Inc. on August 26, 1981. The Company received their Certificate of Authority on May 7, 1981.

On September 23, 1981, AHI-PA acquired the net assets and operations of a prepaid health care plan which had operated as a health maintenance organization in southeastern Pennsylvania since 1976.

On January 17, 1983, AHI-PA changed its name to United States Health Care Systems of Pennsylvania, Inc. and again changed its name to its current name, Aetna Health Inc., on May 1, 2002.

AHI-PA was a wholly-owned subsidiary of Primary Investments, Inc., a wholly-owned subsidiary of Primary Holdings, Inc. Primary Holdings, Inc. was a wholly-owned subsidiary of Aetna Inc. ("Aetna"), formerly Aetna U.S. Healthcare Inc. On December 9, 2003, Primary Investments, Inc. contributed all of the outstanding capital stock of AHI-PA to Aetna Health Holdings, LLC. Following this transaction, AHI-PA became a wholly-owned subsidiary of Aetna Health Holdings, LLC, whose ultimate parent is Aetna. On October 1, 2007, Aetna Health Inc., a New Hampshire corporation, merged with and into AHI-PA. On October 1, 2007, Aetna Health Inc., a New Hampshire corporation, merged with and into AHI-PA. On December 31, 2007, Aetna Health Inc., a Massachusetts corporation, and Aetna Health Inc., an Ohio corporation, both merged with and into AHI-PA. As part of these mergers, AHI-PA obtained health maintenance organization licenses with the Ohio Department of Insurance, the

Kentucky Office of Insurance, the Indiana Department of Insurance and the Massachusetts Division of Insurance in 2007.

The Company lists the following lines of business in the 2007 Annual Statement: Comprehensive (Medical and Hospital), Federal Employees Health Benefit Plans and Title XVIII Medicare.

As of their 2007 annual statement for Pennsylvania, the Company reported health premium earned for all lines of business as \$1,657,479,752 and total member months of 4,836,006.

IV. FORMS

The Company was requested to provide a list and copies of all policies and or member's certificates of coverage, riders and endorsements forms used during the experience period. The forms provided and forms reviewed in various sections of the exam were reviewed to ensure compliance with Insurance Company Law, Section 354, Insurance Company Law, No. 150, Section 5 (40 P.S. §764g) and Insurance Company Law, Section 602-A (40 P.S. §908-2).

No violations were noted.

V. CLAIMS

The claims review consisted of a review of the Company's claim manuals and a review of the claim files. The Company was requested to provide copies of all procedural guidelines including all manuals, memorandums, directives and any correspondence or instructions used for processing alcohol and substance abuse and mental illness claims during the experience period. The Company provided the following claims manuals, procedures and guidelines:

1. Summary and description of Aetna's policy and procedures pertaining to Pennsylvania (PA) – Code 255.5 Treatment & Control of Drug & Alcohol Abuse – Disclosure of Information
2. Summary and description of Aetna's policy and procedures pertaining to Pennsylvania (PA) Act 106, 40 P.S. 908-1- 908-8 – Alcoholism & Substance Abuse
 - a. Training Alert (Workflow for PA Act 106)
3. Claims Processing Instructions
 - a. In-Patients Benefits
 - b. Intensive Outpatient Benefits (IOP)
 - c. Medical Mental Conditions
 - d. Out-Patient Behavioral Health Co-Payments
 - e. Precertification
 - f. Out-Patient Pre-Certification Waiver
 - g. Remit Codes
 - h. Referrals
 - i. Residential Facility
4. Summary and description of Aetna's policy and procedures pertaining to Pennsylvania Serious Mental Illness Coverage

The claim manuals and procedures were reviewed for any inconsistencies, which could be considered discriminatory, specifically prohibited by statute or regulation, or unusual in nature. No violations were noted.

Although no violations were noted the following concern is notable.

Department Concern:

The only lawful prerequisite before an insured obtains non-hospital residential and outpatient coverage for alcohol and drug dependency treatment is a certification and referral from a licensed physician or licensed psychologist. The certification and referral from a licensed physician or licensed psychologist in all instances controls both the nature and duration of treatment.

As detailed in the Company's internal claim handling procedures, in order to invoke alcohol and drug dependency minimum mandated benefits, the Company requires a written certification from a licensed physician or psychologist as to the nature and duration of the requested treatment.

The provider claim procedures for the processing of alcohol and substance abuse claims is on the Company's website. The procedures list the services including alcohol and substance abuse services that require precertification/authorization. Precertification is defined on the website as the utilization review process to determine whether the requested service or procedure meets the company's clinical criteria for coverage. The Department is concerned that the provider's precertification guidelines listed on the website are misleading. By omitting and not providing instruction of the Company's internal claim procedures on the submission requirements to invoke the alcohol and drug abuse mandated benefit coverage, the providers are led to believe that the Company through a utilization review determines and controls the nature and duration of treatment.

The claim file review consisted of 3 areas:

- A. Alcohol and Drug Claims Denied
- B. Mental Illness Claims Denied
- C. Alcohol and Drug Services Denied

All claim files were reviewed for compliance with requirements of the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171); Section 602-A of the Insurance Company Law (40 P.S. §908-2), Alcohol/Drug Abuse and Dependency Mandated Policy Coverage and Options; Title 31, Pennsylvania Code, Section 89.612, Minimum covered services; Section 5 of the Insurance Company Law, No. 150 (40 P.S. §764g), Coverage for Serious Mental Illnesses; Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166) Prompt Payment of Provider Claims and Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

A. Alcohol and Drug Claims Denied

The Company was requested to provide a list of all Alcohol and Drug claims denied during the experience period. The Company identified a universe of 7,776 Alcohol and Drug denied claims. From the original universe of 7,776 claims, the Department utilizing an audit program, extracted claims that had denial codes that were considered most susceptible for non-compliance with the Alcohol and Drug mandated benefit. The extracted universe of denied claims was 184 claims. A random sample of 50 claim files was requested, received and reviewed to ensure that the Company's claims adjudication process was adhering to the provisions of the policy contract, as well as complying with minimum mandated benefit laws.

The following is a synopsis of the denial codes and the 50 claims sampled:

Description of Denial Codes	Number of Claims
Procedure Not Pre-Certified	38
NP Deny No Precert	5
Admission Not Precertified	2
Hospital Services Not Precertified	2
Internal Review	2
Prov Appeals Address	1

The following violations were noted.

2 Violations - Insurance Company Law, Section 602-A (40 P.S. §908-2)

Alcohol/Drug Abuse and Dependency Mandated Policy Coverages and Options.

(a) All group health or sickness and accident insurance policies providing hospital or medical/surgical coverage and all group subscriber contracts or certificates issued by any entity subject to this act, to 40 Pa. C.S. Ch. 61 (relating to hospital plan corporations), the act of December 29, 1972 (P.L. 1701, No. 364), known as the "Health Maintenance Organization Act" or the act of July 29, 1977 (P. L. 105, No. 38), known as the " Fraternal Benefit Society Code," providing hospital or medical/surgical coverage, shall in addition to other provisions required by this act include within the coverage those benefits for alcohol or other drug abuse and dependency as provided in Sections 603-A, 604-A, and 605-A.

Under the provisions of the statute and as clarified in the Pennsylvania Bulletin Notice 2003-06, Drug and Alcohol Use and Dependency Coverage, 33 Pa .B. 4041, dated August 8, 2003, the only prerequisite before an insured obtains non-hospital residential and outpatient coverage for alcohol and drug treatment dependency treatment is a certification and referral from a licensed physician or licensed psychologist. The certification and referral in all instances controls both the nature and duration of treatment. The denial of coverage was not in compliance with the mandated benefit for the 2 claims noted.

4 Violations – Act 205, Section 5 (40 P.S. §1171.5)

(a) “Unfair Methods of Competition” and “Unfair or Deceptive Acts or Practices” in the business of insurance means:

(10) Any of the following acts if committed or performed with such frequency as to indicate a business practice shall constitute unfair claim settlement or compromise practices:

- (i) Misrepresenting pertinent facts or policy or contract provisions relating to coverages at issue.*
- (ii) Failing to acknowledge and act promptly upon written or oral communications with respect to claims arising under insurance policies.*
- (iii) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.*
- (iv) Refusing to pay claims without conducting a reasonable investigation based upon all available information.*
- (v) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed and communicated to the company or its representative.*
- (vi) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which the company’s liability under the policy has become reasonably clear.*

The claim processing of the 4 claims noted was inconsistent with the Company’s claim procedures and as a result the claims were inappropriately denied.

3 Violations –Insurance Company Law No. 112, Section 2, (40 P.S. §3042) and Insurance Company Law No. 284, Section 2116 (40 P.S. §991.2116)

Requirement – An insurer shall reimburse an insured or provider for medically necessary services that are provided in a hospital emergency facility due to medical emergency. (b) Information. – A hospital emergency facility shall provide to an insurer, with any claim for reimbursement of services, information on the presenting symptoms of the insured as well as the services provided. (c) Factors considered. – An insurer shall consider both the presenting symptoms and the service provided in processing a claim for reimbursement of emergency services. Emergency transportation and related emergency service provided by a licensed ambulance constitutes an emergency service.

The 3 emergency service claims noted were inappropriately denied.

15 Violations - Insurance Company Law of 1921, Section 2166 (A) (40 P.S. §991.2166), Prompt Payment of Provider Claims

(A) A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim. Claim files for the sampled clean claims paid over 45 days were reviewed to validate the accuracy of the claim report data provided by the Company.

The 15 clean claims noted were not paid within the required 45 days.

1 Violation – Insurance Company Law of 1921, Section 2166 (B) (40 P.S. §991.2166), Prompt Payment of Provider Claims

If a licensed insurer or a Managed Care Plan Fails to remit payment as provided under subsection (a), interest at ten per centum (10%) per annum shall be added to the amount owed on the clean claim, interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. The licensed

insurer or managed care plan shall not be required to pay any interest calculated to be less than two (\$2) dollars.

The required interest was not paid on the claim noted.

1 Violation – Title 31, Pennsylvania Code, Section 154.18(c) Prompt Payment

Interest due to a health care provider on a clean claim shall be calculated and paid by the licensed insurer or managed care plan to the health care provider and shall be added to the amount owed on the clean claim. The interest shall be paid within 30 days of the payment of the claim.

The interest payment was not paid within 30 days on the claim noted.

B. Mental Illness Claims Denied

The Company was requested to provide a list of all Mental Illness claims denied during the experience period. The Company identified a universe of 16,435 mental illness denied claims. A random sample of 50 claims was reviewed on-line with the staff from the company's claims department. The claim files were reviewed to ensure the Company claims adjudication process was adhering to the provisions of the policy contract, as well as complying with mental illness minimum mandated benefits. No violations were noted.

C. Alcohol and Drug Services Denied

The Company was requested to provide a list of all Alcohol and Drug Services Denied during the experience period. The Company identified a universe of 15 Alcohol and Drug Clinical Services denied coverage during the same period. All 15 clinical service files were requested, received and reviewed. The files were reviewed to ensure the Company's denial of services for access to alcohol and drug use and dependency coverage services were not in violation of Alcohol and Drug minimum mandated benefit laws. The following violations were noted.

2 Violations – Insurance Company Law of 1921, Section 2166 (A) (40 P.S. §991.2166), Prompt Payment of Provider Claims

A licensed insurer or a managed care plan shall pay a clean claim submitted by a health care provider within forty-five (45) days of receipt of the clean claim.

The 2 claims noted were not paid within the required 45 days.

1 Violation – Title 31, Pennsylvania Code, Section 154.18(c) Prompt Payment

Interest due to a health care provider on a clean claim shall be calculated and paid by the licensed insurer or managed care plan to the health care provider and shall be added to the amount owed on the clean claim. The interest shall be paid within 30 days of the payment of the claim.

The full interest amount was not paid for the claim noted within the required 30 days of claim payment.

VII. RECOMMENDATIONS

The recommendations made below identify corrective measures the Department finds necessary as a result of the number of some violations, or the nature and severity of other violations, noted in the Report.

1. The Company must review internal control procedures to ensure compliance with requirements of Section 602-A of the Insurance Company Law of 1921 (40 P.S. §908-2) and Title 31, Pennsylvania Code, Section 89.612, relating to alcohol and substance abuse mandated benefits.
2. The company must review internal control procedures to ensure compliance with prompt and fair claim settlement requirements of Section 5 of the Unfair Insurance Practices Act (40 P.S. §1171.5).
3. The company must review internal control procedures to ensure compliance with emergency claim settlement requirements of Section 2 of the Insurance Company Law, No. 112 (40 P.S. §3042) and Section 2216 of Insurance Company Law, No 284 (40 P.S. §991.2116)
4. The Company must review internal control procedures to ensure compliance with requirements of Section 2166 of the Insurance Company Law of 1921 (40 P.S. §991.2166), relating to prompt payment of provider claims.
5. The Company must review internal control procedures to ensure interest is added to the claim amount as required by Section 2166 of the Insurance Company Law of 1921 (40 P.S. §991.2166). Within 30 days of the Report issue date, the Company must provide to the Insurance Department proof of interest payment on the claim noted in the examination.

VIII. COMPANY RESPONSE



Aetna Health Inc.
980 Jolly Road, U13N
Blue Bell, PA 19422

Nancy W. Smith
Regulatory Compliance
Law & Regulatory Affairs
215-775-6813
Fax: 860-754-9685
SmithNW@aetna.com

July 21, 2009

Daniel A. Stemcosky, AIE, FLMI, MCM
Market Conduct Division Chief
Pennsylvania Insurance Department
Office of Market Regulation
Life and Health Division
1227 Strawberry Square
Harrisburg, PA 17120

**Re: Examination Warrant Number: 07-M27-056
Response to Report of Examination of Aetna Health Inc.**

Dear Mr. Stemcosky,

This letter is in response to the Pennsylvania Insurance Department's (Department's) report of examination dated June 22, 2009 regarding the market conduct examination of Aetna Health Inc. The exam focused on the Company's claim handling practices and procedures related to alcohol and substance abuse and mental illness coverage covering the experience period of January 1, 2007, through December 31, 2007. We thank you for your acknowledgement of Aetna's mostly successful efforts at compliance through this report.

Our responses below address the Department's five recommendations contained in § VII of the exam report.

- 1. The Company must review internal control procedures to ensure compliance with requirements of Section 602-A of the Insurance Company Law of 1921 (40 P.S. §908-2) and Title 31, Pennsylvania Code, Section 89.612, relating to alcohol and substance abuse mandated benefits.**

The Company accepts this recommendation. The Company has completed a review of our internal policy and procedures with requirements of Section 602-A of the Insurance Company Law of 1921 (40 P.S. §908-2) and Title 31, Pennsylvania code, Section 89.612, relating to alcohol and substance abuse mandated benefits ("Act 106").

The Company has reviewed existing provider communications, training materials and monitoring tools and will be taking further action to ensure that these documents meet the requirements of Act 106.

The additional steps for implementation encompass the following:

- *Post on the Company's website the provider certification requirements necessary for eligibility for alcohol and substance abuse mandated benefits.*
- *Update clinical training on the requirements of Act 106 to include documentation standards for clinical records in which the treating provider requests mandated alcohol and substance abuse benefits.*
- *Refresher training for our clinical area and supporting units on the requirements of Act 106.*
- *Monitoring of compliance with documentation standards and retention of certifications received specific to Act 106 provider requests for services.*

We believe these additional steps will strengthen the Company's monitoring and compliance with requirements of Act 106.

2. **The Company must review internal control procedures to ensure compliance with prompt and fair claim settlement requirements of Section 5 of the Unfair Insurance Practices Act (40 P.S. §1171.5).**

The Company accepts this recommendation, will emphasize its prompt and fair claim settlement procedures with claim staff, and believes that the additional actions noted below in items #3-5 will contribute towards improvement and consistency regarding this cited statute.

3. **The Company must review internal control procedures to ensure compliance with emergency claim settlement requirements of Section 2 of the Insurance Company Law, No. 112 (40 P.S. §3042) and Section 2216 of Insurance Company Law, No. 284 (40 P.S. §991.2116).**

The Company accepts this recommendation and has completed a review of our internal policy and procedures with respect to the Emergency Claim settlement as required under Section 2 of PA Insurance Company Law, No. 112 (40 P.S. §3042) and Section 2216 of PA Insurance Company Law, No. 284 (40 P.S. §991.2116).

The Company has reviewed existing monitoring tools and will be taking further action to ensure that Emergency Services are correctly considered and adjudicated in compliance with PA Insurance Company Law, No. 112 (40 P.S. §3042) and Section 2216 of PA Insurance Company Law, No. 284 (40 P.S. §991.2116).

The additional steps for implementation encompass the following:

- *Refresher training for our claim area and supporting units on the requirements of PA Insurance Company Law, No. 112 (40 P.S. §3042) and Section 2216 of PA Insurance Company Law, No. 284 (40 P.S. §991.2116).*
- *Enhancing our internal routing system to specifically identify claims involving Emergency Services and flag them for appropriate review.*
- *Our Quality Assessment Team has also been advised of these findings and will place additional emphasis on Emergency Services to negate future occurrences. Identification of any future issues regarding Emergency Services claims will be communicated and any additional corrective actions necessary will be employed on an immediate basis.*

We believe these additional steps will strengthen the Company's monitoring and compliance with the cited statutes.

4. **The Company must review internal control procedures to ensure compliance with requirements of Section 2166 of the Insurance Company Law of 1921 (40 P.S. §991.2166), relating to prompt payment of provider claims.**

The Company accepts this recommendation. The Company has implemented several initiatives to improve the timeliness of claim processing during and subsequent to the prior exam period. These initiatives have positively impacted our claim turnaround results.

The following is a summary of these initiatives.

Root Cause Analysis Team

The Company's Root Cause Analysis team focuses, on a state by state level, prompt pay and late claim interest compliance. This team consists of selected staff with particular skills and experience in

claim processing. The team conducts root cause analysis of late claims and implements targeted training, policies and process improvements to address any identified causes.

Late Claim Interest Workgroup

A national multi-functional Late Claim Interest workgroup is in place to increase awareness among the various business units of prompt pay and late claim interest requirements and assist in identification and resolution of issues.

Examples of Actions

- *Created daily timeliness report for managers which identifies all clean claims that are approaching the state time frame for payment*
- *Implemented a weekly timeliness call for managers to identify claims at risk of not meeting time frame and determine how to manage the work accordingly*
- *Implemented refresher training for staff*
- *Implemented multiple systems enhancements to improve system functionality*
- *Implemented a web-based interactive training program to educate staff on accurate assignment of claim received date*
- *Simplified the calculation of interest for claim processors*
- *Enhanced process to route correspondence to correct area for processing*

- 5. The Company must review internal control procedures to ensure interest is added to the claim amount as required by Section 2166 of the Insurance Company Law of 1921 (40 P.S. §991.2166). Within 30 days of the Report issue date, the Company must provide to the Insurance Department proof of interest payment on the claim noted in the examination.**

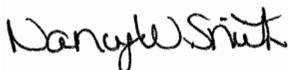
The Company accepts the recommendation and as discussed above, several actions have been employed to ensure interest is added to the claim amount as required under Section 2166 of the PA Insurance Company Law of 1921 (40 P.S. §991.2166). In addition to the actions noted above, the Company has also implemented the following compliance monitoring initiatives:

- *The Inventory Team posts site reports on a daily basis that include company-wide information regarding claims approaching prompt pay timeframes.*
- *Timeliness Root Cause Analysis folder was created to house information on the root causes related to late claim payment; all claim sites have access to and can use this information.*
- *A Segment Late Claim Interest and Penalty SharePoint site houses all prompt pay related meeting minutes, Late Claim Interest and Penalty Reminders, and other useful information.*

The claim interest noted in the examination has been reprocessed. Please refer to the enclosed documentation as proof of the interest payment within 30 days of the Report issue date.

Thank you for providing us with the opportunity to respond to this Report and for the opportunities for open dialogue and correspondence exchange throughout the examination process.

Sincerely,



Nancy W. Smith
Compliance Manager

Enclosure