

**REPORT OF
MARKET CONDUCT EXAMINATION
OF**

AETNA LIFE INSURANCE COMPANY
Hartford, Connecticut

**AS OF
October 5, 2009**

COMMONWEALTH OF PENNSYLVANIA



**INSURANCE DEPARTMENT
BUREAU OF MARKET CONDUCT**

Issued: November 23, 2009

AETNA LIFE INSURANCE COMPANY

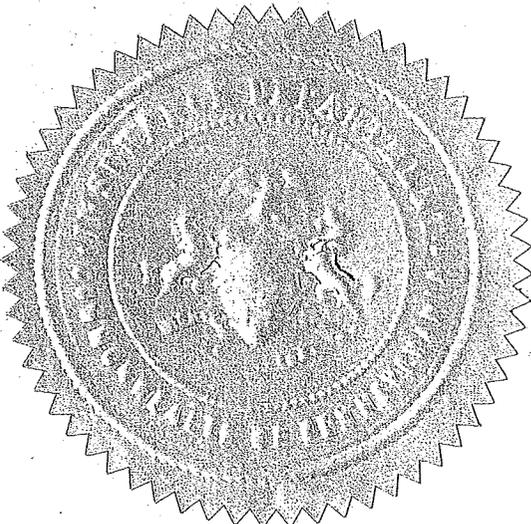
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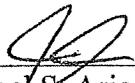
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BEFORE THE INSURANCE COMMISSIONER
OF THE
COMMONWEALTH OF PENNSYLVANIA

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

Aetna Life Insurance Company
Market Conduct Examination as of the
close of business on September 11, 2009

Docket No.
MC09-11-010

ORDER

A market conduct examination of Aetna Life Insurance Company (referred to herein as “Respondent”) was conducted in accordance with Article IX of the Insurance Department Act, 40 P.S. § 323.1, et seq., for the period January 1, 2008 through December 31, 2008. The Market Conduct Examination Report disclosed exceptions to acceptable company operations and practices. Based on the documentation and information submitted by Respondent, the Department is satisfied that Respondent has taken corrective measures pursuant to the recommendations of the Examination Report.

It is hereby ordered as follows:

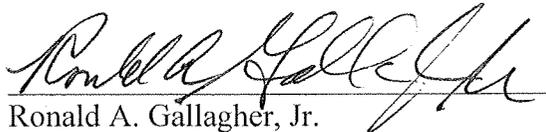
1. The attached Examination Report will be adopted and filed as an official record of this Department. All findings and conclusions resulting from the review of the Examination Report and related documents are contained in the attached Examination Report.
2. Respondent shall comply with Pennsylvania statutes and regulations.

3. Respondent shall comply with the recommendations contained in the attached Report.

4. 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.

The Department, pursuant to Section 905(e)(1) of the Insurance Department Act (40 P.S. § 323.5), will continue to hold the content of the Examination Report as private and confidential information for a period of thirty (30) days from the date of this Order.

BY: Insurance Department of the Commonwealth
of Pennsylvania

 (November 18, 2009)
Ronald A. Gallagher, Jr.
Deputy Insurance Commissioner

I. INTRODUCTION

The Market Conduct Examination was conducted on Aetna Life Insurance Company; hereafter referred to as "Company," at the Company's office located in Blue Bell, Pennsylvania, June 1, 2009, through September 11, 2009. 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.

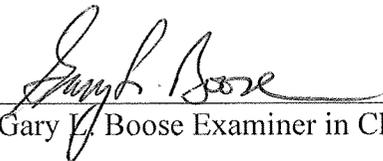
Daniel Stemcosky, AIE, FLMI, MCM
Market Conduct Division Chief

Gary L. Boose, MCM
Market Conduct Examiner

Michael T. Vogel, 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).



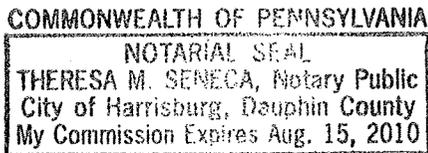
Gary L. Boose Examiner in Charge

Sworn to and Subscribed Before me

This *16* Day of *September*, 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, 2008, through December 31, 2008, 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 operation in areas such as: Advertising, Producer Licensing, Consumer Complaints, Forms, Underwriting Practices and Procedures, Rating and Claim Handling Practices and Procedures.

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 Life Insurance Company ("ALIC") was incorporated in Connecticut in June, 1853.

ALIC was a publicly held corporation until 1967, when all the outstanding shares of its stock were acquired by Aetna Life and Casualty Company ("AL&C") in a share exchange. In 1996, AL&C changed its name to Aetna Services, Inc. ("ASI") and became a wholly owned subsidiary of Aetna Inc., a Connecticut corporation ("Old Aetna"). On October 31, 2000, ASI merged into Old Aetna, and on November 3, 2000 ALIC became a wholly-owned subsidiary of Aetna U.S. Healthcare Inc., a Pennsylvania corporation ("New Aetna"), which was a wholly owned subsidiary of Old Aetna at such time. On December 13, 2000, Old Aetna sold its financial services and international businesses and simultaneously spun-off New Aetna to its shareholders. On the same date, New Aetna was renamed Aetna Inc. Shares of New Aetna are traded on the New York Stock Exchange. ALIC is a for profit stock corporation.

ALIC is licensed as a life and accident and health company in all 50 states.

As of the December 31, 2008, annual statement for Pennsylvania, the Company reported direct premium for ordinary and group life insurance, annuities and deposit type contracts, in the amount of \$74,149,694 and direct premium for accident and health insurance in the amount of \$538,300,650.

IV. ADVERTISING

The Company was requested to provide a copy of the Advertising Certificate of Compliance submitted to the Department for the experience period. The certification was requested to ensure compliance with Title 31, Pennsylvania Code, Section 51.5. Section 51.5 provides that “A company required to file an annual statement which is now or which hereafter becomes subject to this chapter shall file with the Department with its Annual Statement a Certificate of Compliance executed by an authorized officer of the company wherein it is stated that to the best of his knowledge, information and belief the advertisements which were disseminated by the company during the preceding statement year complied or were made to comply in all respects with the provisions of the insurance laws and regulations of this Commonwealth.” No violations were noted.

V. FORMS

The Company was requested to provide a list and copies of all policy and/or member forms, conversion contracts, applications, riders, amendments and endorsements used during the experience period. The forms provided and forms reviewed in various underwriting sections of the exam were reviewed to ensure compliance with Insurance Company Law, Section 354 and Title 18, Pennsylvania Consolidated Statutes, Section 4117(k), Fraud notice.

No violations were noted.

VI. PRODUCER LICENSING

The Company was requested to provide a list of all producers active and terminated during the experience period. Section 671-A (40 P.S. §310.71) of the Insurance Department Act prohibits producers from doing business on behalf of or as a representative of any entity without a written appointment from that entity. Section 641.1-A (40 P.S. §310.41a) of the Insurance Department Act prohibits a company from accepting insurance applications or securing any insurance business through anyone acting without a license. Section 671.1-A (40 P.S. §310.71a) of the Insurance Department Act requires the Company to report all producer terminations to the Department.

The Company provided a list of 9,164 active and terminated producers. A random sample of 100 producers was compared to departmental records of producers to verify appointments, terminations and licensing. In addition, a comparison was made on the individuals identified as producers on applications reviewed in the policy issued sections of the exam.

No violations were noted.

VII. CONSUMER COMPLAINTS

The Company was requested to identify all consumer complaints received during the experience period and provide copies of consumer complaint logs for 2005, 2006, 2007 and 2008. The Company identified 270 consumer complaints received during the experience period. Of the 270 complaints identified, 38 were forwarded from the Department. All 38 complaint files were requested, received and reviewed. The Company provided complaint logs as requested. The Department's list of written consumer complaints that were forwarded to the Company during the experience period was compared to the Company's complaint log.

The complaint files and the 4 years of complaint logs were reviewed for compliance with the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171). Section 5(a)(11) of the Act requires maintenance of a complete record of all complaints received during the preceding four (4) years. The record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of the complaint and the time it took to process each complaint. Written complaint files involving claims were also reviewed for compliance with Title 31, Pennsylvania Code, Section 146.5(b) and 146.5(c), Unfair Claims Settlement Practices.

The following violation was noted:

1 Violation – Title 31, Pennsylvania Code, Section 146.5 Failure to Acknowledge Pertinent Communication

(b) Every insurer, upon receipt of an inquiry from the Department respecting a claim shall, within 15 working days of receipt of the inquiry, furnish the Department with an adequate response to the inquiry.

(c) An appropriate reply shall be made within 10 working days on other pertinent communication from a claimant which reasonably suggest that a response is expected.

The Company response was untimely to the complainant in the file noted.

VIII. UNDERWRITING

The Underwriting review was sorted and conducted in 3 general segments.

- A. Underwriting Guidelines
- B. Medical Conversions Issued
- C. Individual Whole Life Conversions

Each segment was reviewed for compliance with underwriting practices and included forms identification and producer identification. Issues relating to forms or licensing appear in those respective sections of the Report and are not duplicated in the Underwriting portion of the Report.

A. Underwriting Guidelines

The Company was requested to provide all underwriting guidelines and manuals utilized during the experience period. The documentation provided was reviewed to ensure underwriting guidelines were in place and being followed in a uniform and consistent manner and that no underwriting practices or procedures were in place that could be considered discriminatory in nature, or specifically prohibited by statute or regulation. No violations were noted.

The following guidelines were reviewed:

- 1. Medical Underwriting Manual
 - A. Nervous (System)
 - B. Cardiovascular
 - C. Eye & Ear
 - D. Gastrointestinal
 - E. Genitourinary

- F. Endocrine
- G. Miscellaneous
- H. Respiratory
- I. Musculoskeletal
- J. Manual Revisions/Life Guidelines
- K. Conditions by Name
- L. Pictures & Diagrams
- M. Debits
- N. Resources

2. Underwriting Manuals

- A. Pennsylvania Small Group Underwriting Guidelines
 - 14.92.839.1-PA D (12/07)
 - 14.02.930.1-PA-E (12/08)
- B. SRC* New Business Underwriting Guidelines
- C. Financial Underwriting Guidelines
- D. Financial Underwriting Guidelines (Large Group)

* - Strategic Resource Company or SRC is a wholly-owned subsidiary of Aetna and is a third party administrator and sales organization with a long history of administering so-called group "limited benefit" plans on behalf of various insurance companies. Apart from certain run-out business, it only provides services exclusively for Aetna plans since being acquired in January of 2005.

The manuals were reviewed to ensure underwriting guidelines were in place and being followed in a uniform and consistent manner and no underwriting practices or procedures were in place that could be considered discriminatory in nature, or specifically prohibited by statute or regulation. No violations were noted.

B. Medical Conversions Issued

The Company was requested to provide a list of all conversion policies issued during the experience period. The Company identified a list of 13 medical conversion policies issued. All 13 policy files were requested, received and reviewed. The policy files were reviewed to determine compliance to issuance and underwriting. No violations were noted.

C. Individual Whole Life Conversions

The Company identified a universe of 84 individual whole life conversion policies issued during the experience period. A random sample of 25 files was requested, received and reviewed. The files were reviewed to determine compliance to issuance and underwriting statutes and regulations. No violations were noted.

IX. INTERNAL AUDIT & COMPLIANCE PROCEDURES

The Company was requested to provide copies of their internal audit and compliance procedures. The audits and procedures were reviewed to ensure compliance with Insurance Company Law, Section 405-A (40 P.S. §625-5). Section 405-A provides for the establishment and maintenance of internal audit and compliance procedures which provides for the evaluation of compliance with all statutes and regulations dealing with sales methods, advertising, and filing and approval requirements for life insurance and annuities. The procedures shall also provide for the following:

- (1) Periodic reviews of consumer complaints in order to determine patterns of improper practices.
- (2) Regular reporting to senior officers and the board of directors or an appropriate committee thereof with respect to any significant findings.
- (3) The establishment of lines of communication, control and responsibility over the dissemination of advertising and promotional materials, including illustrations and illustration explanations, with the requirement that such materials shall not be used without the approval by company employees whose compensation, other than generally applicable company bonus or incentive plans, is not directly linked to marketing or sales.
- (4) The laws requires that each insurer shall make available for the Department's inspection upon request its internal audit and compliance procedures which are instituted as required by this section.

No violations were noted.

X. 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 claims during the experience period. The Company provided the following claim manuals:

1. Long Term Care (LTD) Claims Procedures
2. Short Term Disability (STD) Claim Procedures
3. Group Life Claims Manual
4. Pharmacy Claims Manual
5. Medical Claims Manual

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.

The claim file review consisted of 9 areas:

- A. Group Life Claims
- B. Life Conversion Claims
- C. Long Term Disability Claims
- D. Short Term Disability Claims
- E. Long Term Care Claims
- F. Dental Claims
- G. Medical Claims
- H. Prescription Claims
- I. Vision Claims

All claim files sampled were reviewed for compliance with requirements of the Unfair Insurance Practices Act, No. 205 (40 P.S. §1171) and Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

A. Group Life Claims

The Company was requested to provide a list of claims received during the experience period. The Company identified a universe of 1,529 group life claims received. A sample of 50 group life claims was requested, received and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 and Insurance Company Law, Section 411B, Payment of Interest (40 P.S. §511b). The following violations were noted:

4 Violations - Title 31, Pennsylvania Code, Section 146.5

Every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. The Company failed to acknowledge the 4 claims noted within 10 working days.

7 Violations - Title 31, Pennsylvania Code, Section 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay

and state when a decision on the claim may be expected. The Company failed to provide a timely status letter within 30 days for the 7 claims noted.

3 Violations - Title 31, Pennsylvania Code, Section 146.7

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the insurer shall advise the first-party claimant of the acceptance or denial of the claim. The Company failed to provide notice of acceptance or denial within 15 working days for the 3 claims noted.

B. Life Conversion Claims

The Company was requested to provide a list of claims received during the experience period. The Company identified 76 conversion life claims received. A sample of 25 life conversion claims was requested, received and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146 and Insurance Company Law, Section 411B, Payment of Interest (40 P.S. §511b). The following violations were noted:

1 Violation - Title 31, Pennsylvania Code, Section 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to provide a timely status letter for the claim noted.

C. Long Term Disability Claims

The Company was requested to provide a list of claims received during the experience period. The Company identified a universe of 378 long term disability claims. A random sample of 25 claims was requested, received and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. The following violations were noted:

1 Violation - Title 31, Pennsylvania Code, Section 146.5

Every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such period. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. The Company failed to acknowledge the 4 claims noted within 10 working days.

1 Violation - Title 31, Pennsylvania Code, Section 146.6

Every insurer shall complete investigation of a claim within 30 days after notification of a claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected. The Company failed to provide a timely status letter within 30 days for the claim noted.

1 Violation - Title 31, Pennsylvania Code, Section 146.7

Within 15 working days after receipt by the insurer of properly executed proofs of loss, the insurer shall advise the first-party claimant of the acceptance or denial of the claim.

The Company failed to provide notice of acceptance or denial within 15 working days for the claim noted.

D. Short Term Disability Claims

The Company was requested to provide a list of claims received during the experience period. The Company identified a universe of 1,346 short term disability claims. A random sample of 25 claims was requested, received and reviewed. The claim files were reviewed for compliance with Title 31, Pennsylvania Code, and Chapter 146. No violations were noted.

E. Long Term Care Claims

The Company was requested to provide a list of claims received during the experience period. The Company identified a universe of 6 long term care claims. All 6 claims were requested. Five files were outside the scope of the examination and not provided for review; therefore, 1 file was received and reviewed. The file provided was reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. No violations were noted.

F. Dental Claims

The Company was requested to provide a list of claims received during the experience period. The Company identified 142,731 dental claims received. A random sample of 25 claims was requested, received and reviewed. The claim files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims and the insured submitted claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. The following violation was noted:

1 Violation - Title 31, Pennsylvania Code, Section 146.5

Every insurer, upon receiving notification of a claim, shall within ten working days, acknowledge the receipt of such notice unless payment is made within such period of time. If an acknowledgement is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. The Company failed to acknowledge the claim noted within 10 working days.

G. Medical Claims

The Company was requested to provide a list of claims received during the experience period. The Company identified 80,557 medical claims received. A random sample of 50 claims was requested, received and reviewed. The claim files were reviewed to ensure that the Company's claims adjudication process was adhering to the provisions of the policy contract, as well as complying with pertinent state insurance laws and regulations. The following violations were noted:

2 Violations – Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of 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. The 2 clean claims noted were not paid within 45 days of receipt.

H. Prescription Claims

The Company was requested to provide a list of claims received during the experience period. The Company identified 70,386 prescription claims received. A random sample of 25 claims was requested, received and reviewed. The provider submitted claim files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims and the insured submitted claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. No violations were noted.

I. Vision Claims

The Company was requested to provide a list of claims received during the experience period. The Company identified 10,728 vision claims received. A random sample of 25 claims was requested, received and reviewed. The provider submitted claim files were reviewed for compliance with Insurance Company Law of 1921, Section 2166 (40 P.S. §991.2166), Prompt Payment of Claims and the insured submitted claim files were reviewed for compliance with Title 31, Pennsylvania Code, Chapter 146. No violations were noted.

XI. 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 Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.
2. The Company must review 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.

XII. COMPANY RESPONSE



Aetna Life Insurance
Company
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Blue Bell, PA 19422

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November 4, 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: 09-M24-004
Response to Report of Examination of Aetna Life Insurance Company**

Dear Mr. Stemcosky,

This letter is in response to the Pennsylvania Insurance Department's (Department's) report of examination dated October 5, 2009 regarding the market conduct examination of Aetna Life Insurance Company. The exam focused on the Company's operation in areas such as: Advertising, Producer Licensing, Consumer Complaints, Forms, Underwriting Practices and Procedures, Rating, and Claim Handling Practices and Procedures.

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

1. The Company must review internal control procedures to ensure compliance with requirements Title 31, Pennsylvania Code, Chapter 146, Unfair Claims Settlement Practices.

The Company accepts this recommendation and will review its internal control procedures and revise as necessary to ensure ongoing compliance.

2. The Company must review procedures to ensure compliance with requirements of Section 2166 of the Insurance Company Law of 1921 (40 P.S. § 991.216), relating to prompt payment of provider claims.

The Company accepts this recommendation. The Company has initiated refresher training for the claim processors who handled the two sample claims associated with these findings. In addition, the Company's Root Cause Analysis team continues to focus on prompt pay and late claim interest compliance at a state-specific level. 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.

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

Sincerely,

Nancy W. Smith
Compliance Manager