

DELAWARE DEPARTMENT OF INSURANCE
MARKET CONDUCT EXAMINATION REPORT

Aetna Health Inc. (a Pennsylvania corporation)
NAIC #95109

980 Jolly Rd.
Blue Bell, PA 19422

As of

June 30, 2012

Karen Weldin Stewart, CIR-ML
Commissioner



Delaware Department of Insurance

I, Karen Weldin Stewart, Insurance Commissioner of the State of Delaware, do hereby certify that the attached REPORT ON EXAMINATION, made as of June 30, 2012 on

AETNA HEALTH INC. (A PENNSYLVANIA CORPORATION)

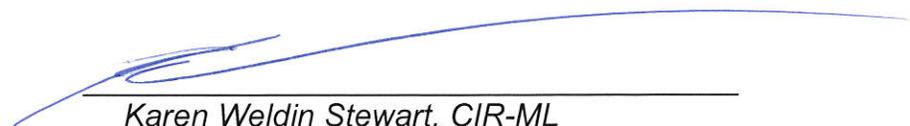
is a true and correct copy of the document filed with this Department.

Attest By:

A handwritten signature in blue ink, appearing to be "Karen Stewart", written over a horizontal line.



In Witness Whereof, I have hereunto set my hand and affixed the official seal of this Department at the City of Dover.



Karen Weldin Stewart, CIR-ML
Insurance Commissioner

Karen Weldin Stewart, CIR-ML
Commissioner



Delaware Department of Insurance

REPORT ON EXAMINATION
OF THE
AETNA HEALTH INC. (A PENNSYLVANIA CORPORATION)
AS OF
June 30, 2012

The above-captioned Report was completed by examiners of the Delaware Department of Insurance.

Consideration has been duly given to the comments, conclusions and recommendations of the examiners regarding the status of the Company as reflected in the Report.

This Report is hereby accepted, adopted and filed as an official record of this Department.

A handwritten signature in blue ink, appearing to read "Karen Weldin Stewart", written over a horizontal line.

Karen Weldin Stewart, CIR-ML
Insurance Commissioner

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Honorable Karen Weldin Stewart CIR-ML
Insurance Commissioner
State of Delaware
841 Silver Lake Boulevard
Dover, Delaware 19904

Dear Commissioner Stewart:

In compliance with the instructions contained in Certificate of Examination Authority Number 95109-12-C-1, and pursuant to statutory provisions including 18 Del. C. §318-322, a market conduct examination has been conducted of the affairs and practices of:

Aetna Health Inc. (a Pennsylvania corporation)

Aetna Health Inc. (a Pennsylvania corporation) or AHI-PA is a Pennsylvania domestic for profit Health Maintenance Organization (HMO). AHI-PA was incorporated on May 7, 1981. The examination consisted of two phases, an on-site phase and an off-site phase. The on-site phase of the examination was conducted at the following Company location:

980 Jolly Rd.
Blue Bell, PA 19422

The off-site examination phase was performed at the offices of the Delaware Department of Insurance, hereinafter referred to as the "Department" or "DDOI," or other suitable locations.

The report of examination herein is respectfully submitted.

EXECUTIVE SUMMARY

Aetna Health Inc. (a Pennsylvania corporation) or AHI-PA is a Pennsylvania domestic for profit Health Maintenance Organization (HMO). AHI-PA was incorporated on May 7, 1981. The Company's legal home office and principal executive office address is 980 Jolly Road, Blue Bell, Pennsylvania, 19422.

As of their December 31, 2011, annual statement for the State of Delaware, AHI-PA reported individual health premiums earned in the State of Delaware in the amount of \$28,098 and group health premiums earned in the State of Delaware in the amount of \$42,770,997.

The scope of the examination included the review of the Company's practices and procedures relating to Chiropractor Claims and Complaints handling, as well as the practices, policies and procedures with regards to the chiropractor claims administered by the Company's Third Party Administrator, American Specialty Health Network (ASHN).

The following exceptions were noted in the areas of operation reviewed:

- 3 Exceptions - 18 Del. C. §2304. 18 Del. C. §2304. Unfair Methods Of Competition And Unfair Or Deceptive Acts Or Practices Defined.
- 29 Exceptions – 18 Del. Admin. Code 902 §1.2.1.3. Unfair Claim Settlement Practices - Failure to implement prompt investigation of claims arising under insurance policies within 10 working days upon receipt of the notice of loss by the insurer.
- 25 Exceptions -18 Del. Admin. Code 1310 § 6.0. Processing of Clean Claim - Failure to pay the total allowed amount of the clean claim within 30 days of receipt.
- 8 Exceptions - 24 Del. C. § 716. Chiropractic practitioners eligible for compensation from insurance - Failure to pay copayment or coinsurance equal to or less than 25% of the fee due or to be paid to the doctor of chiropractic under the policy for the treatment, therapy, or service provided.

No other exceptions were noted in the areas of operations reviewed.

SCOPE OF EXAMINATION

The Market Conduct Examination was conducted pursuant to the authority granted by 18 Del. C. §§318-322 and covered the experience period of January 1, 2010 through June 30, 2012, unless otherwise noted. The purpose of the examination was to determine compliance by the Company with Delaware insurance laws and regulations related the Company's Chiropractor Claims and Complaints handling.

The examination was a target market conduct examination of the Company's chiropractor business in the following areas of operation: Company Operations & Management; Claims Handling, Complaints Handling and Grievance & Appeals Handling. The exam also reviewed the practices, policies and procedures with regards to the chiropractor claims administered by the Company's Third Party Administrator, American Specialty Health Network (ASHN).

METHODOLOGY

This examination was performed in accordance with Market Regulation standards established by the Department and examination procedures suggested by the NAIC. While the examiners' report focuses on the errors found in individual files, the examination also focuses on general business practices of the Company.

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.

Delaware Market Conduct Examination Reports generally note only those items, to which the Department, after review, takes exception. An exception is any instance of Company activity that does not comply with an insurance statute or regulation. Exceptions 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 exceptions identified during the examination and review written summaries provided on the exceptions found.

COMPANY HISTORY AND PROFILE

Aetna Health Inc. (a Pennsylvania corporation) or AHI-PA is a Pennsylvania domestic for profit health maintenance organization with a d/b/a in the Commonwealth of Pennsylvania of Aetna Better Health Kids. AHI-PA was incorporated on May 7, 1981 and its legal home office address and its principal executive office address is 980 Jolly Road, Blue Bell, Pennsylvania, 19422. AHI-PA is a wholly-owned subsidiary of Aetna Health Holdings, LLC, a Delaware limited liability company, whose ultimate parent is Aetna Inc.

AHI-PA is licensed as a Health Maintenance Organization (HMO) in 19 states and markets both HMO contracts and Point of Service (POS) contracts.

As of their December 31, 2011 annual statement for the State of Delaware, AHI-PA reported individual health premiums earned in the State of Delaware in the amount of \$28,098 and group health premiums earned in the State of Delaware in the amount of \$42,770,997.

COMPANY OPERATIONS AND MANAGEMENT

A. Internal Audits-ASHN

The Company was requested to provide a narrative statement explaining the internal control methods and audits used to assure compliance with Delaware Insurance Laws and the Company's established policies and procedures with regards to chiropractor claims administered by American Specialty Health Network (ASHN). The Company was also requested to provide a list of all internal audits performed in the last five years on American Specialty Health Network.

The Company provided the following Policy and Reports:

1. NCO Delegation and Contract Audit/Oversight Policy
2. National Delegation Management Oversight Policy
3. A list of 5 Audit Reports
4. 3 Audit Reports.

The internal audit policy and reports were reviewed to ensure that the Company had internal control methods and audits were in place to ensure compliance with Delaware Insurance Laws and the Company's established policies and procedures.

No exceptions were noted.

B. Contractual Agreements

The Company was requested to provide a copy of the contract(s) including the effective date between the applicable Aetna companies and American Specialty Health Network (ASHN).

The Company provided the following contractual agreements:

1. Master Agreement – American Specialty Health Network, Inc. - Effective Date: 05/01/2006.
2. First Amendment To The National. Provider Agreement – July 02, 2011.
3. American Specialty Health Network, Inc. Effective July 1, 2011 - National Provider Agreement
4. Third Amendment To The National Provider Agreement Dated July 01, 2011 Effective Date: December 1, 2011
5. American Specialty Health Network, Inc. May 1, 2006 - Delegated Claims Agreement.
6. Delegated Claims Agreement - American Specialty Health Network, Inc. May 1, 2006.
7. Delegated Patient Management Agreement – American Specialty Health Network, Inc. - Effective Date: 05/01/2006.
8. American Specialty Health Network, Inc. Chiropractic Provider Services Agreement.
9. January 2010 Amendment to Chiropractic Provider Services Agreement.
10. Attachment 1 – Delaware. Chiropractic Provider Services Agreement State Specific ASH Network Payor and/or Regulatory Contractual Requirements – 01/01/2010.
11. January 2011 Amendment to Chiropractic Provider Services Agreement.
12. Aetna (Benefit Plan) Effective 12/1/11.
13. American Specialty Health Network, Inc. Chiropractor Provider Services Agreement – 01/01/2011.
14. Provider Agreement – Printed: 2/24/10.

The contracts and agreements were reviewed for compliance with Delaware Insurance Laws and the Company's established policies and procedures.

No exceptions were noted.

CLAIMS

A. Claims Handling Procedures

The Company was requested to provide copies of all procedural guidelines including all manuals, and any correspondence or instructions used for processing claims, by

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American Specialty Network (ASHN), during the experience period of January 1, 2010 through June 30, 2012.

The Company provided the following manuals and flow charts:

- ASH Network Claims Procedure Manual for late interest calculations
- ASH and Aetna In-Network Eligibility Verification Process (A) – Flow Chart
- BTS Claim & Correspondence Intake End-to-End Process Flow – Flow Chart
- ASH Network Complete Procedure Manual
- Aetna Out-of-network eligibility verification procedure

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 exceptions were noted.

B. HMO Paid Claims

The Company was requested to provide a list of all chiropractor claims paid during the experience period of January 1, 2010 through June 30, 2012. The Company identified a universe of 123 chiropractor claims paid during the experience period. A random sample of 50 claim files was requested, received and reviewed. The files were reviewed for compliance with 18 Del. Admin. Code 902, 18 Del. Admin. Code 1310, and 24 Del. C. § 716. The following exceptions were noted:

5 Exceptions – 18 Del. Admin. Code 902 §1.2.1.3 Unfair Claim Settlement Practices.

Failing to implement prompt investigation of claims arising under insurance policies within 10 working days upon receipt of the notice of loss by the insurer.

The Company failed to investigate five claims within 10 working days upon receipt.

Recommendation: It is recommended that the Company review its procedures to ensure that all claims are investigated within 10 working days upon receipt as required by 18 Del. Admin. Code 902 §1.2.1.3.

1 Exception - 24 Del. C. § 716. Chiropractic practitioners eligible for compensation from insurance.

(a) For purposes of disability insurance, standard health and accident, sickness, and all other such insurance plans, whether or not they be considered insurance policies, and contracts issued by health service corporations and health maintenance organizations, if the chiropractor is authorized by law to perform a particular service, the chiropractor

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shall be entitled to compensation for that chiropractor's services under such plans and contracts.

(b) Nothing in this section shall prevent the operation of reasonable and nondiscriminatory cost containment or managed care provisions, including but not limited to, deductibles, coinsurance, allowable charge limitations, coordination of benefits and utilization review. Any copayment or coinsurance amount shall be equal to or less than 25% of the fee due or to be paid to the doctor of chiropractic under the policy, contract, or certificate for the treatment, therapy, or service provided.

The copayment amount in one file exceeded 25% of the fee due to the doctor of chiropractic for the service provided.

Recommendation: It is recommended that the Company review its procedures to ensure any copayment or coinsurance amounts charged are equal to or less than 25% of the fee due as required by 24 Del. C. § 716.

C. CBR Paid Claims

The Company was requested to provide a list of all chiropractor claims paid during the experience period of January 1, 2010 through June 30, 2012. The Company identified a universe of 50 chiropractor (CBR) Claims Based Reimbursement claims paid during the experience period. All 50 claim files were requested, received and reviewed. The files were reviewed for compliance with 18 Del. Admin. Code 902 and 18 Del. Admin. Code 1310. The following exceptions were noted:

9 Exceptions -18 Del. Admin. Code 1310 § 6.0 Processing of Clean Claim

6.1 No more than 30 days after receipt of a clean claim from a provider or policyholder, a carrier shall take one of the following four actions:

6.1.1 if the entire claim is deemed payable, pay the total allowed amount of the claim;

The Company failed to pay nine clean claims within 30 calendar days after receipt.

Recommendation: It is recommended that the Company review its procedures to ensure that all clean claims are paid no more than 30 days after receipt as required by 18 Del. Admin. Code 1310 § 6.0.

7 Exceptions - 24 Del. C. § 716. Chiropractic practitioners eligible for compensation from insurance.

(a) For purposes of disability insurance, standard health and accident, sickness, and all other such insurance plans, whether or not they be considered insurance policies, and contracts issued by health service corporations and health maintenance organizations, if the chiropractor is authorized by law to perform a particular service, the chiropractor shall be entitled to compensation for that chiropractor's services under such plans and contracts.

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(b) Nothing in this section shall prevent the operation of reasonable and nondiscriminatory cost containment or managed care provisions, including but not limited to, deductibles, coinsurance, allowable charge limitations, coordination of benefits and utilization review. Any copayment or coinsurance amount shall be equal to or less than 25% of the fee due or to be paid to the doctor of chiropractic under the policy, contract, or certificate for the treatment, therapy, or service provided.

The copayment amount in seven claim files exceeded 25% of the fee due to the doctor of chiropractic for the service provided.

Recommendation: It is recommended that the Company review its procedures to ensure that copayment or coinsurance amounts charged are equal to or less than 25% of the fee due as required by 24 Del. C. § 716.

D. HMO Denied Claims

The Company was requested to provide a list of all chiropractor claims denied during the experience period of January 1, 2010 through June 30, 2012. The Company identified universe of 94 chiropractor denied claims. A random sample of 50 claim files was requested, received and reviewed. The files were reviewed for compliance with 18 Del. Admin. Code 902, 18 Del. Admin. Code 1310 and 24 Del. C. § 716. The following exceptions were noted:

3 Exceptions 18 Del. C. §2304. Unfair Methods Of Competition And Unfair Or Deceptive Acts Or Practices Defined.

*(16) Unfair claim settlement practices. -- No person shall commit or perform with such frequency as to indicate a general business practice any of the following:
b. Failing to acknowledge and act reasonably promptly upon communication with respect to claims arising under insurance policies;*

The Company failed to acknowledge three claims within 30 working days upon receipt.

Recommendation: It is recommended that the Company review its procedures to ensure that all claims are acknowledged within 15 working days upon receipt as required by 18 Del. C. §2304.

24 Exceptions – 18 Del. Admin. Code 902 §1.2.1.3 Unfair Claim Settlement Practices.

Failing to implement prompt investigation of claims arising under insurance policies within 10 working days upon receipt of the notice of loss by the insurer.

The Company failed to investigate twenty four claims within 10 working days upon receipt.

Recommendation: It is recommended that the Company review its procedures to ensure that all claims are investigated within 10 working days upon receipt as required by 18 Del. Admin. Code 902 §1.2.1.3.

16 Exceptions - 18 Del. Admin Code 1310 § 6.0 Processing of Clean Claim

6.1 No more than 30 days after receipt of a clean claim from a provider or policyholder, a carrier shall take one of the following four actions:

6.1.3 if the entire claim is deemed not payable, specifically notify the provider or policyholder in writing why the claim will not be paid;

The Company failed to provide notice of claim denial within 30 days after receipt of sixteen claims.

Recommendation: It is recommended that the Company review its procedures to ensure that all clean claims deemed not payable are denied no more than 30 days after receipt as required by 18 Del. Admin. Code 1310 § 6.0.

E. CBR Denied Claims

The Company was requested to provide a list of all chiropractor claims denied during the experience period of January 1, 2010 through June 30, 2012. The Company identified a universe of four (4) chiropractor CBR (Claims Based Reimbursement) claims denied during the experience period. All four (4) claim files were requested, received and reviewed. The files were reviewed for compliance with 18 Del. Admin. Code 902.

No exceptions were noted.

FORMS

The Company was requested to provide a list of all individual/group policy, certificate forms, conversion contracts, applications, amendments and endorsements used during the experience period of January 1, 2010 to June 30, 2012, for newly issued Health Coverage in Delaware. The list was to include the form number, descriptive name and the Delaware filing/approval date. The Company provided a list of seventy five forms. The list of forms was reviewed to ensure compliance with 18 Del. C. §2712, Filing, approval of forms.

No exceptions were noted.

CONSUMER COMPLAINTS

A. Complaint Handling Procedures-ASHN

The Company was requested to provide a copy of the Company's Consumer/Provider Complaint Handling guidelines and/or procedures, regarding complaints received for chiropractor related services including the Company's complaint handling procedures for complaints submitted to American Specialty Health Network (ASHN).

The Company provided the following Policy and Procedures:

1. Practitioner/Provider Complaint Procedures – Effective: June 1, 2009
2. Practitioner/Provider Complaint Procedures – Effective: January 11, 2012
3. Practitioner/Provider Complaint Procedures – Effective: August 17, 2010
4. Practitioner/Provider Complaint and Appeal Resolution Policy – 6/25/08
5. Practitioner/Provider Complaint and Appeal Resolution Policy – Effective: January 1, 2012
6. Practitioner/Provider Complaint and Appeal Resolution Policy – Effective: August 17, 2010
7. Practitioner/Provider Complaint And Appeal Resolution Policy – Effective: June 1, 2009

The policy and procedures were reviewed to ensure that the Company had complaint procedures in place and that the Company was in compliance with 18 Del. C. §2304 (17) Failure to maintain complaint handling procedures.

No exceptions were noted.

B. Direct Consumer Chiropractor Complaints

The Company was requested to provide a list of all chiropractor related complaints received from Delaware consumers and claimants during the experience period of January 1, 2010 through June 30, 2012. The Company did not identify any chiropractor related complaints received during the experience period.

Complaints are reviewed for compliance with 18 Del. C. §2304 (17). This Section of the Code requires maintenance of a complete record of all complaints received since the date of its last examination. 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. Any written complaint files involving claims are also reviewed for compliance with 18 Del. Admin. Code 902 §1.2.1.2.

No exceptions were noted.

C. Consumer Chiropractor Complaints-Department of Insurance

The Company was requested to provide a list of all chiropractor related complaints referred through the Department of Insurance during the experience period of January 1, 2010 through June 30, 2012. The Company did not identify any chiropractor related complaints received during the experience period.

Complaints are reviewed for compliance with 18 Del. C. §2304 (17). This Section of the Code requires maintenance of a complete record of all complaints received since the date of its last examination. 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. Any written complaint files involving claims are also reviewed for compliance with 18 Del. Admin. Code 902 §1.2.1.2.

No exceptions were noted.

GRIEVANCE AND APPEALS

A. Grievance and Appeals Procedures

The Company was requested to provide a copy of the Company's Appeal and Grievances procedures regarding adverse determinations of chiropractor related claims.

The Company provided the following Policy and Procedures:

1. Practitioner/Provider Complaint and Appeal Resolution Policy – 6/25/08
2. Practitioner/Provider Complaint and Appeal Resolution Policy – Effective Date: January 1, 2012
3. Practitioner/Provider Complaint and Appeal Resolution Policy – Effective Date: August 17, 2010
4. Practitioner/Provider Complaint And Appeal Resolution Policy – Effective Date: June 1, 2009

The policy and procedures were reviewed to ensure that the Company had grievance procedures in place, and that the Company was in compliance with 18 Del. C. §332.

No exceptions were noted.

B. Grievance and Appeals

The Company was requested to provide a list of chiropractor related grievances/appeals received from Delaware consumers and claimants during the experience period of January, 1, 2010 through June 30, 2012. The Company identified three (3) appeals received during the experience period. All three appeals files were requested, received and reviewed. The files were reviewed for compliance with 18 Del. C. §332.

No exceptions were noted.

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CONCLUSION

The recommendations made below identify corrective measures the Department finds necessary as a result of the Exceptions noted in the Report. Location in the Report is referenced in parenthesis.

2.	It is recommended that the Company review its procedures to ensure compliance with the prompt investigation of claims requirements of 18 Del. Admin. Code 902 §1.2.1.3. Unfair Claim Settlement Practices. (HMO Paid Claims)
3.	It is recommended that the Company review its procedures to ensure compliance with the copayment or coinsurance charge requirements of 24 Del. C. § 716. Chiropractic practitioners eligible for compensation from insurance (HMO Paid Claims)
5.	It is recommended that the Company review its procedures to ensure compliance with the prompt payment of clean claim requirements of 18 Del. Admin Code 1310 § 6.0. Processing of Clean Claim. (CBR Paid Claims)
6.	It is recommended that the Company review its procedures to ensure compliance with the copayment or coinsurance charge requirements of 24 Del. C. § 716. Chiropractic practitioners eligible for compensation from insurance (CBR Paid Claims)
7.	It is recommended that the Company review its procedures to ensure compliance with the claim acknowledgement requirements of 18 Del. C. §2304. (HMO Denied Claims)
8.	It is recommended that the Company review its procedures to ensure compliance with the prompt investigation of claims requirements of 18 Del. Admin. Code 902 §1.2.1.3. Unfair Claim Settlement Practices. (HMO Denied Claims))
9.	It is recommended that the Company review its procedures to ensure compliance with the prompt payment of clean claim requirements of 18 Del. Admin Code 1310 § 6.0. Processing of Clean Claim. (HMO Denied Claims)

The examination conducted by Daniel Stemcosky, Frank Kyazze and Heather Harley is respectfully submitted.



Frank W. Kyazze, MCM, CIE, FLMI, ALHC
Examiner-in-Charge
Market Conduct
Delaware Department of Insurance