

**MARKET CONDUCT EXAMINATION REPORT
PROMPT PAY**

of

AETNA HEALTH INC.

as of

June 30, 2006

I, Matthew Denn, Insurance Commissioner of the State of Delaware, do hereby certify that the attached REPORT ON MARKET CONDUCT EXAMINATION, made as of JUNE 30, 2006 of the

**AETNA HEALTH INC.
PROMPT PAY**

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

ATTEST BY:

Antoinette Handy

DATE: 26 JUNE 2007



In Witness Whereof, I HAVE HEREUNTO SET MY HAND AND AFFIXED THE OFFICIAL SEAL OF THIS DEPARTMENT AT THE CITY OF DOVER, THIS 26TH DAY OF JUNE 2007.

Matthew Denn

Insurance Commissioner

REPORT ON MARKET CONDUCT PROMPT PAY EXAMINATION
OF THE
AETNA HEALTH INC.
AS OF
JUNE 30, 2006

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

Consideration has duly been 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 black ink, appearing to read "Matt Denn", written over a horizontal line.

MATTHEW DENN
INSURANCE COMMISSIONER

DATED this 26TH day of JUNE, 2007.

| | |
|--|----|
| EXECUTIVE SUMMARY | 2 |
| HISTORY AND PROFILE | 3 |
| METHODOLOGY | 4 |
| A. COMPANY OPERATIONS/MANAGEMENT | 5 |
| B. COMPLAINTS/GRIEVANCES | 5 |
| C. MARKETING AND SALES | 5 |
| D. NETWORK ADEQUACY | 5 |
| E. PRODUCER LICENSING..... | 5 |
| F. POLICYHOLDER SERVICE..... | 5 |
| G. UNDERWRITING AND RATING | 5 |
| H. CLAIMS | 5 |
| Prompt Payment Standard 1 | 7 |
| Prompt Payment Standard 2 | 7 |
| Prompt Payment Standard 3 | 8 |
| Prompt Payment Standard 4 | 9 |
| Prompt Payment Standard 5 | 11 |
| Prompt Payment Standard 6 | 12 |
| Prompt Payment Standard 7 | 14 |
| SUMMARY | 14 |
| LIST OF RECOMMENDATIONS | 14 |
| CONCLUSION..... | 15 |

May 4, 2007

Honorable Matthew Denn
Insurance Commissioner
State of Delaware
841 Silver Lake Boulevard
Dover, Delaware 19904

Dear Commissioner Denn:

In compliance with instructions contained in Certificate of Examination Authority Number 06.725, and pursuant to statutory provisions, a limited scope, single state, target market conduct examination has been conducted of the affairs and practices of:

Aetna Health Inc.

hereinafter referred to as the "Company." The Company is incorporated under the laws of the State of Delaware. This examination reviewed the operations of the Company as they impact residents, policyholders, providers, and members residing in the State of Delaware or serving Delaware members of the Company. This examination focused on compliance with Delaware requirements for prompt, fair, and equitable settlement of claims for health care services.

This report is as of June 30, 2006. It covers the period from January 1, 2006 through June 30, 2006.

The report of examination thereon is respectfully submitted.

EXECUTIVE SUMMARY

This executive summary addresses areas of concern identified as a result of the examination team's review of the Company's performance measured against the seven (7) examination standards authorized by Certificate of Examination Authority Number 06.725. The examination standards are based on NAIC methodology. The scope of the market conduct examination was limited to verification of compliance with 18 Del. Admin. Code 1310 Standards for Prompt, Fair and Equitable Settlement of Claims for Health Care Services [Formerly Regulation 80].

The principal focus for this examination was compliance with the Delaware insurance laws related to prompt, fair and equitable settlement of claims for health care services. The standards and work plan utilized in this examination were approved by the Delaware Insurance Department.

This target examination tested for compliance with the provisions of 18 Del. Admin. Code 1310, relating to the timely, fair, and equitable payment of clean claims. The issues generating this examination include complaints from a number of providers concerning untimely payment of claims and claim denials.

Prompt Payment Standards 1-7: The examiners found three (3) areas of concern resulting in failure of the Company to comply with Standards 3, 4 and 6. The issues identified were:

- In some cases, clean claims were not processed within 30 calendar days of receipt, constituting non-compliance with 18 Del. Admin. Code 1310 § 6.1.

- In some cases, claims were not processed within 15 calendar days following receipt of requested information, constituting non-compliance with 18 Del. Admin. Code 1310 § 6.1.
- Due to a data entry error on the provider contract, several claims for one provider group were underpaid by 90%, constituting non-compliance with 18 Del. Admin. Code 1310 § 6.1.1. The Company discovered the error and made corrections. However, the error resulted in delays in payment for the corrected amounts.

HISTORY AND PROFILE

The Company was incorporated in Delaware on October 15, 1985 as U.S. Healthcare, Inc.

On June 20, 1997, the Company changed its name from U.S. Healthcare, Inc. to Aetna U.S. Healthcare Inc. On May 14, 1998, the Company changed its name to Aetna U.S. Healthcare Inc. (DE). On March 8, 2002, the Company changed its name to Aetna Health Inc. (DE) and on July 12, 2002, the Company changed its name to Aetna Health Inc., the Company's current name.

Effective September 30, 2003, the Company's sole shareholder, Aetna, contributed all of the capital stock of the Company to Aetna Health Holdings, LLC, a Delaware limited liability company, whose ultimate parent is Aetna Inc. ("Aetna").

The Company's home office and principal executive office address is 980 Jolly Road, P.O. Box 1109, Blue Bell, Pennsylvania 19422.

The management structure of the Company has remained stable throughout the period of examination.

METHODOLOGY

This examination is based on standards approved by the Department, which are based on applicable Delaware Statutes, Rules, and Regulations as referenced herein and testing based on the NAIC methodology.

Some standards are measured using a single type of review, while others use a combination of the types of review. The types of review used in an examination fall into three general categories. The types of review are Generic, Sample, and Electronic.

A "Generic" review indicates that a standard was tested through an analysis of general data gathered by the examiner, or provided by the examinee in response to queries by the examiner.

A "Sample" review indicates that a standard was tested through direct review of a random sample of files using sampling methodology described in the NAIC Market Conduct Examiners Handbook.

An "Electronic" review indicates that a standard was tested through use of a computer program or routine applied to a download of computer records of the examinee. This type of review typically reviews 100% of the records of a particular type.

Standards were evaluated using tests designed to adequately determine how the Company met each standard. Each standard tested is described and the result of testing is provided under the appropriate standard. Only standards tested are shown in this report of the limited scope examination.

Each Standard is accompanied by a "Comment" describing the purpose or reason for the Standard. The "Result" is indicated and the examiner's "Observations" are noted. In some cases a "Recommendation" is made. Comments, Results, Observations, and Recommendations are recited with each Standard.

The following sections are covered in a full scope market conduct examination. They are listed here clarify that this exam was limited to the claims area only.

- A. COMPANY OPERATIONS/MANAGEMENT- not addressed on this exam**
- B. COMPLAINTS/GRIEVANCES-not addressed on this exam**
- C. MARKETING AND SALES- not addressed on this exam**
- D. NETWORK ADEQUACY- not addressed on this exam**
- E. PRODUCER LICENSING-not addressed on this exam**
- F. POLICYHOLDER SERVICE-not addressed on this exam**
- G. UNDERWRITING AND RATING-not addressed on this exam**
- H. CLAIMS**

Comments: The examiners reviewed four separate claims samples. Three of the samples selected were random samples of specific populations and the fourth sample consisted of the entire population of claims. The four samples selected for review are as follows.

- Sample 1. One hundred claims from a population of 33,842 adjudicated by the Company within the examination period.
- Sample 2. Fifty claims from a population of 258 claims adjudicated by the Company in excess of 30 days from the date of receipt.
- Sample 3. Fifty behavioral health claims from a population of 314 adjudicated by Magellan Behavioral Health Systems, LLC. (Magellan) within the examination period.
- Sample 4. The entire population of 17 behavioral health claims adjudicated by Magellan in excess of 30 days from the date of receipt.

The Company's vendor agreement with Magellan for processing new behavioral health claims terminated as of December 31, 2005. However, Magellan processed run off claims for the first two quarters of 2007. The Company assumed processing for new behavioral health claims on January 1, 2006.

The evaluation of standards in this business area is based on Company responses to information requested by the examiners, discussions with the Company's staff, electronic testing of claim databases, and the review of claim files. This portion of the examination is designed to provide a view of how the company treats claimants and whether that treatment is in compliance with applicable statutes, rules, and regulations.

Services provided to the subscribers of the Company do not typically result in a claim by the recipient of care as is usually seen in an indemnity scenario. Claims to the Company usually arise from the provider who delivers services to a subscriber of the Company.

The following Standards were developed to test compliance with Delaware statutes, rules and regulations.

Prompt Payment Standard 1

The Company is using the Department's standards with regard to required elements for a clean claim when processing claims.

18 Del. Admin. Code 1310 § 4.0

Comments: This standard was designed and implemented to determine if the Company is properly identifying clean claims and if their definition of a "clean claim" is in compliance with 18 Del. Admin. Code 1310 § 4.0.

Review methodology for this standard is generic and sample. The examiners reviewed the Company's procedures, training manuals, internal communications, and selected claims samples. The Company provided a demonstration of its claims processing system, at which time the examiners interviewed claims personnel.

Results: PASS

Observation: Reviews, interviews, and testing indicate the Company standards and definitions identifying clean claims are compliant with 18 Del. Admin. Code 1310 § 4.0.

Prompt Payment Standard 2

The Company is correctly processing claims that include unspecified, unclassified, or miscellaneous codes or data elements when an appropriate descriptive narrative is included.

18 Del. Admin. Code 1310 § 4.7

Comments: This standard was designed and implemented to determine if the Company is correctly processing claims which include unspecified, unclassified, or miscellaneous codes or

data elements when an appropriate descriptive narrative is included and in compliance with 18 Del. Admin. Code 1310 § 4.7.

Review methodology for this standard is generic and sample. The examiners reviewed the Company's procedures, training manuals, internal communications and selected samples. The Company provided a demonstration of its claims processing system, at which time the examiners interviewed claims personnel.

Results: PASS

Observation: Reviews, interviews, and testing of claims samples indicate the Company adjudicates claims in a manner that complies with this standard.

Prompt Payment Standard 3

The Company's clean claim processing is timely and in compliance with applicable statutes, rules and regulations.

18 Del. C. § 2304, 18 Del. Admin. Code 1310 § 6.0 and 7.0

Comments: This standard was designed and implemented to determine if the Company processes clean claims on a timely basis and in compliance with 18 Del. Admin. Code 1310 § 6.0 et al which requires adjudication within 30 days and 18 Del. Admin. Code 1310 § 7.0, which states "Within a 36 month period, three instances of a carrier's failure to comply with Section 6 of this Regulation shall give rise to a rebuttable presumption that the carrier has engaged in an unfair practice in violation of 18 Del.C. § 2304."

Review methodology for this standard is generic, sample, and electronic. The examiners reviewed the Company's procedures, training manuals, internal communications, and selected samples. The Company provided a demonstration of its claims processing system, at which time the examiners interviewed claims personnel

Results: FAIL

Observation: Review of the selected samples indicated that nineteen (19) claims from Sample 2 were clean claims and adjudicated in an untimely manner. In addition, seven (7) claims from Sample 4 were clean claims and adjudicated in an untimely manner.

The number of instances found exceed the permissible threshold of three instances in 36 months as specified in 18 Del. Admin. Code 1310 § 7.0, giving rise to a rebuttable presumption that the carrier has engaged in an unfair practice in violation of 18 Del.C. § 2304

***Recommendations:* It is recommended that the Company ensure all claims are adjudicated within the time requirements of 18 Del. Admin. Code 1310 § 6.0 et al.**

Prompt Payment Standard 4

Proper payment is made on clean claims.

18 Del. Admin. Code 1310 § 6.1.1 and 6.1.2

Comments: This standard was designed and implemented to determine: 1) if, at the time the Company determines an entire claim is payable, it pays the total allowable amount; and 2) to

determine if, when only a portion of the claim is deemed payable, it pays the allowable portion in compliance with 18 Del. Admin. Code 1310 § 6.1.1 and 6.1.2.

Review methodology for this standard is generic and sample. The examiners reviewed the Company's procedures, training manuals and internal communications. The Company provided a demonstration of its claims processing system, at which time the examiners interviewed claims personnel.

Results: PASS (with comments below)

Observation: Review of the selected samples indicated that payment for three (3) claims from Sample 2 did not initially include payment of the total amount allowed under the contract provisions, resulting in non-compliance with the requirements of 18 Del. Admin. Code 1310 § 6.1.1.

Non-compliance with the requirements of 18 Del. Admin. Code 1310 § 6.1.1. in regard to the three claims referenced above was the result of a single data input error. The Company discovered the error through its internal audit process and made the necessary payment corrections. The Company does not appear to have engaged in unfair methods of competition and unfair or deceptive acts or practices as defined in 18 Del.C. § 2304, as the non-compliance resulted from a single error on behalf of the company.

Prompt Payment Standard 5

The Company sends proper notification to the provider or claimant when either the entire claim or a portion of a claim will not be paid.

18 Del. Admin. Code 1310 § 6.1.2 and 6.1.3

Comments: This standard was designed and implemented to determine if, when the Company concludes an entire claim or a portion of a claim will not be paid, it sends proper notification to the provider or policyholder in compliance with 18 Del. Admin. Code 1310 § 6.1.2 and 6.1.3

Review methodology for this standard is generic and sample. The examiners reviewed the Company's procedures, training manuals internal communications, and selected samples. The Company provided a demonstration of its claims processing system, at which time the examiners interviewed claims personnel.

Results: PASS

Observation: Review of the selected samples indicate the Company is sending proper written notification to either the provider or policyholder when either an entire claim or portion of a claim will not be paid.

Prompt Payment Standard 6

The Company makes additional information requests for determination of propriety of payment in accordance with statutes, regulations, and rules.

18 Del. Admin. Code 1310 § 6.1.4, 6.2 and 6.3

Comments: This standard was designed and implemented to determine if the Company is making proper requests for additional information to assure that claims are not inappropriately denied. 18 Del. Admin. Code 1310 § 6.1.4 states “if the carrier needs additional information from a provider or policyholder who is submitting the claim to determine the propriety of payment of a claim, the carrier shall request in writing that the provider or policyholder provide documentation that is relevant and necessary for clarification of the claim.” 18 Del. Admin. Code 1310 § 6.2 states in part, “A carrier who requests information under this subsection shall take action... within 15 days of receiving properly requested information.” 18 Del. Admin. Code 1310 § 6.3 limits requests to one per claim except for coordination of benefits information and to determine if a claim is a duplicate.

Review methodology for this standard is generic and sample. The examiners reviewed the Company's procedures, training manuals, and internal communications. The Company provided a demonstration of its claims processing system, at which time the examiners interviewed claims personnel.

Results: PASS (with comments below)

Observation: When the Company requires additional information to determine the propriety of payment, the Company denies the claim and requests additional information concurrently. The denial is a full denial affording the subscriber all rights normally associated with a denial. If the Company receives additional information, the claim is given a new claim number and re-adjudicated based on the information received. This is considered a “soft denial”. The date that the additional information is received by the Company is tracked in the claims system via the C/UC field, which is accessible on various claims screens within the HMO processing system. The Company’s stated procedures are to re-adjudicate claims for which requested information was submitted within 15 days of the receipt of that additional information.

Review of the selected samples indicated that two (2) claims from Sample 2 were not processed within 15 days of receipt of the information requested by the Company, resulting in non-compliance with the requirement of 18 Del. Admin. Code 1310 § 6.2.

Based on the examination team’s observations, as stated above, it does not appear that the Company engaged in unfair methods of competition and unfair or deceptive acts or practices as defined in 18 Del.C. § 2304.

***Recommendations:* It is recommended that the Company ensure all claims are adjudicated within the time requirements of 18 Del. Admin. Code 1310 § 6.0 et al.**

Prompt Payment Standard 7

The Company makes interest payments on claims where appropriate and so ordered in compliance with statutes, rules, and regulations.

18 Del. Admin. Code 1310 § 8.0

Comments: This standard was designed and implemented to determine if the Company made proper interest payments when so ordered. Review methodology for this standard is generic.

Results: PASS

Observation: No interest payments on claims have been ordered to date.

SUMMARY

The Company is a Delaware domiciled health insurer that provides health care coverage in the commercial and individual markets.

This examination focused on compliance with Delaware requirements for prompt, fair, and equitable settlement of claims for health care services.

Recommendations have been made to address the areas of concern noted during the examination.

These are summarized below.

LIST OF RECOMMENDATIONS

It is recommended that the Company ensure that all claims are adjudicated properly and within the time requirements of 18 Del. Admin. Code 1310 § 6 et al.

CONCLUSION

The examination was conducted by the undersigned and respectfully submitted,

A handwritten signature in black ink, appearing to read "Gerald R. Kasper". The signature is written in a cursive style with a prominent initial "G".

Market Conduct Examiner-in-Charge
Delaware Insurance Department