



STATE OF OREGON

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

INSURANCE DIVISION

REPORT OF TARGET MARKET CONDUCT EXAMINATION

OF

**AETNA LIFE INSURANCE COMPANY
HARTFORD, CONNECTICUT**

NAIC COMPANY CODE 60054

AS OF

DECEMBER 31, 2002

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December 1, 2004

Honorable Cory Streisinger, Director
Department of Consumer and Business Services
State of Oregon
350 Winter Street, NE, Room 440
Salem, OR 97301-3883

Dear Director:

In accordance with your instructions and pursuant to ORS 731.300, we have examined the business affairs of

**Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156-9154**

NAIC Company Code 60054

hereinafter referred to as the “Company.” The following report of examination is respectfully submitted.

EXECUTIVE SUMMARY

Aetna Life Insurance Company (the Company) was examined at their offices on 413 Pine Street in Seattle, Washington, during November 2003. The purpose of the examination was to determine if the Company was in compliance with Prompt Payment statutes, rules and regulations, specifically ORS 743.866, ORS 743.868, OAR 836-080-0080 and OAR 836-080-0085.

The examination included the review of claims samples along with the Company's written claims procedures, provider contracts and provider manual to evaluate compliance with the following four standards:

- Prompt Pay Standard #1 – The Company processes all claims that are subject to the application of prompt payment requirements in accordance with all applicable rules and regulations.
- Prompt Pay Standard #2 – The Company's provider contracts are in compliance with applicable statutes, rules and regulations.
- Prompt Pay Standard #3 – The Company's disclosures to providers are in compliance with applicable statutes, rules and regulations.
- Prompt Pay Standard #4 – The Company files the required annual claims processing information in compliance with applicable statutes, rules and regulations.

The Company passed Prompt Pay Standards #2 and #3 without comment. They failed Prompt Pay Standards #1 and #4.

SCOPE OF EXAMINATION

The market conduct examination of the Company was conducted as of December 31, 2002, covering the period of January 1, 2002 through December 31, 2002, and included a review of

material transactions or events which occurred subsequent to the examination cut-off date and were noted during the examination.

A target market conduct emphasis examination was performed. The examination of the Company was conducted pursuant to ORS 731.300 and in accordance with procedures and guidelines established by the Oregon Insurance Division Market Conduct Program. The program generally follows the Market Conduct Examination Handbook as adopted by the National Association of Insurance Commissioners to the extent that it is consistent with Oregon law. The purpose of the examination was to determine if the Company was in compliance with Prompt Payment statutes, rules and regulations. It was further intended to identify and assess the practices and procedures implemented by the Company to comply with Prompt Payment statutes. The findings in this examination demonstrate that the Company needs to develop an action plan to ensure they comply with Prompt Payment statutes.

In order to determine the practices and procedures of the Company's operations, one or more of the following procedures was performed in each phase:

1. A sample of files was selected from listings provided by the Company. The examiner then reviewed each file.
2. The procedure manuals and/or memorandum were evaluated.
3. The Company responded to a series of questions regarding the phase being examined.

The examination was comprised of the following two phases:

Company Operations/Management	Prompt Payment of Claims
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The Company’s underlying data was measured against an established standard. A list of all standards considered can be found in Appendix A at the end of the report. The examiner used the following three classifications to disclose the examination results:

Passed without Comment	The standards the Company passed are displayed in a chart at the beginning of the Findings section of each phase. Items included in this category passed the standard and the examiner did not find it necessary to comment on the findings.
Passed with Comment	Standards the Company passed with some errors noted are included in this classification. Items in this category are not considered to be indicative of a general business practice of noncompliance. Usually, a recommendation is not warranted, but in certain instances a recommendation might be made.
Failed	The Company has not demonstrated compliance with standards that fall into this category. A recommendation for compliance is usually made for each standard the Company fails.

Information regarding some items might be noted in the examination report without remarks.

Some unacceptable or non-complying practices may not have been discovered in the course of this examination. Additionally, findings may not be material to all areas which would serve to assist the Director. Failure to identify or criticize specific Company practices does not constitute acceptance by the Oregon Insurance Division. Examination findings may result in administrative action or further inquiry.

Other areas of concern discovered during the examination that do not fall within the scope of the standards might appear in the report as the last section of each phase and be titled Additional Findings and Procedures.

COMPANY OPERATIONS/MANAGEMENT

Company History

Aetna Life Insurance Company (ALIC) was incorporated in Connecticut in June 1853. ALIC was a publicly held corporation until 1967 when Aetna Life and Casualty Company (AL&C) acquired all the outstanding shares of its stock 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 that 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.

Management and Control

Board of Directors

The members of the Board of Directors as of December 31, 2002 were:

<u>Name</u>	<u>Principal Affiliation</u>
John W. Rowe, M.D.	Chairman and Chief Executive Officer of Aetna, Inc.
Ronald A. Williams	President of Aetna, Inc.
Timothy A. Holt	Senior Vice President and Chief Investment Officer of Aetna, Inc.

Officers

The principal officers of the Company as of December 31, 2002 were as follows:

<u>Name</u>	<u>Office</u>
John W. Rowe, M.D.	Chairman and Chief Executive Officer
Ronald A. Williams	President
Timothy A. Holt	Senior Vice President and Chief Investment Officer
David B. Kelso	Executive Vice President, Strategy and Finance
L. Edward Shaw, Jr.	Executive Vice President and General Counsel
William C. Popik, M.D.	Senior Vice President and Chief Medical Officer
Alan M. Bennett	Senior Vice President and Chief Financial Officer
Dong H. Ahn	Vice President, Group Insurance
William J. Casazza	Vice President, Deputy General Counsel and Corporate Secretary
James A. Geyer	Vice President and Actuary
Paul B. Hebert	Vice President and Director of Internal Audit
Ronald M. Olejniczak	Vice President and Corporate Controller
Alfred P. Quirk, Jr.	Vice President and Treasurer

PROMPT PAYMENT OF CLAIMS

From a population of 370,558 claims finalized during the examination period, a random sample of 25 was selected for review for this examination. In addition, from a population of 356 claims for which the Company had previously provided detailed information regarding claims handling to the Department of Consumer and Business Services (DCBS), a random sample of 25 was selected for review. The Company's written claims procedures, provider contracts and Provider Manual were also reviewed.

Findings

The Company passed the following standards without comment:

<u>Standard</u>	<u>Regulatory Authority</u>
<u>Prompt Pay Standard #2</u> - The Company's provider contracts are in compliance with applicable statutes, rules and regulations.	ORS 743.866(2)
<u>Prompt Pay Standard #3</u> - The Company's disclosures to providers are in compliance with applicable statutes, rules and regulations.	ORS 743.866(3), OAR 836-080-0080(3)

The following exceptions were noted:

Prompt Pay Standard #1 - The Company processes all claims that are subject to the application of prompt payment requirements in accordance with all applicable statutes, rules and regulations.

Reference: ORS 743.866(1), ORS 743.868(1) & (2), OAR 836-080-0080(1) & (2).

Findings: Failed – 84% compliance.

This standard applied to all 50 of the claims reviewed. Of those claims, seven (14%) failed this standard. One file failed because the Company was unable to provide documentation on the handling of the claim. They advised the claim had been processed on a system that was no longer in use. The other six files failed because they were neither paid nor denied within 30 days and no additional information was requested.

In addition, the Company's written procedures did not confirm that notice is being sent to both the member and the provider in all situations in which additional information was requested. In the "Member Submissions" section, the procedures indicated, if additional information is needed from the member, the Company notifies the member of missing information needed within 30 calendar days. In the "Provider Submissions" section, the procedures indicated the Company notifies the provider in writing that additional information is needed within 30 calendar days. An insurer is required to notify both the enrollee and the provider in writing and give both the enrollee and the provider an explanation of the additional information needed to process the claim regardless of whom submits the claim. The Company advised they do provide such notification to both the enrollee and the provider. However, they did not provide written procedures confirming this as requested. They also did not provide a copy of an example of a request for additional information sent to a member with the corresponding notice to the provider

nor a copy of an example of a request to a provider with the corresponding notice to the member. They did provide examples of various types of requests for information, but the examples did not confirm that notice of such requests was being sent to both member and provider.

I recommend the Company process all claims that are subject to the application of prompt payment requirements in accordance with ORS 743.866(1), ORS 743.868(1) & (2) and OAR 836-080-0080(1) & (2).

Prompt Pay Standard #4 - The Company files the required annual claims processing information in compliance with applicable statutes, rules and regulations. Reference: ORS 743.866(5), OAR 836-080-0085.

Findings: Failed – 32% compliance.

This standard applied to the 25 claims reviewed for which the Company had previously provided detailed claims information to DCBS. Of those claims, 17 (68%) failed this standard. Following is a chart summarizing the reasons for failure:

<u>Type of Error</u>	<u># of Files</u>
Reported Date Claim Received was in error. All of these claims involved an Rx charge that was submitted for reimbursement. The date reported as date claim received was actually the date the prescription had been filled rather than the date the claim was received by the Company. In addition, based on the correct dates, the transaction should not have been included in the population of claims finalized more than 30 days after receipt because it was either paid or denied within 30 days.	12
The transaction should not have been included in the population of claims finalized more than 30 days after receipt because it was, in fact, either paid or denied within 30 days.	3

Reported Amount of Claim Payment was in error. The payment amount reported for the claim number in question was \$102.01. That amount was ultimately paid, but under a different claim number. The amount paid under the claim number in the sample was actually zero because the claim was initially applied to deductible.	1
The Company was unable to provide documentation on the handling of the claim and, therefore, could not confirm the information reported to DCBS was correct. They advised the claim had been processed on a system that was no longer in use.	1

I recommend the Company file the required annual claims processing information in compliance with ORS 743.866(5) and OAR 836-080-0085.

CONCLUSIONS/RECOMMENDATIONS

<u>No.</u>	<u>Recommendation</u>	<u>Page</u>
1	I recommend the Company process all claims that are subject to the application of prompt payment requirements in accordance with ORS 743.866(1), ORS 743.868(1) & (2) and OAR 836-080-0080(1) & (2).	10
2	I recommend the Company file the required annual claims processing information in compliance with ORS 743.866(5) and OAR 836-080-0085.	11

ACKNOWLEDGMENT

The cooperation and assistance rendered by the officers and employees of the Company during this examination is hereby acknowledged and appreciated.

A special thanks is extended to the Examination Coordinators for their courtesy and assistance providing, correlating or coordinating all requested documents and statistics necessary to ensure a smooth transition during the overall examination process. The responsibilities that were undertaken during this examination were in addition to the scope of their regular assigned duties.

Respectfully submitted,

Cindy J. Jones, AIE, CPCU, CRM
Manager, Market Surveillance
Insurance Division
Department of Consumer and Business Services
State of Oregon

APPENDIX A

**OREGON INSURANCE DIVISION
MARKET CONDUCT EXAMINATION
Aetna Life Insurance Company**

Claims Prompt Pay

<u>#</u>	<u>Standard</u>	<u>Regulatory Authority</u>
1	The Company processes all claims that are subject to the application of prompt payment requirements in accordance with all applicable statutes, rules and regulations.	ORS 743.866(1), ORS 743.868(1) & (2), OAR 836-080-0080(1) & (2)
2	The Company's provider contracts are in compliance with applicable statutes, rules and regulations.	ORS 743.866(2)
3	The Company's disclosures to providers are in compliance with applicable statutes, rules and regulations.	ORS 743.866(3), OAR 836-080-0080(3)
4	The Company files the required annual claims processing information in compliance with applicable statutes, rules and regulations.	ORS 743.866(5), OAR 836-080-0085