THE STATE OF FLORIDA

OFFICE OF INSURANCE REGULATION
MARKET INVESTIGATIONS

TARGET MARKET CONDUCT FINAL EXAMINATION REPORT

OF

AETNA HEALTH, INC.

AS OF

January 24, 2013

NAIC COMPANY CODE: 95088
NAIC GROUP CODE: 00001

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EXECUTIVE SUMMARY

A sample of 368 claims, and policies and procedures as they apply to the adjudication of out of network medical provider claims, were reviewed. The following table represents general findings, however, specific details are found in each section of the report.

TABLE OF TOTAL VIOLATIONS			
Statute/Rule	**Description**	**Files Reviewed**	**Number of Violations**
641.3903(5)(c)1	The Company did not properly investigate prior to paying, denying, or adjudicating claims.	368	23
641.3155(3)(b)	The Company did not pay, deny, or contest out of network claims within the required timeframe.	368	8
641.3155(4)(a)	The Company did not provide timely acknowledgement of the receipt of out of network claims.	368	11
641.3155(6)	The Company did not pay interest on overdue out of network claims.	368	1

PURPOSE AND SCOPE OF EXAMINATION

The Office of Insurance Regulation (Office), Market Investigations conducted a target market conduct examination of Aetna Health, Inc. (Company) pursuant to Section 624.3161, Florida Statutes. The examination was performed by Examination Resources, LLC. The scope period of this examination was January 1, 2009, through December 31, 2011. The examination was conducted offsite beginning November 5, 2012, and concluded January 24, 2013.

The purpose of this examination was to review the Company's policies and procedures as they apply to the adjudication of out of network medical provider claims and to determine the Company's compliance with Florida Statutes and the Florida Administrative Code.

The examination included the following procedures:

- Review of the Company's claims handling procedures to ensure adoption and implementation of standards for proper investigation and settlement of claims.
- Review the Company's internal policies and procedures to determine the methodology for payment of out of network claims.
- Determine how the Company defines usual and customary for out of network claims.
- Review sample of paid and denied out of network claims to determine timely acknowledgements, reasonable and proper investigation, resolution, timely payment and review for consistency with internal policies and procedures and Florida Statutes.

This Final Report is based upon information from the examiner's draft report, additional research conducted by the Office, and additional information provided by the Company. Procedures and conduct of the examination were in accordance with the *Market Regulation Handbook* produced by the National Association of Insurance Commissioners.

The NAIC Market Conduct Handbooks allows the utilization of Audit Command Language (ACL) software for determining sample sizes and sampling. Sample sizes were calculated by entering a Confidence Level of 95%, an Upper Error Limit of 5%, and an Expected Error Rate of 2%. ACL returned a sample size of 184 for each review area.

COMPANY OPERATIONS

Aetna Health, Inc. is a domestic Health Maintenance Organization licensed to conduct business in the State of Florida on July 1, 1985. The Company provides Individual and Group Health coverage in the State of Florida.

Total Direct Premiums Written in Florida for Accident and Health were as follows:

Year	Total Written Premium In Florida (Per Schedule T of Annual Statement)
2009	1,961,271,150
2010	1,607,501,507
2011	1,466,870,848

OUT-OF-NETWORK CLAIMS HANDLING

I. COMPANY POLICIES AND PROCEDURES REVIEW

The Company's definition of the usual and customary reimbursement rates for out of network claims, including facility and non-facility providers, was in transition during the scope period. Prior to November 1, 2009, the Company's out of network plan benefits were based on the "reasonable and customary" or "prevailing" charges which were typically based upon the Ingenix database. Effective November 1, 2009, renewed policies transitioned to the new standard Aetna Market Fee Schedule (AMFS), which was known as the Aetna Out-of-Network Rates (AONR).

After April 26, 2011, the Company transitioned to the current primary methodology which is based upon the following:

- Professional Claims – 105% of the Medicare Fee Schedule
- Facility Claims – 140% of Medicare Fee Schedule

The Company currently does not require prior authorization for out of network claims, but these claims are paid at a lesser amount than claims paid to in-network providers. In addition, some claims require pre-certification; however, pre-certification applies to any claim whether in or out of network.

II. CLAIMS REVIEW

The Company was requested to provide a list of all out of network claims paid or denied during the scope period. The Company identified a universe of 845,414 paid or denied out of network claims. A random sample of 184 paid out of network claim files and a random sample of 184 denied out of network claim files were reviewed for compliance with Florida Statutes. The following exceptions were noted:

1) **In 23 instances, the Company did not properly investigate prior to paying, denying, or adjudicating claims, in violation of Section 641.3903(5)(c)1, Florida Statutes.**

1a.) CORRECTIVE ACTION: The Company should establish procedures to ensure proper investigation prior to paying, denying, or adjudicating claims.

1b.) COMPANY RESPONSE: The Company agreed with this violation.

2) **In eight (8) instances, the Company did not pay, deny or contest out of network claims within the required timeframe, in violation of Section 641.3155(3)(b), Florida Statutes.**

2a.) CORRECTIVE ACTION: The Company should implement procedures to ensure that out of network claims are paid, denied, or contested within the required timeframe.

2b). COMPANY RESPONSE: The Company agreed with this violation.

3) **In 11 instances, the Company did not provide timely acknowledgement of the receipt of out of network claims, in violation of Section 641.3155(4)(a), Florida Statutes.**

3a.) **CORRECTIVE ACTION:** The Company should implement procedures to ensure timely acknowledgement of the receipt of out of network claims.

3b.) **COMPANY RESPONSE:** The Company agreed with this violation.

4) **In one (1) instance, the Company did not pay interest on overdue out of network claims, in violation of Section 641.3155(6), Florida Statutes**.

4a.) **CORRECTIVE ACTION:** The Company should establish procedures to ensure that overdue payments of out of network claims include the required 12% interest, pay the interest due on the identified claim, and provide proof of payment.

4b.) **COMPANY RESPONSE:** The Company agreed with this violation.

EXAMINATION FINAL REPORT SUBMISSION

The Office hereby issues this Final Report based upon information from the examiner's draft report, additional research conducted by the Office, and additional information provided by the Company.