DELAWARE DEPARTMENT OF INSURANCE

MARKET CONDUCT EXAMINATION REPORT

Aetna Life Insurance Company
NAIC #60054

151 Farmington Avenue
Hartford, CT 06156.

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 LIFE INSURANCE COMPANY

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

Attest By: _____

Insurance Commissioner of the State of Delaware

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

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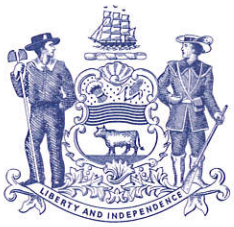
Karen Weldin Stewart, CIR-ML
Commissioner



Delaware Department of Insurance

REPORT ON EXAMINATION

OF THE

AETNA LIFE INSURANCE COMPANY

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.

Karen Weldin Stewart, CIR-ML
Insurance Commissioner

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Contents

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 60054-12-C-2, 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 Life Insurance Company ("ALIC")

Aetna Life Insurance Company ("ALIC") was incorporated in Connecticut on June 14, 1853. The Company's legal home office address, and its principal executive office address, is 151 Farmington Avenue, Hartford, CT 06156.

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 Life Insurance Company ("ALIC") was incorporated in Connecticut on June 14, 1853. ALIC is licensed as a life and accident and health company in all 50 states. The Company's legal home office address, and its principal executive office address, is 151 Farmington Avenue, Hartford, CT 06156.

As of their December 31, 2011 annual statement for the State of Delaware, ALIC reported individual health premiums earned in the State of Delaware in the amount of $8,276,223 and group health premiums earned in the State of Delaware in the amount of $25,413,107.

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

- 6 Exceptions - 18 Del. C. §2304 Unfair Methods Of Competition And Unfair Or Deceptive Acts Or Practices Defined. Failure to acknowledge claims within 30 working days upon receipt.
- 28 Exceptions - 18 Del. Admin. Code 1310 § 6.0 Processing of Clean Claim - Failure to pay clean claims within 30 calendar days after receipt.
- 2 Exceptions - 18 Del. Admin. Code 1310 § 6.0 Processing of Clean Claim - Failure to pay clean claims within 15 days of receiving the requested additional information.
- 35 Exceptions - 24 Del. C. § 716. Chiropractic practitioners eligible for compensation from insurance - Charging copayment and coinsurance amounts that exceeded 25% of the fee due to the doctor of chiropractic for the service provided.
- 1 Exception - 24 Del. C. §717. Opinions and testimony - Failure to use a chiropractic opinion from a chiropractor licensed in the State of Delaware.

No other exceptions were noted in the areas of operation 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 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. The Company's legal home office address and its principal executive office address is 151 Farmington Avenue, Hartford, CT 06156.

ALIC is licensed as a life and accident and health company in all 50 states. The Company's product line for the State of Delaware includes: Indemnity, Preferred Provider Organizations (PPO), Health Savings Accounts, Health Reimbursement Accounts, Medicare Advantage, Student Health, Vision, Dental, Life, and Disability.

As of their December 31, 2011 annual statement for the State of Delaware, ALIC reported individual health premiums earned in the State of Delaware in the amount of $8,276,223 and group health premiums earned in the State of Delaware in the amount of $25,413,107.

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. 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. American Specialty Health Networks/Plans Response to Aetna Annual Claims Delegation oversight Audit – April 23-26, 2012

4. A list of 5 Audit Reports
5. 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 contracts including the effective date between the applicable Aetna companies and American Specialty Health Network (ASHN). The Company provided the contacts and agreements as requested.

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 American Specialty Health Network (ASHN) Chiropractor related Claims Handling Procedures used during the experience period. The Company provided the following policy and procedures manual:

- ASHN Claims Policy and Procedures

The claims policy and procedures manual was reviewed for any inconsistencies, which could be considered discriminatory, specifically prohibited by statute or regulation, or unusual in nature.

No exceptions were noted.

B. CBR Paid Claims-ASHN

The Company was requested to provide a list of all chiropractor claims paid during the experience period of January 1, 2010 to June 30, 2012. The Company identified a universe of 338 American Specialty Health Network (ASHN) Claims Based Reimbursement (CBR) claims processed. A random sample of 76 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:

6 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 six claims within 30 working days upon receipt.

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

28 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 twenty eight 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.

1 Exception - 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:*
6.1.4 *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.*
6.2 *The request pursuant to section 6.1.4 must describe with specificity the clinical information requested and relate only to information the carrier can demonstrate is specific to the claim or the claim's related episode of care. A provider is not required to provide information that is not contained in, or is not in the process of being incorporated into, the patient's medical or billing record maintained by the provider whose services are the subject of inquiry. A carrier may make only one request under this subsection in connection with a claim. A carrier who requests information under this subsection shall take action under sections 6.1.1 through 6.1.3 within 15 days of receiving properly requested information.*

The Company failed to pay one clean claim within 15 calendar days of receiving the requested additional information.

Recommendation: It is recommended that the Company review its procedures to ensure that all clean claims are paid within 15 days of receiving the requested additional information as required by 18 Del. Admin. Code 1310 § 6.2.

31 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.

(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 and coinsurance amount charged in thirty-one 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 and coinsurance amounts charged are equal to or less than 25% of the fee due as required by 24 Del. C. § 716.

C. CBR Denied Claims-ASHN

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 39 American Specialty Health Network (ASHN) Claims Based Reimbursement (CBR) claims denied during the experience period. All 39 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:

1 Exception - 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:*

6.1.4 *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.*

6.2 *The request pursuant to section 6.1.4 must describe with specificity the clinical information requested and relate only to information the carrier can demonstrate is specific to the claim or the claim's related episode of care. A provider is not*

required to provide information that is not contained in, or is not in the process of being incorporated into, the patient's medical or billing record maintained by the provider whose services are the subject of inquiry. A carrier may make only one request under this subsection in connection with a claim. A carrier who requests information under this subsection shall take action under sections 6.1.1 through 6.1.3 within 15 days of receiving properly requested information.

The Company failed to pay one clean claim within 15 days of receiving the requested information.

Recommendation: It is recommended that the Company review its procedures to ensure that all clean claims are paid within 15 days of receiving the requested additional information as required by 18 Del. Admin. Code 1310 § 6.0.

D. Aetna 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 1,070 Aetna chiropractor claims paid during the experience period, which comprised of 148 individuals. A random sample of 100 claim files was selected from the universe of 148 unique paid claims. The claim files were 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:

4 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.

(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 four 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 and coinsurance amounts charged are equal to or less than 25% of the fee due as required by 24 Del. C. § 716.

E. Aetna Denied Claims

The Company identified a universe of 129 Aetna chiropractor claims denied during the experience period, which comprised of 46 individuals. A random sample of 46 unique denied claims was selected. The 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.

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 Company provided a list of 29 forms used during the experience period. 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 indicated that Aetna reviews and resolves all the complaints submitted by members or members' authorized representatives. The Company provided the requested complaint handling guidelines and procedures.

The complaint handling guidelines and procedures were reviewed to ensure that the Company had complaint handling procedures in place that were 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.

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.

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 requested appeal and grievances handling procedures.

The appeal and grievances handling procedures were reviewed to ensure that the Company had grievance and appeals procedures in place that were 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 1 appeal received during the experience period. The 1 appeal file was requested, received and reviewed. The file was reviewed for compliance with 18 Del. C. §332 and the Company's policy and procedure standards. The following exception was noted:

1 Exception – 24 Del. C. §717. Opinions and testimony.

(a) Any chiropractor who is duly licensed as a chiropractic practitioner under this chapter shall be deemed competent to offer opinions in the courts, administrative agencies and other tribunals of this State as to matters of causation, within the scope of chiropractic practice, provided the testimony is offered to as reasonable degree of chiropractic certainty and there is otherwise an adequate foundation for the admission of this testimony.

(b) Any chiropractor duly licensed under this chapter shall also be deemed competent to offer opinions in the courts, administrative agencies and other tribunals of this State as to matters of permanent impairment or disability, provided the testimony is within the scope of chiropractic practice is offered to a reasonable degree of chiropractic certainty and there is otherwise an adequate foundation of the admission of this testimony.

(c) No Doctor of Chiropractic shall be permitted to offer chiropractic opinions for the purpose of determining eligibility for health insurance policy benefits relating to chiropractic care in the State unless the Doctor of Chiropractic is duly licenses and actively practicing in the State. For purposes of this subsection, a Doctor of Chiropractic shall be considered "actively practicing" if that Doctor of Chiropractic maintains an office in the State for treatment of patients and is engaged in the practice of chiropractic in the State more than an average of 10 hours per week. For the purposes of this section "insurance policy" shall include without limitation all health plans and policies for the payment for, provision of or reimbursement for chiropractic or medical services, supplies or both issued by health insurers, health service corporations or managed care organizations.

The Company used a chiropractic opinion in one file from a chiropractor not licensed in the State of Delaware.

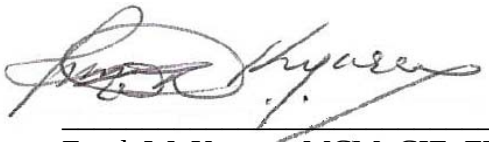
Recommendation: It is recommended that the Company review its procedures to ensure that no Doctor of Chiropractic shall be permitted to offer chiropractic opinions for the purpose of determining eligibility for health insurance policy benefits relating to chiropractic care in the State of Delaware unless the Doctor of Chiropractic is duly licensed and actively practicing in the State as required by 24 Del. C. §717.

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.

1.	It is recommended that the Company review its procedures to ensure compliance with 18 Del. C. §2304. Unfair Methods Of Competition And Unfair Or Deceptive Acts Or Practices Defined. (CBR Paid Claims-ASHN)
2.	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-ASHN)
3.	It is recommended that the Company review its procedures to ensure compliance with the prompt processing of clean claim requirements of 18 Del. Admin Code 1310 § 6.2. Processing of Clean Claim. (CBR Paid Claims -ASHN)
4.	It is recommended that the Company review its procedures to ensure compliance with the copayment and coinsurance charge requirements of 24 Del. C. § 716. Chiropractic practitioners eligible for compensation from insurance**.** (CBR Paid Claims-ASHN)
5.	It is recommended that the Company review its procedures to ensure compliance with the prompt processing of clean claim requirements of 18 Del. Admin Code 1310 § 6.2. Processing of Clean Claim (CBR Denied Claims-ASHN)
6.	It is recommended that the Company review its procedures to ensure compliance with the copayment and coinsurance charge requirements of 24 Del. C. § 716. Chiropractic practitioners eligible for compensation from insurance. (Aetna Paid Claims)
7.	It is recommended that the Company review its procedures to ensure compliance with the use of a chiropractic opinion from a chiropractor licensed in the State of Delaware as required 24 Del. C. §717. Opinions and testimony. (Grievance and Appeals-CHIRO)

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