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THIS REPORT WILL BE MADE PUBLIC AND PUBLISHED ON THE
CALIFORNIA DEPARTMENT OF INSURANCE (CDI) WEBSITE]**

**WEBSITE PUBLISHED REPORT OF THE TARGET MARKET CONDUCT
EXAMINATION OF THE CLAIMS PRACTICES OF**

**AETNA LIFE INSURANCE COMPANY
NAIC # 60054 CDI # 0003-4**

AS OF MARCH 31, 2011

ADOPTED JANUARY 16, 2013

STATE OF CALIFORNIA



**CALIFORNIA DEPARTMENT OF INSURANCE
MARKET CONDUCT DIVISION
FIELD CLAIMS BUREAU**

NOTICE

The provisions of Section 735.5(a) (b) and (c) of the California Insurance Code (CIC) describe the Commissioner's authority and exercise of discretion in the use and/or publication of any final or preliminary examination report or other associated documents. The following examination report is a report that is made public pursuant to California Insurance Code Section 12938(b)(1) which requires the publication of every adopted report on an examination of unfair or deceptive practices in the business of insurance as defined in Section 790.03 that is adopted as filed, or as modified or corrected, by the Commissioner pursuant to Section 734.1.

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DEPARTMENT OF INSURANCE

Consumer Services and Market Conduct Branch
Field Claims Bureau, 11th Floor
300 South Spring Street
Los Angeles, CA 90013



January 16, 2013

The Honorable Dave Jones
Insurance Commissioner
State of California
300 Capitol Mall
Sacramento, California 95814

Honorable Commissioner:

Pursuant to instructions, and under the authority granted under Part 2, Chapter 1, Article 4, Sections 730, 733, 736, and Article 6.5, Section 790.04 of the California Insurance Code; and Title 10, Chapter 5, Subchapter 7.5, Section 2695.3(a) of the California Code of Regulations, an examination was made of the claims handling practices and procedures in California of:

Aetna Life Insurance Company
NAIC # 60054

Group NAIC # 0001

Hereinafter, the Company listed above also will be referred to as Aetna or the Company.

This report is made available for public inspection and is published on the California Department of Insurance website (www.insurance.ca.gov) pursuant to California Insurance Code section 12938(b)(1).

FOREWORD

The examination targeted the claims handling practices of the aforementioned Company on health insurance claims for applied behavioral analysis (ABA) and speech therapy for the treatment of pervasive development disorder (PDD) or autism which are identified in this report under the collective term, autism spectrum disorder (ASD). The review period of the examination covered closed claims from June 1, 2008, through March 31, 2011. The examination was made to discover, in general, if these and other operating procedures of the Company conform to the contractual obligations in the policy forms, the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law. This report contains all alleged violations of laws that were identified during the course of the examination.

The report is written in a “report by exception” format. The report contains a summary of pertinent information about the handling of ABA and speech therapy claims for the treatment of ASD under Individual Health and Group Health policies, details of the non-compliant or problematic activities that were discovered during the course of the examination, and the insurer’s proposals for correcting the deficiencies. When a violation that reflects an underpayment to the claimant is discovered and the insurer corrects the underpayment, the additional amount paid is identified as a recovery in this report. All unacceptable or non-compliant activities may not have been discovered. Failure to identify, comment upon or criticize non-compliant practices in this state or other jurisdictions does not constitute acceptance of such practices.

Alleged violations identified in this report, any criticisms of practices and the Company’s responses, if any, have not undergone a formal administrative or judicial process.

SCOPE OF THE EXAMINATION

To accomplish the foregoing, the examination included:

1. A review of the guidelines, procedures, training plans and forms adopted by the Company for use in California including any documentation maintained by the Company in support of positions or interpretations of the California Insurance Code, Fair Claims Settlement Practices Regulations, and other related statutes, regulations and case law used by the Company to ensure fair claims settlement practices.

2. A review of the application of such guidelines, procedures, and forms, by means of an examination of a sample of individual member claims files and related records.

The review of the sample of member claims files was conducted at the offices of the Company in Rancho Cordova, California.

EXECUTIVE SUMMARY

The denied health claims for ABA and speech therapy for the treatment of ASD included in the review were closed from June 1, 2008 through March 31, 2011, referred to as the “review period”. The sample reviewed was comprised of denied claims for ABA therapy and speech therapy for the treatment of ASD. The claims universes for Individual health and Group health were sorted according to the member’s name and the number of claims per member. Specifically, six members submitted 169 claims that were denied in the Individual health category and 102 members submitted 1,342 claims that were denied in the Group health category during the review period. Of the 108 total members, the examiners reviewed all six members from the Individual claims universe and reviewed 49 members that were randomly selected from the Group claims universe. The examiners then randomly selected a claim number from the list of claims for each member. The examiners reviewed the selected member claim and related claims for ABA therapy and speech therapy.

The examiners cited 276 alleged claims handling violations of the California Insurance Code and the California Code of Regulations from this sample member review. The examiners cited 1,263 alleged claims handling violations of the California Insurance Code in the review of the Company’s Regulatory Rework Project that reprocessed inappropriately denied claims for speech therapy for the treatment of ASD during the review period. As a result of the reviews of the sample member claims and in the Regulatory Rework Project, the examiners cited a combined total of 1,539 alleged claims handling violations of the California Insurance Code and the California Code of Regulations.

Findings of this examination include, but are not limited to, the failure to pay ABA and speech therapy claims for the treatment of ASD in accordance with the California Mental Health Parity Law, established by Assembly Bill 88, effective July 1, 2000.

In response to the passage of Senate Bill 946, effective July 1, 2012, the Company decided it will not apply plan visit limits to physical, occupational, and speech therapy services, nor will a Clinical Claim Review be required for Traditional (Preferred Provider Organization) products. This decision is effective for services incurred on or after December 1, 2011.

SUMMARY OF COMPANY RESPONSES TO CDI QUESTIONNAIRE ON PRACTICES REGARDING COVERAGE OF ASD

General Statement of Coverage for Mental Health

Q. What insurance products does Aetna offer that provide behavioral health treatment coverage, and how many such policies currently exist?

A. All health policies issued by Aetna Life Insurance Company include coverage for Mental Health. As of December 31, 2011, the Company had policies issued in nine different types of plans in California within which there are 80,424 lives covered by Individual policy holders and 41,119 Group Employer Policy holders covering 624,686 lives. All policies issued by the Company in California include benefits for Serious Mental Illness since, or prior to, the implementation of CA AB88, effective July 1, 2000.

Coverage for ABA Therapy

Q. Does Aetna assert for any reason that behavioral health therapy, including ABA, involves services that are not covered?

A. ABA Therapy is excluded from many of the Company's policies as it is considered to be an Educational service. If the policy excludes services that are Educational in nature, then the Educational Exclusion applies to ABA Therapy.

Q. How many requests has Aetna received for behavioral health treatment, including ABA, within the past two years on behalf of insureds with ASD?

A. The Company has received 181 such requests, 56 of which are specific requests for ABA treatment. The Company issued authorizations for 159 of the 181 total requests and 44 of the 56 requests for ABA treatment.

Q. What is Aetna's position regarding whether and to what extent the Mental Health Parity Act mandate for medically necessary treatment for ASD, set forth in California Insurance Code §10144.5, applies to behavioral health treatment, including ABA?

A. The Company implemented the California 1999 Mental Health Parity Act to allow coverage for therapy services provided by licensed medical practitioners. California SB946 expanded coverage to include behavioral intervention therapies such as ABA when furnished by a qualified ASD provider to begin no later than July 1, 2012. Effective April 1, 2012, the Company expanded its coverage to include these services.

Q. What are the educational backgrounds and affiliations of the providers which Aetna uses to provide behavioral health therapies, including ABA; and what are their office or company affiliations? As of what date did the Company require that services be provided by licensed clinicians?

A. The Company's health plans typically require that services be provided by licensed clinicians. Historically, the Company has always required that ABA services be provided by licensed clinicians. Effective April 1, 2012, the Company broadened the scope of providers of ABA therapy to include certified ABA therapists. In the ASD field, there are practitioners with credentials indicating competency (e.g., ABA certification) who would not qualify for independent licensure in the jurisdiction in which they work. These individuals can now become in-network providers with Aetna. In addition, the Company's in-network licensed physicians, psychiatrists, psychologists and other licensed professionals may also be qualified to perform ABA therapy.

Q. How many providers in California are currently utilized by Aetna? Do all provide ABA?

A. The Company currently contracts with approximately 14,000 Psychiatrists, Psychologists and other Behavioral Health providers in California. All such providers may or may not practice ABA therapy.

Q. Where in California are those providers located?

A. Throughout the state, using the following standards:

- Urban and suburban providers: Two psychiatrists, psychologists/masters therapists, or psychiatrists treating children, are within 10 miles or 30 minutes of a member's residence or place of work.
- Rural providers: One psychiatrist, psychologist/masters therapist, or psychiatrist treating children, is within 15 miles or 30 minutes of a member's residence or place of work.
- Number of psychiatrists or psychiatrists treating children: .83 per 1,000 members
- Number of psychologists/other masters therapist: 1 per 1,000 members

Q. Provide copies of all documents that relate to Aetna's consideration of and decision to require providers to use the education CPT code 98960, and all communications with providers and others regarding its use.

A. The use of 98960 was not broadly communicated to the provider community; rather it is done at the time of negotiation and [provider] agreement execution. Certified ABA providers contracted with Aetna are required to use code 98960 when billing for ABA services in accordance with their Services and Compensation Schedule. Providers who are not contracted may bill with 98960 or other recognized behavioral health procedure codes. However, during the ABA precertification process, there is an attempt to negotiate an *ad hoc* agreement. If the non-participating provider agrees to the terms of the *ad hoc*, the agreement would use procedure code 98960 with the appropriate number of units approved for ABA services. Non-participating providers who have agreed to an *ad hoc* arrangement are therefore also required to bill with procedure code 98960. Aetna utilizes nationally recognized coding structures including, but not limited to, AMA Current Procedural Terminology (CPT4), CMS Common Procedure Coding System (HCPCS) Revenue Codes as described by the

Uniform Billing Code, Diagnosis Related Groups (DRGs). Because there is no standard procedure code set for ABA services, and after our due diligence with a number of professional organizations, including the American Academy of Pediatrics, Aetna chose to use code 98960 for its contracted providers. Code 98960 specifies:

Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face to face with the patient (could include caregiver/family; each 30 minutes).

- Q. Provide the number of claims based on CPT code 98960 which Aetna denied from March 31, 2011, to the present, and further provide the number of those claims which involve behavioral health treatment for autism.**
- A. The Company does not have this information readily available. The Company is providing the following in response: 1). For the time period under examination (June 1, 2008 through March 31, 2011), there were 81 such claims denied; a total of 7,622 claims for ASD services were paid. 2). Effective April 1, 2012, ABA Therapy became an allowed benefit on the Company's health plans, pursuant to implementation of SB946.

Coverage for Speech Therapy

- Q. What insurance products does Aetna offer that provide speech therapy for insureds with ASD?**
- A. All health policies issued by Aetna Life Insurance Company include coverage for speech therapy, for any and all diagnoses.
- Q. What insurance products does Aetna offer that exclude or limit speech therapy for such insureds?**
- A. All health policies limit speech therapy for medical necessity and all applied annual number of visit limits, for any and all diagnoses. As of December 1, 2011, annual visit limits for speech, occupational and physical therapy, for patients with a severe mental illness diagnosis, including ASD are no longer applied to the Company's plans.
- Q. What is Aetna's reason for excluding or placing limits on the availability of speech therapy for such insureds?**
- A. Limits were applied for speech therapy for any and all types of diagnoses.
- Q. What is Aetna's position regarding whether and to what extent the Mental Health Parity Act precludes limits on speech therapy for insureds with ASD?**
- A. The Company implemented the California 1999 Mental Health Parity Act to allow coverage for speech therapy services in connection with a diagnosis of ASD subject to the same conditions and limitations applied to other diagnoses.

Effective December 1, 2011, the Company removed visit limits for speech therapy provided in connection with an ASD diagnosis. The Company is aware that there are recent court opinions interpreting the California Mental Health Parity Act as mandating broader coverage for severe mental illness diagnoses than is provided for other medical conditions and that California SB946 does not permit benefit limits for speech therapy.

DETAILS OF THE CURRENT EXAMINATION

Further details with respect to the examination and alleged violations are provided in the following tables and summaries:

LINE OF BUSINESS / CATEGORY	CLAIMS IN REVIEW PERIOD	MEMBERS WITH CLAIMS IN REVIEW PERIOD	SAMPLE MEMBERS REVIEWED	NUMBER OF ALLEGED VIOLATIONS
Accident and Disability / Individual Health / Denied / Autism Spectrum Disorder	169	6	6	39
Accident and Disability / Group Health / Denied / Autism Spectrum Disorder	1,342	102	49	237
TOTALS	1,511	108	54	276

TABLES OF TOTAL CITATIONS

Citation	Description of Allegation	Aetna	
		Member Sample Claim	Member Related Claim
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.	35	83
CIC §10169(i) *[CIC §790.03(h)(1)]	The Company failed to advise the insured of the right to request an independent medical review on letters of denials and on all written responses to grievances in cases in which the insured believes that health care services had been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers.	49	24
CIC §790.03(h)(1)	The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.	29	-
CCR §2695.7(g) *[CIC §790.03(h)(5)]	The Company attempted to settle a claim by making a settlement offer that was unreasonably low.	6	19
CIC §10123.13(a) *[CIC §790.03(h)(5)]	The Company failed to reimburse claims as soon as possible, but no later than 30 working days after receipt of the claim.	1	6
CIC §10123.13(c) *[CIC §790.03(h)(5)]	The Company failed to pay interest on a contested claim after 30 working days.	3	4
CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.	5	-
CCR §2695.7(d) *[CIC §790.03(h)(3)]	The Company failed to conduct and diligently pursue a thorough, fair and objective investigation.	3	-
CCR §2695.11(b) *[CIC §790.03(h)(3)]	The Company failed to provide to the claimant an explanation of benefits including the name of the provider or services covered, the dates of service, and a clear explanation of the computation of benefits.	3	-

Citation	Description of Allegation	Aetna Number of Alleged Violations	
		Member Sample Claim	Member Related Claim
CCR §2695.7(d) *[CIC §790.03(h)(3)]	The Company persisted in seeking information not reasonably required for or material to the resolution of a claims dispute.	2	-
CCR §2695.3(b)(3) *[CIC §790.03(h)(3)]	The Company failed to maintain hard copy files or maintain claims files that are accessible, legible and capable of duplication to hard copy for five years.	2	-
CIC §10123.13(a) *[CIC §790.03(h)(13)]	The Company failed to notify in writing, within 30 working days after receipt of the claim, both the insured and the provider that the claim was denied.	1	-
CCR §2695.11(d) *[CIC §790.03(h)(3)]	The Company failed to provide written notice of the need for additional time every 30 calendar days.	1	-
Total Number of Violations		140	136

In preparation for the examination of ASD claims files, the Company found that, between May 6, 2008 and September 27, 2011, it had inappropriately denied a number of claims for speech therapy for the treatment of ASD. To correct the errors, the Company conducted two phases of a Regulatory Rework Project that reprocessed the impacted claims. This table reflects the Department's findings in both phases of the project.

REGULATORY REWORK PROJECT

Citation	Description of Allegation	Aetna Number of Alleged Violations
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.	896
CIC §10169(i) *[CIC §790.03(h)(1)]	The Company failed to advise the insured of the right to request an independent medical review on letters of denials and on all written responses to grievances in cases in which the insured believed that health care services had been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers.	367
Total Number of Violations		1,263

*DESCRIPTONS OF APPLICABLE UNFAIR CLAIMS SETTLEMENT PRACTICES

- CIC §790.03(h)(1) The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.
- CIC §790.03(h)(3) The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.
- CIC §790.03(h)(5) The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.
- CIC §790.03(h)(13) The Company failed to provide promptly a reasonable explanation of the basis relied upon in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.

TABLE OF VIOLATIONS BY LINE OF BUSINESS

ACCIDENT AND DISABILITY HEALTH	NUMBER OF VIOLATIONS
2008 Direct Written Premium Individual: \$ 102,360,914 2009 Direct Written Premium Individual: \$ 151,472,959 2010 Direct Written Premium Individual: \$ 197,938,277 2008 Direct Written Premium Group: \$ 1,100,070,391 2009 Direct Written Premium Group: \$ 1,285,510,858 2010 Direct Written Premium Group: \$ 1,402,813,759	
AMOUNT OF RECOVERIES \$131,365.40	
CIC §790.03(h)(5)	118
CIC §10169(i) [CIC §790.03(h)(1)]	73
CIC §790.03(h)(1)	29
CIC §2695.7(g) [CIC §790.03(h)(5)]	25
CIC §10123.13(a) [CIC §790.03(h)(5)]	7
CIC §10123.13(c) [CIC §790.03(h)(5)]	7
CIC §790.03(h)(3)	5
CCR §2695.7(d) [CIC §790.03(h)(3)]	3
CCR §2695.11(b) [CIC §790.03(h)(3)]	3
CCR §2695.7(d) [CIC §790.03(h)(3)]	2
CCR §2695.3(b)(3) [CIC §790.03(h)(3)]	2
CIC §10123.13(a) [CIC §790.03(h)(3)]	1
CCR §2695.11(d) [CIC §790.03(h)(3)]	1
TOTAL	276

SUMMARY OF EXAMINATION RESULTS

The following is a brief summary of the criticisms that were developed during the course of this examination related to the violations alleged in this report.

In response to each criticism, the Company is required to identify remedial or corrective action that has been or will be taken to correct the deficiency. The Company is obligated to ensure that compliance is achieved.

Any noncompliant practices identified in this report may extend to other jurisdictions. The Company was asked if it intends to take appropriate corrective action in all jurisdictions where applicable. The Company indicates that these practices are not applicable in other jurisdictions.

Money recovered within the scope of this report was \$38,397.03, including late claim interest, as described in sections number 1(a), 1(b), 1(d), 4(a), 4(b), 4(c), 5, and 6 below. In preparation for the examination of ASD claims files, the Company found that, beginning May 6, 2008 through September 27, 2011, it had inappropriately denied a number of claims for speech therapy for the treatment of ASD. To correct the errors, the Company completed a Regulatory Rework Project in two phases to reprocess claims that were inappropriately denied. The two phases of the Regulatory Rework Project recovered \$92,968.37. Details of the Regulatory Rework Project are presented in section number 1(d) below. The total amount of money, including late claim interest, returned to claimants as a result of the examination was \$131,365.40.

ACCIDENT AND DISABILITY
Individual Health and Group Health
Autism Spectrum Disorder – Denied

1. **In 118 instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear.** Specifically, the Company failed to pay a claim for the treatment of ASD under the provision of the policy that affords coverage for a severe mental illness or a serious emotional disturbance of a child as mandated and defined in CIC §10144.5. With regard to the number of alleged violations for ABA therapy and speech therapy for the treatment of ASD, eight of the instances pertain to member claims files in Individual health plans and 110 instances pertain to member claims files in Group health plans. In addition, 896 instances are identified in the Company's Regulatory Rework Project pertaining to member claims in Group health, as described below in 1(d). The Department alleges these acts are in violation of CIC §790.03(h)(5).

1(a). ABA Therapy Individual Health. The Company incorrectly denied one claim for ABA therapy under its Individual health policies on the basis it had not received requested additional information, which was not required since the Company already had the information. The Department alleges this act is in violation of CIC §790.03(h)(5).

Summary of the Company's Response to 1(a): The Company agrees the claim should have been considered and that it incorrectly pended and subsequently denied the claim for non-receipt of the requested information. The Company reversed the denial and paid \$1,085.58, including interest, as a result of the reprocessing. The Company states its Individual health policy does not have exclusionary language for ABA or educational services.

1(b). Speech Therapy Individual Health. The Company denied seven claims for speech therapy for the treatment of ASD under its Individual health policies. Five of the claims were processed incorrectly resulting in a wrongful denial. Two of the five claims were denied on the basis the policy does not afford coverage for outpatient speech therapy for the treatment of ASD. The Department alleges these acts are in violation of CIC §790.03(h)(5).

Summary of the Company's Response to 1(b): The Company agrees it processed five claims incorrectly which resulted in their inappropriate denial. The Company reversed the denials and paid claims totaling \$2,155.26, including interest, as a result of the reprocessing. The Company states that two claims were appropriately denied as the Individual policy covers speech therapy services incurred in a Skilled Nursing Facility or Home Health Care setting only and excludes outpatient speech therapy except following surgery, injury or non-congenital organic disease. The claims in the universe of the Individual health denied claims were reviewed for inclusion in the Regulatory Rework Project, as described below in subsection 1(d). However, that review concluded that the applicable benefits were applied based on Plan provisions.

Based on these findings, inclusion of Individual claims on the Regulatory Rework Project was not indicated.

The Company believes that the Speech Therapy coverage limitations were in compliance with the law in effect at the time. The limitations were applied equitably to both medical and mental health diagnoses. In addition, absent any comment or guidance from the Department, the Company applied its filed and approved plan language in these instances.

Summary of the Department's Evaluation of the Company's Response to

1(b): The Company's Individual health policies provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, as mandated by CIC §10144.5 under the California Mental Health Parity law. The Department finds the Company does not apply such policy provisions to the processing of speech therapy claims for the treatment of ASD. Therefore, this is an unresolved issue which may result in administrative action.

1(c). ABA Therapy Group Health. The examination reviewed one claim for psychotherapy services prescribed for the treatment of ASD. The Company denied the claim on the basis the Plan excludes ABA therapy. The Department alleges this act is in violation of CIC §790.03(h)(5).

Summary of the Company's Response to 1(c): Aetna states that historically, it has considered ABA therapies to be educational in nature and were, therefore, excluded from coverage. The charges in question were identified as ABA services and were appropriately denied under the educational exclusion of the Plan. Prior to California's enactment of a mandate for coverage of ABA and like therapies, the Company believes it was applying the plan's benefit exclusions appropriately.

Summary of the Department's Evaluation of the Company's Response to

1(c): The Company's Group health policies provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, as mandated by CIC §10144.5 under the California Mental Health Parity law. The Department finds the Company does not apply such policy provisions to the processing of ABA therapy claims for the treatment of ASD. Therefore, this is an unresolved issue which may result in administrative action.

1(d). Speech Therapy Group Health. The review of 49 members' claims files identified 109 claims for speech therapy for the treatment of ASD that were improperly denied. Eighty-five of the claims were denied on the basis that charges for speech therapy are covered only when the speech therapy is expected to restore speech function or to correct a speech impairment resulting from non-chronic conditions; 24 were denied on the basis the policy's annual benefit maximum for speech therapy had been reached. In its Regulatory Rework Project, the Company reprocessed 529 claims that were inappropriately denied for medically necessary speech therapy services on the basis that charges for speech therapy are covered only when the speech therapy is expected to restore speech function or to correct a speech impairment resulting from

non-chronic conditions. The Department alleges these acts are in violation of CIC §790.03(h)(5).

Summary of the Company's Response to 1(d): The Company reversed 13 speech therapy claims it agrees were improperly denied on the basis that charges for speech therapy are covered only when the speech is expected to restore speech function or to correct a speech impairment resulting from non-chronic conditions and paid \$5,164.79, including interest, as a result of the reprocessing. The Company agrees 72 claims were originally processed incorrectly and were reprocessed prior to the examination within the review period.

The Company believes that the Speech Therapy annual limits applied in the remaining 24 instances were in compliance with the law. Many of the Company's current policies and certificates of coverage contain visit limitations. The limits were applied equitably to both medical and mental health diagnoses. In addition, absent any comment or guidance from the Department, the Company applied its filed and approved plan language in these instances.

In preparation for the examination of the ASD claims, the Company performed a thorough analysis of the claims. That review revealed that there were a number of denied claims for speech therapy (CPT 92507) with behavioral health diagnosis codes. Upon further research, the Company discovered that code 92507 was not in a table of codes used by the system to allow the services to auto-adjudicate under the Mental Health Parity requirements. When claims were submitted containing a combination of a behavioral diagnosis code attached to CPT-4 code for speech therapy, 92507, they were inappropriately denied. That processing error commenced on May 6, 2008, when the table and the system logic were first put in place. Prior to that date, all therapy claims required manual processing. The Company prepared the following detailed explanation of the mechanics of the error:

The Company utilizes two 'tables' in its auto-adjudication system. One is named the Legislative Rule Table (LRT) and the other is the Aetna Standard Table (AST). The LRT is used for processing mental health parity claims based on diagnosis codes. The LR Table handles only claims with behavioral health diagnosis codes.

The AST handles all types of claims – including behavioral health. The AST drops a claim into a bucket for manual processing. We look at each table and decide which of these processes will work for the given situation.

We didn't realize speech therapy claims were not directed to the LR Table. [A code for] Speech Therapy is captured by the AST and drops to the processor [for manual processing]. We felt the LR Table was the right vehicle for these claims, but when the LRT didn't work, we realized that the AST was the right vehicle. Autism claim-handling has evolved over time; we learned from our mistakes and we are confident that our current process is working.

The Company's first priority was to correct the error in the table/system logic as described above. This was completed on September 27, 2011. Its second priority was to rework any and all claims on the universe of ASD denied claims that were provided for this examination. To accomplish this, the Company initiated a Regulatory Rework Project (hereinafter referred to as the Project) that would reverse claims that were wrongly denied because of the error in the table/system logic.

The Project was conducted in two phases. The first phase—was completed on December 16, 2011. In February 2012, the Company extended the time period to include May 1, 2008 through September 30, 2011, and expanded the Project to a second phase to address four additional concerns. First, the second phase included a review of fully denied Group claims that were not included in the first phase. Next, the second phase included a review of fully denied claims under Individual plans during this period. Third, the second phase included claims that were improperly denied after the Company determined that two other CPT-4 codes for speech therapy (92506 and 92508) with behavioral health diagnoses were also omitted from its table/system logic. Fourth, the second phase included denied claims in which part of the claim had been denied and part of the claim had been paid. These claims, identified by the Company as partially denied/partially paid, were overlooked in the first phase since the Company included them in the paid claims universe. At the request of the Department, the second phase also identified appeals from either a provider or a member, in which the claim denial was upheld, including those appeals that were denied on the basis the appeal was filed too late. The Company also agreed to identify and rework claims involving a CDI consumer complaint involving such claims which may have been denied inappropriately as a result of the error in its table/system logic. The results of the second phase were reported to the Department on July 19, 2012.

The number of speech therapy claims denied for the treatment of ASD during the examination review period was 1,511 Group health claims and 169 Individual health claims. Due to the expanded time period for the Project (May 1, 2008 through September 30, 2011), the number of group denied claims to be reworked in the project increased from 1,511 to 1,592. As a result of its review of Individual health claims, the Company concluded that their inclusion in the Project was not indicated based on applicable Plan provisions. Therefore, the Project reworked 1,592 speech therapy claims for the treatment of ASD that had been denied during this extended period. Of those claims, the Company determined that 672 had been processed correctly, 21 were denied as duplicates, two were denied for terminated coverage, and one was denied as an overpayment, thus reducing the number of claims eligible for rework to 896.

The remaining 896 claims were then reworked to allow the speech therapy services. Of the 896 reworked claims, 382 resulted in direct payments to members and providers totaling \$77,167.02 (including \$10,805.96 late claim interest). Of the remaining 514 claims, 147 claims were allowed toward plan deductibles totaling \$15,801.35. In these 147 instances, no dollars were paid out because the amounts are a member liability under their plan deductibles. Therefore, the total amount recovered in the Regulatory Rework Project is \$92,968.37.

The Company denied the remaining 367 reworked claims on the basis the annual plan benefit limit for speech therapy had been met.

Aetna provided the Department with a copy of an internal procedures document entitled, "Aetna's Response to the Law, Policy Modified 12/20/2011, Autistic Disorder Coverage." The document reads (in part):

...Autism is both a mental health diagnosis and a medical diagnosis. The treatment of autism often involves both mental health and medical treatment.

As applied to Speech, Occupational and Physical therapy, we interpret this law to mean that we should not limit coverage of these therapies for people with PDD/autism to those that are expected to result in the improvement of a body function...which has been lost or impaired due to an injury; a disease; or congenital defect," or "to restore speech to a person who has lost existing speech function...as the result of a disease or injury."

Traditional Plans

For ease of administration and consistency with our response to other legislation of this nature, our response to AB 88 for Managed Choice, Open Choice, Traditional Choice and Major Medical plans is that we will provide coverage (both in and out of network, if applicable) for all necessary treatment of mental illness on the same basis as any other physical illness (i.e., these expenses may no longer be reimbursed at a lower coinsurance level). Any applicable separate mental illness outpatient calendar year visit maximum or inpatient calendar year day maximum (including partial hospitalization) will be removed.

...Due to a business decision, we will not apply plan visit limits to physical, occupational, and speech therapy services, nor will Clinical Claim review be required for Traditional products (this is an 'unlimited' benefit). This decision is effective for services incurred on/after 12/01/11. An Aetna Standard Table (AST) exception has been created to capture these services.

Summary of the Department's Evaluation of the Company's Response in

1(d): In 24 instances of Group health member claims identified in the examination, the Company denied the claims for speech therapy for the treatment of ASD on the basis that the policy benefit maximum for speech therapy had been reached. In these instances, the Company failed to pay a claim for the treatment of ASD under the provision of the policy that affords coverage for a severe mental illness or a serious emotional disturbance of a child as mandated and defined in CIC §10144.5. Therefore, this is an unresolved issue that may result in administrative action.

In its Regulatory Rework Project, the Company maintained the denial in 367 instances in the reprocessing of claims for medically necessary speech therapy services on the basis that the policy benefit maximum for speech therapy had been reached. In

these instances, the Company failed to pay a claim for the treatment of ASD under the provision of the policy that affords coverage for a severe mental illness or a serious emotional disturbance of a child as mandated and defined in CIC §10144.5. Therefore, this is an unresolved issue that may result in administrative action.

2. In 73 instances, the Company failed to advise the insured of the right to an independent medical review (IMR) on letters of denials and on all written responses to grievances in cases in which the insured believed that health care services had been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. Specifically, the Company failed to provide the IMR notice in these instances in which it denied or limited the payment of Individual and Group health claims for the medically necessary prescribed treatment of ASD. It is also noted in its Regulatory Rework Project, the Company failed to advise the insured of the right to an IMR in 367 instances in which it maintained the denial in the reprocessing of claims for medically necessary speech therapy services on the basis that the policy benefit maximum for speech therapy had been reached. The Department alleges these acts are in violation of CIC §10169(i) and are unfair practices under CIC §790.03(h)(1).

Summary of the Company's Response: The Company states that it routinely provides members with their rights to an Independent Medical Review (IMR) in those instances in which an IMR might be granted (when services are denied for reasons of medical necessity). The Company agrees that it failed to provide the IMR notice in four of the instances. The remaining instances cited to be in violation of CIC §10169(i) were services denied for reasons of coverage and/or benefit limitations under the member's plan. In view of the fact that the Department would prefer that these rights be provided more liberally, the Company is taking action to add IMR rights to all member EOBs. The Company anticipates full implementation of the revised EOB language by no later than February 28, 2013.

3. In 29 instances, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to coverages at issue. The Department alleges these acts are in violation of CIC §790.03(h)(1).

3(a). In 21 instances, the Company's Open Access Managed Choice Benefit Plan, identified as GR-9N, provided conflicting language that therapy services for treatment for ASD are not covered; yet the policy definition of Mental Disorder includes ASD and the schedule of benefits for Outpatient Treatment of Mental Disorders indicates outpatient services are payable subject to the same co-pay, deductible, percentage and maximums that apply to any other illness. The Company's Amendment Rider 1303N issued in October 2011 that was intended to remedy the error failed to correct all conflicting policy language with respect to coverage for ASD.

Summary of the Company's Response to 3(a): The Company explains that the mailing of the Amendment Rider 1303N in October of 2011 was intended to clarify any and all language in the policy that may have unintentionally read that treatment for ASD was not covered under the plan. The Company agrees that it failed to address all

such language in the policy document. The Company did in fact continue to cover treatment for ASD regardless of any residual ambiguous plan language. The Company filed new language with the Department, in November 2011, and is awaiting its approval before issuing new plan documents to its members.

The Company states that it has covered services for the treatment of autism since the California Insurance Code §10144.5 was enacted as part of the California Mental Health Parity Act. It was effective for California policies issued or renewed on or after July 1, 2000. It is the Company's position that the law requires insurers that provide hospital, medical, or surgical coverage also to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person and of serious emotional disturbances of a child (including ASD) under the same terms and conditions that the insurer applies to medical conditions.

3(b). In six instances, the Company provided misleading information regarding the insured's right to appeal the final determination. Specifically, the EOB advises the insured has the right to bring a civil action under §502(a) of ERISA, if applicable. No determination was made that such individual policy is subject to ERISA.

Summary of the Company's Response to 3(b): The Company disagrees with this finding. The Company advises the member of the right to bring a civil action under §502(a) of ERISA on all of its EOB statements because the Company's systems cannot support different EOBs for Individual plans and for other plans not subject to ERISA. The fact that the Company includes the phrase "if applicable" in the notice communicates to the recipient that the right to bring civil action under ERISA is not available under all of the Company's benefit plans. The Company does not believe that this issue warrants administrative action because no member has been harmed by the inclusion of wording which informs members of the possibility of the right to appeal under ERISA. However, the Company is taking this under consideration and will be rewriting the language to make it clear that the rights to appeal under ERISA do not apply to members on a Voluntary Individual plan.

3(c). In one instance, the EOB provides contradictory explanatory remarks. One remark states the insured is not responsible for the unpaid amount and another remark states the insured may be responsible for the unpaid amount.

Summary of the Company's Response to 3(c): This is a claims processor error. The Company reprocessed the claim with the appropriate remark code.

3(d). In one instance, the Company stated the group plan excludes charges for speech therapy. The exclusion as stated is not found in the Plan document provided in the examination.

Summary of the Company's Response to 3(d): The Company states that this claim was inappropriately denied. The diagnoses submitted on the claim indicate autism and speech disturbance. This claim was denied due to processor error as the processor failed to take the diagnosis into consideration and also applied an incorrect

code to the claim resulting in the message on the EOB indicating, “Your Plan excludes charges for Speech Therapy”. The claim was reprocessed on December 21, 2011, as a result of an exam inquiry. A total of \$600 in charges was processed. Of that amount, \$500 was applied to the member’s deductible and \$100 was paid at 70% reimbursement to the member. The Company provided the EOB for this reworked claim to the Department during the course of the examination.

4. In 25 instances, the Company attempted to settle a claim by making a settlement offer that was unreasonably low. The Department alleges these acts are in violation of CCR §2695.7(g) and are unfair practices under CIC §790.03(h)(5).

4(a). In 14 instances, the Company underpaid charges for health and behavior intervention that is billed in 15-minute units under Current Procedural Code (CPT) 96152. Specifically, the Company failed to process the correct number of units included in the charges.

Summary of the Company’s Response to 4(a). The Company agrees that these claims were incorrectly processed. When a CPT code is billed that reflects part of an hour, such as CPT-4 Code 96152, the hours should be converted into the appropriate minutes. For example, if the provider bills one hour for CPT code 96152, this would be converted to 4 units. The correct number of units was not applied to these claims. The Company initiated reprocessing of all impacted claims and issued payments to providers in the total amount of \$12,051.72, including interest.

The Company also states that a contributing factor to the mistakes is that the CPT Code 96152, by definition, should be billed to the carrier with the correct numbers of units already calculated. Therefore, processors may have assumed that the billed number of units is the correct number of units. However, processors are trained to read through all documentation submitted with each claim. When a provider or member provides documentation that clarifies how the units are billed, it will be taken into consideration.

To ensure that proper procedures were followed and that appropriate payments were made during the time period June 1, 2008 – September 20, 2011, the Company performed a search of claims, submitted under Group and Individual Policies, containing an ASD diagnosis along with CPT Code 96152. This search identified a total of 94 ASD claims (for five members) that billed with CPT Code 96152. The results show that 93 claims were processed correctly and one claim, containing 20 segments, required reprocessing of seven segments that were underpaid. These segments were reprocessed on August 29, 2012, which resulted in an additional payment to the member of \$3,815.66, including \$1,073.37 in late claim interest. The Company provided the Department with a copy of the check and corresponding EOB that were sent to the member. As a result of this examination, the total amount recovered for these processing errors is \$15,867.38.

4(b). In 10 instances, the Company allowed the incorrect amount toward the policy deductible. Specifically, in seven of the instances pertaining to one member, the Company failed to integrate expenses applied toward the preferred care deductible with

expenses applied toward the non-preferred care deductible, as provided by the group plan. The failure to combine allowed preferred expenses with non-preferred expenses caused an accumulation of \$2,321.86 in excess of the member's annual policy deductible. It also resulted in unpaid claims.

In three of the instances, involving the reversal of inappropriate denials, the Company incorrectly allowed an additional deductible that had already been met.

Summary of the Company's Response to 4(b). The Company reprocessed the seven impacted claims to reverse the excess amount that had been applied to the member's annual deductible. As a result of the reprocessing, the Company paid \$815.61, including interest, to either the member or provider. The Company explains the error was made in the loading of the integrated deductible provision into its claims system. The Company completed the plan correction on July 2, 2012. In response to the Department's concern that the Company also applied an excess deductible amount to claims submitted by other members insured under the same plan structure, the Company reviewed all of the subscribers covered under the same employer-sponsored group plan in the calendar year 2009. The Company provided the Department with the results of its investigation that indicated no other subscribers to the plan were impacted by this issue during the calendar year 2009.

To correct the three other deductible errors made in reprocessing claims, the Company reversed the errors and paid a combined total of \$670.06, including interest, to either the member or provider.

4(c). In one instance, the Company underpaid the contracted provider rate.

Summary of the Company's Response to 4(c). The claim was priced applying a prior contracted rate for this provider in error due to processor oversight. As a result, the Company paid the provider an additional \$53.60 including interest.

5. In seven instances, the Company failed to reimburse claims as soon as practical but no later than 30 working days after receipt of the claim. The examination found seven claims covering multiple dates of service for the treatment of ASD that had not been processed. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company processed the claims and issued payments totaling \$11,797.46. Although the Company agrees that there were seven instances of claims in which it failed to process in a timely manner, five of those claims were attached to one claim submission and the other two were attached to one other claim submission. In one such instance, the Company states the member submitted claim documentation consisting of 74 pages that was not well organized and difficult to sort. The Company states it rarely receives paper claim submissions. The Company has alerted its claims department of these findings and has reminded staff that careful consideration must be given to all documents submitted with paper claims.

6. In seven instances, the Company failed to pay interest on a contested claim after 30 working days. The Department alleges these acts are in violation of CIC §10123.13(c) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: In the reprocessing of inappropriately denied claims that were overturned on appeal, the processor failed to base the calculation of the interest on the received-date of the claim. The Company reprocessed the claims for the payment of interest and issued interest payments totaling \$787.29.

The Company states that it has reviewed each of these instances and has traced the root cause to the instructions provided by either Customer Service or the Appeals area to the Claims Department. When Claims receives instructions to rework a claim from either Customer Service or Appeals, it relies upon the instruction to set the received-date to be used in the rework. In these instances, the instructions were incorrect in stating that the dates to be used were the dated additional information was received, rather than the original claim received-date.

The Company has notified these three teams of these findings and has clarified the guidelines for rework and applicability for applying the original receipt date of the claim (Aetna error) or the date additional information is received (non-Aetna error). Additionally, as most of these errors were specific to claims reworked due to overturn upon appeal, the Company will review the report of Appeals received during the examination period, identify those for which the appeal resulted in claim rework, and review the rework in those instances for any possible errors in the payment of interest. The Company will monitor compliance through its Quality Program which routinely audits claims for payment accuracy.

7. In five instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies. Specifically, as a result of an internal project intended to rework payments of claims in which pre-certification was required but had not been obtained, the Company wrongly reversed payments of claims for speech therapy services by a non-contracted provider which did not require pre-certification. The Department alleges these acts are in violation of CIC §790.03(h)(3).

Summary of the Company's Response: In May 2008, the Company implemented a system update such that all non-participating providers' claims in referral-based products may receive the participating benefit level if a pre-certification record is found. The system update applied the following logic to such claims: (1) If there was a precertification, the Aetna Standard Table (AST) would not be applied, as the precertification overrides AST; (2) If a precertification did not exist, the AST table should have been applied and claims should have been pended or denied based on the AST rules. This second requirement was not properly implemented. As a result, the AST logic was bypassed as programming did not include checking for a precertification record. This resulted in claims being processed without AST application which generated overpayments.

To correct the improper implementation, the Company initiated a project in August 2010 to identify claims potentially impacted by this issue. The sample claims

were reconsidered in the project and the AST table was applied which resulted in the wrongful denial of the five identified claims.

The claims impacted by the failure of the AST system to check for a precertification record were identified and reprocessed in the Company's Regulatory Rework Project which was completed between November 9 and December 16, 2011, as described in 1(d) above.

The root cause of this error was due to an inadequate testing design for the project in question. The Company has enhanced its processes to include a more robust design for testing before a project goes "live". It is also important to note that this project touched approximately 20,000 claims, but only five errors were detected.

8. In three instances, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation. The instances are found in the Company's handling of appeals and in the investigation of a pre-existing condition. The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

8(a). In one instance, the Company failed to respond to a member's appeal within a reasonable amount of time.

Summary of the Company's Response to 8(a): The Company explains that the member's appeal was initially treated as a provider appeal and was sent to the wrong department for handling. When the error was discovered it was sent to the correct member department for handling. Aetna continues to provide education to the triage area to ensure the appeal is classified as a member or provider request.

8(b). In one instance, the Company delayed the start of a pre-existing condition investigation.

Summary of the Company's Response to 8(b): The Company states the delay in sending pre-existing investigation letters was due to processor oversight.

8(c). In one instance, the Company failed to obtain benefit payment information from Medicare prior to the denial of the claim.

Summary of the Company's Response to 8(c): The Company agrees this claim was not handled appropriately. The processor failed to follow Medicare claim processing policy. The Medicare payments should not have been estimated; the processor should have waited for the Medicare statement to adjust the claim correctly.

The Company will re-emphasize the appropriate handling procedures, with respect to Medicare primary and secondary procedures, with its claim processing staff.

9. In three instances, the Company failed to provide to the claimant and assignee an explanation of benefits including the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits. The Department alleges these acts are in violation of CCR §2695.11(b) and are unfair practices under CIC §790.03(h)(3).

9(a). In one instance, the Company failed to provide an explanation of benefits to the provider although an assignment of benefits was indicated on the claim form submitted by the provider on December 30, 2010.

Summary of the Company's Response to 9(a): The Company explains the sample claim was originally submitted electronically and rejected without being entered into the claim system. Based on its re-review, the Company agrees that the paper claim was submitted with a valid assignment of benefits and the claim should have been assigned to the provider. The error is due to processor oversight. The sample claim was then processed based on the paper submission received December 30, 2010. The amount allowed on the claim was applied to the member's deductible and no monies were paid out.

The reason no provider EOB was produced is because the claim was incorrectly processed as a member reimbursement claim submission. The Company will write a letter to the Provider explaining the error and present information for the Provider to correct its record as opposed to reprocessing the impacted claim that is now two years old.

9(b). In one instance, the Company failed to provide to the claimant and assignee an explanation of benefits including, the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits.

Summary of the Company's Response to 9(b): The Company agrees that the claim detail on the EOB lists the treatment as "Medical Services" and notes that the provider identified the services rendered using the CPT code on the claim submitted for payment. The treatment referenced as "Medical Services" does not comply with the referenced regulation for a clear explanation of benefits. The Company has previously identified this issue and completed corrective action regarding claim detail on the EOB. Current claims would display the code and description as ASSESS HLTH/BEHAVE, for example, on the EOB statement.

9(c). In one instance, the EOB did not clearly explain the re-processing of the charges. Specifically, the amount of charges in consideration appeared to be twice the amount billed.

Summary of the Company's Response to 9(c): The Company states that the original claim segment was inappropriately denied and was subsequently reconsidered. It was coincidental that both claim segment numbers were applied to the same draft generation date. The Company agrees that the EOB does not clearly explain the re-processing.

The Company does not feel that a corrective measure is warranted. This issue occurs only when a claim is adjusted (reworked) before the EOB for the original claim is sent out. This causes the original claim segment to display on the EOB as two separate claims, instead of one adjusted claim. Because it is displayed as one claim, the billed

amounts for the two claims are added together; in this case, it displays \$720 instead of \$360.

The Company evaluated the problem and determined it is known to have happened in the history of the claim system only two or three times in 20 or more years. Generally, claims are not adjusted until the EOB is mailed which may then trigger a subsequent inquiry or complaint.

10. In two instances, the Company persisted in seeking information not reasonably required for or material to the resolution of a claims dispute. In one of the instances, the Company asked for detailed medical information upon receipt of the subject claim when it was not required. In the second instance, the Company asked for detailed medical information upon receipt of the subject claim when it had paid similar claims both before and after the subject claim without the need for detailed medical information. The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: In the first instance, the Company states the request was inadvertently made due to processor oversight. In the second instance, the processor reviewed the claim and based on the diagnoses submitted, referred the claim to the Clinical Claim Review (CCR) area to determine the correct benefit.

The Company has implemented corrective action to address inappropriate requests for medical records when the Company has already received them or when they are not necessary.

First, effective March 22, 2012, the Company added a new category to its Correspondence Unit, known as ECHS, in support of a new workflow for Clinical Claim Review Therapy records requests. The new workflow will direct Clinical Claim Review requested records directly to a Clinical Claim Review team, eliminating the need for transfers from the Claims Department. The use of this category will route the correspondence received directly to CCR and thus reduce the chance of misdirected work tasks.

Second, effective July 1, 2012, Medical Necessity Review is no longer required for these services. Processors are no longer required to request medical records for claims with a diagnosis of ASD.

11. In two instances, the Company failed to maintain hard copy files or maintain claims files that are accessible, legible and capable of duplication to hard copy for five years. The Department alleges these acts are in violation of CCR §2695.3(b)(3) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: In these two instances, the Company states that both it and its vendor neglected to maintain a copy of the plan documents including the specific Plan Certificate containing the member's name. The Company has traced the root cause of this error to its mailing vendor. During the time period under examination, the Company changed vendors. The terminated vendor failed to provide all records to the new vendor during the transition period.

The Company is attempting to recover the missing documents by contacting the terminated vendor to locate a “batch” of records that were not transitioned, by contacting the current vendor to review which documents were transitioned, and by reviewing the document retrieval process with the new vendor.

To ensure that Aetna’s record retention and privacy policies are met by the new vendor, specific record retention requirements are included in the contract with the new vendor. The Company also states that it does maintain a record of which plan the member is enrolled in, and also has records that indicate a copy of those plan documents were mailed to the member. The Company further states it provided a copy of the applicable plan documents during the examination.

12. In one instance, the Company failed to notify in writing, within 30 working days after receipt of the claim, both the insured and the provider that the claim was denied. The Department alleges this act is in violation of CIC §10123.13(a) and is an unfair practice under CIC §790.03(h)(13).

Summary of the Company’s Response: The Company acknowledges that the sample claim was not denied in a timely manner and is therefore noncompliant with CIC §10123.13(a). The Company states it sets standards of 100% compliance with regulatory requirements for timely denials of claims, and routinely processes its claims with greater than 99% compliance to turn-around times. The Company states it will continue to use all possible resources, utilize work balancing strategies, and monitor for compliance with these standards. The Company disagrees that this single incident constitutes an unfair practice under CIC §790.03(h)(13).

13. In one instance, the Company failed to provide written notice of the need for additional time every 30 calendar days. The Department alleges this act is in violation of CCR §2695.11(d) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company’s Response: The Company acknowledges that, in the single instance noted, it failed to provide written notice of the need for additional time every 30 calendar days prior to the release of benefits. The Company states it sets standards of 100% compliance with regulatory requirements for pending claims and requesting additional information from sources outside of the Company. The Company states it will continue to use all possible resources, utilize work balancing strategies, and monitor for compliance with these standards. The Company agrees that this instance is noncompliant with CCR §2695.11(d). The Company disagrees that this single incident constitutes an unfair practice under CIC §790.03(h)(3).