



Arnold Schwarzenegger, Governor
State of California
Business, Transportation and Housing Agency

Department of Managed Health Care
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March 23, 2010

Via FedEx delivery and eFile

Ms. Mary V. Anderson
Western Region General Counsel
AETNA HEALTH OF CALIFORNIA, INC.
2625 Shadelands Drive
Walnut Creek, CA 94598

FINAL REPORT OF ROUTINE EXAMINATION OF AETNA HEALTH OF CALIFORNIA, INC.

Dear Ms. Anderson:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of **Aetna Health of California, Inc. (the "Plan")**, for the quarter ended March 31, 2008, conducted by the Department of Managed Health Care (the Department"), pursuant to Section 1382(a) of the Knox-Keene Health Care Plan Act of 1975.¹ The Department issued a Preliminary Report to the Plan on **January 23, 2010**. The Department accepted the Plan's electronically filed response on **March 11, 2010**. Also, the examination included a detailed review of the Plan's Incurred But Not Reported ("IBNR") liabilities for the quarter ended March 31, 2009.

This Final Report includes a description of the compliance efforts included in the Plan's March 11, 2010 response, in accordance with Section 1382(c).

Section 1382(d) states "If requested in writing by the plan, the director shall append the plan's response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and electronically file modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public."

¹ References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

Please indicate within ten (10) days whether the Plan requests the Department to append its response to the Final Report. If so, please indicate which portions of the Plan's response shall be appended, and electronically file copies of those portions of the Plan's response exclusive of information held confidential pursuant to Section 1382(c), no later than ten (10) days from the date of the Plan's receipt of this letter.

If the Plan requests the Department to append a brief statement summarizing the Plan's response to the report or wishes to modify any information provided to the Department in its March 11, 2010 response, please provide the electronically filed documentation no later than ten (10) days from the date of the Plan's receipt of this letter through the eFiling web portal. Please file this addendum electronically via the Department's eFiling web portal

<https://wps0.dmhc.ca.gov/secure/login/>, as follows:

- From the main menu, select "eFiling".
- From the eFiling (Home) menu, select "File Documents".
- From the File Documents Menu for:
 - 1) File Type; select "Amendment to prior filing";
 - 2) Original Filing, select the "**Filing No. 20080381**" assigned by the Department; and
 - 3) Click "create filing".
- From the Original Filing Details Menu, click "Upload Amendments"; select # of documents; select document type: "Plan addendum response to Final Report (FE5)"; then "Select File" and click "Upload".
- Upload all documents then upload a cover letter as Exhibit E-1 that references to your response.
- After upload, then select "Complete Amendment", complete "Execution" and then click "complete filing".

Questions or problems related to the electronic transmission of the above responses should be directed to Rita Ultreras at (916) 322-5393 or email at rultreras@dmhc.ca.gov. You may also email inquiries to wps0@dmhc.ca.gov.

The Department will make the attached Final Report available to the public in ten (10) days from the Plan's receipt of this letter through the eFiling system. The report will be located at the Department's web site at www.dmhc.ca.gov.

If there are any questions regarding this report, please contact me.

Sincerely,

ORIGINAL SIGNED BY

Stephen Babich
Supervising Examiner

Office of Health Plan Oversight
Division of Financial Oversight

cc: Lucinda Casillas, Regulatory Compliance Director
Mike Cleary, Chief, Division of Financial Oversight
Marcy Gallagher, Chief, Division of Plan Surveys
Crystal McElroy, Staff Counsel, Division of Licensing
Anna Kyumba, Examiner, Division of Financial Oversight



DIVISION OF FINANCIAL OVERSIGHT

AETNA HEALTH OF CALIFORNIA, INC.

FILE NO. 933 0176

DATE OF FINAL REPORT: MARCH 23, 2010

OVERSIGHT EXAMINER: STEPHEN BABICH

EXAMINER-IN-CHARGE: STEPHEN BABICH

FINANCIAL EXAMINERS:

LORI AMBROSINI

EVAN LO

JENNIFER LUM

JESSICA TRAN

HONG TRUONG

BACKGROUND INFORMATION FOR AETNA HEALTH OF CALIFORNIA, INC.

Date Plan Licensed:	August 6, 1981
Organizational Structure:	The Plan is a wholly-owned subsidiary of Aetna Health Holdings, LLC which is a wholly-owned subsidiary of Aetna Inc. The Plan is incorporated in the State of California and commenced operations as a health maintenance organization (HMO) in 1981.
Type of Plan:	The Plan is a full service health care service plan providing medical services for commercial, Medicare and POS beneficiaries.
Provider Network:	The Plan generally compensates independent physician associations through fixed capitation arrangements. There are limited contracts with primary care physicians. The Plan has prospective arrangements for mental health, substance abuse, diagnostic laboratory, radiology and diagnostic imaging services, pediatric treatment, physical therapy, hospitalist and prescription drug dispensing. The Plan has contracts that provide for all-inclusive per diem and per case hospitalization rates and fixed rates for ambulatory surgery, emergency room services and specialist services. The Plan also has capitated agreements with hospitals, as well as agreements with certain integrated health care delivery systems under which the systems are compensated on a substantially fixed prospective basis for medical services, including primary, specialist and hospital care. The arrangements described above cover the majority of medical services.
Plan Enrollment:	381,397 at March 31, 2008 and growing to 476,361 at March 31, 2009.
Service Area:	All of the major population centers throughout the state of California.
Date of last Routine Financial Examination Final Report	April 25, 2005

FINAL REPORT OF A ROUTINE EXAMINATION OF AETNA HEALTH OF CALIFORNIA, INC.

This is the Final Report of a routine examination of the fiscal and administrative affairs of **Aetna Health of California, Inc. ("Plan")**, conducted by the **Department of Managed Health Care (the "Department")** pursuant to Section 1382(a) of the Knox-Keene Health Care Plan Act of 1975.¹ The Department issued a Preliminary Report to the Plan on **January 23, 2010**. The Department accepted the Plan's electronically filed response on **March 11, 2010**.

We examined the financial report filed with the Department for the quarter ended March 31, 2008 as well as other selected accounting records and controls related to the Plan's various fiscal and administrative transactions. Also, the examination included a detailed review of the Plan's Incurred But Not Reported ("IBNR") liabilities for the quarter ended March 31, 2009. A separate examination was performed by the Department that covered a review of the Plan's claims processing system which included detailed testing of various medical claims samples. The final report of that examination has not yet been issued as of the date of this final report. Our findings are presented in this report as follows:

Section I.	Financial Report
Section II.	Calculation of Tangible Net Equity
Section III.	Compliance Issues
Section IV.	Non-Routine Financial Examination

Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any requests for additional corrective action contained in this report, within 30 days after receipt of this report.

¹ References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

SECTION I. FINANCIAL REPORT

Our examination resulted in no adjustments or reclassifications to the Plan's quarter ending March 31, 2008 financial statements filed with the Department or to the Plan's claims payable or IBNR sections of the quarter ending March 31, 2009 financial statements. A copy of the Plan's financial statements can be viewed at the Department's website by typing the link <http://wps0.dmhc.ca.gov/fe/search.asp> and selecting Aetna Health of California, Inc. on the first drop down menu.

No response is required to this Section.

SECTION II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

Net Worth as reported by the Plan as of March 31, 2008	\$ 151,273,241
Less: Receivables from Affiliates	<u>(3,742,993)</u>
Tangible Net Equity @ March 31, 2008	\$ 147,530,248
Required TNE @ March 31, 2008	<u>36,864,129</u>
TNE Excess per Examination Ended March 31, 2008	<u>\$ 110,666,119</u>

As of March 31, 2008, the Plan is in compliance with the TNE requirement of Section 1376 and Rule 1300.76.

No response is required to this Section.

SECTION III. COMPLIANCE ISSUES

All standard claims compliance issues that were found during this routine examination, will not be addressed in this report, those findings will be incorporated into the report for the cyclical claims and provider dispute exam that Janet Nozaki is supervising and for which the on-site exam began in October of 2009 in Walnut Creek due to the current special claims examination of the Plan.

A. UNDERTAKINGS

The Plan entered into twelve (12) Undertakings as a part of the Notice of Material Modification #20061680 (“MM2006”) to subcontract specific claim categories for adjudication services to two vendors in India, approved on March 14, 2007.

Undertaking 2

Undertaking 2 states, “The Plan shall direct the conduct of on-site reviews, at least semiannual, to ensure that delegated functions are properly performed. Plan will maintain at its Administrative office in Fresno, California, copies of on-site review reports and travel documents. The inspection results shall identify each problem, corrective action plan and follow-up. The Plan shall make the written reports of on-site inspections available to the Department on request. The Plan shall maintain at its administrative office in Fresno, California, documentation such as emails, minutes of meetings, and reports, evidencing day-to-day monitoring.”

Undertaking 6

Undertaking 6 states, in part, that “The Plan shall ensure to the Department that the contracted entities performing the Plan’s claim functions outside the country must process only claims of a ministerial nature that do not require any exercise of discretion. Not engage in clinical or other discretionary decision-making, but reserve those functions to California-based Plan personnel. Contested claims will be removed from the Vendor’s queue to be processed in the Fresno, California Service Center. The Vendor will not process any appealed claims submitted by either a member or provider. Appeals will be handled by the Plan using standard provider or member appeals processes.”

Section 1352 states, in part, that “(a) A licensed plan shall, within 30 days after any change in the information contained in its application, other than financial or statistical information, file an amendment thereto in the manner the director may by rule prescribe setting forth the changed information. However, the addition of any association, partnership, or corporation in a controlling, controlled, or affiliated status relative to the plan shall necessitate filing, within a 30-day period of an authorization for disclosure to the director of financial records of the person pursuant to Section 7473 of the Government Code. (b) Prior to a material modification of its plan or operations, a plan shall give thereof to the director, who shall, within 20 business days or such additional time as the plan may specify, by order approval, disapprove, suspend, or postpone the effectiveness of the change, subject to Section 1354.”

Undertaking 8

Undertaking 8 states, “ The Plan shall maintain certain functions and/or records shall remain in California as follows: adjudication of claims involving determinations of medical necessity, denial of claims for emergency services, admitted hospital claims (other than routine claim rework less than \$1000 per adjustment), and claims requiring manual intervention or exercise of discretionary judgment.”

DEFICIENCY REGARDING UNDERTAKING 2

During our examination, it was discovered that the Plan was in violation of Undertaking 2 because its monitoring procedures were inadequate, due to failing to uncover that specific claim types were being adjudicated in India by the Plan's vendors in violation of Undertakings 6 and 8 of MM2006. Also, it was discovered that although audits of claims adjudicated in India were conducted, the claims selected for audit were not California specific, but claims were included that were from other states where Aetna, Inc. operates health care business. This material weakness in the Plan's oversight procedures probably contributed to the Plan's violations of Undertakings 6 and 8 being undetected.

The Preliminary Report required the Plan to modify and strengthen its oversight procedures of claims processes occurring in India so as to bring the Plan into compliance with Undertakings 2, 6 and 8. The Plan was also to provide copies of new or modified policies and procedures for Department review. The Plan was also to state the date of implementation of the corrective action, the management position(s) responsible for ensuring compliance and the controls implemented for monitoring continued compliance.

The Plan stated in its response that during the course of the examination, it discovered that California HMO claim processing by the offshore vendor had occurred prior to the Department's approval of its Notice of Material Modification #20061680 ("MM2006") and had been performed by individuals other than those designated, trained and approved by the Plan to do so. The Plan represented that this occurrence was inadvertent and due to the vendors not fully following the Plan's instruction and because of an unforeseen gap in the Plan's systems. The Plan stated that it took immediate action to halt all California HMO claim processing by the offshore vendors.

The Plan stated in its response that on April 5, 2008, the Plan ordered the vendors to cease processing all California HMO claims and also took the following actions:

- 1. Confirmed that claim processing instructions are aligned with system routing and ensured that applicable identifying fields (i.e., member region) are displaying accurately.*
- 2. Evaluated and confirmed that training curricula is used by the vendors and that the curricula is consistent with how stateside processors are processing California HMO claims.*
- 3. Assigned appropriate training staff to refresh training of staff in the vendors' North and South locations on the process of identifying California HMO work.*
- 4. Assigned managers in vendors' North and South locations to conduct audit follow up to ensure staff are following the process detailed in the training.*
- 5. Researched the historical training curriculum to determine if training may have been modified or covered differently than intended.*
- 6. Instituted stateside daily audits to ensure that no California HMO work was being processed by the vendors.*
- 7. Informed the vendors that a violation of the Plan's instructions would result in system access removal for the individualized processor.*
- 8. Performed a 100% review of all claims processed by the vendors and corrected any errors found.*

The Plan represented that it identified a gap in the system process which made it possible for a claim examiner who was granted access to the HMO system and given claim processing clearances to access claims from all Aetna regions, including California. Although the vendors were given precise instructions to allow only those processors who had been trained to handle California HMO work to do so, there was no system check in place to prevent other processors from accessing the work.

The Plan stated in its response that it then took additional actions to ensure that the vendors complied with the California HMO restriction until permanent system controls could be implemented. This action included implementing a location-specific system tool which prevented processors from accessing California HMO claims and displayed a message advising the processor that they were not authorized to process the claim. This tool was loaded directly to the vendor's desktop computers in April 2008 and was triggered automatically when a claim was accessed. The tool along with daily monitoring of vendor production reports assured that only designated processors would handle California work. If a violation occurred, corrective actions included removal of that processor's access to the entire HMO claim system.

Also, the Plan stated in its response that it immediately began to develop permanent system controls which were fully implemented in November 2009. These controls ensure that only authorized staff may access California HMO claims. Processors must be included in a system table of ID numbers. If they are not included and they attempt to access a claim for a California HMO member, the system displays a message informing them that they are not allowed to process the claim and the processor is unable to move beyond the initial display screen. Furthermore, the Plan stated that it made a business decision not to use the vendors in India for California HMO claims processing and continues to restrict these vendors from processing California HMO claims. The Plan stated that it does not intend to lift that restriction.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and the corrective action required. However, the Plan will be referred to the Department's Office of Enforcement for administrative action for the violation of the Undertaking.

DEFICIENCY REGARDING SECTION 1352

During our examination, it was discovered using ACL analysis, that the Plan subcontracted claims adjudication services to the two vendors in India prior to the Department's approval. The Department had approved MM2006 on March 14, 2007 however; the Plan had been adjudicating claims in India since 2006. This is in violation of Section 1352 of the Act for implementing processes prior to the Department's approval of a material modification.

Also, we randomly selected a sample of 28 claims processed by Aetna's vendors in India. Our examination disclosed that the Plan's India vendors processed claims prior to the Department's approval in eighteen (18) cases or 64% of the sample in violation of Section 1352 of the Act.

The Preliminary Report required the Plan to provide assurance to the Department that in the future the Plan will not implement changes that require the filing of a notice of material modification prior to the Department's completion of its review of the material modification.

Also, the Preliminary Report required the Plan to explain how this particular instance occurred, i.e., a breakdown in the communication process between the Plan and its affiliates involved in the coordination of processing claims that are outsourced to India. Also, the Preliminary Report required the Plan to state the date of implementation of the corrective action, the management position(s) responsible for ensuring compliance and the controls implemented for monitoring continued compliance.

The Plan stated in its response to the Preliminary Report that when it filed its MM2006 with the Department, it was done so with the belief that California HMO claims were being processed by the Fresno, California staff. Upon the Department's approval, the Plan moved forward with training and subsequent routing of certain claims to the offshore vendor.

The Plan also stated that during the course of the exam, the Plan realized that the controls put in place to manage and monitor HMO claims were inadequate and took immediate steps to manage the situation as outlined in the Plan's response to its violation of Undertaking #2. The Plan stated in its response that it assures the Department that this error was inadvertent and was a failure of the vendor to follow the Plan's training and instructions for HMO claim processing and that the vendor adjudicated California HMO claims prior to the Department's approval, without the Plan's authorization.

The Department finds that the Plan's compliance effort is responsive to the deficiency cited and the corrective action required. However, the Plan will be referred to the Department's Office of Enforcement for administrative action for violation of Section 1352 of the Act.

DEFICIENCY REGARDING UNDERTAKINGS 6 AND 8

We randomly selected a sample of 28 claims processed by Aetna's vendors in India. Our examination disclosed that the Plan's India vendors adjudicated inpatient hospital claims in violation of Undertaking #6 and Undertaking #8 in twenty-three (23) cases (82% of the sample).

The Preliminary Report required the Plan to provide copies of new or modified policies and procedures for Department review to ensure that the Plan is in compliance with Undertakings #6 and #8. The Plan is also required to state the date of implementation of the corrective action, the management position(s) responsible for ensuring compliance and the controls implemented for monitoring continued compliance.

The Plan stated in its response to the Preliminary Report that as outlined in the Plan's response to the deficiency regarding Undertaking #2, the Plan has not lifted the restrictions on the offshore vendors and does not intend to do so. Therefore, the Plan has not created new Policies or Procedures specific to Undertaking #6 or #8. The Plan stated that it has already implemented and concluded a corrective action plan which has restricted access to California HMO claims to only those individuals authorized to process them.

In addition, the Plan stated that in order to assure that no California member was harmed by the actions of the vendors, the Plan performed a 100% review of all claims processed by the vendors and corrected any errors found.

The Department finds that the Plan's compliance effort is substantially responsive to the deficiencies cited and the corrective action required. The Plan is required to submit to the Department the report mentioned above that consists of the 100% review of all claims processed by the vendors including the findings. Also, the Plan will be referred to the Department's Office of Enforcement for administrative action for violation of Undertakings 6 and 8.

B. ADMINISTRATIVE CAPACITY

Section 1367(g) requires a plan to have the organizational and administrative capacity to provide services to subscribers and enrollees. Rule 1300.67.3(a) (2) requires the plan to have staffing in fiscal and administrative services sufficient to result in the effective conduct of the plan's business.

Based on our review of the Plan's operations, the Plan had adequate staffing in fiscal and administrative services sufficient to result in the effective conduct of the Plan's business. However, the Plan had deficiencies in failing to provide proper monitoring and oversight of its vendors performing certain claims processing procedures in India.

Our examination disclosed lack of administrative capacity in the following areas which have already been explained in the details under Section "A Undertakings" of this report:

- Our examination disclosed that unbeknownst to the Plan, the vendors in India had been adjudicating certain claims prohibited by Undertakings #6 and #8.
- Our examination also disclosed that the Plan had been unaware that the vendors in India had begun processing certain claims in India prior to the Plan obtaining approval from the Department.

The Department finds that the Plan's response to the findings in Section A are responsive to the deficiencies cited above.

SECTION IV. NONROUTINE EXAMINATION

The Plan is advised that the Department may conduct a non-routine examination, in accordance with Rule 1300.82.1, to verify representations made to the Department by the Plan in response to this report. The cost of such examination will be charged to the Plan in accordance with Section 1382 (b).

No response is required to this section.