STATE OF ILLINOIS
DEPARTMENT OF INSURANCE
COMPLIANCE EXAMINATION
STATUTORY AUTISM BENEFIT REQUIREMENTS

OF

AETNA LIFE INSURANCE COMPANY
MARKET CONDUCT EXAMINATION REPORT

MARKET CONDUCT EXAMINATION REPORT

DATE OF EXAMINATION:	July 20, 2009 through August 28, 2009
EXAMINATION OF:	Aetna Insurance Company
LOCATION OF EXAMINATION:	INS Offices in Philadelphia, PA and Kansas City, MO
PERIOD COVERED BY EXAMINATION:	December 12, 2008 - June 11, 2009
EXAMINERS:	Shelly Schuman Dennis Shoop

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I. SUMMARY

Aetna Life Insurance Company was subject to a limited scope Market Conduct Examination designed to assess compliance with two pieces of legislation 215 ILCS 5/356z.14, Autism Spectrum Disorders, and 215 ILCS 5/356z.12, Dependent Coverage. The Autism Spectrum Disorder legislation was effective December 12, 2008. Its text is attached as Appendix A. The Dependent Coverage legislation was effective June 1, 2009. Its text is attached as Appendix B.

The Company was required to submit information on its underwriting practices to assess compliance with the provisions of 215 ILCS 5/356z.14, Autism Spectrum Disorders.

The Company was required to submit claims information data for all group insurance and individual insurance claims received between December 12, 2008 and June 11, 2009 if an insured had at least one (1) claim for autism submitted during the examination period. Standard industry diagnostic codes commonly referred to as ICD-9 Codes (*International Classification of Diseases, ninth revision)* were used to determine what qualified as an autism claim. Claim information was to be provided regardless of whether autism was listed as a primary or secondary diagnosis in connection with the treatment for which the claim was submitted. For example, claim information relating to an injury suffered by a passenger in an automobile accident which occurred in May 2009 would have been obtained if the injured passenger had had an autism related claim submitted in January 2009. Submitted data was analyzed to review basic statistical information and trends related to claim payment, claim denials, additional information requests and other dispositions.

The company was required to submit information on the steps the company had taken to implement processes and procedures to meet the requirements of 215 ILCS 356z.12, Dependent Coverage.

It should be noted that the examination was limited to the Company's activities relating to its insurance business. The examination did not involve a review of the Company's, or any of its affiliates,' activities as a claims administrator of ERISA qualified self funded plans. ERISA qualified self funded plans are not subject to the provisions of either the Autism Spectrum Disorders legislation or the Dependent Coverage legislation. ERISA qualified self-funded plans are subject to oversight by the US Department of Labor. A significant number of Illinois residents obtain health care coverage through ERISA qualified self funded plans.

II. BACKGROUND

This examination reflects the Illinois insurance activities of the Company, specifically as it relates to the Company's implementation of recently enacted legislation regarding coverage for individuals with autism and coverage for adult dependent children. The examination was conducted on behalf of the Illinois Department of Insurance by INS Regulatory Insurance Services, Inc. It should be noted that the examination was limited to the Company's activities relating to its insurance business. The examination did not involve a review of the Company's, or any of its affiliates,' activities as a claims administrator of ERISA qualified self funded plans. ERISA qualified self funded plans are not subject to the provisions of either the Autism Spectrum Disorders legislation or the Dependent Coverage legislation. ERISA qualified self-funded plans are subject to oversight by the US Department of Labor. A significant number of Illinois residents obtain health care coverage through ERISA qualified self funded plans.

Project Description

A review of autism related claim information was selected from the Company utilizing ACL® software which provides a general evaluation of the payment, denial, pending and other claims handling practices related to claims under review.

Fields to be Collected

The fields selected for inclusion in the data request were extracted from the NAIC *Market Regulation Handbook* Standardized Data Calls. The fields include information designed to provide a snapshot of the numbers of claims received, paid and denied during the examination period.

Specific Information Collected

The Company was sent a letter with two (2) attachments requests along with an examination warrant. The first attachment to this letter was a request for data that included the fields identified for submission in the Company's data file. The second attachment was a series of interrogatories designed to extract information from the Company about its compliance with the recently enacted legislation.

III. COMPANY HISTORY AND ILLINOIS PREMIUM VOLUME

Aetna Life Insurance Company (Company) is a wholly owned subsidiary of Aetna Inc. and its largest operating insurance company. The Company is domiciled in the state of Connecticut. The Company's primary business is Health Insurance, but it also offers some Life and Annuities products. The largest line of business for the Company is Group Accident and Health, followed by Individual Accident and Health, Group Life Insurance, Group Annuities and Ordinary Life, respectively. The Health Care segment consists of medical, pharmacy benefits management, dental, behavioral health and vision plans. The Company also offers some Medicare and Medicaid coverages; however, it is a small part of the Company's overall business mix.

The Company's 2008 Annual Statement reflects $409,537,549 in Illinois direct Group Health insurance policy premiums and $16,072,058 in Illinois Individual Health insurance policy premiums. The Company's 2009 Annual Statement reflects $433,979,577 in Illinois Group Health insurance policy direct premiums and $25,422,490 in Illinois Individual Health insurance policy premiums.

The Company's Illinois Policy Count Report indicates that it had in force 6,557 Large Group Comprehensive Major Medical insurance policies with 21,745 certificate holders and 4,354 Small Group insurance policies with 17,831 certificate holders in 2008. The Company's Illinois Policy Count Report indicates that it had in force 1,206 Large Group Comprehensive Major Medical insurance policies with 21,318 certificate holders and 4,778 Small Group insurance policies with 19,407 certificate holders in 2009.

IV. METHODOLOGY

This limited scope Market Conduct Examination was designed to assess compliance with the Autism Spectrum Disorders law and the Dependent Coverage law. A two-fold approach to the examination included (1) interrogatories and (2) analysis of data submissions.

Interrogatories

There were a total of five (5) questions included in the interrogatories.

The first question related to the identification of the project coordinator.

The second and third questions were designed to determine whether autism was one of the criteria used when underwriting new individual health insurance applications. (Group health insurance policies are not allowed to refuse enrollment based on health status.) In addition, specific data regarding the numbers of applications that were denied coverage was collected.

The fourth question was designed to determine whether the Company was taking necessary actions to implement the requirements of the Autism Spectrum Disorders law.

The fifth question was designed to determine whether the Company was taking necessary actions to implement the requirements of the Dependent Coverage law. This law prohibits termination of individual or group health insurance coverage for dependents prior to their 26th birthday, regardless of the dependent's health status. (Note this legislation is not limited to dependents with autism).

Interrogatory questions are listed below along with the Company's response.

1. **Please provide the name of the individual that is the company coordinator for this project along with telephone and email. This information should be submitted no later than June 25, 2009.**

   This information was supplied via email on June 25, 2009. Contact information was provided for David M. Stitzel and Renea Taylor.

2. **Do the company's underwriting guidelines take into consideration autism?**

When the Company underwrites employer groups, the Company does not take autism into account. The Company indicated it looks at a group's total claims experience, but do not target or deny groups for any specific disease.

When the Company underwrites individuals, it does not automatically deny coverage solely due to autism. The Company uses an age band and scoring process that calculates the total number of points for an application. When applicants exceed a total number of points, the application is declined. The younger the applicant, the less points associated with the age. Current therapies and/or medication accumulate additional points. The number of total applicants on the policy may trigger a family composite rating and therefore allow higher points if other applicants are healthy. The Company indicated that it does not have any individual contracts sitused in Illinois.

3. **Provide the number of applicants denied for each 2008 and 2009 due to autism.**

Year	Number of Applicants Denied due to Autism
2008	0
2009	0

4. **Please explain what steps the company has taken to implement processes and procedures to meet the requirements of 215 ILCS 356z.14. Provide copies of procedures or bulletins issued to comply with this statute.**

a. The Company's process for implementing state mandates begins with a legal analysis of the relevant bill, and distribution to all involved business areas. After distribution of Illinois Senate Bill 934, the Company's staff set up a continuing workgroup to discuss implementing the Illinois autism statute. The Company also began simultaneously to work on possible impact to the Illinois statute after the October 2009 compliance date for the federal mental health parity statute. The Company suggested it is in substantial compliance in coverage offered and claims processed.

b. The Company reviewed processes for addressing the autism mandate prior to the enactment of Senate Bill 934. The Company implemented the following: the online e-Policies tool used by customer service and claims processors, the file language for regulatory approval, the plan documents with approved language, the internal legislation tool, created pre-certification communications, and the subsidiary Company's claims systems.

c. In addition, the Company determined a need for a larger number of certified applied behavioral analysis practitioners in its network. (This decision was not solely based on the Illinois statute.) Since December 2008, it has been working to attract and credential new behavioral analysis practitioners.

d. Recognizing that there is currently no set of diagnostic codes specific to autism, e.g., Applied Behavioral Analysis (ABA), in early 2008 the Company began to develop a list of codes that it continues to expand to capture all the services associated with an autism diagnosis. The Company continues to add to this code set, most recently with codes that the TRICARE demonstration project is mandating for use with ABA staff/unlicensed tutors. In addition, the Behavioral Health medical directors have recently met with representatives from the American Academy of Pediatrics to ask it to request the American Medical Association for the creation of diagnostic codes specific to autism.

e. Finally, the Company requested IT system changes to automate the autism claims identification and adjudication process. The system modification includes the development of an accumulator that would ensure autism benefits are applied separately from all other benefits under the plan.

5. **Please explain what steps the company has taken to implement processes and procedures to meet the requirements of 215 ILCS 356z.12. Provide copies of procedures or bulletins issued to comply with this statute.**

The Company has taken the following actions to meet the requirement of 215 ILCS 356z.12:

- Developed a form for use by military dependents to show proof of eligibility. The form was filed on 03/30/2009, and is currently pending state approval. The approved form will be put into use once approval is received.
- Amended policy forms to include revised language for dependent coverage. Forms were filed on 03/30/2009.
- Updated the on line e-Policies tool.
- Updated the underwriters quoting system to set the limiting age default for dependents to age 26.
- Established a workflow to set up a separate account structure for families with eligible military dependents.
- Updated the Company's plan designs to include the revised dependent age limits.

- Prepared systems to automatically provide semi-annual notices of dependent eligibility benefits. The first mailing was scheduled for November, 2009.
- Distributed field communication to the sales force on 04/17/2009.

V. DATA ANALYSIS

Analysis of Company Data

A summary of the Company data analysis is listed below. The analysis was conducted using ACL® software.

The Company submitted a total of 1,138 transactions involving fifteen policyholders. These fifteen policyholders had had at least one (1) claim for autism submitted during the examination period. However, the majority of the 1,138 transactions were not autism specific claims. The Autism Spectrum Disorders legislation mandates coverage for a number of different treatments and services which are not unique to individuals with autism, such as psychiatric care, psychological care, counseling and speech and behavioral therapies. Accordingly, claim information was to be provided regardless of whether autism was listed as a primary or secondary diagnosis in connection with the treatment for which the claim was submitted. For example, claim information relating to an injury suffered by a passenger in an automobile accident which occurred in May 2009 would have been obtained if the injured passenger had had an autism related claim submitted in January 2009. This broader set of claims was chosen to ensure that coverage was not being denied to any individual with autism for any mandated treatment or service.

The total amount billed on these 1,138 transactions was $279,519.49. Of this amount, the Company paid in full $241,265.57 transactions and partially paid $75,553.82 for a total of $316,819.39. The Company provided the reasons why billed amounts were not paid. The examiners selected and reviewed a sample of claim files for compliance with 215 ILCS 356z.14.

Additional information on the 1,138 claim transactions may be found in Appendix D.

VI. FINDINGS/RECOMMENDATIONS

The Company provided the examiners with documentation, information and materials to support its position that it has developed processes and procedures designed to maintain compliance with 215 ILCS 5/356z.14, Autism Spectrum Disorders and 215 ILCS 5/356z.12, Dependent Coverage. The examiners reviewed this documentation, information and material. The Company also provided the examiners with data and information on all claims submitted by any individual who had had submitted at least one claim with an autism related diagnosis during the examination period. The examiners analyzed this data and reviewed the information as well as a sample of claim files. The examination and sample files did not identify any instances in which the Company was in material non-compliance with the provisions of 215 ILCS 5/356z.14, Autism Spectrum Disorders or 215 ILCS 5/356z.12, Dependent Coverage.

When asked to define what system modifications have been made to support the requirements, the Company responded that it had implemented a manual process but had taken steps to modify its system to facilitate compliance with 215 ILCS 5/356z.14.

Appendix A
Insurance Code Section 356z.14
Autism Spectrum Disorders

(215 ILCS 5/356z.14)

(Text of Section from P.A. 95-1005)

Sec. 356z.14. Autism spectrum disorders.

(a) A group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 95th General Assembly must provide individuals under 21 years of age coverage for the diagnosis of autism spectrum disorders and for the treatment of autism spectrum disorders to the extent that the diagnosis and treatment of autism spectrum disorders are not already covered by the policy of accident and health insurance or managed care plan.

(b) Coverage provided under this Section shall be subject to a maximum benefit of $36,000 per year, but shall not be subject to any limits on the number of visits to a service provider. After December 30, 2009, the Director of the Division of Insurance shall, on an annual basis, adjust the maximum benefit for inflation using the Medical Care Component of the United States Department of Labor Consumer Price Index for All Urban Consumers. Payments made by an insurer on behalf of a covered individual for any care, treatment, intervention, service, or item, the provision of which was for the treatment of a health condition not diagnosed as an autism spectrum disorder, shall not be applied toward any maximum benefit established under this subsection.

(c) Coverage under this Section shall be subject to copayment, deductible, and coinsurance provisions of a policy of accident and health insurance or managed care plan to the extent that other medical services covered by the policy of accident and health insurance or managed care plan are subject to these provisions.

(d) This Section shall not be construed as limiting benefits that are otherwise available to an individual under a policy of accident and health insurance or managed care plan and benefits provided under this Section may not be subject to dollar limits, deductibles, copayments, or coinsurance provisions that are less favorable to the insured than the dollar limits, deductibles, or coinsurance provisions that apply to physical illness generally.

(e) An insurer may not deny or refuse to provide otherwise covered services, or refuse to renew, refuse to reissue, or otherwise terminate or restrict coverage under an individual contract to provide services to an individual because the individual or their dependent is diagnosed with an autism spectrum disorder or due to the individual utilizing benefits in this Section.

(f) Upon request of the reimbursing insurer, a provider of treatment for autism spectrum disorders shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued medical treatment is medically necessary and is resulting in improved clinical status. When treatment is anticipated to require continued services to achieve demonstrable progress, the insurer may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated.

(g) When making a determination of medical necessity for a treatment modality for autism spectrum disorders, an insurer must make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under the policy, including an appeals process. During the appeals process, any challenge to medical necessity must be viewed as reasonable only if the review includes a physician with expertise in the most current and effective treatment modalities for autism spectrum disorders.

(h) Coverage for medically necessary early intervention services must be delivered by certified early intervention specialists, as defined in 89 Ill. Admin. Code 500 and any subsequent amendments thereto.

(i) As used in this Section:

"Autism spectrum disorders" means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

"Diagnosis of autism spectrum disorders" means one or more tests, evaluations, or assessments to diagnose whether an individual has autism spectrum disorder that is prescribed, performed, or ordered by (A) a physician licensed to practice medicine in all its branches or (B) a licensed clinical psychologist with expertise in diagnosing autism spectrum disorders.

"Medically necessary" means any care, treatment, intervention, service or item which will or is reasonably expected to do any of the following: (i) prevent the onset of an illness, condition, injury, disease or disability; (ii) reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury, disease or disability; or (iii) assist to achieve or maintain maximum functional activity in performing daily activities.

"Treatment for autism spectrum disorders" shall include the following care prescribed, provided, or ordered for an individual diagnosed with an autism spectrum disorder by (A) a physician licensed to practice medicine in all its branches or (B) a certified, registered, or licensed health care professional with expertise in treating effects of autism spectrum disorders when the care is determined to be medically necessary and ordered by a physician licensed to practice medicine in all its branches:

(1) Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.

(2) Psychological care, meaning direct or

consultative services provided by a licensed psychologist.

(3) Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual. As used in this subsection (i), "applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

(4) Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas: (i) self care and feeding, (ii) pragmatic, receptive, and expressive language, (iii) cognitive functioning, (iv) applied behavior analysis, intervention, and modification, (v) motor planning, and (vi) sensory processing.

(j) Rulemaking authority to implement this amendatory Act of the 95th General Assembly, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 95-1005, eff. 12-12-08.)

Appendix B
Insurance Code Section 356z.12
Dependent Coverage

215 ILCS 5/356z.12)

Sec. 356z.12. Dependent coverage.

(a) A group or individual policy of accident and health insurance or managed care plan that provides coverage for dependents and that is amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 95th General Assembly shall not terminate coverage or deny the election of coverage for an unmarried dependent by reason of the dependent's age before the dependent's 26th birthday.

(b) A policy or plan subject to this Section shall, upon amendment, delivery, issuance, or renewal, establish an initial enrollment period of not less than 90 days during which an insured may make a written election for coverage of an unmarried person as a dependent under this Section. After the initial enrollment period, enrollment by a dependent pursuant to this Section shall be consistent with the enrollment terms of the plan or policy.

(c) A policy or plan subject to this Section shall allow for dependent coverage during the annual open enrollment date or the annual renewal date if the dependent, as of the date on which the insured elects dependent coverage under this subsection, has:

(1) a period of continuous creditable coverage of 90 days or more; and

(2) not been without creditable coverage for more than 63 days.

An insured may elect coverage for a dependent who does not meet the continuous creditable coverage requirements of this subsection (c) and that dependent shall not be denied coverage due to age.

For purposes of this subsection (c), "creditable coverage" shall have the meaning provided under subsection (C)(1) of Section 20 of the Illinois Health Insurance Portability and Accountability Act.

(d) Military personnel. A group or individual policy of accident and health insurance or managed care plan that provides coverage for dependents and that is amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 95th General Assembly shall not terminate coverage or deny the election of coverage for an unmarried dependent by reason of the dependent's age before the dependent's 30th birthday if the dependent (i) is an Illinois resident, (ii) served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States, and (iii) has received a release or discharge other than a dishonorable discharge. To be eligible for coverage under this subsection (d), the eligible dependent shall submit to the insurer a form approved by the Illinois Department of Veterans' Affairs stating the date on which the dependent was released from service.

(e) Calculation of the cost of coverage provided to an unmarried dependent under this Section shall be identical.

(f) Nothing in this Section shall prohibit an employer from requiring an employee to pay all or part of the cost of coverage provided under this Section.

(g) No exclusions or limitations may be applied to coverage elected pursuant to this Section that do not apply to all dependents covered under the policy.

(h) A policy or plan subject to this Section shall not condition eligibility for dependent coverage provided pursuant to this Section on enrollment in any educational institution.

(i) Notice regarding coverage for a dependent as provided pursuant to this Section shall be provided to an insured by the insurer:

(1) upon application or enrollment;

(2) in the certificate of coverage or equivalent document prepared for an insured and delivered on or about the date on which the coverage commences; and

(3) in a notice delivered to an insured on a semi-annual basis.

(Source: P.A. 95-958, eff. 6-1-09.)

Appendix C
Claims Data Analysis
Definitions

Prior to reviewing the analysis of the data submitted by the company, it may be useful to review the definitions of the terminology used in this report. The following information provides definitions for the headers used to explain the analysis of the data received by and from the Company.

Claim – a notification to an insurance company requesting payment of an amount due under the terms of the policy. One claim may contain multiple transactions or lines of payment requests.

Transaction/Line – A single electronic exchange to request payment for medical visit, product or service. Claims may contain more than one (1) transaction/line. (For example: one (1) claim may include separate bills for the medical visit, physical therapy and equipment. In this instance, the one (1) claim would be comprised of three (3) individual transactions or lines.) Transactions/Lines are often assigned distinct numbers.

Claim Status – The status of the transaction that is currently being processed. The various statuses for claims/transactions according to this Company include: denied, paid or partially paid.

Amount Billed – The fees or charges billed by the provider.

Partial Denied Count – A partially denied count is the number of transactions where a portion of the amount billed by the provider or insured was denied. This may include certain Transactions/Lines within a claim without denying the entire claim.

Partial Denied Billed – A partially denied billed transaction is a transaction where a portion of the amount billed by the provider or insured was denied. There may be contractual reasons for a partial denial such as copayments or coinsurance requirements or payments may be reduced as a result of contracted benefit payments arrangements made with the provider. Partial denials may also occur if the policy's maximum benefit for a period of time has been reached. One (1) example of a maximum benefit may be seen where a policy has limits on the number of outpatient visits for mental/nervous disorders in a calendar quarter.

Uncategorized Claim Status – A transaction that is unidentified in the electronic payment system as not being paid, pending, denied or closed without payment. Generally, the uncategorized transactions are identified as "informational lines" or "adjustment lines" which are inadvertently inserted in a claim. The "informational lines" can cause the sample to be skewed if they are not identified in a population to be studied. The inadvertent selection of these lines will dilute the sample as they contain no actual claim payment information. Examiners needed to review an entire "Claim Event" in order to determine if certain lines were informational only and could be disregarded or if the claim contained any "Lines" that contained treatment codes corresponding to autism treatment even where the event may not appear to be autism related. An example of an uncategorized claim would be for the use of general anesthesia related to simple dental procedures. Normally the procedure would be performed with local dental anesthesia but in the case of an autistic child, more extensive treatment may have been necessary.

Closed Without Payment Transaction Status – A transaction that is closed without any payment.

Denied Transaction Status – A transaction that has been denied for payment. Denial for transactions could be for a number of reasons, such as the policy doesn't cover that type of transaction, the provider is not authorized to bill for that type of transaction, or the coverage was terminated at the time the expense was incurred.

Paid Amount – Actual amount paid by an insurance company during a specified time interval.

Pending Transaction Status – A transaction that has not been paid, denied or closed without payment. Examples of pending transactions may include those that are currently in process or where more information has been requested before payment is considered.

Amount Billed – The amount billed to the insurance company for the claim or transaction.

Patient's Responsibility – The amount of a claim or transaction which is to be paid by the insured. These amounts may apply to deductibles, coinsurance or other provisions in the insurance contract.

Provider Discount – A negotiated discount for services. These provider discounts are agreed to in contracts between the providers and insurance company or other affiliated network.

Maximum Allowable – The maximum amount payable per the contract.

Co-Pay (Copayment) – The copayment is an amount the insured pays in accordance with their insurance contract. This amount may be a flat dollar amount such as $25 per office visit or may be a percentage of the billed amount such as 20% of the amount billed.

Deductible – A deductible is the amount of expenses that must be paid out of pocket before an insurer will cover certain benefits or expenses.

COB (Coordination of Benefits) – A group policy provision which helps determine the primary carrier when an insured is covered by more than one policy. This provision prevents claims overpayments.

EOB (Explanation of Benefits) - A document that is explains the claim and its charges and discounts. The EOB identifies any copay or coinsurance owed, the amount have paid toward a deductible and any network discounts.
A summary of the Company data analysis is listed below. The analysis was conducted using ACL® software.

Appendix D
Claims Payment Information

A summary of the Company data analysis is listed below. The analysis was conducted using ACL® software.

Table 1 (Claim Status by Transaction)

Transaction Status	Transaction Count	Amount Billed	Partial Denied Count	Partial Denied Amount
Denied	235	36,163.92	0	0.00
Paid	884	241,265.57	356	75,553.82
Pending	19	2,090.00	0	0.00
Total	1,138	279,519.49	356	75,553.82

Summary of Table 1 (Claim Status by Transaction)
According to the Company, during the time period under review there were a total 1,138 claim transactions. Of all claims submitted, 78% were paid in the amount of $241,265.57. Three hundred fifty-six (356) of those claims were partially denied in the amount of $75,553.82. Claims denied totaled 235 or 21% of the total claim transactions for an amount totaling $36,163.92.

Table 2 (Claim Payment Breakdown)

Transaction Status	Transaction Count	Paid Amount	Amount Billed	Patient's Responsibility	Provider Discount	Maximum Allowable	Co Pay	Deductible
Denied	235	0.00	36,163.92	0.00	0.00	0.00	0.00	0.00
Paid	884	123,884.44	241,265.57	41,222.78	164,051.51	164,051.51	4,190.76	24,111.94
Pending	19	0.00	2,090.00	0.00	0.00	0.00	0.00	0.00
Totals	1,138	123,884.44	279,519.49	41,222.78	164,051.51	164,051.51	4,190.76	24,111.94

Summary of Table 2 (Claim Payment Breakdown)
The total amount billed for all these claims was $279,519.49, with $164,051.51, or 59% of that being the maximum allowable amount covered by the policy. The amount listed as patient's responsibility is $41,222.78, plus a copayment amount of $4,190.76 and a deductible amount of $24,111.94 for a total of cost to the consumers of $69,525.48 or 25% of the total amount billed.

The reason for denial in the 235 files that were denied in full is included in the following table.

Description	Count	Billed
Charges for or in connection with services or supplies that are, as determined by Aetna, to be experimental or investigational are excluded from coverage under your plan. (Patient Responsibility)	34	1,977.50
We have paid the maximum allowed for these services for this benefit year. (Patient Responsibility)	32	4,159.00
Your claim has been denied because information we previously requested from you or your provider was not received. Please refer to your prior Explanation of Benefits statement for this claim, or log onto Aetna Navigator at www.aetna.com. [HNST - For Internal Use Only]	24	3,115.01
Description not provided	19	13,524.31
The member's plan provides coverage for charges that are reasonable and appropriate as determined by Aetna. The charge for this service does not meet this requirement of the member's plan of benefits because this service is considered mutually exclusive to another procedure performed on the same date of service.	18	1,350.00
The member's plan provides coverage for charges that are reasonable and appropriate as determined by Aetna. This procedure exceeds the maximum number of services allowed for a single date of service.	14	1,677.50
This claim is not payable because our records show your health plan coverage ended before you received these services. Your claim will not be considered unless your employer shows that your coverage was in effect at the time services were rendered.	13	1,783.00
Your claim has been denied because information requested about the claim was not received.	10	116.00
Our records show this is a duplicate claim. Please refer to prior Explanation of Benefits statement you received for this service or log onto Aetna Navigator at www.aetna.com.	9	1,413.00
The amount shown above reflects an error made by your provider in supplying information related to the charges for services you received. You are NOT responsible for this amount.	7	159.00
Charges for or in connection with services or supplies that are, as determined by Aetna, to be experimental or investigational are excluded from coverage under your plan. You are not responsible for this charge unless you agreed in writing to be responsible for the charge before the service was given. The amount shown as the amount this provider "may bill you" will be higher if you agreed to be responsible.	5	325.00
The member's plan of benefits includes a maximum number of visits for this service. This amount is not covered because the member has exceeded that maximum.	4	380.00
The member's plan of benefits includes a maximum number of visits for this service. This amount is not covered because the member has exceeded that maximum.	4	600.00
You are not responsible for this amount. Your plan provides coverage for charges that are reasonable and appropriate as determined by Aetna. The charge for this service is not payable by your plan because this service is part of other services provided to the patient for which reimbursement was or will be considered.	4	82.00
Orthopedic shoes, foot orthotics, or other devices to support the feet are excluded from coverage under your plan. (Patient Responsibility)	4	1,408.00

Description	Count	Billed
The member's plan provides coverage for charges that are reasonable and appropriate as determined by Aetna. This procedure exceeds the maximum number of services allowed for a single date of service. Do not bill the member.	3	347.00
Charges for therapy are covered only when the services are for treatment of an acute condition. Short-term rehabilitation is therapy which is expected to result in the improvement of a body function which has been lost or impaired due to an injury or disease. Therapy shall be expected to result in significant improvement of the person's condition within 60 days from the date the therapy begins. Based on the information provided, this charge for therapy does not meet this coverage requirement.	3	701.50
Charges for therapy are covered only when the services are for treatment of an acute condition. Short-term rehabilitation is therapy which is expected to result in the improvement of a body function which has been lost or impaired due to an injury or disease. Therapy shall be expected to result in significant improvement of the person's condition within 60 days from the date the therapy begins. Based on the information provided, this charge for therapy does not meet this coverage requirement.	3	504.00
The payment for this service is included in the negotiated rate paid to the provider. You are not responsible for this amount.	3	45.00
Our records show this dependent is not enrolled in this plan. YOUR ATTENTION PLEASE: If you have a full-time student who is no longer eligible for coverage, it is your responsibility to contact your employer directly to advise of this change in family eligibility status. Students who are eligible for coverage are any dependent children attending school on a full-time basis (12 semester credit hours or more) and under the age of 24.	2	357.00

Description	Count	Billed
You are responsible for this charge. We have paid the maximum amount covered by your plan for this service.	2	217.00
Your plan excludes charges for or related to services, treatment, education testing or training related to learning disabilities or development delays. (Patient Responsibility)	2	150.00
Your plan provides benefits for covered expenses at the prevailing charge level, as determined by Aetna, made for the service in the geographical area where it was provided. Your provider may not accept this amount as payment in full and you may receive a bill for the difference between the submitted and paid charges. You are responsible for this charge. We have paid the maximum amount covered by your plan for this service	2	260.00
The member's plan provides coverage for charges that are reasonable and appropriate as determined by Aetna. The charge for this service does not meet this requirement of the member's plan of benefits because this service is considered incidental to another procedure performed on the same date of service. Do not bill the member.	2	46.00
Charges for speech therapy are covered only when the speech therapy is expected to restore speech function or correct a speech impairment resulting from non-chronic conditions, acute illnesses and injuries, or gross anatomical defect present at birth. Based on the information provided, this charge is for speech therapy which does not meet this coverage requirement.	2	192.50
This amount represents the difference between your provider's charges and the amount the provider has agreed to accept as payment. You are not responsible for this amount. We have paid the maximum allowed for these services for this benefit year. (Patient Responsibility)	2	145.00
Charges for missed appointments, telephone consultations or completion of claim forms are not covered because they are not necessary for treatment of a non-occupational injury or disease. (Patient Responsibility)	1	150.00
Your medical plan of benefits does not cover prescription drugs. (Patient Responsibility)	1	89.10
Your plan of benefits does not cover vision care. (Patient Responsibility)	1	143.00
This procedure has been billed and allowed the maximum number of times allowed by Aetna payment policy.	1	82.50
Your plan provides coverage for charges that are reasonable and appropriate as determined by Aetna. The charge for this service is not payable by your plan because this service is part of other services provided to the patient for which reimbursement was or will be considered.	1	125.00
Your plan of benefits provides coverage for services or supplies that Aetna determines are necessary. To meet this requirement the service or supply must be accepted under recognized professional standards as appropriate and effective for the diagnosis, care, or treatment of the disease or injury involved. Based on the information provided, this expense does not meet this requirement of your plan of benefits and is excluded from coverage. (Patient Responsibility)	1	168.00
The member's plan provides coverage for charges that are reasonable and appropriate as determined by Aetna. The charge for this service does not meet this requirement of the member's plan of benefits because the global surgical care includes visits for pre-operative services. Do not bill the member.	1	129.00
Payment to the hospital for physician services is denied. The charges must be submitted by the physician on a CMS/HCFA 1500 form.	1	243.00
Total Denials	235	36,163.92

Summary of Table 3 (Reason for Denial)
Of the 235 transactions that were denied, the majority of these denials (34) occurred because the charges for or in connection with services or supplies that are, as determined by Aetna, to be experimental or investigational are excluded from coverage under the plan, for an amount of $1,977.50, or an average of $58.16 per transaction. The second largest amount of denials (32) occurred because the maximum allowed for these services for this benefit year had been achieved, for a total amount of $4,159.00, or an average of $129.97 per transaction. The highest amount per transaction denied was for the nineteen (19) denials categorized to no reason listed for a total amount of $13,524.31 or an average of $711.81 per transaction.

Table 4 (Autism Only Claims)

Claim Status	Record Count	Amount Billed	Partially Denied Count	Partial Denied Amount
Denied	68	6,504.00	0	0
Paid	404	57,312.55	213	29,723.75
Pending	1	440.00	0	0
Totals	473	64,256.55	213	29,723.75

Summary of Table 4 (Autism Only Claims)
Of the original 1,138 claim transactions reported, 473 or 42% of those transactions were specifically coded with an autism related diagnostic code. Of the 473 autism specific claim transactions, 404 were paid in the amount of $57,312.55 with 68 claim transactions being denied in the amount of $6,504.00. There was one pending transaction for an amount of $440.00. There were also 213 partially denied for an amount of $29,723.75.

Table 5 (Reason for the Denial-Autism Only)

Explanation of Denial Reason	Count	Amount Billed
Charges for or in connection with services or supplies that are, as determined by Aetna, to be experimental or investigational are excluded from coverage under your plan. (Patient Responsibility)	34	1,977.50
The member's plan provides coverage for charges that are reasonable and appropriate as determined by Aetna. This procedure exceeds the maximum number of services allowed for a single date of service.	14	1,677.50
Your claim has been denied because information we previously requested from you or your provider was not received. Please refer to your prior Explanation of Benefits statement for this claim, or log onto Aetna Navigator at www.aetna.com.	5	960.00
Our records show this dependent is not enrolled in this plan.	2	357.00
You are responsible for this charge. We have paid the maximum amount covered by your plan for this service.	2	217.00

Explanation of Denial Reason	Count	Amount Billed
Your plan provides benefits for covered expenses at the prevailing charge level, as determined by Aetna, made for the service in the geographical area where it was provided. Your provider may not accept this amount as payment in full and you may receive a bill for the difference between the submitted and paid charges.	2	260.00
Our records show this is a duplicate claim. Please refer to prior Explanation of Benefits statement you received for this service or log onto Aetna Navigator at www.aetna.com.	2	200.00
Charges for speech therapy are covered only when the speech therapy is expected to restore speech function or correct a speech impairment resulting from non-chronic conditions, acute illnesses and injuries, or gross anatomical defect present at birth. Based on the information provided, this charge is for speech therapy which does not meet this coverage requirement.	2	192.50
This claim is not payable because our records show your health plan coverage ended before you received these services. Your claim will not be considered unless your employer shows that your coverage was in effect at the time services were rendered.	1	125.00
This procedure has been billed and allowed the maximum number of times allowed by Aetna payment policy.	1	82.50
The member's plan provides coverage for charges that are reasonable and appropriate as determined by Aetna. This procedure exceeds the maximum number of services allowed for a single date of service. Do not bill the member.	1	189.00
The member's plan provides coverage for charges that are reasonable and appropriate as determined by Aetna. The charge for this service does not meet this requirement of the member's plan of benefits because this service is considered incidental to another procedure performed on the same date of service. Do not bill the member.	1	23.00
Payment to the hospital for physician services is denied. The charges must be submitted by the physician on a CMS/HCFA 1500 form.	1	243.00
Total Denials	68	6,504.00

Summary of Table 5 (Reason for Denial)

The sixty-eight (68) autism specific claim transactions reported as having been denied, the majority of these denials (34) occurred because the charges for or in connection with services or supplies that are, as determined by Aetna, to be experimental or investigational are excluded from coverage under the plan, for an amount of $1,977.50, or an average of $58.16 per transaction. The second largest amount of denials (14) occurred because the member's plan provides coverage for charges that are reasonable and appropriate as determined by Aetna, however the procedure exceeds the maximum number of services allowed for a single date of service, for a total amount of $1,677.50, or an average of $12.68 per transaction. The highest amount per transaction denied was for the one (1) denial because payment to the hospital for physician services must be submitted by the physician on a CMS/HCFA 1500 for a total amount of $243.00.