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

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

**GENWORTH LIFE INSURANCE COMPANY
NAIC # 70025 CDI # 1521-4**

AS OF MARCH 31, 2009

ADOPTED MARCH 19, 2015

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



March 19, 2015

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:

Genworth Life Insurance Company

NAIC # 70025

Group NAIC # 4011

Hereinafter, the Company listed above will also be referred to as Genworth, GLIC, 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 covered the claims handling practices of the aforementioned Company on Accident and Disability Long-term claims closed during the period from April 1, 2008 through March 31, 2009. 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.

The report is written in a “report by exception” format. The report does not present a comprehensive overview of the subject insurer’s practices. The report contains a summary of pertinent information about the lines of business examined, 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. While this report contains violations of law that were cited by the examiner, additional violations of CIC § 790.03, or other laws, not cited in this report may also apply to any or all of the non-compliant or problematic activities that are described herein.

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 claims files and related records.

3. A review of the California Department of Insurance's (CDI) market analysis results; a review of consumer complaints and inquiries about this Company closed by the CDI during the period April 1, 2008 through March 31, 2009; and a review of previous CDI market conduct claims examination reports on this Company; and a review of prior CDI enforcement actions.

The review of the sample of claims files was conducted at the offices of the Company in Richmond, Virginia.

EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED

The Accident and Disability Long-Term Care claims reviewed were closed from April 1, 2008 through March 31, 2009, referred to as the “review period”. The review was focused on the claims population for Long-Term Care line of business only. The examiners randomly selected 70 GLIC policy files for examination. The examiners cited 390 alleged claims handling violations of the California Insurance Code and other specified codes from this sample file review.

Findings of this examination include: failure to provide a clear explanation and computation of benefits; failure to disclose all benefits, coverage, time limits and other policy provisions; delays in claims handling and payment of claims; misrepresentation of benefits; failure to provide appropriate and timely denial notices; wrongful application of expenses as benefits of the policy; failure to pay statutory interest; failure to conduct prompt investigation and facility eligibility processes.

RESULTS OF REVIEWS OF MARKET ANALYSIS, CONSUMER COMPLAINTS AND INQUIRIES, AND PREVIOUS EXAMINATIONS, AND PRIOR ENFORCEMENT ACTIONS

The results of the market analysis review revealed that during 2008, enforcement actions were taken in the states of Maryland and Pennsylvania. These actions pertain to market conduct examinations and unfair insurance practices act violations. There were penalties assessed for \$7,500 and \$25,000 respectively. The examiners focused on these issues during the course of the file review.

The Company was the subject of 11 California consumer complaints and inquiries closed from April 1, 2008 through March 31, 2009, in regard to the lines of business reviewed in this examination. The complaints pertain to seven denials of claims, two claims handling delay, one cancellation, and one prompt pay issue. The examiners focused on these issues during the course of the file review.

The previous claims examination reviewed a period from July 1, 1998 through June 30, 1999. The most significant noncompliance issues identified in the previous examination report were the Company's failure to maintain hard copy claim files; failure to include the CDI denial referral language; failure to notify the beneficiary that interest will be paid or failed to specify the rate of interest; failure to respond to Department inquiries; claim handling delays and gaps in claim activities; failure to respond within regulatory timelines to communications; failure to pay interest on life claims; and failure to provide an explanation of benefits. This previous examination of life and disability insurance resulted in a total of 366 citations. These issues were identified as problematic in the current examination.

DETAILS OF THE CURRENT EXAMINATION

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

GENWORTH LIFE SAMPLE POLICY FILE REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS IN REVIEW PERIOD	SAMPLE FILES REVIEWED	NUMBER OF ALLEGED VIOLATIONS
Accident and Disability / Individual Long-Term Care	3,096	65	359
Accident and Disability / Group Long-Term Care	44	5	31
TOTALS	3,140	70	390

TABLE OF TOTAL ALLEGED VIOLATIONS

Citation	Description of Allegation	Genworth Life Number of Alleged Violations
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.	101
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.	73
CCR §2695.4(a) *[CIC §790.03(h)(3)]	The Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy.	37
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.	30
CCR §2695.7(h) *[CIC §790.03(h)(5)]	The Company failed, upon acceptance of the claim, to tender payment within 30 calendar days.	23
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.	23
CIC §790.03(h)(1)	The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.	20
CCR §2695.7(b) [CIC §790.03(h)(4)]	The Company failed, upon receiving proof of claim, to accept or deny the claim within 40 calendar days. [The Company failed to affirm or deny coverage of claims within a reasonable time after proof of loss requirements had been completed and submitted by the insured.]	14
CIC§10232.8(c) *[CIC §790.03(h)(5)]	The Company allocated the costs to have a licensed health care practitioner certify that an insured meets, or continues to meet the definition of "chronically ill individual", or to prepare written plans of care against the lifetime maximum of the policy or certificate.	9

Citation	Description of Allegation	Genworth Life Number of Alleged Violations
CIC §10235.95(b) *[CIC §790.03(h)(5)]	The Company failed to pay interest at a rate of 10% per annum on the amount of any accepted claim beginning on the first calendar day after the day that the payment of the accepted claim was due.	9
CCR §2695.5(e)(3) *[CIC §790.03(h)(3)]	The Company failed to begin investigation of the claim within 15 calendar days.	8
CCR §2695.7(b)(3) *[CIC §790.03(h)(3)]	The Company failed to reference the California Department of Insurance in its claims denial.	7
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
CCR §2695.7(b)(1) *[CIC §790.03(h)(3)]	The Company failed to provide in writing the reasons for the denial of the claim in whole or in part including the factual and legal bases for each reason given.	6
CCR §2695.5(b) *[CIC §790.03(h)(2)]	The Company failed to respond to communications within 15 calendar days.	5
CCR §2695.3(a) *[CIC §790.03(h)(3)]	The Company failed to maintain all documents, notes and work papers in the claims file.	5
CCR §2695.7(d) *[CIC §790.03(h)(3)]	The Company failed to conduct and diligently pursue a thorough, fair and objective investigation. [The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.]	5
CCR §2695.5(e)(2) *[CIC §790.03(h)(3)]	The Company failed to provide necessary forms, instructions, and reasonable assistance within 15 calendar days.	4
CCR §2695.7(c)(1) *[CIC §790.03(h)(3)]	The Company failed to provide written notice of the need for additional time or information every 30 calendar days.	2

Citation	Description of Allegation	Genworth Life Number of Alleged Violations
CCR §2695.4(d) *[CIC §790.03(h)(3)]	The Company improperly required a claimant to give notification of a claim or proof of claim within a specified time. [The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.]	1
CCR §2695.5(d) *[CIC §790.03(h)(3)]	The Company's claims agent failed to immediately transmit notice of claim to the insurer.	1
CIC§10232.8(c) *[CIC §790.03(h)(3)]	The Company failed to notify the insured of the entitlement to a second assessment by a licensed health practitioner, upon request, who shall personally examine the insured.	1
Total Number of Citations		390

***DESCRIPTION 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)(2) The Company failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.
- 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)(4) The Company failed to affirm or deny coverage of claims within a reasonable time after proof of loss requirements had been completed and submitted by the insured.
- CIC §790.03(h)(5) The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability had become reasonably clear.
- CIC §790.03(h)(13) The Company failed to provide promptly a reasonable explanation of the bases 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 ALLEGED VIOLATIONS BY LINE OF BUSINESS

<p align="center">ACCIDENT AND DISABILITY (Long-term Care)</p> <p>2008 Written Premium: \$213,271,987 2009 Written Premium: \$216,498,724 AMOUNT OF RECOVERIES \$ 1,079,968.98</p>	<p align="center">NUMBER OF ALLEGED VIOLATIONS</p>
CCR §2695.11(b) [CIC §790.03(h)(3)]	101
CIC §790.03(h)(3)	73
CCR §2695.4(a) [CIC §790.03(h)(3)]	37
CIC §790.03(h)(5)	30
CCR §2695.7(d) [CIC §790.03(h)(3)]	28
CCR §2695.7(h) [CIC §790.03(h)(5)]	23
CIC §790.03(h)(1)	20
CCR §2695.7(b)[CIC §790.03(h)(4)]	14
CIC§10232.8(c) [CIC §790.03(h)(5)] / [CIC §790.03(h)(3)]	10
CIC §10235.95(b) [CIC §790.03(h)(5)]	9
CCR §2695.5(e)(3) [CIC §790.03(h)(3)]	8
CCR §2695.7(b)(3) [CIC §790.03(h)(3)]	7
CCR §2695.7(g) [CIC §790.03(h)(5)]	6
CCR §2695.7(b)(1) [CIC §790.03(h)(3)]	6
CCR §2695.5(b) [CIC §790.03(h)(2)]	5
CCR §2695.3(a) [CIC §790.03(h)(3)]	5
CCR §2695.5(e)(2) [CIC §790.03(h)(3)]	4
CCR §2695.7(c)(1) [CIC §790.03(h)(3)]	2
CCR §2695.4(d) [CIC §790.03(h)(3)]	1
CCR §2695.5(d) [CIC §790.03(h)(3)]	1
<p align="center">TOTAL</p>	390

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 states: "We believe California does not have jurisdiction over Genworth's claims practices in other states. It is Genworth's position that our processes in all jurisdictions are compliant with the applicable laws and regulations. We do not believe that 'corrective action' is required to comply with any state's laws and regulations, including the California laws and regulations. Any process changes or enhancements that we have made over the last several years have been made as part of ongoing efforts to improve our customer's claims experience. The Company has, and will continue to, comply with all state laws and regulations and, where appropriate, the enhancements that are not specific to California law may be applied in other states".

Money recovered within the scope of this report was \$68,025.22 as described in section numbers 3, 4, 9, 10, and 13 below. Following the findings of the examination, a closed claims survey as described in section numbers 4 and 9 below was conducted by the Company resulting in additional payments of \$1,011,943.76. As a result of this examination, the total amount of money returned to claimants within the scope of this report was \$1,079,968.98.

ACCIDENT AND DISABILITY / LONG-TERM CARE

1. **In 101 instances, the Company failed to provide to the claimant 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.** In these cases the Company's Explanation of Benefits (EOBs) was inaccurate, incomplete, and/or failed to provide a clear explanation and calculation of benefits. The exceptions are noted below (but not limited to):

- Failure to include the daily benefit amount and/or the applicable weekly maximum amount
- Failure to identify the specific Home Care Services subject to reimbursement
- Failure to identify the specific dates of services paid (non-sequential dates of service were reflected as a general range of dates)
- Improper and/or inaccurate statement of a Medicare offset against policy benefits
- Failure to clarify basis for payment of benefits
- Missing provider of services information, percentage of benefit information, and inflation benefit adjustment
- Failure to specify the amount of Plan of Care/care coordination service charges assessed against the lifetime payment maximum
- Failure to reflect accurate and/or complete bed reservation benefits

Specifically with regard to Privileged Care Coordination charges on both Tax-Qualified (TQ) and Non-Tax Qualified policies, the Department's findings reflect the Company's failure to provide details including dates, provider information, description of services, and specific amounts which were applied against the policies' benefits. These care coordination charges may consist of the following:

1. Coordinating in-home functional assessment
2. Developing an appropriate plan of care
3. Providing the initial and ongoing current eligibility certification
4. Suggesting a variety of formal and informal care and support service providers and possible financial resources available to meet the needs identified in the plan of care
5. Assisting with the implementation of the Plan of care through coordination of the chosen care and support service providers
6. Monitoring the care and support services received including conducting periodic reassessments to determine appropriate revisions to the plan of care

The Department has emphasized to the Company the need for transparency and compliance to provide (for each claim payment) a complete explanation of benefit and/or communication notice as required under CCR 2695.11(b). These notices can come in the form of any format whether in a narrative letter form, or as part of the Company's system EOB. The Company's provision to send quarterly notices on Care Coordination benefits is not deemed appropriate as no legitimate

charges may be incurred, particularly on policies which prohibit these charges against the policies.

The Department alleges these acts are in violation of CCR §2695.11(b) and are unfair practices under CIC §790.03(h)(3).

Summary of Company Response: The Company disagrees it violated the laws cited. Nevertheless, prior to this Examination, as part of its on-going efforts to enhance customer service, the Company had initiated and has now completed (as of December 2009), a project that enhanced its Explanation of Benefits. In an effort to improve the Insured's understanding of the content of each benefit payment, the new Explanation of Benefits is written in an easy-to-read format, and includes policy details such as applicable payment maximums, service dates considered, any excluded amounts and deductible/elimination period. The enhanced EOB contains a reference to the California Department of Insurance whenever a claim is not paid in full due to the application of an Elimination Period, policy maximum or application of any policy exclusion.

Further, the Company has initiated and now completed (as of First Quarter 2010) a process of notifying its insureds through a quarterly letter of any charges for Privileged Care Coordination which may have been deducted from the policy's lifetime maximum over the prior three-month period. The notification letter includes the date(s) of service and the amount billed by the Care Coordinator for the Privileged Care Coordination service.

The Company disagrees that the claims handling provisions of the California Insurance Code and California Code of Regulations apply to four of the instances above where the insured was a resident of another state. Nonetheless, in response to the Department's concern, the Company stated that as of September 2009, the Company applies its communication or process changes under California law to insureds who purchased a policy in California and to insureds who currently reside in California.

2. In 73 instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies. The exceptions are noted below:

- a) Claims handling and procedural delays on: internal referral processes; assignment and completion of functional health assessments; gaps in claim activities; obtaining medical records; unnecessary or duplicative claim form requirements; evaluation of health assessments and reports; et al
- b) Failure to follow-up on: escalated complaint calls; inquiries relevant to policy benefits, supportive equipment needs and other communications; changes or adjustments in the level of care services; validating missing information on claim forms; submission of invoices or verification of services based on an Approved Plan of Care; and coordinating with the Care Coordinators with regard to the delivery of services to the insured

- c) Delay in facility eligibility approval process. The Company delays facility eligibility while awaiting receipt of claim forms, and does not provide direction or instruction with respect to identifying facilities that qualify under the policy's definition of a "nursing home"
- d) Lack of a timely policy or timeline for the review and final claim determination when proof of claim is completed or received (The "Time of Payment" provision of the policy requires that after the Company has received proof of loss, "we will pay any benefits immediately")
- e) Failure to clarify the basis and the cost of services (on Privileged Care Coordination benefits)
- f) Failure to transmit correct communications to appropriate parties/insured representatives
- g) Failure to set-up and establish a claim when a "chronically ill" certification is still pending, or an actual date of injury or sickness recovery has yet to be determined at a future date (The Company prematurely classifies this as a "no claim" when the Company has been reasonably apprised of a possible claim against the policy)

The Department alleges these acts are in violation of CIC §790.03(h)(3).

Summary of the Company's Response: The Company disagrees it violated CIC §790.03(h)(3). However, the Company acknowledges there were several isolated claims identified in the exam which experienced delays that were not consistent with the Company's policies and procedures for claims adjudication. The appropriate Benefit Analysts have been counseled.

The Company has comprehensive processes and sophisticated system controls to ensure that claims are promptly, but thoroughly, reviewed and paid in accordance with the policy and regulatory requirements. The claims submitted under long term care policies must be carefully analyzed before making the determination that an Insured's condition and resulting care needs satisfy the eligibility requirements of the policy. The Company continues to enhance its procedures and improve the customer's experience. While the Company does not agree that its past practices were non-compliant, the Company has carefully considered the Department's concerns.

With respect to determining provider eligibility, as described to the Department in detail, the Company has made the following procedural enhancements:

- **Provider Management Team:** The Company created a Provider Management Team, or PMT (initiated in California in 1st Quarter 2010; implemented nationwide by December 2011) which initiates a review of a facility's eligibility immediately following Notice of Claim. This team uses information from California websites and

current information in the Company's established database to proceed with the facility review. If additional information is required, the Company obtains this information directly from the care facility. This process enables the Company to communicate to its insureds decisions about facilities in a shorter timeframe.

- Auto-approval of certain facilities: In certain circumstances, a facility will be auto-approved and an approval letter sent to the insured within 48 hours of receipt of Notice of Claim.
- Facility Inquiry Process: The Company offers insureds the ability to make a Facility Inquiry in which the Company will review one or more providers, as requested by the insured, and make a determination whether the providers are eligible under the insureds policy. This allows insureds to make an informed decision prior to moving into a facility.
- Care Scout: The Company offers the services of Care Scout to assist insureds with identifying providers that may be appropriate for their care needs. Upon identifying one or more providers which meet their care needs, insureds may ask the Company to perform a Facility Inquiry as outlined above.
- Care Call: In September 2008, the Company created a Care Call process for indemnity long term care policies (such as Nursing Home only policies).
- Addendum with initial claim forms: In early 2010, the packages sent to California insureds upon the initiation of a claim include an addendum containing important details about the policy requirements for a covered facility.

With respect to determining an insured's eligibility, as described to the Department in detail, the Company has made the following procedural enhancements:

- Claim Forms: The Company's initial and ongoing claims review processes collect information about the insured's condition from the Insured, his or her medical provider, and his or her care provider. It is essential to gather information from each of these sources in order to make an appropriate decision regarding eligibility. Over the last five years, the Company has refined and tailored its claim forms process to further ensure that the information necessary for adjudication of a claim is requested at the earliest possible time. The Company's forms have been carefully drafted to obtain relevant information from the appropriate sources. As explained in response to Criticism 6, the Company does not believe its forms are duplicative or unnecessary.
- Enhanced Periodic File Review Process: Once a claim is approved, on a periodic basis determined by the insured's condition, additional claim forms, records and a functional assessment may be requested. The Company enhanced its Periodic File Review process in 2010 to ensure that the review is customized in accordance with the insured's condition and type of care received.
- Communication of eligibility decisions: Beginning in October of 2009, the Company enhanced its claim approval and declination process by requiring a Benefit Analyst to communicate to insureds both in writing and by telephone (either on the same day or no later than the following business day) and by enhancing its separate written approval letter to include further information about the submission of invoices for services and equipment.

With respect to managing its formal complaint resolution process, training has been provided to the Company's Customer Service Representatives and Benefit Analysts on dissatisfied customer procedures and the importance of citing the proper policy requirements when communicating with the insured or his/her representative.

As noted in the Company's response to Criticism 1, the Company initiated and now completed (as of First Quarter 2010) a process of notifying its insureds through a quarterly letter of any charges for Privileged Care Coordination which may have been deducted from the policy's lifetime maximum over the prior three-month period. The notification letter includes the date(s) of service and the amount billed by the Care Coordinator for the Privileged Care Coordination service.

The Company disagrees that the claims handling provisions of the California Insurance Code and California Code of Regulations apply to six of the instances above where the insured was a resident of another state. Nonetheless, in response to the Department's concern, the Company stated that as of September 2009, the Company applies its communication or process changes under California law to insureds who purchased a policy in California and to insureds who currently reside in California.

3. In 37 instances, the Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy. The Company failed to disclose benefits, time limits, coverage or other provisions of the policy to the insured including: covered services, application of the elimination period, inflation benefit increases, benefit maximums, limitations and exclusions on eligibility of facilities and/or providers, and other provisions which affect or trigger benefits to qualify payment. In particular, the Company failed to disclose what is covered and/or approved under an insured's specific plan of care. When supportive equipment was recommended as part of the Plan of Care, and therefore, might reasonably become payable, the Company failed to immediately inform and assist the insured in determining the extent of the insurer's additional liability. The Department alleges these acts are in violation of CCR §2695.4(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company disagrees it violated the laws cited. The Company's standard practice is to disclose all benefits, coverage, time limits or other provisions of the policy. However, in eight (8) isolated instances regarding claims under Indemnity policies, while these Insureds should have access to the terms and conditions of his or her coverage through review of their policies, the Company agrees that it would have provided better customer service if it had discussed the key terms of the coverage with these claimants during the claim process. While the Company does not agree that its past practices were non-compliant, the Company has carefully considered the Department's concerns and has enhanced its process for claims filed under Indemnity policies. As described to the Department in detail, as of September 2008, the Company conducts "Care Calls" with California residents under Indemnity policies during which a Company analyst and the insured reviews, in-depth,

the applicable policy terms and conditions. In addition, as described in detail to the Department, and noted in response to Criticism 2, beginning in October of 2009, the Company enhanced its claim approval process to require a Benefit Analyst to communicate approvals to insureds by telephone and in writing.

Further, the Company continues to reinforce with Customer Service representatives and claims staff the importance of citing proper policy requirements and providing full disclosure of benefits and other provisions of the policy.

The Company disagrees that the claims handling provisions of the California Insurance Code and California Code of Regulations apply to four of the instances above where the insured was a resident of another state. Nonetheless, in response to the Department's concern, the Company stated that as of September 2009, the Company applies its communication or process changes under California law to insureds who purchased a policy in California and to insureds who currently reside in California.

As a result of this examination, the Company has contacted pertinent insureds and inquired as to the existence of any outstanding invoices. The Company subsequently issued additional monies for home care benefits (\$500) and supportive equipment (\$761.86).

4. In 30 instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. The Company failed to equitably consider benefits for the exceptions noted below:

- Supportive equipment
- Confinement days as a result of the delay in the determination of facility eligibility
- Gaps in long-term care services
- Home care convalescent services and "other option" benefits
- Prior confinement stays
- Missing dates of service
- Claims with pending "chronically ill" certifications
- Failure to apply the correct date of first eligibility, and to waive a single elimination period under the Privileged Care Coordination benefits
- Care Coordination services, Plan of Care development, status update assessments, and other administrative task expenses were charged against policy benefits

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

Summary of the Company's Response: The Company disagrees it violated CIC §790.03(h)(5). The Company states its standard practice is to promptly and fairly pay claims. However, in four (4) instances on the same claim, the Company inadvertently did not pay certain benefits owed to the Insured. The Company issued

additional benefits including interest in the amount of \$56,333.33. Further, the appropriate Benefit Analysts were counseled. Additionally, in nine (9) instances, the Company mistakenly paid charges for Plans of Care and Chronically Ill Certifications as benefits, instead of Company expenses. The Company has restored these benefits to the policies (in the total amount of \$2,822.85).

As described at length in response to Criticisms 2, 3 and 4, the Company has documented standards and procedures to promptly and fairly evaluate eligibility, review services, apply applicable policy provisions, and reimburse all covered claims. In an effort to improve the insureds' experience, many of these procedures have been further enhanced since 2008.

As a result of this examination, the Company reprocessed pertinent claims with payment errors. The Company issued additional benefits including applicable interest. The Company also allocated Care Coordination/Plan of Care and other administrative expenses against the policy benefits. The Company restored back policy benefits, and/or reclassified benefits to expenses.

The Company also conducted a self-survey either to repay or restore Privileged Care Coordination (PCC) charges to a population of current and former policyholders with misallocated charges. On July 30, 2010, the Company provided the Department the results of its self-survey of all non-tax-qualified policies (Non-TQ) that were assessed with the Plan of Care (POC), Privileged care coordination (PCC), status update assessments and administrative task charges. The survey included all exhausted (terminated) policies from August 1, 2007 through July 31, 2010, and active/current policies as of July 30, 2010 with the POC/PCC charges. The following payments and/or adjustments were made on 818 policies and totaled \$493,737.44:

- 153 terminated (exhausted) policies were paid \$124,284.63 (inclusive of \$17,721.66 interest paid)
- 481 active policies (with lifetime maximum) were restored with benefits for \$241,743.66
- 184 active policies (with unlimited benefits) were reclassified from benefits to expenses for \$127,709.15

The Company disagrees the claim handling provisions of the California Insurance Code and California Code of Regulations apply to one of the instances above where the insured was a resident of another state. Nonetheless, in response to the Department's concern, the Company stated that as of September 2009, the Company applies its communication or process changes under California law to insureds who purchased a policy in California and to insureds who currently reside in California.

The Company disagrees with the Department with respect to the one claim for Home Health Care where the Department alleges the Company "failed to comply with the policy provisions to waive the elimination period under the Privileged Care Coordination benefits, and failed to determine the correct date of first eligibility." The

Company did not apply two elimination periods to this claim and it is not the Company's general practice to apply two elimination periods. The Company determines the date of eligibility based on information obtained during the course of its investigation of the claim and not solely based on the date of the assessment. Under this insured's policy, Home Health Care provided after a Plan of Care is developed by a Privileged Care Coordinator is not subject to an elimination period. Accordingly, under the policy, dates of services incurred prior to development of a Plan of Care by a PCC are subject to an elimination period. In this instance, as a courtesy to the insured, the Company applied the Plan of Care retrospectively by 30 days so that care received within the 30 days preceding the development of the Plan of Care was not subject to the elimination period. However, care received more than 30 days preceding the development of a Plan of Care by a PCC was subject to the Elimination Period, as per the policy. The Company states that this practice was an extra-contractual enlargement of coverage and not a restriction.

Summary of the Department's Evaluation of the Company's Response: The Company's practice of applying the elimination period prior to the date the Plan of Care is developed by the PCC and its practice of dating the Plan of Care 30 calendar days retrospectively, as a courtesy and as an extra-contractual enlargement of coverage, are not supported by the policy and result in the Company's failure to effectuate fair and equitable settlements of claims. Specifically, the Company fails to pay benefits and fails to waive the elimination period beginning on the date the Company determined the insured eligible for benefits in instances in which the insured utilizes the Privileged Care Coordinator to develop a Plan of Care for Home Health Care. The Company has not provided a corrective action plan.

This is an unresolved issue that may result in administrative action.

5. In 23 instances, the Company failed, upon acceptance of the claim, to tender payment within 30 calendar days. The Company failed to tender payment of claims promptly upon receipt of invoices or charges. The Company processed payment of claims outside of the regulatory timeline of 30 calendar days. The Company also failed to comply with its policy provision to immediately pay claims upon receipt of proof of loss. The Department alleges these acts are in violation of CCR §2695.7(h) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company disagrees it violated the laws cited. However, the Company acknowledges that in seventeen (17) instances noted by the Department, the Company did, inadvertently, pay a portion of a claim submitted outside of the 30-day required timeframe. The appropriate Benefit Analysts have been counseled. The Company believes the other six (6) instances noted by the Department were appropriately paid and thus were not violations of CCR § 2695.7(h). Nonetheless, the Company continues to reinforce the requirement of timely claims handling with all Benefit Analysts.

The Company disagrees that the claims handling provisions of the California Insurance Code and California Code of Regulations apply to two of the instances above where the insured was a resident of another state. Nonetheless, in response to the Department's concern, the Company stated that as of September 2009, the Company applies its communication or process changes under California law to insureds who purchased a policy in California and to insureds who currently reside in California.

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

The Department disagrees that the six instances disputed were paid within the regulatory timeline requirement. The Company states when a long-term care claim is approved, the claim is generally on-going for many months and years. Therefore, the claimant is offered several options for payment, including a payment cycle date system. This system was designed to pay a claim on the same date each month. However, the Department found in these instances, the Company did not adhere to its own schedule and/or delayed payment if invoices were not received within a certain period within the cycle. These acts do not comply with the regulation requirement. Further, the Company has not complied with its own "Time of Payment" policy provision which states in part, "we will pay any benefits immediately".

This is an unresolved issue that may result in administrative action.

6. In 23 instances, the Company persisted in seeking information not reasonably required for or material to the resolution of a claims dispute. The Company persists in duplicative inquiries or requests for information from the insured which may be easily available to the Benefits Analyst through other investigative and claims processing tools, and/or are already contained in the claim files.

The exceptions include the following:

- The facility statement form requires responses about multiple levels of care that are not necessary or are not required in the policy provisions. The questionnaire form includes an inquiry about a Planned Program of Policies and Procedures (PPPP) which is developed, reviewed, and executed by at least one physician and one nurse. This PPPP standard has resulted in delays and/or denial of claims.
- The facility statement form duplicates the on-site facility inspection and medical information already provided in claim forms, medical records, and physician statements. The health assessment personally conducted by the Company's own licensed health care professional already establishes the care needs and the appropriate placement of the insured in the facility.
- Duplicative or unnecessary requests for submission of Attending Physician Statement forms, Medical Authorization forms, and Cognitive Care Questionnaires when insured confinement is in the same facility, and an on-site health assessment and on-site facility inspection have been completed.

- In the re-certification process, multiple claim forms are requested which are not reasonably required when an insured is not expected to recover from the sickness/diagnosis, and there is no change in the confinement facility.
- In face-to-face health assessments, the Company assigns its own licensed health professional and requests the insured to submit additional Attending Physician Statements which are duplicative and not reasonably required in determining claim eligibility.
- The Company required proof and mode of payment for home health care with copies of front and back of cancelled checks in one instance. This form of proof is not reasonably required when the insured is able to provide other forms of payment receipt or confirmation.

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: The Company disagrees it violated the laws cited. The Company has adopted and implemented well-documented processes to ensure the prompt investigation and processing of claims arising under its long term care insurance policies. The Company aims to conduct and diligently pursue a thorough, fair and objective investigation in all claims and does not persist in seeking information not reasonably required for or material to the resolution of a claim dispute. Any attempt to gather information on a claim is done with the intention of performing a complete and reasonable investigation of eligibility.

While the Company disagrees that it committed any violations, as its standard practice is to fairly and diligently investigate claims, in eight (8) instances noted by the Department, the Company agrees it inadvertently requested information already in the claim file. The appropriate Benefit Analysts have been counseled and provided further training.

The Company maintains that the remaining alleged fifteen (15) instances were not erroneous requests for information because each involved an appropriate and material investigation of a claim and thereby are not violations of CCR 2695.7(d).

The Company's business practice regarding claim investigation has always been, and remains, compliant with CCR 2695.7(d). The Company is committed to administering claims in the most practical and efficient way, considering the age and health of the Insured, the requirements of the policy, and the ability to ensure that claims are adjudicated in the most fair and consistent way. While the Company does not agree that its past practices were non-compliant, the Company has carefully considered the Department's concerns and made revisions to its claim forms and processes, as described in detail to the Department. The claim forms developed and used by the Company are carefully drafted in such a way as to obtain relevant information from the Insured, his/her care provider(s) and his/her physician(s) so that the Company may make sound initial and ongoing benefit eligibility determinations.

These claims forms are not duplicative, in that, among other things, the sources of all information are different. The Company seeks information directly from a care provider and from a medical provider, where appropriate, but the insured's involvement is important in many circumstances to ensure that the information sought is current and relevant. Information pertaining to an insured's ongoing eligibility for benefits is material to the claim and, thus, requesting such information does not violate CCR 2695.7(d). In addition to being material to the benefit eligibility determination, the claim forms, care and medical records, and proof of loss documentation are all essential elements in the Company's required fraud prevention program, pursuant to The Insurance Frauds Prevention Act CIC 1871-1879.8. Furthermore, this program is supported by the provisions contained within each long term care insurance policy. Therefore, these actions do not violate CCR 2695.7(d).

In addition, as described in detail to the Department and referenced in response to Criticism 2, the Company has enhanced its Periodic File Review Process. Once a claim is approved, on a periodic basis determined by the insured's condition, additional claim forms, records and a functional assessment may be requested. The Company enhanced its Periodic File Review process in 2010 to ensure that the review is customized in accordance with the insured's condition and type of care received.

The Company maintains that the Department is incorrect in stating that it requires "proof and mode of payment for home health care with copies of front and back of cancelled checks." The Company periodically requests proof of payment documentation for two reasons: to confirm that an expense was incurred, in accordance with the policy requirements, and to ensure that fraudulent activities do not exist. However, the Company does not require, and has never required, that the insured pay for home care services by check. In the particular claim at issue, the Benefit Analyst requested copies of cancelled checks as proof of payment, although the Company would have accepted other forms of proof of payment. The claimant was able to provide copies of the checks, however, had this not been possible, the Benefit Analyst would have worked with the claimant to find the most effective way to obtain the information requested. Nonetheless, the appropriate Benefit Analyst has been counseled.

In addition, the Company disagrees with the Department's allegations that its inquiries in the Provider Information Form as to the facility's "planned program of policies and procedures" are "not necessary or required" by the policy. To the contrary, these questions are specifically drafted to determine whether the facility meets the definition of Nursing Home as set forth in the policy, which itself is based on Medicare law and is not unreasonable.

Finally, the Company disagrees that the California claims-handling regulations apply to out-of-state residents, such as four of the instances above, even when the policy was originally purchased in California. Nonetheless, in response to the Department's concern, the Company stated that as of September 2009, the Company applies its communication or process changes under California law to insureds who purchased a policy in California who now reside in another state.

Summary of the Department's Evaluation of the Company Response: The Company's practice of requiring Facility Statement Forms and other duplicative and unnecessary forms places its own duty to investigate claims on the insured and other third parties, and delays the processing and settlement of claims. The Facility Statement Form contains unrelated inquiries that do not apply to the provisions of the policy, and has been used by the Company to deny facility eligibility. This FST form was utilized on claims that did not contain the PPPP provision. Specifically, the Company requires a strict compliance with the "PPPP factor" or the "doctor/nurse review factor" to deny coverage even when the Company is reasonably able to determine facility eligibility and cognitive care information during its on-site facility inspection, and through governmental agencies' licensing information.

This is an unresolved issue that may result in administrative action.

7. In 20 instances, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to coverages at issue. In ten claims, Company communications did not appropriately reflect the policy provisions. The Company provided inaccurate information about elimination periods. The Company misrepresented the allocation of a one-time charge of \$175.00 for the preparation and implementation of a Plan of Care. The Company misrepresented the definitions of a "nursing home" for facility eligibility, and the requirement of "continual supervision" as a trigger for policy benefits. The Company misrepresented home convalescent benefits to an insured, and sent erroneous information regarding claim closure to an insured. The Company inaccurately identified the "Medicare Non-Duplication" provision, and misquoted a "lack of coverage" as the basis for the denial of benefits.

In the remaining ten instances, the Company inaccurately stated "weekly policy limits" as a denial reason when the amounts did not match the actual weekly limit. The Company also imposed a policy time limit to submit proof of loss requirements. The Company misrepresented requirements for a new full claim evaluation on an existing benefit-eligible claim if it is reopened. The Company misrepresented that total costs including any fees for care coordination benefits will be charged against the lifetime maximum limits on a tax-qualified policy. The Company misrepresented its basis for claim denial by stating that continual supervision prior to September 2, 2007 on a claim is necessary to trigger benefits. The Company misrepresented that a nursing home policy does not cover the services under an assisted living facility. The Company misrepresented the application and waiver of an elimination period for Privileged Care Coordination (PCC) benefits when the policy has already satisfied its one-time elimination period.

The Department alleges these acts are in violation of CIC §790.03(h)(1).

Summary of the Company's Response: The Company disagrees it violated CIC §790.03(h)(1). The Company's standard practice is to clearly and accurately communicate with its insureds. However, the Company acknowledges that in ten (10) instances certain communications to the insured did not appropriately reflect the policy

provisions. The appropriate Benefit Analysts have been counseled. With respect to the remaining ten (10) instances, the Company disagrees that any incorrect information was communicated to its insureds. Nonetheless, the Company has reinforced the importance of communicating the correct policy requirements to insureds with all claims staff.

The Company disagrees that the claims handling provisions of the California Insurance Code and California Code of Regulations apply to two of the instances above where the insured was a resident of another state. Nonetheless, in response to the Department's concern, the Company stated that as of September 2009, the Company applies its communication or process changes under California law to insureds who purchased a policy in California and to insureds who currently reside in California.

8. In 14 instances, the Company failed, upon receiving proof of claim, to accept or deny the claim within 40 calendar days. The Company has an internal policy wherein services or invoices will not trigger acceptance or denial if the Company considers the charges as "insubstantial" or not materially "costly". These include charges for blood pressure machines, glucose monitors, personal care services, et al. Conversely, the Company also has an internal process of excluding charges that the Company considers are "substantial" or "monetarily costly". These include scooters or treadmills, or massage therapy services not provided by a physical therapist. More specifically, of the 14 instances, the Company failed in eight (8) instances to accept or deny "insubstantial" or "materially costly" invoices and charges. The claims are detailed as follows: **a)** mileage or "errand miles" [EOB 8/12/08]; **b)** homemaker services invoice for \$140 was partially paid \$40 [EOB 9/11/08]; **c)** mileage charges of \$1,000, and a Thanksgiving bonus charge of \$25.00. [EOB1/9/09]; and **d)** laundry services of \$300 for 5 weeks (\$60/week) was partially paid \$120 [EOB 9/11/08]. In addition, upon receiving proof of claim, the Company failed to accept or deny the following specific items: **e)** unspecified invoice charges of \$4,130.50 [EOB11/11/08]; **f)** \$3,000 invoice for unspecified days of service [EOB 12/11/08]; **g)** unspecified charges of \$2,864.00, \$340.00 for cleaning services, mileage charges and housekeeping charges of \$720.00 from another provider [EOB 2/11/09]; and **h)** unspecified charges of \$3000 [EOB 4/9/09]. The claim files do not reflect acceptance or denial within 40 calendar days upon receipt of proof of loss.

In six (6) of the 14 instances, the Company did not communicate whether the claim was accepted or denied within 40 calendar days upon receiving proof of claim.

The Department alleges these acts are in violation of CCR §2695.7(b) and are unfair practices under CIC §790.03(h) (4).

Summary of the Company's Response: The Company agrees in three instances. The Company acknowledges that in one (1) instance, in which the claim was denied in full, it did not send written notice of denial within 40 days of receiving proof of loss. This was an inadvertent and isolated error and the Company maintains that one instance is not sufficient to indicate a general business practice. Also, in two (2) instances, the Company states it inadvertently erred and did not provide a written denial

within 40 calendar days upon receiving proof of claim. The Company has counseled the appropriate personnel and emphasized the importance of following Company standards of procedure.

The Company does not agree in 11 instances. Specifically, in eight (8) of the instances pertaining to one insured, the Company states it did not accept coverage for the services; however, the policy's weekly benefit maximum amount had been reached and, accordingly, the charges at issue were not reimbursed to the insured. The Company did not fail to reimburse the insured because the charges were "low in value" or "insubstantial". The Company accepted coverage for the services but did not reimburse the total amount because the amount exceeded the weekly maximum. Additionally, in all eight instances, an Explanation of Benefits was sent to the insured stating the amount of charges that was excluded exceeded the benefit maximum of the policy. However, the Company states the explanation of benefits template has been revised as outlined in summary number one (above) that will enhance explanations of the application of policy maximums.

In two (2) instances, the Company states the insureds were notified of the denial in writing within the required regulatory timeframe upon receipt of proof of loss.

In one (1) instance, the insured's representative indicated that the insured was not interested in submitting invoices for a particular time period, and did not submit invoices for that time period. The Company states no proof of claim was submitted therefore acceptance or denial of the claim was not required.

Summary of the Department's Evaluation of the Company Response: In the eight identified instances in which the Company received invoices for services, the Company failed to communicate the resolution of the claim. That is, the Company failed to notify the insured that the claim was either accepted or denied in whole or in part.

The Company's response, in two instances, that it notified the insured in writing that the claim had been denied within the regulatory timeframe is based on the date the Company states it received proof of loss. However, in each instance, the Examiners determined pertinent information was received that established proof of claim earlier than the Company believes it had proof of loss. Thus, the regulatory requirement to accept or deny no more than 40 days upon receipt of proof of claim was not met.

Regarding the remaining instance, the Company's response that the insured was not interested in submitting a claim does not take into account the health assessment qualifying the insured for care. Specifically, the Company first received an inquiry call on March 7, 2007, for benefits on caregiver services incurred by the insured since December 6, 2006. The Company responded that the insured was not qualified to receive benefits, and that prior care would not be considered. One week later, on March 15, 2007, the Company received the health assessment qualifying the insured for care "24 hours a day 7 times weekly" effective December 6, 2006. The Company failed to accept or deny the claim within regulatory timelines.

These are unresolved issues that may result in administrative action.

9. In nine instances, the Company failed to adhere to the code requirement of allocated costs shall not count against the lifetime maximum of the policy or certificate or entitlement to second assessments. In these instances, the Company allocated costs to have a licensed health care practitioner certify that an insured meets, or continues to meet the definition of "chronically ill individual", or to prepare written plans of care against the lifetime maximum of the policy or certificate with respect to tax-qualified policies. The Care Coordination services/Privileged Care coordination services, as well as administrative tasks, were included as charges against the insured's policy benefits. Plan of Care Development activities are prohibited from being charged as benefits on tax-qualified policies. The Company therefore agreed to a review of Company policies with exhausted (terminated) benefits, and active/current policies with expenses misallocated as benefits on the policy. The transactions were Plan of Care charges, Privileged Care Coordination charges, status assessment charges, Chronically Ill certification charges, and other administrative charges. The Department alleges these acts are in violation of CIC §10232.8(c) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company provided the following statement in response: "The Company acknowledges that developing Plan of Care (POC) services were inadvertently included as charges against the insured's policy benefit maximum on tax-qualified policies instead of allocating them as expenses and/or costs. As described in detail to the Department and referenced in response to Criticism 4, a result of this examination, the Company reviewed the policies for consideration of restoration of benefits to lifetime payment maximum, and/or reclassification of benefits to expenses."

The Company further acknowledged that developing Plan of Care (POC) services were included as charges against the insured's policy benefit maximum on tax-qualified policies instead of allocating them as expenses and/or costs. As a result of this examination, the Company reviewed the policies for consideration of restoration of benefits to lifetime payment maximum, and/or reclassification of benefits to expenses. The Company made adjustments to insureds in the amount of \$972.59. The Company also conducted a self-survey of all tax-qualified policies that were assessed with the Plan of Care (POC) /Privileged care coordination (PCC)/ status update assessments and administrative task charges. The survey included all exhausted (terminated) policies, and active/current policies with the POC/PCC charges. The Company provided the results to the Department on July 30, 2010 reflecting the following payments and/or adjustments for \$518,206.32 on 909 policies:

- 130 terminated (exhausted) policies were paid \$114,149.45 (inclusive of \$16,159.64 interest paid)
- 522 active policies (with lifetime maximum) were restored with benefits for \$255,155.57

- 257 active policies (with unlimited benefits) were reclassified from benefits to expenses for \$148,901.30

10. In nine instances, the Company failed to pay interest at a rate of 10% per annum on the amount of any accepted claim beginning on the first calendar day after the day that the payment of the accepted claim was due. The Department alleges these acts are in violation of CIC §10235.95(b) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company disagrees it violated the laws cited. However, the Company acknowledges that in the nine (9) instances cited, it inadvertently did not include interest pursuant to CIC §10235.95(b). These were isolated instances or error and the appropriate Benefit Analysts have been counseled. As a result of this examination, the Company issued interest payments to the insureds totaling \$863.00 on these nine (9) instances.

11. In eight instances, the Company failed to begin investigation of the claim within 15 calendar days. Upon receipt of initial notice of claim, the Company did not conduct the appropriate and timely investigative activities to adjudicate the long-term care claims within regulatory timelines. In these instances, the Company was provided with pertinent claim information at the onset of the claim. The Company did not initiate appropriate claim processes such as ordering prompt health assessments and identifying and determining facility eligibility under the definition of a "nursing home" until it received the claim forms. The Department alleges these acts are in violation of CCR §2695.5(e)(3) and are unfair practices under CIC §790.03(h)(3).

Summary of Company Response: The Company disagrees it violated the law cited. The Company's standard business practice is to promptly begin the investigation of claims. The Company promptly provided the insureds with the relevant claim forms, including the basic instructions regarding their completion, and then initiated additional investigation when it was known to be required.

However, the Company has carefully considered the Department's concerns. As described to the Department in detail, in September 2008, the Company initiated "Care Calls," a process, for its California insureds, to enhance its prompt investigation of claims under Indemnity policies upon Notice of Claim by telephonically obtaining information about the Insured's diagnosis, long term care needs and care provider, and requesting certain assessments at that time, if necessary. The Company enhanced this process for claims under its Indemnity policies to provide a higher level of assistance to its insureds.

Additionally, in the first quarter of 2010, the Company developed a Provider Management Team which initiates a review of a facility's eligibility immediately following Notice of Claim. This team uses information from California websites and current information in the Company's established database to proceed with the facility review. If additional information is required, the Company obtains this information directly from

the care facility. This process enables the Company to communicate to its insureds decisions about facilities that are not covered, or covered under the Company's Dementia Consideration exception, in a shorter timeframe.

The Company disagrees that the claims handling provisions of the California Insurance Code and California Code of Regulations apply to one of the instances above where the insured was a resident of another state. Nonetheless, in response to the Department's concern, the Company stated that as of September 2009, the Company applies its communication or process changes under California law to insureds who purchased a policy in California and to insureds who currently reside in California.

12. In seven instances, the Company failed to reference the California Department of Insurance in its claims denial. The Company failed to include in seven instances, the required Department reference in its denial notices, including claims for what the Company considers as "insubstantial" charges, and "out of facility" stays by the insured. The Department alleges these acts are in violation of CCR §2695.7(b)(3) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company disagrees it violated the laws cited. The Company believes that its processes at the time of the exam complied with CCR §2695.7(b)(3). However, as of December 2009, the notification required in CCR §2695.7(b)(3) has been included on all Explanations of Benefits where there are exclusions on payment, including application of the Elimination Period, policy maximums or policy exclusions.

In the final instance, the Company agrees that the California Department of Insurance notification was inadvertently not included in a letter to the Insured, which declined benefits for certain dates, because the primary intent of the letter was to approve benefits. This single isolated error is not sufficiently frequent to indicate a general business practice.

The Company disagrees that the claims handling provisions of the California Insurance Code and California Code of Regulations apply to two of the instances above where the insured was a resident of another state. Nonetheless, in response to the Department's concern, the Company stated that as of September 2009, the Company applies its communication or process changes under California law to insureds who purchased a policy in California and to insureds who currently reside in California.

13. In six instances, the Company attempted to settle a claim by making a settlement offer that was unreasonably low. The exceptions included non-payment of level of care charges, charges for covered supplies, facility confinement benefits, and home care services. The Department alleges these acts are in violation of CCR §2695.7(g) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company disagrees it violated the laws cited. The Company states its standard practice is to effectuate prompt, fair and equitable settlement of claim; however, the Company acknowledges that it inadvertently

overlooked certain service dates in the six (6) instances cited, and it has since reimbursed the insureds for those benefits.

As a result of this examination, a total amount of \$5,771.59 was paid to the insureds identified within the examination samples.

14. In six instances, the Company failed to provide in writing the reasons for the denial of the claim in whole or in part including the factual and legal bases for each reason given. In four cases, the Company failed to send a written denial and/or failed to provide the legal basis for non-payment of excluded amounts on benefit services, caregiver services, home convalescent services, and other “excluded amounts” when the weekly maximum benefits had not been exhausted. In two instances, the Company failed to support legal bases for the denial of claims. The Company did not provide a legal basis for denying one claim on the basis that a tax-qualified certification requirement was not satisfied when the insured’s actual date of recovery was still to be determined at a future time. This “chronically ill” certification is a subjective estimate only of the duration of the insured’s functional incapacity and is not a certainty until such time that the 90-day period has actually elapsed. The Company denied a claim on the basis that such certification has yet to be submitted at a future date.

The Company also did not have legal basis to deny a claim using a facility’s confinement notes which was in conflict with an actual health assessment of the insured’s eligibility for long-term care benefits. This health assessment was conducted by the Company’s own licensed health care professional. The Department alleges these acts are in violation of CCR §2695.7(b)(1) and are unfair practices under CIC §790.03(h)(13).

Summary of the Company’s Response: The Company disagrees it violated the laws cited. In two (2) instances, the claims were properly denied in writing with a thorough explanation of the legal basis for the denial, as the insureds did not satisfy the eligibility provisions of the policy. The Department’s disagreement with the Company’s decision to deny these claims does not create violations under the cited regulations and statutes, nor would these denials violate any other regulation or statute as they were supported by documentation and policy provisions. In two (2) instances, the Company made notations on the Explanation of Benefits that satisfied the requirements of CCR §2695.7(b)(1) and CIC §790.03(h)(13). The Company’s Explanation of Benefits, particularly after the 2009 enhancements, serves as a written explanation of the reasons for denying certain dates or services in an ongoing claim, where denial is unrelated to the insured’s eligibility to receive benefits.

While the Company disagrees that it committed any violations, as its standard practice is to provide, in writing, the reason for the denial of a claim, in one (1) instance, the Company admits that it inadvertently did not pay 18 days of benefits owed to the insured in one case. Those days were paid upon recognition of the inadvertent error. In the final one (1) instance, the Company agrees that the explanation regarding

application of the Elimination Period to dates of service was described verbally to the Insured, rather than in writing; however, this was an isolated and inadvertent error. The appropriate Benefit Analyst has been counseled.

The Company disagrees that the claims handling provisions of the California Insurance Code and California Code of Regulations apply to one of the instances above where the insured was a resident of another state. Nonetheless, in response to the Department's concern, the Company stated that as of September 2009, the Company applies its communication or process changes under California law to insureds who purchased a policy in California and to insureds who currently reside in California.

Summary of the Department's Evaluation of the Company's Response: The Company states in four instances it disagrees with the Department's findings. However, written claims denials did not include reference thereto and provide an explanation of the application of the statute, applicable law or provision, condition or exclusion. The EOB enhancements addressed in the Company Response to criticism number one pertain to the explanation or calculation of benefits and do not address the requirements of this cited regulation.

This is an unresolved issue that may result in administrative action.

15. In five instances, the Company failed to respond to communications within 15 calendar days. The Company failed to respond to a policyholder request for withdrawal of a claim; failed to return a call on coverage inquiry; failed to respond to a request for facility eligibility consideration; failed to address an insured's specific request for a callback from the Benefit Analyst; and failed to address follow-up calls from an insured's representative. The Department alleges these acts are in violation of CCR §2695.5(b) and are unfair practices under CIC §790.03(h)(2).

Summary of the Company's Response: The Company disagrees it violated the laws cited. However, the Company acknowledges with respect to one (1) instance that it did not handle the claim withdrawal process in accordance with its internal standard operating procedures. Similarly, the Company acknowledges that in one (1) instance the claim experienced delays that were not in line with the Company's procedures. The Company does not believe these were statutory violations. The appropriate Benefit Analysts have been counseled and additional training has been provided. In addition, the Company acknowledges that in one (1) instance, due to the ongoing nature of the insured's questions, it may have been appropriate for the Benefit Analyst to have called the insured back even where it was noted that a callback was not required. The Company has provided this feedback to the Benefit Analyst. Accordingly, the Company acknowledges this instant as an isolated, inadvertent error. The Company disagrees that the two (2) remaining instances violated CCR §2695.5(b) or CIC §790.03(h)(2) because the Company responded to the insured's telephonic or written communications within 15 days, where it was reasonably suggested that a response was expected. Nonetheless, additional training has been provided to Benefit Analysts regarding the importance of responding to communications from insureds promptly and thoroughly.

and the Company has ensured that it has practices in place to promptly and appropriately respond to inquiries from its insureds and their representatives.

16. In five instances, the Company failed to maintain all documents, notes and work papers in the claims file. In three of these instances, there was no supporting claim or care coordination activities documented to support charges which were applied as benefits, instead of as expenses. In one instance, a claim transmittal letter for a free copy of a policy was missing from a file. In the last instance, the health assessment notes determined the cognitive impairment status of the insured as needing continuous supervision; however, claim documentation was missing with regard to how the Tax-Qualified Chronically Ill certification was changed to “disagree” with the “Cognitive Impairment” status of the insured.

The Department alleges these acts are in violation of CCR §2695.3(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company’s Response: The Company disagrees it violated the laws cited. The Company’s standard practice is to ensure that all necessary documentation is maintained in the claim file for the required period of time. However, the Company acknowledges that it did not have documentation of specific claim invoices from its care coordinator vendor in three (3) of the instances cited. The Company now requires its Care Coordination vendors to maintain detailed records regarding services provided to the insureds, which can be produced upon request from the Company. The Company also acknowledges that in one (1) instance it was unable to produce a copy of a transmittal letter for a free copy of a policy; however, this was an inadvertent and isolated file maintenance error. In the last instance, the Company agrees that the status update report by its vendor contained conflicting information regarding the cognitive status of the insured. The Company states it will work with its vendor to ensure that the appropriate documentation is included in assessment results.

17. In five instances, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation. The Company did not diligently undertake a complete claim determination to promptly bring the claims to a conclusion in five cases. Specifically, gaps in claim file activity, lack of a diary system, and minimal investigation were noted as follows: a) in two instances, all pertinent information and documentation (proof of loss) were received to make a determination of denial. It took the Company 49 days (August 2, 2006-September 20, 2006), and 54 days (October 22, 2008-December 15, 2008) to finalize its secondary review and to transmit the denial letters; b) in one instance, proof of loss and health assessments were received and completed as of September 1, 2008. The secondary review process of the Company took 67 days before the Company accepted the claim on November 7, 2008; c) in one instance, the Company’s own assigned health professional verified (face-to-face assessment) the insured’s eligibility for benefits due to cognitive impairment. The Company improperly imposed time limits for submission of invoices, and closed the claim as a “no claim” without allowing the insured access to policy benefits. The Company did not pay benefits for a cognitively-impaired insured on the sole basis that

the Company allegedly did not receive invoices; d) in the last instance, the Company received proof of loss on October 27, 2008 and delayed acceptance of the claim as the claim documents were misplaced in another claim file.

The Department alleges these acts are in violation of CIC §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company disagrees it violated the laws cited. The Company's standard practice is to diligently pursue a thorough, fair and objective investigation of claims. However, the Company acknowledges that in one (1) instance proof of loss documents were inadvertently placed in another claim file delaying acceptance of the claim. Upon identification of the error, the Company accepted the claim and paid benefits with interest.

The Company disagrees with the Department's allegations of the remaining four instances:

In one of the four instances of disagreement, the Company states the claim was accepted. However, the insured did not submit invoices. The Company states it is unable to, and not required to, keep a claim open indefinitely when invoices are not submitted for payment or when covered services are not placed. The Company responds that the closure of the claim was appropriate and did not jeopardize the insured's "eligibility start date" since services were not placed.

In three (3) of the four instances, the Company states it performed diligent reviews of claims submitted under Nursing Home only policies, where the insured was residing in an assisted living-type facility, in an attempt to pay benefits under those policies. Due to the nature of the claims at issue (e.g. involving dementia consideration), in order to complete a thorough investigation the Benefit Analyst required the amount of time that was taken.

However, the Company has made numerous procedural enhancements with respect to determining provider eligibility and determining any insured's eligibility, as explained in the Summary of Company Response section in Criticism 2. Further, with regard to the Company's internal secondary review process, the Company has represented to the Department that its revised procedures will impact and reduce the cycle time for completing its review. Since 2009, the Company has doubled its staff on the Technical Team and added levels of management to monitor its workload. The work in progress and timing of review is further monitored by senior management several times a week, and the vast majority of the referrals are completed within the Company's internal goal of 10 days. The Company has taken steps to streamline the review process, so the Technical Team Specialists are able to complete their work promptly.

18. In four instances, the Company failed to provide necessary forms, instructions, and reasonable assistance within 15 calendar days. The Company

failed to comply with this regulation in the following instances: a) The Company received notice of claim on June 7, 2007 and mailed the claim forms on June 25, 2007 (18 days later); b) The Company was advised of an insured's move to a new facility in advance; however, the Company did not provide appropriate and immediate assistance in identifying an eligible facility; c) On a comprehensive tax-qualified LTC policy (TQ 7024C), the Privileged Care Coordination benefit refers to a current list of the Company's approved coordinator agencies. The insured was not provided with reasonable assistance with choices of coordinator agencies, a comparison of negotiated daily or hourly rates, and available services under the Privileged Care coordination services; d) An insured with a comprehensive policy was not provided assistance and direction in accessing covered benefits including homemaker services and care coordination benefits at initial notice of claim on August 7, 2008, which was closed as a "no claim" by the Company. The Department alleges these acts are in violation of CCR §2695.5(e)(2) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company disagrees it violated the laws cited. The Company has procedures in place to provide all insureds with the necessary forms, instructions and assistance within 15 days of Notice of Claim. Indeed, in these four instances, the Company immediately provided the insured with the forms and information required for the claim evaluation and therefore believes it satisfied the requirements of CCR §2695.5(e)(2).

The Company also disagrees that it is required, under CCR §2695.5(e)(2) and CIC §790.03(h)(3), to take the actions suggested by the Department regarding Care Coordination agencies and identification of eligible facilities in advance of an Insured's relocation to a new facility (particularly when the Company is provided with notice of the change in facilities less than one business day before the move). It is the Company's position that the Department's suggestions are not supported by or required under §2695.5(e)(2) and CIC §790.03(h)(3).

The Company also disagrees that it is required under CCR §2695.5(e)(2) or CIC §790.03(h)(3) to provide insureds with a list of eligible facilities. Not only is this not required by law, it is also an impracticable request given the sheer volume of facilities in California.

While the Company maintains that its past practices were in compliance with California law, it has carefully considered the Department's concerns and enhanced its processes with respect to determining facility eligibility. As set forth in greater detail in response to Criticism 2, the Company (a) created a Provider Management Team to investigate a provider's eligibility at the same time the Benefit Analysts are investigating the insured's eligibility; (b) determined auto-approval of certain facilities is appropriate; (c) continues to provide a Facility Inquiry Process wherein insureds are able to inquire whether one or more facilities are eligible in advance of placing care; (d) offers the services of Care Scout to assist insureds with identifying providers appropriate for their care needs; (e) instituted Care Calls wherein the insured is contacted by phone following receipt of Notice of Claim to discuss relevant policy terms including the requirements to meet the definition of Nursing Home under the policy; and (f) included

an addendum with the initial claim forms containing important details about the policy requirements for a covered facility so that the insured has an additional reference tool to locate a covered provider and also references the availability of the services of Care Scout and the Facility Inquiry process as well as providing the state websites for locating a California licensed Skilled Nursing Facility and Residential Care Facility for the Elderly.

Summary of the Department's Evaluation of the Company's Response: The Company states it disagrees that in four (4) instances, it failed to provide necessary forms, instructions, and reasonable assistance within 15 calendar days in the following instances:

- a) In one claim, it took the Company 18 days to provide forms to the insured which is outside of the regulatory timeframe of 15 days. The Company's reported procedure in place failed to comply with the regulation requirement in this instance. The Company did not provide corrective action.
- b) In one claim, the insured advised the Company of her move to a new facility. The insured was not provided appropriate assistance in identifying an eligible facility. The Company's corrective action, creation of a Provider Management Team, does not address whether assistance will be provided to identify placement facilities pursuant to the regulation requirement to provide reasonable assistance.
- c) The Company did not offer assistance to the insured with regard to negotiated rates, a list of approved coordinator agencies, or a comparison of available services from coordinator agencies under its Privileged Care Coordinator (PCC) benefits. The insured is not provided assistance to limit his/her out of pocket costs, and/or to maximize the use of his policy limits. The Company's creation of a Provider Management Team does not address corrective action pursuant to the regulation requirement to provide reasonable assistance.
- d) The insured's elderly spouse contacted and advised the Company that he was overwhelmed with being the caretaker for the insured. This insured has a long-term care policy which covered benefits including skilled nursing care, homemaker services, care coordination benefits, and home care benefits. The Company failed to provide immediate assistance to allow the insured access to her comprehensive policy benefits, and noted the claim as a "no claim". The Company subsequently set up a claim for the insured 49 days later.

These are unresolved issues that may result in administrative action.

19. In two instances, the Company failed to provide written notice of the need for additional time or information every 30 calendar days. The Company failed to send the regulatory notices or status update letters, and/or failed to specify what is needed for the Company to make a determination on the claim. The Department

alleges these acts are in violation of CCR §2695.7(c)(1) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company disagrees it violated the laws cited. The Company's standard practice is to provide written notice of the need for additional time every 30 days; however, the Company acknowledges that in one (1) instance the appropriate status letters were inadvertently not sent to the insured. The appropriate Benefit Analyst has been counseled and the Company has added controls to ensure that this follow-up correspondence is timely sent. The Company also acknowledges that in the other one (1) instance, while it notified the insured in writing that there was outstanding information needed in order to make a determination on the claim and that it was in the process of obtaining that additional information directly from the facility, it did not specify the particular information sought from the facility. The appropriate Benefit Analyst has been counseled.

20. In one instance, the Company improperly required a claimant to give notification of a claim or proof of claim within a specified time. The Company's November 24, 2008 and December 22, 2008 letters were returned as "not deliverable". However, the Benefit Analyst sent a final (third) letter to the correct address on January 7, 2009 with a deadline (date) imposed for proof of claim of January 26, 2009. The Company did not address its own mistakes/deficiencies in this instance. The Department alleges this act is in violation of CCR §2695.4(d) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company disagrees it violated the laws cited. The Company's standard practice is not to require insureds to give notice of claim or proof of claim within a specified time; however, the Company acknowledges that in this one (1) instance, because of the previous returned mail, the Benefit Analyst should have sent a second request letter for outstanding information to the correct address rather than the final request letter. The appropriate Benefit Analyst has been counseled. However, the Company stated that it appropriately and reasonably includes a submission date in all letters requesting additional information so that the insured submits the information promptly and the claim is efficiently managed, and does not believe this practice is prohibited under CCR §2695.4(d) and CIC §790.03(h)(3).

21. In one instance, the Company's claims agent failed to immediately transmit notice of claim to the insurer. The insured reported the claim to the agent. The agent failed to transmit notice to the Company. The Department alleges this act is in violation of CCR §2695.5(d) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company disagrees it violated the laws cited. It is the Company's position that if the insured advised the agent of notice of claim, that the agent's failure to provide notice of claim to the Company is the agent's violation of this regulation, not the Company's. It does appear from the claim

file that based on information from the agent, the insured incorrectly believed that a claim could not be opened until the 90-day elimination period was over, although it is unclear whether the insured provided the agent with notice of claim. Had the insured provided the agent with notice of claim, the Company's policies and procedures require the agent to provide the notice to the Company in compliance with CCR §2695.5(d). The required regulatory action for every licensee or claims agent to immediately transmit notice of claim to the insurer is directed to the "licensee", which in this situation is the selling agent. The Company believes it does not create responsibility on behalf of the insurer and, therefore, the Company did not violate CCR §2695.5(d). Upon review, the Company has determined that the agent at issue is no longer active with the Company so it is unable to reinforce the relevant requirements with him.

22. In one instance, the Company failed to notify the insured that upon request he or she shall be entitled to a second assessment by a licensed health care practitioner who shall personally examine the insured. This statute is specific to tax-qualified policies only. The Company failed to notify the insured of the entitlement to a second assessment by a licensed health practitioner, as mandated by statute and the policy language. The only actual face-to-face assessment on the insured was made prior to the 90-day requirement, and it did not address the time frame for potential eligibility. The Company determined the claim denial based on a telephonic assessment without the benefit of a current/latest face-to-face assessment of the insured's functionality. The Department alleges this act is in violation of CIC §10232.8(c) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company disagrees with the laws cited that it was required to offer a second assessment to the insured in this instance. CIC §10232.8(c) provides that "the requirement for a second assessment shall not apply if the initial assessment was performed by a practitioner who otherwise meets the requirements of this section and who personally examined the insured." The insured was personally examined by a licensed and independent healthcare practitioner, namely his own physician. Accordingly, the Company was not required in this instance to notify the insured that he was entitled to a second assessment. A Benefit Analyst contacted the insured to verify the results of the in-person assessment, but the BA was not themselves doing an assessment.

Summary of the Department's Evaluation of the Company's Response: A tax-qualified policy has a specific requirement that a licensed health care practitioner, independent of the insurer, shall certify the "chronically ill" certification; that this independent licensed health care practitioner shall develop a Plan of Care after personally examining the insured; and that in order to be considered "independent of the insurer", a licensed health care practitioner shall not be an employee of the insurer, and shall not be compensated in any manner that is linked to the outcome of the certification. In this instance, the claim file indicates an assessment by a Genworth

vendor, an attending physician's statement (APS) by the insured's licensed healthcare practitioner and a documented telephone call by a Genworth Benefit Analyst. The insured's licensed health care practitioner's APS did not meet the requirement of a second assessment to which the insured was entitled. The evaluation did not have a Plan of Care as required by statute.

This is an unresolved issue that may result in administrative action.