

April 14, 2015

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

Re: Field Claims Examination Report
Genworth Life Insurance Company, NAIC # 70025

Dear Commissioner Jones:

Pursuant to California Insurance Code section 12938(b)(2), Genworth Life Insurance Company ("We" or "GLIC" or "the Company") hereby submits its response to the California Department of Insurance ("Department") report of the market conduct examination of its claims handling practices of long term care insurance claims closed during the period from April 1, 2008 through March 31, 2009, adopted March 19, 2015 ("Exam Report").

GLIC has carefully considered and responded to each of the Department's criticisms in the Exam Report. While we appreciate the Department's feedback, we vigorously object to and deny any allegation that GLIC engaged in a pattern or practice of claims handling that violates California law. Throughout the six year examination process, the Department has attempted to enforce standards that are outside the requirements of California law, sometimes to the detriment of California insureds. In addition, in some instances, the Exam Report mischaracterizes, misstates or simply misunderstands GLIC's practices. In addition, the Department has taken a few isolated instances of inadvertent error and unjustifiably characterized them as demonstrating a general unfair business practice. For these reasons, GLIC disputes the accuracy of the findings in the Exam Report and maintains that it has acted in compliance with California law. GLIC does not herein address every issue raised in the Exam Report and, accordingly, reserves its right to raise any and all objections to the Department's findings at the appropriate time.

1. GLIC's claims handling practices are in compliance with and, in many instances, exceed the requirements of California law.

GLIC believes strongly in the quality of its claims handling and has established a robust, efficient and high-quality claims experience for its insureds. While GLIC objects to any assertion that its claims handling is non-compliant, We continually strive to meet and exceed the requirements of California law and industry best practices. To that end, GLIC invested significant time and resources into enhancing its claims handling policies and procedures,

often in cooperation with the Department, in order to provide the best possible customer experience.

For example, in an effort to improve insureds' understanding of the content of each benefit payment, GLIC enhanced its Explanation of Benefits ("EOB"). The new EOB is written in an easy-to-read format that includes policy details such as applicable maximums, service dates considered, excluded amounts and deductible/elimination periods. In addition, while the Company has always had a comprehensive process and sophisticated system to ensure that claims are promptly, but thoroughly, reviewed and paid, GLIC made a number of procedural enhancements designed to streamline the provider and insured eligibility determination process, including creating a Providing Management Team which initiates review of a facility's eligibility immediately following notice of a claim, continuing to offer a Facility Inquiry Process that allows insureds the ability to inquire whether a provider is eligible prior to moving into a facility and providing Care Scout services to assist insureds with identifying providers that may be appropriate for their care needs, refining and tailoring its claim forms to ensure that the information necessary for adjudication of a claim is requested at the earliest possible time, instituting Care Calls for California residents covered under Indemnity policies, and enhancing its periodic file review process and its communications of claim approvals and declinations to insureds.

The enhancements and commitments made by GLIC exceed the requirements of California law, were undertaken voluntarily, and represent GLIC's ongoing commitment to its customers and industry best practices.

2. The Department seeks to enforce standards that unreasonably exceed the requirements of California law.

Despite GLIC's cooperation throughout the examination process and the tremendous effort made to reasonably respond to the Department's criticisms, the Department persists in imposing standards which are outside the requirements of California law. For example, in criticism 6, the Department alleges that GLIC seeks information not reasonably required for or material to the resolution of the claim. In doing so, the Department is critical of GLIC's claim forms which it contends are duplicative and unnecessary. While the Company did not agree, it carefully considered the Department's concerns and made revisions to its claim forms. Nonetheless, the Department continues to insist that the Company's Facility Statement Form is unnecessary because the Company could determine facility eligibility through onsite facility inspections or through governmental agencies' licensing information. Insisting that the Company conduct onsite facility inspections and rely on licensing databases, rather than use its own claim forms, exceeds the requirements of California law. The claim forms developed and used by GLIC are carefully drafted to obtain relevant information from the insured, his/her care provider(s) and his/her physician(s).

The Department is also critical of the Facility Statement Form because it inquires about the facility's Planned Program of Policies and Procedures. The Department contends that the company's "strict" compliance with the "PPP factor," that is, inquiring about a facility's Planned Program of Policies and Procedures in order to determine whether the facility meets the definition of a Nursing Home, has resulted in unreasonable denials. Here, again, the

Department seeks to impose requirements that exceed the law and broaden the underlying policy language. The Facility Statement Form is specifically drafted to determine whether the facility meets the definition of Nursing Home as set forth in the policy, which itself was approved by the Department and is based on Medicare law.

Finally, in criticism 18, the Department contends that GLIC failed to provide necessary forms, instructions and reasonable assistance to insureds. The Department contends that GLIC must identify eligible facilities prior to an insured's relocation and that it must provide insureds with a list of eligible facilities upon request. Neither of these is required by California law. GLIC has procedures in place to provide all insureds with the necessary forms, instructions and assistance.

GLIC believes it is patently unfair to impose standards upon it that were previously undefined and exceed the requirements of its policies and California law.

3. The Department has mischaracterized, misstated or misunderstood GLIC's claims handling practices.

In certain instances the Exam Report either mischaracterizes, misstates or misunderstands GLIC's claims handling practices. For example, in criticism 4, the Department criticizes GLIC for applying a Plan of Care retrospectively, so that care received within the 30 days preceding the development of the Plan of Care is not subject to the elimination period. GLIC has repeatedly explained to the Department that this practice is an extra-contractual enlargement of coverage granted as a courtesy to its customers as, under the terms of the policy, services incurred prior to the development of a Plan of Care are subject to an elimination period. Yet, the Department continues to misunderstand the practice and mischaracterize it as a failure to effectuate prompt, fair and equitable settlement of claims.

In criticism 8, the Department alleges that GLIC failed to accept or deny a claim within 40 calendar days of receiving proof of claim. Specifically, the Department contends that the Company failed to accept or deny "insubstantial" or "not materially costly" invoices and charges. As GLIC explained to the Department multiple times, this is a misstatement of its practice. The Company did not decline to reimburse the insured because the charges were low in value, instead, it accepted coverage for services but did not reimburse the total amount because the amount exceeded the weekly maximum. In all instances an EOB was sent to the insured stating the amount of the charges that were excluded and explaining that the benefit maximum of the policy had been exceeded. The Department also appears to misunderstand the facts where it contends that GLIC should have denied a claim, even though the Company explained that the insured stated he would not be submitting invoices for the particular time period at issue (and did not submit such invoices).

In criticism 14, the Department alleges that GLIC failed to provide in writing the reasons for the denial of a claim including the factual and legal basis for each reason given. However, GLIC properly denied the claims at issue in writing with a thorough explanation of the legal basis for the denial (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 justify mischaracterizing the denials as incomplete.

Finally, in criticism 22, the Department alleges that the insured was entitled to a second assessment by a licensed health care practitioner pursuant to CIC section 10232.8(c). That code section, however, provides that the requirement for a second assessment does not apply if the first assessment was performed by a healthcare practitioner who personally examined the insured. Here, the Department has misstated or misunderstood the facts. GLIC provided the Department with documentation that the insured was personally examined by a licensed and independent healthcare practitioner (his own physician) and, therefore, was not entitled to a second assessment.

4. The Department has taken a few isolated instances of inadvertent error and unjustifiably branded them as demonstrating a general unfair business practice.

Despite its statements to the contrary in the Exam Report, the Department has failed to identify any violations of CIC section 790.03(h).

CIC section 790.03 defines certain unfair methods of competition and unfair and deceptive acts or practices in the business of insurance. Subsection (h) provides that "knowingly committing or performing with such frequency as to indicate a general business practice" any of the settlement practices listed therein is considered an unfair method of competition and unfair and deceptive act or practice. CIC § 790.03(h). A plain-language, grammatically accurate reading of section 790.03(h) shows that "knowingly" modifies both "committed" and "performed." Accordingly, GLIC must have "knowingly committed" or "knowingly performed" "with such frequency as to indicate a general business practice" the alleged unfair settlement practice in order to violate section 790.03(h). Instances of inadvertent error cannot constitute a "knowing" violation of section 790.03(h). Moreover, a violation of section 790.03(h) must be based on a practice, not a single act. Section 790.03(h) refers only to "unfair claims settlement *practices*" and requires that such practices be so frequent as to indicate a general business *practice*. GLIC disputes many of the allegations in the report. However, in the handful of instances in which it acknowledges an error, these errors were inadvertent and not committed knowingly nor with sufficient frequency as to indicate a general business practice.

In addition, a violation of section 790.03(h) cannot be inferred, as the Department attempts, from a violation of the California Fair Claims Settlement Practices Regulations (10 CCR section 2695.1 *et seq.*) or any other provision of the Insurance Code. The language of 10 CCR section 2695.1(a) impermissibly expands the scope, nature and reach of section 790.03 beyond what was intended by the Legislature. Applying the principle of *expressio unius est exclusio alterius*, it is clear the Legislature expressed the intention to make exclusive the list of unfair methods of competition set forth in section 790.03 and the addition of purportedly unlawful settlement practices is prohibited unless the process set forth in section 790.06 is followed, or the Legislature itself acts. Accordingly, the Exam Report's allegations of violations of the Fair Claims Settlement Practices regulations cannot serve as the basis for a violation of CIC section 790.03(h).

We appreciate this opportunity to provide comments to the Exam Report.

Sincerely,

A handwritten signature in cursive script that reads "Allison K" followed by a long horizontal flourish.

Allison Kusel
Adjudication Leader, Long Term Care Claims