

**[IN ACCORDANCE WITH CALIFORNIA INSURANCE CODE (CIC) SECTION 12938,
THIS 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**

**NIPPON LIFE INSURANCE COMPANY OF AMERICA
NAIC # 81264 CDI # 2442-2**

AS OF MAY 31, 2010

ADOPTED 4/30/14

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



April 30, 2014

The Honorable Dave Jones
Insurance Commissioner
State of California
45 Fremont Street
San Francisco, California 94105

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:

**NIPPON LIFE INSURANCE COMPANY OF AMERICA
NAIC # 81264**

Hereinafter, the Company listed above also will be referred to as Nippon 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 claims closed during the period from June 1, 2009 through May 31, 2010. The examination was made to discover, in general, if these and other operating procedures of the Company conform to the contractual obligations in the policy forms, the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law. This report contains all alleged violations of laws that were identified during the course of the examination.

The report is written in a “report by exception” format. The report 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. 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 June 1, 2009 through May 31, 2010; 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 individual claims files was conducted at the offices of the Company's third party administrator in Des Moines, IA.

EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED

The Accident and Disability claims reviewed were closed from June 1, 2009 through May 31, 2010, referred to as the “review period”. The examination was limited to Group Health Medical claims category only. The examiners randomly selected 70 Nippon claims files for examination. The examiners cited 87 alleged claims handling violations of the California Insurance Code and other specified codes from this sample file review.

Findings of this examination included failure to advise providers of the right to enter into a dispute resolution process, incomplete and/or deficient explanations of benefits, failure to provide factual and legal basis for denial, failure to conduct and diligently pursue a fair and objective investigation, and failure to effectuate prompt, fair and equitable settlements of claims.

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

The results of the market analysis review did not identify any specific issues of concern except as noted below.

The Company was the subject of seven California consumer complaints and inquiries closed from June 1, 2009 through May 31, 2010, in regard to the lines of business reviewed in this examination. There was no specific area of concern identified in the complaint review. However, the Company provided a list of Provider disputes with the Department for the period July 1, 2008 through June 30, 2009. There were 639 provider disputes reported.

The previous claims examination reviewed a period from February 1, 2002 through January 31, 2003. There was no specific area of concern identified in the previous claims examination.

DETAILS OF THE CURRENT EXAMINATION

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

NIPPON SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS IN REVIEW PERIOD	SAMPLE FILES REVIEWED	NUMBER OF ALLEGED CITATIONS
Accident and Disability / Group Health Medical	60,157	70	87
TOTALS	60,157	70	87

TABLE OF TOTAL CITATIONS

Citation	Description of Allegation	NIPPON Number of Alleged Citations
CIC §10123.13(a) *[CIC §790.03(h)(3)]	The Company failed to include a statement to the provider in a contested or denied claim advising of its right to enter into the dispute resolution process described in CIC §10123.137.	39
CCR §2695.11(b) *[CIC §790.03(h)(3)]	The Company failed to provide to the claimant and assignee, if any, an explanation of benefits including, if applicable, the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits.	13
CCR §2695.7(d) [CIC §790.03(h)(3)]	The Company failed to conduct and diligently pursue a thorough, fair and objective investigation of a claim and persisted in seeking information not reasonably required for or material to the resolution of a claims dispute.	6
CIC §10123.13(a) *[CIC §790.03(h)(13)]	The Company failed to include in its notice of a denied claim the portion of the claim that was denied and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for denying the claim.	6
CIC §10123.131(a) *[CIC §790.03(h)(5)]	The Company failed to pay a provider for duplicating all information it requests in connection with a contested claim and for patient records.	5
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.	4
CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.	4
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.	3

Citation	Description of Allegation	NIPPON Number of Alleged Citations
CIC §10169(e) *[CIC §790.03(h)(3)]	The Company failed to advise the insured of the right to an independent medical review whenever health services have been denied, modified, or delayed by the insurer, or by one of its contracting providers, if the decision was based in whole or in part on a finding that the proposed health care services are not medically necessary.	2
CCR §2695.5(b) *[CIC §790.03(h)(2)]	The Company failed to respond to communications within 15 calendar days.	1
CIC §10123.13(c) *[CIC §790.03(h)(5)]	The Company failed to pay interest on a contested claim after 30 working days.	1
CIC §10123.131(b) *[CIC §790.03(h)(3)]	The Company requested information from a provider that is not reasonably necessary to determine liability for payment of a claim.	1
CIC §10123.13(a) *[CIC §790.03(h)(4)]	The Company failed to reimburse claims as soon as possible, but no later than 30 working days after receipt of the claim.	1
CIC §10123.13(a) *[CIC §790.03(h)(13)]	The Company failed to notify in writing, within 30 working days after receipt of the claim, both the insured and the provider that the claim was denied.	1
Total Number of Citations		87

***DESCRIPTONS OF APPLICABLE
UNFAIR CLAIMS SETTLEMENT PRACTICES**

- 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 CITATIONS BY LINE OF BUSINESS

ACCIDENT AND DISABILITY 2008 Written Premium: \$40,308,990 AMOUNT OF RECOVERIES \$48.23	NUMBER OF CITATIONS
CIC §10123.13(a) C[CIC §790.03(h)(3)]	39
CCR §2695.11(b) [CIC §790.03(h)(3)]	13
CCR §2695.7(d) [CIC §790.03(h)(3)]	6
CIC §10123.13(a) [CIC §790.03(h)(13)]	6
CIC §10123.131(a) [CIC §790.03(h)(5)]	5
CIC §790.03(h)(5)	4
CIC §790.03(h)(3)	4
CCR §2695.7(g) [CIC §790.03(h)(5)]	3
CIC §10169(e) [CIC §790.03(h)(3)]	2
CCR §2695.5(b) [CIC §790.03(h)(2)]	1
CIC §10123.13(c) [CIC §790.03(h)(5)]	1
CIC §10123.131(b) [CIC §790.03(h)(3)]	1
CIC §10123.13(a) [CIC §790.03(h)(4)]	1
CIC §10123.13(a) [CIC §790.03(h)(13)]	1
SUBTOTAL	87

TOTAL	87
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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 intends to implement corrective actions in all jurisdictions when applicable.

Money recovered within the scope of this report was \$48.23 as described in sections number 5, 8, and 11 below. As a result of the examination, the total amount of money returned to claimants within the scope of this report was \$48.23.

DISABILITY AND HEALTH

1. **In 39 instances, the Company failed to include a statement to the provider in a contested or denied claim advising of its right to enter into the dispute resolution process described in CIC §10123.137.** The Company denied claims without providing information and notice to both the network and out-of-network providers of the right to enter into a dispute resolution process. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company believes it is in compliance as it does not contract directly with providers. The Company indicates its network providers address dispute resolutions in its provider contracts. The failure to include the dispute resolution wording on the Explanation of Benefits (EOB) was an inadvertent omission on the Company's part as its intentions were to respond to any and all disputes raised by providers. As a result of this examination, the Company has amended its EOB format to include the Dispute Resolution Process (DRP) notice and has implemented these changes in the 1st quarter of 2011.

2. In 13 instances, the Company failed to provide a clear explanation of the computation of benefits. The Company's Explanation of Benefits (EOBs) were inaccurate, incomplete, and/or failed to provide a clear explanation and calculation of benefits. The Company used technical language and codes, and used general language to refer the insured/provider to the benefits booklet instead of identifying the basis of the payment or denial. The Company also lumped or batched all services into one general description without explaining how payments and fee reductions were distributed or allocated. There were improper or inaccurate references to reduction (in \$ amounts) due to agreements with discount network providers. The Company also failed to specify the condition, limitation, exclusion or provision to support the calculation and/or computation of benefits. The Department alleges these acts are in violation of CCR §2695.11(b) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees that there is room for improvement to provide a clear computation and explanation of benefits. The use of some of the standard referral language was intended for the provider. The Company will be working with its staff to make the necessary improvements. The Company provided the Department with a sample copy of some EOB Remarks changes to eliminate the usage of general language and to clarify the payment under prevailing charges. The Company is currently in the process of transitioning from its present third party claims administrator (TPA) to a new one in July 2011. The Company will regularly review, update, and monitor compliance to this regulation.

3. In six instances, the Company failed to conduct and pursue a thorough, fair and objective investigation of a claim and persisted in seeking information not reasonably required for or material to the resolution of a claims dispute. The Company: a) placed a provider and insured on audit and required various documentary requirements and questionnaires when medical records were already available to make a resolution of the claim; b) auto-adjudicated a claim for an automatic denial without the Company verifying if professional fees were indeed owed as charged; c) failed to properly address an appeal; d) failed to diligently review the order of benefit determination for child coverage; e) requested unnecessary and duplicative information in a questionnaire to an insured when these were already covered in a medical report; and f) persisted in requesting copies of Medicare EOBs when primary coverage has already been determined to be with the Company. 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 agrees that none of the claims noted were Special Investigation Unit (SIU) cases and no fraudulent activities had been uncovered. The Company indicates its "pre-payment review" places some providers on "audit" for documentary requirements, and its SmartSuspense Claim Check System identifies claims with "modifiers (26)" for denial. The Company believes these are generally accepted business practices. However, the Company will work with its Administrator (TPA) to institute changes so that providers are contacted by the Company to ensure that the insured/patient is not billed for these professional charges.

The Company will also work with its Administrator to modify the procedures employed to reduce ancillary burdens on insureds. The Company will work toward a system that exempts from the automatic audit requirement those instances where the service provided is mandated by federal or state law, and where the codes for the billing are appropriate for the services provided. Additionally, the Company will work with its Administrator to include a process for individualized, non-automated intervention to ensure that insureds are not burdened by pre-payment reviews.

The Company agrees that certain claims were handled incorrectly. The Company has a system of securing Medicare EOBs through its Medicare crossover agreements with Medicare. The Company has taken corrective action by updating its system to reflect the proper order of payment, and by reviewing pertinent claims with the examiners for additional training and compliance. A corrected/revised EOB was also issued to a provider and the insured on April 28, 2011 as appropriate.

4. In six instances, the Company failed to include in its notice of a denied claim the portion of the claim that was denied and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for denying the claim. The Company did not establish the legal basis and/or wrongfully denied claims pertinent to Medicare coordination of benefits issues, improper denial due to lack of documentation, inaccurate determination of coverage or benefits, and failure to establish legal basis with regard to any policy provision, exclusion, limitation or condition. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(13).

Summary of the Company's Response: The Company agrees the claims were lacking information resulting in the denial of the claims. As a result of this examination, the Company reviewed the pertinent claims and sent corrected denial notices to the claimants as appropriate.

5. In five instances, the Company failed to pay a provider for duplicating all information it requests in connection with a contested claim, and for patient records. In these instances, the Company requested medical records and notes during its pre-payment review process, or when a provider is targeted for audit. The claims were identified for SIU investigation and additional documentation was required including doctor office notes and other records. The Company failed to pay or reimburse the medical providers for any duplicating costs involved. The Department alleges these acts are in violation of CIC § 10123.131(a)(1) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company indicates that its guideline is to inform the provider that the Company is willing to pay a clerical fee for the information requested. As a result of this examination, the Company's processors have been made aware of this requirement and the Company reimbursed all California providers from whom records were requested on these five claims. The total payment issued by the Company to the providers was \$13.05.

6. In four instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.

The Company: a) failed to provide legal basis for the denial of a claim based on lack of medical necessity; b) continued to collect premiums on dependent child coverage without validating coverage promptly upon renewal; c) SmartSuspense Check Claim System improperly denied a claim without appropriate investigation that a “direct service” was not rendered; and d) failed to provide appropriate assistance to an insured/provider in perfecting claims for resolution and payment. The Department alleges these acts are in violation of CIC §790.03(h)(5).

Summary of the Company’s Response: The Company states it has documented standards and procedures in place to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. These include processes for claims investigation, audit or pre-payment review, and automated administrative systems (SmartSuspense) for processing claims in accordance with the policy provisions. The Company believes that these claims were processed according to appropriate guidelines. However, to address the above issues, the Company will enhance its claims processing to incorporate better controls and investigative activities and individualized review handling if appropriate.

7. In four instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.

The Company failed to provide and specify the basis of its “prevailing charges” rates; failed to review medical records/notes submitted by providers; failed to consider in its pre-payment review guidelines the necessity for requiring additional documentation and other requirements; and failed to address a pre-authorization for a mandated benefit. The Department alleges these acts are in violation of CIC §790.03(h)(3).

Summary of the Company’s Response: The Company states that it has a Group SIU Unit which oversees its Audited Providers Database and identifies certain providers for audit. The Company audit procedures include fraud and abuse, licensure issues, plan and contract issues, IRS issues and claim processing issues. The Company agrees that medical notes and records may not have been reviewed and will address these issues and other compliance matters with its claims staff. The Company will also work with its Administrator to review its investigation of claims from providers who have been placed on audit due to past billing histories. The Company will work to add a layer of manual, subjective intervention into the process so that a small claim will not be held to the same level of scrutiny as a claim with multiple charges.

8. In three instances, the Company attempted to settle a claim by making a settlement offer that was unreasonably low.

The Company underpaid on Preferred Provider (PPO) network fees on two claims using its leased discount network through Aetna Signature Administrators (ASA) and PHCS Network. The Company also did not pay for an electrocardiogram and urinalysis benefits covered on the policy. 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 agrees with the finding on the underpayment of the fee schedule. ASA and PHCS quality control analysts perform random sampling audits at both the department and claim re-pricing levels. When errors are uncovered, they are corrected. Additionally, educational reinforcement and training are provided to the re-pricing analysts to ensure that such future errors are limited. As a result of this examination, the Company issued additional monies owed including interest totaling \$35.18.

9. In two instances, the Company failed to advise the insured of the right to an independent medical review whenever health services have been denied, modified, or delayed by the insurer, or by one of its contracting providers, if the decision was based in whole or in part on a finding that the proposed health care services are not medically necessary. The Company's Explanation of Benefits (EOB) limited the information and notice regarding the right to an external review, to claims involving only Experimental or Investigational issues, and excluded the right to review based on medical necessity. The Department alleges these acts are in violation of CIC § 10169(e) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees that its independent medical review (IMR) notice is incomplete and needs to be revised. The Company has amended its EOB form language to eliminate the limited reference to experimental and investigational review. The Company provided the Department with a sample copy of the revised EOB.

10. In one instance, the Company failed to respond to communications within 15 calendar days. The Company failed to address communications (telephone calls) from the insured. The Department alleges this act is in violation of CCR §2695.5(b) and is an unfair practice under CIC §790.03(h)(2).

Summary of the Company's Response: The Company agrees that its account was not updated with the information provided and it was an unintentional error on the part of the examiner. The Company will address this issue with the pertinent personnel for compliance.

11. In one instance, the Company failed to pay interest on a contested claim after 30 working days. The Company received all the pertinent information (invoice) it needed to determine and accept contractual liability to pay for a mandated health benefit. The Company received the claim on May 19, 2009 and paid the claim without the applicable interest on July 7, 2009. The Department alleges this act is in violation of CIC §10123.13(c) and is an unfair practice under CIC §790.03(h)(5).

Summary of the Company's Response: The Company indicates that prior concerns had been identified with the provider's billing practices. The Company agrees

that in this claim, no Special Investigation Unit (SIU) case was opened and no irregularities were found. The Company will work with its Administrator to include a process for individualized, non-automated intervention to ensure that insureds are not burdened by pre-payment reviews. As a result of this examination, the Company issued interest amount due to the provider for \$4.80.

12. In one instance, the Company requested information from a provider that is not reasonably necessary to determine liability for payment of a claim. The Company required medical records/notes for a mandated health benefit which it had pre-authorized for the insured. The Department alleges this act is in violation of CIC § 10123.131(b) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company indicates that the provider was identified on its pre-payment review as an "audited provider" which triggered the additional documentation requirement. The Company will work toward a system that exempts from the automatic audit requirement those instances where the service provided is mandated by federal or state law. Additionally, the Company will work with its Administrator to include a process for individualized, non-automated intervention to ensure that insureds are not burdened by pre-payment reviews.

13. In one instance, the Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. The Company was in receipt of a fully completed claim on July 27, 2009. The Company paid the claim on September 24, 2009 (60 days later) with interest. The Department alleges these acts are in violation of CIC §10123.13(a) and is an unfair practice under CIC §790.03(h)(5).

Summary of the Company's Response: The Company agrees that it should have accepted primary coverage on the claim as Medicare coverage was only secondary. As soon as the Company determined primary payer status, it paid the claim with the appropriate statutory interest. The Company has addressed this issue with the pertinent staff for ongoing training.

14. In one instance, the Company failed to notify in writing, within 30 working days after receipt of the claim, both the insured and the provider that the claim was denied. The Company did not send the appropriate notice to the insured who received services pursuant to the claim. The Department alleges this act is in violation of CIC §10123.13(a) and is an unfair practice under CIC §790.03(h)(13).

Summary of the Company's Response: The Company acknowledges this finding and will be working with its staff to make the necessary adjustments on its EOB system.