

**[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**

**HEALTH NET LIFE
INSURANCE COMPANY**

NAIC # 66141 CDI # 3173-2

AS OF JULY 31, 2012

ADOPTED DECEMBER 18, 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



December 18, 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:

Health Net Life Insurance Company

NAIC # 66141

Group NAIC # 0623

Hereinafter, the Company listed above will also be referred to as Health Net 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 Group and Individual Health claims closed during the period from August 1, 2011 through July 31, 2012. 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; consumer complaints and inquiries closed by the CDI during the period August 1, 2011 through July 31, 2012; previous CDI market conduct claims examination reports; and prior CDI enforcement actions.

4. A review of electronic paid claims data for timeliness of payment of claims, and the proper payment of interest if payment was issued beyond 30 working days from date of receipt.

5. A review of the Company's response to a CDI questionnaire pertaining to Company procedures during the review period (prior to the implementation of SB 946) for complying with the California Mental Health Parity Act (CIC § 10144.5.)

The review of the sample of individual claims files was conducted at the offices of the Company in Rancho Cordova and Woodland Hills, California.

EXECUTIVE SUMMARY

The Company's written premium for the lines of business reviewed was \$1,118,014,048 for 2011 and \$1,005,434,426 for 2012.

The Group and Individual Health claims reviewed were closed from August 1, 2011 through July 31, 2012, referred to as the "review period". The examiners randomly selected 330 Health Net claims files for examination. The examiners cited 218 alleged claims handling violations of the California Insurance Code and the California Code of Regulations from this sample file review.

Findings of this examination included the failure to notify providers of the right to a review by the CDI upon the denial of a claim, the failure to fully explain the reasons for denials, the failure to settle claims within 30 working days of receipt, and low settlement amounts. The total amount of money recovered as a result of the examination was \$298,637.06

Also employed in the examination process was an electronic review of claim data presented by the Company to determine compliance with timeliness of payment and with payment of interest requirements in California law. The electronic data field parameters were: Date Received and Date Paid or Closed. A total of 976,254 paid claims were included in the electronic review. It was observed that 24,444 claims were paid in excess of 30 working days of receipt of the claim, and interest was not included with the payment on 1,833 of these claims for a total of 26,277 alleged violations. In response to the findings of the electronic review, the Company provided additional claim data for the Department's consideration. As a result, the Department alleges 23,887 claims were paid in excess of 30 working days of receipt and interest was not included with the payment on 46 of these claims. Therefore, the Department alleges 23,933 violations of the California Insurance Code.

A more detailed review of 140 paid contested claims was also conducted. This review resulted in an additional 345 alleged violations of the California Insurance Code

and California Code of Regulations on the selected and related claims. These violations included failure to advise the provider, in the written notice that a claim was being contested or denied, of the right to seek a review by the CDI, persistence in seeking information not reasonably required for or material to the resolution of a claim dispute, failure to reimburse claims as soon as practical but no greater than 30 working days after receipt of the claim, and failure to pay interest on a contested claim after 30 working days.

Since the time the work on this examination was conducted, provisions of the Affordable Care Act have become effective. There have been significant changes in the state and federal laws with which health insurers must comply, and insurers, in general, have modified practices and procedures as a result of the changes in the law. As a result, some practices discussed and cited as non-compliant in this examination report may no longer be applicable. The Department has initiated a new examination of Health Net that will review compliance with state and federal mental health parity laws, and will, as part of the new examination, re-evaluate in relation to current law the practices this report identifies as non-compliant.

**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 2011, an enforcement action was taken in the state of Arizona. This action related to timely claim payments and adjustment practices.

The Company was the subject of 203 California consumer complaints and inquiries closed during the review period of August 1, 2011 through July 31, 2012. The reasons for justified complaints include incorrect processing of claims resulting in incorrect payments, failure to process claims timely, failure to properly apply the policy deductible, failure to allow appropriate consideration of emergency charges, and the failure to prominently display information concerning the right of an insured to request an independent medical review if the insured believes a claim has been improperly denied, modified, or delayed.

The examiners focused on the above issues during the course of the file review. Issues similar to those noted in the justified complaints were observed in the examination and are described in the final section of this report.

The previous claims examination reviewed a period from January 1, 2004 through February 29, 2008. The most significant issues identified during this examination were improper policy rescissions. These improper rescissions resulted in a CDI enforcement action on September 4, 2008, which resulted in a Cease and Desist and a penalty of \$3,600,000.00. The Company did not report any rescissions for the current review period.

DETAILS OF THE CURRENT EXAMINATION

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

HEALTH NET LIFE INSURANCE COMPANY SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS IN REVIEW PERIOD	SAMPLE FILES REVIEWED	NUMBER OF ALLEGED VIOLATIONS
Accident & Disability / Group Health - Paid	826,315	70	67
Accident & Disability / Group Health - Denied	106,425	70	33
Accident & Disability / Individual Health - Paid	150,219	70	69
Accident & Disability / Individual Health - Denied	28,706	70	47
Accident & Disability / Member Appeals	2,784	25	0
Accident & Disability / Provider Appeals	25,782	25	2
TOTALS	1,140,231	330	218

HEALTH NET LIFE INSURANCE COMPANY ELECTRONIC FILE REVIEW		
LINE OF BUSINESS / CATEGORY	Number of Claims	Number of Alleged Violations
Accident & Disability / Group Health - Paid	826,175	19,833
Accident & Disability / Individual Health - Paid	150,079	4,100
TOTALS	976,254	23,933

HEALTH NET LIFE INSURANCE COMPANY CONTESTED CLAIMS FILE REVIEW			
LINE OF BUSINESS / CATEGORY	Claims in Review Period	Sample File Review	Number of Alleged Violations
Accident & Disability / Group Health – Contested	5,263	70	170
Accident & Disability / Individual Health – Contested	871	70	175
TOTALS	6,134	140	345

TABLE OF TOTAL ALLEGED VIOLATIONS

HEALTH NET LIFE INSURANCE COMPANY				
Citation	Description of Allegation	Number of Alleged Violations		
		Electronic Analysis	Sample File Review	Contested Claim File Review
CIC §10123.13(a) *[CIC §790.03(h)(3)]	In its written notice that a claim is being contested or denied, the Company failed to advise the provider of the right to a review by the Department of Insurance.	--	193	135
CIC §10123.13(a) *[CIC §790.03(h)(13)]	In its written notice that a claim is being denied, the Company failed to identify the portion of the claim that is denied, and the specific reasons including, for each reason, the factual and legal basis for denying the claim.	--	13	--
CIC §790.03(h)(1)	The Company misrepresented pertinent facts or insurance policy provisions relating to coverages.	--	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.	--	4	10
CIC §10123.13(a) *[CIC §790.03(h)(5)]	The Company failed to reimburse claims no later than 30 working days after receipt of the claim, or after receipt of all information necessary to determine payer liability.	23,887	3	44
CIC §10123.13(b) *[CIC §790.03(h)(5)]	The Company failed to pay interest on an uncontested claim after 30 working days.	46	--	--
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 claim.	--	1	49
CIC §10123.13(c) *[CIC §790.03(h)(5)]	The Company failed to pay interest on a contested claim after 30 working days.	--	--	28
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. Specifically, when conducting a pre-existing condition investigation, the Company requested medical records from the provider for a 12 month period when the look back period is six months.	--	--	27
CCR §2695.11(d) *[CIC §790.03(h)(3)]	The Company failed to provide written notice of the need for additional time every 30 calendar days.	--	--	22

HEALTH NET LIFE INSURANCE COMPANY				
Citation	Description of Allegation	Number of Alleged Violations		
		Electronic Analysis	Sample File Review	Contested Claim File Review
CCR §2695.7(d) *[CIC §790.03(h)(3)]	The Company failed to conduct and diligently pursue a thorough, fair and objective investigation.	--	--	15
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.	--	--	9
CIC §10123.13(a) *[CIC §790.03(h)(3)]	The Company failed to include in its notice of a contested claim the portion of the claim that was contested and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for contesting the claim.	--	--	5
CIC §10123.13(a) *[CIC §790.03(h)(3)]	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 contested.	--	--	1
TOTAL NUMBER OF ALLEGED VIOLATIONS		23,933	218	345

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

- 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)(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 basis 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

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 advised that it intends to take appropriate corrective action in other jurisdictions where applicable, subject to the regulatory requirements of the other jurisdictions.

Money initially recovered during the examination was \$16,589.32 as described in section number 4 below. Following the findings of the electronic analysis, a closed claims survey as described in section 8 was conducted by the Company resulting in additional payments of \$1,262.16. Following the contested file review, an additional amount of \$5,073.62 was recovered as described in sections 12 and 16 below. Additionally, the Company conducted a closed claims survey as described in section 12 and 16 resulting in additional payments of \$275,711.96. The total amount recovered as a result of the examination was \$298,637.06.

ACCIDENT AND DISABILITY (HEALTH) – SAMPLE FILE REVIEW

1. **In 193 instances, in its written notice that a claim is being contested or denied, the Company failed to advise the provider of the right to a review by the Department of Insurance.** These instances were found in the sample files reviewed. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(3).

In addition to the instances cited above, there may be additional violations for any or all Explanations of Benefits (“EOBs”) or Remittance Advice Notices (“RAs”) sent during the review period.

Summary of the Company’s Response: The Company acknowledges that the notice of the right to a review by the CDI was not included on the Remittance Advice Notices (RAs) sent to the providers and that it should have been if a claim had been contested or denied, as in 59 of the 193 violations cited. However, the Company does not agree that violations occurred in the other 134 instances.

The Company states that these 134 instances involved claims where the amounts paid reflect the full benefits available as specified in the insured’s certificates of insurance; 114 of those involved claims that were paid at rates in accordance with Health Net’s contracts with the providers. The Company considers these claims to have been paid in full and neither contested nor denied.

Nevertheless, on March 26, 2013 the Remittance Advice Notice to be sent to providers was amended and the right to a review by the CDI will appear on all RAs, including those involving claims that were paid at contract rates that the Company considers to be paid in full.

2. **In 13 instances, in its written notice that a claim is being contested or denied, the Company failed to identify the portion of the claim that is contested or denied, and the specific reasons including, for each reason, the factual and legal basis for contesting or denying the claim.**

The Explanations of Benefits (EOBs) sent to the insureds and the Remittance Advice Notices (RAs) sent to the providers included one or more of the following phrases:

- a. Services listed not payable under plan.
- b. Treatment and/or supplies received on this claim are not a covered benefit.
- c. Refer to your plan documents for description of covered services.
- d. Service/Diagnosis not payable in Tier 3.

The above remarks do not include the specific reason for the claim denial. If the denial is based on a specific policy provision, condition or exclusion, the denial notice should identify the policy provision, condition or exclusion that is the basis of the denial. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(13).

In addition to the instances cited above, there may be additional violations for any or all EOBs and RAs sent during the review period.

Summary of the Company's Response: The Company acknowledges that its EOBs and RAs should contain more specific explanations regarding the specific reasons why a claim has not been paid. In June 2013, the Company implemented a manual process for claims examiners to enter denial explanations to appear on EOBs and RAs. On March 11, 2014, 16 new denial codes were added to the Company's claims system that provide more specific explanations for denied claims. The Company continues to add new codes, as needed.

3. In four instances, the Company misrepresented pertinent facts or insurance policy provisions relating to coverages. Of the four instances, three involved claims that were returned to the insured with instructions that the insured forward them to a Health Maintenance Organization vendor. The servicing providers were contracted providers and these claims should have been handled internally. The fourth instance involved a representation that the insured's provider was a non-contracted provider when the provider was actually contracted with Health Net. The Department alleges these acts are in violation of CIC §790.03(h)(1).

Summary of the Company's Response: The Company acknowledges that these claims were not processed in a manner consistent with the established Company procedures and attributes this to human error.

As a remedial measure, on April 29, 2013, a communication was sent to all claims examiners to reinforce the Company's procedures, and additional training was conducted on April 29, 2013 on the correct method in which to select denial reasons.

4. In four instances, the Company attempted to settle a claim by making a settlement offer that was unreasonably low. Of the four instances, three involved erroneous denials and one involved a limit that was put on a procedure that did not have a limit. 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 acknowledges that these claims were incorrectly processed. The three erroneous denials resulted from the failure to correctly adhere to established Company procedures. The incorrect limit that was applied resulted from a data entry error.

Of the three erroneously denied claims, two were reopened and \$16,589.32 was paid in November 2012, and one had been discovered internally and paid in January 2012. The claim involving the erroneously applied limit was later paid in accordance with the terms of the provider's contract.

To ensure future compliance, on April 29, 2013 a communication was sent to all claims examiners reminding them of the importance of following the applicable procedural steps. In addition, the Company communicated with the vendor responsible for data entry to reinforce the importance of accuracy.

5. In three instances, the Company failed to reimburse claims no later than 30 working days after receipt of the claim. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company acknowledges that these claims were paid more than 30 working days after they were received. However, interest was included in the payments as required by CIC §10123.13(b).

As a remedial measure, on April 24, 2013 and April 25, 2013, a communication was sent to all claims examiners to remind them that all claims must be processed no later than 30 working days after receipt of the claim.

6. In one instance, the Company persisted in seeking information not reasonably required for or material to the resolution of a claim. The provider was asked to verify the place of services although the Company was already in possession of this information. The Department alleges this act is in violation of CCR §2695.7(d) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges this instance and attributes it to human error.

As a remedial measure, on April 29, 2013, a communication was sent to all claims examiners as a reminder of the importance of careful claim handling.

ACCIDENT AND DISABILITY (HEALTH) – ELECTRONIC ANALYSIS

7. **In 23,887 instances, the Company failed to reimburse claims no later than 30 working days after receipt of the claim.** When the paid claim population was tested for the timeliness of payment parameters of CIC §10123.13(a), the Department's electronic analysis identified 24,444 claims (20,260 group and 4,184 individual) that were paid beyond 30 working days from the receipt of the claim. Of these 24,444 claims, interest was included with the payment on 22,611 claims (18,608 group and 4,003 individual). In response to the findings of the electronic review, the Company provided additional claim data demonstrating that 557 claims were processed correctly. Therefore, the Department alleges 23,887 acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company states the 24,444 claims identified in the Department's electronic analysis as paid beyond 30 working days from receipt represents 2.5% of the total claims population of 976,534 paid claims. Note that 16,438 of these claims include adjustments to previously processed claims. The Company further determined that 356 claims (307 group and 49 individual) were processed correctly. These 356 claims represented "goodwill payments", additional information received and processed within regulatory timeframe, void and re-issue of a prior payment not received, and waiving of timely filing. Additionally, 201 claims were related to administrative payments. An example of an administrative payment is when a benefit is misquoted and the Company agrees to make the provider whole.

The Company is committed to its goal of timely claims payment processing and accurate interest application, when necessary. As a corrective action, a training reminder was published on January 12, 2015 and all claims examiners were retrained by January 30, 2015 on the regulatory timeframes surrounding timely claims adjudication. Additionally, the Company will continue to reinforce this through the annual Fair Claims Training required for all examiners administering any operational processing functions for these claims.

8. **In 46 instances, the Company failed to pay interest on an uncontested claim after 30 working days.** When the paid claim population was tested for the payment of interest on claims not paid within 30 working days, the Department's electronic analysis identified 1,833 claims (1,652 group and 181 individual) that were paid beyond 30 working days from the date of receipt of the claim, and interest was not paid. In response to the findings of the electronic review, the Company provided additional claim data demonstrating that 702 claims were paid with an interest amount of less than \$1.00. The Company submitted data on another 528 claims that had interest applied greater than \$1.00. These items required a manual calculation that was not initially submitted with the electronic population. Finally, the Company reported 557 claims were processed correctly with no interest due. Of the 557 claims, 356 were identified as "goodwill" payments and 201 claims were related to "administrative" payments. Based on the supporting documentation provided by the Company, the

Department alleges 46 acts are in violation of CIC §10123.13(b) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company acknowledges the findings and states it is committed to its goal of timely claims payment processing and accurate interest application, when necessary. The remaining 46 claims identified were placed into an adjustment project to apply the correct amount of interest resulting in additional payments of \$1,262.16. As a corrective action, a training reminder was published on January 12, 2015 and all claims examiners were retrained by January 30, 2015 on the regulatory timeframes surrounding timely claims adjudication. Additionally, the Company will continue to reinforce this through the annual Fair Claims Training required for all examiners administering any operational processing functions for these claims.

ACCIDENT AND DISABILITY (HEALTH) – CONTESTED FILE REVIEW

9. In 135 instances, in its written notice that a claim is being contested or denied, the Company failed to advise the provider of the right to a review by the Department of Insurance. The Company did not comply with notifying providers of the right to a review by the California Department of Insurance when the payment issued was less than the amount billed. 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 reports that on March 26, 2013, the Remittance Advice Notice to be sent to providers was amended and the right to a review by the CDI will appear on all RAs, including those involving claims that were paid in full.

10. In 49 instances, the Company persisted in seeking information not reasonably required for or material to the resolution of a claims dispute. The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

10(a). In 27 instances on claims involving a pre-existing condition investigation, the Company requested medical history from the member for a 12 month period when the policy contains a “look back” period for pre-existing conditions of only six months. In the individual category, 16 instances were noted; in the group category, 11 instances were noted.

Summary of the Company's Response to 10(a): The Company's reports that the Company's Claims Department Desktop instruction for examiners was updated in September 2013 to reflect the 6-month pre-existing look-back period. A request was submitted to revise the wording on the pre-existing condition questionnaire letter to only reflect a 6-month timeframe. The system enhancement was completed on May 23, 2015. It is also important to note that the majority of benefit policies no longer contain a

pre-existing condition provision as of January 1, 2014 as it is only applicable to grandfathered plans. Therefore, the volume of pre-existing questionnaires generated in 2015 should be minimal.

In response to the instances noted in the group category, the Company states the pre-existing condition questionnaire requests information for a 12 month period because a review could encompass that amount of time. The 12 months includes the six months before and after the date the member's coverage became effective date. Although this may result in information requested for a period of more than six months before the member's coverage became effective, the system does not allow for specific dates to be included in the letter. The Company no longer plans to send the pre-existing questionnaire to a member for whom coverage begins on or after January 1, 2014.

10(b). In 12 instances, the Company unnecessarily requested medical records. These instances include requests for records after the service had been authorized, requests for records when Medicare was the primary payer, additional requests for records that were already in the Company's possession and a request for records when the CPT code was not indicative of the need for records.

Summary of the Company's Response to 10(b): The Company reports that the Claims Department New Hire Training Instructions have been enhanced to more clearly address when to request medical records. The individual examiners who processed the 12 specific claim audit files indicated with this finding were retrained on March 7, 2015. Also, a Claims Department Training Alert was distributed on January 12, 2015, and all examiners were retrained by January 30, 2015 on when to request medical records.

10(c). In six instances, the Company requested authorization for services which did not require authorization.

Summary of the Company's Response to 10(c): The Company reports that the claims system has automated edits that contain and apply lists of procedures that require prior authorization which are consistently updated when services are added or removed from the required prior authorization lists. This helps to prevent claims examiners from inadvertently denying a claim for a lack of prior authorization for services that do not require one. Also, claims examiners have instructions to direct claims for services that require authorization to the Medical Review Department for further research and guidance in the event there is no authorization already loaded into the system. A Training Alert was published on January 12, 2005 and all Claims Department examiners were retrained by January 30, 2015 on the processes to automated edits for prior authorization and directing claims for services that require prior authorization to the Medical Review Department for further research and guidance when there is no authorization already loaded into the system.

10(d). In four instances, the Company incorrectly requested information on claims indicating they were subject to pre-existing condition investigations when they were not. Two of these claims were for routine services that had multiple diagnostic codes, but the potential pre-existing diagnostic codes were not tied to the services billed. In one instance, the member's record was not updated that a possible pre-existing condition concern had been resolved. In the remaining instance, the member's record was incorrectly flagged for a pre-existing condition edit.

Summary of the Company's Response to 10(d): The Company reports that the claims system provides automatic edits that apply to claims with diagnosis codes that have a potential to be a pre-existing condition. A Training alert was published on January 12, 2015 and all Claims Department examiners were retrained by January 30, 2015 on the pre-existing condition investigation process, including how to identify when services rendered are routine care or if related to an acute vs. chronic condition. A more in-depth training determined to be not necessary because Health Net policies no longer contain a pre-existing clause due to ACA requirements.

11. In 44 instances, the Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. Delays in reimbursement were due to a number of reasons including failure to recognize that a complete claim had been presented, failure to timely process claims upon receipt of requested information, failure to recognize that an authorization was not required for ancillary services. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company acknowledges these claims were processed more than 30 working days from the original claim received date due to claims being contested for additional information in error. As a remedial measure, the Company implemented a focused audit in September 30 to review contested claims. The audit assessed whether the claims reviews were contested appropriately for additional information, and re-educated claims examiners if an error is identified. The Company will continue to conduct these focused audits on a quarterly basis until at least August 2016. In addition, all claims examiners were retrained by January 30, 2015 on when to request additional information, including but not limited to, medical records, authorization, pre-existing information and corrected bill types/places of service.

12. In 28 instances, the Company failed to pay interest on a contested claim after 30 working days. Twelve of these instances were the result of the Company's unnecessary requests for medical records. The Department alleges these acts are in violation of CIC §10123.13(c) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company acknowledges these errors. As a result of the examination the Company issued interest payments of \$1,327.79 on subject claims and \$1,426.55 on related claims. Because the majority of the 28 instances were due to claims being contested for additional information in error,

causing the examiner to not consider the original claim received date when processing the claim for payment and therefore incorrectly determine whether interest was due on the claim, the Company implemented a focused audit in September 2013 to review contested claims. The audit assessed whether the claims reviewed were contested appropriately for additional information, and retrained claims examiners if an error was identified. The Company will continue to conduct these focused audits on a quarterly basis until at least August 2016. In addition, all claims examiners were retrained by January 31, 2015 on when to request additional information, included but not limited to, medical records, authorizations, pre-existing information and corrected bill types/place of service.

The Claims Department ran a sweep report for all claims processed from August 1, 2011 – December 31, 2014 for members with Medicare as the primary payer, to capture claims with the same scenario where a Medicare Explanation of Benefits had been requested to validate that these contested claims were processed correctly, including interest when applicable, or to adjust any claims that were not processed correctly. As a result of the report, 454 claims were reviewed and adjustments were made to 189 claims resulting in additional payments, with interest, of \$8,464.94.

13. In 27 instances, the Company requested information from the provider that is not reasonably necessary to determine liability for payment of a claim. Specifically, when conducting a pre-existing condition investigation, the Company requested medical records from the provider for a 12 month period when the policy contained a look back period for pre-existing conditions of six months. In the individual category, 16 instances were noted; in the group category, 11 instances were noted. The Department alleges these acts are in violation of CIC §10123.131(b) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges the noted instances in the individual category. The Company states that requests sent to providers incorrectly request a member's health history for 12 months. The Company's Claims Department Desktop instruction for claims examiners was updated in September 2013 to reflect the 6-month pre-existing look-back period. A request was submitted on January 7, 2015 to revise the wording on the pre-existing letter to only reflect a 6-month timeframe. The system enhancement was completed on May 23, 2015.

In response to the instances noted in the group category, the Company states the pre-existing questionnaire requests information for a 12 month period because a review could encompass that amount of time. The 12 months includes the six months before and after the member's coverage became effective date. Although this may result in information requested for a period or more than six months before the member's coverage became effective, the system does not allow for specific dates to be included in the letter. The Company no longer plans to send the pre-existing questionnaire to members for whom coverage begins on or after January 1, 2014.

The Company also states the majority of benefit policies no longer contain a pre-existing condition provision as of January 1, 2014 as it is only applicable to grandfathered plans. Therefore, the volume of pre-existing questionnaires generated in 2015 should be minimal.

14. In 22 instances, the Company failed to provide written notice of the need for additional time every 30 calendar days. The Department alleges these acts are in violation of CCR §2695.11(d) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges these errors which occurred on two separate claims. The errors are attributed to the failure of the examiners to follow established procedures. The examiners have been retrained.

15. In 15 instances, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation. The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

15(a). In five instances, upon receipt of a claim, the Company failed to review and/or update its own records for clarification that an authorization, retro-authorization or investigation had already been established.

Summary of the Company's Response to 15(a): The Company acknowledges these instances. As of October 2, 2013, Medical Management established an internal metric to ensure that all such authorizations are loaded into the claims adjudication system within 10 days of the authorization being issued. Additionally, a weekly report is generated that lists all authorizations that been moved from a denied or contested status to an approved status, allowing the Claims Department to make timely adjustments to claims, as necessary.

15(b). In four instances, upon receipt of requested information, the Company failed to thoroughly review the information received resulting in a continued request for additional information.

Summary of the Company's Response to 15(b): The Company acknowledges these instances. In July 2013, the Company's Claims Department procedure was updated with a link to the website that contains Medicare denial codes to provide examiners with an additional tool to obtain the necessary information without the need to contest a claim. A Training Alert was published on January 12, 2015. Additionally, all Claims examiners were retrained by January 30, 2015, on the proper steps to follow if additional information is needed but has not already been received to alleviate continued requests for the same information.

15(c). In three instances, upon receipt of requested information, the Company failed to forward the information to the appropriate unit for review and processing.

Summary of the Company's Response to 15(c): The Company acknowledges these instances. The Claim Department communicated with the Membership Department and Customer Contact Center on March 7, 2015 to reinforce the importance of promptly forwarding any information that may impact claims to the Claims Department.

15(d). In two instances, the Company failed to investigate its own records and incorrectly advised the provider to resubmit the claim to a pricing vendor in error.

Summary of the Company's Response to 15(d): The Company acknowledges these errors which occurred on two separate claims. The errors are attributed to the failure of the examiners to follow established procedures. The individual examiners have been retrained.

15(e). In one instance, following receipt of a provider appeal, the Company failed to investigate its own records and include all related pending claims on the same member in its resolution of the appeal.

Summary of the Company's Response to 15(e): The Company agrees that the adjuster failed to follow established provider appeal procedures. As a remedial measure, a Training Alert was published on January 12, 2015 and all adjusters were educated on January 30, 2015 to remind them that when processing an adjustment to one claim, the member's history needs to be reviewed for related claims that may also require adjustment.

16. In 10 instances, the Company attempted to settle a claim by making a settlement offer that was unreasonably low. Four of the instances were due to the incorrect application of a pre-certification penalty; three were due to the initial payment being considered at an incorrect tier level. One payment was based on an out of network rate when it should not have been; one was not paid according to the provider contract and one was simply paid incorrectly. 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 reports that in seven instances, the Company became aware of the errors prior to the examination and issued payments to correct these errors. In three instances, as a result of the examination, the Company issued payments totaling \$1,401.22 on subject claims and \$918.06 on related claims and re-educated the specific examiners who committed these errors. A Training Alert was published on January 12, 2015 and all Claims Department examiners were retrained by January 30, 2015 on the proper procedures to follow to identify when pre-certification penalties do and do not apply, as well as a refresher on correct tier determination.

The Company's Claims Department ran a sweep report for all claims processed during the audit timeframe from August 1, 2011 – July 31, 2012 where a pre-certification penalty was applied. This report was used to confirm that any penalties applied were

correct and to adjust any claims that were reduced in error if the penalty was applied incorrectly. The project was completed on March 5, 2015 and adjustments were made on 425 claims resulting in additional payments, with interest, of \$49,092.75. The Company also ran a second sweep report for processed dated from August 1, 2012 – December 31, 2014, for the same criteria, and the project was completed on March 10, 2015. As a result of the second sweep report, the Company adjusted 1,419 claims and issued payments, including interest, totaling \$218,154.27.

17. In nine instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. The initial processing of these claims resulted in an improper denial. Eight of the denials are due to incorrect processing by the claim staff. The remaining instance was due to a system error. The Department alleges these acts are in violation of CIC §790.03(h)(5).

Summary of the Company's Response: Regarding the denials that are due to incorrect processing by the claim staff, the Company acknowledges these errors and has provided individual retraining to the staff involved. In September 2013, the Company implemented a focused audit to review contested claims, and determine if they were contested appropriately. If an error was identified, written retraining was provided to both the examiner and their supervisor, reminding them of the proper process. The Company's Claims Department will continue these focused audits on a quarterly basis until at least August 2016. There is also a procedure in place where higher dollar claims are subject to a second level review. In addition, a Training Alert was published on January 12, 2015 and all Claims Department examiners were retrained by January 31, 2015 regarding correct interest application and when to request additional information; including but not limited to, medical records, authorization, pre-existing information and corrected bill types/place of service.

The denial due to a system error was related to a claim from a medical group that billed for multiple providers. As a result of an inquiry from the provider, the system edit that resulted in the improper denial was deleted prior to the start of the examination.

18. In five instances, in its written notice that a claim is being contested or denied, the Company failed to identify the portion of the claim that is contested or denied, and the specific reasons including, for each reason, the factual and legal basis for contesting or denying the claim. The cited instances are based on claim denials that indicated a Medicare EOB was needed, when the Medicare EOB had been included with the claim submission. What the Company actually needed was clarification of the Medicare "disallow" codes, but this specific detail was not communicated to the provider. 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 acknowledges the noted instances. As a remedial measure, the Company is updating its contested claim notices to instruct providers to resubmit the claim with a Medicare EOB, including any

pertinent denial explanations. The Claims Department continually evaluates and updates their list of disallow/denial reason codes, thus allowing for clearer explanation when denying or contesting a claim. If it is determined that there is not a system generated code that provides an acceptable denial explanation, the examiners have been trained to add a free format description of the denied service and the specific reason for denial to appear on the member's EOB and the provider's RA. This was implemented in June 2013. These free formatted denial explanations are tracked to identify any trends so that these may be added to the system generated explanation codes. Additionally, in July 2013, the Company's Claims Department procedure was updated with a link to the website that contains Medicare denial codes. This provides examiners with an additional tool to obtain this necessary information without the need to contest a claim.

19. 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 contested. The Department alleges this act is in violation of CIC §10123.13(a) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees with this isolated instance. The original claim was received on August 22, 2011 and contested on October 14, 2011 for additional information. Three contest letters were sent to the member and provider, but were not initiated until the claim was 37 working days old. All Claims Department examiners were retrained by January 30, 2015, to emphasize that all claims must be either paid, denied or contested within 30 working days.