

**[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**

**UNITED CONCORDIA INSURANCE COMPANY
NAIC # 85766 CDI # 3739-0**

AS OF APRIL 30, 2012

ADOPTED NOVEMBER 6, 2014

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



November 6, 2014

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:

United Concordia Insurance Company
NAIC # 85766

Hereinafter, the Company listed above also will be referred to as UCIC 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 Dental claims closed during the period from May 1, 2011 through April 30, 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. 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 May 1, 2011 through April 30, 2012; 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 California Department of Insurance in San Francisco, California.

EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED

The Group and Individual Dental claims reviewed were closed from May 1, 2011 through April 30, 2012, referred to as the “review period”. Duplicate claims submissions and claims paid within 45 days of receipt were removed from the populations by both UCIC and the examiner. The examiner randomly selected 70 Group Dental claims files and 50 Individual Dental claims files for examination. The examiner reviewed the selected claim and any related claim that may have been affected by the handling of the selected claim. Sample claim findings and related claim findings are identified separately in the Table of Total Citations, below, in this report. The examiner cited 32 alleged claims handling violations of the California Insurance Code from this sample file review.

Findings of this examination included incomplete explanations of benefits and the misrepresentation of pertinent facts or policy provisions relating to any coverages at issue.

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

Except as noted below, market analysis did not identify any specific issues of concern.

The Company was the subject of six California consumer complaints and inquiries closed from May 1, 2011 through April 30, 2012, in regard to the lines of business reviewed in this examination. Of the complaints and inquiries, the CDI alleged no violations of law.

The previous claims examination reviewed a period from July 1, 2007 through June 30, 2008. There was no specific area of concern identified in the previous claims examination.

The CDI has taken no prior enforcement action against UCIC related to claims handling in the lines of business covered by this examination.

DETAILS OF THE CURRENT EXAMINATION

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

UCIC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS IN REVIEW PERIOD	SAMPLE FILES REVIEWED	NUMBER OF ALLEGED CITATIONS
Disability Health / Group Dental Appeal	245	26	4
Disability Health / Group Dental / Paid & Zero Paid*	194,900	10	1
Disability Health / Group Dental Denied	80,525	34	7
Disability Health / Individual Dental / Paid & Zero Paid*	225	10	0
Disability Health / Individual Dental Denied	390	39	20
Disability Health / Individual Dental Appeal	1	1	0
TOTALS	276,286	120	32

*Claims approved for payment; however, no payment was issued due to allowed deductible, policy maximum, and/or coordination of benefits.

TABLE OF TOTAL CITATIONS

Citation	Description of Allegation	UCIC Number of Alleged Citations	UCIC Number of Alleged Citations in Related Claims
CIC §10123.13(a) *[CIC §790.03(h)(13)]	The Company failed to include in its notice to the insured 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.	17	0
CIC §790.03(h)(1)	The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.	6	5
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.	2	0
CIC §10123.13(b) *[CIC §790.03(h)(5)]	The Company failed to pay interest on an uncontested claim after 30 working days.	2	0
Total Number of Citations		27	5

*DESCRIPTONS OF APPLICABLE UNFAIR CLAIMS SETTLEMENT PRACTICES

- 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.

TABLE OF CITATIONS BY LINE OF BUSINESS

<p>DISABILITY HEALTH DENTAL 2012 Group Written Premium: \$ 51,656,331 2012 Individual Written Premium: \$ 826,065</p>	<p>NUMBER OF CITATIONS</p>
<p>AMOUNT OF RECOVERIES \$ 106.910</p>	
CIC §10123.13(a) [CIC §790.03(h)(13)]	17
CIC §790.03(h)(1)	11
CIC §790.03(h)(5)	2
CIC §10123.13(b) [CIC §790.03(h)(5)]	2
TOTAL	32

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 applicable jurisdictions.

Money recovered within the scope of this report was \$106.91 as described in sections number 2 and 4, below. Pursuant to the findings of the examination as described in section number 2, below, the Company is conducting a closed claims survey. The results of the survey and additional payments, if any, shall be reported to the Department by the end of the first quarter of the year 2015.

DISABILITY HEALTH / DENTAL

1. **In 17 instances, the Company failed to include in its notice to the insured 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.** In 17 instances, the Dental Explanation of Benefits issued to the member failed to provide an explanation of the specific policy provisions to support the denial. In these instances, the explanation provided consisted of the phrase “not covered”. 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 Response: The Company stated that it does not agree that it violated the laws cited, and that it believes the explanation provided in each of these instances reasonably conveyed the basis for the denial. Nevertheless, in the interest of providing further clarification for the member, the Company modified the

U5002 denial language applicable in these cases to indicate, “No payment can be made. This <BCA> service is not included on the <PT1>’s plan benefit schedule, and therefore, is not a covered service.” This modification became effective January 31, 2013.

2. In 11 instances, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue. UCIC has a procedure in place to recode individually-reported periapical, bitewing, and/or occlusal films, taken on the same date of service by the same dentist, to a full mouth series if the allowance is equal to or exceeds the dentist’s allowance for an intraoral complete series. Specifically, the individually-reported radiographs are combined and processed as an intraoral complete series, also known as a FMX (the “Bundling Practice”). As a result of the Bundling Practice subsequent claims may become subject to the same five-year benefit limitation as an intraoral complete series. The Bundling Practice may also result in the wrongful denial of the annual bitewing X-ray benefit and of periapical and/or occlusal X-rays in subsequent years although no FMX has been performed.

The Company cited a particular policy provision as support for its Bundling Practice. However, the policy provision does not clearly notify the member of the Bundling Practice. As such, the Company misrepresented the policy provisions relating to any coverages at issue. The Department alleges these acts are in violation of CIC §790.03(h)(1).

Summary of the Company’s Response: While the Company believes its contract provisions and applicable law permitted the Bundling Practice, the Company agreed to terminate the Bundling Practice effective June 12, 2014. As a result, claims that were subject to the Bundling Practice will be adjudicated and paid as individual radiographs. With respect to the five-year benefit limitation on FMX, the Company will ensure that the five-year benefit limitation is not applied to members whose previous claims were subject to the Bundling Practice. Similarly, with respect to the one-year limitation on bitewings, the Company will ensure that the one-year benefit limitation is not applied to members whose previous claims were subject to the Bundling Practice.

In addition, the Company reviewed the sample of files that were pulled for the examination and determined that four claims for bitewing and periapical X-rays were denied as a result of the Bundling Practice. This review resulted in additional benefit payments totaling \$104.40 to the identified members.

As additional corrective action, the Company is in the process of conducting a review of claims outside the examination sample to address both claims subjected to the Bundling Practice prior to June 12, 2014, as well as subsequent claims that were denied when policy benefit limits were applied because of the Bundling Practice. The review includes two categories of claims: (1) claims from both participating and non-participating providers where the five-year benefit limitation was applied and, (2) claims which bundled separate bitewing, periapical, and occlusal radiographs to a full mouth series. The inclusion of claims by participating providers in the review of category (1)

will ensure that members' claims histories and benefit payments for bitewing, periapical, or occlusal X-rays are accurately recorded for future benefits. The review of category (2) is limited to claims solely from non-participating providers because participating providers had agreed to the Company's bundling of these claims in their contracts with the Company and also because the providers had agreed not to balance-bill members for the additional amounts as a result of the bundling.

The Company will obtain a data file of claims for the review period of January 1, 2008 through June 11, 2014, involving claims that were adjudicated pursuant to the Bundling Practice. Upon review of this data file, the Company will issue additional payments in excess of \$10.00 to providers along with a letter of explanation or with an Explanation of Benefits. Payments will include interest accrued at the statutory rate of 10% per year, calculated beginning the first calendar day after a 30-working day period from receipt of the claim, through June 11, 2014. The Company will provide the Department with the results of the survey by the end of the first quarter of 2015.

3. In two instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. In two instances, the Company denied a claim, in whole or in part, for periodontal scaling and root planing services and subsequently overturned the adverse determination on appeal from the provider based on the same medical information provided with the initial claim submission.

In the first instance, the UCIC dental advisor approved the service for some of the involved teeth and denied the service for the remaining teeth. In the second instance, the UCIC dental advisor reviewed and denied the services in whole on the basis the documentation submitted with the claim, which showed five millimeters of attachment loss, did not demonstrate loss of attachment consistent with the destruction of the periodontal ligament and loss of the adjacent bone support.

The Company explained that its procedure, prior to making a benefit determination, is to review all periodontal scaling and root planing claims by a UCIC dental advisor and that the payment for such services requires proof of attachment loss. UCIC also explained to the Department that the difference between a first determination and a second determination is a professional judgment based on the individual dentist's opinion of what is seen on the X-rays. Each of these appeals was reviewed by a dental advisor other than the initial advisor who denied the claim. In these instances, the second advisor overturned the denial and approved a benefit payment.

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

Summary of the Company's Response: The Company asserts the initial submissions lacked information to support payment of the two claims, and that it received substantial additional medical information in both instances on appeal.

In the first instance, the Company states the provider expanded the diagnostic narrative, providing additional documentation, for consideration, on appeal. In the second instance, the Company states the written documentation submitted by the dentist did not support or indicate the need for periodontal scaling and root planing.

However, in the interest of resolving this criticism, the Company has instituted revised internal processes requiring more robust documentation of appeals that are reversed based upon new information submitted with the appeal. Moreover, the Company agrees to expand its annual training for dental evaluators to include the topics of dental planing and root scaling.

4. In two instances, the Company failed to pay interest on an uncontested claim after 30 working days. In two instances, the Company overturned an adverse benefit decision on appeal in which no new clinical information was provided. Therefore, the claim is considered uncontested and payable at the time the claim was initially received. Since the Company failed to reimburse the claim in whole or in part within 30 working days from the date the claim was received, interest is payable. The Department alleges these 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: To resolve the criticism, the Company issued payments totaling \$2.51 in interest calculated on the claim amounts for the time period between the date the proof of claim was received and the date it was paid following the appeal.