

**[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**

**ANTHEM BLUE CROSS LIFE AND HEALTH
INSURANCE COMPANY
NAIC # 62825 CDI # 3273-0**

AS OF JUNE 30, 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:

Anthem Blue Cross Life and Health Insurance Company

NAIC # 62825

Group NAIC # 0671

Hereinafter, the Company listed above also will be referred to as ABCLHIC 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 Individual and Group Health claims closed during the period from January 1, 2012, through March 31, 2012. The electronic analysis and contested claims examination covered the period from January 1, 2012 through June 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.

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 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 January 1, 2012, through March 31, 2012; and a review of previous CDI market conduct claims examination reports on this Company; and a review of 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 Woodland Hills, California.

EXECUTIVE SUMMARY

The Company's written premium for the lines of business reviewed was \$5,735,549,572 for 2011 and \$ 5,231,339,087 for 2012.

The Individual and Group Health claims reviewed were closed from January 1, 2012 and March 31, 2012, referred to as the "review period". The examiners randomly selected 358 ABCLHIC claims files for examination, including 25 claims relating to treatment of autism. The examiners cited 54 alleged claims handling violations of the California Insurance Code and other specified codes from this sample file review.

Findings of this examination include failure to provide an explanation of the computation of benefits and failure to pay interest on claims after 30 working days after receipt of the claim or after receipt of all information necessary to determine liability. A total of \$67,706.05 was recovered for consumers as a result of the examination.

The examination also included an electronic analysis of all paid claims within a six month review period of January 1, 2012 through June 30, 2012 to determine compliance with timeliness of payment and payment of interest requirements in California law. The electronic data field parameters were: Date Received, Date Acknowledged and Date Paid or Closed. The electronic review identified at least 3,382 alleged violations of the California Insurance Code, which included failure to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim, and failure to include interest on an uncontested claim paid after 30 working days. A more detailed review of 140 paid contested claims was also conducted, to validate the Company's assertion that certain claims initially identified by the electronic analysis as having been paid late were in fact contested and ultimately paid timely following receipt of additional information. This review resulted in 24 additional alleged violations of the California Insurance Code and California Code of Regulations, The findings included claims which should have been paid within 30-working days of date of receipt of the claim but were not, which raised additional concerns regarding potential additional violations of this type from the Company's identified population of contested claims.

Items 14 and 15 in the final section of this report provide more detail on these concerns. Additional recoveries identified in the review of contested claim files are included in the figure shown above.

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 ABCLHIC 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, PREVIOUS EXAMINATIONS, AND PRIOR ENFORCEMENT ACTIONS

The Company was the subject of 389 California consumer complaints and inquiries closed from January 1, 2012 through March 31, 2012, in regard to the lines of business reviewed in this examination. The CDI alleged 214 violations of law including 97 improper denial of claim, 90 unsatisfactory settlement offers, and 15 claim handling delays. The examiners focused on these issues during the course of the file review.

The most recent prior claims examination reviewed a period from January 1, 2004, through February 28, 2006. The most significant noncompliance issues identified in the prior examination report were the Company's failure to promptly investigate, and conclude the Company's pre-existing/retro-rescission (PRE/RETRO) process, failure to properly address insured's entitlement to portability of prior creditable coverage, and the Company's failure to promptly set-up its rescission investigation.

DETAILS OF THE CURRENT EXAMINATION

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

ABCLHIC SAMPLE FILES REVIEW			
Review Period: January 1, 2012 through March 31, 2012			
LINE OF BUSINESS / CATEGORY	CLAIMS IN REVIEW PERIOD	SAMPLE FILES REVIEWED	NUMBER OF ALLEGED VIOLATIONS
Accident and Disability / Group Health / Paid	820,149	70	22
Accident and Disability / Group Health / Denied	134,785	70	1
Accident and Disability / Individual Health/Paid	1,537,993	70	0
Accident and Disability / Individual Health/Denied	303,891	70	0
Accident and Disability/Group Member Appeals	3,096	25	1
Accident and Disability/Group Provider Appeals	7,319	25	3
Autism	446	25	27
Rescissions	3	3	0
TOTALS	2,807,682	358	54

ABCLHIC ELECTRONIC CLAIMS PAID REVIEW

Review Period: January 1, 2012 through June 30, 2012

LINE OF BUSINESS / CATEGORY	NUMBER OF CLAIMS	VIOLATIONS
Accident and Disability / Group Health Claims Paid	1,990,904	15,456
Accident and Disability / Individual Health Claims Paid	2,106,180	712
TOTALS	4,097,084	16,354

ABCLHIC CONTESTED FILE REVIEW

Review Period: January 1, 2012 through June 30, 2012

LINE OF BUSINESS / CATEGORY	Claims Contested in Review Period	Sample File Review	Number of Alleged Violations
Accident & Disability / Group Health – Contested	127,375	70	9
Accident & Disability / Individual Health – Contested	2,568	70	15
TOTALS	129,943	140	24

TABLE OF TOTAL ALLEGED VIOLATIONS

ANTHEM BLUE CROSS LIFE & HEALTH INSURANCE COMPANY				
TABLE OF TOTAL ALLEGED VIOLATIONS				
Citation	Description of Allegation	Number of Alleged Violations		
		Electronic Analysis	Sample File Review	Contested Claim File Review
CIC §10169(i) [CIC §790.03(h)(1)]*	The Company failed to advise the insured of the right to request an independent medical review on letters of denials and on all written responses to grievances in cases in which the insured believed that health care services had been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers.	0	31	0
CCR §2695.11(b) [CIC §790.03(h)(3)]*	The Company failed to provide an explanation of benefits.	0	9	3
CIC §10123.13(c) [CIC §790.03(h)(5)]*	The Company failed to pay interest on a contested claim after 30 working days.	0	3	3
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.	0	2	0
CCR §2695.7(d) [CIC §790.03(h)(3)]*	The Company failed to conduct and diligently pursue a thorough, fair and objective investigation, or persisted in seeking information not reasonably required for or material to the resolution of a claims dispute.	0	2	0
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.	0	2	0
CIC §10123.13(a) [CIC §790.03(h)(3)]*	The Company failed to notify both the insured and the provider in writing within 30 working days after receipt of the claim, that the claim was contested by the insurer.	0	2	0
CIC §10123.13(a) [CIC §790.03(h)(5)]*	The Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim.	8,177	0	7

ANTHEM BLUE CROSS LIFE & HEALTH INSURANCE COMPANY				
TABLE OF TOTAL ALLEGED VIOLATIONS				
Citation	Description of Allegation	Number of Alleged Violations		
		Electronic Analysis	Sample File Review	Contested Claim File Review
CIC §10123.13(b) [CIC §790.03(h)(5)]*	The Company failed to pay interest on an uncontested claim after 30 working days.	8,177	1	6
CIC §790.03(h)(1)	The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverage's at issue.	0	1	0
CIC §10123.13(a) [CIC §790.03(h)(3)]*	The Company failed to include in its notice of a claim being contested or denied that either the insured or the provider may seek a review by the Department.	0	1	5
TOTAL NUMBER OF VIOLATIONS		16,354	54	24

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

- CIC §790.03(h)(1) The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverage's at issue.
- 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.

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.

Money recovered within the scope of this report was \$16,287.21 as described in sections number 3, 4, 7, 13, 15, 17 and 19 below. Following the findings of the examination, a closed claims survey as described in sections 13 and 15 below was conducted by the Company resulting in additional payments of \$392,870.68. As a result of the examination, the total amount of money returned to claimants within the scope of this report was \$409,157.89.

ACCIDENT AND DISABILITY (HEALTH) – SAMPLE FILE REVIEW

1. **In 9 instances, the Company failed to advise the insured of the right to an independent medical review on letters of denials and on all written responses to grievances in cases in which the insured believed that health care services had been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers.** In these instances, claimants were insured under California contracts however they resided and/or received medical care outside of California. The insureds were not informed of their right to an Independent Medical Review. The Department alleges these acts are in violation of CIC §10169(i) and are unfair practices under CIC §790.03(h)(1).

Summary of the Company Response: The Company disagrees with the findings and states that information regarding the insured's right to an Independent Medical Review (IMR) is disclosed on all pertinent documents and notices as required by the statute. Additionally, the out of state affiliate handled notification requirements pursuant to its state laws.

Summary of the Department's Evaluation of the Company's Response: For any portion of the claim that is modified or determined ineligible for reimbursement, claimants have a right to request an independent medical review regardless if the claim is denied in whole or in part. This applies to certificate holders and insured members who are insured/covered under California health contracts who may reside or receive medical treatment outside of California. The Company has not agreed to display the IMR disclosure on all EOBs for claims in which less than 100% of the billed amount was paid, including those for members covered under California policies who reside in other states. Therefore, this is an unresolved issue that may result in administrative action.

2. In six instances, the Company failed to provide an explanation of benefits. In these six instances the insured was not provided an EOB. 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 Response: The Company disagrees and states, "California Insurance regulation 2695.11(b) requires an insurer to provide an explanation of benefits to the claimant and assignee. The Company provides electronic and/or paper EOBs for every claim adjudicated. For EOBs that show a zero balance owed by the insured, the paper EOB to the enrollee is suppressed, but is available electronically online. At the time of enrollment and at the time ID cards are issued, enrollees are instructed how to access this information online." The Company states that information relating to all claims processed, including claims where the member has \$0 liability, is available to members through their on-line account. In addition, for any member that asks to continue to receive the zero-balance EOBs, those EOBs are turned back on for that member.

Summary of the Department's Evaluation of the Company's Response: The Company does not have a procedure in place to provide an EOB for claims adjudicated with a zero balance. The Regulation requires that with each claim payment, the insurer shall provide an explanation of benefits. Therefore, this is an unresolved issue that may result in administrative action.

3. In three instances, the Company failed to pay interest on a contested claim after 30 working days. 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 Response: The Company agrees and reprocessed all three claims with interest resulting in recoveries of \$10.92 in interest. In addition, the Company reinforced claims handling procedures in a weekly meeting with all claims processing units. Additional enhancements include associate training that consist of development and implementation of a training podcast that includes content related to correct application of interest start dates, an overview of regulatory statutes, and the claim

examiner's role in correct application of interest payments; continued 1-on-1 coaching sessions with associates where prompt pay errors have been identified; ongoing/daily feedback on prompt pay guidelines and error feedback to all impacted claim associates and providing the management team with regular updates on prompt pay findings and overall root cause summaries.

4. In two instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. In one instance, the Company improperly denied a claim as a result of a processing error. In the second instance, the Company improperly denied payment to a non-contracted provider. The Department alleges these acts are unfair practices under CIC § 790.03(h)(5).

Summary of the Company Response: The Company agrees the claims were denied in error. In each instance the Company reprocessed and paid the claim with interest, resulting in recoveries totaling \$15,653.38. Further, the Company implemented a Work Force Management (WFM) model to monitor claims inventory, and established a WFM team that's responsible for inventory management, work distribution and review of inventory levels; aged claims and adjustments, as well as the overall inventory strategy. To ensure future compliance, the Company states additional enhancements include monthly prompt payment audits with a "Cross-functional team" to focus on prompt payments and payment accuracy.

5. In two instances, the Company failed to notify both the insured and the provider in writing within 30 working days after receipt of the claim, that the claim was contested by the insurer. In each instance the claim file did not reflect the provider was notified the claim was contested. 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 Response: The Company states in one instance, "the claim was paid directly to Morris Avenue Medical Center by Horizon BCBS of New Jersey. The EOB would be sent by the host plan directly to the provider with their payment." In the other instance the Company states, "our member was treated by a non-contracting provider in New York. We paid the benefits due directly to our member, as Horizon BCBS of New Jersey does not have a contract with this provider." The Company further states when members receive services out of Anthem's California service area, all provider correspondence is produced and mailed by the Blue Cross Blue Shield licensed within that service area. This includes both participating and non-participating providers. The Company states for the claims identified by this finding, providers were notified by the "Host" plan (Horizon BCBS).

Summary of the Department's Evaluation of the Company's Response: The Company was unable to produce written documentation to support the insured and provider were notified in writing the claim was contested. The Company has not provided corrective action to ensure compliance with the statute requirement. Therefore, this is an unresolved issue that may result in administrative action.

6. In two instances, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation and persisted in seeking information not reasonably required for or material to the resolution of a claims dispute. In one instance the Company failed to review information provided by the insured that proved preauthorization was requested for out of network hospital services. In the other instance the Company requested medical records that were already in its possession. 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 Response: The Company agrees in both instances that errors occurred in the handling of the claims. As a remedial measure for failing to acknowledge receipt of proof of pre-authorization from the insured and provider, the Company created a training guide entitled “Quick Tip” for Grievances and Appeals personnel that was published September 24, 2012, which contains the following instruction: “The G&A Analyst will conduct a full investigation of the Appeal. The analyst will confirm if the services were rendered by a participating provider and validate there was no par provider who could have treated the member. The G&A Analyst will approve the appeal even if we cannot verify the existence of an authorized referral during the investigation of the Provider Dispute or Member Appeal if we learn that the member or the provider attempted to obtain a prior authorization.” The Company stated this will also be presented at the next Quality Circle all-staff meeting on October 7, 2012. Regarding requesting information already provided, the Company states, “New ERISA edit created and scheduled for April 2013 implementation will alert the processor that there is a duplicate claim on file. This alert will allow the Processor to check for the receipt of medical records before finalizing their claim.”

7. In one instance, the Company failed to pay interest on an uncontested claim after 30 working days. In one instance payment was incorrectly applied towards the insured’s co-insurance when the annual out-of-pocket had already been met. When the error was discovered and an additional payment was made, interest was not included. The Department alleges this act is in violation of CIC §10123.13(b) and is an unfair practice under CIC §790.03(h)(5).

Summary of the Company Response: The Company agreed an error occurred and reprocessed the claim with interest resulting in a recovery of \$26.52. In addition, the Company reinforced claims handling procedures in a weekly meeting with all claims processing units.

8. In one instance, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to coverages at issue. The Company misrepresented the statute of limitation for filing a claim in an appeal letter. The Department alleges this act is in violation of CIC §790.03(h)(1).

Summary of the Company Response: The Company agreed that the correspondence was mishandled. The Company reviewed the appeal and sent a corrected letter on September 12, 2012. To ensure future compliance the Company states “The PDR Team has updated their PDR Workflow document to ensure thorough research

in regard to timely filing. G&A PDR management has discussed this document and this topic with their staff during numerous staff meetings.” This guideline was also discussed as on June 13, 2013 during a staff meeting.

9. In one instance, the Company attempted to settle a claim by making a settlement offer that was unreasonably low. The Company applied an incorrect co-payment resulting in an underpayment of the claim. The Department alleges this act is in violation of CCR § 2695.7(g) and is an unfair practice under CCR § 790.03(h)(5).

Summary of the Company Response: The Company acknowledges the error. The claim was reprocessed with interest totaling \$31.20. In addition, the claims manager reviewed the claim with the claims processing units to emphasize compliance with the Regulation and procedures.

ACCIDENT AND DISABILITY (HEALTH) – AUTISM FILE REVIEW

10. In 22 instances, the Company failed to advise the insured of the right to an independent medical review on letters of denials and on all written responses to grievances in cases in which the insured believed that health care services had been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. In these instances, claimants were insured under California contracts however they resided and/or received medical care outside of California. The insureds were not informed of their right to an Independent Medical Review. The Department alleges these acts are in violation of CIC §10169(i) and are unfair practices under CIC §790.03(h)(1).

Summary of the Company Response: The Company disagrees with the findings and states that information regarding the insured’s right to an Independent Medical Review (IMR) is disclosed on all pertinent documents and notices as required by the statute. Additionally, the out of state affiliate handled notification requirements pursuant to its state laws.

Summary of the Department’s Evaluation of the Company’s Response: For any portion of the claim that is modified or determined ineligible for reimbursement, claimants have a right to request an independent medical review regardless if the claim is denied in whole or in part. This applies to certificate holders and insured members who are insured/covered under California health contracts and who may reside or receive medical treatment outside of California. Therefore, this is an unresolved issue that may result in administrative action.

11. In three instances, the Company failed to provide an explanation of benefits. In these three instances the insured was not provided an EOB. 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 Response: The Company disagrees and states, “California Insurance regulation 2695.11(b) requires an insurer to provide an explanation of benefits to the claimant and assignee. The Company provides electronic and/or paper EOBs for every claim adjudicated. For EOBs that show a zero balance owed by the insured, the paper EOB to the enrollee is suppressed, but is available electronically online. At the time of enrollment and at the time ID cards are issued, enrollees are instructed how to access this information online. The Company states, in the event an enrollee would like to receive paper copies of zero balance EOBs, the Company will make them available for that enrollee. To date, only one enrollee has asked to have the zero balance EOBs delivered in hard copy.”

Summary of the Department’s Evaluation of the Company’s Response: The Company does not have a procedure in place to provide an EOB for claims adjudicated with a zero balance. The Regulation requires that with each claim payment, the insurer shall provide an explanation of benefits. Therefore, this is an unresolved issue that may result in administrative action.

12. In one instance, the Company failed to include in its notice of a claim being contested or denied that either the insured or the provider may seek a review by the Department. The Department alleges this act is in violation of CIC §10123.13(a) and an unfair practice under CIC §790.03(h)(3).

Summary of the Company Response: The Company agrees the EOBs did not contain reference to CDI. The Company states, “The system error was corrected with a SSCR (Small System Change Request), and it was concluded that this was not a global issue, rather an impact to a handful of EOBs.” The Company implemented a system correction on February 16, 2013, that contains all required language.

13. In one instance, the Company attempted to settle a claim by making a settlement offer that was unreasonably low. The claim was initially denied due to treatment from an unlicensed provider. Upon further review, the Company admitted the provider was in fact licensed, an additional payment was issued. The Department alleges this act is in violation of CCR §2695.7(g) and is an unfair practice under CIC §790.03(h)(5).

Summary of the Company Response: The Company agrees the claim was incorrectly processed. The Company reprocessed the claim and paid the correct-amount with interest, resulting in a recovery totaling \$268.48. The Company states, “A system enhancement was implemented to assure ABA providers and services were updated to pay accurately, and all impacted claims were adjusted in April 2014.” The Company reviewed 1,443 claims from the period of September 2012 through April 2015. Additional payments totaling \$341,451.84 were issued to claimants. In addition, the Company reinforced claims handling procedures in a weekly meeting with all claims processing units.

ACCIDENT AND DISABILITY (HEALTH)- ELECTRONIC REVIEW

14. In 8,177 instances, the Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. When the paid claim population was initially tested for the timeliness of payment parameters of CIC §10123.13(a), the electronic analysis identified 131,417 claims that were potentially paid beyond 30 working days from the date of receipt of the claim. The Company performed a re-evaluation of these files and reported that 129,726 of these required the request and submission of additional information in order to determine liability. The remaining 1,691 (1,598 group claims and 93 individual claims) had not been reimbursed as soon as practical, but no later than 30 working days of receipt of the claim by the Company. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(5).

Further testing was conducted on a sample of the 129,726 claims the Company indicated were contested pending the receipt of additional information. The results of this testing, as described in section 16 below, revealed that in seven instances constituting 5% of the sample, the Company did not require any further information to determine liability but failed to issue payments within 30 days. After evaluating the Company's re-evaluation project, the Department is alleging that liability was clear in a similar percentage (5%) of the population of 129,726 but that payment was not made within 30 days, resulting in violations on an additional 6,486 claims beyond those the Company identified in its self-review.

Summary of the Company Response: The Company agrees the 1,691 claims it identified in its claims sweep were not paid within 30-working days. To ensure future compliance the claims manager reviewed the claims with the claims processing units to emphasize compliance with the Regulation and procedures. Regarding the additional 6,486 (5% of the 129,726 population), the Company reports that its claims sweep review did not find additional issues of failure to reimburse a claims no later than 30 working days after receipt of the claim.

Summary of Department's Evaluation of the Company's Response: The Company has not addressed the results of the Department's testing of the population of 129,726. Therefore, this is an unresolved issue that may result in administrative action.

15. In 8,177 instances, the Company failed to pay interest on an uncontested claim after 30 working days. When the population was tested for the payment of interest parameters of CIC §10123.13(b), the electronic analysis identified 131,417 claims that were potentially paid beyond 30 working days from the date of receipt of the claim, and where the statutory interest was not paid. The Company performed a re-evaluation of these files and reported that 129,726 of these required the request and submission of additional information in order to determine liability. The remaining 1,691 (1,598 group claims and 93 individual claims) had not been reimbursed as soon as practical, but no later than 30 working days of receipt of the claim by the Company, and

the statutory interest was not paid. The Department alleges these acts are in violation of CIC §10123.13(b) and are unfair practices under CIC §790.03(h)(5).

Further testing was conducted on a sample of the 129,726 claims the Company indicated were contested pending the receipt of additional information. The results of this testing, as described in section 16 below, revealed that in seven instances (5%) of the sample the Company did not require any further information to determine liability but failed to issue payments within 30 days and pay the statutory interest. After evaluating the Company's re-evaluation, the Department is alleging that liability was clear in a similar percentage (5%) of the population of 129,726 but that payment was not made within 30 days and the statutory interest was not paid, resulting in violations on an additional 6,486 claims beyond those the Company identified in its re-evaluation review.

Summary of the Company Response: The Company agrees the 1,691 claims identified in its claims sweep were not paid within 30-working days nor was interest paid. The Company stated that these were all California situs policy claims that were not processed in California. The Company reprocessed all 1,691 claims within the electronic review period 1/1/2012 – 6/30/2012. The Company reported the results to the Department on July 29, 2014. The claims sweep survey resulted in \$51,418.84 paid to insureds. In addition, the claims manager met with the claims processing units to emphasize compliance with the Regulation and procedures. Regarding the additional 6,486 (5% of the 129,726 population), the Company reports that its claims sweep review did not find additional issues of failure to pay interest on an uncontested claim after 30 working days.

Summary of Department's Evaluation of the Company's Response: The Company has not addressed the results of the Department's testing of the population of 129,726, to ensure that all other instances within this population that should have had interest added have been corrected. Therefore, this is an unresolved issue that may result in administrative action.

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16. In seven instances, the Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim. The Company had all necessary information in order to determine liability and failed to make the payments within 30 days of receipt of the claim. The Department alleges this act are is a violation of CIC §10123.13(a) and is an unfair practices under CIC §790.03(h)(5).

Summary of the Company Response: The Company acknowledges the finding. As a remedial measure, the Company contacted the claims manager to review the claims, and placed the issue on its agenda for a weekly compliance processing unit meeting to emphasize proper handling of claims.

17. In six instances, the Company failed to pay interest on an uncontested claim after 30 working days. 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 Response: The Company agrees and reprocessed the six claims with interest resulting in recoveries of \$326.97. In addition, the Company reinforced claims handling procedures in a weekly meeting with all claims processing units.

18. In five instances, the Company failed to include in its notice of a claim being contested or denied that either the insured or the provider may seek a review by the Department. 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 Response: The Company agrees the EOBs did not contain reference to CDI. The Company states, “The system error was corrected with a SSCR (Small System Change Request), and it was concluded that this was not a global issue, rather an impact to a handful of EOBs.” The Company implemented a system correction on February 16, 2013, that contains all required language.

19. In three instances, the Company failed to pay interest on a contested claim after 30 working days. 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 Response: The Company agrees in all three instances and reprocessed the claims with interest resulting in recoveries of \$0.94. In addition, the Company reinforced claims handling procedures in a weekly meeting with all claims processing units.

20. In three instances, the Company failed to provide an explanation of benefits. In three instances the insured was not provided an EOB. 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 Response: The Company disagrees and states, “California Insurance regulation 2695.11(b) requires an insurer to provide an explanation of benefits to the claimant and assignee. The Company provides electronic and/or paper EOBs for every claim adjudicated. For EOBs that show a zero balance owed by the insured, the paper EOB to the enrollee is suppressed, but is available electronically online. At the time of enrollment and at the time ID cards are issued, enrollees are instructed how to access this information online. In the event an enrollee would like to receive paper copies of zero balance EOBs, the Company will make them available for that enrollee. To date, only one enrollee has asked to have the zero balance EOBs delivered in hard copy.”

Summary of the Department’s Evaluation of the Company’s Response: The Company does not have a procedure in place to provide an EOB for claims adjudicated with a zero balance. The Regulation requires that with each claim payment, the insurer shall provide an explanation of benefits. Therefore, this is an unresolved issue that may result in administrative action.