

**[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**

**BLUE SHIELD OF CALIFORNIA LIFE & HEALTH
INSURANCE COMPANY
NAIC # 61557 CDI # 1450-6**

AS OF MAY 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.

TABLE OF CONTENTS

SALUTATION	1
FOREWORD.....	2
SCOPE OF THE EXAMINATION.....	3
EXECUTIVE SUMMARY	4
RESULTS OF REVIEWS OF MARKET ANALYSIS, CONSUMER COMPLAINTS AND INQUIRIES, PREVIOUS EXAMINATIONS, AND PRIOR ENFORCEMENT ACTIONS .	6
DETAILS OF THE CURRENT EXAMINATION	8
TABLE OF TOTAL ALLEGED VIOLATIONS	10
SUMMARY OF EXAMINATION RESULTS	13

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:

Blue Shield of California Life & Health Insurance Company

NAIC # 61557

Group NAIC # 2798

Hereinafter, the Company listed above also will be referred to as BSL 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 June 1, 2011 through May 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, including a sample of contested claims, and related records.

3. A review of the California Department of Insurance's (CDI) market analysis results; a review of consumer complaints and inquiries about this Company closed by the CDI during the period June 1, 2011 through May 31, 2012; 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 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 El Dorado Hills, California and at the California Department of Insurance offices in Sacramento, California.

EXECUTIVE SUMMARY

The Company's written premium for the lines of business reviewed was \$1,396,696,109 for 2011 and \$1,965,807,861 for 2012.

The Individual and Group Health claims reviewed were closed from June 1, 2011 through May 31, 2012, referred to as the "review period". The examiners randomly selected 330 claim files (140 paid, 140 denied, 25 provider appeals and 25 member appeal) for examination. In addition, the examiners randomly selected 24 of the Company's 36 policy rescissions files for review. The examiners cited 232 alleged claims handling violations of the California Insurance Code and the California Fair Claims Settlement Practices Regulations from this sample file review. Findings of this examination included the following:

- The Company provided misleading information on explanations of benefits, including a notice regarding the Employee Retirement Income Security Act (ERISA) when it was not clear that the policy was subject to ERISA.
- The Company authorized payment for health care services and rescinded the authorization after the provider rendered the services in good faith.
- The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability had become reasonably clear.
- The Company failed to include in its notice of a contested or denied claim the address, Internet Web site address, and telephone number of the unit within the Department that may review the denial on behalf of the insured or the provider.

A total of \$19,088.57 was recovered for consumers as a result of the examination.

The examination also included an electronic analysis of all paid claims during the review period 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. A total of 2,037,750 paid claims were included in the electronic review. The electronic review resulted in 32,983 alleged violations of the California Insurance Code, including for failure to reimburse

claims as soon as practical, but no later than 30 working days after receipt of the claim, and for failure to pay interest on claims paid in more than 30 working days. The Company provided a sub-set of contested claims, of which, 70 were randomly selected for review. This review resulted in 174 additional alleged violations of the California Insurance Code and California Code of Regulations. These findings included a failure to provide written notice of the need for additional time every 30 calendar days that specified the reason the claim was contested, a failure to conduct and diligently pursue a thorough, fair and objective investigation and a failure to reimburse claims as soon as practical, but no later than 30 working days after receipt of all information necessary to determine liability. Recoveries identified in the review of contested claim files are included in the figure reported 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 BSL 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

For the period June 1, 2011 through May 31, 2012, the Company was the subject of 527 consumer complaints and inquiries in regard to the lines of business reviewed in this examination. Of the complaints and inquiries, the CDI determined that 45 consumer complaints were justified. The CDI alleged 63 violations of law on the justified complaints including, but not limited to; improper claim denials, unsatisfactory settlement offers, claim handling delays, and providing late responses to the Department's inquiries. The examiners focused on these issues during the course of the file review.

The previous claims examination reviewed a sample of claims closed from June 1, 2004, through May 31, 2005, including a targeted sample of rescinded policies. The most significant non-compliant practices identified in the claims closed during the June 1, 2004 through May 31, 2005 period were the Company's failure to pay interest on uncontested claims after 30 working days, failure to pay interest on contested claims after 30 working days, and a failure to provide the insured with the correct information concerning the right to request an independent medical review. These issues were not identified as problematic in the current examination. Due to the findings related to the rescinded policies during the June 1, 2004 through May 31, 2005 time period, an additional targeted examination covering the underwriting and claims practices associated with the policy rescissions during the period from June 1, 2005, through May 31, 2008 was conducted. The most significant non-compliance issues pertaining to rescinded policies as identified in the reports were the Company's failure to conduct rescission investigation timely and thoroughly, and the Company's wrongful denial of claims on policies that were unlawfully rescinded. These issues were not identified as problematic in the current examination.

BSL was the subject of a CDI enforcement action based on the results of these prior examinations, which resulted in a settlement in December of 2008. The terms of the settlement required the Company to make revisions to its procedures for its initial underwriting activities and for its rescission investigation, decision-making, and appeals procedures, offer coverage to certain former insureds whose policies were rescinded and offer to reimburse those former insureds for certain medical expenses, and to provide reports to the CDI on the results of the remediation efforts.

DETAILS OF THE CURRENT EXAMINATION

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

BSL SAMPLE FILE REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS IN REVIEW PERIOD	SAMPLE FILES REVIEWED	NUMBER OF ALLEGED VIOLATIONS
Accident and Disability / Group Health / Claims Paid	1,995,568	70	1
Accident and Disability / Group Health / Claims Denied	244,753	70	30
Accident and Disability / Group Health / Member Appeals	5,089	11	0
Accident and Disability / Group Health / Provider Appeals	18,957	13	5
Accident and Disability / Individual Family Plan Health / Claims Paid	42,182	70	71
Accident and Disability / Individual Family Plan Health / Claims Denied	5,015	70	73
Accident and Disability / Individual Family Plan Health / Member Appeals	12,221	14	0
Accident and Disability / Individual Family Plan Health / Provider Appeals	18,557	12	2
Accident and Disability / Individual Family Plan / Rescissions	36	24	50
TOTALS	2,342,378	354	232

BSL ELECTRONIC CLAIMS PAID REVIEW		
LINE OF BUSINESS / CATEGORY	NUMBER OF CLAIMS	NUMBER OF ALLEGED VIOLATIONS
Accident and Disability / Group Health Claims Paid	1,995,568	32,190
Accident and Disability / Individual Health Claims Paid	42,182	793
TOTALS	2,037,750	32,983,983

BSL CONTESTED FILE REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS IN REVIEW PERIOD	SAMPLE FILES REVIEWED	NUMBER OF ALLEGED VIOLATIONS
Accident and Disability / Group Health Contested	53,379	35	50
Accident and Disability / Individual Health Contested	755	35	124
TOTALS	54,134	70	174

TABLE OF TOTAL ALLEGED VIOLATIONS

BLUE SHIELD LIFE INSURANCE COMPANY				
Citation	Description of Allegation	Number of Alleged Violations		
		Electronic Analysis	Sample File Review	Contested Claim File Review
CIC §790.03(h)(1)	The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.	--	162	34
CIC §796.04 *[CIC §790.03(h)(5)]	The Company authorized payment for health care services and rescinded the authorization after the provider(s) rendered the services in good faith.	--	14	0
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.	--	10	6
CIC §10123.13(a) *[CIC §790.03(h)(3)]	The Company failed to include in its notice of a claim being contested or denied the address, Internet Web site address, and telephone number of the unit within the Department that may review the denial on behalf of the insured or the provider.	--	8	0
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.	--	7	2
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.	32,977	6	0
CIC §10123.13(a) *[CIC §790.03(h)(13)]	The Company failed to include in its notice of a denied claim the portion of the claim that was denied and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for denying the claim.	--	6	2
CCR §2695.7(d) *[CIC §790.03(h)(3)]	The Company failed to conduct and diligently pursue a thorough, fair and objective investigation.	--	4	32

BLUE SHIELD 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)(13)]	The Company failed to notify in writing, within 30 working days after receipt of the claim, both the insured and the provider that the claim was denied.	--	3	4
CIC §10123.137(c) *[CIC §790.03(h)(3)]	The Company failed to resolve each provider dispute consistent with applicable law and issue a written determination within 45 working days after the date of receipt of the provider dispute.	--	3	1
CIC §10123.147(a) *[CIC §790.03(h)(5)]	The Company failed to reimburse emergency services claims as soon as practical, but no later than 30 working days after receipt of the complete claim.	--	2	0
CCR §2695.11(b) *[CIC §790.03(h)(3)]	The Company failed to provide an explanation of benefits.	--	2	1
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.	--	2	70
CIC §10123.13(b) *[CIC §790.03(h)(5)]	The Company failed to pay interest on an uncontested claim after 30 working days.	2	1	0
CIC §10123.13(c) *[CIC §790.03(h)(5)]	The Company failed to pay interest on a contested claim after 30 working days.	4	1	4
CCR §2695.3(a) *[CIC §790.03(h)(3)]	The Company failed to maintain all documents, notes and work papers which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed.	--	1	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 all information necessary to determine payer liability.	--	0	18
TOTAL NUMBER OF ALLEGED VIOLATIONS		32,983	232	174

***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 bases relied upon in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.

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.

Money recovered within the scope of this report was \$19,088.57 as described in the sections numbered 2, 14, 15, 18, 19, 24 and 26 below.

ACCIDENT AND DISABILITY (HEALTH) – Sample File Review

1. **In 162 instances, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to coverages at issue.** In 161 instances, the explanation of benefits (EOB) issued on Individual & Family Plan (IFP) claims advises the insured that they have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act (ERISA), if applicable. No determination was made that such individual policies were subject to ERISA. In one instance, the EOB showed the Company denied a claim on the basis that the billed service exceeded the daily maximum based on a previously processed claim. The actual reason for the denial was that the claim was a duplicate submission. The Department alleges these acts are in violation of CIC §790.03(h)(1).

Summary of the Company's Response: The Company states it does not agree it violated the laws cited. The Company states that ERISA can apply to individual products. An individual product is governed by ERISA when the employer "sponsors" it. One way an employer can sponsor individual coverage is to contribute to the payment of premiums, either directly, or by reimbursing or paying the employees for the premiums they pay on their own, or through a health reimbursement account (HRA). Where an insured's employer reimburses the insured for the premiums the insured pays on an IFP product, the Company would not be aware of the reimbursement and the corresponding fact that the IFP product was part of an employee welfare benefit plan subject to ERISA. Other forms of plan sponsorship by an employer would also not come to the Company's attention where the plan contains individual products. Therefore, the Company is required to provide an ERISA disclosure on its explanation

of benefits in order to comply with federal law. Title 29 Code of Federal Regulation 2560.503-1(k) pre-empts state law to the extent it conflicts with the Department of Labor Regulations requiring the ERISA notice. The Company's rationale for including the ERISA notice on its EOBs is to avoid failing to give that notice in connection with an IFP product that is, without the Company's knowledge, subject to ERISA and thereby to maintain compliance with ERISA notice requirements. The notice has been developed to accommodate all lines of business, both individual and group health plans, ERISA and non-ERISA, etc. However, the notice will not mislead insureds whose products are not governed by ERISA. The ERISA notice makes it clear that it applies only when the coverage is part of "your employer's health plan." The notice clearly states in the beginning: "If your employer's health plan ..." so that anyone reading that part of the notice would easily be able to tell if it applies to their coverage. This issue was also raised and resolved in Blue Shield Life's last market conduct examination. All issues raised in that examination were resolved and settled at that time pursuant to a settlement agreement dated December 30, 2008. With regard to the remaining instance, the Company acknowledges that it provided an incorrect reason for denial and that the claim should have been rejected as a duplicate.

Summary of the Department's Evaluation of the Company's Response:

Although the prior examination raised the issue with BSL, no corrective action was proposed by the Company at that time. The settlement agreement referenced by BSL in its response stipulates that BSL will not engage in practices that violate CIC §790.03, among other provisions of the law, and is stipulated to be the full remedy for all violations set forth in the examination report that occurred during the time period referenced in the report. The Department continues to require the Company's practices in the current time period to be in compliance with the cited statute. The Company's response with regard to ERISA language on EOBs for IFP claims denial does not include a corrective measure. Therefore, this is an unresolved issue that may result in administrative action. With regard to providing the wrong reason for the denial of a claim on an EOB, the Company's response does not include a remedial measure; therefore, this is an unresolved issue that may result in administrative action.

2. In 14 instances, the Company authorized payment for health care services and rescinded the authorization after the provider(s) rendered the services in good faith. Twelve instances were the result of the Company's authorization for a surgical procedure. Twelve claims associated with the prior authorization for this procedure were subsequently denied on the basis that the patient's coverage was not in effect at the time the services were provided. In one instance, the Company issued a prior authorization for radiological services and subsequently denied the claim on the basis that coverage was terminated prior to the date of service. In the remaining instance, the Company issued an authorization for services, but initially denied the claim and then denied the claim a second time upon the submission of an appeal by the provider. The Department alleges these acts are in violation of CIC §796.04 and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company states it does not agree it violated the laws cited, as its policies and procedures support the payment of claims for services that have been authorized, and the Company provided such documentation. However, claims that were covered by the authorization of a surgical procedure and were not paid have been adjusted and paid with interest. As a result of the findings of the examination in these twelve instances, the Company issued payments for all claims related to the procedure totaling \$17,874.01. In one instance, the Company overturned its denial and paid for the authorized service on appeal. In the remaining instance, the Company acknowledges that because this was an authorized service, the claim should not have been denied. This was an inadvertent clerical error and specific to the IFP rescission process, which is no longer in place as of July 1, 2013, due to guaranteed issue under the Affordable Care Act (ACA). As a result of the examination in the remaining instance, the Company issued payment to the provider in the amount of \$1,064.50 including interest.

3. In ten instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.
The Department alleges these acts are in violation of CIC §790.03(h)(5).

3(a). In two instances, the Company incorrectly denied the claim as a duplicate claim.

Summary of the Company's Response to 3(a): The Company states it does not agree it violated the laws cited. In the first instance, the Company agrees the subject claim was denied incorrectly as a duplicate claim. This claim was denied as a duplicate claim by the system as there was already a claim paid for the same Current Procedural Terminology (CPT) code and date of service in the system when it processed. Furthermore, the medical group complicated the adjudication of all claims involved by submitting an appeal prior to submitting claims. In the remaining instance, the Company acknowledges that its processor did not recognize documentation presented which supported that the claim was a corrected claim, rather than a duplicate submission. Follow-up training was conducted to attempt to ensure that processors recognize indications by the billing party that a claim is a corrected claim rather than a duplicate.

3(b). In two instances, the Company incorrectly denied the claim on the basis of a pre-existing condition exclusion.

Summary of the Company's Response to 3(b): The Company states it does not agree it violated the laws cited. In one instance, the claim was initially denied in error as a pre-existing condition and the error was caught and corrected before a pre-existing condition investigation was begun. The Company completed training by August 31, 2012 for all processors who handle these particular claims which covered State mandates related to timely processing and payment of interest. This training is currently conducted annually. The remaining instance was the result of an inadvertent error due

to manual processing. As this was due to a processor manual error, feedback was provided to the responsible claims coordinator and manager on November 27, 2012.

3(c). In two instances, the Company improperly denied a claim on the basis that the service was incidental to another procedure that was allowed on the same date.

Summary of the Company's Response to 3(c): The Company states it does not agree it violated the laws cited. In one instance, the claim was auto-adjudicated and the CPT code 96040 component was denied on the basis that it was included within other services and should not have been billed separately. This was based on a system error triggered by the combination of CPT codes included in the claim. The error was discovered on appeal and the claim was manually reprocessed and paid with interest. The system logic that led to both denials has been rectified and this issue should not recur.

3(d). In one instance, the claim was denied in error as an out of state claim.

Summary of the Company's Response to 3(d): The Company agrees in this instance the claim was incorrectly denied, but does not agree it violated the laws cited. The individual responsible for this human error has been given feedback on the error to determine what went wrong and to help prevent similar errors from occurring in the future.

3(e). In one instance, the Company erroneously denied a laboratory service that should have been allowed.

Summary of the Company's Response to 3(e): The Company states it does not agree it violated the laws cited; however, the Company performed an adjustment of the claim to allow the laboratory service. This adjustment did not result in a payment as the allowed amount was applied to the deductible. The individual responsible for this human error has been given feedback on the error to determine what went wrong and to help prevent similar errors from occurring in the future.

3(f). In one instance, the Company erroneously applied the allowed amount of a medical bill for Preventative Health Services towards the insured's deductible. These services are not subject to annual deductibles.

Summary of the Company's Response to 3(f): The Company states it does not agree it violated the laws cited; however, the Company acknowledges the allowed amount should have been paid instead of applying the amount towards the deductible. When the error was discovered, the Company paid the claim to the provider with interest through the date of payment.

3(g). In one instance, the Company incorrectly denied a claim for Preventive Health Services which the provider appealed and for which the Company initially issued an appeal determination letter upholding the denial. Although the Company ultimately

reversed the determination, the original denial and initial appeal determination were incorrect.

Summary of the Company's Response to 3(g): The Company states it does not agree it violated the laws cited. Although no new information was provided, Provider Dispute Resolution re-examined the available information and determined that the claim was allowable, and paid the claim with interest.

4. In eight instances, the Company failed to include in its notice of a contested or denied claim the address, Internet Web site address, and telephone number of the unit within the Department that may review the denial on behalf of the insured or the provider. All instances were noted in the rescission category. 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 states it does not agree it violated CIC §790.03(h)(3). When a claim is received and there is no member eligibility record because the member has been rescinded, there is no way for the Company's system to identify information to generate an explanation of benefits with California Department of Insurance (CDI) grievance language, and in these instances the EOB is generated with the Department of Managed Health Care (DMHC) grievance language. The Company learned of this system error, which affects only the relatively few insureds whose policies are rescinded. The Company is investigating ways to rectify this error and will implement a correction as soon as practical after a solution is identified. As a result of the findings, the Company conducted a review of all explanations of benefits in the 36 policy rescissions in the individual market for the period of June 1, 2011 to May 31, 2012. The Company identified 96 EOBs sent to providers and 128 EOBs sent to members that failed to reference the unit within the Department that may review the denial on behalf of the insured or provider. This was an inadvertent system error, not consistent with Company practices, and specific to the IFP rescission process which is no longer in place as of July 1, 2013, due to guaranteed issuance under the ACA.

5. In seven instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies. The Department alleges these acts are in violation of CIC §790.03(h)(3).

5(a). In five instances, the Company incorrectly identified receipt of additional information it had requested as an appeal, advising the insured/provider that the Company would respond in 45 working days. The Company has 30 working days to respond to additional information received.

Summary of the Company's Response to 5(a): The Company states it does not agree it violated the laws cited. In the noted instances, the Company acknowledges

that receipt of additional information activated an appeal in error. The Company has conducted general refresher training for its processors which encompassed this issue.

5(b). In one instance, the Company issued payment based on erroneous information submitted by the provider resulting in a payment to the wrong payee. Upon recoupment of the funds, the Company failed to follow its own procedure in applying credits within 30 days.

Summary of the Company's Response to 5(b): The Company disagrees the claim was denied in error or issued payment to the wrong provider. It paid the claim based on information submitted by the provider. The provider corrected its claim upon resubmission, with an additional modifier and also changed the National Provider Identifier (NPI). A change in NPI changes the provider ID number and payee.

Summary of the Department's Evaluation of the Company's Response to 5(b): The Department's allegation was not the result of a wrongful denial or payment to the wrong provider, but a failure to follow its procedures in applying credits within 30 days of recoupment. The Company has provided no corrective action to address this issue. Therefore, this is an unresolved issue that may result in administrative action.

5(c). In one instance, the Company incorrectly directed the provider to file the subject claim with the Company's mental health administrator, after the mental health administrator had correctly directed the provider to file the claim with the Company.

Summary of the Company's Response to 5(c): The Company states it does not agree it violated the laws cited. The subject claim was one that should have been considered under the medical benefits of the plan. The claim was manually processed and determined in error to be the risk of the mental health administrator. This was a manual processing error. Refresher training was provided to the claim processor. The Company continually provides feedback to appropriate processors and managers. The Company also conducts routine quality audits to identify errors in processing.

6. In six instances, the Company failed to reimburse claims as soon as practical, but 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 states it does not agree it violated the laws cited; however, in these instances, the Company agrees it did not pay the claims within 30 working days. The Company provided feedback to the claim processors involved.

7. In six instances, the Company failed to include in its notice of a denied claim the portion of the claim that was denied and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for

denying the claim. The Department alleges these acts are in violation of CIC §10123.13(a) and are unfair practices under CIC §790.03(h)(13).

7(a). In two instances, the EOB lists the type of service provided as “OUTPAT CARE” and the denial reason provided on the EOB states: “This service is specifically excluded from coverage under the subscriber’s Blue Shield plan.”

Summary of the Company’s Response 7(a): The Company disagrees with the Department’s criticism. The Explanation of Coverage (EOC) provides that “Outpatient Facility & Office Mental Health Services for other than Severe Mental Illnesses and Serious Emotional Disturbances of a Child” are “Not Covered.” In addition, the explanation of coverage provides that “No Benefits are provided for Outpatient or Out-of-Hospital Mental Health Services & substance abuse care from MHSA Non-Participating Providers, except for the initial visit.” The explanation given on the EOB was specific; the service is excluded from coverage and is not a benefit.

Summary of the Department’s Evaluation of the Company’s Response to 7(a): Compliance with CIC §10123.13(a) requires the EOB to provide specific reasons for the Company’s denial and does not pertain to the Company’s Explanation of Coverage disclosures. Therefore, this is an unresolved issue that may result in administrative action.

7(b). In one instance, the EOB lists the type of service as “MEDICAL SERVICES” and states “The allowed amount for this claim is based on the provisions of the patient’s plan.”

Summary of the Company’s Response to 7(b): The Company disagrees with the Department’s criticism. The sample claim was neither adjusted nor partially denied. This was a service provided to the member by a non-participating provider. The Company applied the standard allowed price based upon the provider’s location and industry pricing standard. The member’s Explanation of Coverage addresses benefits in general and member responsibility for non-participating provider services.

Summary of the Department’s Evaluation of the Company’s Response to 7(b): Compliance with CIC §10123.13(a) requires the EOB to provide specific reasons for the Company’s (partial) denial and does not pertain to the Company’s Explanation of Coverage disclosures. Therefore, this is an unresolved issue that may result in administrative action.

7(c). In one instance, the EOB lists the type of service provided as “MISC SERVICES” and the denial reason provided on the EOB states “This service is specifically excluded from coverage under the subscriber’s Blue Shield plan.”

Summary of the Company’s Response to 7(c): The Company disagrees with the Department’s criticism. The provider billed with a procedure code that is a non-covered item or service. Providers will bill with this code when they know the service is

not a benefit. The Company provided the same information to the provider/insured as the information provided to the Company by the provider. Per the Company's coding resource, non-covered services are services that are billed to the patient. In many cases, the beneficiary is already aware that the services are non-covered because they are included in the information given in the Medicare handbook (e.g., oral medications, screening mammograms in less than the designated waiting period, etc.) or by their insurance provider. At other times, the services are listed as non-covered because they are considered either experimental or investigational in nature.

Summary of the Department's Evaluation of the Company's Response to 7(c): Compliance with CIC §10123.13(a) requires the EOB to provide specific reasons for the Company's denial. To presume the provider/insured is aware of the reason for the denial due to information provided in the Medicare Handbook or other source does not absolve the Company from the requirements of CIC §10123.13(a). Therefore, this is an unresolved issue that may result in administrative action.

7(d). In one instance, the EOB lists the type of service provided as "surgical" and the denial reason provided on the EOB states "This service is specifically excluded from coverage under the subscriber's Blue Shield plan".

Summary of the Company's Response to 7d): The Company disagrees the reason for the denial on the EOB is non-compliant with CIC §10123.13(a) or that there is a violation of CIC §790.03(h)(3). The EOB specifically states that the service is excluded from coverage under the subscriber's Blue Shield plan. The service that was billed is not a benefit of the member's health plan.

Summary of the Department's Evaluation of the Company's Response to 7(d): For the EOB to solely reference the subscriber's plan does not comply with CIC §10123.13(a). Therefore, this is an unresolved issue that may result in administrative action.

7(e). In one instance, the Company's denial of the claim states that the service is not a benefit of the member's benefit plan. The EOB fails to provide the reason the service is not covered.

Summary of the Company's Response to 7(e): The Company believes the denial explanation is clear and there is no violation of the laws cited. The EOB to the provider identifies the medical director who made the determination so that the provider could contact and discuss the case.

Summary of the Department's Evaluation of the Company's Response to 7(e): While identifying the Medical Director who made the determination may be useful information for the provider, the EOB must provide the specific reason for the denial in order to comply with CIC §10123.13(a). Therefore, this is an unresolved issue that may result in administrative action.

8. In four 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).

8(a). In one instance, the Company's eligibility review unit (ERU) failed to conduct a timely investigation upon receipt of a referral to determine eligibility. The ERU received a referral on February 18, 2011, but did not commence an investigation until May 7, 2011, when medical records were ordered. Additionally, the pre-existing unit and the ERU did not share information that could have expedited the investigation.

Summary of the Company's Response to 8(a): It is the Company's position that a diligent investigation was conducted and there is no violation of the laws cited. An ERU referral does not automatically result in the opening of a file. Upon receipt of an ERU referral, the matter is assigned to an ERU investigator. The investigator begins the investigation by reviewing the initial underwriting and other information then available to the Company and, if it appears from that initial review that there is no eligibility issue, no further action is taken. However, if that initial review indicates that further investigation is warranted, a file is opened and medical records are requested. At the time of this investigation, this initial review process was slowed as a result of the ongoing development of the claims report. The procedures provided for review include a document called ERU Referral Sources. The document includes a list of sources which does not include the pre-existing condition (PEC) investigation and/or unit as a source. PEC investigations are not generally referred to ERU. The two investigations are for different purposes and functions, provide different information, can have different results and be on different timelines for completion. ERU receives a separate claims report which is reviewed for potential eligibility issues. Information can be shared between the departments. For example, when an ERU investigation is closed with no action, the ERU will on occasion provide copies of the medical records obtained to the PEC unit.

Summary of the Department's Evaluation of the Company's Response to 8(a): The Company's current investigational procedures regarding the PEC Unit and the ERU, which act independently of each other, may result in a delay of investigations. Typically, information gathered for one investigation is not shared by both units. This is an unresolved issue that may result in administrative action.

8(b). In one instance, the Company ordered medical records on August 08, 2011, and denied the claim on August 26, 2011, without conducting a review of the records.

Summary of the Company's Response to 8(b): The Company states it does not agree it violated the laws cited. The Company states the claims processor processed the claim and noted that it was a duplicate to another claim and determined that it had been processed incorrectly. At the time the claim was to be reviewed, the guidelines were changing. The guideline used at the time did not require medical records. The processor was in error as the guideline to be used should be the one in

effect for the date of service which did indicate that medical records were required. The processor realized the case had been sent for medical review and requested the case be pulled back from review, with the intention of closing the case to wait until the requested medical records had been received. This case was reviewed and the case was distributed to another processor to finalize. The second processor did not see the first processor's comments about needing medical records, and instead simply processed the case per the review. The individuals responsible for these human errors have been given feedback on the errors to determine what went wrong and to help prevent similar errors from occurring in the future.

8(c). In one instance, the trigger for the pre-existing condition investigation was the receipt of a claim which included a diagnosis code that the Company identified as having a potential for a pre-existing condition. Subsequently, the Company sent pre-existing condition questionnaires to the providers on June 13, 2011. The ERU utilizes a diagnosis code list as a referral source which includes the same diagnosis that triggered the pre-existing condition investigation. The PEC unit first received the Certificate of Individual Health Insurance Coverage on July 7, 2011. Medical Management sent a referral to the ERU on August 12, 2011, as a result of the planned medical treatment. The claims presented and diagnosis leading up to the authorization for the treatment were related to eligibility. The PEC unit and the ERU unit did not collaborate on investigations including the sharing of information.

Summary of the Company's Response to 8(c): The Company states it does not agree it violated the laws cited. The Company states that PEC investigations are not generally referred to ERU. The two investigations are for different purposes and functions, provide different information, can have different results and be on different timelines for completion. For claims received by the Company, ERU receives a separate claims report which is reviewed for potential eligibility issues. However, even the claims listed on that report are not determinative of an eligibility issue; while other information received by the Company can be. A request for prior authorization is not a claim, but is another source which can raise potential eligibility issues. In this case, the referral from Medical Management raised the first eligibility issue for review by ERU. There was no delay in ERU receiving the referral from Medical Management for the request for prior authorization which would trigger a referral to ERU within the time period of coverage. Although this was an eligibility and not a claims investigation (and therefore no claim dispute involved), there is no evidence that the Company was not conducting and diligently pursuing its eligibility investigation or seeking information not reasonably required for or material to the investigation. Therefore, there can be no violation of CCR §2695.7(d). In addition, the Company states the ERU investigation was timely, and sought information reasonably required and material to the eligibility investigation. This is consistent with Company policy to conduct timely investigations. Consequently, there is no evidence indicating a violation of CCR §2695.7(d) or CIC §790.03(h)(3).

Summary of the Department's Evaluation of the Company's Response to 8(c): The Company's current investigational procedures regarding the PEC Unit and

the ERU, which act independently of each other, may result in a delay of investigations. Typically, information gathered for one investigation is not shared by both units. The PEC Unit may conduct an investigation and determine that the billed diagnosis code is not a pre-existing condition. The Company's current investigational procedures would not refer the member to the ERU to investigate even when the diagnosis may be rescindable which could result in a delay in determining eligibility. Therefore, this is an unresolved issue that may result in administrative action.

8(d). In one instance, the ERU received a referral on March 25, 2011, based on a report pertaining to prescription drugs to treat a particular condition, but did not open an investigation until July 1, 2011. The Company was also conducting a pre-existing condition investigation as a result of a submitted claim which included the same diagnosis code. Subsequently, the Company sent a pre-existing condition questionnaire to the provider on March 30, 2011. The PEC unit and the ERU unit did not collaborate on investigations including sharing information thus causing a delay.

Summary of the Company's Response to 8(d): The Company state it does not agree it violated the laws cited. The Company states the ERU works reports in the order of the dates on which they are received. When the March 25, 2011, prescription report came up for review and possible investigation, the ERU investigator determined that it warranted investigation due to a medication used in treating chronic hepatitis, a significant condition that was not disclosed on the insured's application. An ERU investigation was then opened on July 1, 2011. There is no evidence of violation of CCR §2695.7(d) as the Company conducted a thorough, fair and objective investigation and did not seek information not reasonably required in its eligibility investigation. Further, there is no evidence of violation of CIC §790.03(h)(3) as it is the Company's policy to review eligibility issues in a reasonable timeframe and in this instance reviewed the issue as expeditiously as possible and which was reasonable under the circumstances.

Summary of the Department's Evaluation of the Company's Response to 8(d): The Company's current investigational procedures regarding the PEC Unit and the ERU, which act independently of each other, may result in a delay of investigations. Typically, information gathered for one investigation is not shared by both units. The PEC Unit may conduct an investigation and determine that the billed diagnosis code is not a pre-existing condition. The Company's current investigational procedures would not refer the member to the ERU to investigate even when the diagnosis may be rescindable which could result in a delay in determining eligibility. Therefore, this is an unresolved issue that may result in administrative action.

9. In three instances, the Company failed to notify in writing, within 30 working days after receipt of the claim, both the insured and the provider that the claim was denied. The 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 states in these instances, the Company inadvertently did not meet the timing requirement of Insurance Code §10123.13(a); however, the Company states it does not agree it violated CIC §790.03(h)(13). As a remedial measure, the individuals responsible for these human errors have been given feedback on the errors to determine what went wrong and to help prevent similar errors from occurring in the future.

10. In three instances, the Company failed to resolve each provider dispute consistent with applicable law and issue a written determination within 45 working days after the date of receipt of the provider dispute. The Department alleges these acts are in violation of CIC §10123.137(c) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges in these instances the provider disputes were not resolved within 45 working days; however, the Company states it does not agree it violated CIC §790.03(h)(3). These instances were the result of inadvertent errors. Provider Dispute Resolution has received reminders of the deadlines applicable to their reviews.

11. In two instances, the Company failed to reimburse emergency services claims as soon as practical, but no later than 30 working days after receipt of the complete claim. In one instance, the Company incorrectly directed the provider to file the subject claim with its mental health administrator when the Company was responsible for payment of the claim. In the remaining instance, the Company did not pay a portion of the claim until the provider notified the Company of the improper denial. The Department alleges these acts are in violation of CIC §10123.147(a) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company states it does not agree it violated CIC §790.03(h)(5). In the instance regarding the mental health claim, the Company agrees the subject claim was one that should have been considered under the medical benefits of the plan when initially submitted and not the Company's mental health administrator. The Company has procedures in place to determine financial responsibility; however, this was a manual processing error. The Company has provided follow up training to its claim processors to ensure that this sort of manual processing error does not reoccur. The Company continually provides feedback to appropriate processor(s) and management, provides training/refresher training, and updates workflows as needed to reduce and/or prevent processing errors. The Company also has reporting mechanisms in place to identify incorrectly processed claims and initiate re-adjudication of claims in such instances. In the remaining instance, the Company states it does not agree it violated the laws cited. The Company correctly denied a claim submitted from a medical group as incidental to another submitted on the same day; however, upon clarification from the medical group that the two procedures were completed by different physicians, Blue Shield adjusted the claim and paid with interest. The Company pays claims based on the information submitted in the claim. Due to the nature and complexity of medical claims, the provider must

sometimes supplement the information provided in a claim to fully explain the services provided.

Summary of the Department's Evaluation of the Company's Response: In the remaining instance, this is an unresolved issue that may result in administrative action.

12. In two instances, the Company failed to provide an explanation of benefits. The Department alleges these acts are in violation of CCR §2695.11(b) and unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company states it does not agree it violated CIC §790.03(h)(3). In one instance, the Company agrees no member or provider EOB was generated. The Company has performed a corrective action and sent an EOB to the member and provider. In the remaining instance, an EOB was not issued for the adjustment due to a processing error. The Company has provided refresher training to ensure this type of error does not reoccur.

13. In two 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 the errors in the noted instances; however, the Company states it does not agree it violated CIC §790.03(h)(3). As a remedial measure, the Company has provided feedback and additional training to the individuals involved to help prevent these types of error from occurring in the future.

14. In one instance, the Company failed to pay interest on an uncontested claim after 30 working days. 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's Response: The Company states it does not agree it violated the laws cited. However, the Company agrees with the noted instance and has paid interest in the amount of \$11.17.

15. In one instance, the Company failed to pay interest on a contested claim after 30 working days. Specifically, the Company overturned an appeal and failed to include interest in its payment. The Department alleges this act is in violation of CIC §10123.13(c) and is an unfair practice under CIC §790.03(h)(5).

Summary of the Company's Response: The Company states it does not agree it violated the laws cited. However, it stated that interest should have been calculated to pay an additional \$11.63 on this claim. Payment has been issued to the provider for \$21.63 (interest plus \$10 penalty fee).

16. **In one instance, the Company failed to maintain all documents, notes and work papers which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed.** The Department alleges this act is in violation of CCR §2695.3(a) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company states it does not agree it violated the laws cited. The individual responsible for this human error has been given feedback on the error to determine what went wrong and to help prevent a similar error from occurring in the future.

ACCIDENT AND DISABILITY (HEALTH) - ELECTRONIC REVIEW

17. **In 32,977 instances, the Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of the claim.** When tested for the timeliness of payment, the results of the electronic analysis revealed that 32,184 group claims and 793 individual claims were paid in more than 30 working days from receipt of the claim. The Department alleges these 32,977 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 Department's analysis does not take into account a variety of factors which would demonstrate that the claims were timely completed even if the Claim Received and Claim Paid or Claim Closed dates are more than 30 working days apart. For example, claims may properly be pended and the days during which they are pended not counted toward the 30 working-day limit when they are submitted without all of the information necessary to process the claim. Such claims include those that involve a Coordination of Benefits query or audit, a Medicare query, third party liability, or workers compensation. During the audit period, such claims also included claims pended for a pre-existing condition investigation. In addition, claims can be pended when submitted with incomplete subscriber information, when additional information is requested, or when additional medical records have been requested from the provider. The Department's comparison of Claim Received and Claim Paid or Closed dates ignores these factors and thereby substantially over-estimates the number of allegedly untimely claim payments.

Further, when a claim is received concerning an insured who is delinquent in paying premiums, that claim is placed into a pend status until the delinquency period expires and the claim is either denied for non-payment of premium or the insured pays premiums current and the claim is then processed. Again, by simply comparing Claim Received dates with Claim Paid or Closed dates, the Department's analysis over-estimates the number of claims which were allegedly not timely processed.

Additionally, a claim that was timely paid, will appear untimely under the Department's analysis when that payment is later modified or adjusted, such as through an inquiry or appeal. The inquiries or appeals on which such adjustments are based

are necessarily received after processing of the original claim has been completed. When such an appeal or inquiry is received it is paired in the Company's electronic data system with the original Claim Received date so that, if an additional payment is made in response to the appeal or inquiry, interest will be paid from the original Claim Received date. This is also true of adjustments arising from overpayments in which the Company receives a credit-back. Unless account is taken of the relevant fields in the Company's data, such adjustments will inaccurately appear to be claims processed in more than 30 working days, although such adjustments actually take far less than 30 working days to process. Accordingly, by simply comparing Claim Received with Claim Paid or Closed dates, the Department's analysis of the Company's electronic data substantially over-estimates the number of alleged untimely claims payments.

With respect to the 793 IFP claims that were allegedly processed in more than 30 working days, the Company's analysis indicates the following: (1) 214 of them involve Retro-Adjustments (initiated internally by the Company), Recoupments and Credit-Backs; (2) seven are negative or "non-claim" adjustments; and (3) 334 were claims with which the Company paid interest and, hence, there was no violation of CIC § 10123.13 or 790.03(h)(5). In addition, 209 of the allegedly untimely IFP claims decisions were adjustments that were timely processed when viewed from the date of the inquiry or appeal rather than from the date the original claim was received. The 30 remaining claims were original claims that were pended for other reasons, such as for Clinical Integrity Specialist Department (CISD) review.

With respect to the 32,184 Group claims that were allegedly processed in more than 30 working days, the Company's analysis indicates the following: (1) 6,240 of them involve Retro-Adjustments, Recoupments and Credit-Backs; (2) 252 are negative or "non-claim" adjustments; and (3) 15,651 were claims with which the Company paid interest and, hence, there was no violation of CIC § 10123.13 or 790.03(h)(5). In addition, 8,254 of the allegedly untimely Group claims decisions were adjustments that were timely processed when viewed from the date of the inquiry or appeal rather than from the date the original claim was received. The 1,787 remaining claims were original claims that were pended for other reasons, such as for CISD review.

Summary of the Department's Evaluation of the Company's Response:

To ensure all factors of claims processing are considered when performing an electronic analysis, the Department requested the Company provide a clean claim date in its data call. When a claim was pended for additional information, the Company did not provide the date this information was received. Until such time the Company can provide the date in which the Company has received all of the necessary information to process the claim, electronic analysis will demonstrate 32,184 group claims and 793 individual claims were paid in more than 30 working days from receipt of the claim. This remains an unresolved issue that may result in administrative action.

18. In four instances, the Company failed to pay interest on a contested claim after 30 working days. As a result of a manual self-review of 60 group claims with no interest paid, the Company identified four contested claims on which interest was due but was not paid. However, when the Department tested the paid claim population for the payment of interest on claims not paid within 30 working days, the electronic analysis identified 3,573 claims (3,365 group and 208 individual) that were paid beyond 30 working days from the date of receipt, and interest was not paid. In response to the findings of the electronic review, the Company provided additional claim data indicating that on 2,492 group claims, interest was not payable. These claims included zero paid claims (applied to deductible), credit-backs, corrected bills, and claims with a “stop pay and reissue” status. The remaining 873 group claims included 813 claims on which interest was not required to be paid because they involved status adjustments or were claims on which there was a smaller amount due than originally paid. The remaining 60 group claims were manually reviewed by the Company. Of the 60 claims, 54 were on which interest was not payable and six (four contested and two uncontested) were claims on which interest was payable. The 208 individual claims identified by the Department were all zero paid claims (applied to deductible) on which no interest was owed. The Department alleges these four 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 completed manual adjustment of the four contested claims it self-identified and issued interest payments totaling \$4.92.

19. In two instances, the Company failed to pay interest on an uncontested claim after 30 working days. As a result of a manual self-review of 60 group claims with no interest paid, the Company identified two uncontested claims on which interest was due but was not paid. However, when the Department tested the paid claim population for the payment of interest on claims not paid within 30 working days, the electronic analysis identified 3,573 claims (3,365 group and 208 individual) that were paid beyond 30 working days from the date of receipt, and interest was not paid. In response to the findings of the electronic review, the Company provided additional claim data indicating that on 2,492 group claims, interest was not payable. These claims included zero paid claims (applied to deductible), credit-backs, corrected bills, and claims with a “stop pay and reissue” status. The remaining 873 group claims included 813 claims on which interest was not required to be paid because they involved status adjustments or were claims on which there was a smaller amount due than originally paid. The remaining 60 group claims were manually reviewed by the Company. Of the 60 claims, 54 were on which interest was not payable and six (four contested and two uncontested) were claims on which interest was payable. The 208 individual claims identified by the Department were all zero paid claims (applied to deductible) on which no interest was owed. The Department alleges these two 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 completed manual adjustment of the two uncontested claims it self-identified and issued interest payments totaling \$2.60.

ACCIDENT AND DISABILITY (HEALTH) – CONTESTED FILE REVIEW

20. In 70 instances, the Company failed to provide written notice of the need for additional time every 30 calendar days that specified the reason the claim was contested, the information needed to determine liability and the expected determination date. 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 states it does not agree it violated the laws cited. The Company notifies both the member and the provider of the delay and the specific information needed when the claim is first processed. Following the initial notification, the Company sends a 30 day delay letter to the claimant every 30 days until the claim is finalized. At the time the letters giving notice of the delay were sent, the insured was not a "claimant" as defined in the regulations because they were not at that point asserting a right or seeking a recovery under the policy. Rather, the insured had already received the benefits under the policy in the form of medical services. However, at the times the letters giving notice of the delay were sent, the insured's provider was a "claimant" as defined in the regulations and, accordingly, the letters were sent to the provider.

Summary of the Department's Evaluation of the Company's Response: The Department disagrees with the Company's interpretation of "claimant" as defined by CCR §2695.2(c). The Department contends that an insured meets the definition of "claimant" irrespective of the date medical services are rendered. In the instances where the Company sent notices to the provider and/or insured, the 30-day letter failed to include specified reasons for the delay and the expected determination date. Therefore, this is an unresolved issue that may result in administrative action.

21. In 34 instances, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue. Specifically, the explanation of benefits (EOB) issued on Individual & Family Plan (IFP) claims advises the insured that they have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act (ERISA), if applicable. No determination was made that such individual policies were subject to ERISA. The Department alleges these acts are in violation of CIC §790.03(h)(1).

Summary of the Company's Response: The Company states it does not agree it violated the laws cited. The Company states that ERISA can apply to individual products. An individual product is governed by ERISA when the employer "sponsors" it. One way an employer can sponsor individual coverage is to contribute to the payment of premiums, either directly, or by reimbursing or paying the employees for the

premiums they pay on their own, or through a health reimbursement account (HRA). Where an insured's employer reimburses the insured for the premiums the insured pays on an IFP product, the Company would not be aware of the reimbursement and the corresponding fact that the IFP product was part of an employee welfare benefit plan subject to ERISA. Other forms of plan sponsorship by an employer would also not come to the Company's attention where the plan contains individual products. Therefore, the Company is required to provide an ERISA disclosure on its explanation of benefits in order to comply with federal law. Title 29 Code of Federal Regulation 2560.503-1(k) pre-empts state law to the extent it conflicts with the Department of Labor Regulations requiring the ERISA notice. The Company's rationale for including the ERISA notice on its EOBs is to avoid failing to give that notice in connection with an IFP product that is, without the Company's knowledge, subject to ERISA and thereby to maintain compliance with ERISA notice requirements. The notice has been developed to accommodate all lines of business, both individual and group health plans, ERISA and non-ERISA, etc. However, the notice will not mislead insureds whose products are not governed by ERISA. The ERISA notice makes it clear that it applies only when the coverage is part of "your employer's health plan." The notice clearly states in the beginning: "If your employer's health plan ..." so that anyone reading that part of the notice would easily be able to tell if it applies to their coverage. This issue was also raised and resolved in Blue Shield Life's last market conduct examination. All issues raised in that examination were resolved and settled at that time pursuant to a settlement agreement dated December 30, 2008.

Summary of the Department's Evaluation of the Company's Response:

Although the prior examination raised the issue with BSL, no corrective action was proposed by the Company at that time. The settlement agreement referenced by BSL in its response stipulates that BSL will not engage in practices that violate CIC §790.03, among other provisions of the law, and is stipulated to be the full remedy for all violations set forth in the examination report that occurred during the time period referenced in the report. The Department continues to require the Company's practices in the current time period to be in compliance with the cited statute. The Company's response with regard to ERISA language on EOBs for IFP claims does not include a corrective measure. Therefore, this is an unresolved issue that may result in administrative action.

22. In 32 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).

22(a). In 24 instances, the Company requested additional medical records and upon receipt of the records, the Company delayed the referral to a medical review unit which provides recommendations regarding benefits. Delays were also identified in providing a recommendation to the Company by the medical reviewer. In these instances, the total number of days the claims were delayed ranged from 33 days to as many as 88 days.

Summary of the Company's Response to 22(a): The Company disagrees these claims were not processed timely. The Company has demonstrated prompt standards for initiating review of claims. The Company does not have a specific time requirement for transferring files to the medical review unit. Once the medical review is completed, the file along with the recommendation is transferred back to the team and the claim is finalized per the reviewer's instructions.

Summary of the Department's Evaluation of the Company's Response to 22(a): The regulation requires that the Company conduct and diligently pursue a thorough, fair and objective investigation. Regardless of whether the Company does or does not have a specific time requirement for transferring files to the medical review unit, the number of days which ranged from 33 to as many as 88 days does not comply with the subject regulation. Therefore, this is an unresolved issue that may result in administrative action.

22(b). In four instances, when conducting of a pre-existing condition (PEC) investigation, the Company failed to send a PEC questionnaire to the insured and/or appropriate provider.

Summary of the Company's Response to 22(b): The Company states it does not agree it violated the laws cited. In three instances the Company disagrees with the Department's criticism. The Company's process is to send the PEC questionnaire to the billing provider from whom the claim is received. The process does not include sending PEC questionnaires to a referring physician when a claim is received from another referred provider of service. In the remaining instance, the Company agrees the PEC investigation was delayed as a result of not sending the PEC questionnaire to the referring physician.

Summary of the Department's Evaluation of the Company's Response to 22(b): With regard to the three instances in which the Company disagreed with the Department's criticism, the billing provider was either a lab or a diagnostic facility. These facilities do not diagnose, evaluate or treat the patient. In these instances, the Company's process to send the PEC questionnaire to the billing provider did not result in any productive documentation. Therefore, this is an unresolved issue that may result in administrative action.

22(c). In four instances, the Company failed to promptly adjudicate the claim upon receipt of requested medical information.

Summary of the Company's Response to 22(c): The Company states it does not agree it violated the laws cited; however, the Company performs regular training, including annual compliance training on claims processing requirements.

Summary of the Department's Evaluation of the Company's Response: The Company has not clearly outlined the remedial measure(s), including providing

documentation of any training or procedure changes and implementation date(s), to assure that the claim staff has been educated on claims processing requirements. Until such time as the remedial measure is clarified, this is an unresolved issue that may result in administrative action.

23. In 18 instances, the Company failed to reimburse claims as soon as practical, but no later than 30 working days after receipt of all information necessary to determine payer liability. 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 states it does not agree it violated the laws cited. The Company acknowledges these claims were paid more than 30 working days after all necessary information was received. The alleged violation associated with each claim occurred under varying conditions that are not related. At the time the claims were adjudicated, the Company discovered the errors and included interest when the payment was issued after 30 working days. In addition, the Company provided individual processor refresher training.

24. In six instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. Specifically, in five instances the Company denied the claims citing that it had not received previously requested medical information. However, in these instances, the Company had received the medical information necessary to process the claims. In the remaining instance, the Company received a claim that included multiple procedures and wrongfully denied one of the procedures. The Department alleges these acts are in violation of CIC §790.03(h)(5).

Summary of the Company's Response: The Company states it does not agree it violated the laws cited. In four instances, the Company acknowledges the claims were denied in error and the Company provided feedback to the processor who handled these claims. In one instance, the claim system automatically denied the claim after 45 days from the date additional information was requested. The information was received, but not processed timely due to limited resources. When the increase in processing time was identified, the Company dedicated more resources to process contested claims more timely. In the remaining instance, due to manual adjudication, the Company acknowledges a procedure was wrongfully denied. As a remedial measure, the Company provided additional training to the processor and issued payment to the provider with interest in the amount of .50¢. The Company provided processor feedback in instances when processes were inadvertently not followed. The Company also implemented corrective measure as required by statute by paying interest.

25. In four instances, the Company failed to notify in writing, within 30 working days after receipt of the claim, both the insured and the provider that the claim was denied. The 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 states it does not agree it violated the laws cited. In one instance, the Company agrees with the Department's criticism that the claim was not denied within 30 working days.

Summary of the Department's Evaluation of the Company's Response: In one instance, the Company's response does not include a corrective measure. Therefore, this is an unresolved issue that may result in administrative action. In the remaining three instances, the Company has not responded to these allegations. Until the Department receives the Company's response, this is an unresolved issue that may result in administrative action.

26. In four 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's Response: The Company states it does not agree it violated CIC §790.03(h)(5). The Company agrees interest should have been paid in the noted instances. As a remedial measure, the Company has issued four payments totaling \$109.24.

27. In two instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies. In these instances, the Company incorrectly identified receipt of additional information it had requested as an appeal, advising the insured/provider that the Company would respond in 45 working days. The Company has 30 working days to respond to additional information received. The Department alleges these acts are in violation of CIC §790.03(h)(3).

Summary of the Company's Response: The Company states it does not agree it violated the laws cited. When the Company receives previously requested information, on occasion information intended for another internal department is inadvertently identified as a provider dispute. The provider dispute team performs a second layer of filtering to capture misidentified correspondence that is subsequently routed to the appropriate internal department which can result in delays. The Company is aware of this activity and is currently engaged in a corrective action which will increase the accuracy of the sorting process. As part of the corrective action, the Company is partnering with providers and clarifying the correct manner in which to submit correspondence. Additionally, the Company is taking steps internally to reduce turnaround time in the Provider Dispute Resolution (PDR) area along with modifying the Company's agreement with the mail vendor to enable them to more accurately identify and sort incoming correspondence.

28. In two instances, the Company failed to include in its notice of a denied claim the portion of the claim that was denied and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for

denying the claim. The 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 states it does not agree it violated the laws cited. In one instance, the Company disagrees with the allegation. The EOB advises the provider/member that the claim had been reviewed by a medical advisor and was denied based upon that review and the Company's insurance policy. The Company offers to provide more specific information if the insured contacts the Company. In the remaining instance, the Company agrees the EOB fails to provide the specific reasons for the denial.

Summary of the Department's Evaluation of the Company's Response: Compliance with CIC §10123.13(a) requires the EOB to provide specific reasons for the Company's denial. Offering to provide more specific information with regard to the denial only if the insured contacts the Company does not meet the regulatory requirement of CIC §10123.13(a). Therefore, this is an unresolved issue that may result in administrative action. In the remaining instance, the Company's response does not include a corrective measure. Therefore, this is also an unresolved issue that may result in administrative action.

29. In one instance, the Company failed to resolve each provider dispute consistent with applicable law and issue a written determination within 45 working days after the date of receipt of the provider dispute. The Department alleges this act is in violation of CIC §10123.137(c) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees the provider appeal was not resolved in 45 working days; however, does not agree this is a violation of CIC §790.03(h)(3). This was the result of an inadvertent error. Provider Dispute Resolution processors have received reminders and training on the deadlines applicable to their reviews.

30. In one instance, the Company failed to provide an explanation of benefits. Specifically, the Company failed to send an explanation of benefits to the insured. The Department alleges this act is in violation of CCR §2695.11(b) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company acknowledges an explanation of benefits was not sent to the insured; however does not agree this is a violation of CIC §790.03(h)(3). The Company's process includes issuance of an EOB in this instance. The Company provides training to processors on a regular basis, and which has occurred on a regular basis since 2012.