

**[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 HANDLING, RATING, AND UNDERWRITING PRACTICES OF**

**OXFORD LIFE INSURANCE COMPANY  
NAIC # 76112 CDI # 2647-6**

**AS OF FEBRUARY 28, 2014**

**ADOPTED MARCH 17, 2015**

**STATE OF CALIFORNIA**



**CALIFORNIA DEPARTMENT OF INSURANCE  
MARKET CONDUCT DIVISION**

## 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**

Market Conduct Division  
300 Capitol Mall  
Sacramento, CA 95814



March 17, 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 the California Insurance Code Part 2, Chapter 1, Article 4, Sections 730, 733, 736 and Article 6.5, Section 790.04; Chapter 9, Article 6, Sections 1857.2, 1857.3 and 1857.4; and California Code of Regulations Title 10, Chapter 5, Subchapter 7.5, Section 2695.3(a), a limited examination was made of the claims handling, rating, and underwriting practices and procedures in California of:

**Oxford Life Insurance Company**  
**NAIC # 76112**  
**Group NAIC # 0574**

Hereinafter, the Company listed above also will be referred to as OLIC 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](http://www.insurance.ca.gov)) pursuant to California Insurance Code section 12938(b)(1).

## FOREWORD

This limited desk examination covered the claims handling, rating, and underwriting practices of the aforementioned Company's Medicare supplement line of business during the period March 1, 2013 through February 28, 2014. The limited examination was made to discover, in general, if these and other operating procedures of the Company conform to the contractual obligations in the policy forms, the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law.

This report pertains to Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. A separate report pertains to laws other than Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al.

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 identified violations result in payments by the Company to policyholders or claimants, those amounts paid are identified as recoveries in this report. All unacceptable or non-compliant activities may not have been discovered. Failure to identify, comment upon or criticize non-compliant practices in this state or other jurisdictions does not constitute acceptance of such practices.

Alleged violations identified in this report, any criticisms of practices and the Company's responses, if any, have not undergone a formal administrative or judicial process.

## **SCOPE OF THE EXAMINATION**

To accomplish the foregoing, the examination included:

1. A review of specified guidelines, procedures, and forms adopted by the Company for use in California;
2. 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 March 1, 2013 through February 28, 2014; and a review of reports on the previous CDI market conduct examination of this Company; and a review of prior CDI enforcement actions.

This limited examination was conducted at the offices of the California Department of Insurance in San Francisco, California.

## **EXECUTIVE SUMMARY**

This desk examination was limited in scope to market analysis information, including California consumer complaint information, to national enforcement activity and to information provided by the Company in response to the Department's data request. There was no review of underwriting or claims files during this examination.

The finding resulting in an alleged violation of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al., that was identified in the course of the examination is the failure to advise the insured of the right to an independent medical review on letters of denial 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.

Oxford Life Insurance Company reported \$33,339 in written premiums on Medicare supplement insurance coverage in California during 2013. The Company closed 757 Medicare supplement claims during 2013.

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

The market analysis did not identify any specific issues of concern within the scope of this report.

There were no specific areas of concern identified in the complaint review.

The previous examination was completed by the Field Claims Bureau and reviewed the period from November 1, 2001 through October 31, 2002. The most significant noncompliant issue identified in the previous examination report and within the scope of this report was the Company's failure to provide a clear explanation of the computation of benefits for the Group Medicare Supplement claims. The examiner followed up with company management on this issue during the course of this examination.

The Company has not been the subject of an enforcement action by the California Department of Insurance.

## DETAILS OF THE CURRENT EXAMINATION

The following tables summarize the Company’s responses, within the scope of this report, to the Department’s data request and the alleged violations under Section 790.03 and title 10, California Code of Regulations, Section 2695 et al., that resulted from the review of that data. All “NO” answers in the Areas of Review table are addressed in the Summary of Examination Results section of this report. A summary of each of the laws cited due to a “NO” answer is provided in the Cited Statutes and Regulations table.

<b>AREAS OF REVIEW</b>		
<b>SPECIFIC ISSUE REVIEWED</b>	<b>INDICATION OF COMPLIANCE (YES/NO)</b>	<b>SUMMARY OF RESULTS ITEM NUMBER</b>
Certification by a company principal of claims training – CCR §2695.6(b) [CIC §790.03(h)(3)]	YES	-
Copy of written standards for claims – CCR §2695.6(a) [CIC §790.03(h)(3)]	YES	-
Compliance with Special Investigative Unit Regulations – CIC §1875.20 and CCR §§2698.30 through 2698.43 [CIC §790.03(h)(3)]	YES	-
Compliance of letters and forms – CIC §1879.2(a) [CIC §790.03(h)(3)]	YES	-
Acknowledgement of receipt of claim from provider within 15 days and in same form as received -- CIC §10133.66(c) [CIC §790.03(h)(2)]	YES	-
Compliance with requirements of HIPAA regulations on medical authorizations forms – CIC §791.06 [CIC §790.03(h)(3)]	YES	-
Compliance with requirements to pay interest on uncontested claims paid after 30 working days – CIC §10123.13(b) [CIC §790.03(h)(5)]	YES	-
Compliance with requirements to provide a clear EOB – CCR §2695.11(b) [CIC §790.03(h)(3)]	YES	-

<b>AREAS OF REVIEW</b>		
<b>SPECIFIC ISSUE REVIEWED</b>	<b>INDICATION OF COMPLIANCE (YES/NO)</b>	<b>SUMMARY OF RESULTS ITEM NUMBER</b>
Compliance with all requirements of – CIC §10123.13(a) [CIC §790.03(h)(3), and/or (4), and/or (13)]	YES	-
Provider contracts contain required dispute resolution provisions – CIC §10123.137(a) [CIC §790.03(h)(3)]	*N/A	-
Non-contracting provider accessible dispute mechanism – CIC §10123.137(b) [CIC §790.03(h)(3)]	YES	-
Compliance with dispute mechanism report submission – CIC §10123.137(d) [CIC §790.03(h)(3)]	YES	-
Compliance with requirements for providing information on Independent Medical Reviews – CIC §10169.(i) [CIC §790.03(h)(3)]	NO	1
Compliance with requirements for time limits for response to requests for pre-authorization of non-emergency services – CCR §2695.11(e) [CIC §790.03(h)(3)]	*N/A	-
Compliance with requirements for no pre-authorization of emergency services – CCR §2695.11(f) [CIC §790.03(h)(3)]	*N/A	-
Compliance with EOB requirements when emergency services are contested or denied -- CIC §10123.147(a) [CIC §790.03(h)(3)]	*N/A	-
Compliance with requirement to pay interest on emergency services not paid within 30 working days -- CIC §10123.147(b) [CIC §790.03(h)(5)]	YES	-

\*N/A – Not applicable; the Company indicates that this law is not relevant to its particular claims handling, rating or underwriting practice.

<b>CITED STATUTES AND REGULATIONS</b>	
<b>Citation</b>	<b>Description</b>
CIC §10169(i) *[CIC §790.03(h)(1)]	Every disability health insurer shall 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 believes that health care services had been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers.

**\*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 coverages at issue.
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## SUMMARY OF EXAMINATION RESULTS

The following is a brief summary of the practices, within the scope of this report, that were alleged to be non-compliant during the course of this limited examination. This report contains only alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al.

In response to each of the Department's allegations of non-compliance, the Company was 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 and maintained.

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 indicates that these practices are not applicable in other jurisdictions

Within the scope of this report, there were no claims recoveries or return premium as a result of the issues described in this report.

### **MEDICARE SUPPLEMENT**

1. OLIC reported that it failed to advise the insured of the right to request an independent medical review on letters of denial and on all written responses to grievances in cases in which the insured believes that health care services had been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. The Department alleges this act is in violation of CIC §10169(i) and is an unfair practice under CIC §790.03(h)(1).

**Summary of Company Response:** OLIC states it does not make decisions on medical necessity because Medicare determines medical necessity for Medicare supplement policies and the Company administers claims based on Medicare's decision. Nonetheless, the Company acknowledges that it did not include the information concerning the insured's right to request an independent medical review in its

explanation of benefits issued during the review period. As a result of this examination, the Company has updated the remarks portion of the explanation of benefits template to allow the notification to be provided when a claim is contested or denied, effective November 2014.