

**[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**

**CONTINENTAL AMERICAN INSURANCE COMPANY
NAIC # 71730 CDI # 4613-6**

AS OF JULY 31, 2013

ADOPTED SEPTEMBER 29, 2014

STATE OF CALIFORNIA



**CALIFORNIA DEPARTMENT OF INSURANCE
MARKET CONDUCT DIVISION
FIELD CLAIMS BUREAU**

NOTICE

The provisions of Section 735.5(a) (b) and (c) of the California Insurance Code (CIC) describe the Commissioner's authority and exercise of discretion in the use and/or publication of any final or preliminary examination report or other associated documents. The following examination report is a report that is made public pursuant to California Insurance Code Section 12938(b)(1) which requires the publication of every adopted report on an examination of unfair or deceptive practices in the business of insurance as defined in Section 790.03 that is adopted as filed, or as modified or corrected, by the Commissioner pursuant to Section 734.1.

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DEPARTMENT OF INSURANCE

Consumer Services and Market Conduct Branch
Field Claims Bureau, 11th Floor
300 South Spring Street
Los Angeles, CA 90013



September 29, 2014

The Honorable Dave Jones
Insurance Commissioner
State of California
300 Capitol Mall
Sacramento, California 95814

Honorable Commissioner:

Pursuant to instructions, and under the authority granted under Part 2, Chapter 1, Article 4, Sections 730, 733, 736, and Article 6.5, Section 790.04 of the California Insurance Code; and Title 10, Chapter 5, Subchapter 7.5, Section 2695.3(a) of the California Code of Regulations, an examination was made of the claims handling practices and procedures in California of:

**Continental American Insurance Company
NAIC # 71730**

Hereinafter, the Company listed above also will be referred to as the Company.

This report is made available for public inspection and is published on the California Department of Insurance website (www.insurance.ca.gov) pursuant to California Insurance Code section 12938(b)(1).

FOREWORD

The examination covered the claims handling practices of the aforementioned Company on Group Accident and Disability claims closed during the period from August 1, 2012 through July 31, 2013. The examination was made to discover, in general, if these and other operating procedures of the Company conform to the contractual obligations in the policy forms, the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law. This report contains all alleged violations of laws that were identified during the course of the examination.

The report is written in a “report by exception” format. The report does not present a comprehensive overview of the subject insurer’s practices. The report contains a summary of pertinent information about the lines of business examined, details of the non-compliant or problematic activities that were discovered during the course of the examination and the insurer’s proposals for correcting the deficiencies. When a violation that reflects an underpayment to the claimant is discovered and the insurer corrects the underpayment, the additional amount paid is identified as a recovery in this report. All unacceptable or non-compliant activities may not have been discovered. Failure to identify, comment upon or criticize non-compliant practices in this state or other jurisdictions does not constitute acceptance of such practices.

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

SCOPE OF THE EXAMINATION

To accomplish the foregoing, the examination included:

1. A review of the guidelines, procedures, training plans and forms adopted by the Company for use in California including any documentation maintained by the Company in support of positions or interpretations of the California Insurance Code, Fair Claims Settlement Practices Regulations, and other related statutes, regulations and case law used by the Company to ensure fair claims settlement practices.

2. A review of the application of such guidelines, procedures, and forms, by means of an examination of a sample of individual claims files and related records.

3. A review of the California Department of Insurance's (CDI) market analysis results; a review of consumer complaints and inquiries about this Company closed by the CDI during the period August 1, 2012 through July 31, 2013; a review of previous CDI market conduct claims examination reports on this Company; and a review of prior CDI enforcement actions.

The review of the sample of individual claims files was conducted at the offices of the California Department of Insurance in San Francisco, California.

EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED

The Group Accident and Disability claims reviewed were closed from August 1, 2012 through July 31, 2013, referred to as the “review period”. The examiners randomly selected 225 claims files for examination. The examiners cited 94 alleged claims handling violations of the California Insurance Code and the California Code of Regulations from this sample file review.

Findings of this examination included the failure to disclose policy provisions, failure to pay the benefit amount indicated on the policy schedule, failure to diligently investigate claims, failure to provide the reasons for a claim denial, and failure to provide information in claim denials for contacting the California Department of Insurance.

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

Market analysis did not identify any specific issues of concern.

The Company was the subject of no California consumer complaints and inquiries closed from August 1, 2012 through July 31, 2013, in regard to the lines of business reviewed in this examination.

There have been no prior claims examinations conducted upon this Company.

The Company was not the subject of a prior enforcement action by the California Department of Insurance.

DETAILS OF THE CURRENT EXAMINATION

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

CONTINENTAL AMERICAN INSURANCE COMPANY SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS IN REVIEW PERIOD	SAMPLE FILES REVIEWED	NUMBER OF ALLEGED CITATIONS
Accident and Disability / Group Accident – Denied	2446	33	0
Accident and Disability / Group Accident – Appeal	93	11	8
Accident and Disability / Group Accident – Paid	3916	26	16
Accident and Disability / Group Hospital Indemnity – Denied	1142	36	25
Accident and Disability / Group Hospital Indemnity – Appeal	17	8	7
Accident and Disability / Group Hospital Indemnity – Paid	2684	26	18
Accident and Disability / Group Cancer and Critical Illness – Denied	2567	33	6
Accident and Disability / Group Cancer and Critical Illness – Appeal	20	11	7
Accident and Disability / Group Cancer and Critical Illness – Paid	5088	26	1
Accident and Disability / Group Short Term Disability Income – Closed Without Payment & Denied	94	10	3
Accident and Disability / Group Short Term Disability Income – Appeal	1	1	2
Accident and Disability / Group Short Term Disability Income – Paid	136	4	1
TOTALS	18204	225	94

TABLE OF TOTAL CITATIONS

Citation	Description of Allegation	Continental American Insurance Company Number of Alleged Citations
CCR §2695.4(a) *[CIC §790.03(h)(1)]	The Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy.	52
CCR §2695.7(g) *[CIC §790.03(h)(5)]	The Company attempted to settle a claim by making a settlement offer that was unreasonably low.	18
CCR §2695.7(b)(1) *[CIC §790.03(h)(13)]	The Company failed to provide in writing the reasons for the denial of the claim in whole or in part including the factual and legal bases for each reason given.	6
CCR §2695.7(b)(3) *[CIC §790.03(h)(3)]	The Company failed to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance.	6
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.	4
CCR §2695.7(d) *[CIC §790.03(h)(3)]	The Company failed to conduct and diligently pursue a thorough, fair and objective investigation.	4
	The Company persisted in seeking information not reasonably required for or material to the resolution of a claims dispute.	2
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.	1
CIC §10111.2(b) *[CIC §790.03(h)(3)]	The Company failed to notify the insured in writing of information needed to determine liability within 30 calendar days after receipt of the claim.	1
Total Number of Citations		94

***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.
- 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.

TABLE OF CITATIONS BY LINE OF BUSINESS

<p align="center">ACCIDENT AND DISABILITY 2013 Written Premium: \$11,543,318.92</p> <p>AMOUNT OF RECOVERIES \$10,418.75</p>	<p align="center">NUMBER OF CITATIONS</p>
CCR §2695.4(a) [CIC §790.03(h)(1)]	52
CCR §2695.7(g) [CIC §790.03(h)(5)]	18
CCR §2695.7(b)(1) [CIC §790.03(h)(13)]	6
CCR §2695.7(b)(3) [CIC §790.03(h)(3)]	6
CIC §790.03(h)(5)	4
CCR §2695.7(d) [CIC §790.03(h)(3)]	4
CCR §2695.7(d) [CIC §790.03(h)(3)]	2
CIC §790.03(h)(3)	1
CIC §10111.2(b) [CIC §790.03(h)(3)]	1
<p align="center">TOTAL</p>	94

SUMMARY OF EXAMINATION RESULTS

The following is a brief summary of the criticisms that were developed during the course of this examination related to the violations alleged in this report.

In response to each criticism, the Company is required to identify remedial or corrective action that has been or will be taken to correct the deficiency. The Company is obligated to ensure that compliance is achieved.

Any noncompliant practices identified in this report may extend to other jurisdictions. The Company was asked if it intends to take appropriate corrective action in all jurisdictions where applicable. The Company intends to implement corrective actions in all jurisdictions.

Money recovered within the scope of this report was \$5,368.75 as described in sections number 1, 2, and 5 below. Following the findings of the examination, a closed claims survey as described in section number 2 below was conducted by the Company resulting in additional payments of \$5,050.00. As a result of the examination, the total amount of money returned to claimants within the scope of this report was \$10,418.75.

ACCIDENT AND DISABILITY

1. In 52 instances, the Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy. Specifically, by not disclosing available benefits, members were not made aware of covered services and of the procedure to submit documents for benefit reimbursement. In three of these instances, this error resulted in the non-payment of benefits. The Department alleges these acts are in violation of CCR §2695.4(a) and are unfair practices under CIC §790.03(h)(1).

Summary of the Company's Response: The Company acknowledges that it is not fully compliant with regulation 2695.4(a) as defined by the Department of Insurance. As a result of the examination, the Company requested additional information from the member in three of the identified instances and issued benefit payments totaling \$343.75. The Company is developing system enhancements to fully comply with disclosing to claimants when additional benefits might reasonably be payable under

their policy. The Company will apply remark codes to its claims system that are specific to the line of business and to claims situations. The system enhancement is estimated to be fully implemented by the early part of the fourth quarter of 2014.

2. In 18 instances, the Company attempted to settle a claim by making a settlement offer that was unreasonably low. In 18 instances, policy benefits either were reduced or were not paid when the necessary information was in the file. The Department alleges these acts are in violation of CCR §2695.7(g) and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company acknowledges the oversight in the payment of benefits in 18 instances. The Company conducted reinforcement training with all claims specialists at a training session on February 21, 2014. As a result of the examination, the Company issued benefit payments to members in the amount of \$3,740.00.

In one of the instances, the Company paid less than the benefit amount shown on the schedule of benefits. Specifically, the underpayment was the result of an error in loading the plan's \$50.00 health-screening benefit into the system as a \$100.00 benefit. To correct the discrepancy in the identified instance, the Company paid an additional \$50.00 to the member. As a result of this finding, the Company completed an internal audit of all paid health-screening claims filed under the identified group plan from January 1, 2011, which was the inception date of the plan, through January 16, 2014. The Company discovered that for 101 claims, the health screening benefit was paid at \$50.00; but the issued schedule of benefits indicated a benefit of \$100.00. Even though the \$100.00 listed on the schedule of benefits was an error, the Company elected to honor the \$100.00 and subsequently paid the additional \$50.00 to each claimant for a total payment of \$5,050 on January 23, 2014. The Company has provided the necessary documentation to the Department that verifies the review upon completion of the survey on January 17, 2014.

Furthermore, the Company completed an audit of 1,271 other group plan certificates within this same product line on February 17, 2014. Specifically, the Company reviewed a sampling of group plans originating in the state of California that have a Critical Illness plan with wellness benefits. The Company compared the most recent certificate issued with the most recent schedule of benefits issued to certificate holders and also reviewed the groups' benefit proposals. The Company found no other such underpayments.

3. In six instances, the Company failed to provide in writing the reasons for the denial of the claim in whole or in part including the factual and legal bases for each reason given. The Department alleges these acts are in violation of CCR §2695.7(b)(1) and are unfair practices under CIC §790.03(h)(13).

Summary of the Company's Response: The Company agrees that in these instances either correct remark codes were not used or it was not communicated to the member what was needed to perfect the claim. The Company conducted reinforcement training with all claims personnel on July 11, 2014.

4. In six instances, the Company failed to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance. The Department alleges these acts are in violation of CCR §2695.7(b)(3) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company Response: The Company agrees it did not provide the required CDI language. During a recent review of its document process and procedures for the denial of claims, the Company identified that the language in the letter did not clearly state the options for review by the California Department of Insurance. Upon identification, the Company conducted reinforcement training on the correct process and verbiage was provided to employees on September 3, 2013. In addition, on September 4, 2013, a procedure change was implemented to include the use of system-generated non-payment Explanations of Benefits (EOBs) with each denial letter. These non-payment EOBs include instructions and contact information for the claimant to request a review by the California Department of Insurance in the event the claimant believes the claim was denied or rejected in error.

5. In four instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. In two instances, a denial based on a pre-existing condition was not supported. In one instance, the medical records supported payment of a condition but benefits were not paid. In the final instance, the Company wrongly denied a wellness benefit that was payable and then paid the benefit three months later. The Department alleges these acts are in violation of CIC §790.03(h)(5).

Summary of the Company Response: Based on further review, the Company states it agrees that benefits were payable at the time of denial in these instances. In the three instances in which benefits remained unpaid, the Company paid benefits totaling \$1,235.00 to correct the errors. The Company conducted reinforcement training on July 11, 2014, with all claims personnel.

6. In four instances, the Company failed to conduct and diligently pursue a thorough, fair and objective investigation. In three instances, claim documents were submitted and the Company failed to obtain additional information before denying benefits. In one instance, benefits were denied based on no coverage when the denial should have been based on a pre-existing condition. The Department alleges these acts are in violation of CCR §2695.7(d) and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: For all of the instances noted, the Company acknowledges that the claims were not handled appropriately. The Company conducted reinforcement training with all claims personnel on July 11, 2014.

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

Summary of the Company's Response: The Company agrees that a request for additional information was unnecessary and caused a delay in processing. The Company conducted reinforcement training with all claims personnel on July 11, 2014.

8. **In one instance, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.** The member filed a claim for the mammography benefit. The correct benefit was paid; however, the EOB that was issued identified the mammogram as a Pap smear. The Department alleges this act is in violation of CIC §790.03(h)(3).

Summary of the Company Response: The Pap smear benefit of \$100 indicated on the EOB is the result of a system error. The entry information in the claims system is for a mammography benefit under the Hospital Indemnity plan as represented by the benefit type. It has been determined that this system error is the result of the incorrect coverage category entered for this group. The Company conducted an internal audit on October 17, 2013, to determine whether or not the correct benefit description was applied to the EOB. The Company identified 75 groups that had a benefit description of Pap smear when it should have indicated mammography. The Company corrected the EOBs issued for these groups such that they now display the correct benefit as mammography.

9. **In one instance, the Company failed to notify the insured in writing of information needed to determine liability within 30 calendar days after receipt of the claim.** The Department alleges this act is in violation of CIC §10111.2(b) and is an unfair practice under CIC §790.03(h)(3).

Summary of the Company's Response: The Company states it applied a 45-day period for ERISA compliance. However, the Company acknowledges it did not meet the 30-day requirement. The Company changed the 45-day period listed in the written notice to 30-days, effective December 2013.