

**[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**

**SEQUOIA INSURANCE COMPANY  
NAIC # 22985 CDI # 3119-5**

**AS OF APRIL 30, 2014**

**ADOPTED DECEMBER 16, 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

<b>SALUTATION .....</b>	<b>1</b>
<b>FOREWORD.....</b>	<b>2</b>
<b>SCOPE OF THE EXAMINATION.....</b>	<b>3</b>
<b>EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED.....</b>	<b>4</b>
<b>RESULTS OF REVIEWS OF MARKET ANALYSIS, CONSUMER COMPLAINTS AND INQUIRIES, PREVIOUS EXAMINATIONS, AND PRIOR ENFORCEMENT ACTIONS .</b>	<b>5</b>
<b>DETAILS OF THE CURRENT EXAMINATION .....</b>	<b>6</b>
<b>TABLE OF TOTAL ALLEGED VIOLATIONS .....</b>	<b>7</b>
<b>TABLE OF ALLEGED VIOLATIONS BY LINE OF BUSINESS .....</b>	<b>9</b>
<b>SUMMARY OF EXAMINATION RESULTS .....</b>	<b>11</b>

**DEPARTMENT OF INSURANCE**

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



December 16, 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:

**Sequoia Insurance Company  
NAIC # 22985**

**Group NAIC # 0009**

Hereinafter, the Company listed above also will be referred to as SIC or Sequoia 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

The examination covered the claims handling practices of the aforementioned Company on Commercial Automobile, Commercial Multiple Peril and Workers' Compensation claims closed during the period from May 1, 2013 through April 30, 2014 and Workers' Compensation claims open as of April 30, 2014. 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 in this report by the examiners, 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 and related records.

3. A review of the California Department of Insurance's (CDI) market analysis results; a review of consumer complaints and inquiries about this Company closed by the CDI during the period May 1, 2013 through April 30, 2014; a review of previous CDI market conduct claims examination reports on the 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 Company in Monterey and Concord, California.

## **EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED**

The Commercial Automobile, Commercial Multiple Peril and Workers' Compensation claims reviewed were closed from May 1, 2013 through April 30, 2014. The open Workers' Compensation claims reviewed were open as of April 30, 2014. The examiners randomly selected 207 Sequoia claims files for examination, including 70 Workers Compensation files. Utilization Review (UR) referrals were contained in 18 of these files. Utilization Review is a process whereby the Company evaluates the medical treatment services recommended by the physician to determine if the services are medically necessary to cure or relieve the claimant's condition.

The examiners cited 127 alleged claims handling violations of the California Insurance Code and the California Code of Regulations from this sample file review. Six of these alleged violations related to the utilization review process. The primary findings of this examination were identified in the Workers' Compensation line, and included the failure to include statutory self-imposed penalty and interest due to delayed processing of medical bills; the failure to process billed medical services; the failure to correctly pay or object to medical treatment expenses; and the failure to timely respond to a request to provide or authorize medical treatment.

Details with respect to these violations are provided in the Summary of Examination Results.

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

The market analysis review indicated that on April 19, 2013, acquisition of the Company by AmTrust Financial Services, Inc. of New York (AmTrust) was finalized. During the review period of this examination, the Company was transitioning to ownership and control by AmTrust.

The review of consumer complaint information and prior examinations identified no specific areas of concern.

.

## DETAILS OF THE CURRENT EXAMINATION

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

<b>SIC SAMPLE FILES REVIEW</b>			
<b>LINE OF BUSINESS / CATEGORY</b>	<b>CLAIMS IN REVIEW PERIOD</b>	<b>SAMPLE FILES REVIEWED</b>	<b>NUMBER OF ALLEGED VIOLATIONS</b>
Commercial Automobile / 1 <sup>st</sup> Party	51	29	5
Commercial Automobile / 3 <sup>rd</sup> Party	49	28	2
Commercial Automobile / UMBI, CDW, UMPD	2	2	-0-
Commercial Automobile / Med Pay	3	3	-0-
Commercial Multi-Peril / 1 <sup>st</sup> party	439	26	9
Commercial Multi-Peril / 3 <sup>rd</sup> party	749	49	1
Workers' Compensation / Medical Only / [Closed]	701	20	38
Workers' Compensation / Medical Only [Open]	94	10	5
Workers' Compensation / Indemnity [Closed]	331	20	18
Workers' Compensation / Indemnity [Open]	784	10	43
Workers' Compensation / Denied	234	10	6
<b>TOTALS</b>	3,437	207	127

## TABLE OF TOTAL ALLEGED VIOLATIONS

Citation	Description of Allegation	SIC Number of Alleged Violations
*CIC §790.03(h)(5)	The Company failed to include statutory self-imposed penalty and interest due to delayed processing of medical bills.	71
*CIC §790.03(h)(5)	The Company failed to process billed medical services.	20
*CIC §790.03(h)(5)	The Company failed to correctly pay or object to medical treatment expenses.	7
*CIC §790.03(h)(2)	The Company failed to timely respond to a request to provide or authorize medical treatment.	6
CCR §2695.8(b)(1) *[CIC §790.03(h)(5)]	The Company failed to include, in the settlement, the one-time fees incident to transfer of evidence of ownership of a comparable automobile.	3
CCR §2695.9(f) *[CIC §790.03(h)(3)]	The Company failed to fully explain the basis for any adjustment to the claimant in writing.	3
*CIC §790.03(h)(2)	The Company failed to issue timely benefit notices.	3
CCR §2695.7(b) *[CIC §790.03(h)(4)]	The Company failed, upon receiving proof of claim, to accept or deny the claim within 40 calendar days.	2
CCR §2695.7(h) *[CIC §790.03(h)(5)]	The Company failed, upon acceptance of the claim, to tender payment within 30 calendar days.	2
CCR §2695.8(b)(1) *[CIC §790.03(h)(5)]	The Company failed to include, in the settlement, the license fee and other annual fees computed based upon the remaining term of the current registration.	2
*CIC §790.03(h)(5)	The Company failed to calculate and pay benefits timely.	2

Citation	Description of Allegation	SIC Number of Alleged Violations
CCR §2695.4(a) *[CIC §790.03(h)(3)]	The Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy.	1
CCR §2695.7(c)(1) *[CIC §790.03(h)(3)]	The Company failed to provide written notice of the need for additional time or information every 30 calendar days.	1
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.	1
CCR §2695.7(q) *[CIC§790.03(h)(3)]	The Company failed to share subrogation recoveries on a proportionate basis with the first party claimant.	1
CIC §2051.5(b)(1) *[CIC§790.03(h)(3)]	The Company improperly imposed upon an insured a time limit to collect the full replacement cost of the loss. No time limit of less than 12 months from the date that the first payment toward the actual cash value is made shall be placed upon an insured in order to collect the full replacement cost of the loss, subject to the policy limit.	1
*CIC §790.03(h)(5)	The Company failed to calculate and reimburse mileage expenses timely.	1
<b>Total Number of Alleged Violations</b>		<b>127</b>

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

- CIC §790.03(h)(2)      The Company failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.
- 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)(4)      The Company failed to affirm or deny coverage of claims within a reasonable time after proof of loss requirements had been completed and submitted by the insured.
- CIC §790.03(h)(5)      The Company failed to effectuate prompt, fair, and equitable settlements of claims in which liability had become reasonably clear.

**TABLE OF ALLEGED VIOLATIONS BY LINE OF BUSINESS**

<b>COMMERCIAL AUTOMOBILE</b> 2014 Written Premium: \$540,436	<b>NUMBER OF ALLEGED VIOLATIONS</b>
<b>AMOUNT OF RECOVERIES</b> <b>\$12,033.98</b>	
CCR §2695.8(b)(1) [CIC §790.03(h)(5)]	3
CCR §2695.8(b)(1) [CIC §790.03(h)(5)]	2
CCR §2695.7(c)(1) [CIC §790.03(h)(3)]	1
CCR §2695.7(g) [CIC §790.03(h)(5)]	1
<b>SUBTOTAL</b>	<b>7</b>

<b>COMMERCIAL MULTIPLE PERIL</b> 2014 Written Premium: \$25,289,649 Property 2014 Written Premium: \$9,054,291 Liability	<b>NUMBER OF ALLEGED VIOLATIONS</b>
<b>AMOUNT OF RECOVERIES</b> <b>\$190.34</b>	
CCR §2695.9(f) [CIC §790.03(h)(3)]	3
CCR §2695.7(b) [CIC §790.03(h)(5)]	2
CCR §2695.7(h) [CIC §790.03(h)(5)]	2
CCR §2695.4(a) [CIC §790.03(h)(1)]	1
CCR §2695.7(q) [CIC §790.03(h)(5)]	1
CIC §2051.5(b)(1) [CIC §790.03(h)(1)]	1
<b>SUBTOTAL</b>	<b>10</b>

<b>WORKERS' COMPENSATION</b> 2014 Written Premium: \$19,408,630	<b>NUMBER OF ALLEGED VIOLATIONS</b>
<b>AMOUNT OF RECOVERIES</b> <b>\$39,492.61</b>	
CIC §790.03(h)(5)	101
CIC §790.03(h)(2)	9
<b>SUBTOTAL</b>	<b>110</b>

<b>TOTAL</b>	<b>127</b>
--------------	------------

## 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 \$10,006.37 as described in section number 1, 2, 4, 9 and 11 below. Following the findings of the examination, closed claims surveys as described in sections 1, 2, 4 and 11 below were conducted by the Company resulting in additional payments of \$41,710.56. As a result of the examination, the total amount of money returned to claimants within the scope of this report was \$51,716.93.

### **COMMERCIAL AUTOMOBILE**

1. **In three instances, the Company failed to include in the settlement, the one-time fees incident to transfer of evidence of ownership of a comparable automobile.** The Department alleges these acts are in violation of CCR §2695.8(b)(1) and are unfair practices under CIC §790.03(h)(5).

**Summary of the Company's Response:** The Company agrees that in these three instances the total loss settlement calculation did not include the \$15.00 Department of Motor Vehicles (DMV) transfer of ownership fee as required by CCR §2695.8(b)(1). As a result of this examination, the Company paid a total of \$45.00 to the three claimants identified in these instances. The Company also conducted an

internal survey of total loss claims that were closed from May 1, 2011 through April 30, 2014. The Company reviewed 38 total loss claims and paid a total of \$330.00 to 22 claimants for transfer fees. Additionally, the Company has procured the services of a third party vendor to determine the correct amount of one-time transfer fees, vehicle license fees, and unused vehicle registration fees payable to claimants on total loss claims. The vendor has been handling the Company's DMV license and registration fee calculations as of April 13, 2015.

**2. In two instances, the Company failed to include in the settlement the license fee and other annual fees computed based upon the remaining term of the current registration.** The Department alleges these acts are in violation of CCR §2695.8(b)(1) and are unfair practices under CIC §790.03(h)(5).

**Summary of the Company's Response:** The Company agrees that in these two instances the total loss settlement calculations did not include the unused license and other annual DMV fees as required by CCR §2695.8(b)(1). As a result of this examination, the Company paid a total of \$451.32 to the two claimants identified in these instances. The Company also conducted an internal survey of total loss claims that were closed from May 1, 2011 through April 30, 2014. The Company reviewed 38 total loss claims and paid a total of \$3,343.84 to 15 claimants for reimbursement of unused DMV license fees. Additionally, the Company has procured the services of a third party vendor to determine the correct amount of one-time transfer fees, vehicle license fees, and unused vehicle registration fees payable to claimants on total loss claims. The vendor began handling the Company's DMV license and registration fee calculations as of April 13, 2015.

**3. In one instance, the Company failed to provide written notice of the need for additional time or information every 30 calendar days.** The Department alleges this act is in violation of CCR §2695.7(c)(1) and is an unfair practice under CIC §790.03(h)(3).

**Summary of the Company's Response:** The Company agrees that in this instance, the Company failed to transmit the regulatory notice. The Company addressed this matter with the pertinent adjuster for compliance reinforcement.

**4. In one instance, the Company attempted to settle a claim by making a settlement offer that was unreasonably low.** In one instance on an owner-retained salvage, the Company deducted the high salvage bid from the total loss settlement. The Department alleges this act is in violation of CCR §2695.7(g) and an unfair practice under CIC §790.03(h)(5).

**Summary of the Company's Response:** The Company acknowledges the finding. As a result of this examination, the Company reopened the claim to issue an additional \$200.00 to the pertinent claimant. The Company also completed an internal survey of total loss claims that were closed from May 1, 2011 through April 30, 2014. The Company reviewed 38 owner-retained total loss claims and paid a total of

\$7,663.82 to 7 claimants with regard to the determination of the salvage bid amounts which were deducted from the settlements. The Company has addressed this matter with claims staff for consistency in its total loss settlement practices.

## **COMMERCIAL MULTIPLE PERIL**

**5. In three instances, the Company failed to fully explain the basis for any adjustment to the claimant in writing.** The Company's settlement letters failed to provide a clear explanation of the adjustments on the approved settlement amount. The Department alleges these acts are in violation of CCR §2695.9(f) and are unfair practices under CIC §790.03(h)(3).

**Summary of the Company's Response:** The Company agrees that in these three instances the Company failed to provide proof that the insureds received a written explanation of the basis of the adjusted settlement amounts. The Company indicates that these settlements were tendered prior to the acquisition of the Sequoia Insurance Company by AmTrust Financial Services. In late July 2014, the Company conducted training for all adjusters and will continue to conduct random monthly audits. The Company reiterated instructions to its claims staff to provide in writing to the insured the basis of any adjustment as well as a full explanation of how the settlement amount was calculated.

**6. In two instances, the Company failed, upon receiving proof of claim, to accept or deny the claim within 40 calendar days.** The Company received proof of claim and failed to accept or deny the claims within regulatory timelines. The Department alleges these acts are in violation of CCR §2695.7(b) and are unfair practices under CIC §790.03(h)(4).

**Summary of the Company's Response:** The Company agrees with the findings of delay. On August 24, 2014, the Company reinforced this regulation in its mandatory monthly staff meeting for all property adjusters. The Company indicates that it will continue to conduct training and random monthly audits for all property adjusters. The Company has also amended its procedures to emphasize that its Property Claim Managers will be reviewing coverage issues and monitor the timeliness of staff coverage recommendations. The adjusters will be reminded to submit within 10 days of receipt of proof of claim their recommendations on coverage to ensure regulatory compliance.

**7. In two instances, the Company failed, upon acceptance of the claim, to tender payment within 30 calendar days.** The payments for eligible services were delayed beyond regulatory timelines. The Department alleges these acts are in violation of CCR §2695.7(h) and are unfair practices under CIC §790.03(h)(5).

**Summary of the Company's Response:** The Company agrees to the findings and indicates there were systems and administrative errors which contributed to the delay in payment. The Company has addressed the adjuster oversight with pertinent staff for compliance reinforcement. In late July 2014, a training session was held for all adjusters on the results of the Department's examination including emphasis with the 30-day payment timeline. Claim supervisors will also be conducting monthly audits to ensure compliance.

**8. In one instance, the Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy.** The Company failed to disclose provisions on the policy regarding the replacement cost holdback and its potential recovery by the insured. The Department alleges this act is in violation of CCR §2695.4(a) and is an unfair practice under CIC §790.03(h)(1).

**Summary of the Company's Response:** The Company agrees with the finding. The pertinent claims staff has been instructed to reopen the case and provide necessary information to the insured on how to make a supplemental claim under its Replacement Cost Coverage.

**9. In one instance, the Company failed to share subrogation recoveries on a proportionate basis with the first party claimant.** The Department alleges this act is in violation of CCR §2695.7(q) and is an unfair practice under CIC §790.03(h)(5).

**Summary of the Company's Response:** The Company agrees with the finding and indicates that this appears to be an oversight by the subrogation recovery adjuster. As a result of this examination, the pro rate share of the insured's deductible in the amount of \$190.34 has been issued to the insured. In August 2014, the Subrogation unit was instructed that all recoveries are subject to review and that any recoveries owed to the insured are given priority upon receipt of the recovered funds.

**10. In one instance, the Company improperly imposed upon an insured a time limit to collect the full replacement cost of the loss. No time limit of less than 12 months from the date that the first payment toward the actual cash value is made shall be place upon an insured in order to collect the full replacement cost of the loss, subject to the policy limit.** The Company's settlement letter provided a 180-day timeline for the insured to make a claim for depreciation holdback. The Department alleges this act is in violation of CICR §2051.5(b)(1) and is an unfair practice under CIC §790.03(h)(1).

**Summary of the Company's Response:** The Company agrees that in this one instance the loss settlement letter did not convey the correct time limit to the insured to make a claim for the holdback. In a mandatory staff meeting held on October 27, 2014, the Company reinforced compliance with this statute as part of its refresher training.

## **WORKERS' COMPENSATION**

### **11. In 101 instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear**

In a total of 71 instances, the Company failed to include statutory self-imposed penalty and interest as required by LC §4603.2(b)(2) and LC §4603.4(d).

- a. In 60 instances, the billing for medical treatment was not processed within 45 working days
- b. In 11 instances, the itemized electronic billing for medical services was not processed within 15 working days.

In a total of 27 instances, the Company failed to correctly pay or object to medical treatment expenses as required by LC §4603.2(b) and LC §4603.2(d)(2).

- a. In 20 instances, the Company failed to process billing for medical services.
- b. In three instances, the medical bill review failed to pay the correct allowance amount for the same procedures of CPT 99214 and 99070.
- c. In three instances, the medical bill review improperly down-coded initial consultation office visits as established outpatient visit by adjusting CPT code 99204 to CPT code 99214
- d. In one instance, a medical bill review incorrectly denied a billed procedure.

In a total of two instances, the Company failed to issue timely benefits. The Company did not pay a three-day waiting period temporary disability(TD) benefit as required by LC §4652; and did not issue issue timely permanent disability (PD) benefits as required by LC §4650.

In one last instance, the Company did not pay for mileage reimbursement as required by LC §4600(e)(2).

The Department alleges these acts are in violation of Labor Code (LC) §§4600, §4603, §4650 and §4652, and are unfair practices under CIC §790.03(h)(5).

**Summary of the Company's Response:** The Company agrees to the findings. With regard to the incorrect processing, and/or failure to process medical billings, the Company reopened the claims and paid \$2,542.06 for medical services; and \$2,249.08 for self-imposed penalties and interest owed.

The Company acknowledges that its bill reviewers and/or adjusters did not correctly process medical billings, and/or failed to include statutory self-imposed penalty and interest. The Company indicates these issues occurred during the transition period when claims were transferred from its Third-party Administrator (TPA) to the Company during the acquisition period by AmTrust. As of September 15, 2013, the Company had a full-time regular team of eight examiners and two supervisors handling approximately 1,200 indemnity claims and hundreds of Medical Only claims from the previous TPA. The Company believes that the claims handling process has now stabilized under its new management and the Company will adjudicate claims in accordance with the Labor Code and Fair Claims Best Practices.

The Company also completed an internal survey of medical billings that were received from February 1, 2014 through August 1, 2014 and reported the results to the Department on February 26, 2015. The Company received 8,053 medical billings and determined that 829 billings had not been processed timely, and/or did not include the self-imposed penalty and interest. The Company paid a total of \$30,372.90 as a result of this survey.

In addition, the Company has implemented a corrective action plan for the payment of medical bills within 45 days of receipt. The Company's managers met with their staff to reiterate that all bills must be reviewed and paid within 45 days of receipt and if not paid within the required timeframe, penalties and interest are to be paid. The trainings were completed in October 2014 and in May 2015. The Supervisors will also submit a weekly report to management regarding their unit's work production including pending mail in the adjusters' queue and the timeliness of claims handling and processing. A compliance audit has been created to assure conformity with California regulations and timeframes. Quarterly supervisory reviews will be conducted and non-compliance will be addressed with staff including the prompt payment of invoices/medical billings.

On May 7, 2015, the Vice President of Claims met with the claim managers to reiterate the importance of prompt bill payments and the requirement to pay penalty and interest for delayed processing. The claim managers likewise emphasized regulatory and statutory compliance with its claims staff on May 8, 2015.

With regard to the three instances involving disability benefit payments and mileage reimbursement, the Company reopened the claims and paid \$4,328.57 for additional disability benefits, and \$306.75 for mileage reimbursement. The Company believes these were adjuster errors and have counseled pertinent staff. The supervisors will monitor work of its examiners for compliance.

**12. In 9 instances, the Company failed to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.**

- a. In 6 instances, the Company failed to provide a timely Utilization Review determination as required by 8CCR §9792.9(b)(1).

- b. In 3 instances, the Company failed to provide a timely benefit notice as required by 8CCR §§9812(a)(1), 9812(a)(2) and 9812(j).

The Department alleges these acts are in violation of LC §4650, Title 8 CCR §§9792.9 and 9812, and are unfair practices under CIC §790.03(h)(2).

**Summary of the Company's Response:** The Company agrees with the findings. With regard to the six instances involving Utilization Review (UR) standards, the Company conducted training in October 2014 and established different levels of authority to approve treatment requests. To institute a timely UR process and review, the adjusters were delegated with the tasks of approving less invasive treatment requests such as initial physical therapy, MRIs and certain durable medical equipment (DME) requests.

With regard to the three instances of delayed benefit notices, the Company conducted claims trainings to reiterate the importance of regulatory statutes in the issuance of notices. The Company's supervisors are held accountable for monitoring claim diaries and adjuster performance.

As a result of the examination, additional trainings were completed in October 2014 and in May 2015. The supervisors will have a quarterly claim diary review for compliance and staff performance audit. In a management meeting of May 7, 2015, the Vice President of Claims reiterated the importance of prompt UR reviews and timely benefit notices. Emphasis on regulatory and statutory compliance was discussed with claims staff on May 8, 2015.