

**[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**

**BENCHMARK INSURANCE COMPANY
NAIC # 41394 CDI # 1903-4**

AS OF NOVEMBER 15, 2014

ADOPTED OCTOBER 22, 2015

STATE OF CALIFORNIA



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

NOTICE

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

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DEPARTMENT OF INSURANCE

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



October 22, 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:

**Benchmark Insurance Company
NAIC # 41394**

Group NAIC # 0000

Hereinafter, the Company listed above also will be referred to as BIC, 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's Workers' Compensation claims closed during the period from November 16, 2013 through November 15, 2014, and claims open as of November 15, 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 examiner, additional violations of CIC § 790.03, or other laws, not cited in this report may also apply to any or all of the non-compliant or problematic activities that are described herein.

All unacceptable or non-compliant activities may not have been discovered. Failure to identify, comment upon or criticize non-compliant practices in this state or other jurisdictions does not constitute acceptance of such practices.

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

SCOPE OF THE EXAMINATION

To accomplish the foregoing, the examination included:

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

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

3. A review of the California Department of Insurance's (CDI) market analysis results; a review of consumer complaints and inquiries about this Company closed by the CDI during the period November 16, 2013 through November 15, 2014; and 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 Department of Insurance at Los Angeles, California.

EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED

The Workers' Compensation claims reviewed were from both open and closed populations with the Date of Injury no earlier than November 16, 2012. The closed claims reviewed were closed from November 16, 2013 through November 15, 2014. The open claims reviewed were claims with date of injury no earlier than November 16, 2012, and in those claims, the activity reviewed was through November 15, 2014. The examiners randomly selected 70 claim files for examination. The examiners cited 22 alleged claims handling violations of the California Insurance Code and other specified codes from this sample file review.

Findings of this examination include a failure to include statutory self-imposed interest due to delayed processing of medical bills, and a failure to conduct its business in its own name.

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

The Company was the subject of two California consumer complaints and inquiries closed from November 16, 2013 through November 15, 2014, in regard to the lines of business reviewed in this examination. There was no specific area of concern identified in the complaint review.

The previous claims examination reviewed a period from October 1, 2008 through September 30, 2009. The most significant noncompliance issue identified in the previous examination report was the Company's failure to require claims practices training to all its claims adjusters in accordance with California Code of Regulations. This issue was not identified as problematic in the current examination.

DETAILS OF THE CURRENT EXAMINATION

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

BIC SAMPLE FILES REVIEW			
LINE OF BUSINESS / CATEGORY	CLAIMS IN REVIEW PERIOD	SAMPLE FILES REVIEWED	NUMBER OF ALLEGED VIOLATIONS
Workers' Compensation / Indemnity [Closed]	127	14	5
Workers' Compensation / Indemnity [Open]	196	10	6
Workers' Compensation / Medical Only / [Open]	202	10	1
Workers' Compensation / Medical Only / [Closed]	238	27	10
Workers' Compensation / Denied	79	9	0
TOTALS	842	70	22

TABLE OF TOTAL ALLEGED VIOLATIONS

Citation	Description of Allegation	BIC Number of Alleged Violations
*CIC §790.03(h)(5)	The Company failed to include statutory self-imposed interest due to delayed processing of medical bills.	9
CIC §880 [*CIC §790.03(h)(3)]	The Company failed to conduct its business in its own name.	8
*CIC §790.03(h)(1)	The Company misrepresented to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.	2
*CIC §790.03(h)(3)	The Company failed to maintain supporting claims file documentation.	1
*CIC §790.03(h)(3)	The Company failed to send general information pamphlet with first notice of benefits	1
*CIC §790.03(h)(3)	The Company failed to provide timely acceptance letter.	1
Total Number of Alleged Violations		22

*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. |

TABLE OF VIOLATIONS BY LINE OF BUSINESS

<p align="center">WORKERS' COMPENSATION 2014 Written Premium: \$76,241,762</p> <p>AMOUNT OF RECOVERIES \$49,216.87</p>	<p align="center">NUMBER OF ALLEGED VIOLATIONS</p>
CIC §790.03(h)(5) [LC §4603.2(b)(1)]	9
CIC §880 [CIC §790.03(h)(3)]	8
CIC §790.03(h)(1)	2
CIC §790.03(h)(3) [8CCR §9815]	1
CIC §790.03(h)(3) [8CCR §9810(d)]	1
CIC §790.03(h)(3) [8CCR §10101.1(k)]	1
SUBTOTAL	22
TOTAL	22

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 where these practices are applicable

Money recovered within the scope of this report was \$2,636.84 as described in section number one below. Following the findings of the examination, a closed claims survey as described in section one below was conducted by the Company resulting in additional payments of \$46,580.03.. As a result of the examination, the total amount of money returned to claimants within the scope of this report was \$49,216.87.

WORKERS' COMPENSATION

1. In nine instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.

- a. In eight instances, the Company failed to include statutory self-imposed penalty and interest owed because of delayed processing of medical treatment expenses as required by LC §4603.2(b)(1).
- b. In one instance, the Company failed to process medical treatment expenses as required by LC §4603.2(b)(1)

The Department alleges these acts are in violation of Labor Code §4603.2 and are unfair practices under CIC §790.03(h)(5).

Summary of the Company's Response: The Company agrees with the findings.

The nine instances cited in sections 1(a) and 1(b) involved a delay in the processing of medical billings, and/or a failure to process a medical billing. The Company acknowledges that its medical bill reviewers and/or adjusters did not correctly process medical invoices, and/or failed to include statutory self-imposed penalty and interest on delayed medical treatment payments. As a result of the examination, the Company reopened the claims and paid an additional \$2,636.84 for self-imposed penalties and interest.

The Company indicates that it is not their standard procedure to delay the processing of medical invoices. In September 2013, the Company indicated that it terminated its Third Party Administrator (TPA) and transferred the claims handling to the Company. This transition period resulted in processing delays starting in October 2013. Thus, the Company conducted a voluntary self-survey to ensure accurate settlements and payment of statutory self-imposed interest due to delayed processing of medical bills. The survey period was from October 1, 2013 to March 31, 2015, and resulted in additional payments totaling \$46,580.03. Additionally, the Company states it conducts self-audits to assure compliance.

2. In eight instances, the Company failed to conduct its business in its own name. The Department alleges the Company failed to identify Benchmark Insurance Company in all correspondence. The Department alleges these acts are in violation of CIC §880 and CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees with the findings and has revised its template letters to include the name of the underwriting company.

3. In three instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.

- a. In one instance, the Company failed to send a general information pamphlet with its first notice of benefits as required by Title 8, CCR §9810(d).
- b. In one instance the Company failed to provide a Temporary Disability acceptance letter within 14 days of knowledge as required by Title 8, CCR §9815.
- c. In one instance the Company failed to produce a document in its claims file as required by Title 8, CCR §10101.1(k).

The Department alleges these acts are in violation of Title 8, CCR §§9810(d), 9815, and 10101.1(k), and are unfair practices under CIC §790.03(h)(3).

Summary of the Company's Response: The Company agrees with the findings and indicates that these were inadvertent errors by claims staff. The Company has counseled its adjusters and the supervisors will monitor their claims handling for compliance.

4. **In two instances, the Company misrepresented to claimants pertinent facts or insurance policy provisions relating to coverages at issue.** In two instances, the Explanation of Reimbursement (EOR) notices provided to the claimants did not match the values on the claim checks. The Department alleges these acts are in violation of CIC §790.03(h)(1).

Summary of the Company's Response: The Company acknowledges that its systems software failed to provide an accurate settlement amount in its EOR notices in these two instances. This Explanation of Reimbursement (EOR) issue pertains to the Electronic Data Interface (EDI) between the bill review software and the claims software. The Company states that the EOR mapping system pulled the wrong value as it went to reporting in the claims software. This affected one batch of EORs that were transmitted, however it did not hold up the transmittal of the correct check payments. The Company will complete an EDI sweep to revise the incorrect EORs in the claims system. This was a short-lived exception and there has not been any provider complaints related to these EOR errors.