STATE OF CALIFORNIA Steve Poizner, *Insurance Commissioner*

DEPARTMENT OF INSURANCE
CONSUMER SERVICES AND MARKET CONDUCT BRANCH
CLAIMS SERVICES BUREAU
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013
www.insurance.ca.gov

January 11, 2007

Sharon Hulbert
Legal, Associate General Counsel
PacifiCare Life and Health Insurance Company
5757 Plaza Drive, MS CA 124-0157
Cypress, CA 90630

Regarding: Issues with Claims Handling, Customer Service and Regulatory Compliance

Dear Ms. Hulbert:

As you are aware, this Department has received numerous consumer complaints over the last several months. In the course of our investigation of these complaints, certain patterns have developed which we wish to bring to your attention:

- In a number of instances, calls placed by our Department to various representatives within your company have not been returned in a prompt fashion. Several consumers have also raised this allegation. In one instance, the outgoing message of a claims representative who had been terminated several months previous had not been updated to reflect the departure of the employee or to direct the caller to a replacement claim representative. An officer of this Department was among the callers who left unreturned messages on the terminated employee's voicemail.

- Healthcare providers (and other consumers) have alleged that claims have not been processed in a timely fashion or that claims were wrongfully denied or paid at an improper amount.

- Creditable coverage has played a role in many consumer inquiries and our investigations to date have revealed common deficiencies with respect to how claims are processed when the matter of creditable coverage comes into play. For example, consumers are sometimes requested to re-submit certification of creditable coverage when such proof was already provided.

- A total of twenty (20) California Insurance Code Section 10123.13(a) violations have been cited following our investigation of just two of the recent complaints received. Please review our previously issued correspondence in reference to these complaints (our file numbers CSB-6222976 and CSB-6228911) for specific details.

In an effort to address these issues, we request that you:

- Provide us with documentation evidencing your company's procedures in the event an employee leaves employment or is on extended leave. The procedures should address when and how claims and other work is reassigned, steps that are taken to communicate the situation to claimants and others, who is responsible to ensure that voicemail and/or phone extensions are updated, etc.

- Continue to keep the Department abreast of your own ongoing review of submitted claims which may not have drawn formal insurance complaints, but which appear to have claims handling or customer service issues as described above. We are particularly interested in your development of procedures/solutions to remedy any identified issues. We request that you provide us with a timeline for the implementation of your corrective action plan that was previously e-mailed to our Department and a time frame for the completion of the review of the denied claims. The corrective action plan should include but is not limited to the following:

  1. review of the processes for handling the intake of creditable coverage information from members;
  2. review of whether creditable coverage information is readily accessible by claims, appeals and other critical departments;
  3. review of the underwriting process to determine if prior coverage information is obtained at the time of initital underwriting for PPO employer groups and individuals;
  4. review of the handling of pre-existing condition issues involving certificates of creditable coverage within the claims and appeals department;
  5. review of all denials made in 2006 related to the non-receipt of a certificate of creditable coverage;
  6. review of denial letters and EOBs to determine if language concerning denial is clear to the member when the member had creditable coverage but not for the full period of time and therefore may still be subject to a pre-existing conditions denial for a period of time

- Provide our Department with another list of the approximately 3,800 claims denied for pre-existing that includes the member names rather that just the identification numbers. It is our Department's understanding that some of these claims may have been denied in error due to a computer glitch which would delete the previously received proof of creditable coverage after the first claim a member would send in. If the review of the claims reveals such a finding, please provide our Department with a list of the readjusted claims and amount of payment restituted to members along with a solution for correcting the claims processing.

- Provide our Department with your company's proposal and implementation time line to be in full compliance with the California Insurance Code

Section 10198.7. In particular, we are interested in the pre-existing condition provision change to 6 months rather that 12 months for individual policies that cover 3 or more persons. This may mean that policy language would change as well as training would be provided to agents, marketing and claims personnel.

- The Department received several allegations from Sleep Quest (one of your contracted providers). Some of the allegations are that after PacifiCare merged with United Healthcare it paid claims at a different rate not the contracted rate that the provider expected. Our Department requests that your company review this provider's files to ensure that payments, issued after the merger, have been paid at the "agreed to" or "contracted" rate. In addition, the Department requests that your company review its provider payments in general to see if after the merger payments were issued at erroneous rates rather than the contracted rates. If your company finds that such errors have been made, it is requested that we are given a list of provider claims that will be readjusted that would reflect the amounts of underpayment. Per our discussion, this particular area would be handled by another attorney, Mr. Brian Hagedorn (unsure of spelling). Please advise him of our Department's requests.

It is my understanding that the following people comprise the corrective action team. If this should change please provide me with an updated list.

Dani Collier -- Regulatory Project Manager
Katrina Pelto -- Director, Regulatory Appeals
Sharon Hulbert -- Legal, Associate General Counsel
Madeline Harlan -- Legal, Director of Risk Management
Ellen Vonderhaar -- Senior Program Director, Claims
Raynee Andrews -- Director, Claims
Lois Norket -- PPO Claims Manager
Tracy Jordan -- Sales Operation Manager
Ruth Watson -- Director, Service Operations

Also, to facilitate our investigation, as well as to address questions or comments you may have, we request that you and/or other representatives of your company come to the Department's Los Angeles office for a meeting. Please contact me at your earliest convenience to schedule a mutually agreeable date/time.

Sincerely,

Nicoleta Smith
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Phone: 213-346-6586
Fax: 213-897-5891
Email: smithn@insurance.ca.gov

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