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BEFORE THE INSURANCE COMMISSIONER

STATE OF CALIFORNIA

In the Matter of the Licenses and Licensing Rights of: Life Insurance Company of North America, Respondent.	File No.: UPA 2008-00004 OAH No. Pending ORDER TO SHOW CAUSE (Ins. Code Sections 790.03 and 790.05); STATEMENT OF CHARGES/ACCUSATION (Ins. Code Sections 790.03 and 790.05); 704(b) 704.7; NOTICE OF MONETARY PENALTY (Ins. Code Sections 790.03, 790.05 and 790.035). and ORDER TO SHOW CAUSE (Ins. Code Section 790.06) Date: On a date to be set. Time: 9:00 a.m. Place: Office of Administrative Hearings, Los Angeles, CA

ORDER TO SHOW CAUSE

WHEREAS, the Insurance Commissioner of the State of California (hereafter, "the Commissioner") has reason to believe that **Life Insurance Company of North America** (hereinafter "LINA") has engaged in or is engaging in this State in the unfair methods of competition or unfair or deceptive acts or practices, and other unlawful acts, as set forth in the STATEMENT OF SPECIFIC CHARGES/ACCUATION contained herein; and

WHEREAS, the Commissioner has reason to believe that a proceeding with respect to the alleged acts of Respondent would be in the public interest;

NOW, THEREFORE, and pursuant to the provisions of § 790.05 of the California Insurance Code (CIC), Respondent is ordered to appear at the time, date and location specified above, and show cause, if any cause there be, why the Commissioner should not issue an Order requiring Respondent to Cease and Desist from engaging in the methods, acts, and practices set forth in the STATEMENT OF SPECIFIC CHARGES/ACCUSATION contained in Paragraph E herein, and imposing the penalties set forth in § 790.035, 704(b) 704.7; of the CIC and as requested in the PRAYER AND NOTICE OF MONETARY PENALTY.

GENERAL STATEMENT

1. Pursuant to 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 practices and procedures in California of LINA.

2. The examination covered the claims handling practices of LINA during the period February 1, 2005 through June 20, 2006. The examination was made to discover, in general, if these and other operating procedures of LINA conform with the contractual obligations in the policy forms, to provisions of the California Insurance Code (CIC), the California Code of Regulations (CCR) and case law.

To accomplish the foregoing, the examination included:

1. A review of the guidelines, procedures, training plans and forms adopted by LINA for use in California including any documentation maintained by LINA in support of positions or interpretations of fair claims settlement practices.

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

3. A review of consumer complaints received by the California Department of Insurance in the most recent year prior to the start of the examination.

4. The examination was conducted at the offices of LINA in Glendale, California.

At the conclusion of the examination a Report of Examination was provided to LINA and LINA provided its responses to the Report. Further, attached to the Report was the Table of Specific Findings which outlines the names and other identifying information concerning the insureds whose files were reviewed. Those names are not referenced in the Order to Show Cause so as to protect the privacy interests of the insureds. However, as above, Respondent LINA is in possession of this information and has full notice of same.

CLAIM SAMPLE REVIEWED AND OVERVIEW OF FINDINGS

3. The examiners reviewed files drawn from the category of Closed Claims for the period February 1, 2005, through January 31, 2006, commonly referred to as the "review period". There were a total of 1655 Closed Claims for this period. In addition group long-term disability files closed in litigation between November 1, 2004 and June 20, 2006 were reviewed. There were 139 files closed in litigation for this period. The examiners reviewed targeted samples of claims closed and denied during these window periods. The examiners reviewed 224 claim files as follows: 159 for the February 1, 2005 through January 31, 2006 review period; and 20 of the files closed in litigation between November 1, 2004 and June 20, 2006. The examiners cited 57 claims handling violations of the Fair Claims Settlement Practices Regulations and/or California Insurance Code Section 790.03 within the scope of this report, as follows: 39 citations for the February 1, 2005 through January 31, 2006 review period; and 18 for the files closed in litigation between November 1, 2004 and June 20, 2006. In this regard, the ratio of violations (57) to reviewed files (224) is approximately 25%. If this ratio is extrapolated

to the 1794 files in the review periods, it would reflect 448 violations in this regard.

4. In addition, to the Fair Claims Settlement Practices Act violations, the examiners identified five violations instances where the Respondent failed to pay interest on a benefit payment that was not paid within 30 calendar days from receipt of information needed to determine liability. These instances reflect claims in which proof of claim was received and lump sum payments were made after the Respondent's investigation was completed. The Respondent failed to include interest in these lump sum payments issued later than 30 days after receipt of proof from the claimant. The Department alleges these acts are in violation of CICR §10111.2(c).

5. The acts were knowingly committed and or the pattern and frequency of the violations indicate a general business practice.

STATEMENT OF SPECIFIC CHARGES/ACCUSATION

1. In 27 instances, LINA failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies. The Department alleges these acts are in violation of CIC §790.03(h) (3) as follows:

6. In 6 instances, LINA applied a 21-day or 45-day deadline for submission of proof of claim after receiving notice of claim on Group Long Term Disability policies. LINA indicated to the claimant that, if all the information necessary to make a benefit determination was not received in 45 days from the date of notice, LINA would review the information, (or lack of information) in the file and make an initial claim decision. LINA routinely required documentation, as a standard for entitlement of benefits, to include loss of work-related functions documented in medical records, office notes, and reports of comprehensive medical assessments. When the claimant could not produce these documents within 45 days, the claim was denied and entered the appeal process. Three of the claimants indicated there were reports relating to comprehensive medical assessments that the claimant had not been able to acquire yet. The other three claimants indicated outstanding medical records would support their claims. The claims were denied for lack of information, prior to the LINA obtaining any of the above. An allegedly disabled claimant was required to collect all medical records during the

appeal process if the additional records were to be included in the review. There was no policy language or statute to support these deadlines. The Department does acknowledge that Title 29, Chapter XXV Section 2560.503-1 of the United States Labor Code requires an adverse benefit determination to be made within 45 days after proof of claim is received. Section 2560.503-1 specifically allows for additional time and tolls the statute when "information necessary to decide a claim" is to be submitted by the claimant and is unavailable to the administrator. It was unreasonable to deny these claims when LINA was aware that the kind of information it required for potential entitlement of benefits (medical records and medical assessment reports) existed but was not obtained by LINA and reviewed prior to making the denial decision. The 45-day deadline was not supported by policy language, statute or precedent. The Department alleges these acts are in violation of CIC §790.03(h) (3). In its response to the examination, LINA has admitted these violations.

7. In 3 instances, LINA failed to request medical records prior to making a claim determination. These included instances in which LINA failed to work with the treating physicians in obtaining medical records or failed to request any medical records. LINA limited its request by sending two facsimiles to the medical provider. If the medical provider indicated this was not the way he/she operated, the adjuster requested the medical records directly from the claimant. LINA also failed to send a copy service to collect medical records necessary to decide a claim or otherwise work within parameters acceptable to the attending physician. The Department alleges these acts are in violation of CIC §790.03(h) (3). In its response to the examination, LINA has admitted these violations

8. In 5 instances, the claimants had provided significant documentation relating to potentially disabling conditions, but had not paid for or provided their own functional testing. The files reflect the attending physician treated the claimants but did not perform functional testing. LINA failed to perform any functional testing or peer review of medical records on the file while at the same time LINA was utilizing functional test results as the guidepost for medical information necessary to the entitlement of benefits. In addition, LINA asked an attending physician if the attending physician could contact the health insurance carrier of a claimant to arrange and pay for a functional capacity examination. It is unreasonable for LINA

to require the claimants to perform their own functional testing to receive benefits. The Department alleges these acts are in violation of CIC §790.03(h) (3). In its response to the examination, LINA has admitted these violations.

9. In 5 instances, LINA failed to consult with a health care professional who had appropriate training and experience in the field of medicine involved in the medical judgment. These files reflected Physical Therapists performing functional test or medical records reviews of patients with HIV and other conditions such as AIDS, diabetes, cardiovascular disease, lypodystrophy, recent heart surgeries and fecal incontinence. In addition, medical records were reviewed by a LINA Physical Therapist for claimants with chemotherapy related fatigue and multiple sclerosis. The disabling condition indicated by the attending physician was not addressed. The claim files did not address if the claimant could perform an occupation with reasonable continuity. The Department alleges these acts are in violation of CIC §790.03(h)(3). In its response to the examination, LINA has admitted these violations.

10. In 2 instances, LINA utilized the attending physician statement to support its "not disabled" analysis while not clarifying with the attending physician why he/she was indicating continuing disability. LINA failed to have medical personnel review test results reflecting the existence of a potentially disabling condition that came in after the denial. The Department alleges the above acts are in violation of CIC §790.0(h) (3). In its response to the examination, LINA has admitted these violations.

11. In 2 instances, claims were denied during the "any occupation" period in which LINA failed to perform a transferable skills analysis and labor market survey to identify alternate occupations appropriate to the claimants based on their restrictions, limitations, education, training, and station in life. LINA assumed alternate occupations existed based on Dictionary of Occupational Titles classifications such as "sedentary" but failed to identify the alternate occupations. The Department alleges these acts are in violation of CIC §790.03(h) (3). In its response to the examination, LINA has admitted these violations.

12. In 2 instances, the adjuster ignored substantial information that came into the file after the initial denial. This included information received over a period of eleven months including signed authorization; hospital records indicating trauma and coma; completed attending physician statements; and names, addresses and phone numbers of treating specialists.

The Department alleges these acts are in violation of CIC §790.03(h) (3). In its response to the examination, LINA has admitted these violations.

13. In 1 instance, LINA failed to investigate the course and nature of the disabling condition as it related to the first date missed from work and the end of the waiting period. The Department alleges this act is in violation of CIC §790.03(h) (3). In its response to the examination, LINA has admitted this violation.

2. In 17 instances LINA failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. The Department alleges these are violations of CIC 790.03 (h) (5) as follows:

14. In 2 instances, LINA denied claims during the "any occupation" period but failed to perform transferable skills analysis or Labor Market Survey to identify alternate occupations that the claimants could reasonably perform given their restrictions, limitations, education, training and station in life. In its response to the examination, LINA has admitted these violations.

15. In 1 instance, LINA assumed that alternate employers could make an accommodation for the claimant but never provided supporting documentation for this. The Department alleges this act is in violation of CIC §790.03(h) (5). In its response to the examination, LINA has admitted this violation.

16. In 2 instances, LINA applied a 60% threshold to the relation of the wages of alternate occupations to the claimant's pre-disability earnings. The 60% was not supported contractually or by California precedent. The file did not reflect a "station in life" rationale or consideration. The Department alleges these acts are in violation of CIC §790.03(h) (5). In its response to the examination, LINA has admitted these violations.

17. In 2 instances, LINA applied a "national economy" definition during the own occupation on claims in which the claimants could not perform their own occupations. LINA identified alternate occupations in the national economy the claimant allegedly could perform while the file reflected the claimant could not perform the occupation they were performing prior to becoming disabled. The files reflect that the claimants were unable to perform with reasonable continuity the substantial and material acts necessary to pursue their usual occupations in the usual and customary way. The Department alleges these acts are in violation

of CIC §790.03(h) (5). In its response to the examination, LINA has admitted these violations.

18. In 3 instances, LINA failed to consider the course and nature of an illness prior to denial of benefits. LINA identified objective tests results indicating disability once the claimant was properly tested by the proper medical professional. However, as this objective testing did not take place within the waiting period, the claim was denied as the claimant was no longer covered under the policy when disability was documented by subjective test results. LINA failed to ask reasonable and specific questions of the attending physicians and LINA health care professionals as to the course and nature of illnesses such as HIV/AIDS and degenerative disc disease. Claimants receiving conservative treatment initially and going to a specialist only after the end of the waiting period were not given consideration of the nature and course of their disabling condition prior to the denial of the claim. The Department alleges these acts are in violation of CIC §790.03(h) (5). In its response to the examination, LINA has admitted these violations.

19. In one instance each, LINA adjuster:

a. Ignored the medical assessment by LINA's own medical health professional that the claimant was disabled and denied additional benefits. The Department alleges this act is in violation of CIC §790.03(h) (5). In its response to the examination, LINA has admitted this violation.

b. Removed several disabling health conditions (HIV, heart disease, wasting disease) from the claimant's medical history on file prior to requesting an internal health care professional to review and sign-off as to whether the claimant was disabled. None of the claimed disabling conditions were addressed in the assessment summary of LINA nurse consultant. The Department alleges this act is in violation of CIC §790.03(h) (5). In its response to the examination, LINA has admitted this violation.

c. Ignored correspondence received after the initial denial that reasonably required a response. The Department alleges this act is in violation of CIC §790.03(h) (5). In its response to the examination, LINA has admitted this violation.

d. Failed to clarify the claimant's restrictions and limitations with the attending physician who was indicating the claimant was disabled. The Department alleges this act is in violation of CIC §790.03(h) (5). In its response to the examination, LINA has admitted this

violation.

e. Failed to provide complete information in the file to the health care expert performing a peer review of the medical records. In its response to the examination, LINA has admitted this violation.

f. Misapplied the Mental and Nervous two-year policy coverage limitation when the file reflected a physiological condition contributed to the disabling condition. The Department alleges this act is in violation of CIC §790.03(h) (5). In its response to the examination, LINA has admitted this violation.

g. Failed to investigate how the claimant could perform his/her own occupation given the restrictions applied. The file failed to contain supporting documentation that the claimant could reasonably and safely perform the occupation given his/her medical condition and history of passing out unexpectedly. The Department alleges this act is in violation of CIC §790.03(h) (5). In its response to the examination, LINA has admitted this violation.

3. In 6 instances LINA failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue. The Department alleges these acts are violations of CIC §790.03(h) (1) as follows:

20. In 3 of these instances the claims involved government entities. The claimant was sent a denial letter indicating the claim was covered by ERISA (Employee Retirement Income Security Act of 1974). The adjuster did not contact the government entity to determine if they were an exception to the rule regarding government entities not being subject to ERISA. The Department alleges these acts are in violation of CIC §790.03(h) (1). In its response to the examination, LINA has admitted these violations.

21. In 1 instance, LINA misrepresented to the claimant the Mental and Nervous policy limitation as it is to be applied in California. The correspondence indicated the claimant would have to demonstrate that they remained disabled solely due to a physiological condition to remain on benefit. The adjuster failed to indicate that disabling conditions caused by, contributed to or concurrent with a psychological condition would not be applicable to the two-year policy limitation. The Department alleges this act is in violation of CIC §790.03(h) (1). In its response to the examination, LINA has admitted this violation.

22. In 1 instance, the Life Waiver of Premium was discontinued as the claimant was not "totally disabled". LINA applied a guidepost of any income level on a part-time basis would equate to a claimant not being totally disabled. We could find no support for this in California precedent. The Department alleges this act is in violation of CIC §790.03(h) (1). In its response to the examination, LINA has admitted this violation.

23. In 1 instance, LINA sent correspondence to the claimant indicating the policy "requires" them to apply for Social Security Income Disability Insurance. The policy contained no such requirement. The Department alleges this act is in violation of CIC §790.03(h) (1). In its response to the examination, LINA has admitted this violation.

4. In 4 instances, LINA compelled insureds to institute litigation to recover amounts under an insurance policy offering substantially less than the amounts ultimately recovered in actions brought by the insureds, when the insureds have made claims for amounts reasonably similar to amounts ultimately recovered, The Department alleges these acts are in violation of CIC §790.03(h) (6) as follows:

24. All of these files reflected that LINA had failed to perform a proper investigation of the claim or had misapplied policy provisions. These errors were recognized only after the claimant had instituted litigation as referenced below:

25 In 1 instance, LINA misapplied the two year Mental and Nervous Limitation to include disabilities contributed to by a physiological component. In its response to the examination, LINA has admitted to this violation.

26. In 1 instance, LINA failed to address the course and nature of the disabling condition in relation to the date of disability and waiting period. In its response to the examination, LINA has admitted to this violation.

27. In 1 instance, LINA applied a 60% threshold of earnings from the alternate occupation in relation to the pre-disability earnings. The file contained no reference to the claimant's "station in life." In its response to the examination, LINA has admitted to this violation.

28. In 1 instance, LINA failed to investigate how the claimant could perform the

alternate occupation with limited use of her hands. In its response to the examination, LINA has admitted to this violation.

5. In 2 instances, LINA attempted to settle a claim by making a settlement offer that was unreasonably low as follows:

29. In 1 instance, LINA failed to include an additional 10% to the monthly benefit as the policy allowed an additional 10% when income from other income was offset. In its response to the examination, LINA has admitted to this violation.

30. In 1 instance the file reflected a period of disability during which a two year Mental and Nervous limitation was applied to a period of disability contributed to by a physiological condition. The amount recovered for consumers on these two claims was $137, 289.30. The Department alleges these acts are in violation of CCR §2695.7(g). In its response to the examination, LINA has admitted to this violation.

6. In one instance, LINA 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 as follows:

31. The Department identified one instance, only in which LINA failed to include the California Department of Insurance language on a denial letter. The Department alleges this act is in violation of CCR §2695.7(b) (3). In its response to the examination, LINA has admitted to this violation.

NON FAIR CLAIMS SETTLMENT PRACTICE FINDINGS

32. As a result of the examination, the Commissioner, in his official capacity, now alleges that Respondent has violated, in addition to the provisions of the Fair Claims Settlement Practices Regulations above, the following and that these violations constitute acts or practices that are unfair or deceptive: the examiners identified five violations instances where the Respondent failed to pay interest on a benefit payment that was not paid within 30 calendar days from receipt of information needed to determine liability. These instances reflect claims in which proof of claim was received and lump sum payments were made after the Respondent's investigation was completed. The Respondent failed to include interest in these lump sum payments issued later than 30 days after receipt of proof from the claimant. The Department alleges these acts are in violation of CICR §10111.2(c).

PRAYER AND NOTICE OF MONETARY PENALTY

WHEREFORE, Petitioner prays for judgment against Respondent LINA as follows:

1. An Order to Cease and Desist from engaging in such unfair acts or practices in violation of CIC 790.03;

2. Pursuant to CIC Section 790.035, for unfair or deceptive acts in violation of Section 790.03 as set forth above in an amount to be fixed by the Commissioner not to exceed ten thousand dollars ($10,000.00) for each unfair or deceptive act or practice found to be willful; and a penalty in an amount to be fixed by the Commissioner not to exceed five thousand dollars ($5,000.00) for each unfair or deceptive act or practice found not to be willful.

3. Pursuant to CIC 704(b) and 704.7 suspension of Respondent's certificate of authority for not exceeding one year or a fine of fifty -five thousand dollars ($55,000) in lieu of suspension for not carrying out contracts in good faith.

4. Pursuant to CIC Section 790.06, that a declaration be made that the acts identified in paragraph 35 are unfair or deceptive pursuant to Article 6.5 of the California Insurance Code.

Dated: 11-12-2008

STEVE POIZNER
INSURANCE COMMISSIONER

-s-
BY_____
MICHAEL TANCREDI
SENIOR STAFF COUNSEL