CALIFORNIA DEPARTMENT OF INSURANCE
LEGAL DIVISION
Health Enforcement Bureau
Andrea G. Rosen , State Bar No. 116600
300 Capitol Mall, 17th Floor
Sacramento, CA 95814
(916) 492-3508 Phone
(916) 324-1883 Facsimile

Attorneys for The California Department of Insurance

BEFORE THE INSURANCE COMMISSIONER

OF THE STATE OF CALIFORNIA

In the Matter of **PACIFICARE LIFE AND HEALTH INSURANCE COMPANY** Respondent.	File No. UPA 2007-00004 **ORDER TO SHOW CAUSE; STATEMENT OF CHARGES / ACCUSATION; NOTICE OF MONETARY PENALTY** (California Insurance Code §§ 790.05, 700(c), 704, 790.035)

ORDER TO SHOW CAUSE

WHEREAS, the Insurance Commissioner of the State of California (hereafter, "The Commissioner") has reason to believe that Respondent PACIFICARE LIFE AND HEALTH INSURANCE COMPANY hereinafter referred to as "Respondent" has engaged in or is engaging in this State in the unfair methods of competition or unfair or deceptive acts or practices set forth herein, in violation of California Insurance Code Section 790 *et seq.*, and the Fair Claims Settlement Practices Regulations of Title 10, Chapter 5, California Code of Regulations, and has engaged in or is engaging in other unlawful acts alleged herein, each in violation of the cited provisions of the California Insurance Code, as set forth in the STATEMENT OF CHARGES/ACCUSATION 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 Section 790.05 of the California Insurance Code, Respondent is ordered to appear before the Commissioner on a date to be set at the Office of Administrative Hearings in Sacramento, CA 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 SPECIFIC FACTUAL ALLEGATIONS contained in Paragraph 1 and following, and imposing the penalties set forth in Section 790.035 of the Insurance Code and other Insurance Code Sections as requested herein. Further, Respondent is hereby ordered to show why the Commissioner should not exercise his authority pursuant to Section 704 of the California Insurance Code to suspend Respondent's Certificate of Authority for a time not exceeding one year upon finding that Respondent has engaged in and is engaged in not carrying out its contracts in good faith, in violation of Insurance Code Section 704(b).

GENERAL STATEMENT

From March 23, 1987 to the present, Respondent has been the holder of a Certificate of Authority (Certificate Number 3086-6) issued by the Commissioner to transact the classes of Life and Disability insurance in the State of California.

Following the acquisition of PacifiCare by the UnitedHealth Group Incorporated (hereafter "UHG") on or about January 1, 2006, the California Department of Insurance through its Consumer Services Division, specifically, the Claims Service Bureau (hereafter "CSB") has received an unusually high number of claims and related complaints from consumers and health care providers with respect to health insurance coverage underwritten by Respondent.

On December 19, 2005, the Insurance Commissioner entered into an agreement in connection with the acquisition set forth above, commonly referred to as "Undertakings to the California Department of Insurance" executed by Sue Berkel, President of PacifiCare Life and Health Insurance Company and David J. Lubben, General Counsel and Secretary of UnitedHealth Group Incorporated (hereafter "UHG"). These Undertakings were made in response to the filing

of a Form A Statement Regarding the Acquisition of Control of a Commercially Domiciled Insurer (the "Form A") by UHG with respect to Respondent. The Commissioner's purpose in accepting these Undertakings offered by PacifiCare and UHG was to protect consumers from a deterioration in Respondent's operations. The Commissioner expected Respondent to maintain a viable and competitive health insurance enterprise within the legal framework outlined in the California Insurance Code, and more particularly to pay claims correctly and timely and continue to pursue fair and reasonable contracts with participating network providers. The findings of both the Commissioner's Consumer Services Division and Market Conduct Branch with respect to Respondent's conduct will show that both the intent of the acquisition-related undertakings to the California Department of Insurance have been violated many times over.

In the annual Accident and Health Data Call report pursuant to Insurance Code Section 10508.6 *et seq*. Respondent reported insuring 144,440 covered persons under its group and individual hospital, medical and surgical reimbursement insurance policies for the calendar year 2005 and 165,275 insureds under group and individual policies in force during the calendar year 2006.

Under the authority granted pursuant to 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, the Commissioner made an examination of the Respondent's claims practices and procedures in California. The examination covered Respondent's claims and related document handling, provider dispute resolution mechanism, PPO network operations including provider contract loading, provider fee schedule management, provider contract terminations, member and provider appeals and related practices during the period June 23, 2006 through May 31, 2007. ("The 2007 examination"). This targeted examination was initiated in response to a surge of consumer and provider complaints received by the Department's Consumer Services Division starting in mid-2006. Investigation of consumer and provider complaints by the Consumer Services Division revealed a host of deeper and more fundamental problems with Respondent's operations.

The 2007 examination was made to discover, in general, if these and Respondent's other

operating procedures with respect to how they pay claims, resolve consumer complaints, resolve provider complaints and administer their health insurance policies are in conformance with the contractual obligations in the insurance policy forms, the provisions of the California Insurance Code ("CIC"), the California Code of Regulations ("CCR"), other insurance related statutes, and case law. The 2007 examination included:

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

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

c) A review of consumer complaints received by the California Department of Insurance in the most recent year prior to the 2007 Examination and a review of prior CDI market conduct examination reports on the Respondent.

d) A review of provider disputes filed with the Respondent and the Respondent's ability to resolve them within the statutory timeframe.

e) A review of notices used to deny claims such as Explanation of Benefits and Explanation of Payments to determine if the proper statutory notices regarding review by the Department were included.

f) A review of timely acknowledgement of claims, timeliness of payment of claims, and proper payment of interest pursuant to the California Insurance Code.

Since the discovery of Respondent's operational problems, the Department has diligently worked with Respondent to urge them to bring their claims processing operations into compliance. In spite of this effort, Respondent's inability to operate its business within acceptable industry norms continues unabated to this day as evidenced by continuing complaints filed with the Department about Respondent's claims processing practices. The fact that Respondent continues to be unable to meet the most basic statutory and regulatory requirements for processing claims is evidence of a continuing, egregious pattern of unfair practice in the business of insurance.

STATEMENT OF SPECIFIC CHARGES BASED ON THE MARKET CONDUCT EXAM COVERING THE TIME PERIOD JUNE 23, 2006 THROUGH MAY 31, 2007.

As a result of the examination,[1] the Commissioner, in his official capacity, now alleges that Respondent has violated provisions of the Fair Claims Settlement Practices Regulations (CCR, Title 10, Chapter 5, Section 2695.1 et seq.) and other Sections of the CCR and the CIC[2], as follows:

Failure to Acknowledge Claims On Time; Failure to Pay Interest on Uncontested Claims When Due; Failure to Timely Notify Claimants of Contested or Denied Claims or Denied Appeals

1. The Department conducted an electronic analysis of 1,125,707 *paid* claims provided by Respondent during the period from June 23, 2006 through May 31, 2007 using a computer program which was designed to review claims for three metrics: timeliness of acknowledgement of receipt of a claim, timeliness of payment of claims and proper payment of interest. This electronic analysis demonstrated that Respondent failed to identify and acknowledge receipt of paid medical claims within 15 working days for 81,286 paid claims resulting in 81,286 separate violations of CIC §10133.66(c). Respondent's failure to meet this basic statutory requirement is significant in that it prevents providers who submitted claims for services they provided to their insured patients from knowing whether or not Respondent has received their claims. An insurer's failure to acknowledge receipt of a claim wreaks even greater havoc for insureds who have already paid their providers out of pocket and are waiting for reimbursement. This function is one of the most fundamental components of a claims processing operation. Based on findings made during of the examination, the Department alleges that Respondent was unable to timely acknowledge a claim for at least six months during 2006. In addition to the electronic analysis of paid claims, the Department reviewed a sample of *denied* claims (114 group and individual claim files) and documented an additional six violations of Section §10133.66 (c) which requires Respondent to identify and acknowledge a claim and its

[1] Attached as Exhibit 1 is the Report (Pursuant to Insurance Code Section 735.5) of the Market Conduct Examination of the Claims Practices of the Pacificare Life and Health Insurance Company NAIC #70785 CDI #3086-6 as of May 31, 2007.

[2] All references are to the Insurance Code unless otherwise noted.

recorded date of receipt within 15 working days of the date of receipt, whether or not the claim submitted is complete.

2. In the Department's electronic analysis of paid claims referred to above, Respondent failed to reimburse a claim or a portion of a claim which is not contested within 30 working days after receipt of the claim, resulting in 42,137 separate violations of Section 10123.13(a). The Department's sample file review of 114 denied claims documented 139 additional violations of Section 10123.13(a) including failure to reimburse a health care claim no later than 30 working days after receipt, failing to refer to specific policy provisions in the denial, failing 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 ask for review by the Department, and failing to include all the required information on the Explanation of Benefit (EOB) or denial as required by this statute. The Department's sample file review also identified 5 claims for emergency services where the Respondent failed to provide the statutorily required notice in Section 10123.147(a) resulting in 5 violations of this Section.

3. Respondent has violated Sections 10123.13(a) and 10123.147(a) by intentionally omitting the required language designed to notify claimants who file appeals of their right to have the matter reviewed by the Department.

4. In the electronic analysis of paid claims referred to above, Respondent failed to pay interest on uncontested, unpaid claims after 30 working days had elapsed, resulting in 5,432 violations of Section 10123.13(b). The Department's sample file review of denied claims identified an additional 17 violations of Section 10123.13(b).

5. Respondent inappropriately denied 2 claims based on incorrect application of the pre-existing exclusionary period in the insured's policy, which resulted in late payment after the Department discovered the unpaid claims during its sample file review of denied claims. These incorrect denials and consequent late payments resulted in 2 violations of Section 10123.13(c).

6. In 16 separate instances, Respondent violated Section 790.03(h) (3) by

failing to follow its own guidelines for processing member appeals and provider disputes.[3] Specific violations included 10 violations associated with Respondent's failure to process emergency room claims at a participating provider benefit level when the member had no choice regarding provider, failure to process hospital charges for mother and newborn as a single claim as required by their own provider contract and failure to process ancillary providers as "participating" in conjunction with an emergency room bill. In 6 of the 16 instances cited above, Respondent first denied claims based on a presumption of a pre-existing condition without properly investigating the reason for denial and also failed to instruct members that a separate Certificate of Creditable Coverage was needed for minor dependents in order to apply the pre-existing condition clause.

7. In 15 separate instances, in violation of Section 790.03(h)(5), Respondent failed to effectuate prompt, fair and equitable settlement of claims in which liability had become reasonably clear.[3] In these instances, claims were paid using the wrong fee schedule or claims were denied without adequate documentation in the claim file to support denial based on lack of coverage - the alleged reason for denial. In an additional 15 claim files, examiners were unable to find pertinent documents supporting the claims adjudication decision in sufficient detail to allow a second reviewer to reach the same determination resulting in 15 violations of CCR Section 2695.3(a).

8. In 14 instances, examiners found that Respondent failed to maintain hard copy claim files or maintain claim files that are accessible, legible and capable of duplication to hard copy for five years in violation of CCR Section 2695.3(b)(3). This is an essential regulation since the Commissioner is charged with examining the conduct of insurers in order to protect consumers and make sure their claims are correctly processed. If a company fails to maintain hard copy documents sufficient to demonstrate that the claim was correctly processed, examination by the Commissioner's staff is rendered meaningless.

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[3] Exhibit 2 Public Report (pursuant to Insurance Code Section 12938) of the Market Conduct Examination of the Claims Practices of the PacifiCare Life and Health Insurance Company NAIC #70785 CDI #3086-6 as of May 31, 2007.

9. Even when Respondent acknowledged member appeals in 15 calendar days as required by CCR Section 2695.5 (b), it failed to address the issues presented by the members with facts known at the time. Based on the review of sample files only, the Department found this violation in 11 instances.

10. In 8 instances during the sample file review, Respondent failed to provide the claimant with an explanation of benefits (EOB) which included the name of the provider or services covered and a clear computation of benefits in violation of CCR Section 2695.11(b).

11. In 4 instances, Respondent failed to record the date relevant documents were received by Respondent, processed by Respondent and otherwise transmitted by Respondent in violation of the requirements of CCR Section 2695.3(b)(2).

12. During the exam, in 3 instances Respondent failed to respond to a Department inquiry within 21 calendar days as required by CCR Section 2695.5(a).

Failure to Respond Timely to Provider Disputes; Failure to Properly Manage Provider Contract Data; Failure to Remediate Claims Payments Errors resulting from Provider Contract Loading Problems

13. During its examination, the Department attempted to follow up on significant complaints received from health care providers across California about the detrimental impact of Respondent's failure to load provider contract rates and related provider information into its claims system timely and properly. These complaints, submitted by the California Medical Association on behalf of California doctors, and the University of California Health System on behalf of its many hospitals and thousands of doctors, informed the Department that Respondent's inability to maintain provider contract information including failing to load correct fee schedules, failing to remove providers from their system who had terminated their contracts with Respondent, failing to correctly identify providers on network rosters and poorly managing this information in a timely fashion was causing severe errors in Respondent's downstream claims processing. Both organizations provided credible information to the Commissioner in support of their grievances. Respondent's systemic and widespread system failures in handling of provider contract data also resulted in their failure to display a correct listing of PPO Network providers as required by Section 10133.1. This failure, in turn, caused providers to be unable to

notify their patients with certainty whether or not they were participating in Respondent's network. This lack of certainty by patients in knowing whether or not their doctor was participating created undue concern about coverage levels since "in-network" benefits are substantially better in PPO insurance policies than "non-network" benefits.

14. During the exam, the Department requested detailed information about provider contracts loaded into Respondent's provider "Network Data Base (hereafter NDB)" which is sited in Minnesota following Respondent's acquisition by parent UHG. Respondent declined to use the Department's spreadsheet to supply the requested detailed information regarding the management of their provider contract information. The provider data supplied by Respondent in response to the Department's requested data elements was incomplete and did not allow the Department to ascertain the necessary details about how Respondent actually managed the provider contracting process. For example, in over half of the 10,566 providers contracted in Respondent's network, Respondent could not supply the date they received the provider's signed contract. 1,681 provider files had no date indicating when or whether the provider was notified of their contract status. Since Respondent failed to maintain sufficient documentation, notes, computer records and other work papers pertaining to the many provider contract files that were the subject of complaints received by the Commissioner from organizations described above, the Department was unable to fully ascertain the exact nature and scope of the impact of the problems with loading, maintaining and utilizing provider contract data for claims processing and displaying PPO provider networks online and in print as required by Section 10133.1. The Department alleges that these multiple failures in management of provider data violate Sections 790.03 (h)(3), 790.03(h)(4) and 790.03 (h)(5). It is a rather straightforward conclusion that if Respondent cannot properly manage its provider fee schedules and other essential provider information that is the bedrock of claims processing, Respondent is unable to implement reasonable standards for processing claims and unable to affirm or deny coverage if their provider information is incorrect. Further, these violations taken as a whole result in Respondent not effectuating in good faith equitable settlement of claims. Upon examination, the Department discovered that Respondent failed to track:

a. the date provider contracts were received by Respondent;

b. whether or not those provider contracts were complete or not and if they were incomplete when they were returned or completed;

c. when the provider contracts were processed and loaded into Respondent's NDB which links to Respondent's legacy claims processing system;

d. when the provider's contract was linked to a fee schedule;

e. if the linked fee schedule was the correct fee schedule; and,

f. if the fee schedule had been audited for use in both of Respondent's claims systems used to pay Pacificare claims.

15. When asked, Respondent failed to provide sufficient evidence supporting a credible provider contract loading tracking process. Instead Respondent offered general statements of policies and procedures regarding their intended process of loading provider contract information and loading, checking and linking providers to Respondent's fee schedules and updating of provider information in the NDB. Respondent has acknowledged that many fee schedules that were re-constructed for use in the parent United's claims processing system were deficient and that many claims were improperly processed as a result of this major error combined with other errors. In spite of these acknowledgements and many demands by the Department during its consumer complaint investigations, Respondent continues to persist in incorrect claims processing as a result of their continuing failure to mesh a new claims system operated by Respondent's parent with the legacy system operated by Respondent. In the absence of any reasonable confirmation of the Respondent's ability to properly load and manage provider contract data, the Department alleges an ongoing and systemic violation of Sections 790.03 (h)(3), (4) and (5) by failing to process claims that require timely and correct provider contract information as a prerequisite. These unfair practices as alleged above constitute an unfair practice in the business of insurance as defined in Section 790.02 and continue to seriously damage California consumers and their health care providers.

16. Respondent's failure to maintain all notes, documents, computer data and

work papers for its provider contract files resulted in at least 45 violations of Section 734. Further, Respondent's failure to re-adjudicate claims that were improperly processed as a result of its failure to correctly manage provider data resulted in an ongoing violation of Section 790.03 (h)(5) by not attempting to effectuate prompt, fair and equitable settlement of claims and is an unfair practice in the business of insurance as defined in Section 790.02. The pattern and frequency of these violations indicate a general business practice and intentional and flagrant disregard of industry standards with respect to PPO Network operations and management of provider contracts and provider and consumer complaint handling.

17. In two instances, Respondent attempted to settle a claim by making a settlement offer that was unreasonably low in violation of CCR Section 2695.7(g).

Failure to Advise Insureds and their Health Care Providers of the Right to an Independent Medical Review of an Insurer's Claim, Treatment or Coverage Denial

18. Effective January 2001, the California Legislature enacted a comprehensive approach to insuring a consumer's right to request and seek an independent medical review when their insurer denied coverage for care that an insured or their medical provider believes is a covered and medically necessary benefit. Proper notice of this right to the insured and their health care provider is an imperative component of this comprehensive system of Independent Medical Review as outlined in Section 10169(i) *et seq*. This important right includes an expedited review in the event of an imminent threat to life and health found in Section 10169.1 *et seq*. Failure to timely provide a proper, correct and effective notice to the consumer defeats the purpose and value of the entire legislative system and potentially deprives insureds of medically necessary covered benefits. In the Department's sample file review, Respondent failed to provide information concerning the right to request an Independent Medical Review in 27 instances in direct violation of Section 10169(i) including to insureds whose appeals regarding coverage were denied by Respondent.

Failure to Operate a Fast, Fair and Cost-Effective Provider Dispute Resolution Mechanism

19. Respondent reported 16,653 provider disputes received during the 11 month review period-a very high rate of more than 1500/disputes per month. Many provider

disputes involve multiple claims. The Department alleges that the large number of provider disputes relative to the book of insurance business Respondent writes in California is evidence of its failure to carry out its contacts in good faith as required by Section 704(b). It is reasonable to assume that the large number of provider disputes filed with Respondent demonstrates that it cannot manage its provider contracts and negotiations to keep provider disputes at a reasonable level. Further, in 1,510 provider disputes during the review period, Respondent failed to issue written determinations within 45 working days after the date of receipt; in violation of Section 10123.137(c).

Failure to Properly Manage the Pre-Existing Condition Policy Provisions in Insurance Contracts

20. Respondent's practices with respect to claims handling and interpretation and application of its insurance policy pre-existing condition clauses is wholly deficient. In the 2007 examination and in the last several months while investigating many consumer complaints, the Department discovered that Respondent:

a. Failed to adequately track Certificates of Creditable Coverage provided by insureds that serve as the basis for reducing the pre-existing exclusionary period;

b. Denied claims based on alleged pre-existing conditions when there was no obvious basis for doing so;

c. Lost requested medical records in ignored electronic folders when submitted at Respondent's request as part of the pre-existing condition adjudication;

d. Inadequately documented their basis for denying claims and consistently incorrectly assumed claims could be denied based on a pre-existing condition when they had no information to support a denial on that basis;

e. Failed to document upholds of a pre-existing determination as the basis for denying claims when insureds did not respond to requests for Certificates of Creditable Coverage or provide Respondent with

names of treating physicians;

f. Failed to document how pre-existing exclusionary periods were determined;

g. Failed to maintain documentation of an employee's date of hire which in turn determines the end dates of the pre-existing exclusionary period during which claims may be properly denied by Respondent if claims are related to the pre-existing condition;

h. Routinely made multiple and unwarranted requests for medical records and Certificates of Creditable Coverage when these documents had already been submitted, often multiple times by insureds, causing unnecessary delay and harm to insureds and their providers; and,

i. Engaged in unwarranted denials of claims based on a presumption that claims involved pre-existing conditions or that the pre-existing condition exclusionary period was valid.

During the 2007 examination and starting in mid-2006 Department staff have continuously investigated, discovered and documented Respondent's complete and utter inability to manage its insurance policy provisions regarding pre-existing conditions. This willful, repeated and commonplace conduct by Respondent has resulted in multiple violations of Sections 790.03 (h)(3),(4),(5) which constitute an unfair and deceptive practice in the business of insurance as defined in Section 790.02.

STATEMENT OF SPECIFIC CHARGES BASED ON A SAMPLING OF INDIVIDUAL PROVIDER AND CONSUMER COMPLAINTS RECEIVED AND INVESTIGATED BY THE DEPARTMENT

As will be shown below with the recitation of specific consumer complaints in paragraphs 1 through 15 below that were investigated by the Department and resolved after often lengthy and protracted communications with Respondent, Respondent has violated multiple provisions of the CIC Section § 790.03(h) and other provisions of the Insurance Code, and CCR, Title 10, Chapter 5, Section 2695.1 et seq.. Respondent failed to disclose all benefits, coverage, time limits or other

provisions of the insurance policy in violation of CCR Section 2695.4(a). Respondent failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies, in violation of CIC Section 790.03(h)(3). Respondent's claim files often failed to contain all documents, notes and work papers that pertain to the claim in violation of CCR Section 2695.3(a). During the Department's investigation of individual's complaints, Respondent conceded that it simply lost claims that had been sent in for adjudication and payment. Respondent failed to effectuate prompt, fair and equitable settlement of claims in which liability had become reasonably clear, in violation of CIC Section 790.03(h)(5). In numerous cases, Respondent persisted in seeking information not reasonably required for or material to the resolution of a claim dispute in violation of CCR Section 2695.7(d). Repeatedly, Respondent continued to seek copies of documents, such as a consumer's certificate of creditable coverage, which had already been provided by the consumer to Respondent, often multiple times.

1. Patrick R – Improper Claims Processing; Failure to Properly Notify Claimant of Department Review Option; Flagrant Refusal to Reimburse Insured for Pre-authorized covered Services

Patrick R, insured, was diagnosed with severe kertakonis in both eyes and his doctor prescribed intacts surgery for both eyes. Respondent pre-authorized surgery for both eyes on 7/24/2006. Insured received the pre-authorized eye surgeries on 7/24/06 and 8/7/06 from participating network providers incurring both facility fees and surgeon fees for both dates of service (four separate claims). Respondent subsequently improperly denied claims for these covered services multiple times in spite of numerous calls and faxed letters and requests from the insured asking that his claims be reimbursed. Insured was forced to pay the surgery center and his network provider out of his own pocket and seek reimbursement from Respondent for covered, pre-authorized benefits under his insurance policy. After numerous frustrating attempts to seek reimbursement from Respondent, Patrick R. filed a complaint with the Department on 12/26/06. Claims for surgery center services on 7/24/2006 were received by Respondent on 7/31/2006 and for pre-authorized surgical services provided on 8/7/2006 on 8/7/2006. Respondent paid the surgeon directly on 9/07/2006 for the 7/24/2006 surgical services but continued to deny reimbursement to the insured for the surgery center cost. Respondent also paid

the eye surgeon's claim for the 8/7/06 surgery on 9/14/2006 and on that same day improperly denied insured's request for reimbursement of the surgery center fees issuing an Explanation of Benefits with denial remarks of "eye exams, glasses, contact lenses and routine eye refractions are not covered". Finally, after the Department intervened, on 12/27/06, *five* months after the initial reimbursement claim was filed by Patrick R, Respondent reimbursed the insured for the surgery center fees that insured had paid on 7/24/06. In a 1/24/2007 letter to the insured, Respondent acknowledged improperly denying the facility claim for date of service 8/7/06 and finally reimbursed the insured on 1/15/07. Even though the Respondent admitted improperly denying insured's claims and ended up reimbursing him five months after the insured requested reimbursement after the Department intervened, Respondent failed to pay the interest due per Section 10123.13(b). Respondent failed to track the correct dates of receipt of claims for pre-authorized services and repeatedly denied insured's claim for reimbursement for the surgery center fees even while paying the eye surgeon directly for the same dates of service. In Patrick R's case, Respondent violated CCR Sections 2695.3(a), 3695.5(a) and 2695. 7(b)(3) in addition to Insurance Code Section 790.03(h)(5) which states that a licensee is not in compliance if they do not attempt to effectuate a prompt, fair and equitable settlement of claims in which liability has become clear.

2. ALICE J – Deficient Explanation of Benefits; Failure to Notify Provider of Right to Seek Department Review

Alice J filed a complaint with the Department regarding undue delay in the processing of claims for dates of service 10/29/05-1/19/06 which Respondent eventually paid on 1/19/2007. Respondent issued an Explanation of Benefits (EOB) with payment to Alice J's provider on 1/19/2007 and sent her a copy. The EOB can function as a partial claims declination and numerous EOBs had been issued during the year in which Respondent denied Alice J's provider claims. In each and every EOB issued for Alice J's care and more importantly, on each and every EOB issued to a provider in response to any and all claims submitted by providers to Respondent for payment between June 1, 2006 and June 2007, Respondent violated CIC 10123.13 (a). After

months of intervention by the Department's compliance officers, Respondent finally agreed to add notification language required by this statute in June 2007.

CIC 10123.13(a), in relevant part, requires Respondent, when denying or contesting a claim, in whole or in part, to provide a notice to the claimant, including providers submitting on behalf of the insured, that ***" shall advise the provider who submitted the claim on behalf of the insured..... that either may seek review by the department of a claim that the insurer contested or denied, and the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Deparment that performs this review function. The notice to the provider may be included on the explanation of benefits or the remittance advice and shall also contain a statement advising the provider of its right to enter into the dispute resolution process described in Section 10123.137."*** This statute was effective June 1, 2006 with the enactment of (SB 367 Stats.2005 c. 723 §3). Respondent failed to comply with the required provider notice provisions of the Insurance Code for an entire year thus depriving all providers who submitted claims and received EOBs and the insureds who were treated by these providers of the formal notice required by the Insurance Code regarding their right to request a Department review of denied or delayed claims.

3. David D – Respondent lost claims submitted and paid the provider instead of the insured who had already paid the provider

On 11/7/06 David D requested assistance from the Department in receiving reimbursement from Respondent for payment for care received on five dates of service between 8/1/06 and 10/24/06. On 12/8/06 Respondent wrote to David D letting him know that it sent payment for all services in error to the provider even though David D. had already paid the provider for these same services and the provider never submitted claims for these services. Respondent finally reimbursed the insured for the final of five claims in late November 2006. The insured reported faxing claims to Respondent for reimbursement on 8/31/06, 9/12/06 and 10/24/06 and stated that he received no reply from Respondent, even when claims were resubmitted by registered and certified mail. Respondent violated §790.03(h)(5) failure to

effectuate prompt, fair and equitable settlement of claims in which liability has become reasonably clear 5 times in this one case.

4. Brandi S – Respondent failed to do business under its legal name; failed to include required notice of availability of Department's review

Brandi S filed a complaint with the Department on 2/7/07 alleging both delay and improper denial of claims for services filed with Respondent. The Department was satisfied that these claims were properly denied as related to a pre-existing condition, but while investigating this complaint, the Department received copies of correspondence sent to Brandi S by Respondent. In at least three letters, Respondent's letterhead simply stated "PacifiCare" with the signatory as PacifiCare Health Systems, Inc. Nowhere in these letters did Respondent properly identify their name as a licensed insurance company as required by CIC §880. Respondent is the PacifiCare Life and Health Insurance Company and is obligated to properly identify itself using its correct name in the course of doing business. In at least six EOBs sent to providers who treated Brandi S. Respondent failed to include the required notice to the provider as discussed in the paragraph immediately above resulting in six violations of Section 10123.13(a).

5. Kyla G – Incorrect claims payment; failure to adopt reasonable standards for claims processing

On 12/23/06 Kyla G. sought the Department's assistance in straightening out claims payment errors made by Respondent for services she received in June 2006. The first claim in question for date of service June 9, 2006 was received by Respondent on June 29, 2006 and was incorrectly processed at the wrong benefit level (50% instead of 70%) and using the wrong basis for payment (billed charges instead of the insurer's proprietary Limited Fee Schedule for non participating providers) on July 13, 2006 resulting in an overpayment to the provider. This error was discovered on September 13, 2006 and Respondent requested a refund. The second claim in question for date of service on June 13, 2006 was received on July 18, 2006, paid on July 24, 2006 at the wrong benefit level (50% instead of 70%). Respondent reviewed this claim on September 13, 2006 and an additional payment to the provider was made. Each time these claims were incorrectly processed and subsequently adjusted, a different amount is owed by the insured

to the provider. Section 790.03(h)(3) cites the insurer's failure to adopt and implement reasonable standards for the prompt investigation and processing of claims as an unfair claims settlement practice. Clearly, in this claimant's situation combined with facts alleged regarding similarly situated claimants previously and following, Respondent's violation of Section 790.03(h)(3) constitutes an unfair claims settlement practice by improperly processing claims according to the benefits of this insured as well as other's policies in violation of Section 790.02. The Department is in possession of numerous similar complaints demonstrating a strong pattern and practice of unfair claims settlement by Respondent.

6. William L – Failure to use correct business name in correspondence and failure to provide required notice when denying claims

William L. sought the Department's assistance on 1/3/07 after Respondent denied his prescription claims. In its November 2, 2006 correspondence denying the insured's appeal of the claim denial, the Respondent's letterhead simply stated PacifiCare with no reference to the company's licensed name, PacifiCare Life and Health Insurance Company, in violation of Section 880. In its December 20, 2006 letter to insured in which it reported that insured's appeal was reviewed by a PacifiCare Medical Director who was not involved in the original denial, Respondent failed to include any reference to the Department's review information in spite of including this generic language "You may request an additional, voluntary external review as outlined on the next page." Respondent's next page contained multiple references to state and federal law yet failed to include the information required by California Code of Regulations 2695.7(b)(3) which states that such written notification shall include a statement that if the claimant believes all or part of the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance and shall include the address and telephone number of the unit of the Department which reviews claims practices. The two letters sent to claimant (12/20/6 and 1/9/07) failed to include the slightest shred of this required information leaving this *and many other claimants* without the required legal notice of their rights to review by the Department. Every single one of these letters issued by Respondent that lacked the required information failed to comply with CCR 2695.7(b)(3) and constitutes a violation of

this regulation.

7. Gerald M – Failure to Include Required Review Language in EOB documents

Gerald M. turned to the Department for assistance with three claims for services received on July 7. 2006. In all three EOBs Respondent issued while processing these claims, dated 8/12/06, 8/23/06 and 9/13/06, the review language required by CCR 2695.7(b)(3) was entirely absent. The required language is intended to notify the claimant of their right to seek review by the California Department of Insurance and represents a fundamental consumer protection for insureds and their health care providers.

8. Andrew W – Incorrect and conflicting information provided to claimant by Respondent's representatives regarding dependent's student status; failure to receive and retain certificates of creditable coverage; improper claims processing

Andrew W., a student and dependent of the primary insured, suffers from a serious chronic disease which eventually caused him to take a three month medical leave of absence from college in January 2006. His mother spent countless hours with Respondent trying to clarify coverage for her son when he experienced two emergencies starting in December 2006 which resulted Andrew W's decision to take the approved medical leave to receive treatment for his condition. Respondent gave this family conflicting information regarding Andrew's coverage on multiple occasions regarding 1) whether or not dependents under age 25 were required to be students or not in order to continue to be eligible under their insurance policy and 2) who was responsible for verifying such student status and 3) whether verification of full time student status was necessary. Respondent denied claims and repeatedly asked for the same information regarding non existent secondary insurance. In spite of numerous responses provided by Andrew's mother to Respondent's inquiries regarding the secondary insurance questions, Respondent continued to send notices to the insured asking for the same information over and over again.

Claimant experienced the exact same frustrating and inefficient treatment regarding the claims submitted in January 2006 by claimant's health care providers which Respondent denied due to the lack of a certificate of creditable coverage which would have eliminated the application

of the pre-existing condition coverage limit. Claimant's mother faxed Andrew W's certificate of creditable coverage several times, each time following with a call to customer service and tracking each of these calls and the name of the customer service representative involved. Each time Andrew's mother spoke with Respondent (usually a different person each time), she was told that all of the denied claims would be reprocessed within 15-30 days. After she spent the entire month of January getting Respondent to track and recognize Andrew's certificate of creditable coverage, Respondent then started rejecting claims in February 2006 now on the basis of Andrew's alleged failure to meet the full time student eligibility requirement. This occurred in spite of the fact that Andrew's father along with his employer's human resources manager were told by Respondent in December 2005 that Andrew's student status was no longer required as a condition of eligibility. Respondent now informed Andrew's mother that his temporary withdrawal from college for January, February and March so he could receive life-saving medical treatment disqualified him from coverage as a dependent and on that basis Respondent denied payment of medical claims starting in January.

Andrew's mother persisted and spoke to numerous additional representatives of Respondent. Only after three months of claims were denied did Respondent tell Andrew's mother that she would need to pay COBRA to continue Andrew W.'s coverage . She inquired if Andrew would qualify as a disabled dependent under Section 10118 and supplied all of the requested documentation to Respondent but this was never resolved. At that point, Andrew W. contacted the Department which started to investigate the claims handling and information provided to him. In March 2006, claimant was informed by Respondent's representative that none of the claims during the previous 4 months should have been denied and that all claims were being paid. This insured got caught in a poorly executed administrative change instituted by Respondent on January 1, 2006. Though Respondent's policy requirement that students between age 18-25 be full time in order to be eligible under their parent's coverage did not change, the responsibility for verifying this status was shifted away from Respondent to the small group employer itself.

During the Department's investigation, Respondent supplied an undated letter to a "Dear

Valued Employer" explaining this shift in verification responsibility as of January 1, 2006. Clearly, in the instant case, this letter did not achieve Respondent's goal of shifting verification of full time student status to their employer groups and caused untold hours of confusion, worry and stress for this family. While Respondent did, in the end, decide to pay claims for the student even though he was on approved medical leave for winter quarter, payments to providers were delayed and the family endured a huge amount of uncertainty as a result of incorrect, conflicting misinformation provided by Respondent's representatives on multiple occasions.

Respondent's conduct in this case violated Section 790.03(h)(1) which prohibits misrepresentations to claimants of pertinent facts or insurance policy provisions relating to coverage. It is also clear by the facts in this case that Respondent has failed to adopt and implement reasonable standards for claims processing in violation of Section 790.03 (h) 3). Respondent also violated Section 880 in that all letters sent in this case failed to identify Respondent's proper name. 27 violations of CCR Section 2695.7 (b)(3) occurred in Andrew's case when Respondent denied claims in writing and failed to include language notifying the insured of their right to have the matter reviewed by the Department.

9. Chansee A – Failure to Correctly Administer the Pre-Existing Exclusion Clause causing Improper Claims Denial and Late Payment ; Failure to pay late payment interest.

Seven months after receiving coverage with Respondent through her new job, Respondent had failed to pay all of the claims for various services received and covered by Respondent's policy purchased by Chansee's employer. As in many small group policies, services provided to insureds for pre-existing conditions are excluded for a certain time period, usually the maximum allowed six months. The pre-existing exclusionary waiting period, however, can be reduced if the newly insured produces evidence of prior " creditable coverage" which health insurers and plans routinely send out when an insured's coverage ends. In Chansee's case, Respondent repeatedly denied claims even after she faxed her certificate of creditable coverage to Respondent on July 10, 2006. Respondent failed to take Chansee's creditable coverage information and use it to properly administer her benefits; instead Respondent continued to deny claims that occurred after April 29, 2006 which was the end of her pre-existing condition exclusion waiting period. Even

though the first claim in this complaint for date of service 5/11/06 was initially rejected and Chansee A was told that it would be re-processed and paid once her certificate of creditable coverage was received, Respondent did not pay this claim until 11/27/2006 and failed to pay the interest required by Section 10123.13.(b). In this case, an exemplar of many other cases, Respondent violated Section 790.03(h)(1) and (2) by failing to acknowledge and act reasonably upon communications (here the certificate of creditable coverage) with respect to claims arising under insurance policies. The law requires and the Department expects Respondent to be capable of tracking and properly utilizing claims-related documents as important as an insured's certificate of creditable coverage. Without such documents and the ability to track the dates, Respondent is incapable of properly calculating and applying the pre-existing exclusionary period and has demonstrated that this failure leads to improperly denied claims.

10. Stephen B – Failure to Notify Provider of Right to Department Review in EOB

Health care providers, both hospitals and doctors, for Stephen B's dependent filed claims, including claims from out of state hospitals and doctors with Respondent starting on August 17, 2006. Respondent issued a total of at least eight (8) explanation-of-benefits (EOB) to these providers denying all claims for various reasons including lack of information Respondent allegedly needed. None of these EOBs contained any language indicating that the provider had a statutory right to seek review by the Department. On 2/13/07 a complaint was filed with the Department during which all of these EOBs were produced and reviewed. With respect to the two out of state claims, Respondent issued two checks after realizing that the coverage rules had not been properly applied; specifically that a non participating provider was to be paid at participating benefit levels under these circumstances. This necessitated the issuance of two checks for each provider and continued delay in payment.

11. Craig S – Insureds had to avoid seeking care due to non payment of doctor's claims by Respondent; failure to provide sufficient information on EOBs sent to insureds

On October 26, 2006 Craig S. filed a complaint with the Department after trying for 11 months to get Respondent to pay claims for care provided to himself, his wife and his autistic

child. Craig reported mailing and faxing at least 11 copies of the requested Certificate of Creditable Coverage to Respondent which documented his prior Blue Cross coverage thereby reducing the Respondent's policy's waiting period under its pre-existing condition exclusion clause. This insured reported that Blue Cross supplied these certificates between February 2005 through December 2005 and Craig provided copies directly to Respondent after that date *each* time when a claim was improperly denied due to a pre-existing condition. After a protracted period of claims denial by Respondent, insured's wife delayed EKG stress tests out of fear of non payment due to Respondent's continual denial of doctor claims during this timeframe.

Respondent violated Section 10123.13 (a) by failing to provide adequate notice to claimants as to what information Respondent needed in order to re-consider the denied claim. Respondent issued at least 14 EOBs with vague wording such as "this claim is being denied due to lack of information." The purpose of the statutory requirement in Section 10123.13(a) is not to provide an excuse for denial, but rather to put the claimant on notice as to what information exactly is needed before the Respondent can properly adjudicate the claim. EOB language such as this is commonly used by Respondent and routinely fails to truly give the receiver of the EOB any guidance whatsoever as to what information the Respondent actually needs to timely adjudicate the claim presented. No specific information was requested by Respondent that would give the claimant a clue about what to send in. For example, if the claim was being denied based on the pre-existing condition clause, for example, the end date of that period should based on the insured's presentation of the certificate of creditable coverage would be the information needed by the claimant. When claimants are not told what information is needed by Respondent to adjudicate the claim, timely adjudication of claims and benefits that may be due the insured cannot be accomplished. This is a flagrant and gross failure of Respondent to satisfy the core purpose of an insurance policy: to adjudicate claims for coverage when presented in a timely and correct manner. When doctors cannot be paid on a timely and correct basis for services rendered that are covered under an insured's policy, they demand out of pocket payment from the insured. In this situation, the insured is denied the benefit of assignment which they are allowed by Section 10133(a).

Respondent's flagrant and intentional loss or misplacement/mishandling of the multiple copies of the certificate of creditable coverage in Craig S's case caused not only many improper denials of claims and late payments but also caused Craig's wife to delay care recommended by her doctor. Maintenance of basic policyholder information, such as an insured's certificate of creditable coverage in order to properly administer the pre-existing exclusion clause in an insurance policy is fundamental administration of health insurance. Respondent's failure to keep track of these certificates caused a domino effect in improper claims handling and delay and deprivation of covered benefits of Craig S's insurance policy.

12. Paul S – Respondent Loses Claims Four Times; Fails to Pay Late Payment Interest Due

On November 21, 2006 Paul S filed a complaint with the Department stating that Respondent has lost, misplaced or ignored claims four times for both himself and his wife. In a February 20, 2007 letter to claimant, Respondent confirmed that claims(for dates of service 10/14/06 and 12/14/06) were received by Respondent but could not be located. When insured sent the claims to Respondent, they were paid on 2/15/07 and 2/16/07 stating that these claims were sent to their Claims Department for review for interest payment. Respondent reported receiving the claim for date of service 10/14/06 on 11/27/06 and paying it on 2/15/07 more than thirty calendar days after receipt as required by Section 10123.13(a) and 10123.147. Clearly interest was due and should have been paid at the time the claim was paid. Since Respondent lost the claim, there was no information offered that the claim was denied for lack of information; therefore it was due and payable as soon as practicable as required by statute. When filing this complaint, this insured noted that he had this same experience two prior times in the past year with those claims ultimately being paid 90-120 days after the original filing. These costs were paid out of pocket by the insured and they were denied the timely reimbursement and interest that was due.

13. Deni J. – Respondent Received Same Certificate of Creditable Coverage Three Times from Insured Yet Continued to Deny Claims

In late October 2006, Deni J. filed a complaint with the Department asking for resolution

of her fight with Respondent that started in July 2006. Claims for care she received were repeatedly denied, over and over again. Each time when she called, she was told by Respondent to supply either her Certificate of Creditable Coverage or her medical records. In August 2006, Deni J. changed jobs and was paying for her own continued health insurance coverage under COBRA. She incurred more medical bills and those bills were also denied. Each time she faxed Respondent the same Certificate of Creditable Coverage, first on 9/12/06, then again on 9/26/06 and then again on 10/17/06. She begged Respondent to tell her if they needed any more specific information than what she was supplying, but to no avail. Starting in July she requested that Respondent request her medical records from her physician but she was never able to learn if those had been requested or received. Each time she received a notice of claims denials, she had to call Respondent only to be told that they didn't have her Certificate of Creditable Coverage. Four EOBs were issued requesting yet again another copy of her Certificate of Creditable Coverage . Section 2695.7(d) of the California Code of Regulations prohibits an insurer from persisting in seeking information not reasonably required for or material to a resolution of a claim dispute. Yet Respondent continually asked for information from this insured that it had already received. Further this utter failure to track the most basic information caused multiple improper claims denials and late paid claims, both classic unfair claims settlement practices. In Respondent's letter to the claimant, they admit that her Creditable Coverage was received by them on 9/15/06 but the "actual update of this information was not done until 10/31/06". Meanwhile Respondent denied claims improperly causing most of them to be paid late and with interest and much anguish and wasted time by the insured.

14. Carole Z – Failure to use Company's Correct Name; No Notice to Claimant of Right to Department Review

On February 20, 2007 Carole Z. filed a complaint with the Department regarding non network provider claims applying a reimbursement amount arbitrarily determined by Respondent that was at a very low rate. Four EOBs were sent to these Texas providers denying their claims; none of which contained language required by Section 10123.13(a) that would give these providers notice of their right to seek Department review resulting in four separate violations.

Respondent's first letter sent to the surgery center failed to include the company's name in violation of Section 880; the letterhead simply stated "PacifiCare" and rejected the claim asking for the claim to be resubmitted with the correct bill type. Since the surgeon was ultimately reimbursed $173.10 by the insurer (even including the insured's co-pay) two months later for a bill for $1500, it's likely that this surgeon might have sought review by the Department. Inexplicably, Respondent sent an additional payment of $550.25 two months later for services rendered on 7/25/06 with no apparent explanation to the provider or the insured.

15. James R – Continuing Failure to Receive, Retain and Properly Utilize Insured's Certificate of Creditable Coverage to Determine Proper Application of Pre-Existing Condition Clause

After the Department's Consumer Services Division struggled with Respondent for over one year to obtain compliance with a basic requirement to use communications (in this case Certificates of Creditable Coverage) submitted by insureds in determining how to apply the pre-existing condition exclusionary clause, the Department received a complaint on November 5, 2007 from James R. In the documentation submitted with this complaint and verified by the Department, Respondent sent claims denials with EOBs stating: "Not Paid. Please submit medical records to assist with determination of pre-existing condition/ Requested Certificate of Creditable Coverage from prior carrier." James R submitted documents as requested and later Respondent paid claims. Eight months later out of the blue Respondent started denying claims and requesting this same information from the insured in spite of having paid several claims between January when the information was initially supplied and September when Respondent started asking again for the same information that had already been supplied by the insured. This one insured's case demonstrates that over a year later after Respondent had been put on notice by the Department that their system for receiving, retaining, tracking and using Certificates of Creditable Coverage and related medical records in order to apply their pre-existing condition clauses was completely dysfunctional, Respondent persisted in failing to repair this most basic claims processing function. This set of denials, EOB communications and persistent refusal to timely pay claims based on an incorrect presumption that the pre-existing condition clause applied when in fact it did not has resulted in multiple violations of Section 790.03(h)(1),

misrepresenting to claimants insurance policy provisions relating to any coverages at issue, Section 790.03 (h)(2) failing to acknowledge and act reasonably promptly upon communications (such as these Certificates) with respect to claims arising under insurance policies, Section 790.03(h)(3) failing to adopt and implement reasonable standards for the prompt investigation and processing of claims under insurance policies and Section 790.03(h)(4) failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured.

STATEMENT OF GROUNDS FOR RELIEF BASED ON MARKET CONDUCT EXAMINATION FINDINGS AND INDIVIDUAL CONSUMER AND PROVIDER COMPLAINTS INVESTIGATED BY THE DEPARTMENT

1. The Department has received and investigated hundreds of similar individual complaints from consumers and providers typical of those alleged above in paragraphs 1-15 since Respondent was acquired by UHG in 2006.

2. The facts alleged above in paragraphs 1-15 of the STATEMENT OF SPECIFIC CHARGES BASED ON A SAMPLING OF INDIVIDUAL PROVIDER AND CONSUMER COMPLAINTS RECEIVED AND INVESTIGATED BY THE DEPARTMENT show that Respondent did not attempt in good faith to effectuate prompt, fair and equitable settlement of claims in which liability had become reasonably clear, in violation of CIC Section 790.03(h)(1), (2), (3), (4), (5).

3. The facts alleged herein constitute grounds, under Section 790.05, for the Insurance Commissioner to order Respondent to cease and desist from engaging in such unfair acts or practices and to pay a civil penalty not to exceed five thousand dollars ($5,000) for each act, or if the act or practice was willful, a civil penalty not to exceed ten thousand dollars ($10,000) for each act as set forth under CIC Section 790.035.

4. The facts alleged herein show that Respondent has failed to carry out its contracts in good faith, constituting grounds for the Insurance Commissioner to suspend the Certificate of Authority of Respondent for a period not to exceed one year pursuant to CIC Section 704(b).

5. The facts alleged herein show that Respondent as a holder of a certificate of authority issued by the Commissioner has consistently and often willfully failed to comply with

the requirements as to its business as set forth in the Insurance Code in violation of Section 700(c). Specifically numerous violations of the following Sections have been alleged: 10123.13(a) and (b) and (c), 10169(i), 10123.137(c), 10123.147(a), 880, 10133.66(c), 734 and 10198.7(a).

REQUEST FOR ORDER AND MONETARY PENALTY

WHEREFORE, Petitioner prays for judgment against Respondent as follows:

1. An Order to Cease and Desist from engaging in such unfair acts or practices in violation of CIC Section 790.03(h) and the regulations promulgated pursuant to CIC Section 790.10 as set forth above;
2. Pursuant to CIC Section 790.035, for willful acts in violation of CIC Section 790.03 and CCR, Title 10, Chapter 5, Subchapter 7.5, Sections 2695.1 through 2695.17 (adopted pursuant to CIC Section 790.034), as set forth above, a penalty in an amount to be fixed by the Commissioner not to exceed ten thousand dollars ($10,000.00) for each act; and for each unfair or deceptive act or practice not found to be willful, a penalty in an amount to be fixed by the Commissioner not to exceed five thousand dollars ($5,000.00) for each act;
3. Full restitution and or reimbursement for acts or omissions in violation of the above cited provisions of law; and,
4. Costs incurred by the Department in bringing this action and any future costs to the Department to ensure compliance.

Dated: 1/25/08

STEVE POIZNER
Insurance Commissioner

By: Andrea Rosen
ANDREA ROSEN
Staff Counsel

In the Matter of:	)	
	)	DECLARATION OF SERVICE
	)	BY U.S. MAIL
	)	
PACIFICARE LIFE AND HEALTH	)	FILE NO. UPA 2007-00004
INSURANCE COMPANY,	)	
	)	
Respondent.	)	

I am over the age of 18 years, and not a party to this cause.

I am an employee at the Department of Insurance, State of California, employed at 300 Capitol Mall, Suite #1700, Legal Division, Sacramento, CA., 95814.

On January 25, 2008, at Sacramento, California, I sealed into an envelope and deposited in the U.S. Mail, postage there upon fully prepaid, true copies of the following documents in the above-entitled matter; the original, or a true copy, of each document served is attached hereto; said copies were addressed as follows:

c: ORDER TO SHOW CAUSE; STATEMENT OF CHARGES/ACCUSATION; NOTICE OF MONETARY PENALTY and DECLARATION OF SERVICE BY U.S. MAIL were mailed to:

7006 3450 0003 8146 8494
CT Corporation System
818 West Seventh Street
Los Angeles, CA 90017

7006 3450 0003 8146 8470
Sue Berkel
Chief Financial Officer
Pacificare Life and Health Insurance Company
5995 Plaza Drive, Mail Stop CY20-182
Cypress, CA 90630

I declare under penalty of perjury that the foregoing is true and correct.
Executed on January 25, 2008, at Sacramento, California.

Angelina Velez

Exhibit 1

REPORT (PURSUANT TO INSURANCE CODE SECTION 735.5)
OF THE MARKET CONDUCT EXAMINATION

OF THE CLAIMS PRACTICES OF THE

PACIFICARE LIFE AND HEALTH INSURANCE COMPANY
NAIC # 70785 CDI # 3086-6

AS OF MAY 31, 2007

STATE OF CALIFORNIA

DEPARTMENT OF INSURANCE

MARKET CONDUCT DIVISION

FIELD CLAIMS BUREAU

NOTICE REGARDING CONFIDENTIALITY

The provisions of Section 735.5(a) (b) and (c) of the California Insurance Code 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. Section 12938 of the California Insurance Code requires the publication of certain legal documents and examination reports.

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

Steve Poizner, *Insurance Commissioner*

January 18, 2008

The Honorable Steve Poizner
Insurance Commissioner
State of California
45 Fremont Street
San Francisco, California 94105

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 practices and procedures in California of:

PacifiCare Life and Health Insurance Company

NAIC # 70785

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

FOREWORD

This targeted examination covered the claims handling practices of the aforementioned Company during the period June 23, 2006, through May 31, 2007. 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 alleged violations of laws other than Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. A report of violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. will be made available for public inspection and published on the Department's web site pursuant to Section 12938 of the California Insurance Code.

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 resulted in 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

The targeted examination focused on the Company claims processing operations including provider network management and provider contract uploading as a result of complaints received by the Department from consumers and healthcare providers with respect to individual and group health insurance coverage.

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 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 consumer complaints and inquiries about the Company handled by the California Department of Insurance (CDI) during the same time period and a review of prior CDI market conduct examination reports on the Company.

4. A review of electronic paid claims data. This analysis however, was limited to a review of timely acknowledgement of claims, timeliness of payment of claims, and proper payment of interest pursuant to the California Insurance Code (CIC).

The sample of claim files, provider disputes, member appeals and related records were reviewed at the office of the Company in Cypress, California. The review of electronic paid claims data was conducted primarily within the office of the Department of Insurance in Los Angeles, California.

EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED

The examination targeted provider network operations for provider contract loading and claims processing, provider disputes and member appeals as these areas have been the subject of numerous complaints received by the Department from consumers and healthcare providers. The principal areas of concern noted in the examination report are: excessive delays in uploading provider contracts, incorrect payment of claims, lost mail and/or imaged documents such as certificates of creditable coverage and medical records, failure to timely acknowledge receipt of claims, failure to address all issues and respond timely to member appeals, and provider disputes.

The claims reviewed were closed between June 23, 2006 and May 31, 2007, which shall be referred to as the "review period". Using a computer analysis program, the examiners reviewed 1,125,707 paid claims (1,077,024 group health claims and 48,683 individual health claims). The electronic data available allowed only a review of timeliness of acknowledgement, timeliness of payment of claims and proper payment of interest. The electronic data field parameters were: Date Received, Date Acknowledged and Date Paid or Closed. The electronic review resulted in 128,849 alleged violations of the California Insurance Code for failure to reimburse claims no later than 30 working days after receipt, failure to pay interest on an uncontested claim after 30 working days and failure to timely acknowledge receipt of claims. For the on-site review, the examiners randomly selected 339 sample files (114 denied claims files, 96 provider disputes, 79 member appeals and 50 provider contract agreement uploads). The examiners cited 304 alleged claim handling violations of the California Insurance Code from this sample file review which is detailed in the report tables and summaries.

The Company indicated that a spike in processing errors occurred as a result of provider contracting efforts due to a provider network transition effective June 23, 2006. The Company's administrative capacity was affected as follows: a) inaccurate and untimely loading of provider contracts; b) inadequate control over documents for processing claims and provider disputes; and c) inadequate staffing and training. The Company states that it is committed to correcting the deficiencies cited in the report.

RESULTS OF REVIEWS OF CONSUMER COMPLAINTS AND INQUIRIES, AND PREVIOUS EXAMINATIONS

The Company was the subject of 237 consumer complaints and inquiries which includes 68 provider disputes between June 23, 2006 and May 31, 2007. The review of these complaints and inquiries resulted in identification of the following trends in noncompliance: wrongful denials of covered claims; undue delay in claims processing; multiple requests for documentation that was previously provided, including, but not limited to, certification of creditable coverage and inaccurate recording of provider contract data.

The most recent prior examination reviewed a period between July 1, 2005 and June 30, 2006. The most significant noncompliance issues identified in the prior examination report were failure to maintain all documents, notes and work papers in the claim file, failure to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue, and the failure to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies.

DETAILS OF THE CURRENT EXAMINATION

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

PLHIC SAMPLE FILES REVIEWED			
LINE OF BUSINESS / CATEGORY	**FILES FOR REVIEW PERIOD**	**SAMPLE FILES REVIEWED**	**CITATIONS**
Accident and Disability / Group Health Claims Denied	428,126	68	48
Accident and Disability / Group Health Provider Disputes	12,367	55	64
Accident and Disability / Group Health Member Appeals	688	47	53
Accident and Disability / Individual Health Claims Denied	2957	46	21
Accident and Disability / Individual Health Provider Disputes	159	41	21
Accident and Disability / Individual Health Member Appeals	68	32	5
Provider Contract Agreements Effective dates 1/1/06-3/31/07	10,566	50	90
General Category	-	-	2
TOTALS	454,931	339	304

PLHIC ELECTRONIC CLAIMS PAID REVIEW*		
LINE OF BUSINESS / CATEGORY	**NUMBER OF CLAIMS**	**CITATIONS**
Accident and Disability / Group Health Claims Paid	1,077,024	101,720
Accident and Disability / Individual Health Claims Paid	48,683	27,129
TOTALS	1,125,707	128,849

* All claims incurred subject to review

TABLE OF TOTAL CITATIONS

Citation	Description	# Citations
CIC §10123.13(a)	• The Company failed to reimburse a health care claim no later than 30 working days after receipt • The Company failed to refer to specific policy provisions in the claim denial. • 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 Company failed to include all required information on the Explanation of Benefit or denial; the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.	139 File Review 42,137 Electronic Paid Claims Review **42,276 TOTAL**
CIC §790.02	The Company engaged in an unfair or deceptive act or practice.	**47**
CIC §734	The Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company failed to maintain all documents, notes and work papers in the claim file.	**45**
CIC §10169(i)	The Company failed to provide the insured the information concerning the right of an insured to request an independent medical review in cases where the insured believes that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers.	**27**
CIC §10123.13(b)	The Company failed to pay interest on an uncontested claim after 30 working days.	17 File Review 5,432 Electronic Paid Claims Review **5,449 TOTAL**
CIC §10123.137(c)	The Company failed to issue a written determination within 45 working days after the date of receipt of the provider dispute.	**14**

TABLE OF TOTAL CITATIONS

Citation	Description	# Citations
CIC §10133.66(c)	The Company failed to acknowledge receipt of the health claim within 15 days.	6 File Review 81,280 Electronic Paid Claims Review **81,286 TOTAL**
CIC §10123.147(a) *Emergency Services only.*	• The Company failed to refer to specific policy provisions in the claim denial. • 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 Company failed to include all required information on the Explanation of Benefit or denial; the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function. • The Company failed to reimburse a health care claim no later than 30 working days after receipt.	**5**
CIC §10123.13(c)	The Company failed to pay interest on a contested claim after 30 working days.	**2**
CIC §10198.7(a)	The Company failed to provide coverage for any individual on the basis of a pre-existing condition provision for a period greater than 6 months following the individual's effective date of coverage. No health benefit plan that covers 3 or more persons (Group or Individual Coverage) that is issued, renewed or written by any insurer shall exclude coverage for any individual on the basis of a preexisting condition provision for a period greater than 6 months following the individual's effective date of coverage.	**2**
Total Citations		**129,153**

TABLE OF CITATIONS BY LINE OF BUSINESS

ACCIDENT AND DISABILITY 2006 Written Premium: $843,721,575	NUMBER OF CITATIONS		
AMOUNT OF RECOVERIES **$155,787.40**	Electronic Paid Claims Review	Sample File Review	Total
CIC §10123.13(a)	42,137	139	42,276
CIC §734	0	45	45
CIC §790.02	0	47	47
CIC §10169(i)	0	27	27
CIC §10123.13(b)	5432	17	5449
CIC §10123.137(c)	0	14	14
CIC §10123.147(a)	0	5	5
CIC §10133.66(c)	81,280	6	81,286
CIC §10123.13(c)	0	2	2
CIC §10198.7(a)	0	2	2
SUBTOTAL	**128,849**	**304**	**129,153**

TOTAL	**128,849**	**304**	**129,153**

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 to take appropriate corrective action in all jurisdictions where applicable.

Money recovered within the scope of this report was $155,787.40 as described in sections one, three, seven and Electronic Paid Claims Review below.

ACCIDENT AND DISABILITY

1. **In 139 instances, the Company failed to reimburse a health care claim no later than 30 working days after receipt; or the Company failed to refer to specific policy provisions in the claim denial; or 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; or the Company failed to include all required information on the Explanation of Benefits (EOB) or denial; the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function.** The Department alleges these acts are in violation of CIC §10123.13(a).

Summary of Company Response: The Company acknowledges that it failed to either reimburse health claims within 30 working days after receipt or refer to specific policy provisions in the claim denial in 23 claims. In the instances where the Company failed to reimburse claims, payments were issued totaling $16,352.49. The Company conducted additional training in October 2007 to address these issues. The Company will implement focused self-audits of late paid and denied claims to confirm that these claims errors are being mitigated and will continue to update training as needed based on the results of the audits. The Company failed to include required wording in the EOB and Explanation of Payments (EOP) correspondence in 96 claims. The Company was advised of the deficiencies in the EOB/EOP documents prior to the examination by the staff of the Consumer Services Division at the CDI and initiated a Corrective Action Plan (CAP) on March 27, 2007. The final versions were approved and subsequently implemented on June 15, 2007 for group PPO claims, and November 4, 2007 for individual PPO claims. In 12 instances the Company's denial letter sent in response to the member appeal contained Department of Managed Health Care (DMHC) language and not the required DOI language. The Company uphold letter template was updated on September 13, 2007 and the reference to the DMHC has been deleted. An updated template was also provided to staff on September 13, 2007. In the remaining eight instances, the Company's position is that the referenced statute 10123.13(a) applies to the original claims processing and refers to

information included on the EOB. This statute does not apply to the denial letter in response to the appeal request.

This is an unresolved issue and may result in administrative action.

2. **In 27 instances, the Company issued denial letters and other written responses to grievances which failed to provide the insured information regarding their right to request an independent medical review.** In the cited instances, the Company failed to provide information concerning the right of an insured to request an independent medical review in cases where the insured believes that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers. The Department alleges these acts are in violation of CIC §10169(i).

Summary of Company Response: The Company agreed that it failed to provide information concerning the right of the insured to request an independent medical review in 24 of the instances cited. The Company states they were advised of this deficiency prior to the examination by the staff of the Consumer Services Division at the CDI and initiated a Corrective Action Plan (CAP) on March 27, 2007. The final versions were approved and subsequently implemented on June 15, 2007. On three remaining citations, the Company previously responded to an examination referral, respectfully disagreeing with the request to include the right to an IMR according to CIC § 10169(i) in the denial letter. The Company's procedure provides the right to an IMR when services have been denied, modified or delayed based in whole or in part on the findings that the services are not medically necessary, experimental or investigational, or are denied emergency or urgent medical services. The issues for the files in question are not disputed health care services but are coverage decisions.

This is an unresolved issue and may result in administrative action.

3. **In 17 instances, the Company failed to pay interest on an uncontested claim after 30 working days.** The Department alleges these acts are in violation of CIC §10123.13(b).

Summary of Company Response: The Company agreed that it did not pay interest on an uncontested claim after 30 working days. The Company has corrected these 17 claims. As a result, interest was paid on 17 of the cited instances totaling $391.04 ($78.87 Individual Provider Appeals, $49.44 Group Provider Appeals, $262.73 Group Member Appeals). The Company conducted additional training on proper interest application in October 2007. The Company will also implement focused self-audits of late paid claims to confirm that interest payment errors are being mitigated and will update their training as needed based upon the results of the focused audits.

4. **In 14 instances, the Company failed to issue a written determination within 45 working days after the date of receipt of the provider dispute.** In the course of reviewing files, the Examiners identified 14 instances in which the company did not provide a written determination. This issue was brought to the Company attention and the Company was queried as to how many instances this occurred within the window period. The Company indicated there were 16,563 Provider Disputes during the exam window period of which, 15,053 were responded

to within requirements. Thus there were actually 1,510 disputes during the window period that did not receive a written determination within 45 working days after the dispute was received. The Department alleges these acts are in violation of CIC §10123.137(c).

Summary of Company Response: The Company acknowledges that it failed to issue a written determination within 45 working days after the date of receipt of the provider dispute. The Company experienced certain issues related to delays within their correspondence tracking queues. Due to these issues, certain correspondence needed to resolve the provider disputes, such as medical records, were delayed within the tracking queues and thus were not reviewed timely.

The Company's completed, ongoing or planned corrective actions to improve the routing of correspondence include:

- Weekly correspondence inventory and aging reports for each queue have been written – Completed April 2007
- The correspondence queues have been defined and are maintained separately to ease review and routing – Completed Summer 2007
- Owners and back up owners have been identified – Completed Summer 2007
- Queue owners and the Transaction Project Director meet weekly to review progress, inventory levels etc. – Ongoing; Started July 2007
- The policy related to docsDNA correspondence routing has been reviewed and will be completely updated by December 14, 2007.

In addition to the corrective actions related to correspondence, the Company will implement focused audit procedures related to the timeliness of provider dispute resolution (PDR) determinations.

The Company also conducted training with its staff in October 2007 to emphasize the PDR determination letter timeliness requirements of 45 working days from date of receipt to written determination issuance date.

5. In six instances, the Company failed to acknowledge receipt of the claim within 15 days. The Department alleges these acts are in violation of CIC §10133.66(c).

Summary of Company Response: The Company acknowledges that it failed to acknowledge receipt of the claim within 15 days. The Company conducted additional training in October 2007. The Company will also develop reporting by March 1, 2008 to confirm that all un-adjudicated claims aged at greater than 15 days have had acknowledgement letters sent, as well as continue to monitor paper claims submissions to reduce the late loading of claims into the claims system.

6. In five instances, the Company failed to refer to specific policy provisions in the claim denial; or 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; or the Company failed to

include all required information on the Explanation of Benefit or denial; the notice shall include the address, the Internet Web site address, and telephone number of the unit within the Department that performs this review function; or the Company failed to reimburse a health care claim no later than 30 working days after receipt. The Department alleges this act is in violation of CIC §10123.147(a).

Summary of Company Response: The Company agreed that it failed to include required wording in the EOB (Explanation of Benefit) and EOP (Explanation of Payment) correspondence in two instances. The Company was advised of the deficiencies in the EOB/EOP documents prior to the examination by the staff of the Consumer Services Division at the CDI and initiated a corrective action plan on March 27, 2007. The final versions were approved and subsequently implemented on June 15, 2007 for group claims, and November 4, 2007 for individual claims. In one instance, 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 uphold letter template was updated on September 13, 2007 and the reference to the Department of Managed Health Care (DMHC) has been deleted. An updated template was provided as evidence to the Department and to member appeals staff on September 13, 2007. The Company respectfully disagrees that it failed to include the Department of Insurance information and right to appeal in the appeal response in two instances. It is the Company's position that the referenced statute 10123.147(a) applies to the original claims processing and refers to information included on the EOB. This statute does not apply to the denial letter in response to the appeal request.

This is an unresolved issue and may result in administrative action.

7. **In two instances, the Company failed to pay interest on a contested claim after 30 working days.** In one instance, the claim was denied inappropriately for pre-existing condition. As a result of the examination, an additional claim was located from the member that was inappropriately denied and reprocessed. In one instance, it was noted that the Company did not pay the correct interest rate. The Department alleges this act is in violation of CIC §10123.13(c).

Summary of Company Response: The Company acknowledges claims were paid incorrectly in two instances. As a result, interest was paid on the cited instances totaling $251.22 (Group Provider Appeals). The Company conducted additional training on interest application in October 2007. The Company will also implement focused self-audits of late paid claims to confirm that interest payment errors are being mitigated and will update their training as needed based upon the results of the focused audits.

8. **In two instances, the Company failed to provide coverage for any individual on the basis of a pre-existing condition provision for a period greater than 6 months following the individual's effective date of coverage. No health benefit plan that covers 3 or more persons (Group or Individual Coverage) that is issued, renewed or written by any insurer shall exclude coverage for any individual on the basis of a preexisting exclusionary period provision for a period greater than 6 months following the individual's effective date of coverage.** The Company began applying a 12 month pre-existing exclusionary period on group

policies effective January 1, 2004 and continued thru December 2006. The Department alleges these acts are in violation of CIC §10198.7(a).

Summary of Company Response: The Company agreed that it failed to provide coverage for any individual on the basis of a pre-existing exclusionary period provision for a period greater than 6 months following the individual's effective date of coverage.

The Company's training materials were updated to reflect a 6 month pre-existing exclusionary review period and subsequent training of staff was completed in December 2006. An automated update of the claims system was made in December 2006 and the pre-existing field is set for 6 months. In March 2007, the Company issued Large Group plan amendments changing the exclusionary period to 6 months and communications were sent to the affected groups advising them of the changes.

PROVIDER CONTRACT AGREEMENTS

9. **In 45 instances, the Company failed to provide the examiners timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recording relating to the property, assets, business, and affairs of the company being examined. The Company failed to maintain all documents, notes and work papers.** Specifically, the Company failed to maintain all documents, notes, computer data and work papers pertaining to the provider contract file. The Company asserts that 40% of contracts received from physicians were deficient in critical information (i.e. missing tax identification number, missing or incomplete roster, missing or incomplete locations, etc.). However, the Company did not provide documentation to support the lack of critical missing information. As a result, some of the claims were impacted by retroactive contract uploads not appropriately identified and adjudicated. The Department alleges these acts are in violation of CIC §734.

Summary of Company Response: The Company acknowledges that many provider contracts were loaded after the effective date. The Company considers this to be a one time event related to the merger of United Health Group ("UHG") and PacifiCare Health Systems ("PHS") in 2005. The United States Department of Justice ("DOJ") required that UHG, the Company's ultimate parent company, terminate its existing network rental contract with Care Trust Network ("CTN"). The DOJ required that UHG cease using the CTN network within one year from the entry of the final judgment relating to the DOJ's approval of the transaction.

UHG expected to continue accessing the CTN network through the end of 2006, as allowed by the DOJ, to give UHG time to contract with additional providers and preserve the greatest amount of network continuity for UHG's customers in California. However, CTN elected to exercise its contractual right to terminate the network rental arrangement with UHG upon 180 days notice. In late December 2005, several days after the UHG / PHS merger was completed, CTN gave notice of termination, effective June 22, 2006.

Upon receiving the termination notice from CTN in late December 2005, UHG/PHS initiated contracting efforts to replace CTN that resulted in the addition of approximately 9,000 new physicians to the network. In 2006 as the Company replaced CTN, the Company allowed physician contracts to be retroactive, primarily to June 23, 2006, to help ensure continuity of care for UHG's members.

The Department requested certain data elements related to these extensive network development activities. Most of the data elements are tracked systematically and automatically. A very small number of the requested data elements, such as date of contract receipt, were tracked manually.

The Company's standard business practice, outside of this extensive network development in 2006, is not to allow contracts to have retroactive effective dates. Any exception requires senior management approval. The Company's corrective action (as more fully described in Item 11 that follows), expected to be fully implemented by February 4, 2008, is to ensure that claims impacted by any approved retroactive contracts are appropriately identified and re-adjudicated in a timely manner

10. **In 45 instances, the Company engaged in an unfair or deceptive act or practice.** The Company failed to institute provider contract upload mechanisms, required as the result of provider contracting efforts, to ensure timely initiation of contact terms. Consequently, provider claims were not processed correctly as the result of delayed uploading. Additionally, providers were not listed as participating in the PacifiCare Provider Network therefore compromising insured's access to contracted providers. The Department alleges these acts are in violation of CIC §790.02.

Summary of Company Response: The Company's standard business practice, outside of this extensive network development in 2006, is not to allow contracts to have retroactive effective dates. Any exception requires senior management approval. The Company's corrective action (as more fully described in Item 11 that follows), expected to be fully implemented by February 4, 2008, is to ensure that claims impacted by any approved retroactive contracts are appropriately identified and re-adjudicated in a timely manner.

GENERAL BUSINESS PRACTICE

11. **The Company engaged in an unfair or deceptive act or practice.** PacifiCare has admitted it did not consistently address problems in claims adjudication when provider contract uploading was delayed or contracts were back dated. Additionally, PacifiCare can not verify that all claims submitted prior to contract uploading or contract back date were reviewed for correct payment and interest where applicable. The Department alleges these acts are in violation of CIC §790.02.

Summary of Company Response: The Company acknowledges that many provider contracts were loaded after the effective date related to the CTN transition (as more fully described in #9 above). The CDI has identified 14 providers with approximately 500 claims and billed charges of approximately $96,000 that may require rework. We expect to fully review and re-adjudicate, if necessary, these providers by February 4, 2008.

The Company's corrective action included:

- Identifying all new physicians contracted into the PLHIC network from January 1, 2006 through March 31, 2007.
- Comparing the completed provider contract load date to the contract effective date and calculate the number of days of retroactivity.
- Identifying all claims adjudicated between the provider contract effective date and the contract load date for rework, for providers loaded more than 30 days after the contract effective date.
- Re-adjudicating the identified claims.

Effective February 4, 2008, the Company will do the following on a regular basis:

- Identify provider contracts with retro-effective dates.
- Identify impacted claims for providers with retroactive contracts.
- Re-adjudicate impacted claims.
- Maintain appropriate documentation of self-initiated claims reprocessing for retro-effective contracts.

12. The Company engaged in an unfair or deceptive act or practice. PacifiCare does not have a procedure in place to accurately document the proper application of a health policy pre-existing condition exclusion. Pre-existing condition exclusions limit or deny benefits for a medical condition that existed before the date that coverage began. Group policies include a six-month exclusionary period for pre-existing conditions from the first date of the policy coverage waiting period or the first date of coverage, whichever date is earlier. The six-month exclusionary period can be reduced by the number of days the member can provide proof of creditable coverage from a prior insurer. The pre-existing exclusion applies only to conditions for which medical advice, diagnosis, care or treatment, including prescription drugs, was recommended or received within a six-month period ending on the day before the date of hire. This period is known as the "look- back" period.

- There is no documentation in the sample files reviewed confirming member date of hire-a necessary element to apply the pre-existing condition exclusion.
- None of the sample files reviewed document how the Company determined the pre-existing period applicable to the member.

- There is no documentation that employer imposed waiting periods were reviewed and included in the six month pre-existing exclusionary period applied to members without proof of creditable coverage.
- There is no documentation that the benefit effective date, supplied by the employer, was correctly captured by the employer or verified by the Company. The Company is relying on correct employer reporting and verification, "When an employer group determines their own eligibility, the date of hire becomes a null and void element because it is assumed that the employer group has validated that the employee has met all their respective waiting periods, if any, to be enrolled in the plan. If the claims examiner does not have the hire date of the insured, we apply the exclusionary provision based on the effective date the employer group has provided."
- There is no documentation to support Company requirement for a Certificate of Creditable Coverage (COCC) when a possible pre-existing diagnosis claim has been received.
- The Company fails to adequately document their basis for determining a condition is pre-existing when medical records have been provided and they do not support prior medical advice, diagnosis, care or treatment.
- The Company fails to document why it upholds a pre-existing determination when an insured does not respond to a request for a COCC or names of physicians who have treated the member in the past six months. The pre-existing condition claim denial requires the member to provide a COCC or the names of physicians who have provided treatment in the previous six months. The Company does not inform the member that a response is required even if they do not have a COCC or have not received any recent medical treatment. If the Company requires notice from a member affirming no treatment, advice, diagnosis or care was received in the six months prior to date of hire or no COCC is available, correspondence should state specific member response requirements.

The Department alleges these acts are in violation of CIC §790.02.

Summary of Company Response: The Company acknowledges that it does not track the hire date of the insured in certain instances, which prevents the accurate determination of the pre-existing waiting period. The exclusionary period for new enrollees is defined as the six month period ending on the day before the date of hire of medical services for which medical advice, diagnosis, care or treatment was recommended or received. By April 1, 2008, the Company will validate, and revise when necessary, its pre-existing claims processing policy and procedures. In the review, the Company will:

- Rely on employer group hire date information without additional verification.
- Gather missing hire date information.
- Gather the employer group's waiting period, if applicable.
- Define procedures for obtaining COCCs for new members, in advance of claims submissions, to reduce inappropriate pre-existing condition denials.

- Update denial remark code used on pre-existing condition denials used when there is no COCC or prior physician information. The remark code will specifically address what the member must provide for the denied claim to be reconsidered when a COCC is not available and there have been no physician visits within six months of the service denied.
- Define procedures for calculating the waiting period based on the subscriber's hire date and employer group waiting period, where applicable.
- Define the documentation required for the calculation of the waiting period.
- Define the documentation required supporting the request for an insured's COCC.
- Define what medical record information must be documented to support the pre-existing determination when the insured has not responded to a request for COCC or the names of physicians who have treated the member in the past six months.
- Define documentation required for upholding a pre-existing determination when an insured does not respond to a request for a COCC or names of physicians who have treated the member in the past six months.
- Define correspondence with insureds when asking insured to confirm that no treatment, advice, diagnosis or case was received or no COCC is available. The correspondence will specifically outline the required responses.
- Develop a transaction procedure checklist that outlines each step and the required documentation before denying the pre-existing condition and/or requesting a COCC.

ELECTRONIC CLAIMS PAID REVIEW

The examiners received a listing of 1,077,024 group paid claims and 48,683 individual paid claims. The results of the computerized data analysis revealed that 40,808 group paid claims and 1,329 individual paid claims were not reimbursed as soon as practical, but no later than 30 working days of receipt of the claim by the company. The Department alleges these acts are in violation of CIC § 10123.13(a).

The data analysis identified 5,420 of the group paid claims and 12 of the individual paid claims did not include interest with the reimbursement paid over 30 working days of receipt of the claim. The Department alleges these acts are in violation of CIC § 10123.13(b).

The electronic paid claims review also detected that the company did not comply with acknowledgement of claim receipt. This violation occurred in 81,280 paid claims (55,492 group and 25,788 individual). The Department alleges these acts are in violation of CIC § 10133.66(c).

The Company agrees claims were not paid within 30 working days of receipt and that interest is due when reimbursed over 30 days of receipt of the claim. The Company conducted a self-survey of the claims identified in the data analysis review period (6/23/06 – 5/31/07) and manually adjusted the claims to include interest totaling $138,792.65 The Company provided supporting data and proof of additional payments to the Department totaling $33.65 in the 12 individual claims identified and $138,759.00 in the 5,420 group paid claims identified as not including interest with the reimbursement paid over 30 working days of receipt of claim. The Company will reinforce timely reimbursement of claims and has emphasized with managers the importance of continued daily use of inventory reports to monitor the age of claims.

The Company agrees that it is required to send an acknowledgement letter for claims received, if the claim is not otherwise acknowledged by payment and/or issuance of an EOB within 15 calendar days. The acknowledgement letter process was not in compliance for July 2006 through December 2006. Acknowledgement letters for individual claims were corrected in July 2007.

To ensure that all claims acknowledgement letters are produced, the Company's corrective actions include:

- Reporting will be developed by March 1, 2008 to confirm that all un-adjudicated claims aged greater than 15 days have had acknowledgement letters sent.
- Ongoing monitoring of paper claims submissions will continue to reduce late loading of claims into the claims system.

Exhibit 2

PUBLIC REPORT
(PURSUANT TO INSURANCE CODE SECTION 12938)

OF THE MARKET CONDUCT EXAMINATION

OF THE CLAIMS PRACTICES OF THE

PACIFICARE LIFE AND HEALTH INSURANCE COMPANY
NAIC # 70785 CDI # 3086-6

AS OF MAY 31, 2007

[Made available in accordance with CIC Section 12938)]

STATE OF CALIFORNIA

DEPARTMENT OF INSURANCE
MARKET CONDUCT DIVISION
FIELD CLAIMS BUREAU

Format 12938

NOTICE REGARDING CONFIDENTIALITY

The provisions of Section 735.5(a) (b) and (c) of the California Insurance Code 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. Section 12938 of the California Insurance Code requires the publication of certain legal documents and examination reports.

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

Steve Poizner, *Insurance Commissioner*

January 18, 2008

The Honorable Steve Poizner
Insurance Commissioner
State of California
45 Fremont Street
San Francisco, California 94105

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 practices and procedures in California of:

PacifiCare Life and Health Insurance Company

NAIC # 70785

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

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

FOREWORD

This targeted examination covered the claims handling practices of the aforementioned Company during the period June 23, 2006, through May 31, 2007. 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 alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al.

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 resulted in 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

The targeted examination focused on the Company claims processing operations including provider network management and provider contract uploading as a result of complaints received by the Department from consumers and healthcare providers with respect to individual and group health insurance coverage.

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 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 consumer complaints and inquiries about the Company handled by the California Department of Insurance (CDI) during the same time period and a review of prior CDI market conduct examination reports on the Company.

4. A review of electronic paid claims data. This analysis however, was limited to a review of timely acknowledgement of claims, timeliness of payment of claims, and proper payment of interest pursuant to the California Insurance Code (CIC).

The sample of claims files, provider disputes, member appeals and related records were reviewed at the office of the Company in Cypress, California. The review of electronic paid claims data was conducted primarily within the office of the Department of Insurance in Los Angeles, California.

EXECUTIVE SUMMARY OF CLAIMS SAMPLE REVIEWED

The examination targeted provider network operations for provider contract loading and claims processing, provider disputes and member appeals as a result of numerous complaints received by the Department from consumers and healthcare providers. The principal areas of concern noted in the examination report are: failure to adopt and implement reasonable standards for the prompt investigation and processing of claims, failure to file and record documentation, and failure to effectuate prompt, fair and equitable settlements of claims.

The claims reviewed were closed between June 23, 2006 and May 31, 2007, commonly referred to as the "review period". Using a computer analysis program, the examiners reviewed 1,125,707 paid claims (1,077,024 group health claims and 48,683 individual health claims). The electronic data available allowed only a review of timeliness of acknowledgement, timeliness of payment of claims and proper payment of interest. The electronic data field parameters were: Date Received, Date Acknowledged and Date Paid or Closed. The electronic review resulted in no claims handling violations within the scope of this report. For the on-site review, the examiners randomly selected 339 sample files (114 denied claims files, 96 provider disputes, 79 member appeals and 50 provider contract agreement uploads). The examiners cited 90 alleged claim handling violations of the Fair Claims Settlement Practices Regulations and/or California Insurance Code Section 790.03 from this sample file review detailed in the report tables and summaries.

The Company indicated that a spike in processing errors occurred as a result of provider contracting efforts due to a provider network transition effective June 23, 2006. The Company's administrative capacity was affected as follows: a) inaccurate loading of provider contracts; b) inadequate control over documents for processing of claims and provider disputes; and c) inadequate staffing and training. The Company states that it is committed to correcting the deficiencies cited in the report.

RESULTS OF REVIEWS OF CONSUMER COMPLAINTS AND INQUIRIES AND PREVIOUS EXAMINATIONS

The Company was the subject of 237 consumer complaints and inquiries which includes 68 provider disputes between June 23, 2006 and May 31, 2007. The review of these complaints and inquiries resulted in identification of the following trends in noncompliance: wrongful denials of covered claims; undue delay in claims processing; multiple requests for documentation that was previously provided, including, but not limited to, certification of creditable coverage and inaccurate recording of provider contract data.

The most recent prior examination reviewed a period between July 1, 2005 and June 30, 2006. The most significant noncompliance issues identified in the prior examination report were failure to maintain all documents, notes and work papers in the claim file, failure to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue and failure to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies.

DETAILS OF THE CURRENT EXAMINATION

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

PLHIC SAMPLE FILES REVIEWED			
LINE OF BUSINESS / CATEGORY	FILES FOR REVIEW PERIOD	SAMPLE FILES REVIEWED	CITATIONS
Accident and Disability / Group Health Claims Denied	428,126	68	2
Accident and Disability / Group Health Provider Disputes	12,367	55	34
Accident and Disability / Group Health Member Appeals	688	47	32
Accident and Disability / Individual Health Claims Denied	2957	46	3
Accident and Disability / Individual Health Provider Disputes	159	41	19
Accident and Disability / Individual Health Member Appeals	68	32	0
Provider Contract Agreements Effective dates 1/1/06-3/31/07	10,566	50	0
TOTALS	454,931	339	90

PLHIC ELECTRONIC CLAIMS PAID REVIEW*		
LINE OF BUSINESS / CATEGORY	NUMBER OF CLAIMS	CITATIONS
Accident and Disability / Group Health Claims Paid	1,077,024	0
Accident and Disability / Individual Health Claims Paid	48,683	0
TOTALS	1,125,707	0

* All claims incurred subject to review

TABLE OF TOTAL CITATIONS

Citation	Description	# CITATIONS
CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies.	16
CCR §2695.3(a)	The Company's claim file failed to contain all documents, notes and work papers that pertain to the claim.	15
CIC §790.03(h)(5)	The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.	15
CCR §2695.3(b)(3)	The Company failed to maintain hard copy claim files or maintain claim files that are accessible, legible and capable of duplication to hard copy for five years.	14
CCR §2695.5(b)	The Company failed to respond to communications within 15 calendar days or with a complete response based on the facts as then known by the licensee.	11
CCR §2695.11(b)	The Company failed to provide an explanation of benefits or a clear explanation of benefits.	8
CCR §2695.3(b)(2)	The Company failed to record in the file the date the Company received, date the Company processed and date the Company transmitted or mailed every relevant document in the file.	4
CCR §2695.5(a)	The Company failed to respond to a Department of Insurance inquiry within 21 calendar days.	3
CCR §2695.7(g)	The Company attempted to settle a claim by making a settlement offer that was unreasonably low.	2
CIC §790.03(h)(1)	The Company failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue.	2
Total Citations		**90**

TABLE OF CITATIONS BY LINE OF BUSINESS

ACCIDENT AND DISABILITY 2006 Written Premium: $843,721,575	NUMBER OF CITATIONS		
AMOUNT OF RECOVERIES **$667.66**	Electronic Paid Claims Review	Sample File Review	Total
CIC §790.03(h)(3)	0	16	16
CCR §2695.3(a)	0	15	15
CIC §790.03(h)(5)	0	15	15
CCR §2695.3(b)(3)	0	14	14
CCR §2695.5(b)	0	11	11
CCR §2695.11(b)	0	8	8
CCR §2695.3(b)(2)	0	4	4
CCR §2695.5(a)	0	3	3
CCR §2695.7(g)	0	2	2
CIC §790.03(h)(1)	0	2	2
SUBTOTAL	**0**	**90**	**90**

TOTAL	**0**	**90**	**90**

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. This report contains only alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al. 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 to take appropriate corrective action in all jurisdictions where applicable.

Money recovered within the scope of this report was $667.66 as described in section number 3 below. As a result of the examination, the total amount of money returned to claimants within the scope of this report was $667.66.

ACCIDENT AND DISABILITY

1. **In 16 instances, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies.** The Company did not follow its own guidelines for processing member appeals and provider disputes. In ten instances, the Company failed to follow its own procedures including the failure to process no choice emergency room claims at a participating provider level, the failure to pay non-participating ancillary providers at a participating provider level when used as part of a no choice emergency room claim, and the failure to process the hospital charges of a mother and newborn as a single claim rather than splitting the charges and processing separate claims. In six instances, the Company failed to implement standards for the prompt investigation and processing of claims. For example, the Company failed to properly investigate if a condition was pre-existing prior to issuing a pre-existing denial and failed to instruct members that a separate Certificate of Creditable Coverage (COCC) for minor dependants is required when requesting a COCC. The Department alleges these acts are in violation of CIC §790.03(h)(3).

Summary of Company Response: The Company acknowledges that it failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies in 12 of the 16 instances. In October 2007, the Company reinforced its processing procedures with claims staff to ensure future compliance. In the remaining four instances, the Company disagrees it failed to adopt and implement reasonable standards for the prompt investigation and processing of claims.

This is an unresolved issue and may result in administrative action.

2. **In 15 instances, the Company failed to maintain all documents, notes and work papers in the claim file.** The claim files did not include pertinent documents supporting the claims adjudication decision in sufficient detail to reach the same determination by a second reviewer. The Department alleges these acts are in violation of CCR §2695.3(a).

Summary of Company Response: The Company acknowledges it failed to maintain all documents, notes and work papers in the claim file in five of the 15 instances. The Company

conducted additional training in October 2007 to address the specific requirements for properly documenting a claim adjudication decision. In the remaining ten instances, the Company disagrees it failed to maintain all documents, notes and work papers in the file.

This is an unresolved issue and may result in administrative action.

3. **In 15 instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.** Claims were reimbursed using an incorrect fee schedule or claims were denied for payment with no documentation to support billed services that were not covered. The Department alleges these acts are in violation of CIC §790.03(h)(5).

Summary of Company Response: The Company acknowledges that in 9 of the 15 instances, it failed to adjudicate the claims properly. As result of the findings, the Company issued payments totaling $667.66 to claimants. The Company conducted additional training of its claims processing staff in October 2007. The training specifically addressed the audit findings, including proper payment and denials of claims. To confirm that claims processing errors are being mitigated, the Company will implement focused self-audits of both paid and denied claims. In the remaining six instances, the Company states the denials were proper and/or the processing of the claims was based on the recommendation of their software program utilized to adjudicate the claim.

This is an unresolved issue and may result in administrative action.

4. **In 14 instances, the Company failed to maintain hard copy files or claim files that are accessible, legible and capable of duplication to hard copy for five years.** The Department alleges these acts are in violation of CCR §2695.3(b)(3).

Summary of Company Response: The Company believes that it can reproduce claim file documents for CDI purposes. However, the Company acknowledges that in 3 of the 14 instances it failed to maintain documents. The Company states that these appear to be isolated instances. In the remaining 11 instances, the Company disagrees that it failed to maintain hard copy files or claims files that are accessible, legible and capable of duplication to hard copy for five years.

This is an unresolved issue and may result in administrative action.

5. **In 11 instances, the Company failed to respond to communications within 15 calendar days.** The Company failed to respond to member appeals within 15 calendar days with a complete response based on the facts as then known. While communications were responded to within the timeframe requirement, the Company did not address the issues the members brought forth with facts as known. The Department alleges these acts are in violation of CCR §2695.5(b).

Summary of Company Response: The Company respectfully disagrees that it failed to respond to communications within 15 calendar days. The Company complies with CCR §2695.5(b) by sending acknowledgment letters. The Company confirms that an acknowledgment letter was sent within 15 calendar days in all 11 instances mentioned above. In addition, member

appeals for coverage (post-service) issues, medical necessity and investigational/ experimental are processed based on the Company's appeals process, the Policy and Procedure for PPO Enrollee Appeals, Complaint and Grievance Process, which indicates appeals are processed within 30 days in accordance with CIC 10123.135.

This is an unresolved issue and may result in administrative action.

6. **In eight instances, the Company failed to provide to the claimant an explanation of benefits including the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits.** The Department alleges these acts are in violation of CCR §2695.11(b).

Summary of Company Response: The Company agrees that it failed to provide to the claimant a clear explanation of the computation of benefits in six of the eight instances. The Company implemented revised EOB remark codes in October 2007 and conducted training on proper remark code usage. The Company will also include a review of the EOB in their focused audit of paid claims. In the remaining two instances, the Company disagrees that it failed to provide the claimant an explanation of benefits including the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits.

This is an unresolved issue and may result in administrative action.

7. **In four instances, the Company failed to record the date the Company received, date the Company processed and date the Company transmitted or mailed every relevant document in the file.** The Department alleges these acts are in violation of CCR §2695.3(b)(2).

Summary of Company Response: The Company acknowledges in one instance there was no date stamp on an appeal received at our Company. This is an isolated instance since there are processes and procedures already in place to ensure this information is contained within the claims file. The Company will continue to reinforce its existing procedures to ensure compliance. In the remaining three instances, The Company respectfully disagrees that it failed to record the date the Company received, date the Company processed and date the Company transmitted or mailed every relevant document in the file.

This is an unresolved issue and may result in administrative action.

8. **In three instances, the Company failed to respond to a Department of Insurance inquiry within 21 calendar days.** The Department alleges these acts are in violation of CCR §2695.5(a).

Summary of Company Response: The Company acknowledges in one instance that it failed to respond to a Department of Insurance inquiry within 21 calendar days. The complete documentation to support an adjustment made to the claim in question was not initially provided in the appeal file at the time of initial examination. In future examinations, the Company will strive to include all claim related documents in the appeal file in accordance with CCR §2695.5(a). In the remaining two instances, the Company respectfully disagrees that it failed to respond to a Department of Insurance inquiry within 21 calendar days.

This is an unresolved issue and may result in administrative action.

9. **In two instances, the Company attempted to settle a claim by making a settlement offer that was unreasonably low.** The participating provider was paid at a rate that was less than the provider contracted rate. The Department alleges these acts are in violation of CCR §2695.7(g).

Summary of Company Response: As a result of the findings of the examination, the Company is in the process of identifying claims submitted by this provider to determine whether there was an underpayment. The Company reviewed the 2 instances where the Department alleges that the Company attempted to settle a claim by making a settlement offer that was unreasonably low and respectfully disagrees with the Department's allegations. The cited section, CCR 2695.7(g), prohibits an insurer from unfairly settling claims by making a settlement offer that is unreasonably low. The Company disagrees that these two instances represent offers to settle. These two instances involve claims with total billed charges less than $200 in value and were incorrectly paid. These incorrect payments do not represent unfair offers to settle in the meaning of CCR 2695.7(g).

This is an unresolved issue and may result in administrative action.

10. **In two instances, the Company failed to represent correctly to claimants, pertinent facts or insurance policy provisions relating to a coverage at issue.** The Company referenced a one year pre-existing exclusionary period on the EOB when the exclusionary period for pre-existing conditions is six months. The Company began using the EOB language effective January 1, 2004 and continued through December 2006. The Department alleges these acts are in violation of CIC §790.03(h)(1).

Summary of Company Response: The Company acknowledges that its administration of pre-existing exclusionary periods required correction. The Company's training materials were updated to reflect a 6 month exclusionary period and subsequent training of staff was completed in December 2006. An automated update of the claims system was made in December 2006 and the pre-existing field is set for 6 months. In March 2007, the Company issued Large Group plan amendments changing the exclusionary period to 6 months and communications were sent to the affected groups advising them of the changes.

PROVIDER CONTRACT AGREEMENTS

There were no citations alleged or criticisms of insurer practices in this sample file review within the scope of this report.

ELECTRONIC PAID CLAIMS REVIEW

There were no citations alleged or criticisms of insurer practices in this sample file review within the scope of this report.