

PUBLIC REPORT OF EXAMINATION OF THE CLAIMS

PRACTICES OF THE

**THE MEGA LIFE AND HEALTH INSURANCE COMPANY**  
**NAIC # 97055 CDI # 2976-9**

AS OF JANUARY 31, 2001

**STATE OF CALIFORNIA**



**DEPARTMENT OF INSURANCE**

**FIELD CLAIMS BUREAU**

**TABLE OF CONTENTS**

SALUTATION.....1

SCOPE OF THE EXAMINATION.....2

CLAIMS SAMPLE REVIEWED AND OVERVIEW OF FINDINGS.....3

TABLE OF TOTAL CITATIONS.....4

SUMMARY OF CRITICISMS, INSURER COMPLIANCE ACTIONS  
AND TOTAL RECOVERIES.....5

**CALIFORNIA DEPARTMENT OF INSURANCE**

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



September 18, 2002

The Honorable Harry W. Low  
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:

**The MEGA Life And Health Insurance Company**

**NAIC #97055**

Hereinafter referred to as MEGA Life or as 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](http://www.insurance.ca.gov)) pursuant to California Insurance Code section 12938.

## **SCOPE OF THE EXAMINATION**

The examination covered the claims handling practices of the aforementioned Company during the period February 1, 2000 through January 31, 2001. The examination was made to discover, in general, if these and other operating procedures of the Companies conform with the contractual obligations in the policy forms, to provisions of the California Insurance Code (CIC), the California Code of Regulations (CCR), the California Vehicle Code (CVC) and case law. This report contains only alleged violations of Section 790.03 and Title 10, California Code of Regulations, Section 2695 et al.

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 claims files and related records.
3. A review of consumer complaints received by the California Department of Insurance (CDI) in the most recent year prior to the start of the examination.

The examination was conducted primarily at the Company's claims office in Dallas, Texas.

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 only a summary of pertinent information about the lines of business examined and details of the non-compliant or problematic activities or results that were discovered during the course of the examination along with the insurer's proposals for correcting the deficiencies. When a violation is discovered that results in an underpayment to the claimant, the insurer corrects the underpayment and the additional amount paid is identified as a recovery in this report. All unacceptable or non-compliant activities may not have been discovered, however, and failure to identify, comment on or criticize activities does not constitute acceptance of such activities.

Any alleged violations identified in this report and any criticisms of practices have not undergone a formal administrative or judicial process.

## CLAIM SAMPLE REVIEWED AND OVERVIEW OF FINDINGS

The examiners reviewed files drawn from the category of Closed Claims for the period February 1, 2000 through January 31, 2001, commonly referred to as the “review period”. The examiners reviewed 654 MEGA Life And Health Insurance Company disability insurance (DI) and life insurance claim files. The examiners cited 84 claims handling violations of the Fair Claims Settlement Practices Regulations and/or the California Insurance Code section 790.03 within the scope of this report.

<b>The MEGA Life and Health Insurance Company</b>			
<b>CATEGORY</b>	<b>CLAIMS FOR REVIEW PERIOD</b>	<b>REVIEWED</b>	<b>CITATIONS</b>
DI – Health	82,782	408	75
DI – Dental	1,100	158	4
Life	165	88	5
<b>TOTALS</b>	84,047	654	84

<b>TABLE OF TOTAL CITATIONS</b>		
<b>Citation</b>	<b>Description</b>	<b>MEGA Life</b>
CIC § 790.03(h)(5)	The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.	54
CCR § 2695.4(a)	The Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy.	12
CCR § 2695.7(g)	The Company attempted to settle a claim by making a settlement offer that was unreasonably low.	12
CCR § 2695.3(b)(2)	The Company failed to record in the file the date the Company received, date(s) the Company processed and date the Company transmitted or mailed every relevant document in the file.	3
CCR § 2695.3(a)	The Company's claim file failed to contain all documents, notes, and work papers which pertain to the claim.	1
CCR § 2695.7(b)(3)	The Company failed to include a statement in their 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.	1
CIC §790.03(h)(3)	The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims.	1
<b>Total Citations</b>		84

## **SUMMARY OF CRITICISMS, INSURER COMPLIANCE ACTIONS AND TOTAL RECOVERIES**

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. Regardless of the remedial actions taken or proposed by the Company, it is the Company's obligation to ensure that compliance is achieved. The total money recovered was \$1,308.12 within the scope of this report.

**1. The Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear.** In 54 instances, the Company failed to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear. The Department determined that in the 54 instances that the Company had the information sufficient to pay the claims but did not pay the claims within a reasonable time. This includes Company failures to notify claimants that their claim was contested or denied in a reasonable time so as to complete its claim handling promptly. The Department has received an electronic study of the Company's claim payment activity and has determined that there exists the potential of thousands of claims that were not paid in a reasonable time. The Department alleges these acts are in violation of CIC § 790.03(h)(5).

**Summary of Company Response:** The Company acknowledged these violations, which were incurred under their Student Insurance policies. However, the Company believes that the violations were not knowingly committed nor did they occur with such frequency as to indicate a general business practice. The examiners were advised that this was the result of time service issues that existed within the Company. The Student Insurance Division of the Company was not Y2K compliant during the first quarter of 2000 and was not able to maintain production at an acceptable level. The division did not achieve full production until the latter part of March, 2000. The claim system is now fully operational for this product and the processors are maintaining timely production standards.

**2. The Company failed to disclose all policy provisions.** In 12 instances, the Company failed to disclose all benefits, coverage, time limits or other provisions of the insurance policy. The Department alleges these acts are in violation of CCR § 2695.4(a).

**Summary of Company Response:** The Company has acknowledged these citations. As a result of this claim examination, the insurer will conduct a review of

policy provisions and rider benefits to assure that personnel are cognizant of the various benefits available. Procedures will be implemented to address this issue.

**3. The Company attempted to settle a claim by making a settlement offer that was unreasonably low.** In 12 instances, the Company attempted to settle a claim by making a settlement offer that was unreasonably low. These violations occurred due to incorrect interpretation of riders that accompany the basic plans, or a misapplication of policy exclusions. The Department alleges these acts are in violation of CCR § 2695.7(g).

**Summary of Company Response:** The Company has acknowledged these citations. The Company will be working with claim adjusters to assure complete comprehension of all the various plans and available riders that enhance the basic products of all group business.

**4. The Company failed to record claim data in the file.** In three instances, the Company failed to record the date the Company received, date(s) 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 has acknowledged these citations. It is the Company's standard procedure to record all pertinent dates in the claim file or in the data processing claim system. Claim processors will be reminded of these policies and procedures at the next team meeting or with a training memo.

**5. The Company failed to properly document claim files.** In one instance, the Company's file(s) failed to contain all documents, notes, and work papers. The Department alleges this act is in violation of CCR §2695.3(a).

**Summary of Company Response:** The Company has acknowledged this citation. It is the Company's standard procedure to maintain all documents, notes and work papers as part of the claim file or the data processing claim system.

**6. The Company failed to advise the claimant that he or she may have the claim denial reviewed by the California Department of Insurance.** In one instance, the Company failed to include a statement in their 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 Department alleges this act is in violation of CCR § 2695.7(b)(3).

**Summary of Company Response:** The Company has acknowledged this citation. It is the Company's policy to include the appropriate California Department of Insurance language on all denial and Explanation Of Benefits letters that contain denials. The Company will continue to require appropriate language on all denials and will audit claims to assure compliance with this regulation.

7. **The Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims.** In one instance, the Company failed to adopt and implement reasonable standards for the prompt investigation and processing of claims. The Department alleges this act is in violation of CIC §790.03(h)(3).

**Summary of Company Response:** The Company and its claims administrator, Excess, Inc, have acknowledged this citation. The administrator has revised “policies and procedures” to more closely monitor the flow of claims. If a claim is not pended with a follow-up date or paid in 25 days by the main office, contact will be made with that office to determine the reason for the delay.