

PUBLIC REPORT OF EXAMINATION OF THE CLAIMS

PRACTICES OF THE

HEALTH NET LIFE INSURANCE COMPANY
NAIC # 68799 CDI # 1740-0

AS OF JANUARY 31, 2002

STATE OF CALIFORNIA



DEPARTMENT OF INSURANCE

FIELD CLAIMS BUREAU

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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



February 25, 2003

The Honorable John Garamendi
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:

Health Net Life Insurance Company

NAIC #68799

Hereinafter referred to 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) 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, 2001 through January 31, 2002. The examination was made to discover, in general, if these and other operating procedures of the Company 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 at the Company's claims office in Woodland Hills, California.

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, 2001 through January 31, 2002, commonly referred to as the “review period”. The examiners reviewed 241 Health Net Life Insurance Company claim files. The examiners cited 71 claims handling violations of the Fair Claims Settlement Practices Regulations and/or California Insurance Code Section 790.03 within the scope of this report. Further details with respect to the files reviewed and alleged violations are provided in the following tables and summaries.

Health Net Life Insurance Company			
CATEGORY	CLAIMS FOR REVIEW PERIOD	REVIEWED	CITATIONS
Disability – Medical - Indemnity	93,680	100	35
Disability – Medical – PPO/POS	1,495,124	100	34
Group Life	101	41	0
General	-	-	2
TOTALS	1,588,905	241	71

TABLE OF TOTAL CITATIONS		
Citation	Description	Health Net Life Insurance Company
CCR §2695.7(b)(3)	The Company failed to include the claimant's right to a CDI review in partial denial.	43
CCR §2695.3(a)	The Company failed to properly document claim files.	19
CIC §790.03(h)(3)	The Company failed to adhere to a standard of prompt investigation and processing of claim.	5
CCR §2695.7(g)	The Company attempted to settle a claim by making a settlement offer that was unreasonably low.	1
CCR §2695.3(b)(2)	The Company failed to record claim data in the file.	1
CCR §2695.6(b)	The Company failed to provide thorough and adequate training regarding these regulations to all their claims agents.	1
CCR §2695.6(b)(4)	The Company failed to maintain a copy of the certification required by CCR §2695.6(b) (1), (2) or (3) at the principal residence of business.	1
Total Citations		71

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 \$1,185.87 within the scope of this report.

1. The Company failed to advise the claimant that he or she may have the claim denial reviewed by the California Department of Insurance. In 43 instances, the Company failed to include a statement in their Explanation of Benefits 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 these acts are in violation of CCR §2695.7(b)(3).

Summary of Company Response: The Company has acknowledged that the Explanation of Benefits used for explaining the non-allowed amount, allowable amount, benefit amount, non-covered charge did not contain the required language. As a result of this examination, the Company will add the required language in their Explanation of Benefits to comply with the law. The Company provided a copy of the new Explanation of Benefits containing the required language. The Company's Systems Department is in the process of updating the Explanation of Benefits.

2. The Company failed to properly document claim files. In 19 instances, the Company's files 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 acknowledges that the denial letters on 17 claims denied prior to July 2001 were not properly stored in the company's electronic downloading library system. Specifically, the system was blocking the print of denial letters for one specific denial code. As a result of the examination, the block was quickly removed and the documentation exceptions noted above were corrected. The downloading system stores and prints all denial letters upon request. In two instances the above changes in the electronic library system resulted in coding errors. These coding problems have been remedied.

3. The Company failed to adhere to standard of prompt investigation and processing of claim. In five instances, the claims files had gaps in activity and showed failure of resolving issues to move the claim to a prompt conclusion. The Department alleges these acts are in violation of CIC §790.03(h)(3).

Summary of Company Response: In two instances, the Company has acknowledged the lack of action/activity from the proof of loss requirements that was received until the payment of claim. In one instance, the provider appealed to reprocess the claim by submitting additional information. The Company had no explanation for the delay and the lack of action/activity to bring the claim to conclusion. In two other instances, the Company has acknowledged the claims

were in the examiner's queue. The Company has indicated it will reiterate to the claims adjusting staff the need to promptly investigate and process claims.

4. The Company attempted to settle a claim by making a settlement offer that was unreasonably low. In one instance, the Company attempted to settle a claim by making a settlement offer that was unreasonably low. The Department alleges this act is in violation of CCR §2695.7(g).

Summary of Company Response: The Company acknowledges that in one instance, the claim should have been processed under a different schedule of benefits. The apparent mistake by the adjuster resulted in a lower allowed amount. As a result of this examination, an adjustment was made on May 28, 2002 resulting in an additional payment. Health Net will monitor Examiner performance through its quality assurance program and provide remedial response when errors are detected.

5. The Company failed to record claims data in the file. In one instance, the Company failed to record the date the Company received a relevant document in the file. The Department alleges this act is in violation of CCR §2695.3(b)(2).

Summary of Company Response: The Company acknowledges that it failed to document when a pre-authorization letter was received. The Company will be operational with an independent vendor to handle the receipt and scanning of claims and other documents in early 2003. The new vendor operation will continue to improve the Company's date-stamping and subsequent tracking of documents.

6. The Company failed to provide thorough and adequate training regarding these regulations to all their claims agents. The Company failed to provide thorough and adequate training regarding these regulations to all their claims agents. The Department alleges this act is in violation of CCR §2695.6(b).

Summary of Company Response: The Company acknowledged that its claims manual did not contain the Fair Claims Settlement Practices Regulations at the time of the exam and its claims examiners were not provided with written instructions on these regulations. On June 6, 2002, the Company added the Fair Claims Settlement Practices Regulations to its claims operations manual. In August 2002, the Company implemented a computer based training program to provide its staff with an overview of California claims regulations.

7. The Company failed to maintain a copy of the certification required by CCR §2695.6(b) (1), (2) or (3) at the principal place of business. The Company failed to maintain a copy of the certification required by CCR §2695.6(b) (1), (2) or (3) at the principal place of business. The Department alleges this act is in violation of CCR §2695.6(b)(4).

Summary of Company Response: The Company acknowledges that its claims manual did not contain a copy of the Fair Claims Settlement Practices Regulations at the time of the exam and its claims examiners were not provided with written instructions on these regulations. On June 6, 2002, the Company added the Fair Claims Settlement Practices Regulations to its claims operations manual. In August 2002, the Company implemented a computer based training program

to provide its staff with an overview of California claims regulations. The Company has taken steps to comply with CCR §2695.6(b)(4). The Company successfully completed agent training through computer based training (CBT) program and certification was accomplished on August 27, 2002.