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

Format 735.5

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

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.