STATE OF ARIZONA
FILED

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DEPT OF INSURANCE
BY

STATE OF ARIZONA

ARIZONA DEPARTMENT OF INSURANCE

In the Matter of:	Docket No. 10A-028-INS
HEALTH NET LIFE INSURANCE COMPANY NAIC #66141	**CONSENT ORDER**
Respondent.	

On October 14, 2008, the Arizona Department of Insurance ("Department") called a health insurance compliance examination ("Examination") of Health Net Life Insurance Company, ("HNLIC" or "Company") covering the time period January 1, 2007 through December 31, 2008 ("Examination Period"). The Examination Period was divided into four six-month periods ("Partial Examination Periods" or "PEPs") as follows:

PEP 1:	January 1, 2007 – June 30, 2007
PEP 2:	July 1, 2007 – December 31, 2007
PEP 3:	January 1, 2008 – June 30, 2008
PEP 4:	July 1, 2008 – December 31, 2008

The Report of the Health Insurance Compliance Examination of Health Net Life Insurance Company dated July 29, 2009 ("Report"), which is included herein by reference, alleges that HNLIC violated Arizona Revised Statutes (A.R.S.) §§ 20-2533 through 20-2536, A.R.S. § 20-3102, A.R.S. §§ 20-461 through 20-462 and Arizona Administrative Code (A.A.C.) R20-6-801. The Company wishes to resolve this matter without formal proceedings. HNLIC admits the following Findings of Fact are true and consents to the entry of the following Conclusions of Law solely for the purpose of resolving the allegations contained in the Report, and consents to the entry of the following Order.

FINDINGS OF FACT

I. Jurisdiction.

HNLIC is, and throughout the Examination Period was, authorized to operate as a disability insurer pursuant to a Certificate of Authority issued by the Arizona Insurance Director ("Director").

II. Utilization Review and Health Care Appeals.

A. During PEP 1, in 5 of 26 (19% of) health care appeals, HNLIC failed to provide a health care appeals information packet to the member within five business days after the appeal was initiated. In the files the Department reviewed for PEPs 2, 3 and 4, the Department did not find a significant number of files with this violation.

B. During PEPs 1 and 4, in 2 of 2 (100% of) expedited medical reviews where there was an adverse decision, HNLIC failed to notify the member or the member's treating provider by telephone and mail of the adverse decision or of the member's option to immediately proceed to an expedited appeal. In the files the Department reviewed for PEPs 2 and 3, the Department did not find a significant number of files with this violation.

C. During PEP 1, in 8 of 26 (31% of) requests for informal reconsiderations, HNLIC failed to mail a written acknowledgment to the member within five business days after receiving the request, or failed to mail a written acknowledgment to the member's treating provider within five business days after receiving the request or failed to do either. In the files the Department reviewed for PEPs 2, 3 and 4, the Department did not find a

significant number of files with this violation.

D. During PEP 2, in 1 of 4 (25% of) formal appeals, HNLIC failed to mail a written acknowledgment to the member and the member's treating provider within five business days after receiving the formal appeal. In the files the Department reviewed for PEPs 1, 3 and 4, the Department did not find a significant number of files with this violation.

III. Provider Grievances.

HNLIC failed to establish or have an effective internal system for resolving payment disputes and contractual grievances, including:

A. During the Examination Period, failed in 31 of 200 (16% of) health care provider grievances, to categorize health care provider grievances accurately.

B. During PEPs 2, 3 and 4, failed in 41 of 150 (27% of) health care provider grievances, to timely resolve health care provider grievances within the timeframe HNLIC established. In the provider grievances the Department reviewed for PEP 1, the Department did not find a significant number of provider grievances with this violation.

IV. Target Review – Unfair Practices And Frauds.

A. During the Examination Period, in 67 of 80 (84% of) member appeals, HNLIC failed to conduct a reasonable investigation prior to the initial denial of a claim.

B. During the Examination Period, in 67 of 80 (84% of) member appeals, HNLIC failed to promptly provide a reasonable explanation that provided

the basis of the initial denial of a claim.

C. During the Examination Period, in 65 of 80 (81% of) member appeals, HNLIC failed, where appropriate, to pay interest on an overturned claim not paid within thirty days after receipt that contained all information necessary for claim adjudication.

CONCLUSIONS OF LAW

I. Jurisdiction.

The Director has the authority to enter and enforce this Order. A.R.S. § 20-142.

II. Utilization Review and Health Care Appeals.

A. During PEP 1, HNLIC violated A.R.S. § 20-2533(C) by failing to provide a health care appeals information packet to the member within five business days after the date the appeal was initiated.

B. During PEPs 1 and 4, in expedited medical reviews where there was an adverse decision, HNLIC violated A.R.S. § 20-2534(C) by failing to notify the member or the member's treating provider by telephone and mail of the adverse decision or of the member's option to immediately proceed to an expedited appeal.

C. During PEP 1, in requests for informal reconsideration, HNLIC violated A.R.S. § 20-2535(B) by failing to mail a written acknowledgment to the member within five business days after receiving the request, or failed to mail a written acknowledgment to the member's treating provider within five business days after receiving the request or failed to do either.

D. During PEP 2, in formal appeals, HNLIC violated A.R.S. § 20-2536(B) by failing to mail a written acknowledgment to the member and the member's treating provider within five business days after receiving the formal appeal.

III. Provider Grievances.

HNLIC violated A.R.S. § 20-3102(F) by failing to establish or have an effective internal system for resolving payment disputes and contractual grievances, including:

A. During the Examination Period, failing to categorize health care provider grievances accurately.

B. During PEPs 2, 3 and 4, failing to timely resolve health care provider grievances within the timeframe the Company established.

IV. Target Review – Unfair Practices And Frauds.

A. During the Examination Period, HNLIC violated A.R.S. § 20-461(A)(4) by failing to conduct a reasonable investigation prior to the initial denial of a claim of a member's appeal.

B. During the Examination Period, HNLIC violated A.R.S. § 20-461(A)(15) and A.A.C. R20-6-801(G)(1)(a) by failing to promptly provide a reasonable explanation of the basis of the initial denial of a claim of a member's appeal.

C. During the Examination Period, HNLIC violated A.R.S. § 20-462(A) by failing, where appropriate, to pay interest on an overturned claim not paid within thirty days after receipt that contained all information necessary for claim adjudication of a member's appeal.

ORDER

IT IS HEREBY ORDERED THAT:

1. Utilization Review And Health Care Appeals. Within 90 days of the filed date of this Order, HNLIC shall submit to the Arizona Department of Insurance for the Director's approval a Corrective Action Plan (CAP 1) regarding its utilization review and health care appeals violations set forth in this Consent Order. CAP 1 shall provide specific steps that HNLIC has taken or will take by certain dates to assure that by a specified implementation date, the Company is:
    a. Providing a health care appeals information packet to members within five business days after the date the appeal was initiated.
    b. In requests for expedited medical review where there was an adverse decision, notifying the member and the member's treating provider by telephone and mail of the adverse decision, and of the member's option to immediately proceed to an expedited appeal.
    c. In requests for informal reconsideration, mailing a written acknowledgment to the member within five business days after receipt of the request, and mailing a written acknowledgment to the member's treating provider within five business days after receipt of the request.
    d. In formal appeals, mailing a written acknowledgment to the member and the member's treating provider within five business days after receipt of the formal appeal.
2. Provider Grievances. Within 90 days of the filed date of this Order, HNLIC shall submit to the Arizona Department of Insurance for the Director's approval a Corrective Action Plan (CAP 2) regarding its health care provider grievance

violations set forth in this Consent Order. CAP 2 shall provide specific steps HNLIC has taken or will take by certain dates to assure that by a specified implementation date, establish or have an effective internal system for resolving payment disputes and contractual grievances by:

a. Categorizing health care provider grievances accurately.

b. Timely resolving health care provider grievances within the timeframe the Company established.

3. Target Review – Unfair Practices And Frauds. Within 90 days of the filed date of this Order, HNLIC shall submit to the Arizona Department of Insurance for the Director's approval a Corrective Action Plan (CAP 3) regarding the unfair practices and fraud violations set forth in this Consent Order. Cap 3 shall provide specific steps HNLIC has taken or will take by certain dates to assure that by a specified implementation date, establish or have an effective internal system for reviewing member appeals by:

a. Conducting a reasonable investigation prior to the initial denial of a claim.

b. Promptly providing a reasonable explanation that provided the basis of the initial denial of a claim.

c. Where appropriate, paying interest on an overturned claim not paid within thirty days after receipt that contained all information necessary for claim adjudication.

4. Progress in Development of CAP. Until the Director approves each CAP or CAP item, HNLIC shall report to the Director each month about its progress in development each CAP or CAP item. Each such monthly report shall include a

current draft of that CAP or CAP item. The first monthly CAP development reports are due to the Director thirty days from the date of this Order.

5. Corrective Action Plan Requirements. Each CAP described above shall:

a. Specify any items of CAP 1 ('a' through 'd'), CAP 2 ('a' through 'b') or CAP 3 ('a' through 'c') that the Director has either approved as ready for implementation or accepted as implemented before the date of the report and for each one;

i. documentation of the implementation or progress toward implementation, as applicable,

ii. a plan for post implementation Quality Improvement review and follow-up, and

iii. the name and contact information for one individual responsible and accountable for ongoing implementation of each CAP or any item of the CAP.

b. Specify any items of CAP 1 ('a' through 'd'), CAP 2 ('a' through 'b') or CAP 3 ('a' through 'c') that the Director has not approved as ready for implementation or accepted as implemented as of date of the report and for each one include:

i. enough detail to allow the Director to determine whether the CAP will accomplish its purpose,

ii. include testing before final implementation of the CAP or any item of the CAP,

iii. include post implementation Qualify Improvement review and follow-up, and

iv. identify the name and contact information for one individual responsible and accountable for ongoing implementation of each CAP or any item of the CAP.

c. Provide for HNLIC to report to the Director each month starting thirty days from the date the Director approves the CAP regarding development and implementation of each approved CAP or any item of the CAP, in a form that includes documentation and is approved by the Director. If the CAP or any item of the CAP has been implemented, provide documentation that demonstrates the results of the changes. If the CAP or any item of the CAP is in the process of implementation, provide documentation that demonstrates the progress that has been made toward implementation.

d. Provide that within ten business days of receiving notice that the Director has approved a CAP or any item of the CAP, HNLIC shall submit to the Director evidence that the Company has communicated the CAP or any item of the CAP to the appropriate personnel and begun implementation. Evidence of communication and implementation includes, without limitation, memorandums, bulletins, e-mails, correspondence, procedure manuals, print screens and training materials.

6. Civil Penalty. HNLIC shall pay a civil penalty of $153,000.00 to the Director for deposit in the State General Fund for violations cited above as Conclusion of

Law. HNLIC shall remit this civil penalty to the Life & Health Division of the Department prior to the Department filing of this Order.

The Department will file the Report of the Health Insurance Compliance Examination of HNLIC upon the filing of this order.

DATED at Phoenix, Arizona this 9th day of February 2010.

Christina Urias
Director of Insurance

CONSENT TO ORDER

1. HNLIC has reviewed the foregoing Order and carefully considered it in conjunction with its other business and regulatory requirements. HNLIC believes that it is able and prepared to comply fully with the Order, notwithstanding any of its other business and regulatory requirements.
2. HNLIC admits the jurisdiction of the Director of Insurance, State of Arizona, admits the Findings of Fact and consents to the entry of the Conclusions of Law solely for the purposes of resolving the allegations contained in the Report and consents to entry of the Order.
3. HNLIC is aware of the right to a hearing, at which it may be represented by counsel, present evidence and cross-examine witnesses. HNLIC irrevocably waives the right to such notice and hearing and to any court appeals related to this Order.
4. HNLIC states that no promise of any kind or nature whatsoever was made to it to induce it to enter into this Consent Order, and that it has entered into this Consent Order voluntarily.
5. HNLIC acknowledges that the acceptance of this Order by the Director of the Arizona Department of Insurance is solely for the purpose of settling this matter. This Order does not preclude any other agency or officer of this state or its subdivisions or any other person from instituting proceedings, whether civil, criminal, or administrative, as may be appropriate now or in the future and does not preclude the Department from instituting proceedings as may be appropriate on other matters now or in the future.

6. Steven Sell, who holds the office of President of Health Net Life Insurance Company, is authorized to enter into this Order for Health Net Life Insurance Company and on its behalf.

HEALTH NET LIFE INSURANCE COMPANY

1-29-10
Date

By _____
Steven Sell
President
Health Net Life Insurance Company

COPY of the foregoing mailed/delivered
this 10th day of February, 2010, to:

Gerrie Marks
Deputy Director
Mary Butterfield
Assistant Director
Consumer Affairs Division
Helene I. Tomme
Market Oversight Division
Dean Ehler
Assistant Director
Property & Casualty Division
Steve Ferguson
Assistant Director
Financial Affairs Division
David Lee
Chief Financial Examiner
Alexandra M. Shafer
Assistant Director
Life and Health Division
Terry L. Cooper
Fraud Unit Chief

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Cierney Buston