STATE OF ARIZONA
FILED
JUN 25 2002
DEPT. OF INSURANCE
BY Kath

STATE OF ARIZONA

DEPARTMENT OF INSURANCE

In the Matter of:	) Docket No. 02A-114-INS
	)
	) CONSENT ORDER
	)
PACIFICARE OF ARIZONA, INC., NAIC # 95617,	)
	)
Respondent	)

Examiners for the Department of Insurance ("the Department") conducted a market conduct examination of PacifiCare of Arizona, Inc. ("PCA" or "The Company"). The Report of the Examination of the Market Conduct Affairs of the Company, dated September 29, 1999, alleges that the Company has violated A.R.S. §§ 20-461, 20-462, 20-1057, 20-2104, 20-2106, 20-2309, 20-2310, 20-2311, 20-2534, 20-2535, 20-2536, 20-2537, A.A.C. R20-6-801, and prior Consent Order, Docket No. 97A-068.

The Company wishes to resolve this matter without formal proceedings, admits that the following Findings of Fact are true, and consents to the entry of the following Conclusions of Law and Order.

FINDINGS OF FACT

1. The Company is authorized to transact business as a health care services organization in Arizona pursuant to a Certificate of Authority issued by the Director.

2. The Examiners were authorized by the Director to conduct a market conduct examination of the Company. The on-site examination covered the time period from January 1, 1996 through December 31, 1998 and was concluded on September 29, 1999. Based on the findings the Examiners prepared the "Report of

Examination of the Market Conduct Affairs of PacifiCare of Arizona, Inc." dated September 29, 1999.

3. On February 14, 1997 PCA's parent company PacifiCare Health Systems acquired FHP International Corporation, the parent company of FHP, Inc.("FHP"), a California-domiciled health care services corporation authorized to transact business in Arizona. Pursuant to a Transfer and Assumption Agreement between PCA and FHP, dated June 30, 1997, PCA assumed all of FHP's Arizona HMO business effective July 1, 1997, including any and all liabilities of every kind or nature related to the Arizona HMO business.

4. To resolve a prior market conduct examination, on March 28, 1997, FHP, entered into a Consent Order, Docket No. 97A-068, in which FHP was ordered to cease and desist from:

a. Failing to disclose to applicants their rights regarding access to and correction of information gathered during the underwriting process;

b. Failing to respond to grievances, appeals and complaints received from consumers, which reasonably suggest that a response is expected, within ten working days of receipt;

c. Denying emergency room and ambulance claims without conducting a prompt and reasonable investigation based upon all available information;

d. Failing to notify first party claimants of the acceptance or denial of their claims within 15 working days or within the time period specified in the contract after the receipt of properly executed proofs of loss;

e. Failing to send the notice of additional information needed on noncontracted denied claims;

f. Failing to complete the investigation of noncontracted paid claims

within 30 days after notification of the claim, unless such investigation cannot reasonably be completed within such time;

g. Failing to pay interest on claims not paid within 30 days after receipt of an acceptable proof of loss which contains all information necessary for claim payment.

5. The Examiners reviewed the Company's individual plan evidence of coverage and certain of its small group evidences of coverage marketed by the Company during the time frame of the examination that indicate the member's coinsurance responsibility for certain hospital services is a fixed percentage and found as follows:

a. The evidences of coverage characterize the coinsurance as a percentage of eligible charges for the service;

b. Certain of the Company's provider contracts provide for delivery of certain of these services, including emergency services, outpatient hospital services, and inpatient hospital services, on a "capitated" basis;

c. Under a capitation method, services are prepaid by the Company on a "per member per month" basis, and there should be no charge to the member, other than a deductible or copayment;

d. The Company's capitated provider agreements include a reimbursement schedule to be used by the provider for billing a member's "coinsurance stated as a percentage;"

e. The provider agreement instructs the capitated provider to compute the member's coinsurance based on 75% of the provider's usual billed charges;

f. The actual percentage of the member's contribution to the cost of

the services cannot be determined without reviewing additional information.

6. The Examiners reviewed 54 of 54 commercial plan advertising materials used during the time frame of the examination and found that the Company used two pieces of advertising materials without first filing these pieces with the Department.

7. The Examiners reviewed 15 of 15 applications and other forms used during the time frame of the examination where personal information is collected on applicants and found that the Company failed to include on six Notice of Information Practices forms, notice of the right to access and correct personal information secured by the Company and failed to advise of the right to obtain an expanded Notice of Information Practices upon request.

8. The Company failed to file with the Director in 1996 and 1997 actuarial statements certifying that the Company was in compliance with the Accountable Health Plan laws and that its small employer group rates were actuarially sound.

9. The Examiners reviewed 50 of 933 employer group health plans renewed during the time frame of the examination and found as follows:

a. The Company failed to include in 35 renewal notices, an explanation of the extent to which any increase in premium was due to the actual or expected claims experience of the individuals covered under the employers health benefits plan;

b. The Company failed to send renewal notices to 11 groups;

10. The Examiners reviewed the Company's procedures to provide certificates of creditable coverage to eligible members during the time frame of the examination and found that except upon the request of the member for such a Certificate, the Company failed to provide Certificates of Creditable coverage within 30 days after the termination of coverage to group members whose coverage had

terminated for reasons other than through the replacement of group coverage by their employers.

11. The Examiners reviewed 20 claims-related appeals received by the Company prior to July 1, 1998 and found that the Company failed on 11 appeals to send an appropriate reply within ten working days of receipt of the claimant's appeal.

12. The Examiners reviewed four of four Expedited Medical Review requests processed by the Company after July 1, 1998 and found that the Company failed to include the criteria used and the clinical reasons for its decisions in three notices mailed to members and their treating providers.

13. The Examiners reviewed 106 of 106 Informal Reconsideration requests processed by the Company during the time frame of the examination and found that the Company failed in 47 of the notices mailed to members and their treating providers to include the criteria used and the clinical reasons for its decisions.

14. The Examiners reviewed 32 of 32 Formal Appeals processed during the time frame of the examination and found as follows:

a. The Company failed on three files to send a written acknowledgment within five working days of receipt of the claimant's request for a Formal Appeal;

b. The Company sent two members and their treating providers decision letters that contained incorrect and confusing information concerning the next level of appeal;

c. The Company failed in ten decision notices mailed to members and their treating providers to include the criteria used and the clinical reasons for its decisions;

15. The Examiners reviewed four of four External Independent Reviews

processed during the time frame of the examination and found that the Company failed in all four files reviewed to withhold from the External Independent Reviewers, and the organization representing the reviewers, the specific identities of the members and their treating providers.

16. The Examiners reviewed of 50 of 1,038 group New Business issued files and 49 of 49 group files closed prior to issue processed by the Company during the time frame of the examination and found as follows:

a. The Company failed to provide a Notice of Insurance Information Practices to 49 group applicants when personal information was collected on the application or from a source other than the applicant;

b. The Company failed on 61 files to obtain an Information Disclosure Authorization that specified the purpose for which the information is collected and that advised the individual or person authorized to act on behalf of the individual that they are entitled to receive a copy of the authorization form;

c. The Company failed on 26 files where the group renewed coverage during the examination period, to include an explanation of the extent to which any increase in premiums is due to actual or expected claims experience of the individual covered under the employer's health benefit plan contract.

17. The Examiners reviewed 98 of 5,435 individual New Business issued files, 50 individual New Business declined files, 18 individual New Business withdrawn files and 35 individual New Business closed prior to issue application files processed by the Company during the time frame of the examination and found as follows:

a. The Company failed on 201 files reviewed to provide a Notice of Information Practices to the applicant when personal information was collected on the application or from a source other than the applicant;

b. The Company offered identical coverage to individual applicants, identifying certain policies as "standard" and others as "endorsed."

i. Fourteen of the files reviewed were issued as the "endorsed" plan;

ii. Applicants for the "standard" plan were subjected to greater medical underwriting scrutiny than those applying for the "endorsed" plan;

iii. The Company waived the 12 month preexisting condition clause on the "endorsed" plan, but applied the 12 month preexisting condition on the "standard" plan.

iv. Premiums for the "endorsed" plan were approximately five percent lower than premiums for the "standard" plan.

18. The Company's provider agreements allow the Company 30 calendar days to pay claims to contracted providers. The provider agreements were silent as to the time to deny claims.

19. The Examiners reviewed 104 of 245,845 group contracted paid claims and 50 of 19,707 individual contracted paid claims that took 31 calendar days or longer to be paid during the time frame of the examination and found as follows:

a. The Company failed to advise 93 (43 group and 50 individual) claimants of the decision to accept the claim and pay the claim within 30 calendar days of receipt of properly executed proofs of loss, as provided for by the Company's contracts.

b. The Company failed on 15 (individual) claims where the paid amount was less than the billed amount to provide the claimant with an explanation of why a portion of the billed amount was denied.

20. The Examiners reviewed 50 of 17,449 group noncontracted paid claims

and 50 of 1,301 individual noncontracted paid claims that took 31 working days or longer to be paid during the time frame of the examination and found as follows:

a. The Company failed to advise 73 (24 group and 49 individual) claimants of the decision to accept or deny or pay the claim within 30 working days of receipt of properly executed proofs of loss;

b. The Company failed on 73 (24 group and 49 individual) files to advise the claimant within 15 working days of the reason additional time was needed to make a decision to pay or deny the claim;

c. The Company failed on 47 (17 group and 30 individual) files to include an interest payment with the claim payment where the claim was not paid within 30 working days after receipt of an acceptable proof of loss which contained all information necessary for claim adjudication;

d. The Company failed on 11 (4 group and 7 individual) claims to pay the correct amount of interest on a claim that was not paid within 30 working days after receipt of an acceptable proof of loss that contained all information necessary for claim adjudication;

e. The Company failed on 15 (7 group and 8 individual) claims where the paid amount was less than the billed amount to provide the claimant with an adequate explanation of why a portion of the billed amount was denied;

21. The Examiners reviewed 102 of 159,789 group contracted denied claims and 50 of 13,538 individual contracted denied claims that took 31 calendar days or longer to deny during the time frame of the examination and found as follows:

a. The Company failed to advise 99 (49 group and 50 individual) claimants of the decision to deny the claim within 15 workings days of receipt of properly executed proofs of loss.

b. The Company failed on four (group) claims to provide the claimant with an adequate explanation of why the claim was denied.

22. The Examiners reviewed 50 of 26,611 group noncontracted denied claims and 50 of 2,004 individual noncontracted denied claims that took 16 working days or longer to deny during the period of the examination and found as follows:

a. The Company failed to advise 73 (23 group and 50 individual) claimants of the decision to deny the claim and failed to advise the claimants within 15 working days of receipt of properly executed proofs of loss of the reason why more time was needed to determine if the claim would be accepted or denied;

b. The Company failed on 6 (4 group and 2 individual) claims to provide the claimant with an adequate explanation of why the claim was denied.

23. The Examiners reviewed 50 of 6,381 group contracted, 50 of 428 individual contracted, 50 of 1,423 group noncontracted and 50 of 76 individual noncontracted denied emergency room and ambulance claims processed by the Company during the time frame of the examination and found that PCA failed on 25 (3 group contracted, 3 group non-contracted, 9 individual contracted, 10 individual non-contracted) claims to provide the claimant with an adequate explanation of why the claim was denied.

24. The Company's failure to pay interest or include the proper amount of interest on claims not paid within 30 days of receipt resulted in 59 claimants being underpaid a total of $848.46.

CONCLUSIONS OF LAW

1. The Company violated A.R.S. §20-1057(D) by failing to file advertising and sales materials for approval by the Department prior to use.

2. The Company violated A.R.S. § 20-2104(C) by failing to :

a. Notify the applicant of the right to access and correct personal information secured by the Company.

b. Advise the applicant of the right to obtain an expanded Notice of Information Practices upon request.

3. The Company violated A.R.S. §20-2311(E)(1) and (2) by failing to file with the Director in 1996 and 1997, actuarial statements certifying that the Accountable Health Plan is in compliance with the Article and that the rating methods are actuarially sound.

4. The Company violated A.R.S. §20-2309(A) by failing to send renewal notices at least 60 days before the expiration date of the health benefits plan and failing to include in its renewal notices an explanation of the extent to which any increase in premiums was due to actual or expected claims experience of the individuals covered under the health benefits plan.

5. The Company violated A.R.S. §20-2310(F) by failing, except on the request of the member, to provide Certificates of Creditable coverage to group members whose coverage had terminated for reasons other than through the replacement of group coverage by their employers.

6. The Company violated A.R.S. §20-2310(J) by failing to provide Certificates of Creditable coverage within 30 days after the event that triggered issuance of the Certificate.

7. The Company violated A.R.S. §20-461(A)(2), A.A.C. R20-6-801(E)(3) and the prior Order by failing to send an appropriate reply within ten working days of receipt of a pertinent communication from a claimant which reasonably suggests that a response is expected.

8. The Company violated A.R.S. §20-2534(B) by failing to include the

criteria used and the clinical reasons for its Expedited Medical Review decisions.

9. The Company violated A.R.S. §20-2535(D) by failing to include in the notices mailed to members and their treating providers the criteria used and the clinical reasons for its Informal Reconsideration decisions.

10. The Company violated A.R.S. §20-2536(B) by failing to send an appropriate written acknowledgment within five working days of receipt of the request for a Formal Appeal.

11. The Company violated A.R.S. §20-2536(G) by failing to provide members with correct information on how to proceed to an External Independent Review following a Formal Appeal.

12. The Company violated A.R.S. §20-2536(E)(1) and (2) by failing to include the criteria used and the clinical reasons for its decisions in Formal Appeal decision notices.

13. The Company violated A.R.S. §20-2537(H)(3) by failing to withhold from the External Independent Reviewers, and the organization representing the reviewers, the specific identities of the members and their treating providers.

14. The Company violated A.R.S. §20-2104(A)(1) and an Order of the Director by failing to provide a Notice of Insurance Information Practices to the applicant when personal information was collected on the application or from a source other than the applicant.

15. The Company violated A.R.S. §20-2106(6) and (9) by failing to use an Information Disclosure Authorization that included all required disclosures.

16. The Company violated A.R.S. §20-461(A)(5), A.A.C. R20-6-801(G)(1)(a), and an Order of the Director by:

a. Failing to accept contracted provider claims within the period

provided for in the contract;

b. Failing to deny contracted provider claims within 15 working days of receipt of a clean claim;

c. Failing to accept and pay noncontracted provider claims within 30 working days of receipt of a clean claim;

d. Failing to deny noncontracted provider claims within 15 working days of receipt of a clean claim.

17. The Company violated A.R.S. §20-461(A)(3) and A.A.C. R20-6-801(G)(1)(b) by failing to advise claimants within 15 working days of receipt of the claim the reasons more time was needed to investigate the claim.

18. The Company violated A.R.S. §20-462(A) and an Order of the Director by failing to pay interest at the legal rate on noncontracted provider claims not paid within 30 working days of receipt of a clean claim.

19. The Company violated A.R.S. §20-461(A)(14) and A.A.C. R20-6-801(G)(1)(a) by failing to provide the claimant with a specific reason why the claim was denied in whole or in part.

20. Grounds exist for the entry of the following Order in accordance with A.R.S. §§ 20-456, 20-1065, 20-2117, and 20-2508.

ORDER

IT IS HEREBY ORDERED THAT:

1. The Company shall:

a. File advertising and sales materials with the Department.

b. Provide applicants, policyholders, and insureds with a compliant Notice of Information Practices.

c. File with the Director its actuarial statements certifying that the

Company was in compliance with the Accountable Health Plan laws and that its small employer group rates are actuarially sound.

d. Include in its group renewal notices an explanation of the extent to which any increase in premiums was due to actual or expected claims experience of the individuals covered under the health benefits plan.

e. Send a renewal notice at least 60 days before the expiration date of the health benefits plan.

f. Provide Certificates of Creditable coverage within 30 days after the triggering event to group members whose coverage had terminated for reasons other than through the replacement of group coverage by their employers.

g. Respond to a claimant's inquiry within ten working days of receipt of the claimant's appeal.

h. Include the criteria used and the clinical reasons for its Expedited Medical Review, Informal Reconsideration, and Formal Appeal decisions in notices mailed to members and their treating providers.

i. Send a written acknowledgment to the claimant within five working days of receipt of the claimant's request for a Formal Appeal.

j. Provide a Notice of Information Practices when personal information is collected on an application or from a source other than the applicant.

k. Use a compliant Information Authorization Disclosure notice.

l. Accept, deny, and pay claims in accordance with time limits, as applicable, prescribed by the Company's contracts, ERISA and/or by Arizona Insurance statutes and rules.

m. Provide notice to claimants within the time limits prescribed, as applicable, by the Company's contracts, ERISA and/or by Arizona Insurance statutes

and rules of the need for additional information to determine whether the claim should be accepted or denied.

n. Provide the claimant with a specific reason why a claim is denied in whole or in part.

o. Pay interest on claims not paid within the time limits prescribed by the Company's contracts and/or by Arizona Insurance statutes and rules.

2. Within 90 days of this Order's filed date, the Company shall submit to the Director, for approval, evidence that corrections have been implemented and communicated to the appropriate personnel regarding all of the items mentioned in Paragraph 1 of the Order section of this Consent Order. Evidence of corrective action and communication thereof includes, but is not limited to, memos, bulletins, E-mails, correspondence, procedures manuals, print screens and training materials.

3. Within 90 days of the filed date of this Order, the Company shall pay interest to the 28 claimants listed in Exhibit A of this Order. Each payment shall be accompanied by a letter to the claimant in a form previously approved by the Director. A list of the payments, giving the name and address of each party paid, the amount of the interest payment, and the date of payment, shall be provided to the Department within 90 days of the filed date of this Order.

4. The Department shall be permitted, through authorized representatives, to verify that the Company has complied with all provisions of this Order.

5. The Company shall pay a civil penalty of $125,000 to the Director for remission to the State Treasurer for deposit in the State General Fund in accordance with A.R.S. §§ 20-456, 20-1065 and 20-2117. The civil penalty shall be provided to the Market Conduct Examination Section of the Department prior to the filing of this Order.

6. The September 29, 1999 Report of Examination and the letter of objection to the Report filed by the Company shall be filed with the Department upon the filing of this Order.

DATED this 25th day of June, 2002.

Charles R. Cohen
Director of Insurance

EXHIBIT A

Interest Owed to Claimants

Claim Number	Interest Owed
Complaint Number DC-155	$99.62
1634704194030	19.89
1732842777062	17.02
1728991723020	15.92
1732342032043	10.77
1730357563032	8.29
1730740430032	7.68
1732140535012	5.83
1725195048013	5.79
1706406112040	5.18
1727493708071	187.58
1800351941015	82.07
1720490488130	66.17
1808593498040	52.74
1733840028013	50.02
1732541406053	33.17
1734053173022	26.16
1730352777031	19.74
1807742172055	15.25
1823391606010	14.42
1728840640021	12.14
1728450417224	6.62
1825945593061	6.20
1732140577071	6.12
1728641535091	5.63
1702891154	21.38
1731641410	14.27
1700904786	9.35
Total	**$825.02**

CONSENT TO ORDER

1. PacifiCare of Arizona, Inc. has reviewed the foregoing Order.

2. PacifiCare of Arizona, Inc. admits the jurisdiction of the Director of Insurance, State of Arizona, admits the foregoing Findings of Fact, and consents to the entry of the Conclusions of Law and Order.

3. PacifiCare of Arizona, Inc. is aware of the right to a hearing, at which it may be represented by counsel, present evidence and cross-examine witnesses. PacifiCare of Arizona, Inc. irrevocably waives the right to such notice and hearing and to any court appeals related to this Order.

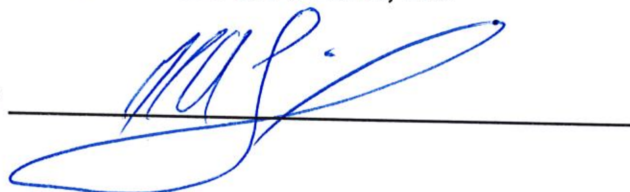
4. PacifiCare of Arizona, Inc. states that no promise of any kind or nature whatsoever was made to it to induce it to enter into this Consent Order and that it has entered into this Consent Order voluntarily.

5. PacifiCare of Arizona, Inc. 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 and 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.

6. MARK S. EL-TAWIL, who holds the office of PRESIDENT of PacifiCare of Arizona, Inc., is authorized to enter into this Order for it and on its behalf.

PacifiCare of Arizona, Inc.

13-JUNE-2002
Date

By 

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2 COPY of the foregoing mailed/delivered
3 this 25th day of June, 2002, to:
4
5 Sara Begley
Deputy Director
6 Mary Butterfield
Assistant Director
7 Consumer Affairs Division
Paul J. Hogan
8 Chief Market Conduct Examiner
Market Conduct Examinations Section
9 Deloris E. Williamson
Assistant Director
10 Rates & Regulations Division
Alexandra Shafer
11 Assistant Director
Life and Health Division
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Assistant Director
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