Report of the

Targeted Market Conduct Examination

for the

Maine Bureau of Insurance

of

Anthem Life Insurance Company

NAIC Company # 61069

Indianapolis, Indiana

October 12, 2023

CONTENTS

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October 12, 2023

Superintendent Timothy N. Schott
Department of Professional and Financial Regulation
Maine Bureau of Insurance
34 State House Station
Augusta, ME 04333-0034

Dear Superintendent Schott:

Pursuant to the authority granted by 24-A M.R.S.A. § 221, your instructions, and in accordance with the NAIC *Market Regulation Handbook*, 2016 ed. ("*Handbook*"), a targeted market conduct examination has been conducted of the short term disability income ("STD") claim handling practices of:

Anthem Life Insurance Company
("Anthem Life" or the "Company")

The report of examination is herewith respectfully submitted.

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Foreword

This report on the targeted market conduct examination of Anthem Life is provided pursuant to the *Handbook*. This report is made by exception.

Background and Scope of Examination

In the spring of 2016 the Maine Bureau of Insurance ("Bureau") received a consumer complaint regarding Anthem Life's handling of STD claims. Review of the matter raised concerns regarding general claim handling practices and compliance with the provisional payment requirements of Bureau Rule 530 ("Rule 530"). See Code Me. R. tit. 02-031 ch. 530,

§ 4. On August 31, 2017, I was appointed to serve as examiner-in-charge for an examination into the affairs of Anthem Life pursuant to 24-A M.R.S.A. § 221. (A copy of my appointment is attached as Exhibit A.) I informed the Company of the examination and my appointment in a letter dated September 15, 2017. That letter advised that this was a targeted market conduct examination concerning the Company's STD claim handling practices during the period January 1, 2011 to August 31, 2017 ("Examination Period"). The examiners' principal areas of focus included reviewing Anthem Life's compliance with Rule 530 and the unfair claims practices statute. See 24-A M.R.S.A. § 2164-D.

Profile of the Company

At all relevant times, Anthem Life has been a life and health insurer domiciled in the State of Indiana and authorized to write life and health insurance in the State of Maine. Anthem Life is a wholly owned subsidiary of Rocky Mountain Hospital and Medical Service, Inc., (NAIC # 11011) a life and health insurer domiciled in the State of Colorado, which is, in turn, a subsidiary of ATH Holding Company, LLC, an intermediate insurance holding company organized in the State of Indiana. ATH Holding Company, LLC is a wholly-owned subsidiary of Anthem, Inc., an Indiana corporation that is the ultimate corporate parent of Anthem Life and of the Anthem Inc. Group (NAIC Group # 0671).

Executive Summary

Examination findings suggest poor claim handling practices within Anthem Life's STD operations including a 60% random sample error rate that suggests potential violations of the unfair claims practices statute. See 24-A M.R.S.A. § 2164-D. Further, though the Company's formal policies regarding the application of Rule 530 are reasonable and appropriate, they were

not actually applied in any of the files reviewed. Areas of particular concern include poor recordkeeping that may frustrate effective management of the STD claim handling operation, claim investigation and claimant communication process weaknesses, and the proper application of policy language.

Factual Findings

The initial examination plan contemplated a review conducted in two "phases". Phase One involved review of the Company's STD policy forms, claim administration manuals, claim training manuals, and claim administration and organizational charts. Phase Two involved review of randomly selected STD claim files. The examination plan was subsequently modified to include a Phase Three involving focused review of claims to which Rule 530 might apply.

Phase 1 – Policy & Procedure Review. The examiners reviewed Anthem Life's claim administration manuals, claim training manuals, and claim administration and organizational charts applicable during the Examination Period for consistency with the applicable STD policies/certificates and the Maine insurance laws. The examiners identified no exceptions.

Phase 2 – Random Sample Review. The examiners reviewed a selection of the Company's STD claim files to evaluate compliance with the applicable STD policies/certificates and the Maine insurance laws. The examiners drew two twenty-five claim samples from a population database of 3,010 Maine claim files.[1] The examiners raised concerns regarding the

[1] The population database -- containing all STD claims filed with Anthem Life or its affiliates by Maine residents during the period January 1, 2011 to August 31, 2017 -- originally included 3,189 entries. (3,133 of these claims -- 98.2% -- were filed with Anthem Life and no more than 1% with any other affiliate). Relying on "Secondary Status" codes provided by the Company, the examiners determined that 3,010 of these files were suitable for review and should be included in the population from which selections were drawn. Random selection was made using the RAND function in Microsoft Excel.

Company's handling in thirty of the fifty randomly selected claim files reviewed -- a 60% error rate (30 files raising concerns / 50 files reviewed = 60%). This observed error rate substantially exceeds the 7% benchmark error rate that has been established for auditing claim practices. See 24-A M.R.S.A. § 2164-D(2) ("It is an unfair claims practices… to commit any act under subsection 3… with such frequency as to indicate a general business practice…"); *Handbook*, p. 184 ("Error rates exceeding these benchmarks are presumed to indicate a general business practice contrary to [unfair trade practice/claims settlement practices] laws"). The observed error rate also permits a conclusion, with a 95% confidence level, that the true error rate in the Company's handling of Maine STD claims during the Examination Period was greater than 50% (i.e. more than 7 times the *Handbook* benchmark). See id.[2]

Among the thirty claim files raising concerns, the examiners noted a total of fifty-eight exceptions. The examiners have grouped these exceptions into seven basic categories as shown in Exhibit B and as summarized in Table 1:

Table 1 – Claim Review Exception Types and Observed Frequency

Exception Type	**Files in which Observed**
Failure to maintain adequate records	19
Inadequate claimant communication	16
Failure to conduct adequate investigation	9
Failure to pay benefits owed	5
Failure to apply policy language	4
False statement of relevant fact	3
Undue delay	2
Total	58

[2] With a population of 3,010 and an assumed population percentage of 7%, a 50 claim sample will permit a confidence interval of 7.01% at a 95% confidence level. See *Handbook*, p. 184 (advocating use of a 7% tolerance level for claim handling investigations) and p. 189 (using the 7% tolerance level as the assumed population percentage). This suggests that the true error rate in the Company's STD claim handling operation during the Examination Period was between 52.99% and 67.01%.

Each type of exception may constitute a violation of one or more of the Maine insurance laws and may be compared with one or more of the claim handling standards set forth in the *Handbook*.

Failure to maintain adequate records – Insurers are required to "develop and maintain documented claim files supporting decisions made regarding liability." 24-A M.R.S.A. § 2164-D(3)(D); cf. *Handbook*, p. 303, Claims Standard 5. The examiners have raised a general concern that claim handlers' case notes were frequently absent, ambiguous, cryptic, or otherwise insufficient to document the steps taken to investigate the claimant's entitlement to benefits and to memorialize the Company's decision-making process. The examiners also raised a general concern that key records (e.g. claim forms; correspondence with the claimant, employer, and medical providers; medical records; and, any analyses/reports on which the claim handler relied) were frequently missing from the Company's claim files. Because the examiners reached the qualitative conclusion that Anthem Life's STD recordkeeping practices were manifestly inadequate during the Examination Period, it was deemed cumulative and unnecessary to develop an exhaustive catalog of missing records and poor quality case notes. The nineteen examples identified as exceptions may therefore be viewed as illustrative and no inference should be drawn regarding the quality of recordkeeping in the thirty-one files for which the examiners have not reported an exception.[3] The Company reports that it has taken significant

[3] The high frequency of recordkeeping exceptions is a very important issue. The examiners note, however, that no single type of exception is determinative in driving the overall error rate. For example, the rate would remain elevated even if the recordkeeping issue were excluded from consideration. To illustrate, exclusion of all recordkeeping-related exceptions would only reduce the overall error rate to 46% and it would still be possible to conclude, at a 95% confidence level, that the true error rate in the Company's STD claim handling operation during the Examination Period was between 38.99% and 53.01%.

action subsequent to the examination period but prior to issuance of this report to improve claims recordkeeping, including but not limited to, implementation of a comprehensive imaging process for claims records and documentation.

Inadequate claimant communication – Insurers must acknowledge claim communications promptly and, when they deny, terminate, or pay only a portion of the benefits requested, they must "promptly provide an accurate written explanation of the basis for those actions." 24-A M.R.S.A. § 2164-D(3)(B) and (J). Even when paying benefits in full an insurer is still obligated to "indicat[e] the coverages under which each payment is made." 24-A M.R.S.A. § 2164-D(3)(H). Insurers are thus under a duty not simply to communicate promptly and announce their benefit determinations but also to explain them in terms of the relevant facts and policy language. Cf. *Handbook*, p. 303 *et seq.* Claims Standards 4, 6 and 9. The examiners are concerned that the Company failed to meet this standard in sixteen of the randomly sampled claim files.

The examiners' concerns in the random sample review centered on Anthem Life's standard STD benefit award letters. The examiners noted that these award letters typically stated that STD had been approved from a specified date, that an elimination period may apply, that offsets/reductions may apply, and that the benefit would be terminated on a specified date absent further information. The examiners expressed concern that these letters failed to state the benefit level actually approved, the policy language under which the benefit was paid, and the policy language governing any elimination period, offset, or reduction. The Company has confirmed that this was its general practice during the Elimination Period but that it instituted a new practice in 2018 to advise members of the benefit level and cite any policy provisions under

which benefits were reduced/offset. The examiners also expressed concerns that the Company was consolidating its award and termination communications in a single letter that did not explain the rationale (including relevant policy language) for the termination decision. The Company responded that its STD award letters did not function as consolidated allowance/termination communications and that, instead, it issued a formal termination letter after the approved benefit period lapsed. The examiners have been unable to locate examples of any such letters in the files produced for review.

The Company reports that it has taken significant action subsequent to the examination period but prior to issuance of this report to address weaknesses in its claimant communication process, including but not limited to, additional training for Claims associates and implementation of improved system letters incorporating important policy benefit and claims elements required by statute.

Failure to conduct adequate investigation – The unfair claims practices act requires that an insurer "adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies" while also prohibiting carriers from "[r]efusing to pay claims without conducting a reasonable investigation." 24-A M.R.S.A. § 2164-D(3)(C) and (E); cf. *Handbook*, p. 299 *et seq.* Claims Standards 2, 3, 6, and 9. The steps necessary to "reasonably" investigate a particular claim will vary depending on the facts presented. As a general rule, however, an insurer should review and integrate the information provided by the claimant, identify the facts necessary to make a claim determination, and make a good faith effort to gather those facts. In circumstances where the examiners were concerned this standard had not been met, the most frequent issues involved failing to contact the treating provider or

failing to follow-up with further investigation after making an initial approval of STD benefits for a limited period. The Company reports that it has taken significant action subsequent to the examination period but prior to issuance of this report to improve claims recordkeeping and claimant communications.

Failure to pay benefits owed – Insurers are required, as a general matter, to pay the benefits called for in the governing policy/certificate and to accurately explain the basis for that payment. See, e.g., 24-A M.R.S.A. § 2164-D(3)(C), (E), and (J); cf. *Handbook*, p. 305 and 309, Claims Standards 6 and 9. The examiners' concerns regarding the payment of benefits arose where the benefit period appeared unsupported (e.g. there was a gap between the date of apparent disability and the date from which benefits were approved) or the benefit calculation appeared to be erroneous (e.g. applying an improper/excessive setoff or reduction). The Company has at least partially accepted the examiners' concern in all five of the claim files presenting this issue, and the examiners acknowledge that the Company reprocessed and paid the impacted claims and notified the impacted claimants accordingly prior to the issuance of this report.

Failure to apply policy language – An insurer that consistently applies a claim determination standard not contained in its policies, adopts an unreasonable interpretation of policy language, or otherwise fails to apply policy language violates the Maine insurance laws. 24-A M.R.S.A. § 2164-D(3)(A), (C), (H), and (J); cf. *Handbook*, p. 305 and 309, Claims Standards 6 and 9. In the random sample review, the examiners identified four instances in which it appeared that a benefit determination may not have been based upon an overall lack of evidence to support the claimant's position but, instead, upon a perceived lack of objective

evidence supporting that position. Application of an "objective evidence" standard can exclude relevant and probative evidence from consideration, including subjective reports (e.g. a patient's description of pain, dizziness, or confusion), impressions based on expert observation (e.g. a patient's affect and demeanor), or test results presented in qualitative terms (e.g. range of motion described as "limited" rather than reduced to degrees). Such exclusions effectively increase the evidentiary burden on claimants and are not supported by the language of Anthem Life's STD policies and certificates.

The Company agrees that all relevant evidence bearing on a claimant's condition -- whether subjective or objective -- should be considered in evaluating a claimant's condition and functional capacity and believes that this occurred in all of the instances raising examiner concerns. The Company reports that it has reminded claims associates of its claims review processes and procedures, the importance of reviewing all documentation submitted with respect to a claim, and the need to record such analysis in the claim file.

False statement of relevant fact – It is an unfair claims practice to "knowingly misrepresent[] to claimants and insureds relevant facts or policy provisions". 24-A M.R.S.A. § 2164-D(3)(A); cf. *Handbook*, p. 305 and 309, Claims Standards 6 and 9. In three claim files, the examiners identified statements made to claimants regarding the sources of information that were not consistent with the record. The apparent misstatements were relevant to the extent they provided context for Company action. The examiners do note, however, that the truth or falsity of the statements did not affect the claimants' entitlement to benefits.

Undue delay – Undue delay in the investigation and settlement of claims or in response to written claimant communications may constitute an unfair claims practice. See 24-A M.R.S.A.

§ 2164-D(3)(C) and (F); *Handbook*, p. 297-301, Claims Standards 1-3. In two claim files, the examiners expressed concerns that the Company had all information necessary to determine a claim and failed to act for an extended period of time. The Company reports that, subsequent to the examination period but prior to issuance of this report, it provided additional training to claims associates to remind them of the required claim timeframes and the importance of adhering to those requirements.

Phase 3 – Rule 530 Review. The purpose of Rule 530 is to establish procedures governing the coordination of health, disability and workers compensation benefits "so that injured workers whose workers' compensation claims have been controverted and who are awaiting Workers' Compensation Board determinations shall not incur any unnecessary financial burden." Rule 530, § 1. "If a workers' compensation claimant is awaiting a Board determination on a claim" this purpose is accomplished by requiring that the STD carrier "determine eligibility and provide benefits to the claimant according to the terms of the [STD] policy but without reference to any policy exclusions for work-related injury or disease." Id., § 4.A. Payment on such determined claims is then contingent upon receipt of certain acknowledgements and information (id., § 4.C) and the STD carrier is entitled to reimbursement should the workers compensation benefit be paid (id., § 5).

To conduct the focused Rule 530 review, the examiners requested production of all STD claims filed by Maine residents between October 1, 2016 and August 31, 2017 in which the Company considered the application of an offset for workers compensation benefits. Anthem Life identified and produced four claim files. Review of these files raises significant concerns

because the examiners identified Rule 530 exceptions in three of the four files reviewed as well as nine unfair claims practices, including at least one in all four files reviewed. See Exhibit C.

The examiners are concerned that Anthem Life is generally non-compliant with Rule 530 because there was no indication in any of the files reviewed that a claim handler, manager, or appeal specialist was aware of the rule or considered its application. In one instance (Claim 530-2), the Company was unaware that the claimant's injury was work-related and therefore made a claim determination without reference to exclusions for work-related injury or disease. The Company thus reached the result required by Rule 530 but this may reflect a mistake as to the underlying facts rather than a proper application of the Maine insurance laws. In three other files (Claims 530-1, Claim 530-3, and Claim 530-4), the Company failed to recognize the existence and applicability of the rule and therefore failed to "determine eligibility and provide benefits to the claimant according to the terms of the [STD] policy but without reference to any policy exclusions for work-related injury or disease." Rule 530, § 4.A. It is particularly noteworthy that, in one instance (Claim 530-4), the claimant included a description of Rule 530's requirements in an appeal from denial of her STD benefits and the appeal specialist still failed to apply the rule. The Company reports that, subsequent to the examination period but prior to issuance of this report, it has taken steps to remind Claims associates of the Company's claims review processes and procedures including addition of a prompt in the claims handling system and is seeing improvement in its "processing protocols".

Review of the four claim files selected for Rule 530 review also raised significant concerns regarding compliance with the unfair claims practices act. Specifically, the examiners identified one or more concerns with the handling of each claim file including a total of eleven

exceptions (excluding those relating to Rule 530). Ten of those exceptions fall within categories described in relation to the random sample review.[4] The eleventh exception – unfair reading of a claim file – involved a failure to give meaningful consideration to the opinion of a medical expert or to analyze important information relayed by that professional and may constitute a violation of 24-A M.R.S.A. § 2164-D(3)(C) and (E). Cf. *Handbook*, p. 305 and 309, Claims Standards 6 and 9.

Summarization & Recommendations

The examiners' review of Anthem Life STD claim files -- both those randomly selected and those included in the Rule 530 review -- revealed poor claim handling practices and suggests potential violations of the unfair claims settlement practices statute. Most of the concerns raised – i.e. those involving the content of claimant communications, the adequacy of investigations, the amount of benefits paid, the proper application of policy language, the accuracy of Company statements, delay in claim determination, and compliance with Rule 530 – have direct consumer impacts. The most far-reaching problem, however, may be the inadequacy of Anthem Life's STD recordkeeping practices because management's ability to effectively audit, administer, and improve the STD claim handling operation is impaired by the absence of complete documentary records and reliable case notes.

[4] With regard to concerns about the failure to apply policy language – the examiners identified a further instance in which Anthem Life appeared to apply an "objective evidence" standard not supported by policy language. The examiners also observed that, in all three claim files where "work-related injuries" were potentially present, the Company appeared to make its benefit determination on the basis of broad descriptive language contained in the STD certificate's prefatory "Schedule of Benefits" section rather than the narrower controlling language that is found in the "Exclusions" section of the STD certificate.

To address the concerns raised in this process, the examiners recommend that the Bureau work with the Company to develop a plan of corrective action including the following elements:

- Agreement as to:
  - The proper contents of a claim file and the information that should be captured in case notes;
  - The necessary elements of STD award, denial, and termination letters; and,
  - Circumstances in which outreach to treating providers is required;
- Confirmation that Anthem Life does not impose an "objective evidence" standard in the handling of STD benefits and that management has developed a training program to drive the message through the organization;
- Confirmation or development of a training, organizational, or systems solution to ensure that Maine STD claims are handled in compliance with Rule 530; and,
- Confirmation or development of an internal audit/quality control process to monitor implementation of the agreement and continued application going forward.

The examiners also recommend that a settlement agreement including a corrective action plan should also make provision for a monitoring period (during which the plan can be implemented) as well as a re-examination (in which compliance with the plan and the insurance laws generally can be verified).

In addition to this recommended regulatory response, the Superintendent may also conclude that the examination findings present reason to believe that the Company is acting in violation of the unfair trade practices act and that, as a result, it is appropriate to notify the Commissioner of Insurance for the State of Indiana, as Anthem Life's domiciliary supervisory official. See 24-A M.R.S.A. § 2167-A. Such notification may be particularly important where inadequate recordkeeping, and thus the potential for inadequate management control, is an area of primary regulatory concern.

Acknowledgment

The examiners wish to thank Anthem Life for its cooperation throughout this process.

Verified Report Submission

The report of examination is herewith respectfully submitted under oath.

Sincerely,

J. David Leslie
Examiner-in-Charge

Sworn before me this 12th day of October, 2023.

Notary Public
My Commission Expires

EILEEN M. BICKFORD
Notary Public
Commonwealth of Massachusetts
My Commission Expires
February 3, 2028

Examiners:

Verrill Dana, LLP

Stuart T. Leslie, Esq.

Margaret C. Fitzgerald, Esq.

Exhibit A – Appointment Letter of August 31, 2017

State of Maine

Bureau of Insurance

I, Eric A. Cioppa, Superintendent of Insurance of the State of Maine, pursuant to the provisions of 24-A M.R.S.A. §223, do hereby appoint:

J. David Leslie
Rackemann, Sawyer & Brewster, P.C.

As a proper person to examine into the affairs of

Anthem Life Insurance Company
NAIC Co. Code: 61069

And to make a report to me in writing of the condition of the said Company

with such other information as deemed requisite.

In Witness Whereof, I have hereunto subscribed by name and affixed the official Seal of the Bureau of Insurance

At the city of Gardiner, Maine

This 31st day of August, 2017

Eric A. Cioppa, Superintendent of Insurance

Exhibit B – Exceptions Observed in Random Sample Review of Claim Files

TABLE OF CLAIMS IN WHICH EACH EXCEPTION TYPE WAS OBSERVED

Exception Types	Observed in files:
Failure to maintain adequate records *19 instances (38% of files)*	CF15, CF19, CF20, CF21, CF23, CF24, CF26, CF27, CF28, CF29, CF32, CF34, CF36, CF37, CF42, CF43, CF44, CF47, CF48
Inadequate claimant communication *16 instances (32% of files)*	CF16, CF21, CF22, CF23, CF29, CF32, CF34, CF37, CF43, CF44, CF45, CF46, CF47, CF48, CF49, CF50
Failure to conduct adequate investigation *9 instances (18% of files)*	CF06, CF21, CF24, CF32, CF34, CF36, CF37, CF41, CF48
Failure to pay benefits owed *5 instances (10% of files)*	CF02, CF06, CF41, CF43, CF50
Failure to apply policy language *4 instances (8% of files)*	CF02, CF08, CF24, CF32
False statement of relevant fact *3 instances (6% of files)*	CF02, CF33, CF41
Undue delay *2 instances (4% of files)*	CF29, CF45

TABLE OF EXCEPTIONS OBSERVED IN EACH CLAIM RAISING CONCERNS

Claim	Exception(s) Observed	Claim	Exception(s) Observed
CF02	False statement of relevant fact Failure to pay benefits owed Failure to apply policy language	CF22	Inadequate claimant communication
CF06	Failure to conduct adequate investigation Failure to pay benefits owed	CF23	Failure to maintain adequate records Inadequate claimant communication
CF08	Failure to apply policy language	CF24	Failure to apply policy language Failure to conduct adequate investigation Failure to maintain adequate records
CF15	Failure to maintain adequate records	CF26	Failure to maintain adequate records
CF16	Inadequate claimant communication	CF27	Failure to maintain adequate records

Claim	Exception(s) Observed
CF19	Failure to maintain adequate records
CF20	Failure to maintain adequate records
CF21	Failure to conduct adequate investigation Failure to maintain adequate records Inadequate claimant communication
CF33	False statement of relevant fact
CF34	Failure to conduct adequate investigation Failure to maintain adequate records Inadequate claimant communication
CF36	Failure to conduct adequate investigation Failure to maintain adequate records
CF37	Failure to conduct adequate investigation Failure to maintain adequate records Inadequate claimant communication
CF41	Failure to conduct adequate investigation Failure to pay benefits owed False statement of relevant fact
CF42	Failure to maintain adequate records
CF43	Failure to maintain adequate records Failure to pay benefits owed Inadequate claimant communication
CF28	Failure to maintain adequate records
CF29	Failure to maintain adequate records Inadequate claimant communication Undue delay
CF32	Failure to apply policy language Failure to conduct adequate investigation Failure to maintain adequate records Inadequate claimant communication
CF44	Failure to maintain adequate records Inadequate claimant communication
CF45	Inadequate claimant communication Undue delay
CF46	Inadequate claimant communication
CF47	Failure to maintain adequate records Inadequate claimant communication
CF48	Failure to conduct adequate investigation Failure to maintain adequate records Inadequate claimant communication
CF49	Inadequate claimant communication
CF50	Failure to pay benefits owed Inadequate claimant communication

Exhibit C – Exceptions Observed in Rule 530 Review of Claim Files

TABLE OF CLAIMS IN WHICH EACH EXCEPTION TYPE WAS OBSERVED

Exception Type	Observed in files:
Rule 530 compliance	Claim 530-1, Claim 530-3, Claim 530-4
Failure to apply policy language	Claim 530-1, Claim 530-3, Claim 530-4
Inadequate claimant communication	Claim 530-2, Claim 530-3, Claim 530-4
Failure to conduct adequate investigation	Claim 530-1, Claim 530-3
Failure to maintain adequate records	Claim 530-4
Undue delay	Claim 530-4
Unfair reading of claim file	Claim 530-4

TABLE OF EXCEPTIONS OBSERVED IN EACH CLAIM REVIEWED

Claim	Exception(s) Observed
Claim 530-1	Rule 530 compliance
	Failure to apply policy language
	Failure to conduct adequate investigation
Claim 530-2	Inadequate claimant communication
Claim 530-3	Rule 530 compliance
	Failure to apply policy language
	Inadequate claimant communication
	Failure to conduct adequate investigation
Claim 530-4	Rule 530 compliance
	Failure to apply policy language
	Inadequate claimant communication
	Failure to maintain adequate records
	Undue delay
	Unfair reading of claim file