

**BEFORE THE INSURANCE COMMISSIONER
OF THE STATE OF CALIFORNIA**

In the Matter of the Order to Show Cause
and Accusation Against:

PACIFICARE LIFE AND HEALTH
INSURANCE COMPANY,

Respondent.

Case No. UPA 2007-00004
OAH No. 2009061395

COMMISSIONER'S DECISION & ORDER

I. Introduction

Since 1959, with the enactment of the Unfair Insurance Practice Act, the California Insurance Commissioner has regulated trade practices in the business of insurance by investigating and penalizing those insurers who engage in unfair or deceptive acts. Such an investigation of unfair business practices led to the allegations at hand.

In January 2008, after an extensive investigation, the California Department of Insurance (CDI or Department) issued an Order to Show Cause alleging PacifiCare Life and Health Insurance Company (PacifiCare) committed over 900,000 unfair business practices, ranging from failing to timely pay claims to failing to inform consumers of their statutory appeal rights. Having calculated a penalty equaling more than \$900 million, CDI recommends an aggregate penalty of \$325 million.

The Commissioner has reviewed the facts and legal arguments pertaining to the nearly 1 million alleged unfair practices and concludes PacifiCare's violations of the Unfair Insurance Practice Act warrant a penalty of \$173,603,750.

II. Background

In 2005, PacifiCare served approximately 120,000 preferred-provider organization members; a relatively small percentage of PacifiCare's overall California business.¹ The parties agree that at that time PacifiCare enjoyed a reputation for excellent customer service and had no significant compliance issues.²

¹ Exh. 5590. The vast majority of PacifiCare's California membership was in its health-maintenance organization (HMO) business and regulated by the Department of Managed Health Care, not CDI. This action pertains only to PacifiCare's preferred-provider organization (PPO) line of business.

² Reporter Transcript (RT) 2317:23-2318:24; RT 124:21-125:5.

A. PacifiCare Merger with UnitedHealth

In July 2005, PacifiCare and UnitedHealth (United) publicly announced their plans for an \$8.2 billion merger; the third largest healthcare merger in history at the time. The acquisition required the approval of several regulators, including the California Insurance Commissioner.

In November 2005, then-Commissioner John Garamendi conducted a public hearing into the merger, during which he expressed concern about United's claims-handling history and PacifiCare's post-merger customer service presence in California.³ In response to Commissioner Garamendi's concerns, PacifiCare executives represented that "the overall employee population for PacifiCare in California [would] remain relatively constant" and that United had revamped its reimbursement policies to address regulatory concerns.⁴

On December 19, 2005, Commissioner Garamendi approved the merger, subject to specific conditions. These conditions were memorialized in a unilaterally-signed document termed "Undertakings." The Undertakings required PacifiCare to timely pay claims and adhere to other performance standards.⁵

The PacifiCare/United merger closed on December 20, 2005.

B. PacifiCare's Post-Merger Operations

Shortly after the merger, United began the process of integrating both companies. The integration included a push by United for cost savings.⁶ As an example of United's expectations, company executives sought \$50 to \$75 million in savings during the first year of integration, and

³ Exh. 625, pp. 7098, 7145-7146.

⁴ Exh. 625, pp. 7097, 7148, 7151.

⁵ Exh. 5191. While the Undertakings include performance assurances from PacifiCare, they are not the subject of this proceeding and PacifiCare's compliance with those Undertakings is irrelevant in determining whether the company violated the Insurance Code and its applicable regulations. (See, Section VII, subdivision E, *infra*, for a complete discussion of this issue.)

⁶ PacifiCare terms these cost-cutting measures "synergies." Synergy opportunities include revenue upside, medical cost savings (resulting from network remediation, clinical management, etc.), and cost reduction in all other areas including FTE's, real estate, vendor contracting, platform synergies, wage rate savings, infrastructure, etc. (See Exh. 434, p. 3044; RT 5378:6-11.)

up to \$350 million in total cost savings over the course of two to three years.⁷ A brief description of United's consolidation efforts and its overall financial impact follows.

In March 2006, PacifiCare announced the layoff of 600 employees and its intent to close its Regional Mail Center, Claims, Customer Service, as well as its Quality and Training departments, all located in Cypress, California.⁸ PacifiCare disclosed the layoffs to the Department of Managed Health Care, but not to CDI.⁹ It is impossible to determine how many employees serviced the PPO operations, as PacifiCare did not apportion the layoffs between its HMO and PPO business.¹⁰

Before the merger, PacifiCare employees manually routed all incoming correspondence, relying upon their experience to forward mail to the correct location.¹¹ In February 2006, PacifiCare decided to outsource all mail handling and routing to Lason, United's preferred vendor, for a savings of \$1.1 million.¹² In July 2006, PacifiCare began routing all its mail to Lason's regional mail operations in Salt Lake City, Utah. Once received in Salt Lake City, correspondence was separated from "keyable" claims, scanned and e-mailed to Lason's facility in India.¹³ Employees in India coded the correspondence by document type in DocDNA, Lason's proprietary document routing software.¹⁴ DocDNA then routed the document to the proper departmental mail queue for additional processing. If Lason employees inaccurately coded the correspondence, DocDNA would route the documents to the wrong PacifiCare department.

⁷ RT 18386:18-18387:4; Exh. 5265.

⁸ Exh. 283, p. 3656.

⁹ RT 9007:17-23. CDI does not have regulatory purview over PacifiCare's organizational or administrative personnel capacity.

¹⁰ RT 8574:3-24.

¹¹ RT 13673:16-24; RT 14314:5-24.

¹² Exh. 517, p. 1847.

¹³ Exh. 5446.

¹⁴ PacifiCare provided Lason's employees in India with a 350-page manual on how to properly categorize each document. (Exh. 5444.)

Similarly, at the time of acquisition, PacifiCare's mail room employees manually sorted and scanned all incoming paper claims to determine eligibility and coverage. Beginning in May 2006, PacifiCare routed all scanned paper claims to Lason's Mexico facility, where employees entered the claims into PacifiCare's RIMS database for PPO claims or NICE database for HMO claims.¹⁵ If Lason employees could not determine whether the claim pertained to an HMO or PPO customer, the claims were either entered into the NICE database by default, or sent back to PacifiCare's offices.¹⁶ Misclassified claims could loop between PacifiCare's data platforms several times before landing in the correct queue.¹⁷

PacifiCare also outsourced "secondary document" retention to Lason's operations in Mexico.¹⁸ Retention required scanning and indexing secondary documents into PacifiCare's FileNet database, where they could be accessed by PacifiCare claims adjusters and other employees. To that end, PacifiCare sent secondary documents to Lason with a cover sheet indicating the claim or member number and expected Lason to scan and index the documents according to claim or member number.¹⁹ If Lason improperly indexed these secondary documents, PacifiCare employees would be unable to retrieve them.²⁰

Before the merger, PacifiCare's Cypress-based employees handled the bulk of claims processing. But within a few months of the merger, PacifiCare migrated "claim processing from higher cost offices to lower cost vendors."²¹ Specifically, PacifiCare laid off 22 claims examiners

¹⁵ At the time of the Market Conduct Examination (MCE), PacifiCare utilized RIMS version 3.10. Evidence in the record demonstrates version 3.10 was outdated at that point in time. In late 2005, RIMS version 3.30 was available and widely used by other insurance companies. (Exh. 655.)

¹⁶ Exh. 571, p. 2270.

¹⁷ Exh. 881.

¹⁸ Exh. 365, p. 6872. Secondary documents, such as medical records or certificates of creditable coverage, are frequently necessary in processing claims.

¹⁹ Exh. 575, p. 4004.

²⁰ RT 6353:7-14; RT 6355:12-16.

²¹ Exh. 550, p. 6321; RT 6196:6-13.

and outsourced this process to MedPlans.²² Unlike PacifiCare employees, MedPlans' employees received payment on a piece-rate basis; that is, remuneration was based on the number of claims processed, regardless of accuracy or actual hours worked.²³ If MedPlans misinterpreted a contract provision or erroneously denied a claim, PacifiCare employees were required to rework the claims themselves.²⁴ PacifiCare saved \$3.2 million annually by outsourcing to MedPlans.²⁵

In March 2006, PacifiCare transferred its paper eligibility processing from its Cypress-based staff to Accenture in the Philippines.²⁶ Accenture employees reviewed and entered all enrollment information for new or existing PacifiCare members, most of which came from group plans.²⁷ Employees who came upon confusing or incomplete applications returned those applications to employer groups. The return process took over two weeks in most cases, and often resulted in members being denied medical care in the interim.²⁸ PacifiCare saved over \$4.4 million annually when it outsourced its eligibility processing to Accenture.²⁹

In March 2006, PacifiCare also transitioned its printing operations, i.e. the printing and mailing of checks, Explanations of Benefits, and acknowledgement letters, to Duncan Printing Services, a United subsidiary.³⁰ Before this transfer, PacifiCare's printing services were performed by the IDC unit of IBM.³¹ Failure to timely issue letters and checks may result in violations of the Code and its applicable regulations. PacifiCare saved \$3 million annually when it subcontracted its printing services to Duncan.³²

²² RT 11333:13-19.

²³ RT 6228:1-7.

²⁴ RT 6226:25-6227:4.

²⁵ Exh. 805, p. 3787, line 21.

²⁶ RT 17672:19-17673:5.

²⁷ Exh. 540, p. 3757.

²⁸ RT 17682:14-21.

²⁹ Exh. 514, p. 3617, line 3.

³⁰ RT 4276:9-18.

³¹ RT 4274:19-4275:3.

³² Exh. 404.

PacifiCare also significantly altered its customer service platform. Before the merger, a customer service representative retained responsibility for a consumer's issue until the insurer resolved the problem. After the acquisition, PacifiCare outsourced its customer service to a call center operated by West Corporation and to a San Antonio-based call center operated by United.³³ These call centers measured employee performance based on the "average handle time" of a customer's call; i.e. the longer the average handling time, the more expensive the problem was to resolve.³⁴ By outsourcing its customer service to call centers and by pushing for a reduction in average handle time, PacifiCare achieved an annual savings of more than \$8.5 million.³⁵

By June 30, 2007, only 18 months after the merger, United surpassed its three-year cost-cutting goal of \$350 million. As of that date, United reported it achieved \$950 million in aggregate savings.³⁶ Of the \$950 million, United attributed \$365 million to "efficiencies" or cutbacks in PacifiCare's operations, which included reduced costs of corporate infrastructure, information technology and non-operational leadership.³⁷ Also, by April 2007, PacifiCare reduced its workforce by 39%, eliminating 4,239 employees.³⁸ Of the 4,239 eliminated positions, 2,202 were California-based employees.³⁹ PacifiCare attributes approximately 50% of its employee turnover to United's integration efforts.⁴⁰ Significantly, employees with three or more

³³ RT 2482:14-25.

³⁴ RT 3392:3-3393:5; Exh. 678, pp. 2770-2771.

³⁵ Exh. 514, p. 3617, lines 7-8.

³⁶ Exh. 457, pp. 9241-9242; RT 4566:19-24. \$950 million is a "run rate" or projection of United's aggregate savings by the end of 2007. (RT 4458:10-13; RT 5382:6-5383:2.)

³⁷ Exh. 457, p. 9242; RT 11245:13-22.

³⁸ Exh. 455, p. 0791.

³⁹ *Id.* at p. 0795.

⁴⁰ *Id.* at p. 0791.

years of service comprised 75% of the turnover, depleting PacifiCare of important institutional knowledge.⁴¹

C. Complaints and CDI's Regulatory Response

In October 2006, less than a year after the merger, CDI noticed an increase in consumer and provider complaints about PacifiCare's claims-handling practices. Between July 2006 and March 2007, CDI processed 44 justified complaints regarding PacifiCare's practices, and identified more than 188 violations of the Insurance Code and the California Code of Regulations, title 10, section 2695.1 et seq.⁴² As a comparison, CDI received only two justified complaints against PacifiCare during the entire preceding year. This increase continued in the following months, and spurred CDI to assign several compliance officers to investigate PacifiCare's internal operations.⁴³

Throughout early 2007, CDI and PacifiCare met regularly to address the rise in consumer and provider complaints, as well as PacifiCare's integration activities. After each meeting, CDI regulators became increasingly frustrated with PacifiCare's failure to meet deadlines and "very slow" progress on corrective action plans.⁴⁴ In addition, in spring 2007, CDI received complaints from the California Medical Association, an independent physician's organization, and the University of California Medical Centers. Both complaints allege PacifiCare failed to properly

⁴¹ *Id.* at p. 0798.

⁴² Unless otherwise stated, citations to regulation numbers refer to the Insurance Commissioner's regulations, codified at California Code of Regulations, title 10, section 2050 et seq. and citations to code sections refer to the Insurance Code.

⁴³ PacifiCare argues CDI received only eight provider complaints about its claims-handling practices during the relevant time frame. (PacifiCare's Brief to Commissioner, 9:1-3.) This assertion ignores the significant number of consumer and other provider complaints CDI received. Also, Exhibit 1189 clearly demonstrates PacifiCare acknowledged receipt of more than 150 complaints during calendar year 2006.

⁴⁴ RT 178:21-179:23.

load contracts and fee schedules, failed to timely pay claims and incorrectly identified participating physicians.⁴⁵

In May 2007, CDI initiated a targeted Market Conduct Examination.⁴⁶ On November 9, 2007, CDI presented PacifiCare with both a public and confidential MCE report.⁴⁷ The MCE reports found PacifiCare violated the Insurance Code nearly one million times.⁴⁸ On December 7, 2007, PacifiCare admitted to approximately 130,000 violations of the Insurance Code but disputed other CDI findings.⁴⁹

III. Procedural History

On January 25, 2008, CDI served PacifiCare with an Order to Show Cause, Statement of Charges and Notice of Monetary Penalty (Order to Show Cause).⁵⁰ The Order to Show Cause charged PacifiCare with nearly one million violations of the Insurance Code in 20 different categories and triggered the request for hearing procedures codified in Government Code sections 11500 et seq. From January 2008 through March 2009, the parties engaged in extensive settlement negotiations. On June 3, 2009, PacifiCare filed its Notice of Defense in this action with the Office of Administrative Hearings (OAH).

OAH Administrative Law Judge (ALJ) Ruth S. Astle presided over the evidentiary hearing, which commenced on December 7, 2009 and concluded on June 27, 2013. Michael J. Strumwasser, Bryce A. Gee, and Rachel A. Deutsch, Attorneys at Law, from Strumwasser & Woocher LLP, represented CDI, along with CDI Staff Counsel Andrea G. Rosen. On April 3,

⁴⁵ Exh. 165; Exh. 5155.

⁴⁶ Pursuant to Insurance Code section 730, the Commissioner may examine the business and affairs of an insurer, including its claim's handling procedure. This examination is typically referred to as a "market conduct examination."

⁴⁷ Exh. 116.

⁴⁸ Exh. 116, p. 1296.

⁴⁹ Exh. 117.

⁵⁰ The CDI subsequently filed four Supplemental Accusations and a First Amended Order to Show Cause, which alleged additional violations discovered during the course of the hearing. The First Amended Order to Show Cause, filed January 9, 2012, is the operative pleading in this proceeding. (See Exh. 1209.)

2012, CDI substituted out Ms. Rosen and substituted in Senior Staff Counsel MaryAnn Shulman. Ronald D. Kent, Steven A. Velkei, Thomas E. McDonald, Katherine J. Evans, Felix Woo and Susan M. Walker, Attorneys at Law, from SNR Denton US LLP, represented PacifiCare.

The administrative record in this matter exceeds 50,000 pages and includes nearly 2,000 exhibits. The transcript comprises more than 230 days of hearing and over 60 witnesses testified during the nearly four-year evidentiary hearing. Before close of the record, each party filed post-hearing briefs exceeding 400 pages.

On August 5, 2013, ALJ Astle's 28-page Proposed Decision found PacifiCare violated the Insurance Code 883,735 times, and penalized PacifiCare for 84,801 of those acts. The Proposed Decision assessed an aggregate penalty of \$11,518,350.⁵¹

On November 14, 2013, Insurance Commissioner Dave Jones rejected the Proposed Decision pursuant to Government Code section 11517, subdivision (c)(2)(E) and ordered additional briefing in this matter. On December 23, 2013, CDI filed its Opening Brief and submitted recommended language for this decision. On January 23, 2014, PacifiCare filed its Response Brief and submitted its own recommended language for this decision. On February 6, 2014, CDI filed its Reply Brief and a revised recommended decision. The Commissioner ordered a transcript of the proceedings on February 18, 2013 and closed the record on March 3, 2014, after receiving the transcripts.⁵²

⁵¹ The Proposed Decision failed to address two of the categories raised by CDI and litigated by the parties; Failure to Timely Respond to Provider Disputes and Illegally Closing or Denying Claims When Requesting Additional Information.

⁵² Gov. Code § 11517, subd. (c)(2)(E)(iv); *Matus v. Board of Admin. of California Public Employees' Retirement System* (2009) 177 Cal.App.4th 597, 606-607.

IV. Summary of Issues

CDI alleges PacifiCare violated the Insurance Code and its applicable regulations over 900,000 times during the course of CDI's investigation. CDI classifies the violations in 20 separate categories, ranging from very serious to minimally serious violations.

More specifically, CDI alleges PacifiCare (1) failed to maintain certificates of coverage; (2) incorrectly denied claims based on an illegal pre-existing condition clause; (3) failed to give providers notice of their appeal rights; (4) failed to inform members of their right to an independent medical review; (5) failed to timely pay claims; (6) failed to pay interest on late-paid claims; (7) failed to correctly pay claims; (8) failed to acknowledge receipt of claims; (9) failed to timely respond to provider disputes; (10) illegally closed claims files; (11) sent untimely collection notices for overpayment; (12) failed to maintain complete claim files; (13) failed to timely respond to CDI inquiries; (14) failed to properly train claims agents; (15) misrepresented facts to CDI; (16) failed to conduct business in its own name; (17) failed to timely respond to claimants; (18) failed to implement a date of receipt policy; (19) failed to thoroughly investigate claims; and (20) misrepresented pertinent facts during a CDI investigation.

V. Parties' Contentions

The parties disagree on the cause, impact and required showing for each of the 20 categories identified above. The parties also disagree on the statutory and regulatory requirements, and the applicable penalties for each type of violation.

CDI contends PacifiCare's push for savings resulted in a total breakdown in customer service and claims administration. CDI argues PacifiCare failed to properly vet and oversee outside vendors, resulting in poorly planned integration and thousands of violations. CDI further argues PacifiCare refused to invest in operational infrastructure and employee retention, causing

corrupted provider data and a lack of institutional knowledge and consistency. Lastly, CDI asserts PacifiCare failed to adequately remediate the rampant corporate defects, demonstrating a callous indifference to California consumers and regulators. CDI contends these alleged failures, taken as a whole, led to an unprecedented one million violations of the Insurance Code. Accordingly, CDI requests a penalty of \$325 million.⁵³

PacifiCare contends CDI misinterprets the Insurance Code and its applicable regulations in accusing PacifiCare of over 900,000 violations. PacifiCare also argues CDI permitted and/or approved PacifiCare's violations, and thus is estopped from penalizing PacifiCare for such violations. In addition, PacifiCare asserts CDI's enforcement and penalty assessment violate the insurer's right to due process and equal protection under the law. Lastly, PacifiCare contends the ALJ's proposed penalty must receive great deference.

VI. Applicable Law

To protect California consumers from "unfair methods of competition and unfair and deceptive acts or practices in the business of insurance," the Legislature enacted the Unfair Insurance Practices Act (UIPA) and charged the Insurance Commissioner with the exclusive authority to investigate and penalize noncompliant insurers.⁵⁴ Pursuant to this grant of authority, the Insurance Commissioner promulgated the Fair Claims Settlement Practice (FCSP) Regulations to "delineate certain minimum standards for the settlement of claims which, when violated . . . shall constitute an unfair claims settlement practice within the meaning of Insurance

⁵³ CDI's Opening Brief to Commissioner, 68:14-16.

⁵⁴ Ins. Code § 790.03. The UIPA is codified at Insurance Code section 790 et. seq. No private right of action exists in the UIPA and extension of such a right was rejected by the California Supreme Court. See, *Moradi-Shalal v. Fireman's Fund Ins. Co.* (1988) 46 Cal.3d 287.

Code section 790.03(h).”⁵⁵ These statutes and regulations serve as the foundation of CDI’s accusations.

A. Unfair Insurance Practice Act Provisions

The Legislature vested the Insurance Commissioner with the express authority “to regulate trade practices in the business of insurance.” To that end, Insurance Code section 790.02 prohibits any person from engaging in “an unfair or deceptive act or practice” as defined in Insurance Code section 790.03 or by the Fair Claims Settlement Practice Regulations.⁵⁶

Section 790.03 defines a broad spectrum of prohibited unfair business practices, including false or misleading advertising, misrepresenting the terms of any policy, and unfair discrimination in insurance rates. Further, Section 790.03, subdivision (h) delineates 16 additional deceptive acts which, when read in conjunction with the applicable regulations, set forth a clear code of conduct in the insurance industry.⁵⁷

1. Section 790.03, subdivision (h)

Insurance Code section 790.03, subdivision (h) prohibits insurers from “knowingly committing or performing with such frequency as to indicate a general business practice” any of the 16 enumerated unfair or deceptive acts. The Insurance Code, its accompanying regulations and general rules on statutory construction, help define the terms within this section, and provide insurers with a clear picture of their regulatory obligations.

a. Single Act or General Business Practice

Section 790.03, subdivision (h) explicitly states that an unfair claims settlement practice must be knowingly committed *or* performed with such frequency as to indicate a general

⁵⁵ Cal. Code of Regs., tit. 10, § 2695.1, subd. (a). The Fair Claims Settlement Practices Regulations are codified at California Code of Regulations, title 10, section 2695.1 et seq.

⁵⁶ Ins. Code § 790.04.

⁵⁷ Ins. Code § 790.03, subd. (h).

business practice. While the parties have much debated the meaning of “or” in this sentence, there is no debating the clear import of the disjunctive “or” nor is there any question of the Legislature’s intent.

PacifiCare contends a single act cannot violate Section 790.03, subdivision (h), and instead CDI must demonstrate PacifiCare employed a general business practice of committing unfair practices.⁵⁸ In support of this assertion, PacifiCare relies upon convoluted grammatical rules and a footnote in *Zhang v. Superior Court* (2013) 57 Cal.4th 364. But PacifiCare fails to consider case law on the use of the disjunctive, and fails to acknowledge the clear mention of “a single act” in accompanying statutes and regulations.

The ordinary and proper meaning of the word “or” is well-settled. It has a disjunctive meaning. That is, the function of “or” is to mark an alternative such as “either this or that.”⁵⁹ As such, there can be no ambiguity that the Legislature intends to punish single acts knowingly committed *or* acts performed with such frequency that they demonstrated a general business practice. Additional support for the Legislature’s intent to punish single acts is found in other portions of the UIPA. For example, Insurance Code section 790.035 levies penalties “for each” deceptive act, Section 790.03, subdivision (h)(7) prohibits attempting to settle “a claim by an insured,” and Section 790.03, subdivision (h)(15) prohibits misleading “a claimant.”⁶⁰

Nor do the regulations accompanying Section 790.03, subdivision (h) support PacifiCare’s assertion. Regulation 2695.1 states in at least two separate provisions that a single act may violate Insurance Code section 790.03, subdivision (h). Specifically, Regulation 2695.1, subdivision (a) defines unfair practices as those acts that, “when either knowingly committed on

⁵⁸ PacifiCare’s Brief to OAH, 71:19-76:9; PacifiCare’s Brief to Commissioner, 23:20-27:24.

⁵⁹ *In re Jesusa V.* (2004) 32 Cal.4th 588, 622; see also, *Acosta v. City of Costa Mesa* (9th Cir. 2013) 718 F.3d 800, 815; *Calif. Correctional Peace Officers Assoc. v. Tilton* (2011) 196 Cal.App.4th 91, 96.

⁶⁰ Additional references to single acts can be found in Section 790.03, subdivisions (h)(9), (h)(13), (h)(14), and (h)(16).

a single occasion, or performed with such frequency as to indicate a general business practice” violate Insurance Code section 790.03. Similarly, Regulation 2695.1, subdivision (a)(1) indicates the regulations are intended to “delineate certain minimum standards for the settlement of claims which, when violated knowingly on a single occasion or performed with such frequency as to indicate a general business practice” constitute unfair claims settlement practices under Insurance Code section 790.03(h).⁶¹

PacifiCare’s reliance on *Zhang, supra*, 57 Cal.4th 364, is similarly misplaced. PacifiCare cites a portion of footnote 8 to support its argument that CDI may punish only a pattern of conduct and not a single act. But *Zhang* does not address the single act/general business practice issue. Instead, the Supreme Court in *Zhang* simply reiterated the holding in *Moradi, supra*, 46 Cal.3d 287; that the UIPA bars a private right of action. The footnote cited by PacifiCare, when read in its entirety, stands for the holding that only administrative sanctions are available under the UIPA. PacifiCare’s reliance on dicta in the footnote from an unrelated decision is unconvincing and insufficient to override the clear statutory and regulatory authority interpreting Section 790.03, subdivision (h).

In short, an insurer violates Insurance Code section 790.03, subdivision (h) by a single act knowingly committed or by actions performed with such frequency as to indicate a general business practice. All other interpretations are inconsistent with the legislative and regulatory intent, the clear language of the statute and case law construing the use of the disjunctive “or.”

b. Definition of “Knowingly Committed”

Insurance Code section 790.034, subdivision (b)(1) requires insurers provide all consumers with notice that “in addition to Section 790.03 of the Insurance Code, Fair Claims

⁶¹ This interpretation is also cited in insurance law treatises. See Croskey et al., Cal. Practice Guide: Insurance Litigation (The Rutter Group 2013) ¶ 14:220.

Settlement Practices Regulations govern how insurance claims must be processed in this state.” Included among the critical FCSP regulations is Regulation 2695.2, which defines the terms of Insurance Code sections 790 et seq.

Regulation 2695.2 defines “knowingly committed” as “performed with actual, implied or constructive knowledge, including, but not limited to, that which is implied by operation of law.”⁶² PacifiCare argues the regulation does not stand for what it plainly states, but instead requires “actual knowledge” on the insurer’s behalf. In support of this argument, PacifiCare ignores the statutory definition and instead relies on the dictionary definition of “knowing” as “deliberate or conscious.”⁶³

PacifiCare’s contention is unpersuasive and contrary to the clear language of the regulation. While the dictionary may narrowly define the term “knowingly,” that definition is irrelevant since the regulations provide the definition applicable to unfair claims settlement practices. In addition, PacifiCare’s narrow interpretation would permit the insurer to ignore a situation and then defend the violation by arguing it did not have “actual knowledge.” The Commissioner can find no support for such a restrictive definition.

“Constructive knowledge” is not a novel concept in the law. Civil Code section 19 specifically states “every person who has actual notice of circumstances sufficient to put a prudent man upon inquiry as to a particular fact, has constructive notice of the fact itself.”⁶⁴ Nor is constructive knowledge unprecedented in the corporate world. Facts known to one part of a corporation place those facts within the constructive knowledge of the corporation as a whole. To hold otherwise would frustrate the legislative purpose of much contract and tort law.⁶⁵

⁶² Cal. Code of Regs., tit. 10, § 2695.2, subd. (l).

⁶³ PacifiCare’s Brief to OAH, 76:10-81:20; PacifiCare’s Brief to Commissioner, 27:25-30:3.

⁶⁴ See also *Brown v. Copp* (1951) 105 Cal.App.2d 1, 6.

⁶⁵ *Monteleone v. Southern Cal. Vending Corp.* (1968) 264 Cal.App.2d 798, 807.

Based on the above, the Commissioner finds no reason to alter the clear definition of “knowingly” provided in Regulation 2695.2, subdivision (l). The regulation’s definition is reasonable, appropriate and entirely consistent with statutory law.

c. Definition of “General Business Practice”

Insurance Code section 790.03, subdivision (h) prohibits both single acts knowingly committed and acts “performed with such frequency as to indicate a general business practice.” Thus, illegal acts not knowingly committed may be the basis of penalties if they were performed with such frequency as to show a general business practice. “Frequency” allows a general business practice to be deduced from the frequency of the conduct.

The dictionary defines “frequency” as the number of occurrences of a repeating event per unit of time.⁶⁶ But neither the Insurance Code nor the regulations explain what frequency suffices to indicate a “general business practice.” PacifiCare argues that frequency requires the number of acts to exceed an unstated tolerance threshold before constituting a general practice.⁶⁷ PacifiCare locates this tolerance threshold in an Examiner’s Handbook adopted by the National Association of Insurance Commissioners (NAIC). CDI contends PacifiCare’s argument serves only to further narrow its liability under the UIPA and is unsupported by case law or the legislative history.⁶⁸

PacifiCare’s arguments regarding a tolerance threshold are unpersuasive. While PacifiCare cites Insurance Code section 733, nothing in that statute or its legislative history requires the Commissioner to use benchmarks suggested by the NAIC when assessing a penalty. The clear intent of Section 733 is to ensure insurers meet the minimum financial regulatory

⁶⁶ Webster’s New World Dict. (3rd college ed. 1988) p. 539, col. 2.

⁶⁷ PacifiCare’s Brief to OAH, 81:22-85:23; PacifiCare’s Brief to Commissioner, 30:4-33:3.

⁶⁸ CDI’s Closing Brief to OAH, 116:4-118:19; 302:1-305:28; CDI’s Closing Brief to Commissioner, 12:1-22.

standards under the NAIC.⁶⁹ The NAIC Handbook has no force or effect under California law except with respect to accreditation of financial examinations.⁷⁰

Nor does Insurance Code section 790.03, subdivision (h), require CDI to show frequency beyond some specific tolerance threshold. While perfection is not required, committing the same violation over and over again indicates a “general business practice.” Indeed, a relatively small number of violations could, depending on the circumstances, indicate sufficient frequency, just as a general business practice may be established by an affirmative admission by the insurer that the company performed the act.

d. Specific Proscriptions in Section 790.03(h)

Of the 16 prohibited actions specified in Section 790.03, subdivision (h), only the first five are relevant to these proceedings. The proscriptions in Section 790.03 are broadly stated and frequently require examination of the corresponding regulations to ascertain the more specific requirements.

i. Section 790.03(h)(1)

Section 790.03, subdivision (h)(1) prohibits insurers from “misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.” A claimant is a first or third party claimant, or any person authorized to represent a claimant.⁷¹ In addition, a provider submitting a claim as a beneficiary of the policy is considered a first party claimant.⁷²

While the statute does not define “misrepresentation,” Regulation 2695.2, subdivision (v) notes that for penalty purposes, the Insurance Code punishes the “commission or omission” of an

⁶⁹ Exh. 872, p. 17.

⁷⁰ Curiously, PacifiCare also argues the Commissioner should apply the 2011 version of the NAIC Handbook, as versions in place at the time of PacifiCare’s MCE do not include the tolerance thresholds PacifiCare advocates for.

⁷¹ Cal. Code of Regs., tit. 10, § 2695.2, subd. (c).

⁷² Cal. Code of Regs., tit. 10, § 2695.2, subds. (a), (f).

act. Thus, a misrepresentation may consist of an affirmative statement or an omission of a material fact where there is a duty to disclose that fact.

PacifiCare overlooks Regulation 2695.2, subdivision (v)'s clear intent and instead argues that non-disclosure or omission of a material fact does not constitute misrepresentation.⁷³ Instead, the insurer asserts "there can be no misrepresentation unless there is a representation." Or more specifically, PacifiCare does not violate Section 790.03, subdivision (h)(1) even if it intentionally fails to disclose material facts to California consumers. The Commissioner finds this argument lacks merit.

By arguing that an insurer cannot be liable for non-disclosure, PacifiCare fails to acknowledge that an insurer possesses an affirmative duty to disclose material facts to consumers. For example, the Insurance Code obligates an insurer to inform consumers of their appeal rights, acknowledge receipt of claims and other communications, and disclose the legal identity of the insurer.⁷⁴ Failing to disclose such facts, when an affirmative obligation exists to do so, is a well-established method of demonstrating misrepresentation.⁷⁵ Given the clear language of Regulation 2695.2, subdivision (v) and California case law regarding non-disclosure, CDI may demonstrate an unlawful misrepresentation by either an affirmative statement or by the omission of a material fact where there is a duty to disclose that fact.

ii. Section 790.03(h)(2)

Section 790.03, subdivision (h)(2) bars insurers from "failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies." In many circumstances, the Legislature and the Commissioner have defined what

⁷³ PacifiCare's Brief to OAH, 85:26-88:18; PacifiCare's Brief to Commissioner, 33:6-34:8.

⁷⁴ Ins. Code §§ 10123.13, subd. (a); 10123.147, subd. (a); 880.

⁷⁵ *Goodman v. Kennedy* (1976) 18 Cal.3d 335, 346; *OCM Principal Opportunities Fund v. CIBC World Market Corp.* (2007) 157 Cal.App.4th 835, 855; *Lingsch v. Savage* (1963) 213 Cal.App.2d 729, 735.

constitutes “reasonably prompt.” For example, Insurance Code section 10133.66, subdivision (c) requires an insurer to acknowledge a health insurance claim within 15 working days from the date of receipt of the claim. In addition, where the law requires the insurer to act within a specific period, that period defines the maximum time that may constitute “reasonably promptly.”

iii. Section 790.03(h)(3)

Insurance Code section 790.03, subdivision (h)(3) states an insurer commits an unfair settlement practice by “failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.” An insurer who merely adopts an investigation or processing standard fails to meet the obligations of this provision. Instead, the Legislature requires that such standards be implemented. An insurer also violates this subdivision when its processing or investigative standards are unreasonable, nonexistent or inconsistently implemented. In addition, what constitutes a “reasonable standard” is outlined by other Insurance Code provisions and the FCSP regulations.⁷⁶ And, as with the previous subsections of Section 790.03, where a statute or regulation imposes a duty to promptly investigate and process a claim within a specific period, that period defines the maximum time for the “prompt investigation and processing of claims.”

iv. Section 790.03(h)(4)

Subdivision (h)(4) prohibits insurers from “failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured.” What constitutes a “reasonable time” is once again defined by statutory and regulatory authority.⁷⁷ And where the law imposes a duty to affirm or deny coverage within a specified period, that period defines the maximum “reasonable time” under this statute.

⁷⁶ See Ins. Code § 10123.13, 10123.47; Cal. Code of Regs., tit. 10, §§ 2695.3 and 2695.7.

⁷⁷ See Ins. Code § 10123.147; Cal. Code of Regs., tit. 10, § 2695.7.

v. **Section 790.03(h)(5)**

Insurance Code section 790.03, subdivision (h)(5) requires insurers to attempt in “good faith to effectuate prompt, fair, and equitable settlement of claims in which liability has become reasonably clear.” Good faith requires that the actor have an actual and reasonable belief that it was complying with the law.⁷⁸ The actor must be candid in its dealings, not evince intent to deceive, or a desire to gain improper advantage.⁷⁹ And the acts in question must be taken with intent to comply with the actor’s legal obligations and without purpose of evading those obligations.⁸⁰ As the California Supreme Court stated, “delayed payment ... inadequate or tardy investigations, oppressive conduct by claims adjusters seeking to reduce the amounts legitimately payable and numerous other tactics” breach the covenant of good faith since they frustrate the insured's right to receive contractual benefits and prompt reimbursement for losses.⁸¹

Various statutes and regulations detail what constitutes “prompt” and “fair” settlements. Where the law imposes a duty to promptly settle claims within a specified period, that period delineates the maximum time that may constitute “prompt” under the law. Similarly, the standard for fairness and equity will depend on other laws prescribing an insurer’s duties with respect to claims payment and handling.

B. Civil Penalty Provisions

Before 1989, the Insurance Code severely restricted the Insurance Commissioner’s ability to penalize insurers for violations of Insurance Code section 790.03. Insurance companies could not be fined unless they continued the unlawful practice after the Commissioner issued a cease-

⁷⁸ *Careau & Co. v. Sec. Pac. Bus. Credit, Inc* (1990) 222 Cal.App.3d 1371, 1401-1402.

⁷⁹ *Egan v. Mutual of Omaha Ins. Co.* (1979) 24 Cal.3d 809, 818; *Whitlow v. Bd. of Medical Examiners* (1967) 248 Cal.App.2d 478, 487.

⁸⁰ *George Arakelian Farms, Inc. v. ALRB* (1985) 40 Cal.3d 654, 667.

⁸¹ *Waller v. Truck Ins. Exchange, Inc.* (1995) 11 Cal.4th 1, 36.

and-desist order. California courts and legislators found the penalty provision served as “little incentive for insurance companies to refrain from unfair and deceptive practices.”⁸²

In 1989, the Legislature passed Senate Bill 1363 and enacted Insurance Code section 790.035, granting the Insurance Commissioner authority to impose penalties for the initial acts which prompt regulator action. The stated purpose of Senate Bill 1363 leaves no question as to the intent of Section 790.035:

Under current law, insurers cannot be fined for practices determined by the Commissioner to be unfair and deceptive practices unless the practices continue after a cease and desist order has been issued. This measure will allow the Commissioner to impose charges for the initial acts which prompt regulator action. The author expresses the belief that such authority will serve as a more effective and flexible regulatory tool than restricting penalties to violations of cease and desist orders only.⁸³

The legislative imperative to strengthen enforcement of the UIPA is also reflected in the Legislature’s decision to adopt Senate Bill 1363 as an urgency statute. As the Legislature stated, immediate implementation is necessary “to effectively protect consumers from deceptive insurance practices and to ensure marketplace stability.”⁸⁴

1. Section 790.035

Insurance Code section 790.035, subdivision (a) subjects insurers to civil penalties depending on the type of UIPA violation:

Any person who engages in any unfair method of competition or any unfair or deceptive act or practice defined in Section 790.03 is liable to the state for a civil penalty to be fixed by the commissioner, not to exceed five thousand dollars (\$5,000) for each act, or, if the act or practice was willful, a civil penalty not to exceed ten thousand dollars (\$10,000) for each act. The commissioner shall have the discretion to establish what constitutes an act. However, when the issuance,

⁸² Sen. Rules Com., Off. of Sen. Floor Analyses, 3d reading analysis of Sen. Bill. No. 1363 (1989-1990 Reg. Sess.) as amended September 11, 1989. A copy of this analysis may be found in Exhibit D of CDI’s Request for Official Notice dated May 31, 2012, and granted by the ALJ on August 9, 2012. (RT 26236:17-18.)

⁸³ Assem. Comm. on Finance and Insurance, Report on Sen. Bill No. 1363 (1989-1990 Reg. Sess.) as amended on July 6, 1989. A copy of this report may be found in Exhibit A of CDI’s Request for Official Notice dated May 31, 2012, and granted by the ALJ on August 9, 2012. (RT 26236:17-18.)

⁸⁴ Sen. Bill. No. 1363, Stats. 1989, ch. 725, sec. 4.

amendment, or servicing of a policy or endorsement is inadvertent, all of those acts shall be a single act for the purpose of this section.

The parties interpret nearly every aspect of this provision differently, and as such, the Commissioner will address each piece of this statute in depth.

a. “Willful” Acts

The large civil penalty disparity between willful and non-willful acts or practices, demonstrates the significance of the term “willful.” Fortunately, the regulations provide insurers, consumers and the Commissioner with clear guidance in this area. Regulation 2695.2, subdivision (y) states “willful” or “willfully” when applied to an act or omission “means simply a purpose or willingness to commit the act, or make the omission referred to in the California Insurance Code or this subchapter. It does not require any intent to violate law, or to injure another, or to acquire any advantage.”

Despite the clear language of Regulation 2695.2, subdivision (y), PacifiCare argues “willful” requires specific intent.⁸⁵ In support of this argument, PacifiCare points to case law and statutes outside of Insurance Code section 790.03. But PacifiCare’s assertions are unsupported by California case law and contrary to the obvious legislative intent.

First, contrary to PacifiCare’s contention, there is no universal meaning regarding the definition of “willful.” In fact, California courts have consistently acknowledged that no uniform definition exists. As the Court of Appeal stated in *Heritage Residential Care, Inc. v. Division of Labor Standards Enforcement* (2011) 192 Cal.App.4th 75, “[t]he word ‘willful’ is used in different statutes with various shades of meaning.”⁸⁶ Case law cited by PacifiCare similarly disclaims the idea of a universal definition stating that “when we turn to other decisions

⁸⁵ PacifiCare’s Brief to OAH, 99:1-107:22; PacifiCare’s Brief to Commissioner, 37:20-38:25.

⁸⁶ 192 Cal.App.4th at p. 84.

involving the meaning of willfulness, we find the concept is not one easily captured in a single, uniformly applicable formula.”⁸⁷

Nor does California case law consistently interpret “willful” as imposing a specific intent standard. For example, Penal Code section 7, subdivision (l) mirrors the definition found in Regulation 2695.2, subdivision (y) and specifically states willfulness “does not require any intent to violate law, or to injure another, or to acquire any advantage.”⁸⁸ Likewise, California is replete with cases following this definition.⁸⁹ In fact, in the context of a regulatory statute imposing civil liabilities, willfulness often denotes knowing or voluntary conduct, but does not require specific intent to injure.⁹⁰ Not requiring a showing of actual intent to do harm also furthers the Legislature's intent to vest the Commissioner with broad enforcement power, including the authority to impose higher penalties.⁹¹

Lastly, PacifiCare cites other Insurance Code provisions requiring specific intent for willful violations. But such citations only further support the argument that the Legislature intended a different meaning under the UIPA. For example, PacifiCare cites Insurance Code section 12340.9 which defines “willful” as requiring “specific intent to commit a violation.” But when one part of a statute contains a term or provision, the omission of that term or provision from another part of the statute indicates the Legislature intended to convey a different meaning.⁹² The Legislature could easily have linked the term “willful” as used in Insurance Code section 790.035 to the definition in Insurance Code section 12340.9, but it did not do so, and the

⁸⁷ *Kwan v. Mercedes-Benz of North America, Inc.* (1994) 23 Cal.App.4th 174, 182.

⁸⁸ Similar language regarding lack of specific intent may be found in Civil Code section 2941.

⁸⁹ *Patarak v. Williams* (2001) 91 Cal.App.4th 826, 829; *Calvillo-Silva v. Home Grocery* (1998) 19 Cal.4th 714, 729-730; *Sumon v. BMW of North America, Inc.* (1994) 23 Cal.App.4th 1, 12.

⁹⁰ *Rick's Elec., Inc. v. California Occupational Safety and Health Appeals Bd.* (2000) 80 Cal.App.4th 1023, 1035. See also, *United States v. Illinois Central R. Co.* (1938) 303 U.S. 239, 242-243.

⁹¹ *Rick's Elec., Inc. v. California Occupational Safety and Health Appeals Bd.*, *supra*, 80 Cal.App.4th at p. 1037.

⁹² *Cornette v. Department of Transp.* (2001) 26 Cal.4th 63, 73-74; *People v. Gardeley* (1996) 14 Cal.4th 605, 621-622.

Commissioner should not rewrite the statute to make it conform to a presumed intent not expressed.⁹³

In short, the Commissioner declines PacifiCare’s invitation to omit language the Legislature specifically included or to alter the plain meaning of Regulation 2695.2, subdivision (y). As clearly stated, a willful act is one committed or omitted with a purpose or willingness to commit the act, or make the omission referred to in the Insurance Code and applicable regulations. It “does not require any intent to violate the law, or to injure another, or to acquire any advantage.”⁹⁴

b. “Inadvertent” Issuance, Amendment or Servicing

Section 790.035 states that “when the issuance, amendment or servicing of a policy or endorsement is inadvertent, all of those acts shall be a single act for purposes of this section.” The import of this section is clear; it is the difference between penalizing over 400,000 separate violations in one category or simply penalizing one act in that category. Neither the statute nor the applicable regulations define “inadvertent” or explain the unique wording of this provision.

CDI argues an insurer does not “inadvertently” service a policy when it incorrectly denies a claim or fails to meet statutory deadlines. Instead, CDI construes “servicing” literally, to address a situation where the decision to service was an inadvertent violation of Section 790.03.⁹⁵ In addition, CDI contends that if the error persisted so long that it should have been identified by the company, the deficiency cannot be dismissed as mere inadvertence.⁹⁶

Conversely, PacifiCare argues “inadvertent” means accidental, careless, negligent or lacking in

⁹³ *Romano v. Mercury Ins. Co.* (2005) 128 Cal.App.4th 1333, 1344; *Cornette v. Department of Transp., supra*, 26 Cal.4th at pp. 73-74; *People v. Leal* (2004) 33 Cal.4th 999, 1008.

⁹⁴ Cal. Code of Regs., tit. 10, § 2695.2, subd. (y).

⁹⁵ CDI’s Opening Brief to OAH, 86:6-13; CDI’s Closing Brief to OAH, 143:8-11.

⁹⁶ CDI’s Opening Brief to OAH, 85:10-87:21; CDI’s Closing Brief to OAH, 142:15-145:8; CDI’s Opening Brief to Commissioner, 20:10-21:2.

attentiveness. But PacifiCare extends its definition of “inadvertent” by way of contradistinction to its alleged antonyms of “deliberate, intentional or knowingly.”⁹⁷

Because neither the statute nor regulations define “inadvertent” in this context, the Commissioner shall give the term its “plain and commonsense meaning.”⁹⁸ It is appropriate in such instances to refer to the dictionary meaning of the word.⁹⁹ Merriam-Webster’s Collegiate Dictionary defines inadvertent as “unintentional.”¹⁰⁰ Similarly, Black’s Law Dictionary defines inadvertence as “accidental oversight; a result of carelessness.”¹⁰¹ Based on the above, the Commissioner adopts the ordinary, commonplace meaning of inadvertent as used in Section 790.035 as “unintentional” or “accidental.”¹⁰²

But adoption of this definition does not end the discussion of how to interpret Section 790.035. For instance, PacifiCare contends that a knowingly committed error, even one continued after PacifiCare was made aware of the unlawful act, remains “inadvertent” for penalty purposes if it was “accidental.” It is unclear how an act can be considered “accidental” if it was committed after notice that the act violated the Insurance Code. Repeating an illegal act after notice, either constructive or actual, is not “accidental” or “unintentional.” Put differently, if an insurer mails out 400,000 letters with the incorrect name of the insurer on the letterhead, one could conceivably believe the action to be “accidental” and thus punishable as only a single act. But if an insurer consciously misstates the name of the insurer, or continues to mail out incorrectly titled letters after notice of its illegal action, the insurer cannot hide behind the term “inadvertent” to protect itself from 400,000 violations. There is simply no reason to believe the

⁹⁷ PacifiCare’s Brief to OAH, 108:24-112:9; PacifiCare’s Brief to Commissioner, 39:1-40:18.

⁹⁸ *Murphy v. Kenneth Cole Productions, Inc.* (2007) 40 Cal.4th 1094, 1103.

⁹⁹ *Wasatch Property Management v. Degrate* (2005) 35 Cal.4th 1111, 1121-1122.

¹⁰⁰ Webster’s 10th Collegiate Dict. (1999) p. 586.

¹⁰¹ Black’s Law Dict. (9th ed. 2009) p. 827.

¹⁰² *Heritage Residential Care, Inc. v. Division of Labor Standards Enforcement, supra*, 192 Cal.App.4th at p. 83.

Legislature intended to protect insurers who ignore or consciously disregard their statutory obligations.¹⁰³

2. Penalty Factors Pursuant to Regulation 2695.12

Having set forth the definition of wilful and considered the meaning of “inadvertent,” the regulations also instruct the Commissioner to consider certain factors before setting the appropriate civil penalty. Of the 14 factors listed, only eight are relevant to the underlying alleged violations. They are not listed in order of importance, nor does Regulation 2695.12 single out one factor as more important than any other.

a. Regulation 2695.12(a)(1): Extraordinary Circumstances

Regulation 2695.12, subdivision (a)(1) requires the Commissioner consider “the existence of extraordinary circumstances” in determining the applicable penalty. The regulations define “extraordinary circumstances” as “circumstances outside of the control of the licensee which severely and materially affect the licensee’s ability to conduct normal business operations.”¹⁰⁴

b. Regulation 2695.12(a)(3): Complexity of Claims

Subdivision (a)(3) obligates the Commissioner to consider “the complexity of the claims involved” when assessing penalties. Neither the Insurance Code nor the regulations define the phrase “complexity of claims.”

While the regulation is silent on a definition, the import of this provision is clear. If a licensee allegedly violates the Insurance Code in the course of processing a claim, the Commissioner shall consider the complexity of that claim in setting a penalty. If the claim is

¹⁰³ CDI contends that when an insurer intends to process a claim but does so wrongfully or incorrectly, that conduct does not constitute inadvertent servicing for purposes of determining the number of violations. But because the alleged violations occurred after notice from CDI, the Commissioner need not address CDI’s contention.

¹⁰⁴ Cal. Code of Regs., tit. 10, § 2695.2, subd. (e). This definition also mirrors the definition of extraordinary circumstances in Insurance Code section 12926.2.

novel or complicated, as compared to the claims an insurer regularly processes, then this factor would serve to mitigate the penalty.

c. Regulation 2695.12(a)(7): Relative Number of Claims

The Commissioner must also consider “the relative number of claims where the noncomplying act(s) are found to exist, the total number of claims handled by the licensee and the total number of claims reviewed by the Department during the relevant time period.”¹⁰⁵

This regulation requires the Commissioner consider the number of claims where violations were found and not, as argued by PacifiCare, the number of claims examined by CDI.¹⁰⁶ Indeed, the Legislature rejected PacifiCare’s comparison during adoption of this subsection as contrary to the report-by-exception format used in market conduct exams.¹⁰⁷

d. Regulation 2695.12(a)(8): Remedial Measures

Subsection (a)(8) requires the Commissioner consider “whether the licensee has taken remedial measures with respect to the noncomplying act(s).” If the licensee undertook remedial measures to correct its noncompliance, both retrospectively and prospectively, then such remediation serves as a mitigating factor in assessing a penalty. Because CDI is concerned with Insurance Code compliance, it would serve little regulatory purpose to credit an insurer for retrospective remediation of claims, where the insurer continues to operate in violation of the law. In addition, a licensee’s failure to take remedial measures will serve as an aggravating factor in issuing a penalty.

e. Regulation 2695.12(a)(9): Previous Violations

¹⁰⁵ Cal. Code of Regs., tit. 10, § 2695.12, subd. (a)(7).

¹⁰⁶ Exh. 1200, p. 38. Exhibit 1200 includes the Statement of Reasons for the amendment of Regulation 2695.12, subd. (a)(7) in 2006; PacifiCare’s Brief to OAH, 117:1-5.

¹⁰⁷ Exh. 1200, p. 38. Under the report-by-exception method of examination, CDI reports only the violations found in the subset reviewed and does not assess the number of properly processed claims. PacifiCare’s argument assumes all unreviewed claims are compliant.

Regulation 2695.12, subdivision (a)(9) instructs the Commissioner to contemplate “the existence or nonexistence of previous violations by the licensee.” The regulation is silent with regard to mergers, where one party possesses an exemplary compliance record and the other possesses a less than stellar compliance history.

CDI argues for the following interpretation: When an insurer with a good compliance record is acquired by another insurer with a poor compliance record, and the latter company exercises management of the former at the time violations occur, the record of the company managing the licensee is to be considered under Regulation 2695.12, subdivision (a)(9).¹⁰⁸ PacifiCare argues that PacifiCare employees committed the alleged violations and thus United’s poor compliance record is irrelevant.¹⁰⁹

PacifiCare’s argument in this instance is not persuasive. The record demonstrates that post-merger, all employees were under United’s umbrella, regardless of whether they worked for PHLIC or some other United affiliate. Any effort to blame PacifiCare-specific employees seems artificial at best.

Instead, the Commissioner finds that in a merger situation as presented herein, it is reasonable to consider the previous compliance history of both parties to determine the proper penalty.

f. Regulation 2695.12(a)(10): Harm

The Commissioner must also address “the degree of harm occasioned by the noncompliance.”¹¹⁰ Although harm is not defined by the regulations, it is reasonable to assume harm includes not only financial injury, but non-pecuniary harm, pain and suffering,

¹⁰⁸ CDI’s Opening Brief to OAH, 96:12-98:18; CDI’s Opening Brief to Commissioner, 24:8-16.

¹⁰⁹ PacifiCare’s Brief to OAH, 114:14-115:3; PacifiCare’s Brief to Commissioner, 42:18-26.

¹¹⁰ Cal. Code of Regs., tit. 10, § 2695.12, subd. (a)(10).

inconvenience to consumers, interference with the health care system, and harm to the regulatory process.¹¹¹

Contrary to PacifiCare's argument, this subsection does not require CDI to demonstrate harm prior to assessing any penalty.¹¹² Harm is but one of 14 factors the Commissioner must consider in calculating a penalty. It is not the "most important" factor, as PacifiCare argues, nor is proof of actual harm required in a civil penalty action such as this.¹¹³

g. Regulation 2695.12(a)(11): Good Faith Attempt To Comply

Subdivision (a)(11) requires the Commissioner to also consider "whether, under the totality of circumstances, the licensee made a good faith attempt to comply with the provisions of the subchapter." As noted above, good faith requires that the actor have an actual and reasonable belief that it was complying with the law.¹¹⁴

h. Regulation 2695.12(a)(12): Frequency & Severity

The Commissioner must also contemplate "the frequency of occurrence and/or severity of the detriment to the public caused by the violation of a particular subsection of this subchapter."¹¹⁵ By specific incorporation, this subsection requires the Commissioner to again consider the number of claims (frequency) and degree of harm (severity) with specific focus on the impact to the general public, not just the policyholder. As noted above, harm includes not only financial injury, but non-pecuniary harm, pain and suffering, inconvenience to consumers, interference with the health care system, and harm to the regulatory process.

¹¹¹ *People ex rel. State Air Res. Bd. v. Wilmshurst* (1999) 68 Cal.App.4th 1332, 1351.

¹¹² PacifiCare's Brief to OAH, 112:15-116:20; PacifiCare's Brief to Commissioner, 42:27-43:7.

¹¹³ *City and County of San Francisco v. Sainez* (2000) 77 Cal.App.4th 1302, 1315.

¹¹⁴ *Careau & Co. v. Sec. Pac. Bus. Credit, Inc, supra*, 222 Cal.App.3d at pp. 1401-1402.

¹¹⁵ Cal. Code of Regs., tit. 10, § 2695.12, subd. (a)(12).

i. Regulation 2695.12(a)(13): Management Awareness

Regulation 2695.12, subdivision (a)(13) instructs the Commissioner to consider “whether the licensee’s management was aware of facts that apprised or should have apprised the licensee of the act(s) and the licensee failed to take any remedial measures.” This subsection differs from subdivision (a)(8) (remedial measures) in that this subsection calls for the Commissioner to examine management’s awareness and actions. If notice is found, the Commissioner must then determine whether management took any remedial measures with respect to the violation charged.

VII. Discussion

CDI contends PacifiCare violated the Insurance Code and its applicable regulations over 900,000 times and classifies the violations in 20 separate categories, ranging from very serious to minimally serious violations. Each of the 20 categories is addressed separately below. In addition, Subsection U, *infra*, addresses PacifiCare’s constitutional arguments against CDI’s proposed penalties and PacifiCare’s deference argument.

A. Incorrect Denial of Claims; Failure to Maintain COCC on File

Insurers may exclude coverage for pre-existing medical conditions for up to six months after a new group insurance policy takes effect if the member does not have evidence of prior coverage.¹¹⁶ But if the insured submits evidence of continuous prior coverage by another insurer, coverage of pre-existing conditions may not be denied.¹¹⁷ This evidence of prior coverage is called a certificate of creditable coverage (COCC).

¹¹⁶ Ins. Code § 10708.

¹¹⁷ Ins. Code § 10198.7, subd. (e).

1. Applicable Law

The Insurance Code and regulatory provisions require an insurer keep the COCC on file and readily retrievable.¹¹⁸ Specifically, Regulation 2695.3, subdivision (a) requires that all insurers maintain for examination “all documents, notes and work papers (including copies of all correspondence) which reasonably pertain to each claim.” And, subdivision (b)(2) requires the insurer record the date it received and processed “every material and relevant document in the file.”

2. Findings of Fact

The Commissioner finds by a preponderance of the evidence the following facts regarding PacifiCare’s alleged failure to maintain COCCs.

When PacifiCare received a claim from a new member that involved a potential pre-existing condition, the insurer denied the claim and instructed the member to provide additional information, such as the COCC.¹¹⁹ PacifiCare permitted its members to fax or mail their COCCs to either Customer Service, Members Services or the Appeals department, at which time PacifiCare would forward the COCC to its Claims department.¹²⁰ The Claims department then sent the COCC to Lason for scanning as a secondary document. In addition, the Claims department updated the member’s records so that future claims would not trigger a request for a COCC.¹²¹ PacifiCare instructed Lason to scan and index each COCC by claim number, and permanently store the COCC in FileNet, PacifiCare’s long-term filing system.¹²²

¹¹⁸ Cal. Code of Regs., tit. 10, § 2695.3, subd. (b).

¹¹⁹ RT 8090:18-8091:11.

¹²⁰ RT 14323:7-20; RT 14311:19-14312:6.

¹²¹ RT 14312:10-16.

¹²² Exh. 348, p. 0679.

In 2006, CDI began receiving consumer complaints regarding PacifiCare's failure to maintain COCCs.¹²³ The most poignant example of these complaints came from Ms. W, whose son suffers from a chronic illness.¹²⁴ After her son underwent emergency surgery in December 2005, PacifiCare denied Ms. W's claim and requested Ms. W provide a COCC. On January 13, 2006, Ms. W faxed PacifiCare a COCC.¹²⁵ On January 20, 2006, Ms. W followed up with PacifiCare and was told to resend her COCC as there was no record of receipt. Ms. W again faxed the COCC on that date.¹²⁶ On January 24, 2006, Ms. W again contacted PacifiCare and was told they had no record of the COCC. She then faxed the COCC a third time.¹²⁷ On January 25, 2006, Ms. W faxed the COCC for a fourth time, this time while a PacifiCare employee waited alongside the fax machine.¹²⁸ Each fax included a cover letter with the claim and member numbers, and contact information for Ms. W, yet PacifiCare failed to record the COCC at least three times.¹²⁹ On March 20, 2006, Ms. W filed a request for assistance with CDI regarding PacifiCare's failure to properly maintain her COCC.¹³⁰

In November 2006, CDI Supervising Insurance Compliance Officer Nicoleta Smith telephoned PacifiCare to discuss the influx of complaints. After several unsuccessful attempts to reach a PacifiCare employee, in December 2006 Ms. Smith eventually spoke with PacifiCare Associate General Counsel Sharon Hulbert, who promised to look into the matter.¹³¹ Internal

¹²³ Exh. 166; RT 58:14-59:2.

¹²⁴ Exh. 128.

¹²⁵ RT 1026:3-15; Exh. 128, p. 5105.

¹²⁶ RT 1026:24-1027:10; Exh. 128, pp. 5105, 5108.

¹²⁷ RT 1027:1-3.

¹²⁸ RT 1027:5-8.

¹²⁹ Exh. 128, pp. 5103, 5105.

¹³⁰ *Id.* at p. 5087.

¹³¹ RT 55:13-56:8; RT 62:25-63:6.

PacifiCare documents demonstrate PacifiCare received a number of member complaints in this area as well.¹³²

On January 11, 2007, CDI sent PacifiCare a letter which outlined the complaints and instructed the insurer to initiate a comprehensive corrective action plan, including review of the processes for handling incoming COCCs.¹³³ CDI also requested PacifiCare review “all denials made in 2006 related to the non-receipt of a certificate of creditable coverage.”¹³⁴ On February 14, 2007, the parties discussed the handling of incoming COCCs as well as a myriad of other consumer complaints.¹³⁵ During this discussion, PacifiCare admitted that “members’ claims end up being denied for lack of information and a failure to provide the requested certificate of creditable coverage, although the member can show sending [the COCC] in several times.”¹³⁶ To remedy this problem, PacifiCare stated it would create a procedure to systematically scan and document the COCC into its database regardless of where the COCC was received.¹³⁷

In March and April 2007, PacifiCare convened workgroups to address the lost COCCs. PacifiCare pointed to Lason and the DocDNA system as the main culprits.¹³⁸ PacifiCare specifically found that Lason failed to properly index the secondary documents in DocDNA, including the COCCs, making it impossible for the insurer to retrieve the information.¹³⁹ In addition, PacifiCare’s routing instructions to Lason were “fragmented” and “complex,” and the DocDNA was “poorly managed.”¹⁴⁰ It sometimes took weeks for a document to reach its destination, with thousands of documents languishing inexplicably in DocDNA queues for over a

¹³² Exh. 1041, p. 3269; Exh. 702, p. 5475.

¹³³ Exh. 5004.

¹³⁴ Exh. 5004, p. 7577.

¹³⁵ Exh. 7.

¹³⁶ Exh. 6, p. 7566.

¹³⁷ *Ibid.*

¹³⁸ Exh. 342, p. 8514; Exh. 355, p. 8501; RT 6353:7-13.

¹³⁹ Exh. 574.

¹⁴⁰ Exh. 373, p. 0560; Exh. 372.

month.¹⁴¹ As a result, PacifiCare repeatedly denied member claims even though it possessed all relevant information. Furthermore, PacifiCare's mail routing system faltered after its merger with United. Ruth Watson, PacifiCare's Vice President of Membership Accounting, testified that much of PacifiCare's mail was no longer being delivered.

I had a manager that went in her pickup truck and loaded the back of her pickup truck with the mail for the entire building. And then we spent three people full time for three days sorting through the mail, and we identified \$5 million in premium checks and the mail for the rest of the building.¹⁴²

PacifiCare received additional COCC complaints after its remediation efforts.¹⁴³

In June 2007, PacifiCare provided CDI with a spreadsheet titled "Updated Listing of COCC Claims that have been reprocessed as requested in an email from Nicoleta Smith to Laura Henggeler dated April 13, 2007."¹⁴⁴ The report acknowledges PacifiCare wrongfully denied 1,799 COCC claims during 2006. After PacifiCare reprocessed the 1,799 COCC claims, the insurer determined 689 claims required additional payments to members.¹⁴⁵

In September 2007, the Department received two additional consumer complaints regarding PacifiCare's failure to maintain previously provided COCCs, even though PacifiCare changed its document handling procedures.¹⁴⁶

3. Parties' Contentions

CDI contends PacifiCare's "poorly planned, rushed transition of document routing and storage functions to Lason" resulted in 1,799 separate violations of the Insurance Code.¹⁴⁷ CDI argues PacifiCare knew or should have known its document scanning and routing system failed to adequately maintain critical documents as required by Regulation 2695.3. In support of this

¹⁴¹ Exh. 361; Exh. 526, p. 2770; Exh. 666, p. 1103.

¹⁴² RT 17704:22-17705:2.

¹⁴³ See Exhs. 29, 41 and 209.

¹⁴⁴ Exh. 5016.

¹⁴⁵ Exh. 103.

¹⁴⁶ Exhs. 76 and 79.

¹⁴⁷ CDI's Opening Brief to Commissioner, 27:3-4.

argument, CDI points to PacifiCare’s internal communications and CDI’s letters to PacifiCare. CDI also argues the frequency of these violations – 1,799 in a single year for a small insurance line – indicates a general business practice.¹⁴⁸ Lastly, CDI asserts PacifiCare exhibited a willingness to violate the Insurance Code when it failed to adopt basic safeguards for COCC handling.

PacifiCare argues that while Exhibit 5016 admits to 1,799 instances where the insurer failed to maintain a COCC, the document does not stand for what it says. Instead, PacifiCare contends the exhibit represents claims that were incorrectly denied based on a misapplied exclusionary period.¹⁴⁹ In addition, PacifiCare argues that failing to maintain COCCs does not constitute misrepresentation or bad faith.¹⁵⁰ PacifiCare also asserts the violations were not knowingly committed, do not constitute a general business practice, and should be considered a single act; not 1,799 separate violations.¹⁵¹

4. Analysis and Conclusions of Law

a. Number of Violations

In June 2007, PacifiCare admitted it improperly processed 1,799 claims when it failed to properly retain COCCs. While PacifiCare now contends Exhibit 5016 speaks to a different set of violations, the Commissioner finds no merit to this claim.

First, on its face Exhibit 5016 speaks directly to the type of claims examined. PacifiCare titled the exhibit “Updated Listing of COCC Claims that have been reprocessed.” The title gives no impression that it speaks to any other alleged violations or any other types of claims. Second, all communications surrounding Exhibit 5016 indicate the exhibit speaks only to COCC

¹⁴⁸ *Id.* at 28:7-9; CDI’s Closing Brief to OAH, 169:6-170:22.

¹⁴⁹ PacifiCare’s Brief to OAH, 259:17-260:6; PacifiCare’s Brief to Commissioner, 45:5-18.

¹⁵⁰ PacifiCare’s Brief to OAH, 263:6-268:4; PacifiCare’s Brief to Commissioner, 45:20-47:22.

¹⁵¹ PacifiCare’s Brief to OAH, 268:5-270:10; PacifiCare’s Brief to Commissioner, 47:24-48:10.

complaints. For example, in a June 13, 2007 letter from PacifiCare to CDI, the insurer referred to the “1799 report” as “spreadsheets related to reworks for the COCC.”¹⁵² Third, PacifiCare’s internal documents demonstrate the COCC rework project was separate from any claims based on the exclusionary period. For instance, in February 2007, in anticipation of a meeting with CDI, PacifiCare drafted a “workplan” that listed the COCC issue and the exclusionary period issue separately.¹⁵³ Similar separation of the issues can be seen in communications dated March 20, 2007 and March 23, 2007.¹⁵⁴ In short, PacifiCare’s argument is unsupported by the evidentiary record. Accordingly, the Commissioner concludes PacifiCare failed to maintain COCCs on 1,799 occasions in 2006.

b. Knowingly Committed or General Business Practice

While CDI need only prove either that the violations were (1) knowingly committed or (2) performed with such frequency as to indicate a general business practice, evidence presented meets both tests.

PacifiCare possessed actual and constructive knowledge of these violations. Both internal and external communications demonstrate PacifiCare “actually” knew of its inability to properly retain COCCs and did not adequately remedy the situation.¹⁵⁵ In addition, PacifiCare is charged with constructive knowledge of documents it receives from its members, and any failure to act on the basis of those documents is knowingly committed. Such an expectation is built into the UIPA and specifically provided for in Regulation 2695.3.

PacifiCare’s documents and the frequency of violations also demonstrate the insurer engaged in a general business practice of incorrectly denying claims based on missing COCCs.

¹⁵² Exh. 5314, p. 7378.

¹⁵³ Exh. 6, pp. 7566-7567.

¹⁵⁴ Exh. 687, pp. 2812-2813; Exh. 11, pp. 7541-7542.

¹⁵⁵ See RT 11250:15-17; Exh. 5265, p. 1946; Exh. 1041, p. 3269.

Internal documents show PacifiCare's general practice of improperly denying claims where COCCs were previously provided. Indeed, PacifiCare noted the insurer needed to develop a process to maintain COCCs for the life of the policy, since one did not already exist.¹⁵⁶ Likewise, 1,799 violations in one year for a small line of insurance are sufficient to demonstrate a general business practice.

c. Specific UIPA Violations

i. 790.03(h)(1)

PacifiCare routinely denied and closed member claims based on the lack of a COCC, even though PacifiCare received and then misplaced the member's COCC. Each such claim denial violates Insurance Code section 790.03, subdivision (h)(1), which prohibits an insurer from misrepresenting pertinent facts relating to insurance coverage. Each time PacifiCare denied and closed a valid claim, it misrepresented its obligation to pay the claim and misrepresented the member's coverage.

ii. 790.03(h)(3)

Similarly, such denials violate Insurance Code section 790.03, subdivision (h)(3) which requires insurers to adopt and implement reasonable investigation and processing standards. Each claim denied for the lack of a COCC represents PacifiCare's failure to adopt and implement reasonable standards for maintaining a critical insurance document.

iii. 790.03(h)(5)

PacifiCare's actions also violate Insurance Code section 790.03, subdivision (h)(5) which mandates an insurer attempt in good faith to effectuate prompt, fair and equitable settlement of claims in which liability has become reasonably clear. PacifiCare's liability in each of the 1,799

¹⁵⁶ Exh. 687, p. 2813; Exh. 11, p. 7546.

claims became clear when it received the member's COCC. By denying or closing each claim, PacifiCare failed to act in good faith.

5. Penalty Assessed

PacifiCare contends it did not willfully violate the Insurance Code, and that the violations caused no material harm to its members.¹⁵⁷ As such, PacifiCare argues any penalty should be minimal.¹⁵⁸

a. Willfulness

A willful act is one committed or omitted with a purpose or willingness to commit the act, or make the omission referred to in the Insurance Code and applicable regulations. It does not require any intent to violate the law, or to injure another, or to acquire any advantage.¹⁵⁹

PacifiCare denies it acted willfully. Instead, PacifiCare argues its failure to adopt reasonable standards is permissible in the context of mergers, and characterizes its improper processing of COCC claims as a “snafu.”¹⁶⁰ The Commissioner cannot find any statutory or case law support for this argument. Whether the violations occurred as a result of a merger or as the result of sloppy recordkeeping is of no consequence. PacifiCare was obligated to maintain the COCCs and process member claims accordingly. By failing to adequately develop and maintain a policy for handling COCCs, PacifiCare willfully violated the Insurance Code, within the meaning of Regulation 2695.2, subdivision (y).

Because PacifiCare willfully violated Insurance Code section 790.03, subdivisions (h)(1), (h)(3) and (h)(5), PacifiCare is liable to the state for a civil penalty not to exceed \$10,000 for each act.

¹⁵⁷ PacifiCare's Brief to OAH, 262:7-25; 270:12-272:15.

¹⁵⁸ PacifiCare's Brief to Commissioner, 48:12-23. PacifiCare's argument regarding deference to the ALJ's penalty is considered in Section VII, Subsection U, *infra*.

¹⁵⁹ Cal. Code of Regs., tit. 10, § 2695.2, subd. (y).

¹⁶⁰ PacifiCare's Brief to OAH, 269:3-9.

b. Single Act or Multiple Violations

The Commissioner adopts the ordinary, commonplace meaning of inadvertent as “unintentional” or “accidental.” PacifiCare does not argue the alleged violations constitute a “single act” nor is there any evidence that PacifiCare inadvertently sent out any of these denial letters. Accordingly, any penalty assessed will be multiplied by 1,799; the number of violations found.

c. Regulatory Factors

The Commissioner considers the degree of harm occasioned, the frequency and severity of the violations, whether PacifiCare made a good faith attempt to comply with the Insurance Code, and any remedial actions PacifiCare undertook, in assessing a penalty for these 1,799 violations.

The Commissioner considers this type of violation to be very serious in nature. First, COCCs ensure continuing insurance coverage for pre-existing conditions. Accordingly, PacifiCare’s improper handling impacts those members with chronic and acute medical conditions for whom continuing care is crucial. By denying or closing claims from those members, PacifiCare’s actions put those already vulnerable members at needless increased risk.¹⁶¹ In addition, as a result of PacifiCare’s actions, some members may have simply waited out the six or 12 month period thereby postponing necessary medical care. Lastly, this type of action, i.e. denial of insurance benefits, is the exact injury the Commissioner seeks to protect consumers against.

Despite this evidence, PacifiCare argues no member suffered material harm from its failure to maintain COCCs. Such an argument is not only unsupported by the record, but completely disregards the passionate testimony of Ms. W, who explained both the emotional and

¹⁶¹ See Exh. 1184, 18:11-18.

financial harm her family suffered as a result of PacifiCare's failure to retain a crucial insurance document. Members spent significant time and effort repeatedly mailing and faxing their COCCs to PacifiCare only to have the documents continually misplaced. The Commissioner does not take such harm lightly.

The Commissioner also finds the frequency and severity of the violations to be an aggravating factor in this instance. PacifiCare admitted to 1,799 violations in 2006 alone; a significant number considering its small number of members. And of those 1,799 claims, PacifiCare owed its members additional monies in 689 instances. The Commissioner also notes PacifiCare knew of its recordkeeping shortfalls in late 2006, yet CDI continued to receive complaints about this issue well into late 2007.¹⁶² Such continuing problems, coupled with Lason's flawed document retention system, do not demonstrate a good faith effort to comply with the Insurance Code.

The Commissioner recognizes PacifiCare's relatively quick response to the issue and its attempt to remediate the problems. PacifiCare acknowledged its defective computer retention system and took some steps to improve its outside vendor. But such efforts proved inadequate.

The very serious and willful nature of the violations supports a baseline penalty of \$6,500 per act. The harm suffered by PacifiCare's members, the frequency and severity of the violations, and PacifiCare's indifference to member's harm serve as aggravating factors which increases the appropriate penalty. In mitigation, the Commissioner notes PacifiCare attempted to remediate the problem within months of CDI's notice. Accordingly, the Commissioner concludes the appropriate penalty for these violations is \$7,000 per act, which is 70% of the maximum, for a total of \$12,593,000.

¹⁶² See Exhs. 76 and 79.

B. Incorrect Denial of Claims: Erroneous Pre-Existing Exclusionary Period

A pre-existing medical condition is one for which the insured sought medical advice, treatment or diagnosis during a specified period preceding their enrollment.¹⁶³

1. Applicable Law

At all times relevant herein, Insurance Code sections 10198.6, subdivision (c) and 10708 permitted an insurer to exclude coverage for a pre-existing medical condition. For health plans covering one or two individuals, the maximum exclusionary period was 12 months after the insured's effective date of coverage.¹⁶⁴ But for plans covering three or more individuals (i.e. group plans), Insurance Code section 10198.7, subdivision (a) permitted an insurer to exclude coverage of a pre-existing condition for no more than six months after the insured's effective date of coverage. An insurer that denies a claim based on pre-existing condition exclusions outside these time periods violates the Insurance Code and its applicable regulations. In addition, an insurer must disclose to claimants and beneficiaries "all benefits, coverage, time limits or other provisions" of the insurance policy.¹⁶⁵

2. Findings of Fact

The Commissioner finds by a preponderance of the evidence the following facts regarding PacifiCare's use of the pre-existing condition exclusionary period.

In January 2004, PacifiCare submitted to CDI a certificate of insurance for a group plan that contained a 12-month, rather than a six month, exclusionary period. CDI approved and authorized the certificate without recognizing the illegal exclusionary language.¹⁶⁶

¹⁶³ Ins. Code § 10198.6, subd. (b).

¹⁶⁴ Ins. Code § 10198.7, subd. (b). Insurance Code section 10198.7 has since been amended to prohibit exclusions for pre-existing medical conditions.

¹⁶⁵ Cal. Code of Regs., tit. 10, § 2965.4, subd. (a).

¹⁶⁶ RT 9215:21-9217:11; Exh. 5299, p. 7549.

In October 2006, CDI contacted PacifiCare regarding the spate of complaints it received. During a telephone conversation between CDI and PacifiCare regarding these complaints, PacifiCare representative Lisa Hubert raised concerns about whether PacifiCare was using the proper exclusionary period.¹⁶⁷ When CDI confirmed PacifiCare was enforcing an improper exclusionary period, it ordered PacifiCare to reprocess any illegally denied claims and pay claimants any additional amounts owed. In April 2007, PacifiCare completed reprocessing 3,862 improperly denied 2006 claims. Of the 3,862 reprocessed claims, PacifiCare owed additional payment and interest to members for 3,019 of these claims, totaling \$765,158.¹⁶⁸

In November 2007, CDI issued its MCE report. The MCE report found PacifiCare failed to document a member's "date of hire" i.e. the day after a member's pre-existing condition exclusion expires. CDI reported that PacifiCare's claim files omitted a member's hire date, and did not explain how PacifiCare calculated the exclusionary period.¹⁶⁹ PacifiCare admitted it did not have a consistent practice of tracking hire dates and agreed to remedy the situation.¹⁷⁰

In January 2008, CDI ordered a focused audit of PacifiCare's corrective action plan. Audit results demonstrated PacifiCare continued to incorrectly deny over 10% of claims based on the pre-existing condition exclusion. PacifiCare attributed the errors to MedPlans, its outside claims processor.¹⁷¹ An April 2008 audit reported a similarly unsatisfactory error rate for pre-existing condition denials.¹⁷²

¹⁶⁷ RT 63:20-64:10.

¹⁶⁸ Exh. 601, p. 9162.

¹⁶⁹ Exh. 118, p. 3423.

¹⁷⁰ Exh. 118, p. 3424; RT 6930:11-21.

¹⁷¹ Exh. 355, p. 8498; RT 3467:23-3468:11.

¹⁷² Exh. 741, p. 6726.

In July 2008, PacifiCare reworked an additional 3,030 claims it previously denied between October 2006 and March 2008 on the basis of pre-existing conditions.¹⁷³ This rework resulted in PacifiCare owing an additional \$147,414 on 826 of these claims.¹⁷⁴

3. Parties' Contentions

CDI acknowledges that it approved PacifiCare's certificate of insurance which included an improper exclusionary period. But CDI contends such approval does not provide PacifiCare with carte blanche to violate the Insurance Code. Instead, CDI contends all insurers and all claim examiners are charged with knowing and correctly implementing the Insurance Code and its regulations.¹⁷⁵ As such, CDI argues PacifiCare and its vendor should have detected the illegal policy and remedied the situation. CDI also notes that PacifiCare continued to improperly process pre-existing condition claims well into 2008.

PacifiCare contends CDI may not "transform this mutual mistake into an unfair claims settlement practice."¹⁷⁶ More specifically, PacifiCare contends it may not be penalized for violating the Insurance Code since CDI failed to recognize the violation in 2004. In addition, PacifiCare argues that its illegal exclusionary period is neither a misrepresentation of the policy terms nor bad faith processing of claims. That is, PacifiCare argues that since its denial of claims conformed with the provisions of the policy, albeit illegal provisions, CDI cannot contend PacifiCare's denial constitutes misrepresentation.¹⁷⁷ Lastly, PacifiCare asserts any violations were not knowingly committed, were inadvertent and should not be penalized.¹⁷⁸

¹⁷³ Exh. 601, p. 9161.

¹⁷⁴ *Id.* at p. 9162.

¹⁷⁵ CDI's Closing Brief to OAH, 178:11-179:10.

¹⁷⁶ PacifiCare's Brief to OAH, 241:1-245:17; PacifiCare's Brief to Commissioner, 49:17-52:11.

¹⁷⁷ PacifiCare's Brief to Commissioner, 50:4-19.

¹⁷⁸ PacifiCare's Brief to OAH, 246:1-255:23.

4. Analysis and Conclusions of Law

a. Number of Violations

PacifiCare admits it incorrectly denied 3,862 claims based on an illegal 12-month pre-existing condition exclusionary period, 3,019 of which required additional monetary payment after they were reworked. The Commissioner finds no reason to challenge PacifiCare's own admission.

b. Knowingly Committed or General Business Practice

Regulation 2695.2, subdivision (l) defines "knowingly committed" as "performed with actual, implied or constructive knowledge, including, but not limited to, that which is implied by operation of law." It is undisputed that all insurers are charged, by operation of law, with having a thorough knowledge of the Insurance Code and FCSP regulations.¹⁷⁹ Accordingly, PacifiCare is charged with knowing the applicable pre-existing condition exclusionary periods set forth in the Insurance Code. PacifiCare's failure to properly apply the exclusionary period is thus a knowingly committed violation. PacifiCare's arguments to the contrary rest upon an inaccurate redefinition of "knowingly."

Even assuming PacifiCare did not knowingly commit these acts, the frequency of violations and PacifiCare's own statements demonstrate the insurer engaged in a general business practice of incorrectly denying claims based on an improper exclusionary period. First, PacifiCare improperly processed over 3,800 claims in 2006 alone based on the illegal exclusionary period. The small number of members makes this amount significant. In addition, PacifiCare admits it programmed its computer to automatically deny claims based on a 12-month exclusionary period. Consequently, PacifiCare rejected 100% of claims that should have been

¹⁷⁹ Cal. Code of Regs., tit. 10, § 2695.1, subd. (e).

subject to a six month exclusionary period, thereby creating a general business practice that violated the Insurance Code.

c. Specific UIPA Violations

i. 790.03(h)(1)

Insurance Code section 790.03, subdivision (h)(1) prohibits insurers from misrepresenting pertinent facts relating to insurance coverage. There is no question that PacifiCare distributed policies that misrepresented the legally permissible exclusionary period. Indeed, each denial or claim closure based on the improper exclusionary period misrepresented the member's policy and coverage. While PacifiCare contends it did not misrepresent the policy terms, the Commissioner finds this argument is without merit. Under California law, "insurance policies are governed by the statutory and decisional law in force at the time the policy is issued. Such provisions are read into each policy thereunder, and become a part of the contract with full binding effect upon each party."¹⁸⁰ As a result, the legally permissible exclusionary period of six months was automatically incorporated into each policy by operation of law. Each claim denial or closure that misapplied the exclusionary period misrepresented the policy terms.

ii. 790.03(h)(3)

Section 790.03, subdivision (h)(3) also requires insurers adopt and implement reasonable standards for prompt investigation and processing of claims. Each of these violations represents a failure to adopt and implement reasonable standards for processing claims. Claims examiners were not trained in the FCSP regulations and failed to recognize the illegal exclusionary period. In addition, PacifiCare failed to adopt a standard for documenting a member's hire date thereby resulting in inaccurate claims handling.

¹⁸⁰ *Interins. Exch. of the Auto. Club of S. Cal. v. Ohio Cas. Ins. Co.* (1962) 58 Cal.2d 142, 148; *Stephan v. Unum Life Ins. Co. of America* (9th Cir. 2012) 697 F.3d 917, 927.

iii. 790.03(h)(5)

Lastly, Insurance Code section 790.03, subdivision (h)(5) requires insurers to attempt in good faith to effectuate a fair and equitable settlement of claims when liability has become reasonably clear. In each of the improperly denied claims, PacifiCare's liability became reasonably clear upon expiration of the six month exclusionary period. Yet, PacifiCare continued to deny these claims rather than attempting to effectuate prompt payment.

5. Penalty Assessed

PacifiCare argues the violations caused no material harm to its members and were sanctioned by CDI.¹⁸¹ Accordingly, PacifiCare argues the penalty should be no more than \$500 per violation.¹⁸²

a. Willfulness

CDI does not argue these violations were willful and the Commissioner does not find sufficient evidence to demonstrate willfulness as defined in Regulation 2695.2, subdivision (y). Thus, PacifiCare is liable to the state for a civil penalty not to exceed \$5,000 for each act.

b. Single Act or Multiple Violations

Section 790.035 states that "when the issuance, amendment or servicing of a policy or endorsement is inadvertent, all of those acts shall be a single act for purposes of this section." As discussed above, inadvertent means "unintentional" or "accidental."

PacifiCare contends that since the inclusion of an illegal policy term was "accidental" all violations stemming from that act must be considered a single act under the regulations. But such an argument is contrary to the regulatory purpose and unsupported by statutory language. Section 790.035 does not state that when one of the root causes of the violation is accidental, all of those

¹⁸¹ PacifiCare's Brief to OAH, 250:5-255:23.

¹⁸² PacifiCare's Brief to Commissioner, 53:4-10.

violations should be considered a single act. Instead, it states that when the servicing of the policy is inadvertent, all of those acts shall be charged as a single act. The record is devoid of any evidence demonstrating PacifiCare accidentally serviced the policies or accidentally denied the claims. Consequently, any penalty assessed will be multiplied by 3,862.

c. Regulatory Factors

Pursuant to Regulation 2695.12, it is appropriate to consider the degree of harm occasioned, the frequency and severity of the violations, PacifiCare's remedial actions and CDI's own culpability in assessing the appropriate per act penalty.

The Commissioner considers this type of violation to be very serious in nature. Like those claims denied based on a lack of COCC, the members impacted by PacifiCare's improper policy term are those members with chronic and acute medical conditions for whom continuing care is crucial. By denying or closing claims from those members, PacifiCare's actions put those already vulnerable members at needless increased risk both emotionally and financially.¹⁸³ Also, some members may have simply waited out the improper 12 month period thereby postponing necessary medical care as a result of PacifiCare's actions.

Additional harm is demonstrated by the amount PacifiCare belatedly paid out to its members. After reprocessing the improperly denied 2006 claims, PacifiCare owed over \$750,000 to its members. This is not an insignificant number and assumes that PacifiCare fully remediated its members. Further, the large number of members affected and the severity of the violations serves to increase the applicable penalty. PacifiCare's illegal policy impacted the health and well-being of over 2,000 Californians.

In mitigation, the Commissioner acknowledges that PacifiCare called CDI's attention to the improper policy language and took quick measures to remediate those 2006 claims. While

¹⁸³ See Exh. 1184, 29:24-30:4.

PacifiCare is charged by law with knowledge of the Insurance Code, the Commissioner notes that CDI failed to detect the illegal policy term upon review of the certificate of insurance. But the Commissioner is also troubled by PacifiCare's apparent inability to correctly process the pre-existing condition claims even after altering its computer system and training MedPlans' employees. The 2007 MCE report found PacifiCare still failed to document a member's hire date in its database, and a 2008 internal audit showed MedPlans' accuracy rate for pre-existing condition claims was less than 90%. Continued claims processing problems in this area more than 18 months after notice of the violation does not demonstrate a good faith attempt to comply with the Insurance Code.

The very serious nature of the violations, coupled with the harm upon PacifiCare's members, the frequency and severity of the violations and PacifiCare's incomplete remediation efforts supports a baseline penalty of \$3,750 per act. Yet the Commissioner finds PacifiCare's voluntary admission and CDI's lapse in oversight to be significant factors in mitigation. Accordingly, the Commissioner concludes the appropriate penalty for these violations is \$750 per act, or 15% of the maximum penalty, for a total of \$2,896,500.

C. Failure to Give Providers Notice of Right to CDI Appeal

1. Applicable Law

In 2005, the California Legislature enacted Senate Bill 367, titled the Patient and Provider Protection Act. The newly enacted statute, effective January 1, 2006, required CDI to establish a program to investigate provider complaints regarding denied and contested claims. It also required an insurer, in all communications notifying providers that it was contesting or denying a claim "or portion thereof," to inform them of their right to seek review by CDI and provide them with CDI's address, website address, and telephone number:

The notice shall advise the provider who submitted the claim . . . and the insured that either may seek review by the department of a claim that the insurer contested or denied, and the notice shall include the address, Internet Web site address, and telephone number of the unit within the department that performs this review function.¹⁸⁴

In explaining the importance of this statute, the Legislature noted consumers and providers are frequently confused about the identity of the appropriate State regulator, i.e. the Department of Managed Health Care or the Department of Insurance. To that end,

[i]t is the intent of the Legislature to reduce confusion about the identity of the appropriate regulator, to provide all patients who have health care coverage and their health care providers with an easy and effective mechanism within the Department of Insurance to effectively resolve complaints as already intended for health care providers through the Department of Managed Health Care, and to assure the public that the law is properly implemented.¹⁸⁵

Section 10123.13, subdivision (a) also requires an insurer to include notice of provider appeal rights “on either the explanation of benefits or remittance advice.”¹⁸⁶ Similar language and requirements are also found in Insurance Code 10123.147, subdivision (a).

2. Findings of Fact

The Commissioner finds by a preponderance of the evidence the following facts regarding PacifiCare’s alleged failure to notify providers of their CDI appeal rights.

On December 6, 2006, CDI received a complaint from a medical provider alleging PacifiCare failed to pay the contractually-agreed upon rate. CDI investigated the complaint and learned that PacifiCare’s Explanation of Payments (EOPs) failed to include the statutorily required appeal language. Rather than providing notice of the right to appeal to CDI,

¹⁸⁴ Ins. Code § 10123.13, subd. (a).

¹⁸⁵ Legis. Counsel’s Dig., Sen. Bill No. 367 (2005-2006 Reg. Sess.).

¹⁸⁶ To distinguish between Explanations provided to members versus those sent to providers, the Commissioner will refer to Explanation of Benefits (EOB) when referencing member communications and Explanation of Payments (EOP) when referring to provider communications.

PacifiCare's EOPs indicated a provider's only recourse was to PacifiCare's Appeal Department.¹⁸⁷

On February 21, 2007, CDI informed PacifiCare that its EOPs illegally omitted the required right-to-CDI review language.¹⁸⁸ In citing PacifiCare for its failure to include provider appeal rights, CDI instructed PacifiCare to comply with Section 10123.13, noting that "noncompliance may result in additional action by the Department of Insurance."¹⁸⁹

On March 23, 2007, PacifiCare forwarded to CDI sample appeal language it intended to add to all EOPs.¹⁹⁰ PacifiCare also represented the statutorily-required language would be included in EOPs beginning April 8, 2007. This representation proved to be false. PacifiCare omitted the mandated CDI appeal language in its EOPs for group claims until June 15, 2007.¹⁹¹ Similarly, PacifiCare did not include the required appeal language in its EOPs for individual claims until November 4, 2007.¹⁹²

From February 22, 2007 through June 15, 2007, PacifiCare issued, by its own count, at least 462,805 EOPs without the statutorily-required CDI appeal rights.¹⁹³ The record is devoid of any evidence regarding the number of deficient EOPs issued from June 16 through November 4, 2007, although there is clear evidence that PacifiCare continued to issue defective EOPs well after June 16, 2007.¹⁹⁴

3. Parties' Contentions

CDI charges PacifiCare with only those violations that occurred from February 22, 2007 through June 15, 2007. In so doing, CDI contends PacifiCare knowingly violated Insurance Code

¹⁸⁷ Exh. 24, p. 3088.

¹⁸⁸ Exh. 683, p. 9289.

¹⁸⁹ *Id.* at p. 9290.

¹⁹⁰ Exh. 11, p. 7542.

¹⁹¹ Exh. 118, p. 3415; RT 8889:18-20.

¹⁹² Exh. 118, p. 3415; See also Exh. 823.

¹⁹³ Exh. 549; Exh. 1182; RT 5986:16-5987:4.

¹⁹⁴ See Exh. 1206.

sections 10123.13 and 790.03, subdivision (h) by issuing deficient EOPs. CDI further argues these violations were willful and not inadvertent, since PacifiCare failed to remedy the violations after notice from CDI.¹⁹⁵ But CDI also acknowledges that a “per act” penalty of \$3,500, as recommended, would result in an exorbitant penalty amount. As such, CDI argues for a graduated penalty formula resulting in a total category penalty of \$332,990,250.¹⁹⁶

PacifiCare asserts its legislative analysts misinterpreted Senate Bill 367, citing the statute’s unclear use of the term “department” and the sheer volume of legislation in 2005 as the culprits.¹⁹⁷ The insurer further contends it remedied the situation within a reasonable amount of time, noting that CDI “never directed PacifiCare to complete the revisions to the EOPs by any specified time.”¹⁹⁸ PacifiCare also argues the actual number of violations is less than 462,805 because there is no evidence each of the 462,805 EOPs denied or contested claims.¹⁹⁹ Lastly, PacifiCare contends any violations were inadvertent and constitute only a single act under the UIPA.²⁰⁰

4. Analysis and Conclusions of Law

a. Number of Violations

PacifiCare admitted it issued 462,805 non-compliant EOPs after February 21, 2007; the date CDI notified PacifiCare of its failure to comply with Insurance Code section 10123.13, subdivision (a). PacifiCare now argues for a smaller number of violations, asserting that not every EOP issued during this time period required the appeal language, since not all EOPs denied or contested claims.

¹⁹⁵ CDI’s Opening Brief to OAH, 148:15-149:22; CDI’s Closing Brief to OAH, 232:24-235:13; CDI’s Opening Brief to Commissioner, 34:3-15.

¹⁹⁶ CDI’s Opening Brief to OAH, 152:5-27; CDI’s Closing Brief to OAH, 241:2-242:-2; CDI’s Opening Brief to Commissioner, 34:16-26.

¹⁹⁷ PacifiCare’s Brief to OAH, 142:1-145:16; PacifiCare’s Brief to Commissioner, 58:24-28.

¹⁹⁸ PacifiCare’s Brief to OAH, 145:18-147:15; PacifiCare’s Brief to Commissioner, 59:1-12.

¹⁹⁹ PacifiCare’s Brief to OAH, 147:18-149:14.

²⁰⁰ PacifiCare’s Brief to OAH, 156:4-157:12.

The statute and accompanying regulations are clear. An insurer must provide notice of appeal rights in every EOP where a claim, or any portion thereof, is denied or contested. In practice, this means that every EOP must include the appeal language. First, nearly every claim is paid below the fully billed amount. This is because most providers and insurers operate under a contract that permits the carrier to pay a lesser amount. Paying less than the fully billed amount is tantamount to denying a portion of the claim and thus requires statutory notice of CDI appeal rights.²⁰¹ Second, the right to appeal a payment resides with the provider, not with the insurer. While PacifiCare may believe it fully paid the claim, a provider may believe otherwise. Notice of the statutory appeal language is necessary to protect providers in that instance. There is no evidence the Legislature intended the insurer to be the final arbiter of when a provider may appeal a payment. Consequently, there is sufficient evidence in the record to demonstrate each of the EOPs sent by PacifiCare required the statutory appeal language.

Accordingly, the Commissioner finds that from February 22, 2007 through June 15, 2007, PacifiCare issued at least 462,805 statutorily-deficient EOPs.

b. Knowingly Committed or General Business Practice

There can be no question that PacifiCare knowingly committed these violations. CDI provided PacifiCare with notice of the violations on February 21, 2007, and charges PacifiCare with only those violations that took place *after* PacifiCare had actual knowledge that the EOPs did not comply with the Insurance Code.

c. Specific UIPA Violations

Insurance Code section 790.03, subdivision (h)(1) prohibits insurers from misrepresenting pertinent facts relating to insurance coverage. PacifiCare does not deny that it

²⁰¹ CDI is also charged with ensuring compliance in contracts between providers and insurers. Cal. Code of Regs., tit. 10, § 2694, subd. (a)(4).

issued EOPs that misrepresented a provider's appeal rights. Instead, PacifiCare contends its misrepresentation was unintentional because it misinterpreted Senate Bill 367. PacifiCare further argues providers are not "claimants" and thus are not covered by Section 790.03. The Commissioner finds no merit to either of these claims.

The Commissioner takes no position on PacifiCare's assertion that it misinterpreted Senate Bill 367. While the purpose of the legislation is stated on its face, i.e. "to reduce confusion about the identity of the appropriate regulator," perhaps PacifiCare simply failed to understand the statute. But such an argument is irrelevant to these proceedings. CDI only charges PacifiCare with violations that occurred *after* the insurer received notice of its misinterpretation and violation. PacifiCare's belief before this notice is of no consequence.

While PacifiCare also contends Section 790.03 does not protect "providers," legislative intent and applicable law clearly hold otherwise. Section 790.03, subdivision (h)(1) specifically protects "claimants," and not, as PacifiCare argues, "insureds." Had the Legislature sought to limit the applicability of this section, it could have used the term "insured" as it did in subdivisions (h)(6) and (h)(7). In addition, Regulation 2695.2, subdivision (c) defines a first party claimant as "any person asserting a right under the insurance policy as a named insured, other insured or beneficiary under the terms of the insurance policy." The regulations define a beneficiary as "the party or parties entitled to receive the proceeds or benefits occurring under the policy in lieu of the insured."²⁰² Accordingly, the Commissioner concludes the term claimants, as used in Section 790.03, includes providers, and further finds that PacifiCare misrepresented provider rights by failing to include notice of appeal rights in each EOP.²⁰³

²⁰² Cal. Code of Regs., tit. 10, § 2695.2, subd. (a)(1).

²⁰³ PacifiCare also ignores that Regulation 2695.7, subdivision (b)(3) already required insurers notify claimants of their right to a CDI appeal.

5. Penalty Assessed

PacifiCare argues the violations were non-willful and accidental, thereby resulting in only a single act. PacifiCare also argues no harm resulted from these violations, and thus the penalty must be minimal.

a. Willfulness

There is no question that PacifiCare “willfully” violated the Insurance Code, as that term is defined in Regulation 2695.2, subdivision (y). CDI notified PacifiCare of its noncompliance but the insurer continued to issue deficient EOPs for several more months. This deliberate misrepresentation of providers’ rights reflects “a purpose or willingness” to commit the act and to violate the Insurance Code. Because PacifiCare willfully violated Insurance Code section 790.03, subdivisions (h)(1), PacifiCare is liable to the state for a civil penalty not to exceed \$10,000 for each act.

b. Single Act or Multiple Violations

Section 790.035 states that “when the issuance, amendment or servicing of a policy or endorsement is inadvertent, all of those acts shall be a single act for purposes of this section.” PacifiCare argues its failure to include notice of a provider’s appeal rights was accidental or inadvertent, and thus should constitute a single act. The Commissioner finds this argument unpersuasive.

While PacifiCare argues the 462,805 violations were accidental, clear evidence demonstrates PacifiCare knew its conduct violated the Insurance Code and chose not to take any action until several months later. It is unclear how an intentional failure to comply with the statute can be considered accidental. PacifiCare could argue that before February 21, 2007, its violations were unintentional. But after February 21, 2007, PacifiCare’s failure to comply was

not inadvertent, but intentional and deliberate. Indeed, PacifiCare acknowledges that it could have complied with the law, but chose not to:

If PacifiCare had known that each day that it did not include a statutory notice, in an EOP it would be subjected to penalties, it would have surely issued new EOP forms earlier.²⁰⁴

Nor is PacifiCare's argument that it was not provided with a specific compliance date persuasive in reducing the violations to a single act. An insurer is required to know and comply with the Insurance Code and its applicable regulations at all times. The provisions of the Insurance Code are not waived or deferred while an insurer determines how best to comply with the law. Even so, evidence demonstrates CDI notified PacifiCare that continued noncompliance could result in further action, yet PacifiCare chose not to implement the statutorily-required language for several months.²⁰⁵ Therefore, this argument is also without merit.

Based on the overwhelming evidence demonstrating PacifiCare's intentional noncompliance from February 22, 2007 through June 15, 2007, the Commissioner concludes PacifiCare's actions were not "inadvertent" as defined in Insurance Code section 790.035 and thus cannot constitute a single act for penalty purposes.

c. Regulatory Factors

In assessing the appropriate penalty for these violations, the Commissioner considers the relative harm and seriousness of the violations, the high volume of illegal acts, as well as PacifiCare's delays in remediating the violations.

The Commissioner recognizes that this type of violation does not result in the denial of medical care or other serious injury. Nevertheless, the Legislature considered notice and access to a neutral complaint process significant enough to warrant strict guidelines, and PacifiCare's

²⁰⁴ PacifiCare's Brief to OAH, 156:27-28.

²⁰⁵ Exh. 683, p. 9290.

willful misrepresentation of these rights is not trivial. Indeed, the Legislature enacted Section 10123.13 in response to provider confusion. Such a response indicates that provider confusion was both real and significant.²⁰⁶ The moderately serious nature of this willful violation supports a baseline penalty of \$2,500 per act.

In aggravation, the Commissioner notes the harm suffered by PacifiCare's actions. The relative harm may be gleaned from the number of complaints CDI received after PacifiCare included the statutory appeal rights in its EOPs. In the six months after EOP compliance, CDI saw a 10% increase in appeals from PacifiCare providers.²⁰⁷ CDI satisfactorily resolved these appeals within one month, despite years of prior correspondence with PacifiCare on the same issue; further demonstrating the importance of this provision.²⁰⁸

The number and frequency of non-conforming acts, as well as PacifiCare's compliance delay serve as further aggravating factors.²⁰⁹ PacifiCare knowingly and intentionally issued over 450,000 non-compliant EOPs from February 22, 2007 through June 15, 2007. The result is over 450,000 violations of the Insurance Code. Such volume is more than significant. In addition, PacifiCare's four to eight month delay in remediating the violation is unreasonable and unacceptable. By its own admission, PacifiCare could have chosen to comply with the statute sooner, but chose not to because it did not believe it would be subject to continued penalties.²¹⁰ Such statements do not demonstrate a good faith attempt to obey the law nor do they reflect an urgent compliance response.

There is also considerable evidence that PacifiCare's management was aware of the ongoing violations and failed to take the matter seriously. Several PacifiCare executives testified

²⁰⁶ RT 17181:11-16.

²⁰⁷ Exh. 5622, p. 15; RT 22111:2-11.

²⁰⁸ See Exh. 18; Exh. 20.

²⁰⁹ Cal. Code of Regs., tit. 10, § 2695.12, subds. (a)(7), (a)(8), (a)(12).

²¹⁰ PacifiCare's Brief to OAH, 156:27-28; RT 9305:13-15.

they knew about the non-compliant EOPs and indeed many of those managers participated in conference calls and meetings with CDI regulators where this issue was discussed.²¹¹ Yet despite management awareness, PacifiCare did not remedy the violations until several months later. Management's awareness and sluggish remedial efforts serve as a further aggravating factor.

The moderate harm suffered by providers, coupled with the significant number of violations and PacifiCare's unreasonable delay in remediating the violations leads the Commissioner to conclude the appropriate penalty for these violations is \$3,000 per act or 30% of the maximum penalty. That said, the Commissioner acknowledges that a penalty of \$3,000 for each of the 462,805 violations results in a penalty of \$1,388,415,000; an amount disproportionate to the type of violations found. As such, the Commissioner concludes penalizing PacifiCare for only a portion of the violations results in a more appropriate penalty.

Pursuant to Insurance Code section 790.035, the Commissioner may issue a per act penalty for willful violations, such as these, "not to exceed ten thousand dollars." The Insurance Code does not set forth a minimum penalty for each act, nor does the Insurance Code require the Commissioner to issue a penalty for each violation.²¹² As such, the Commissioner has discretion under Section 790.035 to penalize, or not penalize, each act. In addition, case law supports the Commissioner's use of discretion in penalizing only a portion of the violations committed. For instance, in *United States v. Mackby* (9th Cir. 2003) 339 F.3d 1013, the court entered judgment against the defendant under the False Claims Act for damages stemming from 8,499 false claims. While the defendant was liable for civil penalties for each of the 8,499 false claims, the government assessed the \$5,000 per act penalty on only 111 of the claims.²¹³ The court did not

²¹¹ Exh. 188, p. 3415; RT 9272:8-9273:1; RT 9304:8-9405:25.

²¹² PacifiCare's witness also concedes the Commissioner has discretion to penalize, or not penalize, each violation. (RT 24709:22-25.)

²¹³ *U.S. v. Mackby, supra*, 330 F.3d at p. 1015.

question the government’s discretion to proceed in this manner, instead noting that the government’s decision appropriately reduced the penalty from \$85 million to \$555,000.²¹⁴ Similarly, in *U.S. ex rel. Bunk v. Gosselin World Wide Moving, N.V.* (4th Cir. 2013) 741 F.3d 390, the defendant submitted 9,136 false invoices, subjecting the company to a civil penalty under the False Claims Act of more than \$50 million. In approving the government’s decision to penalize the defendant for only half of the false claims, the Court of Appeal noted that “the court must permit the government or its assignee the freedom to navigate its claims” and penalize a defendant for only a fraction of the violations where the imposition of the statutorily-permitted penalty might prove out of proportion to the violations committed.²¹⁵

Given the Commissioner’s penalty-setting discretion, the Commissioner concludes that penalizing PacifiCare for only 10,000 of the more than 460,000 violations is sufficient punishment for PacifiCare’s unlawful acts. The Commissioner selected this threshold of 10,000 violations after considering PacifiCare’s culpability, the deterrent effect of the penalty and the nature of PacifiCare’s violations.²¹⁶ Fining PacifiCare for less than 10,000 violations does not provide the necessary deterrent effect going forward and does not sufficiently penalize PacifiCare for violating the Insurance Code over 460,000 times. The Commissioner notes that PacifiCare continued to conceal statutory appeal rights from its members and providers even after being warned by CDI that its conduct violated the Insurance Code. But punishing PacifiCare for more than 10,000 violations, while permitted by the Legislature, is excessive in this instance. By penalizing PacifiCare for 10,000 of the violations, the Commissioner maintains

²¹⁴ *Id.* at p. 1018.

²¹⁵ *U.S. ex rel. Bunk v. Gosselin World Wide Moving, N.V.*, *supra*, 741 F.3d at p. 407; see also *United States v. Bickel* (C.D. Ill. Feb. 22, 2006) No. 02-3144, 2006 WL 1120439, at *3; *Peterson v. Weinberger* (5th Cir. 1975) 508 F.2d 45, 55.

²¹⁶ *U.S. ex rel. Bunk v. Gosselin World Wide Moving, N.V.*, *supra*, 741 F.3d at p. 409 (“we must consider the award’s deterrent effect on the defendant and on others”).

the deterrent effect of the statute while balancing the regulatory considerations and the proportionality of the punishment. Accordingly, the Commissioner concludes the appropriate and reasonable penalty for this category of violations is \$30,000,000, which is 2.1% of the maximum penalty permitted by the Insurance Code for this type of violation.

D. Failure to Provide Notice of Right to Independent Medical Review

1. Applicable Law

In 1999, the Legislature enacted Assembly Bill 55, creating the independent medical review (IMR) system within CDI. The IMR system guarantees patients the opportunity to seek an independent review whenever health care services have been denied, modified, or delayed based, in whole or in part, on consideration of medical necessity.²¹⁷ CDI must also treat IMR requests that do not meet the requirements for review as a request for CDI to review the grievance.²¹⁸

To make consumers aware of this newly enacted safeguard, the Legislature required insurers to “prominently display” information concerning the right of an insured to request an IMR on a broad range of communications to members:

in every insurer member handbook or relevant informational brochure, in every insurance contract, on insured evidence of coverage forms, on copies of insurer procedures for resolving grievances, on letters of denial issued by either the insurer or its contracting organization, and on all written responses to grievances.²¹⁹

The notice must inform members how to contact CDI, as well as the member’s right to provide additional information to CDI.²²⁰

²¹⁷ Ins. Code § 10169, subd. (d).

²¹⁸ Ins. Code § 10169, subd. (d)(1).

²¹⁹ Ins. Code § 10169, subd. (i).

²²⁰ Ins. Code § 10169, subd. (m).

2. Findings of Fact

The Commissioner finds by a preponderance of the evidence the following facts regarding PacifiCare's alleged failure to provide its members with notice of their right to an IMR.

As early as 2006, PacifiCare issued EOBs informing its members of their right to "appeal adverse decisions regarding . . . Medical Necessity, effectiveness or efficiency."²²¹ Unfortunately, the EOBs did not provide any of the statutory information regarding the right to seek an independent medical review from CDI. Instead, PacifiCare provided information for its own internal grievance and appeal process.

In March 2007, CDI learned that PacifiCare's EOBs failed to include IMR language. On March 23, 2007, CDI instructed PacifiCare to comply with Insurance Code section 10169 by including IMR language in all of its EOBs. CDI noted that PacifiCare already included IMR language on its certificates of coverage, appeal resolution letters, and denial letters, so EOB compliance should be simple.²²² PacifiCare indicated a willingness to correct the problem. CDI further warned that "[f]ailure to provide the insureds with their legal rights is a violation of 10169."²²³

On April 20, 2007, nearly one month later, PacifiCare indicated in an electronic message to CDI that it had developed a draft IMR disclosure and further represented that "outgoing EOBs . . . will contain this language as of April 30, 2007."²²⁴ Rather than merely copying its already compliant IMR language, PacifiCare drafted a new IMR disclosure which failed to describe

²²¹ Exh. 23, p. 3093.

²²² Exh. 5303, p. 8208; RT 8855:16-21; Exh. 5300, pp. 7515-7516.

²²³ *Id.* at p. 8210.

²²⁴ Exh. 5357, p. 0597.

when IMR is available and how to request such a review.²²⁵ On that same day, CDI informed PacifiCare that the draft language did not meet the statutory requirements, and suggested additional language to include in the EOBs.²²⁶

On May 8, 2007, PacifiCare sent yet another draft of the IMR language.²²⁷ That same day, CDI advised PacifiCare that this draft, too, was legally deficient as it still failed to tell members with what entity they may file requests for IMRs. CDI again urged the insurer “to refer to the existing language in PLHIC’s appeal responses, Certificates of Insurance, and CDI’s website to facilitate a quicker and more compliant version of the required notice. Corrective action must be a priority and accomplished expeditiously.”²²⁸

On May 11, 2007, PacifiCare sent CDI an excerpted paragraph of IMR language.²²⁹ CDI reviewed the language that same day and informed PacifiCare that the language itself appeared to be compliant. CDI asked PacifiCare to “start implementing [the new language] as soon as possible.”²³⁰ Rather than implementing the required language, on May 15, 2007, PacifiCare sent another draft of the IMR language to CDI. This version placed the IMR language in the same paragraph that discussed rights available under ERISA and enforced by the Department of Labor.²³¹ CDI indicated inclusion of IMR rights in the ERISA section served only to confuse members, and suggested PacifiCare revise its IMR placement. PacifiCare sent two additional drafts on May 23, and May 29, 2007, before finally inserting the statutorily-required language in

²²⁵ *Id.* at p. 0598.

²²⁶ Exh. 5358.

²²⁷ Exh. 5307, p. 4392.

²²⁸ Exh. 5308.

²²⁹ Exh. 5309, p. 0174.

²³⁰ *Id.* at p. 0173.

²³¹ Exh. 5360, p. 4399.

group plan EOBs on June 15, 2007.²³² Beginning November 4, 2007, PacifiCare began including the statutorily-required IMR language in its individual health insurance EOBs.

In November 2007, CDI issued its MCE report, which cited PacifiCare for failing to include IMR language in its EOBs. In response to the MCE citations, PacifiCare “agreed” with CDI’s findings:

The Company failed to include required wording in the EOB and Explanation of Payments (EOP) correspondence. The Company was advised of the deficiencies in the EOB/EOP documents prior to the examination by the staff 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. Please reference Attachments 02, 03 & 04 for the revised EOB/EOP documents.²³³

Between March 24, 2007 and June 15, 2007, PacifiCare issued at least 336,085 EOBs that failed to include the IMR language.²³⁴ During that period, PacifiCare denied 57 claims based on medical necessity.²³⁵ It is unclear how many of those claims resulted in IMR requests.²³⁶

The record does not contain any information regarding the number of EOBs PacifiCare issued on individual claims from June 15, 2007 through November 4, 2007. The record is also silent regarding the number of claims denied based on medical necessity from June 15, 2007 through November 4, 2007.

PacifiCare’s delay in including the required IMR language was based, in part, on the insurer’s desire to fit all of the appeal and grievance language on one page.²³⁷ In addition, PacifiCare asserts CDI did not specifically request changes to EOBs for individual plan forms.²³⁸

²³² Exh. 5366, p. 7874.

²³³ Exh. 118, p. 3415.

²³⁴ Exh. 549; Exh. 1183.

²³⁵ Exh. 5298, p. 7305.

²³⁶ PacifiCare contends it received 10 IMR requests during this time period. (Exh. 5298, p. 7306.) But this number is curious since IMR requests are processed by CDI, not PacifiCare. CDI did not provide testimony regarding the number of IMR requests received.

²³⁷ RT 11144:16-24; Exh. 5311, p. 4405.

3. Parties' Contentions

CDI contends PacifiCare knowingly violated Insurance Code sections 10169 and 790.03, subdivision (h) at least 336,085 times by issuing deficient EOBs. CDI further argues these violations were willful and not inadvertent, since PacifiCare failed to remedy the violations after notice from CDI.²³⁹

Notwithstanding its prior representations, PacifiCare now contends EOBs do not fall within the types of documents that require IMR notice, and thus the insurer may not be penalized for failing to include IMR language in its EOBs.²⁴⁰ PacifiCare also argues it remedied the situation within a reasonable amount of time and that no member suffered harm as a result of its failure to comply.²⁴¹ Lastly, PacifiCare contends any violations were inadvertent and constitute only a single act under Section 790.035.²⁴²

4. Analysis and Conclusions of Law

a. Number of Violations

PacifiCare admitted it issued 336,085 EOBs between March 24, 2007 and June 15, 2007. While PacifiCare initially agreed that Insurance Code section 10169 required notice of IMR rights, PacifiCare now argues IMR language is not required in EOBs. The Commissioner finds no merit to this argument.

Insurance Code section 10169, subdivision (i) requires insurers to prominently display IMR information in "copies of insurer procedures for resolving grievances" as well as all "letters of denial." Each of PacifiCare's EOBs included a "Know Your Rights" page that informed

²³⁸ PacifiCare's Brief to OAH, 123:24-28; RT 13538:3-9.

²³⁹ CDI's Opening Brief to OAH, 166:8-167:8; CDI's Closing Brief to OAH, 262:1-264:21; CDI's Opening Brief to Commissioner, 37:22-38:9.

²⁴⁰ PacifiCare's Brief to OAH, 123:21-127:24; PacifiCare's Brief to Commissioner, 53:17-55:3.

²⁴¹ PacifiCare's Brief to OAH, 137:5-138:13.

²⁴² PacifiCare's Brief to OAH, 133:25-137:2.

consumers of various ways in which they could challenge PacifiCare's claim adjudication, including their right to appeal adverse decisions to the company itself.²⁴³ In addition, insurers frequently send EOBs when a claim is being denied or contested. Indeed, Insurance Code section 10123.13, subdivision (a) specifically states that notice of claim denial or contest "may be included on either the explanation of benefits or remittance advice." Since PacifiCare's EOBs included its grievance procedure and served as a means to deny claims, it is clear the Legislature intended for such EOBs to include the IMR language.

This conclusion is also supported by additional provisions of Insurance Code section 10169. Although PacifiCare argues notice of the IMR process in EOBs is premature and confusing to consumers, the Legislature obviously did not share PacifiCare's concerns. In fact, Insurance Code section 10169, subdivision (d)(1) provides for the possibility that members may file early IMR requests and requires CDI to treat such premature requests as general requests for investigations. That the Legislature contemplated and provided for this situation demonstrates that the express purpose of the statute is to provide members with notice of their rights as early as possible.

PacifiCare's argument is also undermined by its own words and actions. Throughout CDI's investigation, PacifiCare's representatives admitted that Section 10169 required notification of IMR rights in each EOB. For example, in communications between the parties dated April 20, 2007, May 8, 2007 and May 11, 2007, PacifiCare representatives provided sample IMR language for inclusion in the insurer's EOBs.²⁴⁴ At no time during this exchange did PacifiCare contend Section 10169 did not require such compliance. Likewise, in response to CDI's MRE report, PacifiCare admitted its EOBs violated the law by failing to include IMR

²⁴³ See Exh. 23, p. 3093.

²⁴⁴ See Exh. 5357, p. 0597; Exh. 5307; Exh. 5308.

language. As PacifiCare stated, the insurer “agree[d] with the finding” that the EOBs violated Insurance Code section 10169 since they did “not include reference to the right to IMR.”²⁴⁵ And finally, evidence in the record demonstrates PacifiCare routinely included IMR language on other “premature” documents. For instance, PacifiCare included IMR language on letters denying preauthorization requests on coverage grounds; determinations for which IMR is not available.²⁴⁶

Accordingly, based on the vast evidence discussed above, the Commissioner concludes PacifiCare’s EOBs required inclusion of IMR language and PacifiCare violated Insurance Code section 10169 over 336,000 times by failing to include the required appeal language.

b. Knowingly Committed or General Business Practice

CDI provided PacifiCare with notice of the violations on March 27, 2007, and charges PacifiCare with only those violations that took place *after* PacifiCare had actual knowledge that its EOBs failed to include the statutorily-required IMR language. Hence, there can be no question that PacifiCare knowingly committed these violations.

c. Specific UIPA Violations

i. 790.03(h)(1)

PacifiCare contends its failure to include statutorily-required appeal language in its EOBs does not “misrepresent” pertinent insurance policy provisions.²⁴⁷ But, as discussed above, PacifiCare’s omission of material facts it is required to disclose constitutes misrepresentation.²⁴⁸ In addition, the parties do not dispute that the right to seek an IMR is a “pertinent fact” that relates to a member’s coverage pursuant to Insurance Code section 790.03, subdivision (h)(1).

²⁴⁵ Exh. 118, pp. 3415, 3419; Exh. 1205, p. 7639.

²⁴⁶ RT 9234:25-9236:3; Exh. 5301, p. 7524.

²⁴⁷ PacifiCare’s Brief to OAH, 128:20-130:21.

²⁴⁸ Cal. Code of Regs., tit. 10, § 2695.2, subd. (v).

Therefore, PacifiCare's failure to inform members of their right to an IMR misrepresented the member's appeal rights, in violation of Insurance Code section 790.03, subdivision (h)(1).

ii. 790.03(h)(3)

Similarly, PacifiCare's failure to include IMR language demonstrates a failure to adopt reasonable standards for the prompt investigation and processing of claims. Providing complete and accurate information to claimants, especially when denying their claims, is one of the fundamental "standards for the prompt investigation and processing of claims." By failing to issue compliant EOBs, PacifiCare demonstrated a failure to implement reasonable processing standards in violation of Insurance Code section 790.03, subdivision (h)(3).

5. Penalty Assessed

PacifiCare argues the violations were non-willful and accidental, thereby resulting in only a single punishable act. PacifiCare also argues no harm resulted from these violations, and thus the penalty must be minimal.

a. Willfulness

Regulation 2695.2, subdivision (y) states that "willful" "means simply a purpose or willingness to commit the act, or make the omission referred to in the California Insurance Code or this subchapter. It does not require any intent to violate law, or to injure another, or to acquire any advantage." CDI notified PacifiCare of its noncompliance in March 2007 but the insurer continued to issue deficient EOBs for several more months. PacifiCare's deliberate misrepresentation after notice reflects both "a purpose and willingness" to commit the act *and* to violate the Insurance Code. Because PacifiCare willfully violated Insurance Code section 790.03, subdivisions (h)(1) and (h)(3), PacifiCare is liable to the state for a civil penalty not to exceed \$10,000 for each act.

b. Single Act or Multiple Violations

Insurance Code section 790.035 permits multiple violations to be considered a single act only “when the issuance, amendment or servicing of a policy or endorsement is inadvertent.” PacifiCare argues its failure to include IMR language in over 330,000 EOBs was inadvertent, and any delay in implementation was the result of CDI’s actions. The Commissioner finds these arguments unconvincing.

As in Section C, *ante*, PacifiCare argues the 336,085 violations were accidental. Yet, the record demonstrates PacifiCare’s issuance of deficient EOBs was not accidental, but intentional. Insurance Code section 730.035 does not stand for the proposition that a deliberate failure to comply with the statute can be considered accidental. While PacifiCare could argue that before March 2007, its violations were unintentional, after that date PacifiCare’s failure to comply was not inadvertent, but knowing and intentional.

Nor is PacifiCare’s argument that CDI delayed implementation persuasive in reducing the violations to a single act. From the outset, CDI instructed PacifiCare to include IMR language in each EOB and responded to PacifiCare’s questions within the same day. And, although under no obligation to do so, CDI provided PacifiCare with sample IMR language. CDI took such action even though a variety of PacifiCare’s forms and letters *already included* compliant IMR language. Yet despite possession of acceptable language and despite CDI’s admonitions to promptly comply, PacifiCare implemented the required language several months after CDI’s order and did not explain its delay.

Based on the overwhelming evidence demonstrating PacifiCare’s intentional noncompliance from March 27, 2007 through June 15, 2007, the Commissioner concludes

PacifiCare's actions were not "inadvertent" as defined in Insurance Code section 790.035 and thus cannot constitute a single act under the statute.

c. Regulatory Considerations

In assessing the appropriate penalty for these violations, the Commissioner considers the relative harm and seriousness of the violations, the high volume of illegal acts, as well as PacifiCare's delays in remediating the violations.

The Commissioner considers these violations to be moderately serious in nature. Typically, consumers are unaware of their legal rights to appeal health care determinations outside of an insurer's own grievance system. PacifiCare's failure to notify claimants of their IMR rights likely denied them the opportunity to obtain assistance from CDI. And the denial of medically necessary treatment is both emotionally and physically harmful, and serves as an aggravating factor. That said, it is impossible to ascertain how many consumers could have obtained assistance, either by obtaining an IMR or by other regulatory intercession, if PacifiCare had issued compliant EOBs before June 2007. Accordingly, the Commissioner finds the lack of IMR notice to be less serious than some other conduct punishable under Section 790.035, and concludes a baseline penalty of \$3,000 per act is appropriate for this willful violation.

The number and frequency of non-conforming acts, as well as PacifiCare's compliance delay serve as further aggravating factors.²⁴⁹ PacifiCare knowingly and intentionally issued 336,085 non-compliant EOBs from March 27, 2007 through June 15, 2007. The result is over 330,000 violations of the Insurance Code. This is a significant number of violations. In addition, PacifiCare's four to eight month delay in remediating the violation is unreasonable, especially since it already possessed compliant language in its other forms and documents.

²⁴⁹ Cal. Code of Regs., tit. 10, § 2695.12, subs. (a)(7), (a)(8), (a)(12).

The Commissioner finds some mitigation in the company's initial attempt to comply, recognizing PacifiCare quickly submitted revised language after receiving CDI-staff comments. But the Commissioner also recognizes that at all times relevant herein, PacifiCare possessed compliant language and simply chose not to replicate it in order "to fit it all on one page." The Commissioner also finds some mitigation in PacifiCare's purported belief that it was entitled to await staff "approval" of its proposed language.

The moderate harm suffered by providers, coupled with the significant number of violations and PacifiCare's unreasonable delay in remediating the violations leads to Commissioner to conclude the appropriate penalty for these violations is \$2,275 per act. But the Commissioner acknowledges that a penalty of \$2,275 for each of the 336,085 violations results in a penalty of \$764,593,375; an amount disproportionate to the nature of violations found.

As outlined in Subsection C, *ante*, the Insurance Code does not set forth a minimum penalty for each act, nor does the Insurance Code require the Commissioner to issue a penalty for each violation. In addition, case law supports the Commissioner's use of discretion in penalizing only a fraction of the violations committed.²⁵⁰ Given the Commissioner's penalty-setting discretion, the Commissioner concludes that penalizing PacifiCare for only 10,000 of the more than 330,000 violations is sufficient punishment for PacifiCare's unlawful acts. The Commissioner again selected this threshold of 10,000 violations after considering PacifiCare's culpability, the deterrent effect of the penalty and the nature of PacifiCare's violations.²⁵¹ Fining PacifiCare for less than 10,000 violations does not provide the necessary deterrent effect going

²⁵⁰ *U.S. v. Mackby*, *supra*, 330 F.3d at p. 1018; *U.S. ex rel. Bunk v. Gosselin World Wide Moving, N.V.*, *supra*, 741 F.3d at p. 407; see also *United States v. Bickel*, *supra*, 2006 WL 1120439, at *3; *Peterson v. Weinberger*, *supra*, 508 F.2d at p. 55.

²⁵¹ *U.S. ex rel. Bunk v. Gosselin World Wide Moving, N.V.*, *supra*, 741 F.3d at p. 409 ("we must consider the award's deterrent effect on the defendant and on others").

forward and does not sufficiently penalize PacifiCare for violating the Insurance Code over 330,000 times. The Commissioner notes that PacifiCare continued to conceal statutory appeal rights from its members and providers even after being warned by CDI that its conduct violated the Insurance Code. But punishing PacifiCare for more than 10,000 violations, while permitted by the Legislature, is excessive in this instance. By penalizing PacifiCare for 10,000 of the violations, the Commissioner maintains the deterrent effect of the statute while balancing the regulatory considerations and the proportionality of the punishment. Accordingly, the Commissioner concludes the appropriate penalty for this category of violations is \$22,750,000, which is 3% of the maximum penalty permitted by the Insurance Code.

E. Failure to Timely Pay Claims

1. Applicable Law

In 1986, the Legislature enacted Assembly Bill 4206 (AB 4206) with the stated purpose of adding specific time limits for the processing of claims under UIPA. As stated in the Legislative Counsel's Digest, "[e]xisting law, with respect to policies of disability insurance, self-insured employee welfare benefit plans, nonprofit hospital service plans, and health care service plans does not set a specific time limit for reimbursement of claims made pursuant to the policy or plan. This bill would provide for reimbursement as soon as practical but no later than 30 working days after receipt of the claim."²⁵² The Senate Floor Analyses also confirms that the intent of AB 4206 was the payment of health insurance claims no later than 30 working days after receipt.²⁵³

²⁵² Legis. Counsel's Dig., Assem. Bill No. 4206 (1985-1986 Reg. Sess.).

²⁵³ Exh. 1206, p. LIS-9b.

Once in effect, AB 4206 added the following to Insurance Code section 10123.13, subdivision (a):

Every insurer issuing group or individual policies of health insurance that covers hospital, medical, or surgical expenses, including those telemedicine services covered by the insurer as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, shall reimburse claims or any portion of any claim, whether in state or out of state, for those expenses as soon as practical, but no later than 30 working days after receipt of the claim by the insurer unless the claim or portion thereof is contested by the insurer, in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the insurer.

2. Findings of Fact

The Commissioner finds by a preponderance of the evidence the following facts regarding PacifiCare's alleged failure to timely pay claims.

In 2006, CDI received an influx of complaints from consumers and providers regarding PacifiCare's failure to timely pay claims. One such example is the case of Mr. R. In July 2006, doctors diagnosed Mr. R with a serious disease in both eyes which, without surgery, would result in permanent blindness. Before performing the surgery, Mr. R's physician sought and received pre-approval from PacifiCare.²⁵⁴ Mr. R paid \$3,500 on his credit card for the surgeries assuming PacifiCare would reimburse his costs. After the surgery, Mr. R promptly submitted claims to PacifiCare, only to have those claims "misplaced."²⁵⁵ Mr. R resubmitted the claims via facsimile three times before PacifiCare acknowledged receipt.²⁵⁶ In August 2006, Mr. R called PacifiCare's customer service nearly every day in an attempt to get his claims paid. Mr. R testified that for a long period, PacifiCare's phone lines were busy or no one would pick up the phone and sometimes the line did not even ring.²⁵⁷ Over the next several months, during which

²⁵⁴ Exh. 135, p. 9760; RT 1716:15-16.

²⁵⁵ Exh. 135, p. 9886; RT 1720:20-24.

²⁵⁶ RT 1723:10-16.

²⁵⁷ RT 1726:2-4; RT 1726:10-1727:3; RT 1727:9-17.

Mr. R continuously resubmitted his claims, PacifiCare denied the claims for multiple different reasons. On December 21, 2006, having still not received reimbursement, Mr. R filed a complaint with CDI.²⁵⁸ By January 15, 2007, PacifiCare paid Mr. R's claims, but not until Mr. R incurred significant interest charges on his credit card, out-of-pocket expenses to send multiple faxes and substantial time on the telephone trying to resolve the issue.²⁵⁹

Ms. W, whose complaint was initially discussed in Section A, *ante*, described a similar serious incident. Ms. W recounted how in March 2007 she was required to pay a provider \$500 out-of-pocket to ensure her son would receive a time-sensitive treatment. The provider required this payment by Ms. W specifically because PacifiCare had not timely paid \$15,000 in claims from prior treatments.²⁶⁰ Ms. W also testified that another provider balance-billed her when PacifiCare did not remit payment within ninety days.²⁶¹ After CDI investigated each of the consumer complaints, it found PacifiCare violated Insurance Code section 10123.13 at least 239 times.²⁶²

PacifiCare's failure to timely pay claims was not limited to consumers. Many providers also filed complaints regarding PacifiCare's delayed payments. For example, in February 2007, the California Medical Association filed a complaint with CDI on behalf of 20 of its providers.²⁶³ The complaint stated that following the merger PacifiCare engaged in widespread misconduct, specifically alleging PacifiCare did not timely enter provider contract rates into its computer systems, failed to timely process contract terminations, failed to respond to physicians' payment disputes, and used incorrect contract rates to pay claims, all of which resulted in claims not being

²⁵⁸ Exh. 135, p. 9535-9536.

²⁵⁹ Exh. 140, pp. 9725, 9738; RT 1742:3-14.

²⁶⁰ RT 1034:24-1035:5.

²⁶¹ Exh. 144; RT 1035:13-19.

²⁶² See CDI's Opening Brief to OAH, 185:5-186:13 for a list of those complaints.

²⁶³ Exh. 5354.

fully and correctly paid in a timely fashion.²⁶⁴ The University of California Medical Centers raised similar concerns in mid-2007, alleging PacifiCare incorrectly paid thousands of claims over a period of several years.²⁶⁵

In September 2007, in response to a request from CDI, PacifiCare admitted it failed to timely pay group claims in 37,238 instances.²⁶⁶ On November 9, 2007, CDI served PacifiCare with the written MCE reports, which found 42,137 violations for failing to timely pay claims.²⁶⁷ On December 7, 2007, PacifiCare “acknowledge[d] that 42,137 claims or 3.7% were paid after 30 working days.”²⁶⁸

At trial, PacifiCare’s witness Susan Berkel admitted the insurer paid 38,567 claims more than 42 calendar days after receipt.²⁶⁹ Ms. Berkel further asserted that 3,633 of the 38,567 late-paid claims did not violate the Insurance Code because they were either overpaid claims, claims that had been previously timely contested, or claims paid under self-directed accounts.²⁷⁰ As a result of this testimony, CDI withdrew those 3,633 claims from its total and now contends PacifiCare failed to timely pay claims in 34,934 instances.²⁷¹

PacifiCare’s late payments can be blamed on a number of complications. First, PacifiCare experienced a serious problem with mail receipt and processing. The transition from IBM to Xerox in mail processing resulted in 60 days of delayed mail.²⁷² Since PacifiCare received at least 45% of its claims through the mail, the mail processing failure caused substantial

²⁶⁴ Exh. 165, pp. 8506-8507.

²⁶⁵ RT 11863:10-14; Exh. 485, p. 4073.

²⁶⁶ Exh. 108, p. 4758.

²⁶⁷ Exh. 116, p. 1302. CDI’s number was based on its own examination of PacifiCare’s computerized records.

²⁶⁸ Exh. 118, p. 3426.

²⁶⁹ Exh. 5369, p. 7875.

²⁷⁰ RT 7640:8-7643:22.

²⁷¹ Exh. 1177, ¶ 25. CDI’s Closing Brief to OAH, 309:27. CDI is not charging PacifiCare with the thousands of alleged violations raised by the University of California Medical Centers.

²⁷² Exh. 5258, p. 7105.

compliance problems.²⁷³ Second, PacifiCare experienced major problems with its claims processor Lason. PacifiCare noted, as early as March 2007 that Lason employees did not understand the DocDNA system and misdirected a large number of claims into a “black hole.”²⁷⁴ Lason also suffered from an eligibility matching problem. Initial reports showed Lason erroneously matched members and their claims 62% of the time due to database access issues.²⁷⁵ In fact, by August 2007, internal PacifiCare emails called for Lason “to be absolutely micro-managed into the ground.”²⁷⁶ Third, PacifiCare’s software programs corrupted provider demographic data. Beginning in November 2006, PacifiCare noticed the merged United/PacifiCare provider database reactivated outdated addresses in PacifiCare’s old database, and that provider checks were often sent to these old addresses and then returned to PacifiCare.²⁷⁷ By the time these claim payment checks were sent to the providers’ correct addresses, more than 30 working days had elapsed.²⁷⁸ PacifiCare did not remedy this problem until early 2008.²⁷⁹

3. Parties’ Contentions

CDI contends PacifiCare knowingly violated Insurance Code sections 10123.13 and 790.03, subdivision (h) on at least 34,934 occasions. In support of this argument, CDI notes an insurer is charged with constructive knowledge of claim receipt and payment. In addition, CDI contends PacifiCare willfully violated the Insurance Code by recklessly and knowingly utilizing a claims processing system it knew was insufficient.²⁸⁰

²⁷³ RT 7419:17-24.

²⁷⁴ Exh. 666, p. 1103; Exh. 5258, p. 7105; RT 7568:20-7569:5; RT 7570:17-21.

²⁷⁵ Exh. 554, p. 0310.

²⁷⁶ Exh. 575, p. 4003.

²⁷⁷ Exh. 759, p. 6084; Exh. 495.

²⁷⁸ Exh. 917, p. 6488.

²⁷⁹ Exh. 604, pp. 3764, 3767.

²⁸⁰ CDI’s Opening Brief to OAH, 186:19-187:18; CDI’s Closing Brief to OAH, 301:16-26; CDI’s Opening Brief to Commissioner, 40:15-28.

PacifiCare asserts that during the relevant time period it boasted a 97% timely payment rate and that the statute itself permits late payments, thereby rendering PacifiCare's late payments lawful.²⁸¹ In addition, PacifiCare contends CDI is estopped from penalizing PacifiCare because CDI waived this right by agreeing to Undertaking No. 19.²⁸² Lastly, PacifiCare contends any alleged violations were not knowingly or willfully committed.²⁸³

4. Analysis and Conclusions of Law

a. Number of Violations

PacifiCare admitted it issued 34,934 late payment EOBs during the MCE period.²⁸⁴ The Commissioner finds no reason to challenge PacifiCare's own admission.

b. Knowingly Committed or General Business Practice

"Knowingly committed" is defined as "performed with actual, implied or constructive knowledge, including, but not limited to, that which is implied by operation of law."²⁸⁵ It is undisputed that all insurers are charged, by operation of law, with having a thorough knowledge of the Insurance Code and its applicable regulations.²⁸⁶ Accordingly, PacifiCare is charged with knowing the claims processing deadlines set forth in the Insurance Code. PacifiCare's failure to adhere to these deadlines is thus a knowingly committed violation. In addition, an insurer is charged with constructive knowledge of when a claim is received, and therefore has knowledge of when a claim must be paid. PacifiCare's arguments to the contrary again rest upon an inaccurate redefinition of "knowingly."

²⁸¹ PacifiCare's Brief to OAH, 199:6-200:19.

²⁸² PacifiCare's Brief to OAH, 206:19-209:13; PacifiCare's Brief to Commissioner, 60:21-61:21.

²⁸³ PacifiCare's Brief to OAH, 216:6-217:13; 220:3-26; PacifiCare's Brief to Commissioner, 64:24-65:5.

²⁸⁴ Exh. 5369, p. 7875.

²⁸⁵ Cal. Code of Regs., tit. 10, § 2695.2, subd. (l).

²⁸⁶ See Cal. Code of Regs., tit. 10, § 2695.1, subd. (e).

c. Specific UIPA Violations

Initially, PacifiCare contends the “agreed-upon” Undertakings estop CDI from alleging PacifiCare violated Section 790.03. The Commissioner finds this argument to be without merit.

First, the Undertakings were not an “agreed-upon” performance standard intended as a substitute for the Insurance Code provisions. The Undertakings is a unilaterally-signed document intended to address the then-Commissioner’s concerns regarding the PacifiCare/United merger.²⁸⁷ In response to United’s “history of complaints about its claims handling,” PacifiCare and United unilaterally committed to meeting specific performance metrics. This performance metric was based on PacifiCare’s claims-handling performance before the merger, so as to address the Commissioner’s expressed concerns that the merger would lead to a degradation of claims handling. If PacifiCare failed to meet this performance threshold, it agreed to pay CDI a \$315 penalty for each justified complaint that exceeded the threshold.²⁸⁸ As the parties admit, the Undertakings differ significantly from the Insurance Code requirements and do not constitute a binding contract, as only the insurer executed the document.²⁸⁹

Second, contrary to PacifiCare’s contention, the facts do not make a case for equitable estoppel. To establish estoppel, PacifiCare must demonstrate (1) CDI was apprised of the facts; (2) CDI intended that its conduct be acted upon, or so acted that PacifiCare had the right to believe it was so intended; (3) PacifiCare was ignorant of the true state of facts; and (4) PacifiCare relied upon the conduct to its injury.²⁹⁰ Further, equitable estoppel “will not apply against a governmental body except in unusual instances when necessary to avoid grave injustice

²⁸⁷ See Exh. 5191.

²⁸⁸ Exh 829.

²⁸⁹ RT 10085:13-18; Exh. 5191, p. 9396.

²⁹⁰ *City of Goleta v. Superior Court* (2006) 40 Cal. 4th 270, 279.

and when the result will not defeat a strong public policy.”²⁹¹ PacifiCare fails to demonstrate even one of these elements, let alone all four.

There is no evidence CDI knew PacifiCare believed compliance with the Undertakings substituted for compliance with the Insurance Code. Indeed, there is no testimony that PacifiCare’s representatives even believed this fact. In addition, there is no evidence showing CDI acted with the intent to trick PacifiCare into reliance upon the Undertakings. Nor is there any evidence that PacifiCare relied upon the Undertakings when it violated the Insurance Code nearly 35,000 times. In short, PacifiCare’s argument fails to satisfy the required elements and further fails to demonstrate the insurer will suffer a grave injustice absent estoppel.

Finally, nothing in the Undertakings, or any other document, permits PacifiCare to violate the Insurance Code or its applicable regulations, nor do they estop CDI from penalizing PacifiCare for such violations. Accordingly, this argument is rejected.

i. 790.03(h)(2)

Section 790.03, subdivision (h)(2) prohibits “failing to acknowledge and act reasonably promptly upon communications with respect to claims arising upon insurance policies.” Insurance Code section 10123.13, subdivision (a) defines what is “reasonable” by requiring insurers to reimburse members and providers within 30 working days of receipt of the claim. By failing to communicate with members and providers within 30 working days of receipt of a claim, PacifiCare violates Insurance Code 790.03, subdivision (h)(2).

ii. 790.03(h)(3)

Similarly, Section 790.03, subdivision (h)(3) punishes an insurer for failing to adopt and implement “reasonable standards for the prompt investigation and processing of claims.”

²⁹¹ *Ibid.*

PacifiCare relies upon its 97% compliance rate to demonstrate it adopted reasonable standards for claims processing. The Commissioner finds this argument unpersuasive.

Initially, the evidentiary record indicates several problems with PacifiCare's compliance percentage. To arrive at 97%, PacifiCare divided the number of charged violations (34,934) by the total number of claim entries during the MCE period (1,126,107).²⁹² Thus, this percentage assumes that all entries not cited by CDI were timely paid claims. Unfortunately, the record demonstrates that is not the case. Instead, the record demonstrates thousands of those claims PacifiCare argues were timely paid, were in fact based on the wrong received date. For example, PacifiCare presented evidence that it timely paid thousands of rework claims; claims that needed to be reprocessed because they were incorrectly processed the first time. With regard to such claims, PacifiCare recorded the "date received" as the date the request for rework was received, not the date the claim was originally filed.²⁹³ By so altering the date received, PacifiCare's database then considered the claim timely paid although by law it was not.²⁹⁴ Similarly, PacifiCare's compliance figure counts as timely paid those claims where an overpaid amount was recouped and those claims that were untimely paid but no monies were owed.²⁹⁵ These facts cast serious doubt as to the validity of PacifiCare's compliance percentage.

Further, PacifiCare's compliance percentage is irrelevant. Unlike the Department of Managed Health Care, which expressly incorporates compliance percentages in their regulations, the FCSP regulations do not permit CDI to "accept" a set number of violations of the law.²⁹⁶

²⁹² PacifiCare's Brief to OAH, 200:6-13.

²⁹³ RT 2368:11-25.

²⁹⁴ RT 22176:25-22177:14; RT 22178:18-22; Exhs. 1157, 1158, 1159, 1160.

²⁹⁵ RT 22190:10-22191:1; RT 22196:2-22197:12.

²⁹⁶ See Cal. Code of Regs., tit. 28, § 1300.71, subd. (a)(8).

Instead, CDI operates under a “report by exception” format, which identifies non-compliant acts in a claim file, but makes no representations on the number of compliant acts.²⁹⁷

Contrary to PacifiCare’s arguments, evidence demonstrates the insurer did not adopt a reasonable standard for claims processing. Testimony and internal documents show a severely flawed processing system that PacifiCare took years to fix in any meaningful way. Although PacifiCare was aware as early as November 2006 that claims were being misplaced in a “black hole,” it did not remedy the situation until early 2008. And, PacifiCare’s remedy did not require fixing one or two defective systems, but instead necessitated new training, new computer databases and micro-management of one of PacifiCare’s vendors. The problems do not demonstrate PacifiCare adopted a reasonable processing standard. Accordingly, the Commissioner concludes PacifiCare violated Insurance Code section 790.03(h)(3).

iii. 790.03(h)(4)

Insurance Code section 790.03, subdivision (h)(4) penalizes insurers who do not affirm or deny coverage within a reasonable period. The Legislature has set that “reasonable” amount of time at 30 working days from receipt of the claim. PacifiCare contends that “affirming or denying” coverage is different than affirming or denying a claim, and thus its conduct does not violate subdivision (h)(4).²⁹⁸ The Commissioner finds this to be a distinction without a difference and rejects PacifiCare’s argument.

Health insurance claims differ significantly from other types of insurance. Unlike other lines of insurance where coverage and liability are discussed between the claimant and the insurer, health insurers routinely unilaterally decide claims, by either affirming or denying coverage. PacifiCare’s witnesses acknowledged this difference by explaining that PacifiCare

²⁹⁷ RT 13431:23-13432:4; RT 22275:16-20.

²⁹⁸ PacifiCare’s Brief to OAH, 214:1-215:12; PacifiCare’s Brief to Commissioner, 64:6-11.

communicates its claim decisions through EOBs that either affirm coverage by including a reimbursement check, or deny coverage by failing to include repayment.²⁹⁹

In health insurance, unlike settling an automobile claim where you may have a discussion with the insurance company and the insurance company says, “Yes, I’ll pay your claim. Yes, I’ll agree to pay you X number of dollars,” that’s affirming or denying coverage. That really doesn’t happen in health insurance. They adjudicate it, they make a decision, I mean, either they pay it or deny it or contest it.³⁰⁰

The distinction between health insurance lines and other lines of insurance is further illustrated by Regulation 2695.7. Regulation 2695.7 requires insurers in most lines to accept or deny claims within 40 calendar days of receipt, and after acceptance, insurers must pay those accepted claims within 30 days.³⁰¹ In essence, under this regulation, there is a difference between acknowledging coverage and paying the claim. But as PacifiCare admits, these time frames and these rules do not apply to health insurance claims.³⁰² Indeed, that the regulation specifically excludes health insurance claims further supports that no difference exists between affirming coverage and affirming a claim under section 790.03, subdivision (h)(4). In short, for lines of health insurance, if an insurer fails to act upon a claim within 30 working days, that insurer has failed to affirm coverage within a reasonable amount of time, and has violated Insurance Code section 790.03, subdivision (h)(4).

iv. 790.03(h)(5)

Insurance Code section 790.03, subdivision (h)(5) requires insurers attempt “in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear.” PacifiCare suggests the statute should be read to require the insurer to attempt in good faith to effectuate *either* prompt settlements of claims, *or* fair settlements of claims, *or*

²⁹⁹ RT 18043:10-17.

³⁰⁰ RT 25281:11-18.

³⁰¹ Cal. Code of Regs., tit. 10, § 2695.7, subds. (b), (h).

³⁰² Cal. Code of Regs., tit. 10, § 2695.7, subds. (b)(4), (h)(1); PacifiCare’s Brief to OAH, 214:21-24.

equitable settlements of claims.³⁰³ In addition, PacifiCare argues it acted in good faith.³⁰⁴ The Commissioner finds both these arguments to be without merit.

First, PacifiCare's reading of the statute is inaccurate and illogical. The statute does not use the disjunctive "or" but instead uses the conjunctive "and." The ordinary and usual usage of "and" is to mean "an additional thing," "also" or "plus."³⁰⁵ Accordingly, the statute requires that insurers do all three; that is, settle claims promptly, fairly and equitably. Likewise to read the statute otherwise would lead to an illogical result. There is no evidence that the Legislature intended to give insurers the option of effectuating payments fairly, but not promptly or equitably, or effectuating payments promptly but not fairly or equitably. In fact, such a reading of the statute is contrary to its ordinary and plain meaning.

Second, PacifiCare argues it acted in good faith. Good faith requires an insurer demonstrate an objective and subjective belief that it was complying with the law.³⁰⁶ In this case, good faith requires PacifiCare show it objectively and subjectively believed it was paying claims within the required 30 working days. There is simply no evidence demonstrating PacifiCare believed it was acting in good faith. Instead, the evidentiary record demonstrates PacifiCare's knew its failed computer integration and protracted remediation attempts resulted in thousands of untimely-paid claims. Such evidence does not demonstrate a good faith attempt to promptly pay claims, as required by the statute.

5. Penalty Assessed

PacifiCare argues the violations were non-willful and resulted in no harm. In addition, PacifiCare argues it acted in good faith, and as such, the penalty must be minimal.

³⁰³ PacifiCare's Brief to OAH, 215:13-216:3.

³⁰⁴ PacifiCare's Brief to Commissioner, 64:18-22.

³⁰⁵ *In re C.H.* (2011) 53 Cal.4th 94, 101.

³⁰⁶ *Careau & Co. v. Sec. Pac. Bus. Credit, Inc.*, *supra*, 222 Cal.App.3d at pp. 1401-1402.

a. Willfulness

PacifiCare willfully violated the Insurance Code as that term is defined in Regulation 2695.2, subdivision (y). The evidentiary record shows PacifiCare continued to willingly utilize business processes it knew were insufficient and routinely caused violations. PacifiCare knew as early as November 2006 that it was failing to timely pay thousands of claims. Despite this awareness, PacifiCare did not remedy this problem for over one year. In addition, an insurer that pays tens of thousands of claims over a month late is willingly failing to effectuate prompt payment of claims.

Because PacifiCare willfully violated Insurance Code section 790.03, subdivisions (h)(2), (h)(3), (h)(4) and (h)(5), PacifiCare is liable to the state for a civil penalty not to exceed \$10,000 for each act.

b. Single Act or Multiple Violations

Insurance Code section 790.035 permits multiple violations to be considered a single act only “when the issuance, amendment or servicing of a policy or endorsement is inadvertent.” PacifiCare does not contend, nor does the evidence support, a finding of inadvertence. Accordingly, the Commissioner may assess a penalty for each of the 34,934 violations.

c. Regulatory Considerations

In assessing the appropriate penalty for these violations, the Commissioner considers the relative harm and seriousness of the violations, the frequency and number of claims, as well as PacifiCare’s attempts in remediating the violations.

The Commissioner considers these violations to be of average seriousness and rejects PacifiCare’s argument that no harm resulted from its failure to timely pay claims.³⁰⁷ The relative importance of these violations depends in part on the amount of delay. A one or two day delay in

³⁰⁷ Cal. Code of Regs., tit. 10, § 2695.12, subd. (a)(10).

paying claims is less serious than a month delay. But the impact of these violations does not absolve PacifiCare of complying with the law. Timely claims payment remains one of the most important goals of Section 790.03 and the FCSP regulations. As such, the Commissioner concludes that the serious nature of the violation supports a baseline penalty of \$5,000 per willful act.

Members suffer significant harm from delayed payments. For example, Mr. R repeatedly contacted PacifiCare to get reimbursed for pre-authorized services. PacifiCare failed to return his calls, provided him incorrect information and did not reimburse him for more than six months. While PacifiCare contends the \$22.60 payment of interest adequately compensated Mr. R,³⁰⁸ Mr. R disagrees. In fact, the \$22.60 interest payment did not even repay the monies Mr. R spent faxing and refaxing his claims to PacifiCare, let alone compensate Mr. R for his credit card interest.³⁰⁹ Similarly, PacifiCare's failure to timely pay its claims resulted in both financial and emotional harm to Ms. W. PacifiCare's failure to timely pay \$15,000 worth of claims led directly to a denial of medical care by one provider. And in order for Ms. W's son to receive medically-required treatment, she was forced to make a "good faith" payment to the provider herself. While PacifiCare believes such harm is insignificant,³¹⁰ the Commissioner concludes such harm is both serious and exactly the type of harm the statute is intended to prevent. As such, the relative harm of these violations serves as an aggravating factor in determining the appropriate penalty.

The Commissioner also finds that management's awareness and failure to promptly remedy the situation serves as an additional aggravating factor. Insurers are aware that accurate eligibility and address information are crucial to claims handling. But PacifiCare did not act promptly when it learned many claims were returned with incorrect addresses or that its vendor

³⁰⁸ PacifiCare's Brief to OAH, 221:22-25.

³⁰⁹ RT 1742:3-18.

³¹⁰ PacifiCare's Brief to OAH, 221:5-6.

did not have access to member records in the computer system. In addition, PacifiCare did not implement a system to audit Lason's claims handling until well after problems arose and well after claims ended up in a "black hole."

On the other hand, the Commissioner considers the relative number of claims and the frequency of claims to be slight mitigating factors.³¹¹ While PacifiCare's actual compliance rate was not established, 34,934 violations is not an overwhelming number of violations given the overall number of claims received. In addition, the Commissioner gives PacifiCare some credit for its remedial efforts.³¹² Although PacifiCare took over a year to investigate and detect its database and vendor problems, PacifiCare made an effort, albeit belatedly, to fix all the problems.³¹³

Based on the above factors, the Commissioner concludes the appropriate penalty for these violations is \$5,500 per act, which is 55% of the maximum penalty. But the Commissioner acknowledges that a penalty of \$5,500 for each of the 34,934 violations results in a penalty of \$192,137,000; a large amount based on the nature of the violations found.

As outlined in Subsection C, *ante*, the Insurance Code does not set forth a minimum penalty for each act, nor does the Insurance Code require the Commissioner to issue a penalty for each violation. In addition, case law supports the Commissioner's use of discretion in penalizing only a fraction of the violations committed.³¹⁴ Given the Commissioner's penalty-setting discretion, the Commissioner concludes that penalizing PacifiCare for only 10,000 of the more than 34,934 violations is sufficient punishment for PacifiCare's unlawful acts. Fining PacifiCare

³¹¹ Cal. Code of Regs., tit. 10, § 2695.12, subds. (a)(7), (a)(12).

³¹² Cal. Code of Regs., tit. 10, § 2695.12, subd. (a)(8).

³¹³ The remaining penalty factors presented neither aggravating nor mitigating circumstances. (Cal. Code of Regs., tit. 10, § 2695.12, subds. (a)(1), (a)(3), (a)(9)).

³¹⁴ *U.S. v. Mackby*, *supra*, 330 F.3d at p. 1018; *U.S. ex rel. Bunk v. Gosselin World Wide Moving, N.V.*, *supra*, 741 F.3d at p. 407; see also *United States v. Bickel*, *supra*, 2006 WL 1120439, at *3; *Peterson v. Weinberger*, *supra*, 508 F.2d at p. 55.

for less than 10,000 violations does not provide the necessary deterrent effect. The Commissioner notes PacifiCare's actions resulted in the denial of medical care and its statements demonstrate indifference to its statutory obligations. By penalizing PacifiCare for 10,000 of the violations, the Commissioner maintains the deterrent effect of the statute while balancing the regulatory considerations and the proportionality of the punishment. Accordingly, the Commissioner concludes the appropriate penalty for this category of violations is \$55,000,000, which is 28.6% of the maximum penalty permitted by the Insurance Code.

F. Failure to Pay Interest on Late Claims

1. Applicable Law

In 1986, the Legislature set a 30 working day deadline for the processing of insurance claims.³¹⁵ Three years later, the Legislature amended section 10123.13, to "encourage compliance with this law by providing a deterrent for those who currently disregard it."³¹⁶ By ratifying Assembly Bill 865, the Legislature added a separate requirement that insurers pay interest on health claims paid after 30 working days:

If an uncontested claim is not reimbursed by delivery to the claimant's address of record within 30 working days after receipt, interest shall accrue and shall be payable at the rate of 10 percent per annum beginning with the first calendar day after the 30-working day period.³¹⁷

In essence, subdivision (b) provides an automatic sanction against late paying insurers that encourages compliance with existing law, but also seeks to compensate, at least in part, those harmed by insurer delays.

³¹⁵ Ins. Code § 10123.13, subd. (a).

³¹⁶ Exh. 5682, p. 49.

³¹⁷ Ins. Code § 10123.13, subd. (b).

2. Findings of Fact

The Commissioner finds by a preponderance of the evidence, the following facts regarding PacifiCare's alleged failure to pay interest on untimely-processed claims.

When CDI examined PacifiCare's electronic claims records in 2007, it uncovered thousands of claims that were paid more than 30 working days after receipt, but contained no payment of interest. Specifically, CDI found 5,432 instances in which PacifiCare paid a claim late but paid \$0 in interest.

On December 7, 2007, PacifiCare admitted that it failed to pay statutorily-required interest on 5,432 late paid claims.³¹⁸ In addition, the insurer represented to CDI that it had reprocessed and paid all required interest by November 2, 2007.³¹⁹ The resulting interest payments totaled \$138,792.65.³²⁰ The average amount of interest owed after reprocessing was around \$30 per claim. Twenty-five of the additional interest payments exceeded \$1,000, and one claim, originally submitted in 2004, was reprocessed three years later with an additional interest payment of approximately \$21,000.³²¹

In November 2007, PacifiCare trained its employees on the requirements of Insurance Code section 10123.13, subdivision (b).³²² In addition, in January 2008, the insurer implemented a weekly interest-focused audit program.³²³ But internal documents and testimony establish that in October 2008, PacifiCare found the programs and training made little impact on the problem.³²⁴

³¹⁸ Exh. 118, p. 3426.

³¹⁹ *Ibid.*

³²⁰ Exh. 1, p. 3525; Exh. 5252, p. 6938.

³²¹ RT 10061:13-10062:17.

³²² RT 7652:25-7653:13; Exh. 5252, p. 6940.

³²³ RT 7649:9-7650:19; Exh. 5252, p. 6940.

³²⁴ Exh. 712, p. 9316; RT 10072:9-13.

On June 10, 2010, PacifiCare representative Sue Berkel admitted PacifiCare's December 2007 remediation claims were false. While PacifiCare indicated it had fully remediated all late claims in November 2007, in fact PacifiCare had reprocessed and paid interest on only 4,634 of the 5,432 claims as of June 2010.³²⁵ PacifiCare paid interest on the remaining 813 claims by July 2010. PacifiCare did not explain this misrepresentation.

PacifiCare's compliance rate during the MCE time period was 82%; that is to say that PacifiCare failed to pay interest in 18% of the claims where interest was required by statute. CDI determined this rate by comparing the number of claims on which PacifiCare failed to pay interest to the number of claims that required interest. During the MCE period, PacifiCare paid interest on 23,658 late claims and failed to pay interest on 5,195 late claims.³²⁶ It follows that the total number of claims where interest was due equals 28,853 (23,658 + 5,195). Dividing the total number of claims that PacifiCare paid with interest by the total number of claims requiring interest, results in an 82% compliance rate.³²⁷

PacifiCare's problems in paying interest can be traced to a number of factors. First, PacifiCare's RIMS software made the task of accurately calculating interest extremely challenging. When PacifiCare received a new claim, a claims examiner recorded the original received date in RIMS. But if that claim required subsequent reworking, the RIMS software recorded the date the examiner received the rework as the "received date" for that claim.³²⁸ It was then up to that claims examiner to find and manually change the original received date so that interest would be paid correctly.³²⁹ If a claims examiner did not manually change the received date on a rework claim, interest would be incorrectly calculated. In addition, the RIMS

³²⁵ RT 7646:13-7647:17; Exh. 5252, p. 6937.

³²⁶ Exh. 5252, p. 6937; RT 7645:7-18.

³²⁷ $23,658/28,853 = 0.8199$ or 82%. See also RT 24432:1-3.

³²⁸ RT 2368:11-18; RT 2369:9-12.

³²⁹ RT 2368:18-25.

software did not automatically calculate the interest payment required. Instead, PacifiCare relied upon its claims examiners to independently calculate interest, thereby adding another area for error.³³⁰

3. Parties' Contentions

CDI contends PacifiCare failed to pay interest on untimely processed claims in 5,195 instances, in violation of Insurance Code section 790.03, subdivisions (h)(1), (h)(3) and (h)(5).³³¹ CDI asserts these violations were knowingly committed and willful as defined by Regulation 2695.2, subdivision (y). CDI further asserts the violations were not inadvertent, and that a penalty of \$1,700 per act is appropriate.³³²

PacifiCare argues that interest is the sole penalty for violations of Insurance Code section 10123.13, subdivision (b), and as such, its failure to pay interest on claims cannot constitute a violation of the UIPA.³³³ Further, PacifiCare maintains the business judgment rule insulates the insurer from further penalties.³³⁴ Lastly, PacifiCare contends the violations were not knowingly committed and were not willful, and thus do not warrant a total penalty of more than \$5,000.³³⁵

4. Analysis and Conclusions of Law

a. Number of Violations

PacifiCare admits it failed to pay interest on 5,195 claims during the MCE period.³³⁶ The Commissioner finds no reason to challenge PacifiCare's own admission and concludes PacifiCare violated Insurance Code section 10123.13, subdivision (b) at least 5,195 times.

³³⁰ RT 7649:4-8.

³³¹ Although CDI initially found 5,432 violations, CDI ultimately reduced the number of violations charged to 5,195; a number PacifiCare also agreed to. (See CDI's Opening Brief to OAH, 198:9-10; Exh. 5369, p. 7874.)

³³² CDI's Opening Brief to OAH, 199:17-200:12; CDI's Opening Brief to Commissioner, 43:6-22.

³³³ PacifiCare's Brief to OAH, 226:18-231:16.

³³⁴ *Id.* at 224:6-225:14; 226:5-17.

³³⁵ *Id.* at 233:1-234:15; 236:18-25; PacifiCare's Brief to Commissioner, 68:1-28.

³³⁶ Exh. 5369, p. 7874.

b. Knowingly Committed or General Business Practice

PacifiCare contends it did not “knowingly” commit these violations since they were the result of human error. The Commissioner finds this argument to be unpersuasive.

Regulation 2695.2, subdivision (l) defines “knowingly committed” as “performed with actual, implied or constructive knowledge, including, but not limited to, that which is implied by operation of law.” PacifiCare is charged with knowing the statutory claims processing deadline and the law regarding interest payments. PacifiCare’s failure to adhere to these laws is thus a knowingly committed violation. In addition, an insurer is charged with constructive knowledge of when a claim is received, and therefore has knowledge of when a claim is untimely paid. Nothing in the statute or the regulations absolves an insurer of liability if a representative testifies the violations were the result of human error.

The evidentiary record also establishes that PacifiCare had actual knowledge that its claims processing system failed to calculate the required interest payments. As the end users of the RIMS software, PacifiCare knew the software did not calculate interest and knew its employees manually calculated interest payments. PacifiCare also knew its procedures altered the received date on all reworked claims and required claims examiners to manually change the received date to comply with the Insurance Code. That PacifiCare employees, or those of its outside vendors, may have failed to comply with the law does not render the violations unknowingly committed. In fact, the record demonstrates the violations were knowingly committed as defined by the regulation.

And even assuming the violations were not knowingly committed, the evidentiary record demonstrates PacifiCare employed a general business practice that violated the Insurance Code.

PacifiCare admits it failed to pay interest on at least 5,195 claims during the MCE period. These 5,195 violations, by themselves, represent a frequency that indicates a general business practice.

Accordingly, the Commissioner concludes these violations were knowingly committed or performed with such frequency as to indicate a general business practice.

c. Specific UIPA Violations

Initially, PacifiCare contends Insurance Code section 790.03, subdivision (h) does not apply where an insurer fails to remit the required interest payments. In so arguing, PacifiCare notes that Section 790.03 does not specifically mention the term “interest.” While this statement is true, it does not preclude a finding that PacifiCare violated the UIPA. As noted above, each of the 16 subsections of Section 790.03, subdivision (h) is written broadly and is not intended to serve as the exclusive definition of all unfair claims settlement practices. Instead, other methods, act(s), or practices not specifically delineated in the statute or accompanying regulations may also be subject to Insurance Code section 790.03, subdivision (h).³³⁷ Accordingly, the Commissioner rejects this argument as unsupported.

i. 790.03(h)(1)

Section 790.03, subdivision (h)(1) prohibits an insurer from misrepresenting to claimants pertinent facts or insurance policy provisions. An insurer who fails to pay the required interest on an untimely processed claim incorrectly represents to a claimant that the full amount owed has been paid.

PacifiCare argues this provision does not apply when the insurer misrepresents a statutory remedy. But this argument lacks merit. Whether PacifiCare misrepresents the amount owed under the law or misrepresents the amount owed under a policy is inconsequential. Either way,

³³⁷ Cal. Code of Regs., tit. 10, § 2695.1, subd. (b).

the insurer misrepresented a pertinent fact. Accordingly, PacifiCare's actions violate Section 790.03, subdivision (h)(1).

ii. 790.03(h)(3)

Insurance Code section 790.03, subdivision (h)(3) penalizes an insurer "for failing to adopt and implement reasonable standards" for the prompt processing of claims. PacifiCare argues CDI must demonstrate what an insurer's standards are and further must prove, by "expert testimony," that such standards are unreasonable.³³⁸ The Commissioner rejects this argument as unsupported and instead finds sufficient evidence that PacifiCare failed to adopt and implement reasonable processing standards.

First, PacifiCare adds language to the statute that does not exist. Nowhere in Section 790.03, subdivision (h) is the term "expert testimony" used, nor does PacifiCare cite any case law or regulatory support for its assertion. Instead, a finding that PacifiCare violated Section 790.03, subdivision (h) falls squarely within the province of the trier of fact, in this case the Commissioner. Second, the statute prohibits an insurer from "failing to adopt and implement reasonable standards." Accordingly, it is PacifiCare's failure to adopt and implement reasonable standards that CDI must show. PacifiCare's attempt to read new language and obligations into the statute must be disallowed.

The record establishes that PacifiCare failed to adopt and implement reasonable standards for prompt claims processing. PacifiCare's RIMS incorrectly recorded a claim's date of receipt and PacifiCare's employees were not adequately trained or monitored to ensure entry of the correct date of receipt. In addition, PacifiCare required employees to manually calculate interest payments but did not provide training on this requirement until November 2007. And such training proved inadequate as evidenced by an internal PacifiCare document indicating

³³⁸ PacifiCare's Brief to OAH, 229:12-18.

employees were “still struggling with RIMS PPO interest accuracy” in October 2008.³³⁹

PacifiCare cannot stand behind a “business judgment” argument in failing to implement adequate systems. Instead, each of these facts show PacifiCare either failed to adopt or failed to implement reasonable standards for the prompt processing of claims.

Accordingly, the Commissioner concludes PacifiCare violated Section 790.03, subdivision (h)(3).

iii. 790.03(h)(5)

Insurance Code section 790.03, subdivision (h)(5) punishes an insurer for “not attempting in good faith to effectuate prompt, fair and equitable settlements of claims.” PacifiCare argues that its failure to pay interest does not violate subsection (h)(5), since a claim is paid in full even if it fails to include the statutorily-required interest. The Commissioner finds this argument unpersuasive.

Insurance Code section 10123.13, subdivision (b) requires an insurer to pay an added 10% interest on untimely processed claims. PacifiCare failed to effectuate a fair and equitable settlement of the claim since it failed to fully compensate its claimants. Further, PacifiCare’s failed interest calculation process does not demonstrate “good faith” as required by the statute. Failure to adequately train and monitor staff and failure to adopt an efficient and accurate software program shows instead an indifference to statutory compliance.

Accordingly, the Commissioner finds PacifiCare’s actions violated Insurance Code section 790.03, subdivision (h)(5).

³³⁹ Exh. 712, p. 9316.

5. Penalty Assessed

a. Willfulness

PacifiCare's failure to pay interest on untimely processed claims was willful and purposeful. PacifiCare failed to adequately train its claims examiners in the statutory requirements and utilized a software program that created more problems than it solved. And PacifiCare knew as early as November 2006 that it was failing to pay the required interest, yet problems continued well into the next year. Further, an insurer who fails to pay interest on 18% of claims where interest is due is willingly committing the act.

Because PacifiCare willfully violated Insurance Code section 790.03, subdivisions (h)(1), (h)(3), and (h)(5), PacifiCare is liable to the state for a civil penalty not to exceed \$10,000 for each act.

b. Single Act or Multiple Violations

PacifiCare argues the Commissioner should combine all 5,195 violations into a single act "because the failure to pay interest was inadvertent."³⁴⁰ PacifiCare asserts it intended to pay interest but because its software system was not properly calibrated, the violations were inadvertent. But this argument rests upon an illogical reading of Section 790.035 and must be rejected.

Section 790.035, subdivision (a) requires an insurer demonstrate that the "issuance, amendment or servicing of a policy or endorsement is inadvertent." It does not, as PacifiCare argues, protect insurers who violate the Insurance Code by acting carelessly or recklessly. In addition, there is no evidence in the record showing that PacifiCare inadvertently created and implemented the RIMS program. PacifiCare knew its software did not calculate interest and it knew the program required manual entry of the proper received date. There is no statutory or

³⁴⁰ PacifiCare's Brief to OAH, 233:11; PacifiCare's Brief to Commissioner, 68:1-15.

case law support for finding that an insurer who knowingly implements an inadequate program may be absolved by later arguing the execution was “inadvertent.”

Thus, the Commissioner may assess a penalty for each of the 5,195 violations.

c. Regulatory Considerations

The Commissioner considers the relative harm and seriousness of the violations, PacifiCare’s remedial actions, any good faith actions and the relative number of violations, in assessing the appropriate penalty for these violations.

The Commissioner considers this type of violation to be less serious than those previously discussed. There is no evidence that this type of violation jeopardizes a claimant’s medical care and while some amount of financial harm exists, it is usually a small amount. Accordingly, the Commissioner concludes a baseline per act penalty of \$1,000 is appropriate for this willful violation.

In 85% of the claims, PacifiCare owed its claimants \$10 or less, and the median interest payment for all claims was \$0.86. The Commissioner considers the relatively small amount of harm as a mitigating factor, while also acknowledging that for low-income Californians even \$10 can be a significant amount.

Similarly, the Commissioner considers the relative number of noncomplying acts to be a slight mitigating factor. During the MCE period, PacifiCare failed to pay interest on over 5,000 claims, and while a compliance rate of 82% is far from acceptable, PacifiCare did pay the required interest in over 23,000 claims.

PacifiCare’s failure to take remedial action on its noncomplying acts and management’s awareness serve as aggravating factors. PacifiCare knew in November 2007 that it had failed to pay interest on 5,195 claims and indicated that it had remedied this problem during that same

month. But this representation proved to be false. In fact, as of July 2010, nearly three years later, PacifiCare had failed to reprocess 813 of those late-paid claims. PacifiCare did not justify this delay or explain its misrepresentation to CDI. In addition, PacifiCare failed to remedy the underlying cause of the violation. While PacifiCare indicated it trained employees to properly calculate interest, internal documents demonstrate such training proved insufficient. And PacifiCare's software still does not automatically calculate interest; a change that could help eliminate the "human error" factor PacifiCare discusses.

Nor does the Commissioner find that under the totality of the circumstances, PacifiCare made a good faith attempt to comply with the Insurance Code. It is true that PacifiCare ultimately paid interest on all untimely processed claims, but the nearly three-year delay in reworking some claims cannot be considered good faith. This is especially true given PacifiCare's misrepresentation to CDI that all claims had been reprocessed and paid in November 2007.³⁴¹

Based on the above factors, the Commissioner concludes the appropriate penalty for these violations is \$1,500 per act, which is 15% of the statutory maximum penalty, for a total of \$7,792,500.

G. Failure to Correctly Pay Claims

1. Applicable Law

CDI alleges PacifiCare failed to properly load provider contracts, and as a result, failed to correctly pay providers. In addition to Insurance Code section 790.03, subdivision (h) which delineates minimum standards for the processing of claims, Regulation 2695.7, subdivision (g)

³⁴¹ The remaining penalty factors presented neither aggravating nor mitigating circumstances. (Cal. Code of Regs., tit. 10, § 2695.12, subs. (a)(1), (a)(3), (a)(9)).

prohibits insurers from “attempt[ing] to settle a claim by making a settlement offer that is unreasonably low.”

2. Findings of Fact

The Commissioner finds by a preponderance of evidence the following facts regarding PacifiCare’s alleged failure to correctly pay claims.

At the time of the United/PacifiCare merger in late 2005, PacifiCare provided services to its California members through the Care Trust Network (CTN), a provider network leased from Blue Shield. To address antitrust concerns, in October 2005 the U.S. Department of Justice required United to terminate the CTN lease no later than July 1, 2006.³⁴² In late 2005, United began planning to replace the CTN with PacifiCare’s network, to contract with high volume CTN providers not already contracted with PacifiCare, and to “remediate” any PacifiCare contracts that prevented access by PacifiCare affiliates.³⁴³ Pursuant to lease terms, Blue Shield terminated United’s access to CTN providers as of June 23, 2006.³⁴⁴

Also on June 23, 2006, PacifiCare ceased to maintain provider data in its RIMS claims platform. Instead, the insurer began using a “data bridge,” called the Electronic Provider Data Exchange (EPDE) to transfer provider demographic and contract data from United’s network database (NDB) to RIMS. During each nightly EPDE feed, every record that had been changed in United’s NDB was transmitted to RIMS and overwrote the RIMS record. Thus, if the data in the NDB system was incorrect, any correct data in RIMS would be replaced with the incorrect data. According to PacifiCare, at the time it launched EPDE, 20 percent of California provider data in the NDB was incorrect.³⁴⁵

³⁴² RT 10596:4-19; Exh. 457, p. 9244; Exh. 5341.

³⁴³ Exh. 5343, p. 7736.

³⁴⁴ Exh. 5344.

³⁴⁵ Exh. 767, p. 3316.

In August 2006, PacifiCare knew some portion of its provider data and fee schedules had been corrupted as a result of the data bridge.³⁴⁶ Internal documents reflect serious concern among PacifiCare employees about the accuracy of provider data and efforts being made to remedy the problem.³⁴⁷ In addition, testimony provided by Dr. Griffin and Ms. Griffin, his practice manager, establish that providers contacted PacifiCare multiple times regarding incorrect fee schedules, and underpayment of claims. Ms. Griffin repeatedly telephoned and faxed PacifiCare regarding underpayments and on most occasions received no response from the insurer.³⁴⁸ In fact, Ms. Griffin resolved her claim issues only after she contacted CDI and filed a formal complaint in 2007. Similarly, Dr. Mazer and other providers expended significant time and energy seeking restoration of their contracted reimbursement rates, and were only able to resolve their complaints after CDI or CMA intervened.³⁴⁹

As previously discussed, in late 2006 CDI began receiving a large number of complaints regarding PacifiCare's claims handling procedures. Among other problems, providers reported to CDI that they were being reimbursed at non-contracted rates, that claim checks were being sent to old and outdated addresses, and that PacifiCare was using incorrect provider tax identification numbers to process claims. The California Medical Association reported similar problems to CDI in early 2007.³⁵⁰

In February 2007, the parties discussed the contract loading, fee schedule and demographic errors. At the time, PacifiCare was unable to explain why these errors occurred. In March 2007, PacifiCare indicated the problem lay with the EPDE data bridge, and estimated the "net financial impact of these three challenges (retro-effective contract loads, fee schedule

³⁴⁶ Exh. 5256, p. 2468; Exh. 775, p. 2803. See also Exh. 773, p. 2319.

³⁴⁷ Exh. 775, p. 2803; RT 11014:12-11015:22.

³⁴⁸ RT 2667:14-25; 2668:16-2670:11.

³⁴⁹ RT 3022:7-19; Exh. 1019, p. 7977.

³⁵⁰ Exh. 165, p. 8506-8507; Exh. 1019, p. 7974.

corrections and demographic errors) . . . to be approximately \$250K in provider underpayments requiring adjustments.”³⁵¹ When CDI challenged the \$250,000 amount, PacifiCare admitted the \$250,000 estimate did not reflect the total dollar amount of claims processed, nor did it include the claims paid on behalf of United's ASO members.³⁵²

In November 2007, CDI presented PacifiCare with its MCE report. The report identified at least 45 instances where PacifiCare failed to properly load contracts and accurately pay provider claims.³⁵³ CDI found at least 14 providers with about 500 claims that had yet to be reworked as a result of PacifiCare’s database problems. These claims totaled approximately \$95,000. In addition, CDI found PacifiCare did not record the date it loaded each contract, leading to gaps in the data tracking.³⁵⁴ In response, PacifiCare admitted,

it did not consistently address problems in claims adjudication when provider contract uploading was delayed or contracts were back dated. Additionally, PacifiCare cannot verify that all claims submitted prior to contract uploading or contract back date were reviewed for correct payment and interest where applicable.³⁵⁵

That same month, PacifiCare’s Director of Provider Relations, Anne Harvey, described major problems she faced in navigating the contract uploading process, including having to wait several weeks for a response to a technical issue. After airing her concerns, Ms. Harvey concluded:

I am sure someone who understands things can take a look at these scenarios and say "oh well, that is because they should have done this... " But that is my point. We don't have that resource. There are no documented process flows for a) loading physician rosters b) contracts on PHS, diCarta or Emptoris paper, c) linking contracts to the docs, d) how to trouble shoot when problems occur, and finally e) no org charts to help us escalate issues when critical. I am sure that in a few more months we will have be very conversant in how to get things done, but

³⁵¹ Exh. 8, p. 1870.

³⁵² Exh. 5348, p. 8450.

³⁵³ Exh. 118, pp. 3422-3423.

³⁵⁴ *Id.* at pp. 3421-3422.

³⁵⁵ *Id.* at p. 3423.

this is not helping us in the short term, which of course is our most mission critical time of year.³⁵⁶

In mid-2008, PacifiCare informed CDI it had incorrectly processed 3,700 provider claims due to retroactively loaded contracts or the CTN transition, resulting in an underpayment of approximately \$250,000.³⁵⁷

3. Parties' Contentions

CDI argues PacifiCare violated Insurance Code section 790.03, subdivisions (h)(1), (h)(3) and (h)(5) at least 3,700 times. CDI alleges these acts were knowingly committed and also demonstrate a general business practice of inaccurately paying claims.³⁵⁸ CDI contends PacifiCare's violations were willful and not inadvertent.³⁵⁹ As a result, CDI seeks a penalty of \$6,000 per violation.³⁶⁰

PacifiCare initially takes issue with the number of violations charged, alleging the true number is 2,662.³⁶¹ In addition, PacifiCare argues inaccurately paid claims do not violate Insurance Code section 790.03, subdivision (h).³⁶² And even assuming inaccurate payments violate Section 790.03, subdivision (h), PacifiCare contends it did not knowingly violate the statute.³⁶³ Further, PacifiCare argues its violations were not willful, did not cause harm and do not warrant a penalty higher than \$1,000 per act.³⁶⁴

³⁵⁶ Exh. 787, p. 7409.

³⁵⁷ RT 2212:9-15; RT 10710:1-17. This number omits the thousands of incorrectly paid claims sent by the University of California providers. (See Exh. 619.)

³⁵⁸ CDI's Opening Brief to OAH, 213:10-21; CDI's Closing Brief to OAH, 345:8-347:15; CDI's Opening Brief to Commissioner, 45:23-46:2.

³⁵⁹ CDI's Opening Brief to OAH, 213:22-214:17; CDI's Closing Brief to OAH, 347:18-28.

³⁶⁰ CDI's Opening Brief to Commissioner, 46:8-13.

³⁶¹ PacifiCare's Brief to OAH, 274:23-276:2; PacifiCare's Brief to Commissioner, 70:1-22.

³⁶² PacifiCare's Brief to OAH, 279:13-281:26; PacifiCare's Brief to Commissioner, 71:9-73:11.

³⁶³ PacifiCare's Brief to OAH, 273:3-279:12; PacifiCare's Brief to Commissioner, 71:4-8.

³⁶⁴ PacifiCare's Brief to OAH, 282:2-285:5; PacifiCare's Brief to Commissioner, 73:13-19.

4. Analysis and Conclusions of Law

a. Number of Violations

In 2008, PacifiCare admitted it issued inaccurate claims payments in 3,700 instances. PacifiCare now contends that amount was an “estimate” and the true number of claims equals 2,662. In support of this argument, PacifiCare points to Exhibit 5252 introduced on June 8, 2010, the 61st day of hearing. The Commissioner finds this argument unpersuasive, as it is contrary to both a clear reading of Exhibit 5252 and PacifiCare’s own witness testimony.

Exhibit 5252, page 6929, titled “Retroactive Provider Contracts,” concludes that PacifiCare reworked 2,662 claims due to incorrectly entered retroactive contracts. But the chart does not list those claims reworked because of inaccurate fee schedules, or incorrect demographic information. In essence, the chart is only a subset of the 3,700 reworked claims. This conclusion is supported by Ms. Berkel, who testified that Exhibit 5252, page 6929 “just looked at a subset of self-initiated rework for retroactivity.”³⁶⁵ It follows then that Exhibit 5252 is not an “updated” number of reworked claims, but instead just a subgroup of the 3,700 admitted to initially.

This conclusion is also supported by the testimony of PacifiCare Vice President Elena McFann. Ms. McFann testified that in mid-2008 she informed CDI that “3,700 claims were impacted by retro loaded contracts or associated with the CTN transition for additional payment of a little bit over \$200,000.”³⁶⁶ Ms. McFann reiterated the number of reworked claims and the associated payments several times during the evidentiary hearing.³⁶⁷ At no point did Ms. McFann testify that 2,662 was the correct number of reprocessed claims. Instead, Ms. McFann clarified that “net financial impact of these three challenges (retro-effective contract loads, fee schedule

³⁶⁵ RT 9892:17-20.

³⁶⁶ RT 2212:6-15.

³⁶⁷ RT 10710:1-9; RT 12785:7-10.

corrections and demographic errors)” was “approximately \$250K in provider underpayments requiring adjustments.”³⁶⁸

Lastly, PacifiCare fails to support its contention that the 2,662 figure was arrived at by “deducting duplicate claims.”³⁶⁹ In addition, the Commissioner could find no such support in the evidentiary record. Accordingly, the Commissioner concludes PacifiCare incorrectly paid 3,700 claims.

b. Knowingly Committed or General Business Practice

PacifiCare contends it did not “knowingly” commit these acts since CDI presented no evidence that PacifiCare knew it was incorrectly paying claims. In addition, PacifiCare argues CDI must demonstrate the “reason for the allegedly incorrect payment” before the trier of fact may find a “knowingly committed” act.³⁷⁰ The Commissioner finds these arguments to be without merit.

Regulation 2695.2, subdivision (l) defines “knowingly committed” as “performed with actual, implied or constructive knowledge, including, but not limited to, that which is implied by operation of law.” The evidentiary record demonstrates PacifiCare knew as of August 2006 that its EPDE data bridge overrode correct demographic information and resulted in misaddressed claims payments. PacifiCare also had actual knowledge its computer system applied inaccurate fee schedules to many provider claims, and further had actual knowledge of its delay in loading updated provider contracts.³⁷¹ As such, PacifiCare’s argument is without merit.

Likewise, nothing in Insurance Code section 790.03, subdivision (h) or Regulation 2695.2, subdivision (l) requires CDI establish the “reason” for the alleged violations. Nor does

³⁶⁸ RT 12954:3-6; Exh. 8, p. 1870.

³⁶⁹ PacifiCare’s Brief to OAH, 274:26-27.

³⁷⁰ PacifiCare’s Brief to OAH, 278:12-27.

³⁷¹ Exh. 5256, p. 2468; Exh. 775, p. 2803. See also Exh. 773, p. 2319.

PacifiCare provide any case law support for this claim. While the reason behind PacifiCare’s violations may mitigate some penalty or negate a finding of willfulness, PacifiCare’s motive is irrelevant in determining whether the act was “knowingly committed.”

Hence, the Commissioner concludes PacifiCare knowingly committed the above acts, as that term is defined in Regulation 2695.2, subdivision (l).

c. Specific UIPA Violations

i. 790.03(h)(1)

Section 790.03, subdivision (h)(1) prohibits an insurer from misrepresenting to claimants pertinent facts or insurance policy provisions. An insurer who pays an incorrect claim amount misrepresents to a claimant that the full amount owed has been paid.

PacifiCare argues an accidental payment error cannot be a misrepresentation of a pertinent fact or policy provision. In support of this argument, PacifiCare cites *Williams v. United States* (1982) 458 U.S. 279, for the proposition that “the simple act of making a payment” is not a representation. But PacifiCare’s reliance on this case is misguided.

First, *Williams* did not address alleged insurer misrepresentations. Instead, that case discussed whether knowingly writing checks against an account that contained insufficient funds constituted making a false statement. Therein, the Court indicated that a check is an unconditional promise to pay a certain sum, but that it does not “make any representation as to the state of [the drawer’s] bank account.”³⁷² There is no correlation here between PacifiCare’s statutory obligation to accurately represent pertinent facts or policy provisions and an individual’s writing a check with insufficient funds.

PacifiCare also ignores that with each inaccurate payment sent to providers PacifiCare also sent an EOP that misrepresented the full amount owed on the claim. The EOPs disclose the

³⁷² *Williams v. United States*, *supra*, 458 U.S. at pp. 285-285.

provider's discount, i.e. the difference between the billed amount and the amount the provider has agreed to accept. By applying the incorrect fee schedule, PacifiCare misrepresented the provider's discount.

Based on the above discussion, the Commissioner concludes PacifiCare's incorrect payment of claims violates Insurance Code section 790.03, subdivision (h)(1).

ii. 790.03(h)(3)

Insurance Code section 790.03, subdivision (h)(3) penalizes an insurer who fails to adopt and implement reasonable standards for the prompt investigation and processing of claims. PacifiCare argues its incorrect payments were "inadvertent" and therefore do not demonstrate a failure to implement reasonable standards. The Commissioner concludes this argument lacks merit.

Section 790.03, subdivision (h)(3) does not require an element of intent, as argued by PacifiCare. An insurer fails to adopt and implement reasonable standards when it adopts an unreasonable policy, fails to adopt a policy at all, or commits violations that would not have occurred had a reasonable policy been in place. That said, PacifiCare's statements establish that the insurer failed to adopt and implement reasonable claims processing standards. In November 2006, PacifiCare's Director of Provider Relations stated "there are no documented process flows" for loading physician rosters and contracts onto PacifiCare's computer system, and no process to trouble shoot problems that arise.³⁷³ In addition, PacifiCare admitted "it did not consistently address problems in claims adjudication when provider contract uploading was delayed or contracts were back dated."³⁷⁴

³⁷³ Exh. 787, p. 7409.

³⁷⁴ Exh. 118, p. 3423.

Similarly, PacifiCare’s failure to adopt and implement reasonable standards is demonstrated by the number of reworked claims and by evidence of its inadequate computer database. PacifiCare admits its data bridge overrode accurate provider information and fee schedules. Uploading accurate contract and provider data is a necessary step in promptly processing claims. By relying upon a flawed data system, PacifiCare failed to adopt and implement reasonable claims processing standards.

The Commissioner concludes these facts sufficiently demonstrate PacifiCare violated section 790.03, subdivision (h)(3).

iii. 790.03(h)(5)

Section 790.03, subdivision (h)(5) requires insurers to attempt in good faith to effectuate prompt, fair and equitable settlements of claims. The evidentiary record establishes PacifiCare carelessly managed its database, failed to adopt reasonable processing standards, and did not remedy these issues until mid-2008. Such actions do not demonstrate a good faith effort to promptly or equitably settle claims. Hence, PacifiCare violated Insurance Code section 790.03, subdivision (h)(5).

5. Penalty Assessed

a. Willfulness

PacifiCare contends CDI must demonstrate the insurer acted “with a specific intent to violate the law” to establish willfulness. But PacifiCare’s argument is contrary to the definition of “willful.” In addition, the evidentiary record demonstrates PacifiCare acted willfully, as that term is defined in Regulation 2695.2, subdivision (y).

Regulation 2695.2, subdivision (y) states “willful” or “willfully” when applied to an act or omission “means simply a purpose or willingness to commit the act, or make the omission

referred to in the California Insurance Code or this subchapter. It does not require any intent to violate law, or to injure another, or to acquire any advantage.” As the regulation clearly states “intent” is not required, this argument must be rejected.

Further, the evidentiary record shows PacifiCare purposefully implemented and continued to use the EPDE data bridge, knowing the program corrupted provider data. The Commissioner concludes it is not “reasonable to launch a program to change provider data, on whose accuracy appropriate claim adjudication depends, without fully understanding how that program will affect the data and without instituting and maintaining rigorous quality controls to detect errors.”³⁷⁵ It is also undisputed that PacifiCare continued to rely upon this database even though it knew the result was thousands of incorrectly paid claims.

As such, the Commissioner concludes PacifiCare’s actions were “willful” as defined by the regulations. Because PacifiCare willfully violated Insurance Code section 790.03, subdivisions (h)(1), (h)(3), and (h)(5), PacifiCare is liable to the state for a civil penalty not to exceed \$10,000 for each act.

b. Single Act or Multiple Violations

PacifiCare does not argue the violations constitute a “single act” nor is there any evidence that PacifiCare inadvertently issued incorrectly processed payments. Accordingly, any penalty assessed will be multiplied by 3,700; the number of violations found.

c. Regulatory Considerations

In setting the appropriate penalty, the Commissioner considers the relative harm and seriousness of the violations, PacifiCare’s remedial actions, the relative number of violations, the complexity of the claims and any good faith actions from PacifiCare.

³⁷⁵ CDI’s Opening Brief to OAH, 214:2-5.

The Commissioner finds this type of violation to be relatively serious and of moderate harm. As reflected in the number of statutes and regulations pertaining to claims processing, the Legislature finds the accurate and prompt payment of insurance claims to be of extreme importance. While the direct financial harm may be small, by penalizing noncompliant insurers, the Legislature provided a deterrent for those who currently disregard their Insurance Code obligations. Further, the incorrect payment of claims adversely impacts both members and providers. Not only do claimants not receive the correct amount due, they also face an administrative burden through repeated calls and letters to the insurer. And an incorrect payment can result in the patient having to pay more than the appropriate amount. For example, Dr. Mazer noted PacifiCare incorrectly considered him an out-of-network provider, which resulted in incorrect reimbursement and higher out-of-pocket costs to patients.³⁷⁶ Accordingly, the Commissioner concludes the serious nature of this willful violation supports a baseline penalty of \$5,000 per act.

The Commissioner also finds in aggravation that PacifiCare failed to act in good faith. By installing a data bridge without adequate testing and quality control, PacifiCare acted recklessly. Further, by continuing to use the inadequate system, PacifiCare demonstrated a disregard for the Insurance Code and a disregard for its claimants.³⁷⁷

In mitigation, the Commissioner finds some of these violations were the result of complex fee agreements. The Commissioner also gives PacifiCare slight credit for its remedial efforts. Although PacifiCare had not corrected its internal contract loading problems by 2008, the insurer did attempt to rework the inaccurately paid claims and did make efforts to ultimately comply with the Insurance Code.

³⁷⁶ See also Exh. 1019, p. 7977.

³⁷⁷ The Commissioner does not consider the uncharged violations to be an aggravating factor in setting this penalty.

The Commissioner also concludes CTN termination did not represent an extraordinary circumstance, as defined in the regulations, because the termination was not outside the company's control.³⁷⁸ First, the Commissioner notes the CTN termination was the direct result of the PacifiCare/United merger; a decision entirely within PacifiCare's control. Second, the Department of Justice ordered PacifiCare in October 2005 to terminate the relationship by July 1, 2006. PacifiCare had time to prepare for the CTN termination. That Blue Shield terminated PacifiCare's lease six days before the July 1, 2006 deadline does not constitute a circumstance outside PacifiCare's control.

Based on the above factors, the Commissioner concludes the appropriate penalty for these violations is \$6,000 per act, which is 60% of the maximum penalty, for a total of \$22,200,000.

H. Failure to Acknowledge the Receipt of Claims

1. Applicable Law

In 2005, the Legislature enacted Senate Bill 634, which added new requirements to the Health Care Providers Bill of Rights. Specifically, Senate Bill 634 added Insurance Code section 10133.66, subdivision (c), which provides:

The receipt of each claim shall be identified and acknowledged, whether or not complete, and the recorded date of receipt shall be disclosed in the same manner as the claim was submitted or provided through an electronic means, by telephone, Web site, or another mutually agreeable accessible method of notification, by which the provider may readily confirm the insurer's receipt of the claim and the recorded date of receipt within 15 working days of the date of receipt of the claim by the office designated to receive the claim.

If a claimant submits a claim to a health insurer using a claims clearinghouse, its identification and acknowledgment to the clearinghouse within the timeframes set forth above shall constitute compliance with this section.

³⁷⁸ Cal. Code of Regs., tit. 10, §§ 2695.12, subd. (a)(1), 2695.2, subd. (e).

As the Legislative analysis explains, Section 10133.66, subdivision (c) simply “[r]equires insurers to acknowledge receipt of a claim, in the same manner as the claim was received, within 15 working days of the date of receipt.”³⁷⁹

Similarly, Regulation 2695.5, subdivision (e) requires insurers to acknowledge claims within 15 calendar days. While Insurance Code section 10133.66, subdivision (c) applies to providers, Regulation 2695.5, subdivision (e) applies to both members and providers. In addition, this regulation requires insurers to acknowledge the receipt of a claim in writing, unless the insurer makes a notation of acknowledgment in the claim file.

2. Findings of Fact

The Commissioner finds by a preponderance of the evidence the following facts regarding PacifiCare’s alleged failure to acknowledge the receipt of claims.

In late 2005, PacifiCare performed an internal analysis of Insurance Code section 10133.66, subdivision (c). Based on its analysis of the bill, PacifiCare concluded the statute required an insurer to acknowledge receipt of a provider’s claim in the same manner the claim was received. PacifiCare implementation logs for Section 10133.66, subdivision (c), reflects this conclusion: “[T]he provider needs to be able to confirm via same method of receipt of claim.”³⁸⁰ Likewise, PacifiCare’s implementation log for Regulation 2695.5 indicates the insurer was required to send acknowledgement letters to both members and providers.³⁸¹

On September 10, 2007, CDI requested PacifiCare produce data on the dates the company acknowledged the receipt of claims processed during the MCE review period.³⁸² On September 19, 2007, PacifiCare employee Suzanne Lookman sent an electronic message to

³⁷⁹ Sen. Rules Com, Off. of Sen. Floor Analyses, Rep. on Sen. Bill No. 634 (2004-2005 Reg. Sess.) May 10, 2005, p. 3; See also Exh. 5679, p. 109.

³⁸⁰ Exh. 5316, p. 7534.

³⁸¹ Exh 811, p. 7628.

³⁸² Exh. 110, p. 4828.

Francis Orejudos, PacifiCare’s representative in charge of responding to CDI. In that message, Ms. Lookman reported a “gap” in PacifiCare’s process for sending out acknowledgment letters.³⁸³ As Ms. Lookman explained, an acknowledgment letter would be generated only if the claim had already been loaded in RIMS; if the claim was in a queue or in the Claims Exchange pre-processing system, a letter would not be generated. In response to Ms. Lookman’s discovery, Mr. Orejudos stated “[a]t this point I would rather not disclose the gap in our process for sending out ack letters, but simply indicate that this data is not available for reporting. If the CDI probes further we can disclose the below information.”³⁸⁴ Mr. Orejudos then proposed PacifiCare send CDI a response that did not disclose the “gap” and instead represented to CDI that acknowledgment letters were being sent but that PacifiCare was unable at that time to provide the date of acknowledgment of those letters on an automated basis. On September 20, 2007, PacifiCare followed Mr. Orejudos’ advice and sent CDI a response indicating it was complying with Section 10133.66, subdivision (c), although PacifiCare knew this statement to be false.

On October 12, 2007, CDI again requested that PacifiCare “[p]rovide a description of the measures taken to ensure compliance with CIC § 10133.66(c).”³⁸⁵ CDI also requested PacifiCare deliver 10 sample provider acknowledgment letters.³⁸⁶

On October 16, 2007, PacifiCare admitted that it did not generate acknowledgment letters from July 2006 until January 2007. As a means of explaining its noncompliance, PacifiCare stated its vendor, Duncan, failed to print these letters.³⁸⁷ PacifiCare further indicated it addressed the lapse with Duncan. PacifiCare also traced the failure to an entry in its internal database. Apparently a parameter in the RIMS setup contained an “N” instead of the “Y” that was required

³⁸³ Exh. 1139, p. 9768.

³⁸⁴ *Id.* at p. 9767.

³⁸⁵ Exh. 113.

³⁸⁶ Exh. 115.

³⁸⁷ *Ibid.*

to generate the acknowledgment letters.³⁸⁸ PacifiCare promised CDI it would generate a weekly report “to ensure acknowledgement letters are sent timely and appropriately, and will allow us to generate reports that link acknowledgement letter dates to claim numbers.”³⁸⁹ PacifiCare never implemented this weekly report.³⁹⁰ On October 25, 2007, PacifiCare informed CDI that it was “unable to provide carbon copies of the [sample] letters at this time” and instead provided what it represented was a “sample letter” recreated using its template.³⁹¹

On December 7, 2007, PacifiCare responded to CDI’s MCE reports. In its response, PacifiCare “agree[d] that it is required to send an acknowledgment letter for claims received, if the claim is not otherwise acknowledged by payment and/or issuance of an EOB within 15 calendar days.” PacifiCare further stated the “acknowledgement letter process was not in compliance for July 2006 through December 2006; 55,492 acknowledgement letters for group claims were not sent during that time period. The Company provided a file of 48,783 individual paid claims; 25,778 individual claims were not paid or acknowledged within 15 days. Acknowledgement letters for individual claims were corrected in July 2007.”³⁹² Based on this representation, CDI initially charged PacifiCare with 81,270 violations of the law.³⁹³

In March 2008, the parties discussed PacifiCare’s alleged failure to send acknowledgment letters. During this discussion, PacifiCare indicated for the first time, its belief that it had complied with Insurance Code section 10133.66, subdivision (c) by instituting a web portal for its providers.³⁹⁴ PacifiCare’s website provides the status of a claim once the claim has been fully adjudicated. It does not provide the date a claim was received, nor is access granted to

³⁸⁸ Exh. 732.

³⁸⁹ Exh. 113, p. 9893.

³⁹⁰ RT 2400:6-13.

³⁹¹ Exh. 114.

³⁹² Exh. 118, p. 3427. Exh. 117, p. 3409.

³⁹³ See Exh. 1, p. 3524.

³⁹⁴ Exh. 817, p. 6516.

all providers.³⁹⁵ Only PacifiCare-contracted providers may check the status of their claims. Out of network providers do not have access to this portion of the website.³⁹⁶

In June 2010, PacifiCare admitted it failed to send provider acknowledgment letters from January 2006 until March 1, 2008,³⁹⁷ and failed to send member acknowledgment letters from around August 2006 until March 13, 2007.³⁹⁸ PacifiCare also recalculated the number of claims that went unacknowledged during the MCE time period. After factoring out electronically submitted and acknowledged claims, PacifiCare failed to send providers a paper acknowledgement letter for 41,970 group claims and 13,505 individual claims.³⁹⁹ In addition, PacifiCare failed to acknowledge 688 group claims from members and 300 individual claims from members.⁴⁰⁰ In total, PacifiCare failed to acknowledge 56,463 claims.

3. Parties' Contentions

CDI asserts PacifiCare knowingly violated the Insurance Code 56,463 times by failing to acknowledge the receipt of claims. CDI contends this failure was not inadvertent, and further argues PacifiCare's actions caused harm to both providers and members.⁴⁰¹ Lastly, CDI argues the Commissioner should fine PacifiCare \$1,410 per act, since PacifiCare attempted to conceal the extent of their noncompliance.⁴⁰²

PacifiCare argues Insurance Code section 10133.66, subdivision (c) permits an insurer to acknowledge a claim in a variety of ways and requires little more than an internal entry in the insurer's computer system.⁴⁰³ In addition, PacifiCare contends CDI misinterprets the legislative

³⁹⁵ RT 14641:17-14642:1.

³⁹⁶ RT 8029:12-15.

³⁹⁷ RT 7877:12-7878:2.

³⁹⁸ RT 7706:25-7707:13.

³⁹⁹ Exh. 1181, p. 2.

⁴⁰⁰ Exh. 1181, p. 3; Exh. 732.

⁴⁰¹ CDI's Closing Brief to OAH, 380:11-381:9; 383:6-387:2.

⁴⁰² CDI's Opening Brief to OAH, 238:15-240:2; CDI's Opening Brief to Commissioner, 49:21-50:2.

⁴⁰³ PacifiCare's Brief to OAH, 173:6-176:4.

history of Section 10133.66, which the insurer asserts parallels DMHC's regulations.⁴⁰⁴ Lastly, PacifiCare contends it did not knowingly violate the Insurance Code, that any such violation was inadvertent and as such, only a minimal penalty should apply.⁴⁰⁵

4. Analysis and Conclusions of Law

a. Number of Violations

While not acknowledging it violated the UIPA, PacifiCare concedes that it failed to acknowledge 56,463 paper claims during the MCE period. The Commissioner finds no reason to challenge PacifiCare's own admission.

b. Knowingly Committed or General Business Practice

PacifiCare again argues that it did not "knowingly commit" these acts because it did not have actual knowledge of the violations. As noted previously, "knowingly committed" does not require actual knowledge. Knowledge may be implied as a matter of law or may be constructive in nature. Herein, PacifiCare is charged with constructive knowledge of its own policies and practices and is similarly charged with implied knowledge of the law. To find otherwise would permit insurers to turn a blind eye to violations to avoid responsibility.

Even assuming the acts were not knowingly committed the frequency of PacifiCare's violations serve as evidence of a general business practice. It is undisputed that for two years, PacifiCare failed to send paper acknowledgment letters to providers in violation of Insurance Code section 10133.66, subsection (c). In essence, PacifiCare's general business practice was not to send paper acknowledgment letters.

Accordingly, the Commissioner concludes PacifiCare knowingly committed the above acts, as that term is defined in Regulation 2695.2, subdivision (l).

⁴⁰⁴ *Id.* at 176:7-179:3.

⁴⁰⁵ *Id.* at 187:17-193:12.

c. Specific UIPA Violations

Initially, PacifiCare argues Insurance Code section 10133.66, subdivision (c) requires little more than an internal data entry and does not require an affirmative action on the part of PacifiCare.⁴⁰⁶ This assertion is based on the supposition that acknowledging receipt of a claim is the same action as disclosing the date of receipt. But such an assumption is unsupported.

The statute “requires insurers to acknowledge receipt of a claim, in the same manner as the claim was received.” And the statute calls for acknowledgment to be made to members and providers, not to PacifiCare itself. It is unclear, based on such legislative intent and language, why PacifiCare concludes the Legislature was concerned only with the insurer’s internal database.

Likewise, the definition of “acknowledge” does not support PacifiCare’s argument. To “acknowledge” a fact or condition is “to recognize,” rights, authority, status, or validity or “to disclose” knowledge or agreement.⁴⁰⁷ Black’s Law Dictionary notes that to acknowledge is “to make known the receipt of.”⁴⁰⁸ While PacifiCare argues it stands ready to acknowledge claims should a provider telephone or visit its website, PacifiCare’s argument actually shifts the burden of acknowledging the claim from the insurer to the provider or member. There is no evidence the Legislature intended the burden to rest with the provider. In fact, the statute specifically requires the insurer take an affirmative step to acknowledge receipt of a claim.

And lastly, neither PacifiCare’s telephone system nor its website provides the statutorily-required information. PacifiCare’s website denied access to at least 20 percent of its providers and did not provide the date a claim was received. In addition, evidence established that

⁴⁰⁶ PacifiCare’s Brief to OAH, 174:21-176:4.

⁴⁰⁷ Merriam-Webster’s Online Dict. (2012) < <http://www.merriam-webster.com/dictionary>> [as of March 17, 2014].

⁴⁰⁸ Black’s Law Dict. (8th ed. 2004), p. 24, col. 1.

PacifiCare’s customer service representatives were unable to provide date of receipt or other pertinent information.⁴⁰⁹ As such, the Commissioner rejects PacifiCare’s initial defense.

i. 790.03(h)(2)

Insurance Code section 790.03, subdivision (h)(2) requires an insurer to acknowledge and act reasonably promptly upon communications with respect to claims. PacifiCare contends it did not violate this provision or Section 10133.66, because the statutes do not require a specific form of communication. The Commissioner finds this argument unpersuasive.

PacifiCare’s reading of Insurance Code section 10133.66, subdivision (c) is contrary to the plain, unambiguous language of the statute. The statute requires an insurer acknowledge and the record the date of receipt *in the same manner as the claim was submitted*. While the statute lists several ways in which a receipt date may be disclosed, the statute ultimately requires the insurer acknowledge the claim in the same manner it was received. For instance, if a claim is submitted through an electronic means, then an insurer must disclose the recorded date of receipt of that claim through that same electronic means. And, if a paper claim is received, then by statute, the insurer must acknowledge the date of receipt of that claim by letter. PacifiCare’s new interpretation of the statute simply ignores entire clauses and is contrary to its own legislative analysis.

PacifiCare also points to the DMHC’s regulations for support, although this argument is similarly unpersuasive.⁴¹⁰ In 2003, the DMHC adopted California Code of Regulations, title 28, section 1300.71. DMHC Regulation 1300.71, subdivision (c) requires insurers to acknowledge claims by “an electronic means, by phone, website, or another mutually agreeable accessible method of notification.” PacifiCare relies upon this language and the Legislature’s casual

⁴⁰⁹ RT 9386:20-23.

⁴¹⁰ PacifiCare’s Brief to OAH, 176:6-179:3.

mention of DMHC Regulation 1300.71 to support its claim that an insurer may respond in any way it prefers. But DMHC Regulation 1300.71 does not require an insurer respond “in the same manner as the claim was submitted” as is required by Insurance Code section 10133.66, subdivision (c). And, when one part of a statute contains a term or provision, the omission of that term or provision from another part of the statute indicates the Legislature intended to convey a different meaning.⁴¹¹ The Legislature’s failure to mirror DMHC Regulation 1300.71 in enacting Insurance Code section 10133.66 illustrates the Legislature’s intent to convey different requirements. Likewise, the Legislature mentioned the DMHC in Section 10133.66’s legislative history only to inform its members that a similar requirement already existed for HMO insurers. At no point does the Legislature suggest the requirements of Insurance Code section 10133.66 are identical to those of DMHC Regulation 1300.71.

By failing to respond by letter to paper claims submitted by providers and members within 15 working days, PacifiCare failed to acknowledge and act reasonably promptly with respect to incoming claims. Accordingly, the Commissioner finds PacifiCare violated Insurance Code section 790.03, subdivision (h)(2).

ii. 790.03(h)(3)

PacifiCare suggests it is irresponsible to send paper responses in “today’s paperless age” and an insurer who fails to send a paper acknowledgment letter cannot be liable under the Insurance Code.⁴¹² Nevertheless, there is no evidence that by enacting Insurance Code section 790.03 or section 10133.66, the Legislature intended insurers go paperless.

⁴¹¹ *Cornette v. Department of Transp.*, *supra*, 26 Cal.4th at pp. 73-74; *People v. Gardeley*, *supra*, 14 Cal.4th at pp. 621-622.

⁴¹² PacifiCare’s Brief to OAH, 185:21-187:13; PacifiCare’s Brief to Commissioner, 77:25-78:5.

While much communication today is electronic-based, PacifiCare acknowledged that nearly 50 percent of its claims are filed by “traditional snail-mail communications.”⁴¹³ And while the Legislature recognized the shift towards paperless processing by permitting electronic claim acknowledgment, the statute does not mandate electronic acknowledgement nor does it absolve insurers who fail to properly respond. In essence, by requiring an insurer to respond in the same manner the claim was received, the Legislature required insurers to communicate with claimants in the manner most comfortable for the claimant.

Nor does PacifiCare’s adoption of a telephone or web-based acknowledgment system satisfy the requirements of the Insurance Code. First, the website does not provide the statutorily-required information and is not available to all providers. Second, even assuming the telephone and website included all pertinent information, PacifiCare still owes its providers an affirmative duty to acknowledge paper claims with a letter. By failing to adopt and implement an acknowledgment letter system, PacifiCare violated Insurance Code section 790.03, subdivision (h)(3).

5. Penalty Assessed

a. Willfulness

CDI does not argue these violations were willful and the Commissioner does not find sufficient evidence to demonstrate willfulness as defined in Regulation 2695.2, subdivision (y). Thus, PacifiCare is liable to the state for a civil penalty not to exceed \$5,000 for each act.

⁴¹³ PacifiCare’s Brief to OAH, 185:24; RT 7419:17-24.

b. Single Act or Multiple Violations

PacifiCare argues all 56,463 violations constitute a single act because the failure to send written acknowledgment resulted from “the inadvertent insertion of an ‘N’.”⁴¹⁴ But this argument rests upon a specious reading of Section 790.035 and must be rejected.

Section 790.035, subdivision (a) requires an insurer demonstrate that the “issuance, amendment or servicing of a policy or endorsement is inadvertent.” It does not, as PacifiCare argues, protect insurers who violate the Insurance Code by acting carelessly or recklessly. The evidentiary record established that PacifiCare failed to send written acknowledgment letters for nearly two years and failed to recognize and correct this deficiency. And after PacifiCare became aware of the violations in September 2007, it failed to remedy the situation until March 2008.

Thus, the Commissioner may assess a penalty for each of the 56,463 violations.

c. Regulatory Considerations

In setting the appropriate penalty, the Commissioner considers the relative harm and seriousness of the violations, PacifiCare’s remedial actions, the relative number of violations, and PacifiCare’s misrepresentations in dealing with the issue.

The Commissioner finds this type of violation to be less serious than other types of violations under Section 790.03, subdivision (h). For example, failing to send an acknowledgment letter does not interfere with a member’s medical care nor does it financially burden a provider. But that is not to say that failing to comply with Insurance Code section 10133.66, subdivision (c) is inconsequential. Failing to send required acknowledgement letters may administratively burden claimants. For instance, claimants may be forced to track down whether and when their claims were received by the insurer. And such failures also may make it difficult for claimants to determine whether the insurer paid the appropriate interest on late-paid

⁴¹⁴ PacifiCare’s Brief to OAH, 192:16-18.

claims.⁴¹⁵ Accordingly, the Commissioner concludes a baseline penalty of \$500 per act is sufficient for this type of non-willful violation.

The Commissioner finds PacifiCare's lack of good faith, the volume of violations and failure of PacifiCare's management to take remedial actions are aggravating factors.⁴¹⁶ The Commissioner finds PacifiCare's repeated misrepresentations to be egregious. PacifiCare intentionally concealed relevant information from CDI and deliberately misrepresented its compliance with Insurance Code section 10133.66, subdivision (c).⁴¹⁷ These actions do not reflect "good faith" by PacifiCare. In addition, PacifiCare did not divulge the full scope of its noncompliance until June 2010, during the evidentiary hearing, further demonstrating management's failure to promptly remedy the issue. Lastly, the record established a relatively high number of violations. During the MCE period, PacifiCare failed to send acknowledgment letters for provider paper claims 100 percent of the time. Likewise, PacifiCare failed to issue acknowledgment letters for member's paper claims in 8 out of the 11 MCE-covered months.

In mitigation, the Commissioner credits PacifiCare with eventually complying with Section 10133.66, subdivision (c). In March 2007, PacifiCare began sending member acknowledgment letters, and in March 2008, PacifiCare began sending provider acknowledgment letters.

Based on the above factors, the Commissioner concludes the appropriate penalty for these violations is \$750 per act, which is 15% of the maximum. The Commissioner acknowledges that a penalty of \$750 for each of the 56,463 violations results in a penalty of \$42,347,250; a large amount based on the nature of the violations found.

⁴¹⁵ Exh. 1184, p. 120:11-14.

⁴¹⁶ Cal. Code of Regs., tit. 10, § 2695.12, subds. (a)(7), (a)(11), (a)(13).

⁴¹⁷ See Exh. 1139, p. 9767-9768.

As outlined in Subsection C, *ante*, the Insurance Code does not set forth a minimum penalty for each act, nor does the Insurance Code require the Commissioner to issue a penalty for each violation. In addition, case law supports the Commissioner’s use of discretion in penalizing only a fraction of the violations committed.⁴¹⁸ Given the Commissioner’s penalty-setting discretion, the Commissioner concludes that penalizing PacifiCare for only 10,000 of the more than 56,463 violations is sufficient punishment for PacifiCare’s illegal acts. Fining PacifiCare for less than 10,000 violations does not provide the necessary deterrent effect going forward and does not sufficiently penalize PacifiCare for deliberately concealing its unlawful actions from CDI. By penalizing PacifiCare for 10,000 of the violations, the Commissioner maintains the deterrent effect of the statute while balancing the regulatory considerations and the proportionality of the punishment. Accordingly, the Commissioner concludes the appropriate penalty for this category of violations is \$7,500,000, which is 17.7% of the maximum penalty permitted by the Insurance Code.

I. Failure to Timely Respond to Provider Disputes

1. Applicable Law

Insurance Code section 10123.137 requires that each contract between a health insurer and provider contain provisions requiring a fast, fair, and cost-effective dispute resolution mechanism under which providers may submit disputes to the insurer.⁴¹⁹ In defining a “fast” dispute resolution mechanism, the statute compels the insurer to issue a written determination within 45 working days after the date of receipt of the provider dispute.⁴²⁰

⁴¹⁸ *U.S. v. Mackby*, *supra*, 330 F.3d at p. 1018; *U.S. ex rel. Bunk v. Gosselin World Wide Moving, N.V.*, *supra*, 741 F.3d at p. 407; see also *United States v. Bickel*, *supra*, 2006 WL 1120439, at *3; *Peterson v. Weinberger*, *supra*, 508 F.2d at p. 55.

⁴¹⁹ Ins. Code § 10123.137, subd. (a).

⁴²⁰ Ins. Code § 10123.137, subd. (c).

2. Findings of Fact

The Commissioner finds by a preponderance of the evidence the following facts regarding PacifiCare's alleged failure to timely respond to provider disputes.

In August 2006, PacifiCare saw an influx of provider disputes. For instance, while in July 2006, PacifiCare only received five provider disputes, in August 2006, the insurer received 226 provider complaints. By October 2006, the number of complaints rose to 1,205 per month and by January 2007 PacifiCare was receiving 1,839 provider disputes per month.⁴²¹

On January 30, and February 14, 2007, CDI requested PacifiCare's internal guidelines for processing provider disputes.⁴²² On June 13, 2007, PacifiCare produced copies of its provider dispute resolution procedures.

In November 2007, CDI completed its MCE report. CDI examined 96 provider disputes, and found PacifiCare failed to issue a written determination within the statutory period in 14 instances.⁴²³ PacifiCare ultimately admitted it had received 16,563 provider disputes during the MCE review period, and had failed to timely respond to 1,510 of those disputes.⁴²⁴ Indeed, on several occasions, PacifiCare failed to respond at all to the provider disputes.⁴²⁵ The complaints show that most provider disputes focused on PacifiCare's failure to accurately pay claims.⁴²⁶ In addition, providers reported that when they contacted PacifiCare regarding their disputes, they often received incorrect information from customer service or were simply told to resend their

⁴²¹ Exh. 5046, p. 2229. By April 2007, the number of complaints per month rose to 2,815.

⁴²² Exh. 4, p. 7941; Exh. 5, p. 0706.

⁴²³ Exh. 1, p. 3517.

⁴²⁴ Exh. 118, p. 3418.

⁴²⁵ Exh. 116, pp. 1331-1333.

⁴²⁶ *Id.* at 1331-1340.

dispute.⁴²⁷ PacifiCare admits it responded incorrectly to some complaints and upheld some complaints without researching them.⁴²⁸

In December 2007, PacifiCare stated it implemented a corrective action plan that called for training Lason staff members on the proper routing of provider disputes and promised updated DocDNA policies and procedures. But an April 2008 audit of the provider dispute process established that PacifiCare still failed to issue a timely determination in 25% of the cases.⁴²⁹

PacifiCare's document routing and storage functions are at least partially to blame for PacifiCare's failure to send timely determination letters. For example, in some cases medical records not attached to a specific claim, such as those sent by providers with a dispute, were routed to an "undetermined" queue that was backlogged.⁴³⁰ In other instances, documents, including provider disputes and supporting material, were "locked" in DocDNA and not uploaded to the resolution tracking system (REVA) for processing.⁴³¹

3. Parties' Contentions

CDI contends PacifiCare's failure to issue timely dispute resolution letters violates Insurance Code section 790.03, subdivisions (h)(2) and (h)(3). CDI asserts PacifiCare knowingly committed these acts and that the violations were willful.⁴³² As such, CDI recommends a penalty of \$4,400 per act.⁴³³

PacifiCare contends it has a general business practice of timely responding to provider disputes. While not denying it failed to timely respond to 1,510 provider disputes, PacifiCare

⁴²⁷ Exh. 287, p. 6168; Exh. 5320, p. 8939.

⁴²⁸ Exh. 717, p. 5404.

⁴²⁹ Exh. 741, p. 6731-6732.

⁴³⁰ Exh. 882, p. 7640.

⁴³¹ Exh. 341, p. 3978.

⁴³² CDI's Opening Brief to OAH, 247:18-248:12; CDI's Closing Brief to OAH, 395:2-396:13.

⁴³³ CDI's Opening Brief to OAH, 248:19-250:9; CDI's Opening Brief to Commissioner, 52:24-53:2.

argues its 91% compliance cannot constitute an unfair claims settlement practice.⁴³⁴ In addition, PacifiCare argues CDI must present evidence regarding the nature of provider disputes as well as evidence regarding the average dispute processing time. Lastly, PacifiCare argues its acts were not willful, did not result in actual harm and thus should result in a minimal penalty.⁴³⁵

4. Analysis and Conclusions of Law

a. Number of Violations

PacifiCare concedes that it failed to timely respond to 1,510 provider disputes during the MCE period.⁴³⁶ The Commissioner finds no reason to challenge PacifiCare's own admission.

b. Knowingly Committed or General Business Practice

Regulation 2695.2, subdivision (l) defines "knowingly committed" as "performed with actual, implied or constructive knowledge, including, but not limited to, that which is implied by operation of law." Under this standard, PacifiCare is charged with knowledge of when it receives provider disputes and when and how it responds to those disputes; a conclusion it does not deny. Accordingly, the Commissioner finds PacifiCare knowingly committed the acts charged in this section.

c. Specific UIPA Violations

i. 790.03(h)(2)

Insurance Code section 790.03, subdivision (h)(2) requires an insurer "act reasonably promptly upon communications with respect to claims." PacifiCare urges the Commissioner to ignore the requirements of Insurance Code section 10123.137, subdivision (c) and independently assess what constitutes "reasonably promptly." But the Commissioner is bound by the language

⁴³⁴ PacifiCare's Brief to OAH, 330:1-331:10; PacifiCare's Brief to Commissioner, 79:15-23.

⁴³⁵ PacifiCare's Brief to OAH, 332:9-334:18; PacifiCare's Brief to Commissioner, 80:12-24.

⁴³⁶ Exh. 118, p. 3418.

of Insurance Code section 10123.137, subdivision (c) and thus PacifiCare's request must be denied.

Section 10123.137, subdivision (c) requires an insurer respond to a provider dispute within 45 working days. If the insurer fails to respond within 45 working days, it has failed to promptly respond. Nothing in the statute permits the Commissioner to waive this deadline based upon the nature of the dispute or the insurer's average dispute processing timeline. That said, had PacifiCare demonstrated it responded to these 1,510 disputes on the 46th working day, the Commissioner could certainly consider such evidence in mitigation. But PacifiCare failed to provide such evidence, and instead the facts show that in several instances, the insurer simply ignored the provider's written complaint.

Accordingly, PacifiCare's failure to issue providers a written determination within 45 working days demonstrates a failure to act "reasonably promptly" as required by Insurance Code section 790.03, subdivision (h)(2).

ii. 790.03(h)(3)

Section 790.03, subdivision (h)(3) requires an insurer adopt and implement reasonable standards for the prompt investigation of claims. PacifiCare contends its 91% compliance rate demonstrates it adopted such a standard. Even assuming PacifiCare's true compliance rate equaled 91%, this fact alone does not demonstrate PacifiCare adopted and implemented a reasonable claims processing standard.

First, PacifiCare admits its document routing and storage system failed to adequately account for provider disputes. PacifiCare's vendor misrouted some disputes, and lost required documents, resulting in PacifiCare's inability to comply with the statutory deadline. This fact does not demonstrate PacifiCare adopted and implemented a reasonable document routing

system. Instead, it establishes quite the opposite. Second, neither the Insurance Code nor the FCSP regulations permit an insurer to violate the law some percentage of time with impunity. While PacifiCare may have responded promptly 91% of the time, the record still demonstrates PacifiCare knew it was relying on a flawed document routing system. In fact, an April 2008 audit demonstrated PacifiCare failed to promptly respond to provider complaints 25% of the time. Such evidence is sufficient for the Commissioner to conclude PacifiCare's actions violated Insurance Code section 790.03, subdivision (h)(3).

5. Penalty Assessed

a. Willfulness

PacifiCare again contends CDI must demonstrate the insurer acted "with a specific intent to violate the law" to establish willfulness. As discussed above, PacifiCare's argument is contrary to the definition of "willful." In addition, the evidentiary record demonstrates PacifiCare acted willfully.

Regulation 2695.2, subdivision (y) states "willful" or "willfully" when applied to an act or omission "means simply a purpose or willingness to commit the act, or make the omission referred to in the California Insurance Code or this subchapter. It does not require any intent to violate law, or to injure another, or to acquire any advantage." Since the regulation clearly states "intent" is not required, PacifiCare's argument must be rejected.

Further, the evidentiary record shows PacifiCare knew documents, including provider disputes, were being misrouted or lost in the DocDNA system yet the insurer continued to rely on this system for document routing and storage. Likewise, PacifiCare's delay in establishing quality control mechanisms and redesigning the document routing procedures reflect a willful

failure to adopt reasonable standards related to claims and a willingness to delay its response to providers.

As such, the Commissioner concludes PacifiCare's actions were "willful" as defined by the regulations. Because PacifiCare willfully violated Insurance Code section 790.03, subdivisions (h)(2) and (h)(3), it is liable to the state for a civil penalty not to exceed \$10,000 for each act.

b. Single Act or Multiple Violations

There is no evidence that PacifiCare inadvertently failed to send out timely responses to provider disputes, nor does PacifiCare argue the violations constitute a "single act" under the Insurance Code. Accordingly, the Commissioner may assess a penalty for each of the 1,510 violations.

c. Regulatory Considerations

The Commissioner considers the relative harm and seriousness of the violations, PacifiCare's remedial actions, the relative number of violations, PacifiCare's good faith in addressing the issue and the complexity of the claims in setting the appropriate penalty for these violations.

The Commissioner finds these violations to be moderately serious. While these violations do not result in denial of medical care, they may result in serious financial harm. The timely adjudication of provider disputes is critical to accurate and prompt claims processing. Most provider disputes addressed claims PacifiCare had failed to pay or had incorrectly paid. And many providers waited over nine months to receive even an automatic denial letter. In addition, the time a provider spends repeatedly contacting an insurer in hopes of resolving its dispute is neither "very minimal" as argued by PacifiCare, nor adequately remedied by an interest

payment. In fact, many frustrated providers may simply abandon their valid claims. Likewise, by failing to timely respond to provider disputes, PacifiCare increased CDI's workload, as irritated providers frequently contacted CDI with their complaints. Based on the above, the Commissioner concludes a baseline penalty of \$4,000 per act is sufficient for this type of willful violation.

The Commissioner considers the relative number of non-complying claims to be an aggravating factor.⁴³⁷ During an 11-month period, PacifiCare failed to timely respond to 1,510 disputes. This is a significant number for a small insurer. Likewise, of the 96 complaints CDI examined during the MCE period, PacifiCare failed to timely respond in 14 cases.

In mitigation, PacifiCare demonstrated good faith by voluntarily disclosing the 1,510 violations.⁴³⁸ Similarly, the Commissioner notes that provider complaints are routinely more difficult to resolve, and thus the Commissioner finds the complexity of these disputes to be another mitigating factor. Lastly, the Commissioner gives PacifiCare some credit for its remedial efforts. While evidence demonstrates PacifiCare struggled to comply with the statutory requirements and delayed changes to its DocDNA system, PacifiCare did ultimately take some remedial actions.

Based on the above factors, the Commissioner concludes the appropriate penalty for these violations is \$3,700 per act, which is 37% of the maximum penalty, for a total of \$5,587,000.

⁴³⁷ Cal. Code of Regs., tit. 10, § 2695.12, subd. (a)(7).

⁴³⁸ Cal. Code of Regs., tit. 10, § 2695.12, subd. (a)(12).

J. Illegally Closing/Denying Claims When Requesting Additional Information

1. Applicable Law

As discussed in Section C, *ante*, Insurance Code section 10123.13, subdivision (a) requires every insurer reimburse claims or any portion of any claim, no later than 30 working days after receipt of the claim, unless the claim or portion thereof is contested by the insurer. If a claim is contested, “the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the insurer. The notice that a claim is being contested or denied shall identify the portion of the claim that is contested or denied and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for contesting or denying the claim.” Insurance Code section 10123.147, subdivision (a) contains similar language and similar obligations.

Likewise, Regulation 2695.7, subdivision (d) requires every insurer “conduct and diligently pursue a thorough, fair and objective investigation” and not persist in seeking information not reasonably required for the resolution of a claim.

2. Findings of Fact

The Commissioner finds by a preponderance of the evidence the following facts regarding PacifiCare’s alleged unlawful closing of claim files.

The evidentiary record contains facts regarding 14 separate instances where PacifiCare automatically closed claims files before requesting additional information.⁴³⁹ Two such instances are discussed below.

On December 12, 2005, PacifiCare received a claim from Dr. Jurkowski requesting payment for a member’s annual physical examination.⁴⁴⁰ On December 13, 2005, PacifiCare

⁴³⁹ See Exh. 23, p. 3090; Exh. 24, p. 3086; Exh. 30, p. 1045; Exh. 35, p. 1049; Exh. 40, p. 4014; Exh. 41, p. 9454; Exh. 128, pp. 5095-5098, 5100, 5109, 5123 and 5195.

denied and closed the claim based on the member's pre-existing condition. PacifiCare did not request additional information before closing the claim file, nor did the insurer request a COCC. By closing the claim file, PacifiCare forced Dr. Jurkowski to file an appeal on the claim, which languished at PacifiCare for several years. On February 13, 2007, Dr. Jurkowski filed a complaint with CDI regarding PacifiCare's claims processing policies. On March 8, 2007, 16 months after filing the original claim, PacifiCare paid Dr. Jurkowski's claim. On April 4, 2007, CDI cited PacifiCare for automatically closing Dr. Jurkowski's claim file rather than contesting the claim by requesting additional information.

On April 4, 2006, PacifiCare received a claim from Dr. Anderson requesting payment for services rendered.⁴⁴¹ On April 12, 2006, PacifiCare denied the claim based on the member's pre-existing condition. PacifiCare did not request additional information before it closed the claim file. Instead, PacifiCare forced Dr. Anderson and the insured to appeal the claim. Dr. Anderson and the insured appealed and sent PacifiCare a COCC on June 6, 2006. Despite receiving the required information, PacifiCare did not pay Dr. Anderson until March 20, 2007, one month after he filed a complaint with CDI and nearly a year after he originally filed the claim.

PacifiCare admits its policy is to close or deny a claim when additional information is required, rather than to contest the claim and request additional information.⁴⁴²

3. Parties' Contentions

CDI contends PacifiCare's actions violate Insurance Code section 790.03, subdivision (h)(1) and (h)(3), since they misrepresent pertinent facts regarding coverage. CDI asserts PacifiCare knowingly committed these acts and also admitted to a general business practice of

⁴⁴⁰ Exh. 40, p. 4014.

⁴⁴¹ Exh. 41, pp. 9454-9455.

⁴⁴² PacifiCare's Brief to OAH, 295:24-27; RT 8090:18-8091:11.

closing claims files before adequately investigating the claims.⁴⁴³ Although CDI does not allege the violations were willful, it considers the acts to be moderately serious and requests a penalty of \$2,625 per act.⁴⁴⁴

PacifiCare initially challenges two of the acts herein on the basis of “administrative hearsay,” arguing CDI’s citation letters are insufficient evidence of violations.⁴⁴⁵ In addition, PacifiCare contends it acted within statutory guidelines by closing claim files and did not unreasonably delay claims processing by its actions.⁴⁴⁶

4. Analysis and Conclusions of Law

a. Number of Violations

CDI presented evidence that PacifiCare closed 14 claim files before it requested additional information necessary to process the claims. PacifiCare does not deny the number of instances cited. Accordingly, the Commissioner concludes PacifiCare violated the Insurance Code 14 times.

b. Knowingly Committed or General Business Practice

PacifiCare had actual and constructive knowledge of its practice of prematurely denying or closing claims. In addition, PacifiCare admits it performed these acts pursuant to its business practice of closing or denying claims when requesting additional information.⁴⁴⁷ Thus, the Commissioner concludes these acts were knowingly committed and also performed pursuant to a general business practice.

⁴⁴³ CDI’s Opening Brief to OAH, 254:7-22; CDI’s Opening Brief to Commissioner, 54:14-20.

⁴⁴⁴ CDI’s Opening Brief to OAH, 254:23-255:22.

⁴⁴⁵ PacifiCare’s Brief to OAH, 296:26-297:11.

⁴⁴⁶ PacifiCare’s Brief to OAH, 297:12-298:18.

⁴⁴⁷ RT 8090:18-8091:16.

c. Specific UIPA Violations

PacifiCare argues the two citations issued by CDI cannot serve as evidence in this proceeding, as they constitute “administrative hearsay.” The Commissioner finds this argument lacks merit.

First, CDI citations constitute business records and “records by a public employee” under Evidence Code sections 1271 and 1280, and thus serve as an exception to the hearsay rule. Evidence Code section 1280 states that evidence of a writing made as a record of an act, condition, or event is admissible in any civil proceeding if made within the scope of duty and made at or near the time of the event. In addition, evidence admissible under Evidence Code section 1280 is also admissible under Evidence Code section 1271, the business records exception.⁴⁴⁸ The citations detail CDI’s investigation and were issued after CDI examined each of the complaints. PacifiCare does not challenge the trustworthiness of these citations.

Second, although unnecessary under Evidence Code section 1280, CDI produced at hearing the public employee who investigated both complaints and issued the citations. PacifiCare had an opportunity to cross-examine this employee and dispute the underlying facts. CDI entered the citations into evidence on the third day of hearing providing PacifiCare ample opportunity to challenge both the principal facts and the employee. The employee testified as to the foundation of the citations and explained in detail the investigation process.

Based on Evidence Code sections 1271 and 1280, and CDI’s production of the employee who authored the citations, the Commissioner concludes the citations are admissible and provide adequate support for CDI’s allegations.

⁴⁴⁸ Cal. Law Revision Com. com., West’s Ann. Evid. Code (2014) foll. § 1280.

i. 790.03(h)(1)

Insurance Code section 790.03, subdivision (h)(1) prohibits an insurer from misrepresenting pertinent facts relating to coverage. By denying and closing a claim before adequately investigating the claim or requesting additional information, PacifiCare misrepresented to claimants that the services were not covered. In addition, many of the EOBs and EOPs failed to inform claimants that PacifiCare would reconsider the claims if additional information was provided. And in some instances, PacifiCare misrepresented that claimants had failed to respond to prior requests for information, although no such request had been made.

ii. 790.03(h)(3)

Subdivision (h)(3) requires insurers to adopt and implement reasonable standards for the prompt investigation and processing of claims. PacifiCare admits its practice called for denying and closing claim files, before investigating those claims. PacifiCare routinely closed claims on the basis of a pre-existing condition, where such a condition was either irrelevant or when COCCs had already been provided. This practice of automatically closing claims violates Insurance Code section 790.03, subdivision (h)(3).

5. Penalty Assessed

a. Willfulness

CDI does not argue these violations were willful and the Commissioner does not find sufficient evidence to demonstrate willfulness as defined in Regulation 2695.2, subdivision (y). Thus, PacifiCare is liable to the state for a civil penalty not to exceed \$5,000 for each act.

b. Single Act or Multiple Violations

There is no evidence PacifiCare inadvertently closed these claims, nor does PacifiCare argue the violations constitute a “single act” under the Insurance Code. Accordingly, the Commissioner may assess a penalty for each of the 14 violations.

c. Regulatory Considerations

The Commissioner considers the relative harm and seriousness of the violations, the relative number of violations, and PacifiCare’s good faith in setting the appropriate penalty.

The Commissioner finds this type of violation to be moderately serious, as accurate claim processing is the bedrock of the UIPA and the FCSP regulations. But the Commissioner considers these violations to be less serious than those instances where PacifiCare failed to disclose appeal rights or failed to timely pay claims. As such, the Commissioner concludes the nature of the non-willful violation supports a baseline penalty of \$2,500 per act.

In aggravation, the Commissioner finds PacifiCare’s practice of closing claim files before requesting relevant information harmed providers and members. PacifiCare’s practice also resulted in administrative frustration and unnecessarily delayed provider payments by as much as 16 months.

The Commissioner finds PacifiCare’s remediation efforts to be both an aggravating and mitigating factor. While PacifiCare ultimately paid the prematurely closed claims, that payment came only after CDI involvement and years after the claims were filed. In mitigation, the Commissioner finds the relative number of violations to be minimal and finds little harm to the general public.

Based on the above factors, the Commissioner concludes the appropriate penalty for these 14 violations is \$2,500 per non-willful act, which is 50% of the maximum penalty, for a total of \$35,000.

K. Sending Untimely Collection Notices on Overpaid Amounts

1. Applicable Law

Insurance Code section 10133.66, subdivision (b) restricts an insurer's ability to demand reimbursement for overpaid claims:

Reimbursement requests for the overpayment of a claim shall not be made, including requests made pursuant to Section 10123.145, unless a written request for reimbursement is sent to the provider within 365 days of the date of payment on the overpaid claim. The written notice shall clearly identify the claim, the name of the patient, and the date of service, and shall include a clear explanation of the basis upon which it is believed the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

An insurer who fails to meet these conditions may not seek reimbursement on overpaid claims absent some showing of fraud.

2. Findings of Fact

The Commissioner finds by a preponderance of the evidence the following facts regarding PacifiCare's alleged untimely collection notices.

In May 2007, United assigned PacifiCare's collection functions to United's Audit Recovery Operations department.⁴⁴⁹ In January 2008, United assigned several thousand PacifiCare PPO "historical claims" to United's debt recovery vendor, Johnson & Rountree Premium (J&R).⁴⁵⁰ Many of these claims had been initially paid in 2005 and 2006, with some dating as far back as January 2004.⁴⁵¹

⁴⁴⁹ RT 6608:5-10.

⁴⁵⁰ Exh. 592, p. 0713.

⁴⁵¹ Exh. 584.

On January 4, 2008, J&R issued demand letters seeking reimbursement from providers on allegedly overpaid claims.⁴⁵² J&R designated each of these letters as “Second Request” letters, and asserted PacifiCare had previously requested but not received reimbursement from the provider.⁴⁵³ The letters further warned providers: “[i]f a response is not received, PacifiCare may offset future payments by the refund amount requested.”⁴⁵⁴ United did not verify that the “first request” letters were sent before it instructed J&R to issue second request letters.⁴⁵⁵

On April 18, 2008, CMA forwarded to PacifiCare a complaint from Dr. Mazer, who received “Second Request” letter from J&R on April 8, 2008. The letter to Dr. Mazer requested repayment of \$49.13 on a claim that was initially paid by PacifiCare on October 18, 2005.⁴⁵⁶ In addition to being untimely, Dr. Mazer testified he never received a first request. In fact, Dr. Mazer’s office had previously contacted PacifiCare in October 2005 to inform the insurer they believed the claim to be overpaid. At that time, PacifiCare promised to reprocess the claim, but never did.⁴⁵⁷ PacifiCare investigated Dr. Mazer’s claim and was unable to produce a first request letter. As a result, PacifiCare withdrew its reimbursement request.⁴⁵⁸

On May 28, 2008, CMA forwarded another complaint to PacifiCare; this time from Dr. Chiu. In early 2007, Dr. Chiu received a repayment request from PacifiCare on a claim initially paid on January 22, 2007.⁴⁵⁹ Dr. Chiu promptly repaid PacifiCare the overpaid amount and produced evidence that PacifiCare cashed his check on April 17, 2007. Despite having repaid PacifiCare, Dr. Chiu received a letter from J&R asking for repayment.

⁴⁵² Exh. 319, p. 2.

⁴⁵³ RT 2972:6-12.

⁴⁵⁴ Exh. 331, p. 1003.

⁴⁵⁵ RT 6721:18-6722:13.

⁴⁵⁶ *Ibid.*

⁴⁵⁷ Exh. 331, p. 1005.

⁴⁵⁸ Exh. 592, p. 0715.

⁴⁵⁹ *Ibid.*

On June 19, 2008, PacifiCare informed CDI it was auditing PacifiCare’s “historical claims” to verify that a timely first request letter had been sent.⁴⁶⁰ On June 30, 2008, PacifiCare determined 2,912 reimbursement requests were “invalid” and needed to be canceled.⁴⁶¹ Based on this admission, CDI initially charged PacifiCare with 2,912 violations of the Insurance Code.⁴⁶²

In May 2010, during the evidentiary hearing, PacifiCare began searching for additional first request letters. As a result of the new search, PacifiCare admitted there were 1,934 claims for which PacifiCare either was unable to find a first request letter or had sent an untimely first request letter.⁴⁶³ PacifiCare also claimed it located 1,846 timely sent first request letters. But PacifiCare’s data is unreliable. In fact, the data reflect that a number of these first request letters were sent the very same day PacifiCare paid the claim or sent *before* the claim was initially paid.⁴⁶⁴ It seems unlikely that PacifiCare would issue overpayment letters the day it paid the claim. In fact, PacifiCare could not explain these discrepancies.

In September 2010, PacifiCare produced approximately 3,200 pages of documents that purported to be copies of the first request letters PacifiCare located in May 2010. But these letters also raised concerns. For example, 592 of the letters failed to include the required claim number, and 584 of the letters failed to include the required date of service.⁴⁶⁵ Likewise, many of the letters failed to include the referenced “attachment,” failed to provide the patient’s name or failed to explain the basis upon which the request was made.⁴⁶⁶

In February 2011, PacifiCare produced several hundred documents purporting to be the missing attachments from its September 2010 production. These documents also included

⁴⁶⁰ *Ibid.*

⁴⁶¹ Exh. 590, p. 4553.

⁴⁶² Exh. 290, pp. 34-35.

⁴⁶³ Exh. 5392, p. 1645.

⁴⁶⁴ Exh. 840, p. 1, lines 3-9, 10-52.

⁴⁶⁵ Exh. 842; Exh. 843.

⁴⁶⁶ Exh. 841, p. 8627; Exh. 845; Exh. 847.

inconsistencies. For example, some letters had different account numbers than the attached documents and were dated well before or well after the date of the corresponding letters.⁴⁶⁷

Between 2006 and 2008, PacifiCare unlawfully collected over \$190,000 from untimely issued overpayment letters.⁴⁶⁸ In one instance, PacifiCare unlawfully requested and received reimbursement in the amount of \$106,076 from a provider.⁴⁶⁹ PacifiCare admits it did not return the illegally collected funds to its providers.⁴⁷⁰

3. Parties' Contentions

CDI contends PacifiCare issued 1,934 untimely collection notices to providers in violation of Insurance Code section 10133.66, subdivision (b) and that such conduct also violates Insurance Code section 790.03, subdivisions (h)(1) and (h)(3). CDI further alleges PacifiCare knowingly committed these acts and that the violations were willful.⁴⁷¹ As such, CDI recommends a penalty of \$4,200 per violation.⁴⁷²

PacifiCare contends the issuance of untimely collection notices does not violate Insurance Code section 790.03, subdivision (h). PacifiCare also argues its conduct was not willful and did not result in any actual harm to providers.⁴⁷³ Lastly, PacifiCare contends that 223 of the violations pertain to Medicare claims, which permit a longer collection timeframe, and that its conduct constitutes only a single act.⁴⁷⁴

⁴⁶⁷ Exh. 1002; Exh. 1008; Exh. 1009.

⁴⁶⁸ Exh. 839.

⁴⁶⁹ Exh. 839, p. 2, line 106.

⁴⁷⁰ RT 12697:23-12698:11.

⁴⁷¹ CDI's Opening Brief to OAH, 269:16-270:10; CDI's Opening Brief to Commissioner, 56:27-57:9.

⁴⁷² CDI's Opening Brief to OAH, 270:16-272:5; CDI's Opening Brief to Commissioner, 57:10-15.

⁴⁷³ PacifiCare's Brief to OAH, 293:6-294:4; PacifiCare's Brief to Commissioner, 85:8-11.

⁴⁷⁴ PacifiCare's Brief to OAH, 287:22-24; 291:1-12.

4. Analysis and Conclusions of Law

a. Number of Violations

In May 2010, PacifiCare admitted it issued 1,934 untimely overpayment collection letters.⁴⁷⁵ While PacifiCare now claims that number must be reduced by 223, the Commissioner finds no support for this argument.

PacifiCare states that “223 letters relate to recoveries sought in connection with Medicare claims, for which PacifiCare is allowed two years to initiate recovery efforts.”⁴⁷⁶ In support of this argument, PacifiCare cites the testimony of Brian Bugiel, PacifiCare’s designated person most knowledgeable about the J&R overpayment issues. But PacifiCare misinterprets Mr. Bugiel’s testimony. Mr. Bugiel testified that “Medicare’s timely filing guidelines allow providers to bill Medicare, I believe, up to two years for claims or for services provided.”⁴⁷⁷ He did not testify that insurers have two years to seek reimbursement for overpaid Medicare claims. Indeed, a provider’s Medicare billing rights have no bearing on the allegations herein. Lastly, PacifiCare fails to cite any statutory or regulatory support for its contention that it may collect Medicare overpayments two years after initial payment.

Based on the above discussion and PacifiCare’s own admission, the Commissioner concludes PacifiCare issued 1,934 untimely collection notices.

b. Knowingly Committed or General Business Practice

PacifiCare had actual and constructive knowledge of its practice of sending out untimely collection notices. In fact, PacifiCare does not deny that it knew, or should have known, whether it had timely sent first notice overpayment demand letters. Nor does PacifiCare challenge CDI’s assertion that it knew or should have known that thousands of the supposed second notice letters

⁴⁷⁵ Exh. 5392, p. 1645.

⁴⁷⁶ PacifiCare’s Brief to OAH, 287:22-24.

⁴⁷⁷ RT 12729:3-24.

were untimely sent. In addition, the issuance of 1,934 untimely overpayment letters during a five month period is sufficient to establish a general business practice.

Thus, the Commissioner concludes these acts were knowingly committed and also performed pursuant to a general business practice.

c. Specific UIPA Violations

i. 790.03(h)(1)

An insurer who misrepresents pertinent facts to claimants violates Insurance Code section 790.03, subdivision (h)(1). PacifiCare contends it did not misrepresent pertinent facts to its providers because its collection notices correctly represented that PacifiCare had overpaid a claim.⁴⁷⁸ The Commissioner finds this argument unpersuasive.

PacifiCare's untimely demand for reimbursement incorrectly represents to claimants that PacifiCare has the right to collect additional funds. While it may be true that PacifiCare initially overpaid the claim, PacifiCare has no right to seek reimbursement for overpayments unless a request is made within 365 days of the initial payment. Any demand made 365 days after the initial payment misrepresents the claimant's obligation to PacifiCare and violates Section 790.03, subdivision (h)(1).

ii. 790.03(h)(3)

An insurer who fails to adopt and implement reasonable standards for the prompt investigation and processing of claims violates Insurance Code section 790.03, subdivision (h)(3). PacifiCare argues that because it had written policies for collecting overpayments, its conduct does not violate subdivision (h)(3). The Commissioner finds no merit to this argument.

Subdivision (h)(3) requires more than the simple adoption of a reasonable written policy. An insurer must implement reasonable investigation and processing standards. The evidentiary

⁴⁷⁸ PacifiCare's Brief to OAH, 289:1-2.

record establishes that PacifiCare failed to adopt and implement reasonable standards under this provision. While the Insurance Code requires an insurer send a written demand for reimbursement within 365 days of the initial claim payment, PacifiCare admits it did not verify the timeliness of its reimbursement requests.⁴⁷⁹ And while Section 10133.66 mandates that the demand letters include the date of service, the claim number and other pertinent information, PacifiCare's letters failed to include the required information. This lapse further demonstrates PacifiCare failed to adopt and implement reasonable standards for the processing of these claims.

Accordingly, the Commissioner concludes PacifiCare violated Insurance Code section 790.03, subdivision (h)(3).

5. Penalty Assessed

a. Willfulness

The evidentiary record establishes PacifiCare failed to adopt and implement proper controls when it outsourced overpayment recoveries to J&R. This failure resulted in untimely overpayment letters. PacifiCare admitted that both the insurer and its vendor failed to verify that timely first notice letters were sent. This failure reflects a willful refusal to adopt and implement reasonable standards for the prompt investigation and processing of claims. While PacifiCare may not have intended to violate the law, Regulation 2695.2, subdivision (y) makes clear that such intent is unnecessary to find willfulness. Thus, PacifiCare is liable to the state for a civil penalty not to exceed \$10,000 for each act.

⁴⁷⁹ RT 6721:18-6722:13.

b. Single Act or Multiple Violations

PacifiCare argues the Commissioner should combine all 1,934 violations into a single act, arguing that regardless of the number of violations, its actions constitute a single unfair practice.⁴⁸⁰ This argument lacks any statutory or regulatory support.

First, Regulation 2695.1, subdivision (a)(1) makes clear that a single knowingly committed act, not a single knowing practice, violates Insurance Code section 790.03, subdivision (h). If the Commissioner accepted PacifiCare's interpretation, all violations of section 790.03, subdivision (h) would be punishable by only a single penalty; an absurd result. For example, if the Commissioner adopted PacifiCare's argument, an insurer who purposefully fails to pay 100 percent of its claims would be charged with only a single \$5,000 or \$10,000 penalty. There is simply no evidence to support such a result.

Second, PacifiCare's argument is in direct conflict with Insurance Code section 790.035. Section 790.035 authorizes penalties of up to \$10,000 *for each act*. Likewise subdivision (a) of that section provides that "when the issuance, amendment or servicing of a policy or endorsement is inadvertent, all of those acts shall be a single act for the purpose of this section." If, as PacifiCare argues, only one penalty may be assessed per unfair practice, Section 790.035's language would be meaningless.

Lastly, there is no evidence PacifiCare inadvertently issued collection notices. In fact, the record clearly establishes that PacifiCare willingly and intentionally issued those notices. Based on the above analysis, the Commissioner may assess a penalty for each of the 1,934 violations.

⁴⁸⁰ PacifiCare's Brief to OAH, 291:1-11.

c. Regulatory Considerations

In assessing an appropriate penalty for these violations, the Commissioner considers the seriousness and harm caused by PacifiCare's actions, PacifiCare's attempts to remediate the issue and any good faith attempts to comply with the statute.

The Commissioner finds this type of violation to be moderately serious in nature. While PacifiCare's actions did not result in a denial of medical care, its actions resulted in a significant administrative burden to providers. Dr. Mazer expressed his frustration in "having to make phone calls, write and send letters, and retrieve years-old claims."⁴⁸¹ And certainly "nobody wants to get a collection notice."⁴⁸² As such, the Commissioner concludes the nature of this willful violation supports a baseline penalty of \$3,000 per act.

As an additional aggravating factor, PacifiCare failed to make a good faith attempt to comply with the statute before issuing the untimely collection notices. PacifiCare did not confirm the issuance of first notices, nor did PacifiCare ensure the second letters were timely sent. Similarly, while PacifiCare acknowledged it collected over \$190,000 in unlawful reimbursements, PacifiCare made no attempt to return this money to providers. This fact demonstrates both bad faith and a failure to remediate the violations.

In mitigation, the Commissioner credits PacifiCare with cancelling its overpayment requests when it could not locate a first request letter. While this action came after CMA and CDI complaints, PacifiCare did act quickly.

Based on the above factors, the Commissioner concludes the appropriate penalty for these 1,934 violations is \$3,500 per act, which is 35% of the maximum penalty, for a total of \$6,769,000.

⁴⁸¹ RT 3051:12-23.

⁴⁸² RT 2980:24-25.

L. Failure to Maintain Complete Claim Files

1. Applicable Law

The Insurance Code and the FCSP regulations express strict guidelines regarding the maintenance of claim files. For example, Regulation 2695.3, subdivision (a) permits the Commissioner to examine every licensee's claim files and requires those files contain "all documents, notes and work papers (including copies of all correspondence) which reasonably pertain to each claim in such detail that the pertinent events and the dates of the events can be reconstructed and the licensee's actions pertaining to the claim can be determined."

Subdivision (b) specifies three additional requirements for insurers — that they:

- (1) maintain claim data that are accessible, legible and retrievable for examination so that an insurer shall be able to provide the claim number, line of coverage, date of loss and date of payment of the claim, date of acceptance, denial or date closed without payment. This data must be available for all open and closed files for the current year and the four preceding years
- (2) record in the file the date the licensee received, date(s) the licensee processed and date the licensee transmitted or mailed every material and relevant document in the file; and
- (3) maintain hard copy files or maintain claim files that are accessible, legible and capable of duplication to hard copy; files shall be maintained for the current year and the preceding four years.

An insurer who does not maintain all documents and data pertaining to each claim violates this regulation.

2. Findings of Fact

The Commissioner finds by a preponderance of evidence the following facts regarding PacifiCare's alleged failure to maintain complete claim files.

In March 2006, CDI received a complaint from Ms. W, as described in Section A, *ante*.⁴⁸³ Specifically, in January 2006, Ms. W repeatedly sent PacifiCare copies of her COCC. Each time Ms. W faxed this document, she received a transmittal indicating PacifiCare received the document.⁴⁸⁴ But PacifiCare failed to record receipt of her COCC until the document had been sent and received on four separate occasions.⁴⁸⁵

On November 20, 2006, CDI received a member complaint which alleged PacifiCare wrongly denied a claim.⁴⁸⁶ CDI investigated the complaint and requested, on three separate occasions, a complete copy of the claimant's file. While PacifiCare provided some information, it did not provide the complete claim file. CDI noted that several letters from PacifiCare to the member were missing from the claim file. Those letters had been previously provided to CDI by the member. As a result, on January 24, 2007, CDI cited PacifiCare for violating Regulation 2695.3. PacifiCare did not respond to the citation.

On December 16, 2006, CDI received and investigated another wrongful denial complaint against PacifiCare.⁴⁸⁷ CDI twice requested a complete copy of the claim file. PacifiCare's produced some documents but omitted a number of letters from PacifiCare to the claimant. Those letters had been previously provided to CDI by the claimant. Consequently, on February 7, 2007, CDI cited PacifiCare. PacifiCare did not respond to the citation.

On February 7, 2007, CDI received a provider complaint against PacifiCare. CDI investigated the complaint and found that PacifiCare failed to record the date it received

⁴⁸³ Exh. 128.

⁴⁸⁴ Exh. 128, pp. 5107-5108.

⁴⁸⁵ RT 1025:11-1027:10.

⁴⁸⁶ Exh. 180, p. 3519.

⁴⁸⁷ Exh. 141, pp. 9705-9706.

correspondence from the provider.⁴⁸⁸ Accordingly, on March 30, 2007, CDI cited PacifiCare for violating Regulation 2695.3. Again, PacifiCare failed to respond to the citation.

On August 31, 2007, CDI received another complaint against PacifiCare. During the investigation of the complaint, PacifiCare admitted it could not locate the claim file or produce a copy of the correspondence dated October 2006.⁴⁸⁹ As a result, CDI cited PacifiCare for failing to maintain the claim file. PacifiCare did not respond to the citation.

On September 10, 2007, CDI received yet another complaint against PacifiCare for improper claims handling. CDI investigated and found that PacifiCare failed to record the date it received the member's COCC.⁴⁹⁰ Accordingly, CDI issued PacifiCare another citation.

In November 2007, CDI issued its MCE report. The MCE report found 29 total acts in violation of Regulation 2695.3, subdivisions (a) and (b). Specifically, CDI found 15 instances where PacifiCare failed to maintain all documents, notes and work papers in the claim file.⁴⁹¹ In addition, CDI found 14 cases where PacifiCare failed to maintain hard copy files or claim files that are accessible, legible and capable of duplication to hard copy for five years.⁴⁹² In response, PacifiCare admitted that in five instances it failed to maintain all documents in the claim file. Similarly, PacifiCare admitted to three instances where it failed to maintain hard copies of documents. In total, PacifiCare admitted to eight violations.⁴⁹³

On November 29, 2007, CDI received and investigated another complaint against PacifiCare. CDI established that PacifiCare failed to record the date it received a claim for

⁴⁸⁸ Exh. 38, p. 4086.

⁴⁸⁹ Exh. 85, p. 4453.

⁴⁹⁰ Exh. 79, p. 6318.

⁴⁹¹ Exh. 1, p. 3537.

⁴⁹² *Id.* at p. 3538.

⁴⁹³ *Id.* at p. 3537.

medical benefits.⁴⁹⁴ As a result, CDI cited PacifiCare for this violation. PacifiCare did not respond to the citation.

On January 25, 2008, CDI issued an Order to Show Cause in this matter. The Order to Show Cause alleged 29 instances where PacifiCare failed to maintain complete claim files based on CDI's MCE report.⁴⁹⁵ On January 20, 2010, CDI issued its First Supplemental Accusation to its Order to Show Cause. The First Supplemental Accusation alleged six additional violations of Regulation 2695.3, subdivisions (a) and (b), based on the six citations described above.⁴⁹⁶ On May 19, 2010, CDI issued its Second Supplemental Accusation. The Second Supplemental Accusation alleged one additional violation based on Ms. W's testimony.⁴⁹⁷

On January 9, 2012, CDI issued its First Amended Order to Show Cause. The Amended Order to Show Cause reduced the initial 29 alleged violations to 15 total instances where PacifiCare failed to maintain complete claim files; eight instances admitted to during the MCE, six instances from the citations and one instance from Ms. W's complaint.

3. Parties' Contentions

CDI contends PacifiCare knowingly failed to maintain complete claim files in 15 instances, in violation of Insurance Code section 790.03, subdivisions (h)(2) and (h)(3). CDI also contends PacifiCare misplaced 1,846 overpayment letters in 2008 or 2009, and that such facts should be taken into consideration in assessing the penalty. Based on the amount of harm, CDI recommends a per act penalty of \$425.⁴⁹⁸

⁴⁹⁴ Exh. 57.

⁴⁹⁵ Exh. 1, p. 3481, ¶¶ 7 & 8.

⁴⁹⁶ Exh. 290, ¶¶ 10, 28, 51, 57, 77 & 92.

⁴⁹⁷ Exh. 597, ¶¶ 12-14.

⁴⁹⁸ CDI's Opening Brief to OAH, 275:10-277:13; CDI's Opening Brief to Commissioner, 58:13-59:6.

PacifiCare initially contends CDI did not raise 14 of the allegations until after the close of evidence, and thereby deprived PacifiCare of the opportunity to rebut the evidence presented.⁴⁹⁹ PacifiCare also alleges CDI's citations constitute "administrative hearsay" and are insufficient proof in this instance.⁵⁰⁰ Lastly, PacifiCare argues the violations were not knowingly committed, not willful and resulted in minimal harm.⁵⁰¹

4. Analysis and Conclusions of Law

PacifiCare states that with one exception, "CDI did not assert these allegations until it filed its Fourth Supplemental Accusation on October 25, 2011 – after the close of evidence and nearly four years after CDI filed its Order to Show Cause."⁵⁰² But PacifiCare is simply wrong. The record demonstrates CDI initially raised these violations in 2008.

In January 2008, CDI issued its original Order to Show Cause. The Order to Show Cause alleged 29 violations for failing to maintain complete claim files. These 29 allegations mirror those found in CDI's MCE report and were introduced well before the beginning of the evidentiary hearing.⁵⁰³ In fact, PacifiCare knew the facts underlying these allegations as early as November 2007, when it received the MCE report.

In January 2010, CDI issued its First Supplemental Accusation. The First Supplemental Accusation included six additional allegations regarding PacifiCare's failure to maintain complete claim files.⁵⁰⁴ Those six allegations pertained to CDI citations issued in 2007 and 2008. Again, CDI raised these allegations long before the close of evidence and provided PacifiCare ample opportunity to respond.

⁴⁹⁹ PacifiCare's Brief to OAH, 299:17-26; 300:22-301:5; PacifiCare's Brief to Commissioner, 85:17-22.

⁵⁰⁰ PacifiCare's Brief to OAH, 301:7-302:11; PacifiCare's Brief to Commissioner, 85:23-86:7.

⁵⁰¹ PacifiCare's Brief to OAH, 303:22-306:21; PacifiCare's Brief to Commissioner, 86:26-87:14.

⁵⁰² PacifiCare's Brief to Commissioner, 85:18-20.

⁵⁰³ Exh. 1, p. 3481, ¶¶ 7 & 8.

⁵⁰⁴ Exh. 290, ¶¶ 10, 28, 51, 57, 77 & 92.

Curiously, the one allegation PacifiCare contends is timely raised was the last allegation to be included in a formal Accusation. While PacifiCare contends the allegation regarding Ms. W was timely filed, that accusation was not included in CDI's Order to Show Cause until May 19, 2010; two and a half years after the first 29 allegations. Based on the evidence in the record, PacifiCare's argument is simply erroneous.

a. Number of Violations

While CDI found dozens of instances where PacifiCare failed to maintain complete case files, CDI alleges only 15 violations of the Insurance Code. PacifiCare admitted to eight violations. As to the remaining seven allegations, PacifiCare contends CDI's evidence is insufficient to demonstrate a violation of the Insurance Code.

Six of the violations concern CDI citations issued in 2007 and 2008. As in Section J, *ante*, PacifiCare argues the citations cannot serve as evidence in this proceeding. The Commissioner again finds this argument lacks merit. First, CDI citations constitute business records and "records by a public employee" under Evidence Code sections 1271 and 1280, and thus serve as an exception to the hearsay rule. Second, the citations clearly explain the basis for the complaint and were issued as part of CDI's investigation. Lastly, the citations provide PacifiCare with sufficient detail to present a defense. PacifiCare's failure to defend against these letters, both when they were issued and at the evidentiary hearing, do not render the letters insufficient.

PacifiCare also challenges Ms. W's testimony as "weak" and "insufficient to support a UIPA violation."⁵⁰⁵ But Ms. W's testimony was consistent with her complaints and confirmed by documentary evidence. Ms. W testified as to the exact dates and times she telephoned PacifiCare and provided both the name of the PacifiCare representatives she spoke with and the reference

⁵⁰⁵ PacifiCare's Brief to OAH, 302:5-11.

number PacifiCare provided her. This testimony went unchallenged by PacifiCare. Ms. W also provided transmittals establishing PacifiCare received her COCCs, yet in each instance PacifiCare failed to record receipt as required by Regulation 2695.3. The Commissioner concludes such unopposed evidence is sufficient to establish a violation of the Insurance Code.

Accordingly, based on PacifiCare's own admissions and CDI's citations, the Commissioner concludes there is sufficient evidence to find 15 violations of the Insurance Code.

b. Knowingly Committed or General Business Practice

PacifiCare is charged with constructive knowledge of its own business practices and claims handling procedures. In addition, PacifiCare is charged with constructive knowledge of the contents of its own claim files. Thus, PacifiCare's failure to maintain its claim files is knowingly committed act, as that term is defined in Regulation 2695.2, subdivision (1).

c. Specific UIPA Violations

i. 790.03(h)(2)

Subsection (h)(2) requires an insurer to acknowledge and act reasonably promptly regarding claims communications. When an insurer fails to maintain a complete record of all communications, the insurer is prevented from acknowledging and acting reasonably promptly upon communications with respect to claims. As such, PacifiCare's failure to record and maintain complete claim files violates Insurance Code section 790.03, subdivision (h)(2).

ii. 790.03(h)(3)

An insurer violates Section 790.03, subdivision (h)(3) by failing to adopt and implement reasonable standards for the prompt investigation and processing of claims. While PacifiCare argues this allegation is "totally speculative," the evidentiary record demonstrates otherwise. As Ms. W testified, claimants repeatedly sent documents to PacifiCare only to have those

documents go missing. Such evidence establishes PacifiCare failed to implement reasonable records maintenance standards.

5. Penalty Assessed

a. Willfulness

CDI does not argue these violations were willful and the Commissioner does not find sufficient evidence to demonstrate willfulness as defined in Regulation 2695.2, subdivision (y). Thus, PacifiCare is liable to the state for a civil penalty not to exceed \$5,000 for each act.

b. Single Act or Multiple Violations

There is no evidence PacifiCare inadvertently omitted pertinent correspondence and data from the claim files, nor does PacifiCare argue the violations constitute a “single act” under the Insurance Code. Accordingly, the Commissioner may assess a penalty for each of the 15 violations.

c. Regulatory Considerations

In assessing an appropriate penalty for this type of violation, the Commissioner considers the seriousness of the violation, any harm to claimants, PacifiCare’s remedial actions and any good faith on the insurer’s part.⁵⁰⁶

The Commissioner considers this type of violation to be less serious than some of the others already discussed herein. It is unlikely this type of violation will result in denial of medical care or extreme financial hardship to a claimant. Thus, the nature of this non-willful violation supports a baseline penalty of \$500 per act.

In aggravation, PacifiCare’s failure to maintain claim files resulted in some harm to members. For example, Ms. W testified as to the increased administrative burdens claimants face when they are forced to re-submit information multiple times.

⁵⁰⁶ The Commissioner will not consider any uncharged allegations in determining the appropriate penalty.

The record is silent as to PacifiCare's remedial attempts. PacifiCare's MCE indicated some training took place in October 2007, but the Commissioner finds there is insufficient evidence in the record to support this claim. As such, this element serves as neither an aggravating or mitigation factor. Similarly, there is no evidence regarding PacifiCare's good faith attempt to comply with the regulation. Thus, this factor is neither aggravating nor mitigating. Lastly, there is no evidence of extraordinary circumstances and no evidence that the claims at issue were complex. The Commissioner considers in mitigation the relative low number of violations in the category.

Based on the above factors, the Commissioner concludes the appropriate penalty for these 15 violations is \$350 per act, which is 7% of the maximum penalty, for a total of \$5,250.

M. Failing to Timely Respond to CDI Inquiries

1. Applicable Law

Regulation 2695.5 requires insurers to promptly respond to CDI inquiries. Upon receiving any written or oral inquiry from the Department of Insurance concerning a claim,

every licensee shall immediately, but in no event more than twenty-one (21) calendar days of receipt of that inquiry, furnish the Department of Insurance with a complete written response based on the facts as then known by the licensee. A complete written response addresses all issues raised by the Department of Insurance in its inquiry and includes copies of any documentation and claim files requested. This section is not intended to permit delay in responding to inquiries by Department personnel conducting a scheduled examination on the insurer's premises.

2. Findings of Fact

The Commissioner finds by a preponderance of evidence the following facts regarding PacifiCare's alleged failure to respond to CDI inquiries.

On January 2, 2007, CDI requested a complete response regarding the status of a claim at issue. PacifiCare failed to respond within 21 calendar days, failed to provide the complete claim file, and failed to provide a complete response.⁵⁰⁷

On January 25, 2007, CDI again requested a complete response regarding a provider's complaint. PacifiCare failed to respond within 21 calendar days, failed to provide the complete underwriting file, and failed to provide a complete response.⁵⁰⁸

On January 26, 2007, while investigating yet another complaint, CDI requested a complete response regarding a claim at issue. PacifiCare provided a complete response, but the response was not issued within 21 calendar days as required by the regulation.⁵⁰⁹

On February 7, 2007, during the investigation of a member complaint, CDI again requested a complete response regarding a claim at issue. PacifiCare provided a complete response to this complaint on March 16, 2007, more than 21 calendar days after CDI's inquiry.⁵¹⁰

On February 28, 2007, CDI requested PacifiCare provide a complete response regarding a claim at issue. PacifiCare's response did not provide a complete copy of the claim file as the response omitted copies of the EOBs.⁵¹¹

On March 2, 2007, CDI requested a complete response regarding another claim at issue. PacifiCare's response failed to include the actual bill submitted as well as other relevant claim information.⁵¹²

⁵⁰⁷ Exh. 141.

⁵⁰⁸ Exh. 188.

⁵⁰⁹ Exh. 185.

⁵¹⁰ Exh. 190.

⁵¹¹ Exh. 41.

⁵¹² Exh. 38.

On March 7, 2007, CDI requested a complete response regarding a claim at issue. On April 12, 2007, PacifiCare responded to CDI's inquiry. This response was not received within 21 calendar days as required by the regulation.⁵¹³

In addition to the above described inquiries, on 22 additional occasions CDI requested, but failed to receive, a complete and timely response from PacifiCare regarding its claim files.⁵¹⁴ In each of the 29 total instances, CDI cited PacifiCare and detailed the circumstances surrounding the both the complaint and the citation. Each of these citations is included in the evidentiary record. In addition, in December 2007, PacifiCare admitted that on one occasion, it did not provide a timely response to CDI's inquiry.⁵¹⁵

PacifiCare blames the dramatic increase in provider and member complaints for its failure to comply with Regulation 2695.5. In mid-2006, PacifiCare averaged 75-80 CDI inquiries per month. By February 2007, the number of inquiries jumped to 220 per month.⁵¹⁶ Internal PacifiCare documents blame United's takeover of "PacifiCare Claims shop, Customer Service, Membership Accounting, and the mail room — all of which generated large numbers of DOI complaints and still do."⁵¹⁷ In addition, PacifiCare admitted that case research on CDI inquiries was "not beginning until day 10-20 after day of receipt" of the inquiry.⁵¹⁸

3. Parties' Contentions

CDI alleges PacifiCare failed to provide a timely and complete response to CDI inquiries on at least 29 occasions in violation of Insurance Code section 790.03, subdivision (h)(2). CDI

⁵¹³ Exh. 201.

⁵¹⁴ See Exhs. 69, 83, 92, 133, 166, 169, 171, 180-182, 184, 184 and 223.

⁵¹⁵ Exh. 1, p. 3539.

⁵¹⁶ Exh. 670, p. 0435.

⁵¹⁷ *Id.* at p. 0432.

⁵¹⁸ Exh. 671, p. 1546.

does not contend PacifiCare willfully violated the Insurance Code, nor does CDI contend these violations are serious in nature.⁵¹⁹ As such, CDI recommends a per act penalty of \$450.

PacifiCare repeats its administrative hearsay argument and contends the citations cannot serve as evidence in this proceeding.⁵²⁰ PacifiCare also argues CDI must prove PacifiCare received the citations before a penalty may issue.⁵²¹ Lastly, PacifiCare contends its alleged 96% compliance rate demonstrates compliance with Regulation 2695.5 and the Insurance Code, and thus no penalty should issue.⁵²²

4. Analysis and Conclusions of Law

a. Number of Violations

The evidentiary record establishes that on at least 29 occasions, PacifiCare failed to provide CDI with a complete and timely response as required by Regulation 2695.5, subdivision (a). CDI provided the citations, and the details supporting those citations, during the evidentiary hearing and PacifiCare did not refute those findings. In fact, PacifiCare admitted to failing to respond on at least one occasion.

As in Sections J and L, *ante*, PacifiCare argues the citations cannot serve as evidence in this proceeding. The Commissioner again finds this argument lacks merit. First, CDI citations constitute business records and “records by a public employee” under Evidence Code sections 1271 and 1280, and thus serve as an exception to the hearsay rule. In addition, the citations explain the basis for both the complaint and CDI’s findings. Lastly, the citations provide PacifiCare with sufficient detail to present a defense. PacifiCare’s failure to defend against these

⁵¹⁹ CDI’s Opening Brief to OAH, 281:3-282:19; CDI’s Opening Brief to Commissioner, 59:7-60:10.

⁵²⁰ PacifiCare’s Brief to OAH, 336:11-17; PacifiCare’s Brief to Commissioner, 88:10-16.

⁵²¹ PacifiCare’s Brief to OAH, 337:1-12; PacifiCare’s Brief to Commissioner, 88:17-20.

⁵²² PacifiCare’s Brief to OAH, 337:15-339:6; PacifiCare’s Brief to Commissioner, 88:21-89:15.

citations, both when they were issued and at the evidentiary hearing, do not render them insufficient.

Accordingly, the Commissioner concludes PacifiCare failed to comply with Regulation 2695.5, subdivision (a) on 29 occasions.

b. Knowingly Committed or General Business Practice

PacifiCare is charged with knowing and recording the dates it receives inquiries from CDI and is similarly charged with knowing the dates its responses are due. Such knowledge is implied by the Insurance Code and the FCSP regulations, which require insurers to maintain and record all pertinent documentation and issue timely claim responses.⁵²³ Similarly, PacifiCare is charged with constructive knowledge of applicable response dates and its failure to comply with such dates.

PacifiCare argues its conduct does not constitute a general business practice, pointing to an alleged 96% compliance rate. Even assuming PacifiCare is correct, Section 790.03, subdivision (h) does not require CDI establish a general business practice. It is sufficient under the Insurance Code to demonstrate that *either* the insurer knowingly committed the acts, or that the acts were performed with such frequency as to demonstrate a general business practice. Because PacifiCare knowingly committed these acts, the Commissioner need not determine whether the conduct demonstrates a general business practice.

c. Specific UIPA Violations

Insurance Code section 790.03, subdivision (h)(2) requires an insurer to “acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.” With regard to CDI inquiries, Regulation 2695.5, subdivision (a) defines “reasonably promptly” as providing a complete written response within 21 calendar days of

⁵²³ See Cal. Code of Regs., tit. 10, § 2695.3; Ins. Code § 10123.137; Ins. Code § 10123.13.

receipt of the inquiry. The written response must also include a complete copy of the insurer's claim file. Therefore, an insurer who fails to provide CDI with a complete written response and complete claim file within 21 calendar days violates Insurance Code section 790.03, subdivision (h)(2).

PacifiCare argues CDI must prove PacifiCare received each citation before it may be penalized. But this argument is contrary to the Evidence Code and evidence presented at trial. First, Evidence Code section 641 presumes PacifiCare received CDI's inquiries in the ordinary course of mail.⁵²⁴ PacifiCare did not demonstrate CDI's inquiries were improperly addressed and did not otherwise rebut this presumption. Second, the distance between PacifiCare's Cypress, California offices and CDI's Los Angeles office, where the inquiries originated, supports an inference that CDI's inquiries were likely received the following day. Third, PacifiCare's own internal documents establish that PacifiCare received CDI inquiries but did not begin to process those requests "until day 10-20 after day of receipt," if PacifiCare processed the inquiries at all.⁵²⁵

Accordingly, the Commissioner concludes PacifiCare violated Section 790.03, subdivision (h)(2) on 29 occasions.

5. Penalty Assessed

a. Willfulness

CDI does not argue these violations were willful and the Commissioner does not find sufficient evidence to demonstrate willfulness as defined in Regulation 2695.2, subdivision (y). Thus, PacifiCare is liable to the state for a civil penalty not to exceed \$5,000 for each act.

⁵²⁴ Evidence Code section 641 states "A letter correctly addressed and properly mailed is presumed to have been received in the ordinary course of mail."

⁵²⁵ Exh. 671, p. 1546; Exh. 83; Exh. 92.

b. Single Act or Multiple Violations

There is no evidence PacifiCare inadvertently sent incomplete or untimely responses to CDI, nor does PacifiCare argue the violations constitute a “single act” under the Insurance Code. Accordingly, the Commissioner may assess a penalty for each of the 29 violations.

c. Regulatory Considerations

The Commissioner considers the relative harm and seriousness of the violations, PacifiCare’s remedial actions, the relative number of violations, and PacifiCare’s good faith in setting the appropriate penalty.

As in Section I, *ante*, the Commissioner finds these violations to be moderately serious. First, the Commissioner notes that failure to timely respond to the state’s regulatory agency demonstrates a disregard for both the Commissioner and the California consumer. CDI inquiries should be treated with the utmost care and handled appropriately. Indifference to such inquiries demonstrates contempt for the Insurance Code and its precepts. Second, while these violations do not result in denial of medical care, they may result in serious administrative harm. Accurate and prompt complaint processing requires that insurers timely respond to CDI inquiries. In addition, CDI inquiries stem from unresolved provider and member complaints. These claimants have already sought resolution from PacifiCare and been denied a satisfactory result. Likewise, PacifiCare’s failure to timely respond to CDI inquiries results in an increased workload for CDI’s investigative staff, since staff must repeatedly contact PacifiCare for information not previously provided. Accordingly, the Commissioner concludes a baseline penalty of \$4,000 per non-willful act, the same baseline penalty issued when insurers fail to timely respond to provider disputes, is appropriate for this type of violation.

In mitigation, the Commissioner notes that PacifiCare demonstrated good faith in addressing the underlying causes of the delay and took remedial action.⁵²⁶ The Commissioner also notes PacifiCare's actions did not harm the general public.⁵²⁷ But evidence regarding the relative number of violations is insufficient to serve as either an aggravating or mitigating factor.

Based on the above regulatory factors, the Commissioner concludes the appropriate penalty for these 29 violations is \$3,500 per act, for a total penalty of \$101,500.

The Commissioner is cognizant that this amount is larger than the amount sought by CDI. The Commissioner believes CDI's recommended penalty failed to account for the seriousness of this violation. As explained above, indifference towards a regulatory agency's investigations demonstrates contempt for both the Insurance Code and the California consumer. In fact, the entire regulatory framework depends upon a timely response to CDI. A penalty of \$450 per act, as proposed by CDI, suggests that disregarding a state agency's investigation is no more serious than failing to maintain a complete claim file. In addition, the Commissioner concludes failing to timely respond to a CDI inquiry is as serious as failing to timely respond to a provider or member. As such, the penalty for failing to respond to CDI must at least parallel the penalty for failing to respond to a provider. Accordingly, the Commissioner concludes PacifiCare's failure to timely respond to CDI's inquiries warrants a per act penalty of \$3,500.

N. Failure to Train Claims Agents on FCSP Regulations

1. Applicable Law

Regulation 2695.6 requires insurers provide "thorough and adequate training regarding the regulations to all their claims agents."⁵²⁸ A "claims agent" is defined as

⁵²⁶ Cal. Code of Regs., tit. 10, § 2695.12, subds. (a)(12), (a)(8).

⁵²⁷ Cal. Code of Regs., tit. 10, § 2695.12, subds. (a)(7), (a)(12).

⁵²⁸ Cal. Code of Regs., tit. 10, § 2695.6, subd. (b).

any person employed or authorized by an insurer, to conduct an investigation of a claim on behalf of an insurer or a person who is licensed by the Commissioner to conduct investigations of claims on behalf of an insurer.⁵²⁹

The term does not apply to attorneys retained to defend a claim brought against an insurer or any persons hired solely to provide valuation of a claim.

2. Findings of Fact

The Commissioner finds by a preponderance of the evidence the following facts regarding PacifiCare's alleged failure to train claims agents.

PacifiCare's Appeals & Grievances department processes claims appeals filed by members.⁵³⁰ Appeals processors are second-level reviewers; that is they determine whether the initial claim adjudication was correct.⁵³¹ As of May 2007, PacifiCare's Appeals & Grievance department employed 11 Appeals Coordinators and three Appeals Nurses.⁵³²

Appeal Coordinators "research case[s], including but not limited to: request denial file(s), pull claims info from RIMS and adhoc, request additional medical records, review Cust Svc documentation and benefits."⁵³³ Further, they determine contractual liability with the assistance of Appeals Nurses and send determination letters to members.⁵³⁴ Similarly, Appeals Nurses review the appeals to determine whether additional medical records or reports are needed and study a member's evidence of coverage to determine eligibility.⁵³⁵ Appeals Nurses also review the outcome of each appeal.

⁵²⁹ Cal. Code of Regs., tit. 10, § 2695.2, subd. (d).

⁵³⁰ RT 1541:16-18. Provider appeals are directed to a different department.

⁵³¹ RT 1550:23-1551:8.

⁵³² Exh. 5046, p. 2222.

⁵³³ *Id.* at p. 2224; RT 1058:4-12.

⁵³⁴ Exh. 5046, p. 2224.

⁵³⁵ RT 14518:18-14519:3.

In May 2007, PacifiCare trained its 14 Appeals and Grievance department employees on the FCSP regulations.⁵³⁶ Before May 2007, these employees were not trained in FCSP regulations.⁵³⁷

Also in 2007, PacifiCare outsourced a portion of its appeals processing to J&R; its vendor for overpayment collection. PacifiCare limited J&R's appeal processing to those cases where during an attempt to collect a payment from a provider, the provider disputes the overpayment.⁵³⁸ Specifically, the J&R contract called for the vendor to receive, document and resolve each provider appeal within 30 days.⁵³⁹ The contract further required J&R to issue a determination letter to providers "clearly outlining the reason for the resolution."

At all times relevant herein, J&R employed nine Appeals Processors.⁵⁴⁰ There is no evidence J&R trained its nine appeals processors in FCSP regulations. In addition, Mr. Bugiel, PacifiCare's designated person most knowledgeable about the J&R issues, testified he did not know whether J&R employees received training on the FCSP regulations.⁵⁴¹

3. Parties' Contentions

CDI argues PacifiCare's failure to train its own Appeals Processors, and those employed by J&R, constitute 23 violations of Insurance Code section 790.03, subdivision (h)(3). CDI does not contend PacifiCare willfully violated the Insurance Code, but does contend these violations are very serious in nature.⁵⁴² As such, CDI recommends a per act penalty of \$3,300.⁵⁴³

⁵³⁶ RT 1545:17-1546:1; See also Exh. 5046, p. 2222.

⁵³⁷ RT 1546:2-5.

⁵³⁸ RT 2924:10-18.

⁵³⁹ Exh. 312, pp. 6-7 of 92, ¶ 4.17.3.

⁵⁴⁰ RT 2896:8-19.

⁵⁴¹ RT 3732:19-22.

⁵⁴² CDI's Opening Brief to OAH, 285:5-286:15; CDI's Opening Brief to Commissioner, 61:4-17.

⁵⁴³ CDI's Opening Brief to OAH, 286:16-19.

PacifiCare argues its Appeals Processors, and those employed by J&R, are not “claims agents” as that term is defined by the regulations.⁵⁴⁴ PacifiCare further argues CDI failed to prove these employees did not receive the required FCSP training.⁵⁴⁵ And lastly, PacifiCare argues no penalty should issue for these violations.⁵⁴⁶

4. Analysis and Conclusions of Law

a. Number of Violations

The evidentiary record proves that a total of 23 employees investigated and responded to member and provider appeals. PacifiCare contends these employees were not “claims agents” as defined by Regulation 2695.2, subdivision (d), and therefore any failure to train these employees is irrelevant. The Commissioner finds no merit to this argument.

A “claims agent” is any person authorized by an insurer, to conduct an investigation of a claim on behalf of an insurer. The term “investigate” is an expansive one under the regulations. Regulation 2695.2, subdivision (k) defines “investigation” as “all activities of an insurer or its claims agent related to the determination of coverage, liabilities, or nature or extent of loss or damage for which benefits are afforded . . .” PacifiCare’s witnesses testified that Appeal Processors and Appeals Nurses reviewed claims and medical records, studied the member’s evidence of coverage, and ultimately determined whether a claim was covered by the insurance policy.⁵⁴⁷ Similarly, J&R employees received, documented and resolved each provider appeal “clearly outlining the reason for the resolution.”⁵⁴⁸

The evidence demonstrates these 23 employees investigated and resolved claims appeals. As such, the Commissioner concludes these employees are “claims agents” under Regulation

⁵⁴⁴ PacifiCare’s Brief to OAH, 323:19-324:23; PacifiCare’s Brief to Commissioner, 90:9-11.

⁵⁴⁵ PacifiCare’s Brief to OAH, 325:10-25.

⁵⁴⁶ PacifiCare’s Brief to Commissioner, 90:12-20.

⁵⁴⁷ RT 1508:4-12; RT 14518:18-14519:3; See also Exh. 5046, p. 2224.

⁵⁴⁸ Exh. 312, pp. 6-7, ¶ 4.17.3.

2695.2, subdivision (d), and PacifiCare's failure to train these employees violates Regulation 2695.6.

b. Knowingly Committed or General Business Practice

PacifiCare is charged with knowing the regulations that pertain to its operations and whether it has complied with those regulations. PacifiCare is also charged with knowing whether it has properly trained its employees in accordance with the regulations. Accordingly, the Commissioner concludes these acts were knowingly committed as that term is defined by the regulations.

c. Specific UIPA Violations

Insurance Code section 790.03, subdivision (h)(3) requires insurers to adopt or implement reasonable standards for the prompt investigation and processing of claims. By failing to train claims agents on FCSP regulations, as required by Regulation 2695.6, subdivision (b), an insurer fails to adopt and implement reasonable standards for the investigation of claims. Therefore, PacifiCare's failure to train its 23 claims agents violates section 790.03, subdivision (h)(3).

PacifiCare argues CDI failed to prove the 23 employees were not trained in FCSP regulations. This argument is without merit. First, PacifiCare's witness testified that before May 2007, appeal processors and nurses were not trained in FCSP regulations.⁵⁴⁹ This testimony was not challenged by any other witness. Second, Regulation 2695.6, subdivision (b)(4) requires an insurer maintain copies of its training certificates. At no time during the investigation and evidentiary hearing did PacifiCare present its training certificates. Accordingly, the evidentiary record establishes that PacifiCare failed to train its claims agents in FCSP regulations, in violation of section 790.03, subdivision (h)(3).

⁵⁴⁹ RT 1546:2-5.

5. Penalty Assessed

a. Willfulness

CDI does not argue these violations were willful and the Commissioner does not find sufficient evidence to demonstrate willfulness as defined in Regulation 2695.2, subdivision (y). Thus, PacifiCare is liable to the state for a civil penalty not to exceed \$5,000 for each act.

b. Single Act or Multiple Violations

There is no evidence PacifiCare inadvertently failed to train its claims agents, nor does PacifiCare argue the violations constitute a “single act” under the Insurance Code. Accordingly, the Commissioner may assess a penalty for each of the 23 violations.

c. Regulatory Considerations

The Commissioner considers the relative harm and seriousness of the violations, PacifiCare’s remedial actions, the relative number of violations, and PacifiCare’s good faith in setting the appropriate penalty.

The Commissioner finds this type of violation to be serious in nature. Accurate claims processing is the bedrock of the FCSP regulations. Failing to train claims agents may lead to errors in processing claims and result in additional violations of law. Further, the training requirement is not difficult to comply with and PacifiCare’s failure to do so reflects a disregard for the regulations. Accordingly, the Commissioner concludes the nature of this non-willful violation supports a baseline penalty of \$2,500 per act.

Harm to claimants also flows directly from inaccurate claims processing. Claimants may be forced to wait prolonged periods to receive reimbursement and a member’s medical care may be adversely affected by erroneous claims processing. In the instant case, the harm is greater

since PacifiCare failed to provide any training whatsoever, rather than providing inadequate training.

In mitigation, the Commissioner notes PacifiCare implemented the required training in May 2007 and took steps to remedy the violations. Further, the Commissioner notes that the harm to the general public was minimal and that PacifiCare acted in good faith when it learned of the violations.

The Commissioner finds that 23 acts in violation is a relatively small number. But as this number represents a majority of PacifiCare's appeals processors, the small number of violations does not serve as a mitigating factor herein.

Based on the above regulatory factors, the Commissioner concludes the appropriate penalty for these 23 violations is \$2,250 per act, which is 45% of the maximum penalty, for a total of \$51,750.

O. Misrepresentations to CDI

1. Applicable Law

Insurance Code section 790.03, subdivision (e) makes it an unfair and deceptive act to make any false statement or to willfully omit any material fact pertaining to the business of the insurer with the intent to deceive any examiner. Such conduct also violates Regulation 2695.5, subdivision (a), which requires that insurers respond to CDI inquiries with "a complete written response based on the facts as then known by the licensee."

2. Findings of Fact

The Commissioner finds by a preponderance of evidence the following facts regarding PacifiCare's alleged misrepresentations to CDI.

In July 2007, CDI requested PacifiCare provide a list of all claims processing personnel, along with their average caseload and attrition rate.⁵⁵⁰ Internal documents demonstrate many PacifiCare claims personnel were laid off or left their employment, citing “[d]issatisfaction with benefits and overtime.” But PacifiCare representatives agreed to withhold this information from CDI: “I think it is safe to indicate all of the reasons you mention except, as you say, the second one regarding dissatisfaction with benefits and overtime.”⁵⁵¹

On September 10, 2007, CDI requested the dates that the insurer acknowledged the receipt of claims processed during the MCE review period.⁵⁵² PacifiCare responded that those data were “not available at this time” since RIMS did not track those dates. At the time PacifiCare made this statement, PacifiCare representatives knew the statement was false. In fact, PacifiCare was unable to provide CDI dates of acknowledgment because PacifiCare was not sending acknowledgment letters at that time.⁵⁵³

3. Parties’ Contentions

CDI is not alleging these misrepresentations constitute separate violations of the Insurance Code. Instead, CDI presents these facts as an aggravating penalty factor for Section H, *ante*.⁵⁵⁴

PacifiCare contends its statements do not constitute misrepresentations and further contends that such facts may not be used as aggravating factors absent a finding that the statements violate the Insurance Code.⁵⁵⁵

⁵⁵⁰ Exh. 363, p. 5972.

⁵⁵¹ *Ibid*.

⁵⁵² Exh. 110, p. 4828.

⁵⁵³ Exh. 113, p. 9893; Exh. 117, p. 3410.

⁵⁵⁴ CDI’s Opening Brief to OAH, 289:12-15; CDI’s Opening Brief to Commissioner, 62:6-8.

⁵⁵⁵ PacifiCare’s Brief to OAH, 352:20-356:17.

4. Analysis and Conclusions of Law

As discussed in detail in Section H, *ante*, PacifiCare's representatives knew they had not complied with Insurance Code 10133.33, yet chose to intentionally conceal that information from CDI. This intentional act, memorialized in PacifiCare's internal electronic mail system, was not a "good faith mistake" as argued by PacifiCare. Instead, it was deliberate attempt to obfuscate relevant facts and delay CDI's investigation.

CDI is not seeking a penalty for PacifiCare's alleged misrepresentations and thus is not obligated to prove those statements violate Insurance Code section 790.03. While CDI could have raised this allegation as a separate violation, it chose not to do so, and the Commissioner finds no reason to overrule this prosecutorial decision. Nor does CDI's failure to raise this allegation separately preclude the trier of fact from considering those facts in aggravation. Regulation 2695.12, subdivision (11) permits the Commissioner to consider admissible evidence on whether, under the totality of circumstances, the insurer made a good faith attempt to comply with regulatory provisions. PacifiCare's intentional misrepresentation to CDI speaks to whether PacifiCare made a good faith attempt to comply with regulations. In addition, Regulation 2695.12, subdivision (13) permits the Commissioner to consider management's awareness of relevant facts and management's remedial actions. Again, PacifiCare's management knew of its non-compliance and intentionally withheld that information from CDI. Based on the above, the Commissioner concludes the trier of fact may consider these misrepresentations as aggravating factors in assessing penalties.

P. Failure to Conduct Business in Own Name

1. Applicable Law

Insurance Code section 880 requires that “every insurer shall conduct its business in this State in its own name.” As such, insurers must identify the legal name of the underwriting company on all correspondence to members and providers, such as claim-related letters, EOBs and EOPs.

2. Findings of Fact

The Commissioner finds by a preponderance of the evidence the following facts regarding PacifiCare’s alleged failure to conduct business in its own name.

PacifiCare Health Systems, LLC operates a number of different entities, including PacifiCare of California, PacifiCare Life Assurance Company, PacifiCare Health Systems, PacifiCare Health Plans Administrators, Inc., PacifiCare Behavioral Health, Inc., and PacifiCare Life and Health Insurance Company.⁵⁵⁶ The entity involved depends upon geographic location, type of benefit being covered and type of health plan involved.

On January 5, 2007, CDI investigated a member’s complaint against PacifiCare and noticed that in two instances PacifiCare issued letters that mention several licensee names, but failed to clearly state which carrier underwrote the policy.⁵⁵⁷ As a result, on February 21, 2007, CDI cited PacifiCare for this violation. PacifiCare did not respond to the citation.

On February 7, 2007, CDI discovered three instances where PacifiCare failed to clearly identify PacifiCare Life and Health Insurance Company as the underwriting carrier.⁵⁵⁸ Instead, the letters, dated July 7, 2006, July 25, 2006 and February 26, 2007, showed only “PacifiCare” as

⁵⁵⁶ Exh. 5252, p. 6927.

⁵⁵⁷ Exh. 183, p. 2171.

⁵⁵⁸ Exh. 175.

the apparent underwriting carrier. On March 8, 2007, CDI cited PacifiCare for these violations.⁵⁵⁹ PacifiCare did not respond to the citation.

In addition to the above incidents, CDI found 12 additional instances where PacifiCare failed to list the insurer's legal name on documents, totaling an additional 24 violations.⁵⁶⁰ In each of the instances, CDI cited PacifiCare and detailed the circumstances surrounding the complaints and citations. The ALJ admitted each of these citations into evidence.

3. Parties' Contentions

CDI argues PacifiCare violated Insurance Code section 790.03, subdivision (h)(1) on 29 occasions by failing to include the insurer's legal name on all correspondence. CDI does not argue the violations were willful and finds the violations caused little harm. As such, CDI urges a penalty of \$250 per act.⁵⁶¹

PacifiCare revisits its administrative hearsay argument asserting that CDI failed to provide sufficient evidence of the violations.⁵⁶² In addition, PacifiCare argues Insurance Code section 880 "does not specify how precise a company must be in describing its name" and as such, PacifiCare's conduct does not violate the Insurance Code.⁵⁶³ Lastly, the insurer argues the violations do not result in harm and any penalty must be minimal.⁵⁶⁴

4. Analysis and Conclusions of Law

a. Number of Violations

The evidentiary record establishes that on 29 occasions, PacifiCare failed to use its legal name on correspondence as required by Insurance Code section 880. CDI citations, and the

⁵⁵⁹ *Ibid.*

⁵⁶⁰ See Exhs. 38, 134, 168, 177, 193, 200, 201, 206, 207, 220, and 223.

⁵⁶¹ CDI's Opening Brief to OAH, 292:7-293:5.

⁵⁶² PacifiCare's Brief to OAH, 316:19-317:8; PacifiCare's Brief to Commissioner, 92:21-27.

⁵⁶³ PacifiCare's Brief to OAH, 318:3-25; PacifiCare's Brief to Commissioner, 92:7-20.

⁵⁶⁴ PacifiCare's Brief to OAH, 321:14-28.

details supporting those citations, were admitted as evidence during the evidentiary hearing and were not refuted.

As in Sections J and L, *ante*, PacifiCare argues the citations cannot serve as evidence in this proceeding. The Commissioner again finds this argument lacks merit. CDI citations constitute business records and “records by a public employee” under Evidence Code sections 1271 and 1280, and thus serve as an exception to the hearsay rule. Further, the citations explain the basis for both the complaint and CDI’s findings. The citations also provide PacifiCare with sufficient detail to present a defense. PacifiCare’s failure to defend against these citations, both when they were issued and at the evidentiary hearing, do not render them insufficient.

Accordingly, the Commissioner concludes PacifiCare violated Insurance Code section 880 on 29 occasions.

b. Knowingly Committed or General Business Practice

PacifiCare is charged with knowledge of the contents of its correspondence, particularly with respect to something as important as identification of the company’s legal name. CDI is not required to demonstrate PacifiCare deliberately misstated its company name. Instead, the record need only demonstrate PacifiCare acted with “actual, implied or constructive knowledge.” There can be no question that PacifiCare had at least constructive and implied knowledge of the contents of their own correspondence. As such, the Commissioner concludes PacifiCare knowingly committed these acts.

c. Specific UIPA Violations

Insurance Code section 790.03, subdivision (h)(1) punishes insurers who misrepresent pertinent facts or insurance policy provisions. The legal name of the insurer is a pertinent fact

and misrepresenting that fact, either by failing to include the legal name or by including a variety of names, violates Section 790.03, subdivision (h)(1).

PacifiCare argues it did not misrepresent its legal name when it referred to the insurer as “PacifiCare.” PacifiCare cites *Handyman Connection of Sacramento, Inc. v. Sands* (2004) 123 Cal.App.4th 867 for support. In *Handyman Connection of Sacramento*, the Court of Appeal reviewed Business and Professions Code section 7117 which requires contractors to do business “in the name of the licensee as set forth in the license.” In that case, the licensee Handyman Connection of Sacramento frequently used the shorted name of Handyman Connection on contracts and correspondence. In holding that use of a shortened version did not violate section 7117, the Court of Appeal stated that while the labor estimate:

bears only the name “Handyman Connection,” and not “Handyman Connection of Sacramento, Inc.,” it contains all the information about the name of the contractor needed to comply with the policy of the License Law. As well as a short form of the business name, it gives the business's address, telephone number, and license number. The name on the contract—“Handyman Connection”—was not a departure from but was rather an abbreviation of the contractor's full legal name. It was as if a contract had said “Sears” rather than “Sears Roebuck and Company, Inc.”⁵⁶⁵

This holding does not support PacifiCare’s use of a shortened name. In contrast to the above case, PacifiCare’s correspondence provided only the telephone number and address of the parent corporation. It did not provide the address, phone number or any other information pertaining to the affiliated company. Furthermore, unlike Handyman Connection, PacifiCare’s affiliated entities all use the same “PacifiCare” identifier, making it impossible to determine which entity is the correct one. A reference to PacifiCare could mean PacifiCare of California, PacifiCare Life Assurance Company, PacifiCare Health Systems, PacifiCare Health Plans Administrators, Inc., PacifiCare Behavioral Health, Inc., or PacifiCare Life and Health Insurance Company. A

⁵⁶⁵ *Handyman Connection of Sacramento, Inc. v. Sands*, *supra*, 123 Cal.App.4th at pp. 887-888.

claimant seeking assistance would be hard pressed to determine which entity sent the letter. Indeed, the statute's intent is to eliminate such confusion.

Based on the above stated facts, the Commissioner concludes PacifiCare's failure to include its legal name on all correspondence violates Insurance Code section 790.03, subdivision (h)(1).

5. Penalty Assessed

a. Willfulness

CDI does not argue these violations were willful and the Commissioner does not find sufficient evidence to demonstrate willfulness as defined in Regulation 2695.2, subdivision (y). Thus, PacifiCare is liable to the state for a civil penalty not to exceed \$5,000 for each act.

b. Single Act or Multiple Violations

There is no evidence PacifiCare inadvertently issued the correspondence, nor does PacifiCare argue the violations constitute a "single act" under the Insurance Code. Accordingly, the Commissioner may assess a penalty for each of the 29 violations.

c. Regulatory Considerations

The Commissioner considers the relative harm and seriousness of the violations in assessing the appropriate penalty, finding no additional aggravating or mitigating factors.

Compared to other violations discussed herein, PacifiCare's failure to conduct business in its own name is less serious than the average transgression. But that is not to say that the violation does not harm members or providers. PacifiCare's failure to identify the proper affiliate in its communications may confuse claimants and may delay, or even prevent, the proper filing of an appeal. Indeed, the Legislature determined that eliminating such confusion was important enough to warrant a specific statute addressing the issue. The Commissioner will not second-

guess the Legislature’s judgment by concluding that no harm stems from this type of violation. Based on the nature of this non-willful violation, the Commissioner concludes a baseline penalty of \$250 per act is appropriate.

The Commissioner does not find any aggravating or mitigating factors in the remaining Regulation 2695.12 factors. There is no evidence of extraordinary circumstances, no evidence that the claims involved were complex, no evidence of remedial measures and no evidence that PacifiCare made a good faith attempt to comply.

Based on the above regulatory factors, the Commissioner concludes the appropriate penalty for these 29 violations is \$250 per act, which is 5% of the maximum, for a total penalty of \$7,250.

Q. Failure to Timely Respond to Claimants

1. Applicable Law

Both the Insurance Code and FCSP regulations require an insurer act “reasonably promptly” upon communications from providers and members. In fact, Regulation 2695.5, subdivision (b) requires insurers respond “immediately, but in no event more than fifteen (15) calendar days after receipt of that communication:”

Upon receiving any communication from a claimant, regarding a claim, that reasonably suggests that a response is expected, every licensee shall immediately, but in no event more than fifteen (15) calendar days after receipt of that communication, furnish the claimant with a complete response based on the facts as then known by the licensee. This subsection shall not apply to require communication with a claimant subsequent to receipt by the licensee of a notice of legal action by that claimant.

An insurer that fails to respond to a claimant within 15 days, or otherwise fails to provide a complete response to a claimant, violates this provision.

2. Findings of Fact

The Commissioner finds by a preponderance of evidence the following facts regarding PacifiCare's alleged failure to timely respond to claimants.

On February 20, 2007, CDI received a provider complaint against PacifiCare. The complaint alleged PacifiCare incorrectly processed and denied a claim.⁵⁶⁶ CDI investigated and learned that on September 14, 2006, the provider sent a facsimile to PacifiCare regarding the denied claim. PacifiCare did not respond to this facsimile forcing the provider to call on November 9, 2006 for an update.⁵⁶⁷ As a result of this failure to respond, CDI cited PacifiCare.

On February 27, 2007, CDI investigated another PacifiCare complaint. This provider complaint alleged PacifiCare incorrectly processed a claim and sent payment to the wrong provider.⁵⁶⁸ CDI learned that on September 29, 2006 and February 23, 2007, the provider sent letters to PacifiCare demanding the insurer properly process the claim. PacifiCare did not respond to either of these communications.⁵⁶⁹ Thus, CDI cited PacifiCare for each instance it failed to timely respond.

On July 30, 2007, CDI received a member complaint against PacifiCare. The complaint stated PacifiCare failed to deliver copies of EOBs after repeated requests by the member.⁵⁷⁰ CDI established that on April 9, 2007, the member requested copies of EOBs. PacifiCare did not respond to the member's request and did not provide these EOBs until August 14, 2007, after the member filed their complaint with CDI. PacifiCare acknowledged that it received the request on

⁵⁶⁶ Exh. 41, p. 9453.

⁵⁶⁷ *Id.* at p. 9455.

⁵⁶⁸ Exh. 38, p. 4086.

⁵⁶⁹ *Id.* at p. 4087.

⁵⁷⁰ Exh. 218, p. 9673.

April 9, 2007, yet failed to timely respond.⁵⁷¹ As a result, CDI cited PacifiCare for its failure to timely respond.

On August 7, 2007, CDI received another provider complaint against PacifiCare. This complaint alleged PacifiCare failed to terminate the provider's contract and failed to respond to provider communications.⁵⁷² CDI determined the provider requested PacifiCare terminate the contract effective January 1, 2006. When PacifiCare failed to respond or terminate the contract, the provider contacted PacifiCare again on March 15 and May 14, 2007 seeking termination of the contract. PacifiCare did not respond to the provider until August 31, 2007, after a complaint was filed with CDI.⁵⁷³ Consequently, CDI cited PacifiCare for each instance it failed to timely respond to the provider's communications.

In December 2008, PacifiCare audited its appeals process. During this audit, PacifiCare determined that in two instances it failed to issue a complete and timely response to a member's appeal.⁵⁷⁴ PacifiCare's witness confirmed this failure during the evidentiary hearing.⁵⁷⁵

3. Parties' Contentions

CDI alleges PacifiCare knowingly failed to issue a timely and complete response to a claimant in violation of Insurance Code section 790.03, subdivision (h)(2). CDI does not contend PacifiCare willfully violated the Insurance Code, but does contend these violations are moderately serious in nature.⁵⁷⁶ As such, CDI recommends a per act penalty of \$1,000.

PacifiCare argues the trier of fact may not rely on CDI's citations to establish violations of the Insurance Code.⁵⁷⁷ In addition, PacifiCare contends providers are not "claimants" as

⁵⁷¹ *Ibid.*

⁵⁷² Exh. 53, p. 9178.

⁵⁷³ *Ibid.*

⁵⁷⁴ Exh. 235.

⁵⁷⁵ RT 1653:5-12.

⁵⁷⁶ CDI's Opening Brief to OAH, 295:12-296:2; CDI's Opening Brief to Commissioner, 63:8-28.

⁵⁷⁷ PacifiCare's Brief to OAH, 340:19-27; PacifiCare's Brief to Commissioner, 93:13-18.

defined by the regulations and that CDI failed to demonstrate PacifiCare received any communications from claimants.⁵⁷⁸ Lastly, the insurer argues the violations do not result in harm and that no penalty is warranted.⁵⁷⁹

4. Analysis and Conclusions of Law

a. Number of Violations

The evidentiary record establishes that on nine occasions, PacifiCare failed to issue a timely and complete response to claimants in violation of Regulation 2695.5, subdivision (b). CDI citations, and the details supporting those citations, were admitted as evidence during the evidentiary hearing and were not refuted by PacifiCare.

PacifiCare again argues the citations cannot serve as evidence in this proceeding. The Commissioner again finds this argument lacks merit. CDI's citations constitute business records and "records by a public employee" under Evidence Code sections 1271 and 1280, and thus serve as an exception to the hearsay rule. The citations explain the basis for both the complaint and CDI's findings. And, the citations provide PacifiCare with sufficient detail to present a defense. PacifiCare's failure to defend against these citations, both when they were issued and at the evidentiary hearing, do not render them insufficient.⁵⁸⁰

PacifiCare also argues providers are not "claimants" as defined by the regulations. This assertion is simply wrong. Regulation 2695.2 states a "claimant" is a first or third party claimant, or any person authorized to represent a claimant.⁵⁸¹ A provider submitting a claim as a beneficiary of the policy is considered a first party claimant.⁵⁸² Hence, a provider is a "claimant"

⁵⁷⁸ PacifiCare's Brief to OAH, 340:12-18; 341:1-21; PacifiCare's Brief to Commissioner, 93:19-23.

⁵⁷⁹ PacifiCare's Brief to OAH, 344:1-22; PacifiCare's Brief to Commissioner, 94:1-8.

⁵⁸⁰ This argument also fails to acknowledge that PacifiCare admitted to two violations of the regulation.

⁵⁸¹ Cal. Code of Regs., tit. 10, § 2695.2, subd. (c).

⁵⁸² Cal. Code of Regs., tit. 10, § 2695.2, subds. (a), (f).

as defined by the regulations and PacifiCare's failure to timely respond to providers is a violation of Regulation 2695.5, subdivision (b).

Accordingly, the Commissioner concludes PacifiCare failed to issue timely and complete responses to claimants on at least nine occasions.

b. Knowingly Committed or General Business Practice

PacifiCare is charged with knowing the dates it receives communications from claimants and the dates it responds to those communications. At a minimum, PacifiCare had constructive knowledge that its responses were untimely. PacifiCare's arguments to the contrary are based on its own revised definition of "knowingly" and are unsupported by the statute and regulations.

c. Specific UIPA Violations

Insurance Code section 790.03, subdivision (h)(2) requires insurers acknowledge and act "reasonably promptly" upon any communications with respect to claims. Regulation 2695.5, subdivision (b) defines what is meant by "reasonably promptly" in the context of communications with claimants. Insurers are required to respond "immediately, but in no event more than fifteen (15) calendar days after receipt of that communication." Thus, an insurer who fails to respond to a claimant's communication within 15 calendar days violates both Regulation 2695.5, subdivision (b) and Insurance Code section 790.03, subdivision (h)(2).

PacifiCare again argues it may not be charged with violating section 790.03, since CDI did not prove PacifiCare received claimants' communications. The Commissioner finds this argument lacks merit. First, Evidence Code 641 presumes letters are received in the ordinary course of mail. PacifiCare did not attempt to rebut this presumption. In fact, PacifiCare's representatives confirmed receipt of at least one of the letters and further admitted to an untimely

response.⁵⁸³ Second, PacifiCare acknowledged it received electronic messages and facsimiles the day they were sent.⁵⁸⁴ This admission covers several violations. Lastly, PacifiCare failed to prove it did not receive claimants' communications. Accordingly, the Commissioner concludes the evidentiary record is sufficient to sustain nine violations of the Insurance Code.

5. Penalty Assessed

a. Willfulness

CDI does not argue these violations were willful and the Commissioner does not find sufficient evidence to demonstrate willfulness as defined in Regulation 2695.2, subdivision (y). Thus, PacifiCare is liable to the state for a civil penalty not to exceed \$5,000 for each act.

b. Single Act or Multiple Violations

There is no evidence PacifiCare inadvertently sent incomplete or untimely responses to its claimants, nor does PacifiCare demonstrate these violations constitute a "single act" under the Insurance Code. Accordingly, the Commissioner may assess a penalty for each of the nine violations.

c. Regulatory Considerations

The Commissioner considers the relative harm and seriousness of the violations in assessing the appropriate penalty, finding no additional aggravating or mitigating factors.

As in Section I, *ante*, the Commissioner finds these violations to be moderately serious. While these violations do not result in denial of medical care, they may result in serious financial harm. The requirement that insurers timely respond to claimant communications is critical to accurate and prompt claims processing. Most disputes addressed claims PacifiCare had denied or had incorrectly paid. And many claimants received a response only after contacting CDI.

⁵⁸³ See Exh. 218. Two additional violations are also based on PacifiCare's admissions to untimely responses. (See Exh. 235.)

⁵⁸⁴ PacifiCare's Brief to OAH, 340:14-17.

Further, the time a claimant spends repeatedly contacting an insurer is neither “very minimal” as argued by PacifiCare, nor adequately remedied by an interest payment. In fact, many claimants’ experienced significant frustration, pain and suffering as a result of PacifiCare’s conduct.⁵⁸⁵ Likewise, PacifiCare’s failure to timely respond to claimant communications resulted in an increased workload for CDI’s investigative staff, as irritated providers frequently contacted CDI with their complaints. Accordingly, the Commissioner concludes a baseline penalty of \$3,500 per act, nearly the same baseline penalty issued when insurers fail to timely respond to provider disputes and CDI inquiries, is appropriate for this type of non-willful violation.

The Commissioner does not find any aggravating or mitigating factors in the remaining Regulation 2695.12 factors. There is no evidence of extraordinary circumstances, no evidence that the claims involved were complex, no evidence of remedial measures and no evidence that PacifiCare made a good faith attempt to comply. In fact, the evidentiary record demonstrates PacifiCare still had difficulty meeting its regulatory obligations as late as December 2008.

Based on the above regulatory factors, the Commissioner concludes the appropriate penalty for these nine violations is \$3,500 per act, which is 35% of the maximum, for a total penalty of \$31,500.

The Commissioner is cognizant that this amount is larger than the amount sought by CDI. The Commissioner believes CDI’s penalty request failed to account for the seriousness of this violation. As explained above, indifference towards a claimant’s communications demonstrates contempt for both the Insurance Code and the California consumer. A penalty of \$1,000 per act, as proposed by CDI, suggests that disregarding a member’s concerns is no more serious than failing to maintain a complete claim file. In fact, failing to timely respond to a member’s inquiry is as serious as failing to timely respond to a provider or CDI. As such, the penalty for failing to

⁵⁸⁵ RT 1040:11-17.

respond to claimants must be analogous to the penalty for failing to respond to providers or CDI. Accordingly, the Commissioner concludes PacifiCare's failure to timely respond to CDI's inquiries warrants a per act penalty of \$3,500.

R. Failure to Implement Date of Receipt Recording Policy

1. Applicable Law

Regulation 2695.3, subdivision (a) requires insurers maintain in claim files information in such detail that the dates of the events can be reconstructed and the licensee's actions pertaining to the claim can be determined. To that end, subdivision (b)(2) requires all insurers record the date it received, processed and transmitted or mailed every material and relevant document in the file.

2. Findings of Fact

The Commissioner finds by a preponderance of evidence the following facts regarding PacifiCare's alleged failure to implement a policy recording the date of receipt for each piece of correspondence.

In early 2007, CDI received a member complaint that alleged PacifiCare failed to timely process a claim.⁵⁸⁶ Specifically, the member submitted two separate claims multiple times, but reported that PacifiCare had no record of them. PacifiCare investigated the complaint and found that while it had received the claims, it could not locate either a hard or electronic copy of the claims.⁵⁸⁷ And after finally locating a copy of the claims in February 2007, PacifiCare expressed doubt as to the proper recording of the received date.

My question is this: The claims have been paid but the received date was 2/11/2006 (the date that appeals found the information)[.] Should we reprocess

⁵⁸⁶ Exh. 224.

⁵⁸⁷ *Id.* at p. 2394.

the claims using [t]he 11/27/06 date since I have to include that documentation with my letter to DOI?⁵⁸⁸

In response to this question, Heather Mace-Meador, PacifiCare's Director of Appeals and Grievances, instructed her staff to use the earlier date.

On January 7, 2010, Ms. Mace-Meador testified in this evidentiary hearing. On cross-examination, Ms. Mace-Meador admitted that in February 2007 PacifiCare's Appeals department did not have a policy for determining or documenting the original receipt date of a claim. Precisely, Ms. Mace-Meador stated "[w]e did not have as part of our appeals research process specific instructions on documenting or how to determine the original receipt date of the claim."⁵⁸⁹

3. Parties' Contentions

CDI contends PacifiCare's failure to adopt a date of receipt policy constitutes a single violation of the Insurance Code section 790.03, subdivision (h)(3). In addition, CDI alleges another violation for failing to properly record the date of receipt for the member complaint discussed in the Findings of Fact above.⁵⁹⁰ CDI does not allege these violations were willful and suggests a per act penalty of \$3,250.⁵⁹¹

PacifiCare contends the insurer had a "general business practice of accurately recording the receipt date of claims."⁵⁹² In support of this contention, PacifiCare directs the Commissioner's attention to testimony from other PacifiCare employees and to computer-

⁵⁸⁸ *Id.* at p. 2387.

⁵⁸⁹ RT 1589:8-11.

⁵⁹⁰ CDI's Opening Brief to OAH, 299:1-9.

⁵⁹¹ *Id.* at 299:14-25; CDI's Opening Brief to Commissioner, 64:22-28.

⁵⁹² PacifiCare's Brief to OAH, 345:16-17.

generated reports. In addition, PacifiCare contends two violations are insufficient to demonstrate a “general business practice” and any penalty should be minimal.⁵⁹³

4. Analysis and Conclusions of Law

a. Number of Violations

Facts provided prove by a preponderance of the evidence that PacifiCare failed to record the date it received the member’s claims in violation of Regulation 2695.3. PacifiCare did not challenge this finding. In addition, Ms. Mace-Meador admitted that PacifiCare’s Appeals and Grievance division did not have a policy regarding recording the original date PacifiCare received a claim or other correspondence. The failure to adopt a policy is a separate and distinct violation of the regulations. Accordingly, the Commissioner concludes the record proves two violations of Regulation 2695.3.

b. Knowingly Committed or General Business Practice

PacifiCare is charged with knowing both the regulatory requirements regarding claims processing as well as its internal policies, or lack thereof. The evidence establishes that Ms. Mace-Meador knew the Appeals and Grievance division lacked a policy for recording the date of receipt. PacifiCare’s arguments to the contrary are based on its own revised definition of “knowingly” and are unsupported by the statute and regulations.

c. Specific UIPA Violations

Insurance Code section 790.03, subdivision (h)(3) requires insurers adopt and implement reasonable standards for the prompt investigation and processing of claims. “Reasonable standards” requires a policy that records the date an insurer receives, processes and transmits or mails every material and relevant document in the file. Thus, at a minimum, PacifiCare must have in place a policy that accurately records the date claims are received.

⁵⁹³ *Id.* at 347:5-28; PacifiCare’s Brief to Commissioner, 95:6-27.

PacifiCare contends its policy of date stamping all received claims demonstrates it complied with the Insurance Code.⁵⁹⁴ But this fact does not absolve PacifiCare of responsibility nor does it counter Ms. Mace-Meador’s own testimony. While company policy may be to date stamp all incoming claims, that does not guarantee that the receipt date is correctly entered into the computer system or even that the claim can be located. Indeed, employees in the Appeals and Grievance division expressed uncertainty about which date of receipt to use. This admission does not support PacifiCare’s argument of a company-wide policy.

PacifiCare also points to a computer generated report to support its argument.⁵⁹⁵ The report, titled “Claims Header Inquiry Screen” includes a column for the “received date.” PC argues that inclusion of a “received date” column shows the insurer adopted and implemented a company-wide policy. But this fact proves only that the computer system provided a field to enter the received date. It does not prove PacifiCare’s Appeals and Grievance division had a policy that recorded such a date.

Since PacifiCare admitted its Appeals and Grievance division lacked such a policy, and evidence establishes that PacifiCare failed to record the receipt date on at least one occasion, the Commissioner concludes PacifiCare’s conduct violates Insurance Code section 790.03, subdivision (h)(3).

5. Penalty Assessed

a. Willfulness

CDI does not argue these violations were willful and the Commissioner does not find sufficient evidence to demonstrate willfulness as defined in Regulation 2695.2, subdivision (y). Thus, PacifiCare is liable to the state for a civil penalty not to exceed \$5,000 for each act.

⁵⁹⁴ PacifiCare’s Brief to OAH, 345:16-25.

⁵⁹⁵ *Id.* at 345:26-28.

b. Single Act or Multiple Violations

There is no evidence PacifiCare inadvertently failed to record the receipt date, nor does PacifiCare demonstrate these violations constitute a “single act” under the Insurance Code. Accordingly, the Commissioner may assess a penalty for each of the two violations.

c. Regulatory Considerations

The Commissioner considers the seriousness of the violation, the relative harm to providers and members, and the number of non-complying acts in setting the appropriate penalty.

The Commissioner concludes this type of violation is serious in nature. The regulations make clear that adopting a date received policy is critical to the proper claim processing. Despite this specific obligation, PacifiCare’s Appeals and Grievance division failed to adopt a policy and failed to ensure its employees complied with this regulation. The harm that flows from this type of violation is not illusory. The received date governs the entire claims processing time frame, from when a claim is considered “timely” processed, to when a claim is late and requires interest payments. Failure to adopt a policy that accurately records this date calls into question PacifiCare’s claims processing framework and its commitment to regulatory compliance. Accordingly, the Commissioner concludes the nature of this non-willful violation supports a baseline penalty of \$3,250 per act.

The Commissioner finds no factors in mitigation. PacifiCare did not demonstrate the Appeals division ultimately adopted a policy regarding the received date, nor is there any evidence PacifiCare attempted to comply in good faith. In addition, while CDI only alleges two violations of the Insurance Code, the number of violations is not indicative of PacifiCare’s general compliance. There is no evidence that anyone reviewed the over 1.3 million claims

received and concluded that PacifiCare had properly entered the date received on those claims. Accordingly, this factor cannot be used in mitigation.

Based on the above regulatory factors, the Commissioner concludes the appropriate penalty for these two violations is \$3,250 per act, which is 65% of the maximum, for a total penalty of \$6,500.

S. Failure to Conduct a Thorough Investigation

1. Applicable Law

Regulation 2695.7, subdivision (d) states that “[e]very insurer shall conduct and diligently pursue a thorough, fair and objective investigation and shall not persist in seeking information not reasonably required for or material to the resolution of a claim dispute.” An insurer who automatically rejects claims and repeats requests for additional information violates this regulation.

2. Findings of Fact

The Commissioner finds by a preponderance of evidence the following facts regarding PacifiCare’s alleged failure to conduct a thorough investigation into submitted claims.

As discussed in detail in Section A, *ante*, on January 3, 2006, Ms. W submitted information to PacifiCare regarding her son’s medical condition.⁵⁹⁶ In early January 2006, PacifiCare requested Ms. W resubmit that same medical information an additional two times in order to process her son’s claim.⁵⁹⁷ On January 13, 2006, Ms. W submitted the COCC PacifiCare requested.⁵⁹⁸ On January 20, January 24 and January 25, 2006, PacifiCare requested Ms. W resubmit the COCC.⁵⁹⁹ In the summer of 2006, PacifiCare made another request for the medical

⁵⁹⁶ RT 1019:7-1019:23.

⁵⁹⁷ RT 1019:24-1020:6.

⁵⁹⁸ RT 1026:2-8.

⁵⁹⁹ RT 1026:20-1027:10.

records; the same medical records that it had previously requested and that had been provided.⁶⁰⁰ That last request nearly resulted in the denial of medical care to Ms. W's son.⁶⁰¹ On March 6, 2007, PacifiCare made yet another request for the same medical records.⁶⁰² This request, along with PacifiCare's failure to timely pay claims, did result in the denial of medical care.⁶⁰³ PacifiCare does not dispute that it possessed all medical information necessary to properly process Ms. W's claims.

As discussed in detail in Section E, *ante*, in July 2006, doctors diagnosed Mr. R with a serious eye disease that required immediate surgery. Before performing the surgery, Mr. R's physician sought and received pre-approval from PacifiCare.⁶⁰⁴ Mr. R paid \$3,500 on his credit card for the surgeries and promptly submitted claims to PacifiCare, only to have those claims "misplaced."⁶⁰⁵ In fact, Mr. R resubmitted the claims via facsimile three times before PacifiCare acknowledged receipt.⁶⁰⁶ Over the next several months, during which Mr. R continuously resubmitted his claims, PacifiCare denied the claims for multiple different reasons. On December 21, 2006, having still not received reimbursement, Mr. R filed a complaint with CDI.⁶⁰⁷ By January 15, 2007, PacifiCare had paid Mr. R's claims, but not before Mr. R incurred significant interest charges on his credit card, out-of-pocket expenses for multiple faxes and substantial time on the telephone trying to resolve the issue.⁶⁰⁸

On December 4, 2006, CDI received a member complaint alleging PacifiCare failed to properly process six claims. CDI investigated and determined that on six separate occasions,

⁶⁰⁰ RT 1036:11-20.

⁶⁰¹ RT 1036:14-1037:1.

⁶⁰² RT 1038:11-18; Exh. 145.

⁶⁰³ RT 1037:11-17; RT 1039:2-12.

⁶⁰⁴ Exh. 135, p. 9760; RT 1716:15-16.

⁶⁰⁵ Exh. 135, p. 9886; RT 1720:20-24.

⁶⁰⁶ RT 1723:10-16.

⁶⁰⁷ Exh. 135, p. 9535-9536.

⁶⁰⁸ Exh. 140, pp. 9725, 9738; RT 1742:3-14.

PacifiCare issued EOBs requesting information the insurer already possessed.⁶⁰⁹ In a January 3, 2007 letter to the complainant, PacifiCare admitted it requested this unnecessary information. As a result, on February 8, 2007, CDI cited PacifiCare for each of the six requests for additional information.⁶¹⁰

On April 13, 2007, CDI received another member complaint regarding PacifiCare's claims handling process. CDI established that on March 28, 2005, August 17, 2006 and on October 20, 2006, the member submitted claims for counseling services provided.⁶¹¹ In each instance, PacifiCare requested information it already possessed or had previously requested. In May 2007, after the complaint to CDI, PacifiCare properly paid the claims. On June 29, 2007, CDI cited PacifiCare for each of the three requests for additional information.⁶¹²

On May 15, 2007, CDI received a provider complaint against PacifiCare. CDI determined that from March 2006 through July 2006, the complainant filed seven claims with PacifiCare.⁶¹³ The claims contained all necessary medical records and information necessary to process the claims. But in each instance PacifiCare denied the claims based on pre-existing conditions without investigating the accuracy of that conclusion. In fact, PacifiCare possessed the member's COCC and possessed medical records that demonstrated continuing coverage.⁶¹⁴ In June 2007, after the complaint to CDI, PacifiCare paid the seven claims. On April 11, 2008, CDI cited PacifiCare for each of the seven instances where PacifiCare failed to investigate the claims.⁶¹⁵

⁶⁰⁹ Exh. 182, p. 8214.

⁶¹⁰ Exh. 182.

⁶¹¹ Exh. 48, p. 9388.

⁶¹² Exh. 48.

⁶¹³ Exh. 29, p. 1032.

⁶¹⁴ *Ibid.*

⁶¹⁵ Exh. 29.

On June 28, 2007, CDI received another provider complaint alleging PacifiCare improperly processed three claims. CDI established the provider sent claims to PacifiCare in July 2006, November 2006 and February 2007. In each case, PacifiCare denied the claims based on the pre-existing condition exclusion although PacifiCare possessed the COCC and other relevant information.⁶¹⁶ On August 22, 2007, CDI cited PacifiCare for each of the three instances where PacifiCare failed to investigate the claims.⁶¹⁷

On 15 additional occasions, CDI found instances where PacifiCare failed to thoroughly investigate a claim, totaling an additional 18 violations.⁶¹⁸ In each of these instances, CDI cited PacifiCare and provided the insurer with the details of each complaint and citation. Each of these citations was admitted into evidence during the evidentiary hearing.

3. Parties' Contentions

CDI alleges PacifiCare failed to thoroughly investigate claims on at least 46 occasions thereby violating Insurance Code section 790.03, subdivisions (h)(1), (h)(3) and (h)(5). CDI does not allege these violations were willful and suggests a per act penalty of \$3,250.⁶¹⁹

PacifiCare contends CDI failed to establish a violation of Regulation 2695.7, subdivision (d). In support of this assertion, PacifiCare reiterates its administrative hearsay argument, contends Ms. W and Mr. R's testimony is insufficient and revisits its general business practice argument.⁶²⁰ PacifiCare also argues the penalty should not exceed \$1,000 per act.⁶²¹

⁶¹⁶ Exh. 22, p. 9512.

⁶¹⁷ Exh. 22.

⁶¹⁸ See Exhs. 40, 41, 49, 57, 65, 76, 78, 79, 81, 87, 93, 94, 95, 102 and 166.

⁶¹⁹ CDI's Opening Brief to OAH, 303:13-304:4; CDI's Opening Brief to Commissioner, 65:14-25.

⁶²⁰ PacifiCare's Brief to OAH, 308:3-309:26; PacifiCare's Brief to Commissioner, 96:7-97:18.

⁶²¹ PacifiCare's Brief to Commissioner, 97:20-98:2.

4. Analysis and Conclusions of Law

a. Number of Violations

The evidentiary record establishes that on 46 occasions, PacifiCare failed to thoroughly investigate claims in violation of Regulation 2695.7, subdivision (d). CDI citations, and the details supporting those citations, were admitted as evidence during the evidentiary hearing and were not refuted by PacifiCare.

PacifiCare again argues the citations cannot serve as evidence in this proceeding. The Commissioner again finds this argument lacks merit. CDI citations constitute business records and “records by a public employee” under Evidence Code sections 1271 and 1280, and thus serve as an exception to the hearsay rule. The citations explain the basis for both the complaint and CDI’s findings, and they provide PacifiCare with sufficient detail to present a defense. PacifiCare’s failure to defend against these citations, both when they were issued and at the evidentiary hearing, do not render the citations insufficient.

PacifiCare also argues Ms. W and Mr. R’s testimony is insufficient to establish a violation of Regulation 2695.7, subdivision (d) or the Insurance Code. PacifiCare alleges Mr. R “did not provide any documentary evidence that he actually had submitted the claims multiple times.”⁶²² The Commissioner finds no reason to question the veracity of Mr. R’s statements. Mr. R’s testimony is consistent with his CDI complaint and PacifiCare did not refute the substance of his testimony. In addition, neither the Evidence Code nor the Government Code requires CDI present both testimonial and documentary evidence to support a violation. With regard to Ms. W’s testimony, PacifiCare blames Ms. W for “unnecessarily submitting multiple copies of

⁶²² PacifiCare’s Brief to OAH, 308:19-20.

documents.”⁶²³ This argument is disingenuous, since Ms. W submitted the documents in response to a request by PacifiCare representatives.⁶²⁴

Accordingly, the Commissioner concludes PacifiCare failed to conduct a thorough investigation of member and provider claims on at least 46 occasions.

b. Knowingly Committed or General Business Practice

PacifiCare had actual knowledge of its claims handling process and knew it employed a policy that rejected claims without thoroughly investigating their merit. In addition, PacifiCare had constructive knowledge of all the documents it received. PacifiCare’s failure to adequately maintain those documents does not absolve the insurer of “knowledge” under the statute. PacifiCare’s arguments to the contrary are based on its own requirement that CDI demonstrate a “general business practice” and are unsupported by the statute and regulations.

c. Specific UIPA Violations

i. 790.03(h)(1)

Insurance Code section 790.03, subdivision (h)(1) makes it unlawful to misrepresent pertinent facts or insurance policy provisions. PacifiCare’s denial of claims without a thorough investigation misrepresented pertinent facts to claimants. For instance, by repeatedly requesting additional information from Mr. R and by denying his pre-approved claims, PacifiCare misrepresented Mr. R’s coverage and policy provisions. Accordingly, the Commissioner concludes PacifiCare actions violate Insurance Code section 790.03, subdivision (h)(1).

ii. 790.03(h)(3)

Subdivision (h)(3) requires an insurer adopt and implement reasonable standards for the prompt investigation and processing of claims. Failing to conduct a thorough, fair and objective

⁶²³ *Id.* at 309:5-6.

⁶²⁴ See RT 1026:23-1027:10.

investigation and persisting in seeking unnecessary information reflects a failure to adopt and implement reasonable standards for the prompt investigation and processing of claims.

Accordingly, the Commissioner concludes PacifiCare's actions violate Insurance Code section 790.03, subdivision (h)(3).

iii. 790.03(h)(5)

Section 790.03, subdivision (h)(5) requires insurers to attempt in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear. PacifiCare's failure to thoroughly investigate the 46 claims discussed above demonstrates PacifiCare did not make a good faith attempt to fairly settle the claims. Indeed, PacifiCare did not timely process Mr. R's claims even though it had established liability *before* claim submission. Accordingly, the Commissioner concludes PacifiCare violated Insurance Code section 790.03, subdivision (h)(5).

5. Penalty Assessed

a. Willfulness

CDI does not argue these violations were willful and the Commissioner does not find sufficient evidence to demonstrate willfulness as defined in Regulation 2695.2, subdivision (y). Thus, PacifiCare is liable to the state for a civil penalty not to exceed \$5,000 for each act.

b. Single Act or Multiple Violations

There is no evidence PacifiCare inadvertently failed to investigate claims, nor does PacifiCare demonstrate these violations constitute a "single act" under the Insurance Code. Accordingly, the Commissioner may assess a penalty for each of the 46 violations.

c. Regulatory Considerations

The Commissioner considers the seriousness of the violation and the relative harm to providers and members in setting the appropriate penalty.

The Commissioner concludes this type of violation is serious in nature. The regulation and the Insurance Code make clear that a thorough and fair investigation is critical to the proper processing of claims. PacifiCare's automatic denial of claims and its failure to investigate demonstrate indifference towards its members and providers. And the harm that flows from this type of violation is not illusory. Both Ms. W and Mr. R testified to the emotional and financial harm caused by PacifiCare's actions. In the case of Ms. W's son, PacifiCare's actions resulted in denial of medical treatment and out-of-pocket expenses. Further, PacifiCare's actions frustrated both Mr. R and Ms. W, both of whom spent significant work hours addressing PacifiCare's repeated requests for documents.⁶²⁵ As such, the Commissioner concludes a baseline penalty of \$3,250 per act is appropriate for this type of non-willful violation.

The Commissioner finds no factors in mitigation. PacifiCare did not demonstrate it ultimately implemented an adequate investigatory process, nor is there any evidence PacifiCare attempted to comply in good faith.

Based on the above regulatory factors, the Commissioner concludes the appropriate penalty for these 46 violations is \$3,250 per act, which is 65% of the maximum, for a total penalty of \$149,500.

T. Misrepresentations of Pertinent Facts

1. Applicable Law

Insurance Code section 790.03, subdivision (h)(1), which prohibits insurers from “[m]isrepresenting to claimants pertinent facts or insurance policy provisions relating to any

⁶²⁵ See RT 1040:11-17.

coverages at issue.” In addition, Regulation 2695.4, subdivision (a) requires insurers disclose “all benefits, coverage, time limits or other provisions of any insurance policy issued by that insurer that may apply to the claim presented by the claimant.”

The regulation further requires that “[w]hen additional benefits might reasonably be payable under an insured’s policy upon receipt of additional proofs of claim, the insurer shall immediately communicate this fact to the insured and cooperate with and assist the insured in determining the extent of the insurer’s additional liability.”⁶²⁶

2. Findings of Fact

The Commissioner finds by a preponderance of the evidence the following facts regarding PacifiCare’s alleged misrepresentation of pertinent facts.

On September 14, 2006, PacifiCare denied Mr. R’s pre-authorized eye surgeries stating that “Eye exams, glasses, contact lenses and routine eye refractions are not covered.”⁶²⁷ After Mr. R filed a complaint with CDI, PacifiCare paid Mr. R’s claims.⁶²⁸

On January 13, 2007, PacifiCare sent Mr. R an EOB indicating his August 2006 claim was “ineligible” for coverage.⁶²⁹ PacifiCare later admitted this EOB was inaccurate and ultimately paid that claim.⁶³⁰

On January 24, 2007, PacifiCare sent Mr. R a letter representing that PacifiCare had not received Mr. R’s August 2006 claim until January 5, 2007. On that basis, PacifiCare refused to pay Mr. R interest on his claim.⁶³¹ But Mr. R submitted the August 2006 claim multiple times; the first time within a day of having treatment.⁶³² In fact, PacifiCare denied Mr. R’s claim *before*

⁶²⁶ Cal. Code of Regs., tit. 10, § 2695.4, subd. (a).

⁶²⁷ Exh. 140, p. 9721; Exh. 243.

⁶²⁸ Exh. 140, p. 9725.

⁶²⁹ *Id.* at p. 9734.

⁶³⁰ *Id.* at pp. 9725, 9738.

⁶³¹ Exh. 138, p. 9751.

⁶³² Exh. 135, p. 9888; RT 1722:17-21; RT 1723:21-24.

January 5, 2007; the date PacifiCare contends it first received the claim.⁶³³ CDI charges PacifiCare with three violations based on these facts.

On March 29, 2007, CDI received a member complaint alleging PacifiCare failed to properly process claims. CDI established that on seven occasions PacifiCare sent EOBs to both the member and provider that misrepresented the patient's financial responsibility and the provider's discount.⁶³⁴ On July 11, 2007, CDI cited PacifiCare for 14 violations of the FCSP regulations.

On April 13, 2007, CDI received another member complaint. CDI found that in May 2007 PacifiCare sent a letter to the complainant falsely stating that claims had never been received. In fact, the claim file revealed that PacifiCare had received the claims twice before.⁶³⁵ CDI also found that on November 14, 2006, PacifiCare issued an EOB that falsely informed the insured that the services exceeded the maximum allowable benefit provision of the policy. On June 29, 2007, CDI cited PacifiCare for two violations of the Insurance Code and FCSP regulation.⁶³⁶

On April 20, 2007, CDI received another complaint regarding PacifiCare's claims handling process. CDI investigated and found that PacifiCare issued multiple EOBs that falsely stated PacifiCare had not authorized the services. In fact, the insured's claim file reflected that PacifiCare had authorized the services and documented the authorization in case entry notes and in correspondence.⁶³⁷ On September 27, 2007, CDI cited PacifiCare for five violations of the Insurance Code and its applicable regulations.⁶³⁸

⁶³³ RT 1748:18-1749:6.

⁶³⁴ Exh. 49.

⁶³⁵ Exh. 48, p. 9388

⁶³⁶ *Id.* at p. 9387.

⁶³⁷ Exh. 55.

⁶³⁸ *Ibid.*

On June 28, 2007, CDI received a provider complaint alleging PacifiCare provided incorrect information on its EOBs. CDI established that from September 2006 through July 2007, PacifiCare issued multiple EOBs to the insured and provider that included incorrect remark codes and incorrect patient responsibility amounts.⁶³⁹ As a result, on August 22, 2007, CDI cited PacifiCare for 18 instances of misrepresentation.

On August 7, 2007, CDI received another provider complaint alleging PacifiCare misrepresented pertinent facts. CDI's investigation revealed that PacifiCare issued multiple EOBs that incorrectly represented the contract status of the provider, the provider's discounts, the amounts payable by PacifiCare, and the patient's financial responsibility. PacifiCare's reconsideration letters also provided the same misinformation.⁶⁴⁰ On September 13, 2007, CDI cited PacifiCare for 20 instances of misrepresentation.⁶⁴¹

On September 4, 2007, a member telephoned PacifiCare's customer service telephone number to inquire about their coverage. PacifiCare's customer service representative incorrectly informed the member that they were enrolled in an HMO plan.⁶⁴² During this same telephone call, PacifiCare also indicated the member's social security number appeared on their insurance identification cards.⁶⁴³ This information was false. At that time, social security numbers were not being printed on PPO cards.⁶⁴⁴

On September 13, 2007, CDI received yet another complaint regarding PacifiCare's claims handling process. CDI found that PacifiCare issued a claim denial letter stating PacifiCare had not received the claim before June 20, 2007.⁶⁴⁵ But the claim file included a PacifiCare letter

⁶³⁹ Exh. 22.

⁶⁴⁰ Exh. 53, p. 2884.

⁶⁴¹ *Id.* at p. 2883.

⁶⁴² Exh. 349, p. 6625.

⁶⁴³ *Id.* at p. 6624.

⁶⁴⁴ RT 9437:13-9438:3.

⁶⁴⁵ Exh. 78.

dated April 14, 2007, that confirmed PacifiCare's receipt of the claim and all information necessary to process the claim. Based on these facts, CDI cited PacifiCare for misrepresentation.⁶⁴⁶

On 15 additional occasions, CDI found PacifiCare failed to thoroughly investigate a claim, totaling an additional 20 violations.⁶⁴⁷ In each of these additional instances, CDI issued PacifiCare a citation which detailed the facts of the complaint and citation. These citations were admitted into evidence at the evidentiary hearing.

3. Parties' Contentions

CDI alleges PacifiCare misrepresented pertinent facts on at least 85 occasions thereby violating Insurance Code section 790.03, subdivision (h)(1). CDI does not allege these violations were willful and suggests a per act penalty of \$1,500.⁶⁴⁸

PacifiCare contends its actions do not violate the Insurance Code. In support of these assertions, PacifiCare reiterates its administrative hearsay argument, argues providers are not claimants, challenges the testimony of Mr. R, and revisits its argument regarding a general business practice.⁶⁴⁹

4. Analysis and Conclusions of Law

a. Number of Violations

The evidentiary record establishes that on 85 occasions, PacifiCare misrepresented pertinent facts in violation of Regulation 2695.4, subdivision (a) and Insurance Code section 790.03, subdivision (h)(1). CDI citations, and the details supporting those citations, were admitted as evidence and were not refuted by PacifiCare.

⁶⁴⁶ *Ibid.*

⁶⁴⁷ See Exhs. 36, 39, 51, 60, 70, 77, 81, 85, 90, 94, 133, 180, 205, 207, and 222.

⁶⁴⁸ CDI's Opening Brief to OAH, 308:24-309:16; CDI's Opening Brief to Commissioner, 65:26-66:24.

⁶⁴⁹ PacifiCare's Brief to OAH, 349:13-351:17; PacifiCare's Brief to Commissioner, 98:4-26.

PacifiCare again argues the citations cannot serve as evidence in this proceeding. The Commissioner finds this argument lacks merit. CDI citations constitute business records and “records by a public employee” under Evidence Code sections 1271 and 1280, and thus serve as an exception to the hearsay rule. The citations explain the basis for both the complaint and CDI’s findings, and provide PacifiCare with sufficient detail to present a defense. PacifiCare’s failure to defend against these citations, both when they were issued and at the evidentiary hearing, do not render them insufficient.

PacifiCare’s argument that providers are not “claimants” under the Insurance Code is similarly without merit. The regulations make clear that a provider submitting a claim as a beneficiary of a policy is considered a first party claimant.⁶⁵⁰ Any argument to the contrary must be dismissed.

Lastly, PacifiCare challenges Mr. R’s allegations. PacifiCare alleges Mr. R “did not provide any documentary evidence that he actually had submitted the claims multiple times.”⁶⁵¹ The Commissioner finds no reason to question the veracity of Mr. R’s statements. Mr. R’s testimony is consistent with his CDI complaint and PacifiCare did not refute the substance of his testimony. In addition, neither the Evidence Code nor the Government Code requires that CDI present both testimonial and documentary evidence to support a violation.

Accordingly, the Commissioner concludes CDI demonstrated sufficient evidence that PacifiCare misrepresented pertinent facts on 85 occasions.

b. Knowingly Committed or General Business Practice

PacifiCare is charged with knowing the pertinent facts of its insurance policies. For instance, the company should know whether a particular insured is enrolled in an HMO or PPO

⁶⁵⁰ Cal. Code of Regs., tit. 10, § 2695.2, subds. (a), (f).

⁶⁵¹ PacifiCare’s Brief to OAH, 350:18-19.

plan; whether a claim is for a covered or uncovered service; or the correct date that PacifiCare received a claim. In fact, an insurer that does not know such fundamental aspects of its business, does not have adequate control over its operations and lacks sufficient competence to run its company. PacifiCare's arguments to the contrary are based on its own requirement that CDI demonstrate a "general business practice" and are unsupported by the statute and regulations.

c. Specific UIPA Violations

Insurance Code section 790.03, subdivision (h)(1) makes it unlawful to misrepresent pertinent facts or insurance policy provisions. The evidentiary record demonstrates that PacifiCare misrepresented member coverage, receipt of documents, provider discounts and the type of coverage a member possessed. Accordingly, the Commissioner concludes PacifiCare actions violate Insurance Code section 790.03, subdivision (h)(1).

5. Penalty Assessed

a. Willfulness

CDI does not argue these violations were willful and the Commissioner does not find sufficient evidence to demonstrate willfulness as defined in Regulation 2695.2, subdivision (y). Thus, PacifiCare is liable to the state for a civil penalty not to exceed \$5,000 for each act.

b. Single Act or Multiple Violations

There is no evidence PacifiCare inadvertently misrepresented pertinent facts, nor does PacifiCare demonstrate these violations constitute a "single act" under the Insurance Code. Accordingly, the Commissioner may assess a penalty for each of the 85 violations.

c. Regulatory Considerations

In setting the appropriate penalty, the Commissioner considers the seriousness of the violation and the relative harm to providers and members.

The Commissioner concludes this type of violation is moderately serious. The regulation and the Insurance Code make clear that providing claimants with accurate policy information is critical to proper claims handling. In addition, misinforming consumers about eligibility, coverage and benefits, can lead patients to defer needed medical care because they believe it will not be reimbursed.⁶⁵² Such misrepresentations also can result in significant delays in claim reimbursements, as the evidence here reflects. In many instances, PacifiCare's misrepresentations caused claims to be paid many months late. Such delays have serious financial consequences for the consumer.⁶⁵³ As such, the nature of this non-willful violation supports a baseline penalty of \$1,500 per act.

The Commissioner finds no factors in mitigation. PacifiCare did not demonstrate it ultimately implemented an adequate investigatory process, nor is there any evidence PacifiCare attempted to comply in good faith.

Based on the above regulatory factors, the Commissioner concludes the appropriate penalty for these 85 violations is \$1,500 per act, which is 30% of the maximum, for a total penalty of \$127,500.

U. PacifiCare's Constitutional and Deference Contentions

The bulk of PacifiCare's defense consists of constitutional arguments regarding CDI's Order to Show Cause and recommended penalty.⁶⁵⁴ First, PacifiCare contends it did not receive notice that its violations of the Insurance Code and FCSP regulations could result in civil penalties. Second, PacifiCare argues CDI's recommended penalty violates the Excessive Fines Clause of the United States Constitution. Third, PacifiCare argues CDI singled out PacifiCare for

⁶⁵² Exh. 1184, p. 171:18-21.

⁶⁵³ RT 1741:10-1742:20.

⁶⁵⁴ The Proposed Decision does not address PacifiCare's due process or equal protection arguments.

this action thereby violating the Equal Protection Clause of the Fourteenth Amendment. Lastly, PacifiCare contends the Commissioner must accept the ALJ's proposed penalty.

For the reasons explained below, the Commissioner finds each of these arguments to be unpersuasive.

1. PacifiCare's Due Process Arguments

PacifiCare challenges CDI's accusations and the recommended penalty on due process grounds.

a. No Notice That Conduct Might be Subject to Penalty

Initially, PacifiCare argues that "treating a violation of a non-penal statute as a violation of a penal statute" violates due process.⁶⁵⁵ This argument is premised on CDI's alleged failure to provide PacifiCare with notice that violations of FCSP regulations could constitute a violation of Insurance Code section 790.03, subdivision (h). PacifiCare points to its obligation to timely pay claims as an example of this argument. PacifiCare acknowledges that Insurance Code section 790.03, subdivision (h)(4) requires an insurer to affirm or deny a claim "within a reasonable period of time." PacifiCare also acknowledges that Regulation 10123.13, subdivision (a) requires a health insurer to pay claims within 30 working days. But while acknowledging these legal obligations, PacifiCare argues CDI cannot use the substantive 30-day requirement of Regulation 10123.13 to penalize the insurer under Insurance Code section 790.03, subdivision (h)(4) for failing to timely pay claims. In support of this argument, PacifiCare points to the United States Supreme Court's decision in *FCC v. Fox Television Stations, Inc.* (2012) __ U.S. __, 132 S.Ct. 2307. Unfortunately, neither *FCC v. Fox Television Stations*, nor any other statute or case law support PacifiCare's contention.

⁶⁵⁵ PacifiCare's Brief to OAH, 70:15-16; PacifiCare's Brief to Commissioner, 12:9-15:14.

In *FCC v. Fox Television Stations*, the Supreme Court reiterated that “[a] fundamental principle in our legal system is that laws which regulate persons or entities must give fair notice of conduct that is forbidden or required.”⁶⁵⁶ A punishment violates due process if the statute or regulation under which it is obtained fails to provide a person of ordinary intelligence fair notice of what is prohibited.⁶⁵⁷ In essence, regulated parties should know what is required of them so they may act accordingly. Here, there is no question PacifiCare knew what conduct was forbidden or required. PacifiCare knew it was required to timely process claims and knew that timely processed meant within 30 working days of receipt of the claim. In fact, had Regulation 10123.13 not been adopted, PacifiCare could have argued it did not know how many days constituted a “reasonable time” under Section 790.03, subdivision (h)(4). By enacting Regulation 10123.13, the Commissioner provided insurers with fair notice of its required conduct so that they may act accordingly.

PacifiCare also argues CDI “introduced new interpretations of section 790.03 which PacifiCare could not have reasonably anticipated.”⁶⁵⁸ PacifiCare notes that 88% of its violations are based on the omission of statutory appeal rights in EOPs and EOBs. PacifiCare argues it could not have reasonably known that CDI considered such omission of statutory notices to be an omission of a “pertinent fact or policy provision.” But this argument is wholly irrelevant. CDI is only charging PacifiCare with violations that occurred *after* CDI informed PacifiCare that its conduct violated the Insurance Code. PacifiCare’s belief before CDI’s notice is of no consequence, as PacifiCare is not being charged with any violations that occurred prior to CDI’s notice to PacifiCare.

⁶⁵⁶ *FCC v. Fox Television Stations, Inc.*, *supra*, 132 S.Ct. at p. 2317.

⁶⁵⁷ *Ibid.*

⁶⁵⁸ PacifiCare’s Brief to Commissioner, 14:16-17.

There is nothing ambiguous or unconstitutional about applying substantive statutory standards when interpreting what actions are prohibited under Insurance Code section 790.03. Accordingly, the Commissioner rejects PacifiCare's due process argument.

b. CDI Penalty Violates Excessive Fines Clause

PacifiCare makes three separate Excessive Fines Clause arguments.⁶⁵⁹ First, PacifiCare asserts CDI failed to provide notice of the severity of the penalty. Second, PacifiCare contends the penalty must be proportionate to the amount of harm its conduct caused. Lastly, PacifiCare asserts CDI must issue a penalty consistent with prior UIPA cases. Each of these arguments is addressed in turn.

i. No Notice of Severity of Penalty

PacifiCare argues that due process requires that "a person receive fair notice not only of the conduct that will subject him to punishment, but also of the severity of the penalty the State may impose."⁶⁶⁰ Citing *BMW of North America v. Gore* (1996) 517 U.S. 559 (*Gore*) and *State Farm Mutual Automobile Insurance Co. v. Campbell* (2003) 538 U.S. 408 (*State Farm*),

PacifiCare argues CDI failed to assess a constitutionally proportionate penalty.⁶⁶¹ But PacifiCare's reliance on this case law is misguided.

In both *Gore* and *State Farm*, the Supreme Court considered the constitutionality of private-action punitive damages. The Supreme Court noted that due process prohibits excessive punitive damages because "[e]lementary notions of fairness enshrined in our constitutional jurisprudence dictate that a person receive fair notice not only of the conduct that will subject

⁶⁵⁹ The Eighth Amendment provides that: "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted."

⁶⁶⁰ PacifiCare's Brief to OAH, 42:26-27.

⁶⁶¹ *Id.* at 42:25-45:3.

him to punishment, but also of the severity of the penalty that a State may impose.”⁶⁶² But this concern about fair notice does not apply to statutory damages, because those damages are identified and constrained by the authorizing statute. In fact, California case law makes clear that neither *Gore* nor *State Farm* is applicable to civil penalties. In *People ex rel. Bill Lockyer v. Fremont Life Insurance Company* (2002) 104 Cal.App.4th 508, the Attorney General brought an action against an insurer for violating the Unfair Competition Law in the sale of annuities. Therein, the Court of Appeal rejected the insurer’s attempt to rely upon *Gore* in reviewing the constitutionality of a civil penalty:

Appellant’s reliance on *BMW of North America, Inc. v. Gore* (1996) 517 U.S. 559 is misplaced because the guidelines there address the propriety of a punitive damage award, not a civil penalty.⁶⁶³

The Court of Appeal rejected an identical argument in *People v. First Federal Credit Corporation* (2002) 104 Cal.App.4th 721. In upholding a \$200,000 civil penalty under the Unfair Competition Law, the Court of Appeal held that punitive damage case law “does not apply to statutory penalties due to fundamental differences between punitive damages and such penalties.”⁶⁶⁴

Similarly, the federal courts have explicitly rejected using *Gore/State Farm* to review legislatively created remedies. These courts have variously reasoned that *Gore/State Farm* is inapplicable because it addressed open-ended punitive damages, not bounded legislatively created remedies;⁶⁶⁵ that examining the disparity between punitive damages and plaintiff harm (the second *Gore* guidepost) does not translate well to statutory damages, which often are

⁶⁶² *State Farm Mutual Automobile Insurance Co. v. Campbell*, *supra*, 538 U.S. at p. 574.

⁶⁶³ 104 Cal.App.4th at p. 527.

⁶⁶⁴ *Id.* at p. 732.

⁶⁶⁵ *Zomba Enterprises v. Panorama Records* (6th Cir. 2007) 491 F.3d 574, 586, cert. den. (2008) 553 U.S. 1032.

available in the absence, or proof, of plaintiff harm;⁶⁶⁶ and that the Court's due process concern about "fair notice" of potential penalties is absent when a statutory range for the remedy exists—the statute gives citizens notice of the maximum remedy to which they are exposed.⁶⁶⁷ In fact, the Supreme Court has never held that the punitive damages guideposts apply to statutory damages.⁶⁶⁸ As the Court of Appeal stated in *Capitol Records, Inc. v. Thomas-Rasset, supra*, the guideposts "would be nonsensical if applied to statutory damages."⁶⁶⁹

Instead, the U.S. Supreme Court has adopted a different test to assess the constitutionality of civil penalties under the Excessive Fines Clause. In *U.S. v. Bajakajian* (1998) 524 U.S. 321, the federal government sought forfeiture of over \$357,000 in currency, which was the amount the defendant was seeking to transport out of the United States. A federal statute requires that a person leaving the United States report to authorities the transport of more than \$10,000 in currency. Bajakajian pleaded guilty to violating that statute. A separate forfeiture statute provided that a person convicted of willfully violating the reporting statute (as well as many other statutory criminal offenses) shall forfeit "any property . . . involved in such [an] offense." This statute mandated total forfeiture of any property involved in the offense with no boundaries imposed on the amount or value of the property to be forfeited.

In a 5-4 decision, the Supreme Court held that forfeiture of the approximately \$357,000, given the circumstances of the case, violated the Excessive Fines Clause.⁶⁷⁰ The majority announced that "a punitive forfeiture violates the Excessive Fines Clause if it is grossly

⁶⁶⁶ *Capitol Records, Inc. v. Thomas-Rasset* (8th Cir. 2012) 692 F.3d 899, 907-908; *Verizon California Inc. v. Onlinenic, Inc.* (N.D. Cal., Aug. 25, 2009) C 08-2832 JF, 2009 WL 2706393 at *8.

⁶⁶⁷ *Sony BMG Music Entertainment v. Tenebaum* (1st Cir. 2013) 719 F.3d 67, 70-71; *Capitol Records, Inc. v. Thomas-Rasset, supra*, 692 F.3d at p. 908. For a detailed discussion of the Excessive Fines Clause and its applicability, see Murphy, *Reviewing Congressionally Created Remedies for Excessiveness* (2012) 73 Ohio St. L.J. 651.

⁶⁶⁸ *Sony BMG Music Entertainment v. Tenebaum, supra*, 719 F.3d at p. 71; *Capitol Records, Inc. v. Thomas-Rasset, supra*, 692 F.3d at p. 907; *Zomba Enterprises v. Panorama Records, supra*, 491 F.3d at pp. 586-588.

⁶⁶⁹ 692 F.3d at p. 907.

⁶⁷⁰ *U.S. v. Bajakajian, supra*, 524 U.S. at pp. 323, 337.

disproportional to the gravity of a defendant's offense.”⁶⁷¹ But the *Bajakajian* majority rejected a requirement of strict proportionality between the amount of a punitive forfeiture and the gravity of the offense, asserting instead that “judgments about the appropriate punishment for an offense belong in the first instance to the legislature” and that “any judicial determination regarding the gravity of a particular criminal offense will be inherently imprecise.”⁶⁷² It then set out four considerations: (1) the defendant's culpability; (2) the relationship between the harm and the penalty; (3) the penalties imposed in similar statutes; and (4) the defendant's ability to pay.⁶⁷³ Both federal and California courts apply these four considerations when examining civil penalties under the Excessive Fines Clause.

In applying *Bajakajian*, courts have consistently held that any penalty below the legislatively-created maximum is constitutional. For example, in *Balice v. United States Dep't of Agriculture* (9th Cir. 2000) 203 F.3d 684, the Ninth Circuit Court of Appeal held that a \$225,500 fine did not violate the Eighth Amendment where the maximum fine was \$528,000, notwithstanding the lack of monetary loss suffered by the government.⁶⁷⁴ Similarly, in *United States v. Mackby, supra*, the Court of Appeal ruled that \$729,454.92 in civil penalties and treble damages against the owner of a physical therapy clinic who violated the False Claims Act did not violate the Excessive Fines Clause, where the owner's maximum penalty was almost \$86 million and the maximum treble damages award was almost \$1 million.⁶⁷⁵ This rationale is mirrored in *Pharaon v. Board of Governors of Fed. Reserve Sys.* (D.C. Cir. 1998) 135 F.3d 148, where the court held that a \$37 million penalty did not violate the Excessive Fines Clause since “the

⁶⁷¹ *Id.* at p. 334.

⁶⁷² *Id.* at p. 336.

⁶⁷³ *Id.* at pp. 337–338; *People ex rel. Lockyer v. R.J. Reynolds Tobacco Co.* (2005) 37 Cal.4th 707, 728; *City and County of San Francisco v. Sainez, supra*, 77 Cal.App.4th at pp. 1320–1322.

⁶⁷⁴ *Balice v. United States Dep't of Agriculture, supra*, 203 F.3d at p. 699.

⁶⁷⁵ *United States v. Mackby, supra*, 339 F.3d at p. 1018.

penalty [was] proportional to [the] violation and well below the statutory maximum [of \$111.5 million].”⁶⁷⁶ This same logic has been repeated in many other federal appellate court rulings.⁶⁷⁷

In fact, some federal courts have held that if a monetary fine is within the boundaries set by the legislature, the fine cannot violate the Excessive Fines Clause. For instance, in *Kelly v. U.S. EPA* (7th Cir. 2000) 203 F.3d 519, the Court of Appeal affirmed a \$7,000 penalty where the maximum fine equaled \$100,000 stating “[w]e can't say the fine is grossly disproportionate to the gravity of the offense when Congress has made a judgment about the appropriate punishment.”⁶⁷⁸ Likewise, both the First and Fifth Circuit Courts of Appeal have consistently held that “[n]o matter how excessive (in lay terms) an administrative fine may appear, if the fine does not exceed the limits prescribed by the statute authorizing it, the fine does not violate the Eighth Amendment.”⁶⁷⁹ Accordingly, “[c]ivil penalty awards in which the amount of the award is less than the statutory maximum do not run afoul of the Excessive Fines Clause.”⁶⁸⁰

As of the date of this decision, the Commissioner can find no reported federal or California court decision that invalidates, under the Excessive Fines Clause, the amount of a penalty imposed within legislative boundaries. In this decision, the Commissioner imposes penalties *below* the legislative maximum. Accordingly, PacifiCare’s constitutional argument must be dismissed as without merit.

⁶⁷⁶ *Pharaon v. Board of Governors of Fed. Reserve Sys.*, *supra*, 135 F.3d at p. 157.

⁶⁷⁷ See *United States v. Emerson* (1st Cir. 1997) 107 F.3d 77, 79 (holding that “a fine one-half the size of that permitted by the relevant statute, assessing \$5,000 for each of [defendant's] thirty-seven admitted violations rather than the statutory maximum of \$10,000 per violation ... though substantial, is constitutionally permissible.”); *Korangy v. U.S. F.D.A.* (4th Cir. 2007) 498 F.3d 272, 277-278 (“Congress authorized up to \$10,000 for each violation . . . The \$3,000 per violation penalty imposed by the FDA thus represents a substantial reduction of the penalty authorized by Congress.”)

⁶⁷⁸ *Kelly v. U.S. EPA*, *supra*, 203 F.3d at p. 524.

⁶⁷⁹ *Martex Farms, S.E. v. U.S. EPA* (1st Cir. 2009) 559 F.3d 29, 34; *Newell Recycling Co. v. U.S. EPA* (5th Cir. 2000) 231 F.3d 204, 210; see also *Gonzalez v. U.S. Dep't of Commerce Nat'l Oceanic & Atmospheric Admin.* (5th Cir. 2011) 420 F.App'x 364, 370.

⁶⁸⁰ *U.S. v. Eghbal* (C.D. Cal. 2007) 475 F.Supp.2d 1008, 1017, *affd.* (9th Cir. 2008) 548 F.3d 1281.

ii. Penalty Must be Proportionate to Harm Caused

PacifiCare also contends the Commissioner's civil penalty must be proportional to the actual harm caused by its violations.⁶⁸¹ In support of this argument, PacifiCare again relies on *State Farm, supra*, 538 U.S. 408. But PacifiCare's argument relies on inapplicable case law regarding punitive damages. While the Supreme Court in *State Farm* adopted a punitive damage to compensatory damage ratio, California courts have consistently held that such a ratio is inapplicable in the civil penalty arena.

First, California courts note that the purpose of a civil penalty is to "secure obedience to statutes and regulations imposed to assure important public policy objectives."⁶⁸² As such, it is common for a civil penalty statute to require no proof of actual harm since "[a] penalty statute presupposes that its violation produces damage beyond that which is compensable."⁶⁸³ Indeed, neither the Insurance Code section 790.03, subdivision (h), nor any other statute or regulation at issue herein, requires proof of harm. Similarly, Insurance Code section 790.035 permits the imposition of a civil penalty without regard to the actual harm suffered.

Second, California courts have unfailingly rejected arguments like those made by PacifiCare and instead have held that "regulatory statutes would have little deterrent effect if violators could be penalized only where a plaintiff demonstrated quantifiable damages."⁶⁸⁴ For example, in *Wilmshurst, supra*, a defendant car dealer selling automobiles not certified as complying with state emission standards argued that because "there was no evidence any of the

⁶⁸¹ PacifiCare's Brief to OAH, 45:12-48:23; PacifiCare's Brief to Commissioner, 18:16-19:23.

⁶⁸² *Starving Students, Inc. v. Department Of Industrial Relations, Div. of Labor Standards Enforcement* (2005) 125 Cal.App.4th 1357, 1367-68; see also *Home Depot U.S.A. Inc. v. Superior Court* (2010) 191 Cal.App.4th 210, 225; *Kizer v. County of San Mateo* (1991) 53 Cal.3d 139, 147-148.

⁶⁸³ *Starving Students, Inc., supra*, 125 Cal.App.4th at p. 1368; see also *City and County of San Francisco v. Sainez, supra*, 77 Cal.App.4th at p. 1315; *Kinney v. Vaccari* (1980) 27 Cal.3d 348, 352.

⁶⁸⁴ *People ex rel. State Air Resources Bd. v. Wilmshurst, supra*, 68 Cal.App.4th at p. 1351; *State of California v. City & County of San Francisco* (1979) 94 Cal.App.3d 522, 531.

vehicles had emissions in excess of those tolerated under the law,” the Board was “not entitled to any penalty assessment.”⁶⁸⁵ The court soundly rejected this argument:

Their argument that damage must be paramount to deterrence in penalty-setting once again raises the untenable spectre of forcing the Board in every individual case to prove the amount of emissions stemming from a particular vehicle, an enforcement scheme the Legislature has eschewed. Having violated the Legislature's carefully crafted strategy for minimizing the pollution effects of mobile sources in interstate commerce, it is a sufficient basis for the penalty that they be deterred from ever doing so again.⁶⁸⁶

Similarly, in *Kizer v. County of San Mateo*, *supra*, the California Supreme Court held that the County may impose a civil penalty for violations of nursing home regulations with “no showing of actual harm per se.”⁶⁸⁷ And in *Ojavan Investors v. California Coastal Comm.* (1997) 54 Cal.App.4th 373, the Court of Appeal upheld a \$9.5 million civil penalty for selling coastal parcels where there was “very little or no physical damage to the properties involved,” holding that the penalty was permissible to secure “uniform compliance” with the coastal protection act.⁶⁸⁸

Federal courts also routinely uphold administrative civil penalties without a showing of specific harm. For example, in *Qwest Corporation v. Minnesota Public Utilities Commission* (8th Cir. 2005) 427 F.3d 1061, the local exchange carrier brought an action against the utilities commission, challenging the state’s imposition of a \$26 million penalty. While the carrier’s transgressions were “filing offenses” that did not result in specific harm, the Court of Appeal found the penalty did not violate the Excessive Fines Clause since the carrier’s actions “affected the state regulatory body, the competitive environment in Minnesota” and impacted the carrier’s

⁶⁸⁵ *People ex rel. State Air Resources Bd. v. Wilmshurst*, *supra*, 68 Cal.App.4th at p. 1351.

⁶⁸⁶ *Ibid.*

⁶⁸⁷ *Kizer v. County of San Mateo*, *supra*, 53 Cal.3d at p. 147.

⁶⁸⁸ *Ojavan Investors v. California Coastal Comm.*, *supra*, 54 Cal.App.4th at pp. 397-398; see also *Fremont Life Insurance Company*, *supra*, 104 Cal.App.4th at p. 527.

competitors.⁶⁸⁹ Likewise, in *U.S. ex rel. Bunk v. Gosselin World Wide Moving, N.V.*, *supra*, the Court of Appeal stated that the concept of harm need not be confined to the economic realm, since such violations shake the public's faith in the regulatory body and may encourage others to act in a like fashion.⁶⁹⁰

In summary, the Commissioner may impose a civil penalty without proof of actual harm since the penalty statute "presupposes that its violation produces damage beyond that which is compensable."⁶⁹¹ Requiring otherwise would have "little deterrent effect" and would not assure the important public policy objectives the penalties serve.⁶⁹²

iii. Penalty Must be Consistent with Prior CDI Actions

PacifiCare further argues that any penalty issued by CDI must be proportional to prior penalties issued.⁶⁹³ In support of this contention, PacifiCare again relies on *Gore*, *supra*. But neither due process nor the APA requires penalties consistent with past agency action.

With regard to civil penalties, *Gore* states only that the range of prior civil penalties may be evidence of the reasonableness of a punitive damage award.⁶⁹⁴ It does not, as PacifiCare argues, state that in setting civil penalties, the court must consider penalties issued in comparable cases. PacifiCare selects excerpts from *Gore* to cobble together this argument which California courts have repeatedly rejected. As the Court of Appeal stated in *Fremont Life Insurance*, *supra*, "*BMW v. Gore* refers to civil penalties for the purposes of comparison with punitive damage awards to evaluate whether the awards were excessive. But *BMW v. Gore* does not apply the

⁶⁸⁹ *Qwest Corporation v. Minnesota Public Utilities Commission*, *supra*, 427 F.3d at p. 1070; see also *U.S. v. Gurley* (6th Cir. 2004) 384 F.3d 316, 325 (upholding \$1.9 million penalty for failing to respond to EPA information requests).

⁶⁹⁰ *U.S. ex rel. Bunk v. Gosselin World Wide Moving, N.V.*, *supra*, 741 F.3d at p. 409.

⁶⁹¹ *Starving Students, Inc.*, *supra*, 125 Cal.App.4th at p. 1368.

⁶⁹² *People ex rel. State Air Resources Bd. v. Wilmshurst*, *supra*, 68 Cal.App.4th at p. 1351.

⁶⁹³ PacifiCare's Brief to OAH, 49:20-55:28; PacifiCare's Brief to Commissioner, 19:24-21:9.

⁶⁹⁴ *BMW v. Gore*, *supra*, 517 U.S. at p. 575.

guidelines to civil penalties.”⁶⁹⁵ In fact, California courts have consistently held that there is no requirement that charges similar in nature must result in identical penalties.⁶⁹⁶ And an administrative agency is not bound to deal with a current case in the same manner as it has dealt with past cases.⁶⁹⁷ Indeed, courts that overturn penalties on the basis that prior violators received lesser penalties have been found to have abused their discretion.⁶⁹⁸

PacifiCare’s reliance on prior settlement orders is equally misplaced. First, the APA specifically forbids basing a penalty on prior settlement orders. Government Code section 11425.50, subdivision (e) states “a penalty may not be based on a guideline, criterion, bulletin, manual, instruction, order, standard of general application or other rule . . . unless it has been adopted as a regulation.” In addition, the APA states that “a decision may not be expressly relied on as precedent unless it is designated as a precedent by the agency.”⁶⁹⁹ Since the settlement orders are not precedential, they may not be relied upon in this, or any other, proceeding. Furthermore, Regulation 2695.12 specifically directs the Commissioner on how to assess penalties under the UIPA. The regulation does not permit the Commissioner to consider previous settlements or penalty orders in issuing a penalty. Accordingly, this argument is without merit and must be dismissed.

2. PacifiCare’s Equal Protection Argument

Although not raised in its Brief to the Commissioner, PacifiCare argued to the ALJ that CDI’s prosecution of PacifiCare’s nearly one million violations constitutes a violation of the

⁶⁹⁵ *People ex rel. Bill Lockyer v. Fremont Life Insurance Co.*, *supra*, 104 Cal.App.4th at p. 521.

⁶⁹⁶ *Coleman v. Harris* (1963) 218 Cal.App.2d 401, 404; *Talmo v. Civil Serv. Comm.* (1991) 231 Cal.App.3d 210, 230-231; *Kolendar v. San Diego County Civil Serv. Comm.* (2005) 132 Cal.App.4th 716, 723.

⁶⁹⁷ *Grannis v. Board of Medical Examiners* (1971) 19 Cal.App.3d 551, 566; *Butz v. Glover Livestock Comm’n Co.* (1973) 411 U.S. 182, 187 (“[t]he employment of a sanction within the authority of an administrative agency is ... not rendered invalid in a particular case because it is more severe than sanctions imposed in other cases”); *FCC v. WOKO* (1946) 329 U.S. 223, 228.

⁶⁹⁸ *Pegues v. Civil Serv. Comm.* (1998) 67 Cal.App.4th 95, 106.

⁶⁹⁹ Gov. Code § 11425.60, subd. (a).

Equal Protection Clause of the United States Constitution.⁷⁰⁰ Specifically, PacifiCare argues it was treated differently from all other similarly situated insurers, that CDI singled PacifiCare out for differential treatment and that there is no rational basis for CDI's prosecution of PacifiCare.⁷⁰¹ The Commissioner finds this argument lacks merit for the reasons that follow.

i. "Class of One" Jurisprudence

Typically, equal protection jurisprudence is concerned with government classifications that impact groups of citizens differently than others. But in *Village of Willowbrook v. Olech* (2000) 528 U.S. 562, the United States Supreme Court "recognized successful equal protection claims brought by a 'class of one,' where the plaintiff alleges that she has been intentionally treated differently from others similarly situated and that there is no rational basis for the difference in treatment."⁷⁰² While acknowledging the "class of one," the Supreme Court has nonetheless further held that "[t]he class-of-one doctrine does not apply to forms of state action that 'by their nature involve discretionary decision making based on a vast array of subjective, individualized assessments.'"⁷⁰³

In *Engquist, supra*, a former state employee laid off in a reorganization brought a class of one equal protection claim arguing that she had been fired for "arbitrary, vindictive, and malicious reasons." The Supreme Court held that the "class-of-one theory of equal protection has no application to public employment decisions," largely because such decisions "by their nature involve discretionary decision making based on a vast array of subjective, individualized assessments."⁷⁰⁴ The Court distinguished *Olech*, explaining:

⁷⁰⁰ PacifiCare's Brief to OAH, 60:1-65:18.

⁷⁰¹ *Id.* at 60:20-24.

⁷⁰² 528 U.S. at p. 564.

⁷⁰³ *Engquist v. Oregon Dept. of Agric.* (2008) 553 U.S. 591, 603.

⁷⁰⁴ *Id.* at p. 603.

There are some forms of state action however, which by their nature involve discretionary decision making based on a vast array of subjective, individualized assessments. In such cases the rule that people should be treated alike, under like circumstances and conditions is not violated when one person is treated differently from others, because treating like individuals differently is an accepted consequence of the discretion granted. In such situations, allowing a challenge based on the arbitrary singling out of a particular person would undermine the very discretion that such state officials are entrusted to exercise.⁷⁰⁵

Courts have extended the rationale of *Engquist* to other contexts where a plaintiff challenges a discretionary state action under a class of one equal protection theory. For instance, in *United States v. Moore* (7th Cir. 2008) 543 F.3d 891, the Seventh Circuit refused to apply the class of one theory to prosecutorial discretion, stating “an exercise of prosecutorial discretion cannot be successfully challenged merely on the ground that it is irrational or arbitrary; in the realm of prosecutorial charging decisions, only invidious discrimination is forbidden.”⁷⁰⁶ Similarly, in *Flowers v. City of Minneapolis* (8th Cir. 2009) 558 F.3d 794, the Court of Appeal refused to apply the class of one theory to investigative decisions by police officers. “We conclude that while a police officer’s investigative decisions remain subject to traditional class-based equal protection analysis, they may not be attacked in a class-of-one equal protection claim.”⁷⁰⁷

Based on the above case law, the Commissioner rejects PacifiCare’s “class of one” argument. The decision to prosecute an insurer is “discretionary decisionmaking based on a vast array of subjective, individualized assessments” and permitting a challenge on the arbitrary

⁷⁰⁵ *Ibid.*

⁷⁰⁶ *United States v. Moore, supra*, 543 F.3d at p. 900.

⁷⁰⁷ *Flowers v. City of Minneapolis* (8th Cir. 2009) 558 F.3d at p. 799-800. See also *Kolstad v. County of Amador* (E.D.Cal. Nov.14, 2013) 13-01279, 2013 WL 6065315, at *7 (noting that it was “questionable” whether plaintiffs’ equal protection class of one claim based on selective enforcement of the county code against plaintiffs’ property may proceed against the county).

singling out of a particular insurer “would undermine the very discretion that such state officials are entrusted to exercise.”⁷⁰⁸

ii. Rational Basis Test

The Ninth Circuit Court of Appeals has not addressed whether a plaintiff can bring a “class of one” Equal Protection claim against a prosecutorial decision of a state agency. Nonetheless, PacifiCare cannot assert such a claim, since it has not shown to whom it was similarly situated, nor has PacifiCare demonstrated CDI lacked a rational basis for bringing an Order to Show Cause against PacifiCare.

In *Gerhart v. Lake County Montana* (9th Cir. 2011) 637 F.3d 1013, the Ninth Circuit explained that in order for a plaintiff to succeed on a class of one claim, the plaintiff “must demonstrate that [the defendant]: (1) intentionally (2) treated [the plaintiff] differently than other similarly situated [insurers], (3) without a rational basis.”⁷⁰⁹ The groups must be comprised of similarly situated persons so that the factor motivating the alleged discrimination can be identified. An equal protection claim will not lie by “conflating all persons not injured into a preferred class receiving better treatment” than the plaintiff.⁷¹⁰ In fact, with respect to the differential treatment element, a plaintiff must demonstrate that “the level of similarity between plaintiff and the persons with whom they compare themselves [is] extremely high.”⁷¹¹ To succeed, plaintiffs “must demonstrate that they were treated differently than someone who is prima facie identical in all relevant respects.”⁷¹² And once PacifiCare has found an identically-situated insurer, it must demonstrate CDI lacked a rational basis for its prosecution. In other

⁷⁰⁸ *Engquist v. Oregon Dept. of Agric.*, *supra*, 553 U.S. at p. 604.

⁷⁰⁹ *Gerhart v. Lake County Montana*, *supra*, 637 F.3d at p. 1022.

⁷¹⁰ *Thornton v. City of St. Helens* (9th Cir. 2005) 425 F.3d 1158, 1167.

⁷¹¹ *Wilson v. City of Fresno* (E.D. Cal. Oct. 2, 2009) No. CV F 09–0887 LJO SMS, 2009 WL 3233879, at *7 (citing to *Neilson v. D’Angelis* (2nd Cir. 2005) 409 F.3d 100, 104).

⁷¹² *Purze v. Village of Winthrop Harbor* (7th Cir. 2002) 286 F.3d 452, 455; *Solis v. City of Fresno* (E.D. Cal., Nov. 17, 2011) No. 1:11-CV-00053 AWI, 2011 WL 5825661.

words, PacifiCare must show that the difference in treatment was “so unrelated to the achievement of any combination of legitimate purposes that we can only conclude that the [government's] actions were irrational.”⁷¹³ Proving the absence of a rational basis is exceedingly difficult, and in “some circumstances involving complex discretionary decisions, the burden may be insurmountable.”⁷¹⁴

PacifiCare fails to meet even the first step of this test, since it failed to identify an identically-situated insurer. PacifiCare does not point to another insurer who suffered from the same marked increase in complaints in such a short period nor does the evidentiary record establish that such an insurer exists. PacifiCare also fails to demonstrate that another insurer received formal complaints from the California Medical Association and the University of California, intentionally withheld information from CDI, or violated the Insurance Code nearly one million times. Absent a similarly situated insurer, PacifiCare’s equal protection claim fails and must be dismissed.

Even assuming PacifiCare provided evidence of an identically-situated insurer, PacifiCare did not provide evidence that CDI targeted them without a rational basis. The sheer volume of complaints received by CDI alone is sufficient to demonstrate a rational basis. And there can be no question that the targeted market conduct examination was a rational response to the increase in complaints. In fact, CDI was not alone in examining PacifiCare’s operations. In April 2007, the DMHC examined PacifiCare’s operations, and the record establishes that regulators from Oregon and Washington also questioned PacifiCare’s claims handling process as

⁷¹³ *Las Lomas Land Co. v. City of Los Angeles* (2009) 177 Cal.App.4th 837, 859; *Griffith v. City of Santa Cruz* (2012) 207 Cal.App.4th 982, 994.

⁷¹⁴ *Las Lomas Land Co. v. City of Los Angeles*, *supra*, 177 Cal.App.4th at p. 859.

early as October 2006.⁷¹⁵ The volume of complaints and the results of CDI's MCE establish a rational basis for CDI's Order to Show Cause.

While PacifiCare argues that no other insurer has been subject to the volume of accusations and penalties at a hearing, PacifiCare fails to acknowledge that it is the first insurer CDI has taken to hearing. Accordingly, the number of violations charged in this proceeding has no parallel. And although PacifiCare argues CDI permitted other insurers to "substantially comply" with the Insurance Code, this argument too lacks merit. PacifiCare's evidence of "substantial compliance" is limited to those insurers who settled CDI accusations. PacifiCare did not settle with CDI and as such it cannot rely on this argument to support its equal protection claim.

Even if PacifiCare could make a class of one claim with respect to CDI's discretionary decision to prosecute PacifiCare's violations of the Insurance Code, PacifiCare's equal protection argument is meritless because PacifiCare failed to present similarly situated insurers and failed to demonstrate an irrational basis for CDI's investigation.

3. PacifiCare's Deference Argument

PacifiCare argues throughout its Brief that the Commissioner can and should reverse the ALJ's findings and conclusions, most of which favor CDI. Yet, PacifiCare also argues the Commissioner is bound by the ALJ's recommended penalty.⁷¹⁶ Having reviewed the relevant statutes and case law, the Commissioner concludes PacifiCare's argument lacks merit.

PacifiCare argues it would be an "abuse of discretion" for the Commissioner to issue a penalty in excess of the \$11.5 million penalty recommended by the ALJ. In support of its contention, PacifiCare cites *Garza v. Workmen's Compensation Appeals Bd.* (1970) 3 Cal.3d

⁷¹⁵ Exh. 5408; Exh. 5265, p. 1946.

⁷¹⁶ PacifiCare's Brief to Commissioner, 21:10-23:7.

312, *Apte v. Regents of the University of California* (1988) 198 Cal.App.3d 1084, and *California Youth Authority v. State Personnel Bd.* (2002) 104 Cal.App.4th 575.⁷¹⁷ But none of the cases cited by PacifiCare invoke the Administrative Procedure Act. In those cases, the ALJ and the reviewing boards were guided not by the Government Code but by their own internal regulations. Herein, the proceedings are governed entirely by the APA, which only defers to an ALJ on witness credibility findings.⁷¹⁸ Since the ALJ's decision is devoid of any credibility determinations, the Proposed Decision does not receive any deference. In addition, Government Code section 11517, subdivision (c)(2)(E) specifically permits the Commissioner to reject the ALJ's proposed decision and unilaterally decide the case. Such a provision would be entirely meaningless if the Commissioner was then obligated to defer to the ALJ's proposed penalty.

The Commissioner's conclusion is further supported by California case law interpreting the APA. In reviewing the revocation of a real estate broker's license, the Court of Appeal held that the statutory scheme under the APA contemplates that the Commissioner will have and exercise the final and ultimate responsibility for determining the penalty to be imposed.⁷¹⁹ "He is not mandated to accept the recommendation of the administrative law judge."⁷²⁰ This conclusion has been affirmed by California courts and none of the authorities cited by PacifiCare stand for the proposition that the Commissioner's decision to proceed under Government Code section 11517 bars him from imposing a penalty more severe than that recommended by the ALJ.⁷²¹

Accordingly, the Commissioner rejects PacifiCare's deference argument as unsupported by statutory and case law. The Commissioner is not mandated to accept the ALJ's recommended

⁷¹⁷ *Id.* at 22:10-19. PacifiCare also cites *Universal Camera Corp. v. NLRB* (1951) 340 U.S. 474. *Universal Camera* addresses the deference given to an agency's final decision by a reviewing court. Such principles are irrelevant when considering the deference the Commissioner must give to the ALJ's proposed decision under California's Administrative Procedure Act.

⁷¹⁸ Gov. Code § 11425.50, subd. (b).

⁷¹⁹ *Golde v. Fox* (1979) 98 Cal.App.3d 167, 188.

⁷²⁰ *Ibid.*

⁷²¹ *Alford v. Department of Motor Vehicles* (2000) 79 Cal.App.4th 560, 567-568.

penalty and is permitted to issue a penalty consistent with the Insurance Code and its applicable regulatory guidelines.

VIII. Aggregate Penalty

The number of violations per category and the per-act penalties result in an aggregate penalty of \$173,603,750 as demonstrated in the following table:

Violation Category	Number of Acts in Violation	Number of Acts Penalized	Unit-Penalty	Penalty for the Category
Incorrect Denial of Claims: Failure to Maintain COCCs on File	1,799	1,799	\$7,000	\$12,593,000
Incorrect Denial of Claims: Illegal Exclusionary Period	3,862	3,862	\$750	\$2,896,500
Failure to Give Providers Notice of Right to CDI Appeal	462,805	10,000	\$3,000	\$30,000,000
Failure to Provide Notice of Right to IMR	336,085	10,000	\$2,275	\$22,750,000
Failure to Timely Pay Claims	34,934	10,000	\$5,500	\$55,000,000
Failure to Pay Interest on Late Claims	5,195	5,195	\$1,500	\$7,792,500
Failure to Correctly Pay Claims	3,700	3,700	\$6,000	\$22,200,000
Failure to Acknowledge Receipt of Claims	56,463	10,000	\$750	\$7,500,000
Failure to Timely Respond to Provider Disputes	1,510	1,510	\$3,700	\$5,587,000
Illegally Closing Files When Requesting Additional Information	14	14	\$2,500	\$35,000
Untimely Collection Notices on Overpaid Claims	1,934	1,934	\$3,500	\$6,769,000
Failure to Maintain Complete Claim Files	15	15	\$350	\$5,250
Failure to Timely Respond to CDI Inquiries	29	29	\$3,500	\$101,500
Failure to Train Claims Agents on FCSP Regulations	23	23	\$2,250	\$51,750

Misrepresentations to CDI	8	8	\$0	\$0
Failure to Conduct Business in Own Name	29	29	\$250	\$7,250
Failure to Timely Respond to Claimants	9	9	\$3,500	\$31,500
Failure to Implement Date of Receipt Policy	2	2	\$3,250	\$6,500
Failure to Conduct a Thorough Investigation	46	46	\$3,250	\$149,500
Misrepresentation of Pertinent Facts	85	85	\$1,500	\$127,500
TOTAL	908,547	58,260		\$173,603,750

A. Aggregate Penalty is Appropriate in this Case

PacifiCare contends any penalty over \$655,000 is inappropriate.⁷²² The Commissioner finds this argument unpersuasive given the magnitude of PacifiCare's noncompliance and the Legislature's guidelines.

While this penalty is the largest fine issued by the Department of Insurance, this is the first, and only, UIPA case ever litigated to either a proposed or final decision. All other matters settled long before the litigation and penalty phase. This matter also has no parallel in either number of violations found or maximum potential penalty. No other insurer has violated UIPA or other provisions of the Insurance Code hundreds of thousands of times.⁷²³ And no other insurer has repeatedly misrepresented its business practices, failed to correct the root causes of its violations, or ignored its statutory obligations to the extent shown herein. In short, this litigation is unprecedented because the depth and breadth of PacifiCare's unlawful actions are unprecedented.

⁷²² PacifiCare's Brief to OAH, 55:18-24.

⁷²³ In fact, the prior settlements relied upon by PacifiCare largely involve rescission matters where the penalty is limited to \$118 per violation. (See Ins. Code § 10400.)

The Commissioner also recognizes that flagrant and repeated violations of the Insurance Code shakes the public's confidence in the health insurance industry, during a time when healthcare is on the minds of many California consumers. A significant and proportionate penalty discourages other insurers from acting in a like fashion while assuring consumers that the Commissioner will adequately penalize those insurers who violate the Insurance Code. In fact, the Commissioner should consider the award's deterrent effect on both PacifiCare and others contemplating such conduct.⁷²⁴

Lastly, the Commissioner notes the Legislature set the UIPA penalties and determined that a UIPA violation is a serious offense for which the appropriate penalty is up to \$10,000 per willful act. The Commissioner found 908,547 violations and weighed the seriousness of the violations and aggravating and mitigating factors. The \$173.6 million penalty ordered by the Commissioner is well within the legislatively-authorized maximum penalty. The Commissioner concludes a penalty that is well within the maximum fine established by the Legislature is not grossly disproportionate to the gravity of PacifiCare's violations since the Legislature has already made a judgment about the appropriate maximum penalty for such violations.⁷²⁵

Under the circumstances of this case, the Commissioner is satisfied that a civil penalty of \$173.6 million for 908,547 Insurance Code violations appropriately reflects the gravity of PacifiCare's offenses and provides the necessary deterrent effect going forward.

B. Aggregate Penalty Does Not Render PacifiCare Insolvent

The Commissioner is charged with monitoring the financial solvency of California insurers. The Commissioner may prevent a solvent insurer from taking action that would

⁷²⁴ *U.S. ex rel. Bunk v. Gosselin World Wide Moving, N.V.*, *supra*, 741 F.3d at p. 409.

⁷²⁵ See *Kelly v. U.S. EPA*, *supra*, 203 F.3d at p. 524.

jeopardize that solvency, and may stay his own hand to avoid a similar risk.⁷²⁶ In that vein, it is appropriate for the Commissioner to evaluate the impact of the aggregate penalty on PacifiCare's financial condition. Having reviewed PacifiCare's financial evidence in the record, the Commissioner concludes the aggregate penalty does not jeopardize the insurer's solvency.⁷²⁷

As of June 30, 2011, PacifiCare had \$728.8 million in surplus and \$221.2 million in net written premium.⁷²⁸ Based on these surplus and net premium amounts, CDI's Financial Surveillance Branch assessed PacifiCare's capital need using two separate quantitative tests.⁷²⁹ The first test applied a basic surplus to premium ratio to PacifiCare's values. Pursuant to this ratio, an insurer needs \$1 of surplus for every \$3 of net written premium.⁷³⁰ Accordingly, PacifiCare needs \$73.8 million in surplus to sustain its operations.⁷³¹ PacifiCare's surplus of \$728.8 million is \$655 million *more* than the insurer needs to maintain financial stability.⁷³²

CDI also evaluated PacifiCare's solvency using the risk-based capital ratio. Risk-based capital is a method of measuring the minimum amount of capital appropriate for a reporting entity to support its overall business operations in consideration of its size and risk profile.⁷³³ Under the risk-based capital formula, PacifiCare would need a surplus of \$20.8 million to support its business volume.⁷³⁴ PacifiCare's surplus of \$728.8 million significantly exceeds the minimum requirement under this formula, and further demonstrates that a penalty of \$173 million would not impact the insurer's financial solvency.

⁷²⁶ See Ins. Code § 1065.1.

⁷²⁷ The Commissioner did not review or consider United's financial condition, since PacifiCare argued during the evidentiary hearing that United's financial standing is irrelevant to these proceedings. (RT 22452:23-22457:19.)

⁷²⁸ Exh. 1184, p. 173:18-23.

⁷²⁹ PacifiCare concedes these tests are standard industry tools used to evaluate an insurer's financial solvency. (RT 24715:6-24716:8.)

⁷³⁰ Exh. 1184, p. 173:24-26; See also *Hill v. State Farm Mut. Auto. Ins. Co.* (2008) 166 Cal.App.4th 1438, 1463.

⁷³¹ \$221.2 million/3 = \$74 million.

⁷³² \$728.8 million - \$73.8 million = \$655 million.

⁷³³ 1A Couch on Insurance (3d ed. 2013) § 9.5.

⁷³⁴ Exh. 1184, p. 173:26-27.

In addition to the solvency tests discussed above, CDI examined PacifiCare's rate of return on average capital and surplus from 2006 through 2008; the relevant time periods discussed in this proceeding. Over those three years, PacifiCare reported an after-tax, net income of \$600.5 million.⁷³⁵ CDI divided each year's after-tax earnings by each year's mean capital and surplus to arrive at PacifiCare's rate of return on its capital and surplus. The result produced an average three-year rate of return on capital and surplus of 46.83%.⁷³⁶ This rate of return is more than double the returns received by the four companies having the largest number of insured lives,⁷³⁷ and further demonstrates PacifiCare's financial solvency.

Based on standard industry solvency tests and analysis of PacifiCare's capital and surplus, the Commissioner concludes an aggregate penalty of \$173.6 million would not render PacifiCare insolvent. PacifiCare's surplus of over \$728 million permits the insurer to absorb the penalty and still conduct its business affairs in a fiscally responsible manner.⁷³⁸

IX. Order

1. Pursuant to the Findings of Fact and Legal Conclusions above, PacifiCare Life and Health Insurance Company is assessed an aggregate penalty of \$173,603,750.

2. PacifiCare shall remit the aggregate penalty within ten days after the effective date of this decision, pursuant to Insurance Code section 12976, but no later than July 22, 2014.

3. PacifiCare is ordered to Cease and Desist from engaging in all unfair acts or practices in violation of the law set forth above.

⁷³⁵ *Id.* at p. 174:7-8.

⁷³⁶ *Id.* at p. 174:9-15.

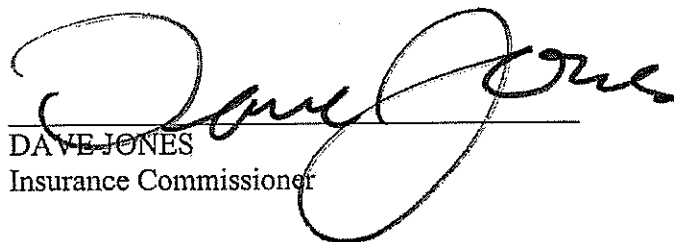
⁷³⁷ *Id.* at p. 174:20-23; Exh. 1184E.

⁷³⁸ PacifiCare did not challenge CDI's recommended penalty of \$325 million on solvency grounds.

4. With the exception of the 10,000 violations threshold applied in the Penalty subsections of Discussion sections C, D, E and H, *ante*, the entirety of this decision is designated precedential pursuant to Government Code section 11425.60, subdivision (b).

IT IS SO ORDERED.

Dated: June 9, 2014



DAVE JONES
Insurance Commissioner

