EXECUTIVE SUMMARY

Precedential Decision & Order Issued by California Insurance Commissioner
In the Matter of the Order to Show Cause and Accusation Against
PacifiCare Life and Health Insurance Company

As detailed in the attached letter to ACLHIC President and CEO Brad Wenger, the California Insurance Commissioner (the "Commissioner") recently issued a legally flawed and problematic Decision & Order against PacifiCare Life and Health Ins. Co. ("PacifiCare") in which the Commissioner interpreted numerous statutory provisions and regulations in a way never before accepted by any court to impose a $173.6 million penalty for routine audit and administrative issues. The Commissioner deemed his entire Decision "precedential," which means that all California health insurers are now subject to the following standards, among others:

- Payment of all claims within 30 days after receipt, with any late payment subject to a penalty of up to $10,000 (the Commissioner penalized PacifiCare $5,500 for each late payment);

- Payment of requisite statutory interest associated with late claim payments, with every failure subject to a penalty not to exceed $10,000 (the Commissioner imposed a $1,500 penalty for each instance that PacifiCare failed to correctly pay interest);

- One hundred percent payment accuracy, with each incorrect claim payment subject to a penalty of up to $10,000 (PacifiCare was penalized $6,000 for every inaccurate payment); and

- An obligation to acknowledge the receipt of all written claims in writing – even if the insurer maintains electronic, telephone and/or website acknowledgement systems – with each failure to provide a written acknowledgement subject to a penalty not to exceed $5,000 (the Commissioner penalized PacifiCare $750 for each instance that it failed to send a written acknowledgement).

Pursuant to the Decision and Order, the California Department of Insurance may now characterize unauthorized, unintentional, accidental and/or infrequent acts or omissions as unfair claims settlement practices subject to significant monetary penalties to be determined at the sole discretion of the Commissioner. PacifiCare is seeking to overturn the Decision and Order but, given its impact on the entire California health insurance industry, we believe that a third-party challenge by ACLHIC on behalf of California payers is extremely important to that effort.

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July 10, 2014

Brad Wenger
President and CEO
Association of California Life & Health Insurance Companies
1201 K Street, Suite 1820
Sacramento, CA 95814

Dear Brad,

We seek ACLHIC's support and assistance in challenging a "precedential" Decision and Order recently issued by the California Commissioner of Insurance (the "Commissioner") in which the Commissioner imposes a $173.6 million penalty against PacifiCare Life and Health Ins. Co. ("PacifiCare") for what amount to routine audit and administrative issues. This extraordinary penalty is based upon novel interpretations of numerous statutory provisions and regulations that (a) have never been endorsed by any court, (b) constitute a radical departure from past practice and industry standards, and (c) were accomplished without the benefit of any traditional notice-and-comment rulemaking to address the practical and legal issues arising from the interpretations. If this decision is permitted to become the law governing the industry, it will create new and sweeping duties for the Association's members and drastically expand the potential liability associated with processing health insurance claims in California. PacifiCare is seeking to overturn the Decision and Order in a recently filed Petition for Writ of Administrative Mandamus in the California Superior Court in Orange County. However, given the impact of the Decision and Order on the entire California health insurance industry, we believe that a third-party challenge by ACLHIC on behalf of California payers is extremely important to that effort.

Background. This case concerns the California Department of Insurance's ("CDI") scope of authority to penalize insurers under California Insurance Code § 790.03 – the Unfair Insurance Practices Act ("UIPA") – which proscribes "knowingly committing or performing with such frequency as to indicate a general business practice [certain enumerated] unfair claims settlement practices… ." Cal. Ins. Code § 790.03(h). Each violation of UIPA is punishable by a civil penalty of up to $5,000 or, in the case of "willful" violations, up to $10,000. Cal. Ins. Code § 790.035(a). Each act in violation of the statute may be penalized individually except that, where numerous acts result from an insurer's inadvertent conduct, all of those acts must be penalized as a single act. *Id.* CDI's position in the case is that routine audit and administrative issues – which are not enumerated as unfair claims settlement practices in UIPA – can violate UIPA and be penalized under UIPA. As summarized by Deputy Commissioner Cignarale, insurers are now "on notice in general that any claims standard that the Department feels violates

790.03, which might not specifically be enumerated in either 790.03 or in [regulation] 2695 [of the] California Code of Regulations, could be considered violations of [Section] 790.03." Neither the Department nor any other regulator to our knowledge has ever previously taken such a position.

The history of the case dates back to a market conduct exam ("MCE") in which CDI alleged only 90 violations of UIPA for the period June 22, 2006 to May 31, 2007. CDI's initial report expressly concluded that the other conduct identified in the report was not UIPA-governed conduct. However, on the eve of the primary in which the then-Commissioner was running, CDI wildly inflated the number of UIPA violations – to more than 850,000 purported violations – by referring to the very same conduct it previously stated was something other than conduct governed by UIPA. PacifiCare contested the Department's position in a three-year long trial in front of a neutral Administrative Law Judge ("ALJ"). In August of last year, the ALJ issued a Proposed Decision that recommended an aggregate penalty of $11.5 million.

Last December, the Commissioner rejected the ALJ's Proposed Decision. Six months later, the Commissioner – who did not personally attend any of the trial – issued the "precedential" Decision and Order in which he increased the ALJ's proposed penalty by more than fifteen fold. The Commissioner's Decision and Order shoehorned the routine audit and administrative issues into unfair claims settlement practices and vastly expanded UIPA's proscriptions by diluting the definitions of (1) "knowingly" to only require "implied or constructive knowledge"; (2) "general business practice" to mean a "relatively small number of violations"; and (3) "willful" to mean nothing more than a "willingness to commit the act," rather than an intent to violate the law. As a result, under the Decision and Order, CDI may now characterize unauthorized, unintentional, accidental and/or infrequent acts or omissions as unfair claims settlement practices subject to UIPA's heightened $10,000 penalty.

Here are some examples of how the Commissioner wielded UIPA in his Decision and Order:

1. The Commissioner imposed a $55 million penalty for not paying 3% of all claims received during the relevant period within thirty-days of receipt, a time period that the Commissioner borrowed from a non-penal statute that is not part of UIPA. The Commissioner found that PacifiCare "knowingly" and "willfully" violated UIPA simply because it knew the date of the receipt of each claim and it knew the payment date of each claim. The Commissioner imposed a penalty of $5,500 per late claim (the Commissioner capped the number of violations at 10,000), notwithstanding the fact that evidence showed PacifiCare's payment of 97% of claims within thirty days exceeded NAIC standards.

2. The Commissioner imposed a $7.7 million penalty for not paying interest on 0.5% of all claims at issue during the relevant time period. The Commissioner found that PacifiCare "knowingly" and "willfully" violated UIPA because it is charged with knowing the statutory claims processing deadline and the law regarding interest payments. The Commissioner imposed a $1,500 penalty for each failure to timely pay interest despite the undisputed facts that (a) the median interest due on each claim was a mere $0.87; and (b) PacifiCare had already paid all requisite interest prior to the Decision and Order.

3. The Commissioner imposed a $22.2 million penalty for PacifiCare's incorrect payment of a mere 0.3% of all claims processed during the relevant time period. The Commissioner found that PacifiCare "knowingly" and "willfully" violated UIPA in tendering inaccurate payments despite undisputed evidence that (a) nearly half of the inaccurate payments resulted from providers submitting incomplete information; and (b) PacifiCare voluntarily reworked the incorrectly paid claims and ultimately paid providers in full, plus 10% statutory interest. The Commissioner's imposition of a $6,000 penalty for each incorrect payment signals that California insurers will face significant liability should they achieve anything short of 100% payment accuracy.

4. The Commissioner imposed a $7.5 million penalty against PacifiCare for its failure to send written acknowledgement letters in response to 5% of all physician and member claims. The Commissioner found that PacifiCare "knowingly" and "willfully" violated UIPA even though the Insurance Code provides that 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... ." Cal. Ins. Code § 10133.66(c). At all relevant times, PacifiCare maintained telephone, Web site and automated electronic acknowledgment systems that complied with Section 10133.66(c). Moreover, 95% of claims during the MCE review period resulted in some form of written acknowledgement—a rate of compliance (regardless of the method of acknowledgment) that is well within the acceptable tolerance threshold set forth in the NAIC Handbook. Nevertheless, and without ever having provided advance written notice to the insurance industry regarding his interpretation, the Commissioner imposed a $750 per-violation penalty (the Commissioner capped the number of violations at 10,000).

5. The Commissioner penalized PacifiCare $22.75 million for omitting certain language from its EOBs (a notice of right to an independent medical review) and $30 million for omitting certain language from its EOPs (a notice of right to CDI review). Again, the Commissioner premised these violations upon requirements set forth in non-penal

statutes that are not referenced in, nor a part of, UIPA. *See* Cal. Ins. Code §§ 10169(i), 10123.13(a) and 10123.147(a). The Commissioner imposed these substantial penalties notwithstanding the fact that (a) PacifiCare included the required notices in other documents (*e.g.*, its certificates of coverage, appeal resolution letters, denial letters, etc.); and (b) PacifiCare was awaiting CDI approval of the specific language to be used in the EOBs and EOPs. Even though PacifiCare's alleged violations were clearly inadvertent under these circumstances, the Commissioner refused to limit the penalties to single acts as required by UIPA and penalized PacifiCare $2,275 for each incorrect EOB and $3,000 for each incorrect EOP (the Commissioner capped the violations at 10,000).

Procedure. On July 10, 2014, PacifiCare filed a Petition for Writ of Administrative Mandamus in the Superior Court in Orange County seeking to overturn the Decision and Order. While we certainly will make best efforts to argue the industry's concerns with the Decision and Order, we anticipate that the Commissioner will argue that PacifiCare lacks standing and/or is the wrong party to raise the interests of other insurers. Given ACLHIC's charter and membership, we believe that the Association is in a unique position to raise the industry impact of the Decision and Order. In particular, a third-party action by ACLHIC could address why, for example, (i) it will be virtually impossible for insurers to comply with the Commissioner's new standards of perfection; (ii) designating the Decision and Order as precedential, without judicial review of these statutory interpretations of first impression, risks exposing insurers to additional substantial liability, making insurance operations in California more expensive, and deterring new insurers from entering the California insurance market; and (iii) the Commissioner's new interpretation of UIPA constitutes an illegal underground regulation that violates due process by failing to give advance notice of the conduct allegedly required, *see, e.g., Federal Communications Commission v. Fox Television Stations*, Inc., 132 S.Ct. 2307, 2317 (2012); *Tidewater marine Western, Inc. v. Bradshaw*, 14 Cal.4th 557, 571 (Cal. 1996).

Timing. We filed our Petition in the Superior Court on July 10, 2014. We will inform you of the briefing schedule as soon as one is set by the Court. We believe that a third-party challenge that follows closely on the heels of our Petition would mount the most effective and comprehensive challenge to the Decision and Order.

We welcome the opportunity to discuss this case with you and to provide any additional information you require, including discussing options for funding a third-party challenge by ACLHIC. We would very much appreciate ACLHIC's support in addressing this important issue, and we thank you in advance for considering this request.

Sincerely,

Kara Baysinger
Partner

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