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BEFORE THE INSURANCE COMMISSIONER
OF THE STATE OF CALIFORNIA

In the Matter of the Accusation Against:

**PACIFICARE LIFE AND HEALTH
INSURANCE COMPANY**

Respondent.

Case No. UPA 2007-00004

OAH No. 2009061395

**CALIFORNIA DEPARTMENT OF
INSURANCE'S REQUEST FOR
OFFICIAL NOTICE**

Judge: Hon. Ruth Astle

Hrg. Dates: December 7, 2009,
continuing from day to day
thereafter

1 Pursuant to Government Code section 11515 and Evidence Code section 452, the
2 California Department of Insurance (“Department”) hereby requests that official notice be
3 taken of the following documents, true and correct copies of which are attached hereto:

4 1. **Exhibit A** hereto is a true and correct copy of the Assembly Committee on
5 Finance and Insurance’s Hearing Report on Senate Bill 1363 (1989-1990 Regular Session),
6 as amended July 6, 1989. Pursuant to Government Code section 11515 and Evidence Code
7 section 452, subdivision (c), the Administrative Law Judge (“ALJ”) may take official notice
8 of “[o]fficial acts of the legislative, executive, and judicial departments of the United States
9 and of any state of the United States.” (Evid. Code, § 452, subd. (c); see Gov. Code, §
10 11515 [official notice may be taken of “of any fact which may be judicially noticed by the
11 courts of this State”].) Legislative committee reports are judicially noticeable as “official
12 acts.” (See *Jones v. Lodge at Torrey Pines Partnership* (2008) 42 Cal.4th 1158, 1172, n. 5.)

13 2. **Exhibit B** hereto is a true and correct copy of the Senate Insurance, Claims
14 and Corporations Committee’s Hearing Report on Senate Bill 1363 (1989-1990 Regular
15 Session), as introduced March 9, 1989. Pursuant to Government Code section 11515 and
16 Evidence Code section 452, subdivision (c), the ALJ may take official notice of “[o]fficial
17 acts of the legislative, executive, and judicial departments of the United States and of any
18 state of the United States.” (Evid. Code, § 452, subd. (c).) Legislative committee reports
19 are judicially noticeable as “official acts.” (*Jones, supra*, 42 Cal.4th at p. 1172, n. 5.)

20 3. **Exhibit C** hereto is a true and correct copy of the California Department of
21 Finance’s analysis of Senate Bill 1363 (1989-1990 Regular Session), as amended May 9,
22 1989. The analysis is dated May 22, 1989. Pursuant to Government Code section 11515
23 and Evidence Code section 452, subdivision (c), the ALJ may take official notice of
24 “[o]fficial acts of the legislative, executive, and judicial departments of the United States
25 and of any state of the United States.” (Evid. Code, § 452, subd. (c).) Executive branch
26 analyses of pending legislation are judicially noticeable as “official acts.” (*Kaufman &*
27 *Broad Communities, Inc. v. Performance Plastering* (2005) 133 Cal.App.4th 26, 40.)

1 4. **Exhibit D** hereto is a true and correct copy of the Senate Rules Committee's
2 Floor Analyses of Senate Bill 1363 (1989-1990 Regular Session), as amended September
3 11, 1989. Pursuant to Government Code section 11515 and Evidence Code section 452,
4 subdivision (c), the ALJ may take official notice of "[o]fficial acts of the legislative,
5 executive, and judicial departments of the United States and of any state of the United
6 States." (Evid. Code, § 452, subd. (c).) Legislative committee reports are judicially
7 noticeable as "official acts." (*Jones, supra*, 42 Cal.4th at p. 1172, n. 5; *Kaufman & Broad*
8 *Communities, supra*, 133 Cal.App.4th at p. 39.)

9 5. **Exhibit E** hereto is a true and correct copy of the California Department of
10 Finance's Enrolled Bill Report for Senate Bill 1363 (1989-1990 Regular Session), as
11 amended on September 11, 1989. The report is dated September 19, 1989. Pursuant to
12 Government Code section 11515 and Evidence Code section 452, subdivision (c), the ALJ
13 may take official notice of "[o]fficial acts of the legislative, executive, and judicial
14 departments of the United States and of any state of the United States." (Evid. Code, § 452,
15 subd. (c).) Enrolled bill reports are judicially noticeable as "official acts." (*Kaufman &*
16 *Broad Communities, supra*, 133 Cal.App.4th at p. 40.)

17 6. **Exhibit F** hereto is a true and correct copy of the California Department of
18 Insurance's Enrolled Bill Report for Senate Bill 1363 (1989-1990 Regular Session). The
19 Enrolled Bill Report is dated September 20, 1989. Pursuant to Government Code section
20 11515 and Evidence Code section 452, subdivision (c), the ALJ may take official notice of
21 "[o]fficial acts of the legislative, executive, and judicial departments of the United States
22 and of any state of the United States." (Evid. Code, § 452, subd. (c).) Enrolled bill reports
23 are judicially noticeable as "official acts." (*Kaufman & Broad Communities, supra*, 133
24 Cal.App.4th at p. 40.)

25 7. **Exhibit G** hereto is a true and correct copy of the Assembly Committee on
26 Finance and Insurance's "Background Information Request" form for Senate Bill 1363
27 (1989-1990 Regular Session). The filled out Background Information Request is dated June
28 23, 1989. Pursuant to Government Code section 11515 and Evidence Code section 452,

1 subdivision (c), the ALJ may take official notice of “[o]fficial acts of the legislative,
2 executive, and judicial departments of the United States and of any state of the United
3 States.” (Evid. Code, § 452, subd. (c).) Legislative committee reports and similar
4 legislative history materials are judicially noticeable as “official acts.” (*Jones, supra*, 42
5 Cal.4th at p. 1172, n. 5; *Kaufman & Broad Communities, supra*, 133 Cal.App.4th at p. 39.)

6 8. **Exhibit H** hereto is a true and correct copy of the Legislative Counsel’s
7 Digest for Senate Bill 367 (Stats. 2005, ch. 723). Pursuant to Government Code section
8 11515 and Evidence Code section 452, subdivision (c), the ALJ may take official notice of
9 “[o]fficial acts of the legislative, executive, and judicial departments of the United States
10 and of any state of the United States.” (Evid. Code, § 452, subd. (c).) Legislative Counsel’s
11 digests are judicially noticeable as “official acts.” (E.g., *Jones, supra*, 42 Cal.4th at pp.
12 1169-1170.)

13 9. **Exhibit I** hereto is a true and correct copy of the Legislative Counsel’s Digest
14 for Assembly Bill 4206 (Stats. 1986, ch. 957). Pursuant to Government Code section 11515
15 and Evidence Code section 452, subdivision (c), the ALJ may take official notice of
16 “[o]fficial acts of the legislative, executive, and judicial departments of the United States
17 and of any state of the United States.” (Evid. Code, § 452, subd. (c).) Legislative Counsel’s
18 digests are judicially noticeable as “official acts.” (E.g., *Jones, supra*, 42 Cal.4th at pp.
19 1169-1170.)

20 Date: May 31, 2012

Respectfully submitted,

21 STRUMWASSER & WOOCHELL LLP

22 CALIFORNIA DEPARTMENT OF INSURANCE
23 LEGAL DIVISION

24
25 By:  _____

26 Bryce Gee

27 *Attorneys for the California Department of*
28 *Insurance*

EXHIBIT A

Date of Hearing: July 11, 1989

ASSEMBLY COMMITTEE ON FINANCE AND INSURANCE
Patrick Johnston, Chair

SB 1363 (Robbins) - As Amended: July 6, 1989

SENATE ACTIONS:

COMMITTEE INS., CL. & CORPS. VOTE 5-2 COMMITTEE APPR. VOTE SEN. RULE 28.8

FLOOR VOTE 33-1

SUBJECT: Penalties against insurance licensees for engaging in unfair methods of competition or unfair and deceptive acts or practices.

DIGEST

Urgency statute. 2/3 vote required.

Existing law provides that the Insurance Commissioner, if she has reason to believe that a person subject to her jurisdiction is engaged in an unfair method of competition or any unfair or deceptive act, may initiate a hearing to determine whether a cease and desist order should be issued. The provisions on Unfair Practices in current law, which are extensive, enumerate a wide array of conduct which constitutes unfair methods of competition or unfair and deceptive acts or practices in the business of insurance. If the charges concerning such conduct are justified, such an order may be issued, subject to review.

Furthermore, if such a cease and desist order has been issued and is violated, the Commissioner may, after a hearing, impose a fine of \$5,000 for such a violation, unless the violation is willful. In the latter circumstance the penalty may not exceed \$55,000.

This bill:

- 1) Provides that any person engaging in any unfair method of competition or any unfair or deceptive act or practice is liable to the state for a civil penalty not to exceed \$1,000 for each act. If the act is willful, the penalty is \$5,000. These penalties are made appealable by means of judicial review under the Insurance Code or pursuant to provisions of the Government Code relating to administrative adjudication.

- continued -

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- 2) Revises the procedure and requirements for hearings pertaining to cease and desist orders to a) notify the party of their potential liability pursuant to the above provision, to b) include within the scope of the hearing a determination of whether imposition of penalties pursuant to the above provision is appropriate in addition to the cease and desist order, and c) providing for the issuance of an order to pay the penalty.
- 3) Authorizes, after an additional hearing, penalties for violations of cease and desist orders or orders to pay penalties of a) \$5,000 plus any prior penalties which remain unpaid or b) \$55,000 plus unpaid penalties in the case of willful violations.

FISCAL EFFECT

Minor revenue increases to the Department of Insurance based upon the expanded penalty authority contained in this bill.

COMMENTS

Under current law, insurers cannot be fined for practices determined by the Commissioner to be unfair and deceptive 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.

SPONSOR: Author
SUPPORT: None Received
OPPOSITION: None Received

EXHIBIT B

SENATE BILL NO. 1363 (Robbins) As Introduced March 9, 1989
Insurance Code

Source: Author

Prior Legislation: SB 1012 (Robbins) Chapter 953, Statutes of 1987

Support: Sacramento Urban League

California Conference of Machinists

Congress of California Seniors

FAIR (Fair Automobile Insurance Rates)

California Commission on Aging

Opposition: Association of California Insurance Companies

SUBJECT

Increases penalties that may be assessed against insurers by the Insurance Commissioner for illegal acts under the Unfair Practices code sections.

DIGEST

1] Description: SB 1363 establishes a procedure for assessing monetary penalties for violations of the unfair or deceptive practices as defined in Insurance Code Section 790.03 as follows:

1. Any insurer that violates the unfair or deceptive practices sections is subject to a fine not to exceed \$5,000 each day the insurer engaged in that illegal act or practice or, if the act or practice is willful, a fine not to exceed \$55,000 for each day.
2. The Commissioner serves an order to show cause and a notice of hearing, along with a statement of the potential monetary fine. The hearing on the legality of these practices must take place within 30 days of serving the order on the insurer.
3. After the hearing, if the charges are upheld by the Commissioner, the Commissioner is required to issue a cease-and-desist order requiring the insurer to stop the practices found unfair or deceptive and pay the amount of the fine.
4. If the insurer fails to pay the penalty or violates the cease-and-desist order, the Commissioner may assess an additional \$5,000 fine, or if the violation is found to be willful, an additional \$55,000, in addition to licensee revocation procedures.

2] Background: Article 6.5 of the Insurance Code (commencing with Section 790), regulates insurance practices that constitute unfair methods of competition or unfair and deceptive acts or practices. If the Insurance Commissioner believes an insurer is violating the outlawed practices, she

3



may issue a Cease and Desist Order after an initial hearing. If that practice is not discontinued, the Commissioner may petition the court through the Attorney General for an appropriate order and assess a fine of up to \$5,000 or \$50,000 if the violation is proven to be willful.

Under Section 79C.03, insurance companies are prohibited from engaging in such practices as:

1. Making misleading or false claims in advertising or presentations;
2. Making false claims regarding the practices or solvency of a competitor, or using boycotts, intimidation or other unreasonable restraints of trade;
3. Keeping false books;
4. Discriminating in the rates charged individuals in the same class of insurance;
5. Making claims the insurer is guaranteed or insured against insolvency; and
6. Committing a pattern of certain undesirable, specified practices in settling claims. (These claims settlement practices are contained in Section 790.03(h) that was the subject of review in both the Royal Globe and the Moradi-Shalal decisions.)

Last year, SB 1012 (Robbins) increased the amount of penalties from \$50 to \$5,000 for a violation of a cease and desist order or, if a willful violation, from \$500 to \$50,000.

FISCAL EFFECT Fiscal Committee: Yes

STAFF COMMENTS

The author is addressing three major deficiencies in the law:

1. Inconsistent with Proposition 103 regulatory structure: In light of the regulatory changes made effective by the passage of Proposition 103, the Commissioner is left without tools to induce compliance because she cannot mete out civil or criminal penalties until the insurer violates the cease-and-desist order. The timing of the fine doesn't allow it to be used as a deterrent, but it does work to reward those that profit from illegal acts.

Neither in the various codes governing regulation of businesses and professions nor in regulations for any industry governing itself such as that of securities representatives and brokers, could another system of penalties similar to that in Article 6.5 be found.



2. Proportionate fines: With the present limitation of \$5,000 maximum or, if found a willful violation, a \$55,000 maximum fine, there is no flexibility to design an assessment to reflect the actual severity of the violation. The range of assessments provided for in SB 1363 would allow the Commissioner to differentiate between serious and lesser violations.

3. No incentive to act lawfully: With the repeal of the Royal Globe decision (that allowed third parties to file suit against an insurer believed to be delaying payment of claims), and the present structure of not fining for the illegal act but the violation of a cease-and-desist order, there is little incentive for insurance companies to refrain from unfair or deceptive practices. California Chief Justice Lucas in his majority opinion in Moradi-Shalal v. Fireman's Fund Insurance Companies, the case that overturned Royal Globe, states:

"We caution, however, that our decision is not an invitation to the insurance industry to commit the unfair practices proscribed by the Insurance Code. We urge the Insurance Commissioner and the courts to continue to enforce the laws forbidding such practices to the full extent consistent with our opinion."

This bill is consistent with the spirit of Moradi-Shalal by giving adequate power to the Commissioner to dissuade insurers from unfair practices, and by providing an incentive to the insurance industry to refrain from such practices. Under present law, the economic advantage of postponing settlements on a wide scale basis, for example, is not offset by any economic sanction.

4. In its letter of opposition, the Association of California Insurance Companies (ACIC) objects to the fines being assessed on a basis of each day of violation. ACIC reasons that: "Alleged violations of these particular sections are not cut-and-dried matters." To impose per day penalties when it is not clear that a violation has taken place until "... several months after the alleged violation has taken place" is "... draconian in nature," according to the ACIC letter.

5. SB 1363 is a companion bill to SB 1364 which deals with McBride-Grunsky rate violations.

LEAH CARTABRUNO
Consultant

SENATE BILL NO. 1363

05/03/89

(800) 666-1917

LEGISLATIVE INTENT SERVICE



EXHIBIT C

Honorable Alan Robbins
Member of the Senate
State Capitol, Room 5114
Sacramento, CA 95814

DEPARTMENT Finance	AUTHOR Robbins	BILL NUMBER SB 1363
SPONSORED BY	RELATED BILLS	AMENDMENT DATE May 9, 1989

BILL SUMMARY

INSURER PENALTIES FOR UNFAIR PRACTICES

This bill would authorize the Insurance Commissioner to assess specified fines for violations of existing law relating to unfair practices and deceptive acts.

FISCAL SUMMARY--STATE LEVEL

Code/Department Agency or Revenue Type	SO LA CO RV	(Fiscal Impact by Fiscal Year)			Code Fund
		(Dollars in Thousands)			
		FC 1988-89	FC 1989-90	FC 1990-91	
2290 - Insurance	SO	-----See Fiscal Analysis-----			

Impact on State Appropriations Limit--No

ANALYSIS

A. Specific Findings

Existing law provides that if an insurer violates certain statutory provisions relating to unfair practices and deceptive acts, the Insurance Commissioner may hold a hearing to determine whether a violation exists. If, after a hearing, the Commissioner determines that any act or practice by an insurer is in violation of law, the Commissioner may issue an order requiring the insurer to cease and desist. Under existing law, an insurer is not liable for a penalty unless it violates the order issued by the Commissioner.

This bill would provide that an insurer that violates statutory provisions relating to unfair practices or deceptive acts before an order is issued by the Commissioner is liable for a penalty of up to \$1,000 for each act, or \$5,000 for each act for a willful violation. The penalty would be assessed by the Commissioner in connection with the hearing on the order.

This bill is intended to discourage insurance companies from violating existing unfair practices and deceptive acts statutes.

B. Fiscal Analysis

This bill would not increase state agency expenditures but has the potential for increasing General Fund revenue from fines and penalties. However, neither the number of violations that may occur nor the number that would result in a fine or a penalty can be predicted at this time.

POSITION: Neutral	Department Director	Date	
Principal Analyst (743) E. Juliusson	Date	Program Budget Manager (700) Wallis L. Clark	Date
<i>E. Juliusson</i> 5/22/89		<i>Wallis L. Clark</i> 5/22/89	
FR1p/0162F		Governor's Office	
		Position noted	
		Position approved	
		Position disapproved	
		by:	date:

SFA-5

LEGISLATIVE INTENT SERVICE (800) 666-1917

EXHIBIT D

UNFINISHED BUSINESS

SENATE RULES COMMITTEE Office of Senate Floor Analyses 1100 J Street, Suite 120 445-6614	Bill No.	SB 1363
	Author:	Robbins (D)
	Amended:	9/11/89 in Assembly
	Vote Required:	2/3 - Urgency

Committee Votes:

COMMITTEE: INS/CLAIMS/CORPS		
BILL NO.:	SB 1363	
DATE OF HEARING:	9-3-89	
SENATORS:	AYE	NO
Davis	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Deddeh	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Doolittle	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Cecil Green	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Keene	<input checked="" type="checkbox"/>	<input type="checkbox"/>
McCorquodale	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Montoya	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Nielsen (VC)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Robbins (Ch)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
TOTAL:	5	2

PLACED
ON FILE
PURSUANT
TO SENATE
RULE 28.8

Senate Floor Vote: Page 3977, 9/14/89

Senate Bill 1363—An act to amend Sections 790.05 and 790.07 of, and to add Section 790.035 to, the Insurance Code, relating to insurance, and declaring the urgency thereof, to take effect immediately.

Bill presented by Senator Robbins.

Roll Call

The roll was called and the Senate concurred in Assembly amendments by the following vote:

AYES (29)—Senators Alquist, Bergeson, Beverly, Boatwright, Campbell, Davis, Deddeh, Dills, Doolittle, Cecil Green, Leroy Greene, Keene, Kopp, Leonard, Marks, Mello, Morgan, Nielsen, Petris, Presley, Robbins, Roberti, Rosenthal, Royce, Russell, Seymour, Torres, Vuich, and Watson.

NOES (1)—Senator Stirling.

Above bill ordered enrolled.

Assembly Floor Vote: 69-2, P. 4675, 9/12/89

SUBJECT: Insurance: unfair practices penalties

SOURCE: Author

DIGEST: This bill provides that a person engaged in the business of insurance who violates provisions relating to unfair and deceptive acts is liable for a penalty of up to \$5,000 for each act, or \$10,000 for a willful violation for each act. The penalty would be assessed by the Insurance Commissioner in connection with the cease and desist order. A failure to pay the penalty would constitute a violation of the cease and desist order. (See analysis below for specifics.)

Assembly Amendment:

- Increases the penalty from \$1,000 to \$5,000 for each act that is violated and \$5,000 for \$10,000 for a willful violation for each act.
- Clarifies that the penalties are appealable by means of any remedy provided by existing law.
- The Insurance Commissioner shall have the discretion to establish what constitutes an act under this bill. However, when the issuance, amendment, or servicing of a policy or endorsement is inadvertent, all of those acts shall be a single act for the purposes of this section.

ANALYSIS: Article 6.5 of the Insurance Code (commencing with Section 790), regulates insurance practices that constitute unfair methods of competition or unfair and deceptive acts or practices. If the Insurance Commissioner believes

an insurer is violating the outlawed practices, she may issue a Cease and Desist Order after an initial hearing. If that practice is not discontinued, the Commissioner may petition the court through the Attorney General for an appropriate order and assess a fine of up to \$5,000 or \$50,000 if the violation is proven to be willful.

Under Section 790.03, insurance companies are prohibited from engaging in such practices as:

1. Making misleading or false claims in advertising or presentations;
2. Making false claims regarding the practices or solvency of a competitor, or using boycotts, intimidation or other unreasonable restraints of trade;
3. Keeping false books;
4. Discriminating in the rates charged individuals in the same class of insurance;
5. Making claims the insurer is guaranteed or insured against insolvency; and
6. Committing a pattern of certain undesirable, specified practices in settling claims. (These claims settlement practices are contained in Section 790.03(h) that was the subject of review in both the Royal Globe and the Moradi-Shalal decisions.)

Last year, SB 1012 (Robbins) increased the amount of penalties from \$50 to \$5,000 for a violation of a cease and desist order or, if a willful violation, from \$500 to \$50,000.

SB 1363 establishes a procedure for assessing monetary penalties for violations of the unfair or deceptive practices as defined in Insurance Code Section 790.03 as follows:

1. Any insurer that violates the unfair or deceptive practices sections is subject to a fine not to exceed \$5,000 each illegal act or practice or, if the act or practice is willful, a fine not to exceed \$10,000 for each act.
2. The Commissioner serves an order to show cause and a notice of hearing, along with a statement of the potential monetary fine. The hearing on the legality of these practices must take place within 30 days of serving the order on the insurer.
3. After the hearing, if the charges are upheld by the Commissioner, the Commissioner is required to issue a cease-and-desist order requiring the insurer to stop the practices found unfair or deceptive and pay the amount of the fine.
4. If the insurer fails to pay the penalty or violates the cease-and-desist order, the Commissioner may assess an additional \$5,000 fine, or if the violation is found to be willful, an additional \$55,000, in addition to licensee revocation procedures.

Prior legislation: SB 1012 (Robbins) - Chapter 953, Statutes of 1987.

FISCAL EFFECT: Appropriation: No Fiscal Committee: Yes Local: No

The bill could result in unknown revenue to the General Fund from penalties imposed on persons in the insurance business found to engage in unfair or deceptive acts.

SUPPORT: (Verified 9/13/89)

Sacramento Urban League
California Conference of Machinists
Congress of California Seniors
FAIR (Fair Automobile Insurance Rates)
California Commission on Aging

ARGUMENTS IN SUPPORT: According to the author's office, SB 1363 is addressing three major deficiencies in the law:

1. Inconsistent with Proposition 103 regulatory structure: In light of the regulatory changes made effective by the passage of Proposition 103, the Commissioner is left without tools to induce compliance because she cannot mete out civil or criminal penalties until the insurer violates the cease-and-desist order. The timing of the fine doesn't allow it to be used as a deterrent, but it does work to reward those that profit from illegal acts.

Neither in the various codes governing regulation of businesses and professions nor in regulations for any industry governing itself such as that of securities representatives and brokers, could another system of penalties similar to that in Article 6.5 be found.

2. Proportionate fines: With the present limitation of \$5,000 maximum or, if found a willful violation, a \$55,000 maximum fine, there is no flexibility to design an assessment to reflect the actual severity of the violation. The range of assessments provided for in SB 1363 would allow the Commissioner to differentiate between serious and lesser violations.
3. No incentive to act lawfully: With the repeal of the Royal Globe decision (that allowed third parties to file suit against an insurer believed to be delaying payment of claims), and the present structure of not fining for the illegal act but the violation of a cease-and-desist order, there is little incentive for insurance companies to refrain from unfair or deceptive practices. California Chief Justice Lucas in his majority opinion in Moradi-Shalal v. Fireman's Fund Insurance Companies, the case that overturned Royal Globe, states:

"We caution, however, that our decision is not an invitation to the insurance industry to commit the unfair practices proscribed by the Insurance Code. We urge the Insurance Commissioner and the courts to continue to enforce the laws forbidding such practices to the full extent consistent with our opinion."



This bill is consistent with the spirit of Moradi-Shalal by giving adequate power to the Commissioner to dissuade insurers from unfair practices, and by providing an incentive to the insurance industry to refrain from such practices. Under present law, the economic advantage of postponing settlements on a wide scale basis, for example, is not offset by any economic sanction.

SB 1363 is a companion bill to SB 1364 which deals with McBride-Grunsky rate violations.

ASSEMBLY FLOOR VOTE:

SENATE BILL NO. 1363 (Robbins)—An act to amend Sections 790.05 and 790.07 of, and to add Section 790.035 to, the Insurance Code, relating to insurance, and declaring the urgency thereof, to take effect immediately.

Bill read third time, and presented by Assembly Member Bane.

The question being on the passage of the bill.

Bill passed by the following vote:

AYES—69

Allen	Elder	Johnston	Pringle
Areias	Epple	Jones	Quackenbush
Bader	Farr	Katz	Roos
Baker	Felando	Kelley	Roybal-Allard
Bane	Ferguson	Klehs	Senstrand
Bates	Filante	Lancaster	Speler
Bentley	Floyd	Lempert	Statham
Bronzan	Frazee	Leslie	Tanner
Calderon	Friedman	Lewis	Vasconcellos
Campbell	Hannigan	Margolin	Waters, Maxine
Chacon	Hansen	Mojonnier	Waters, Norman
Chandler	Harris	Moore	Woodruff
Clute	Harvey	Mountjoy	Wright
Connelly	Hauser	Murray	Wyman
Cortese	Hayden	Nolan	Mr. Speaker
Costa	Hill	O'Connell	
Eastin	Hughes	Peace	
Eaves	Isenberg	Polanco	

NOES—2

Brown, Dennis McClintock

Bill ordered transmitted to the Senate.

DLW:jk 9/13/89 Senate Floor Analyses

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EXHIBIT E

DEPARTMENT
Finance

BILL NUMBER
SB 1363

AUTHOR
Robbins

AMENDMENT DATE
September 11, 1989

SUBJECT

INSURER PENALTIES FOR UNFAIR PRACTICES

This bill would authorize the Insurance Commissioner to assess specified fines for violations of existing law relating to unfair practices and deceptive acts.

The bill is an urgency measure.

SUMMARY OF REASON FOR SIGNATURE

SB 1363 would discourage insurance companies from violating statutes relating to unfair practices and deceptive acts and thereby enhance the protections available to consumers.

HISTORY, SPONSORSHIP, AND RELATED BILLS

Sponsored by the author.

This bill is similar to SB 1364 relating to violations of insurance rate provisions of proposition 103.

Assembly 69-2

Senate 33-1

FISCAL SUMMARY--STATE LEVEL

Code/Department Agency or Revenue Type	STATE LEVEL	(Fiscal Impact by Fiscal Year)			Code Fund
		(Dollars in Thousands)			
		FC 1989-90	FC 1990-91	FC 1991-92	
2290 - Insurance	SO	-----See Fiscal Analysis-----			

Impact on State Appropriations Limit--No

ANALYSIS

A. Specific Findings

Existing law provides that if an insurer allegedly violates certain statutory provisions relating to unfair practices and deceptive acts, the Insurance Commissioner may hold a hearing to determine whether a violation exists. If, after a hearing, the Commissioner determines that any act or practice by an insurer is in violation of law, the Commissioner may issue an order requiring the insurer to cease and desist. Under existing law, an insurer is not liable for a penalty unless it violates the order issued by the Commissioner.

(Continued)

RECOMMENDATION:	Department Director	Date		
Sign the bill - JRW	<i>Richard J. ...</i>	SEP 21 1989		
Principal Analyst	Date	Program Budget Manager	Date	Governor's Office
James A. ... (744) C. Ramos	9/19/89	Betsy Wallis L. Clark (700) Wallis L. Clark	9/22/89	Position noted Position approved Position disapproved
				by: date: PE-3

FR:0637F

LEGISLATIVE INTENT SERVICE (800) 666-1917

BILL ANALYSIS/ENROLLED BILL REPORT--(Continued)

Form DF-43

AUTHOR

AMENDMENT DATE

BILL NUMBER

Robbins

September 11, 1989

SB 1363

ANALYSIS

A. Specific Findings (Continued)

This bill would provide that an insurer who violates statutory provisions relating to unfair practices or deceptive acts before an order is issued by the Commissioner is liable for a penalty of up to \$5,000 for each act or combination of inadvertent acts, or \$10,000 for each act for a willful violation. The penalty would be assessed by the Commissioner in connection with the hearing on the order.

This bill is intended to discourage insurance companies from violating existing unfair practices and deceptive acts statutes.

B. Fiscal Analysis

This bill would not increase State agency expenditures but has the potential for increasing General Fund revenue from fines and penalties. However, neither the number of violations that may occur nor the number that would result in a fine or a penalty can be predicted at this time.

FR:0637F

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LEGISLATIVE INTENT SERVICE

PE-11

EXHIBIT F

ENROLLED BILL REPORT

Business, Transportation and Housing Agency

DEPARTMENT INSURANCE	AUTHOR ROBBINS	BILL NUMBER SB 1263
SUBJECT SUMMARY		SB 1363

SB 1363 imposes a penalty for committing an unfair or deceptive practice.

SPONSOR *insurance*

This is the author's own bill. The contact person is Sal Bianco at 5-0825.

IMPACT ASSESSMENT

This bill imposes a penalty upon any person engaging in an unfair method of competition, or any unfair, deceptive, or other specified act. The fine is not to exceed \$5,000.00 for each act or \$10,000.00 for each willful act. The commissioner has discretion to define the act, except if the issuance, amendment or servicing of a policy is inadvertent, all of those acts shall be considered a single act for the purpose of the penalty.

The penalty shall be determined and imposed as part of the hearing on the charges that the person has engaged in an illegal act. The penalty may be appealed according to specified procedures.

Under current law, a monetary penalty may be imposed only if a person violates a cease and desist order issued by the commissioner upon a determination that charges against the person are justified.

ARGUMENTS PRO

Under current law, the commissioner has no power to impose a penalty until an insurer violates a cease and desist order, thus there is no meaningful deterrent against a violation of the Unfair Practices Act itself.

This bill is consistent with the spirit of Moradi - Shalal because it provides an incentive for insurers to refrain from unfair acts.

According to the author's office, the bill is supported by:

- Sacramento Urban League
- California Conference of Machinists
- Congress of California Seniors
- FAIR (Fair Automobile Insurance Rates)
- California Commission on Aging

RECOMMENDATION SIGN

DEPARTMENT <i>Insurance</i>	DATE	AGENCY <i>State Council</i>	DATE <i>9/20/87</i>
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Enrollment Bill Report/SB 363/Page Two

ARGUMENTS CON

There is no known opposition.

RECOMMENDATION

The department recommends that the Governor SIGN SB 1363.

Expert: Roxani Gillespie
ATSS: 8-597-9624

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PE-6

EXHIBIT G

ASSEMBLY COMMITTEE ON FINANCE AND INSURANCE
Patrick Johnston, Chairman

BACKGROUND INFORMATION REQUEST

Measure: SB 1363
Author : Senator Robbins

1. Origin of the bill:

a. Who is the source of the bill? What person, organization, or governmental entity requested introduction?

author

b. Has a similar bill been before either this session or a previous session of the legislature? If so, please identify the session, bill number and disposition of the bill.

no

c. Has there been an interim committee report on the bill? If so, please identify the report.

no

2. What is the problem or deficiency in the present law which the bill seeks to remedy?

Under present law, insurance companies committing unfair or deceptive practices cannot be fined unless they continue the practice after the Insurance Commissioner issues a cease-and-desist order. This bill will make the insurance companies liable for the initial act.

3. Please attach copies of any background material in explanation of the bill, or state where such material is available for reference by committee staff.

A copy of the Senate ICC analysis is attached.

4. Please attach copies of letters of support or opposition from any group, organization, or governmental agency who has contacted you either in support or opposition to the bill.

5. If you plan substantive amendments to this bill prior to hearing, please explain briefly the substance of the amendments to be prepared.

An amendment requested by the Insurance Department is planned, considered technical by the author.*

6. List the witnesses you plan to have testify.

Not known at this time.

RETURN THIS FORM TO: ASSEMBLY COMMITTEE ON FINANCE AND INSURANCE
Phone 445-9160

Questions should be directed to Leah Cartabruno at 5-0825.

* amended bill attached.

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AP-1

LEGISLATIVE INTENT SERVICE (800) 666-1917

EXHIBIT H

Senate Bill No. 367

CHAPTER 723

An act to amend Sections 10123.13, 10123.147, 12921.1, and 12921.3 of, and to add Sections 10123.137, 10133.66, and 10133.67 to, the Insurance Code, relating to health care coverage.

[Approved by Governor October 7, 2005. Filed with Secretary of State October 7, 2005.]

LEGISLATIVE COUNSEL'S DIGEST

SB 367, Speier. Health care complaint system.

Existing law provides for the licensure and regulation of health insurers by the Department of Insurance and requires the Insurance Commissioner to establish a program to investigate and respond to complaints concerning insurers. Under existing law, a health insurer is required to reimburse a provider's complete claim within a specified timeframe or to provide a notice to the provider explaining its reasons for denying or contesting the claim.

This bill would require the commissioner on or before July 1, 2006, to establish an Internet Web page dedicated exclusively to processing complaints and inquiries from insureds and their health care providers relating to health insurance issues and providing information concerning the process for filing complaints and making inquiries concerning health insurers. The bill would also require the commissioner by that date to provide announcements regarding the complaint system and to process those complaints as specified. The bill would also require a health insurer to provide a copy of its notice denying or contesting a provider's claim to each insured who received services and to each provider who provided services pursuant to that particular claim and to include a statement within that notice of the basis for contesting or denying the claim and that the provider or insured may request review by the department of the insurer's action. The bill would also require each contract between a health insurer and a provider to provide for a dispute resolution mechanism, and would require the mechanism to also be available to noncontracting providers. The bill would require annual reports by health insurers to the department in that regard beginning on July 1, 2007.

The bill would incorporate changes made by AB 729 that would become operative if both bills are enacted and this bill is enacted after AB 729.

The people of the State of California do enact as follows:

SECTION 1. (a) The Legislature finds and declares the following:

(1) Health care services must be available to Californians without unnecessary administrative procedures, interruptions, or delays.

(2) As of May 2002, the Department of Insurance estimated that it regulated insurers covering 28.79 percent of the total accident and health care market and that, with respect to those commercial products that are comparable between the Department of Insurance and the Department of Managed Health Care regulated products, the Department of Insurance regulated 16.8 percent of the comprehensive commercial health insurance provided to Californians.

(3) With two separate departments responsible for regulating entities that provide health care coverage, patients and their health care providers are often confused about the identity of the appropriate regulator.

(b) It 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.

SEC. 2. This act shall be known and may be cited as the Patient and Provider Protection Act.

SEC. 3. Section 10123.13 of the Insurance Code is amended to read:

10123.13. (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. 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. If the reason is based solely on facts or solely on law, the insurer is required to provide only the factual or the legal basis for its reason for contesting or denying the claim. The insurer shall provide a copy of the notice to each insured who received services pursuant to the claim that was contested or denied and to the insured's health care provider that provided the services at issue. The notice shall advise the provider who submitted the claim on behalf of the insured or pursuant to a contract for alternative rates of payment 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. The notice to the provider may be included

on either the explanation of benefits or remittance advice and shall also contain a statement advising the provider of its right to enter into the dispute resolution process described in Section 10123.137. The notice to the insured may also be included on the explanation of benefits.

(b) 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.

(c) For purposes of this section, a claim, or portion thereof, is reasonably contested when the insurer has not received a completed claim and all information necessary to determine payer liability for the claim, or has not been granted reasonable access to information concerning provider services. Information necessary to determine liability for the claims includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for the insurer to determine the medical necessity for the health care services provided to the claimant. If an insurer has received all of the information necessary to determine payer liability for a contested claim and has not reimbursed a claim determined to be payable within 30 working days of receipt of that information, interest shall accrue and be payable at a rate of 10 percent per annum beginning with the first calendar day after the 30-working day period.

(d) The obligation of the insurer to comply with this section shall not be deemed to be waived when the insurer requires its contracting entities to pay claims for covered services.

SEC. 4. Section 10123.137 is added to the Insurance Code, to read:

10123.137. (a) Each contract between a health insurer and a provider shall contain provisions requiring a fast, fair, and cost-effective dispute resolution mechanism under which providers may submit disputes to the insurer, and requiring the insurer to inform its providers, upon contracting with the insurer, or upon change to these provisions, of the procedures for processing and resolving disputes, including the location and telephone number where information regarding disputes may be submitted.

(b) An insurer shall also ensure that a dispute resolution mechanism is accessible to noncontracting providers for the purpose of resolving billing and claims disputes.

(c) Disputes are to be submitted to the insurer in writing and shall include provider name, provider tax identification number, patient name, insurer's identification information, dates of service, description of dispute, and, if applicable, billed and paid amounts. The insurer shall resolve each provider dispute consistent with applicable law and issue a written determination within 45 working days after the date of receipt of the provider dispute.

(d) On and after July 1, 2007, an insurer shall annually submit a report to the department regarding its dispute resolution mechanism. The report shall be public information and include, at a minimum, information on the

number of providers that utilized the dispute resolution mechanism and a summary of the disposition of those disputes. To the extent the commissioner requires detailed information disclosing emerging or established patterns of provider disputes or corrective action by the insurer, the commissioner may maintain the confidentiality of any information found to be proprietary, upon written request of the insurer. In no event shall the commissioner find the required minimum information described in this subdivision to be proprietary.

(e) If an insurer has an affiliated or subsidiary company that is licensed as a health care service plan under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, the insurer may use the same procedures relating to the provider dispute resolution process established by the affiliated or subsidiary entity pursuant to subdivision (h) of Section 1367 of the Health and Safety Code.

SEC. 5. Section 10123.147 of the Insurance Code is amended to read:

10123.147. (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 each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the complete claim by the insurer. However, an insurer may contest or deny a claim, or portion thereof, by notifying the claimant, in writing, that the claim is contested or denied, within 30 working days after receipt of the complete claim by the insurer. The notice that a claim, or portion thereof, is contested shall identify the portion of the claim that is contested, by revenue code, and the specific information needed from the provider to reconsider the claim. The notice that a claim, or portion thereof, is denied shall identify the portion of the claim that is denied, by revenue code, and the specific reasons for the denial, including the factual and legal basis known at that time by the insurer for each reason. If the reason is based solely on facts or solely on law, the insurer is required to provide only the factual or legal basis for its reason to deny the claim. The insurer shall provide a copy of the notice required by this subdivision to each insured who received services pursuant to the claim that was contested or denied and to the insured's health care provider that provided the services at issue. The notice required by this subdivision shall include a statement advising the provider who submitted the claim on behalf of the insured or pursuant to a contract for alternative rates of payment and the insured that either may seek review by the department of a claim that was contested or denied by the insurer and the address, Internet Web site address, and telephone number of the unit within the department that performs this review function. The notice to the provider may be included on either the explanation of benefits or remittance advice and shall also contain a statement advising the provider of its right to enter into the dispute resolution process described in Section 10123.137. An insurer may delay payment of an uncontested portion of a complete claim for

reconsideration of a contested portion of that claim so long as the insurer pays those charges specified in subdivision (b).

(b) If a complete claim, or portion thereof, that is neither contested nor denied, is not reimbursed by delivery to the claimant's address of record within the 30 working days after receipt, the insurer shall pay the greater of fifteen dollars (\$15) per year or interest at the rate of 10 percent per annum beginning with the first calendar day after the 30-working-day period. An insurer shall automatically include the fifteen dollars (\$15) per year or interest due in the payment made to the claimant, without requiring a request therefor.

(c) For the purposes of this section, a claim, or portion thereof, is reasonably contested if the insurer has not received the completed claim. A paper claim from an institutional provider shall be deemed complete upon submission of a legible emergency department report and a completed UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the insurer within 30 working days of receipt of the claim. An electronic claim from an institutional provider shall be deemed complete upon submission of an electronic equivalent to the UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the insurer within 30 working days of receipt of the claim. However, if the insurer requests a copy of the emergency department report within the 30 working days after receipt of the electronic claim from the institutional provider, the insurer may also request additional reasonable relevant information within 30 working days of receipt of the emergency department report, at which time the claim shall be deemed complete. A claim from a professional provider shall be deemed complete upon submission of a completed HCFA 1500 or its electronic equivalent or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the insurer within 30 working days of receipt of the claim. The provider shall provide the insurer reasonable relevant information within 15 working days of receipt of a written request that is clear and specific regarding the information sought. If, as a result of reviewing the reasonable relevant information, the insurer requires further information, the insurer shall have an additional 15 working days after receipt of the reasonable relevant information to request the further information, notwithstanding any time limit to the contrary in this section, at which time the claim shall be deemed complete.

(d) This section shall not apply to claims about which there is evidence of fraud and misrepresentation, to eligibility determinations, or in instances where the plan has not been granted reasonable access to information under the provider's control. An insurer shall specify, in a written notice to the provider within 30 working days of receipt of the claim, which, if any, of these exceptions applies to a claim.

(e) If a claim or portion thereof is contested on the basis that the insurer has not received information reasonably necessary to determine payer liability for the claim or portion thereof, then the insurer shall have 30

working days after receipt of this additional information to complete reconsideration of the claim. If a claim, or portion thereof, undergoing reconsideration is not reimbursed by delivery to the claimant's address of record within the 30 working days after receipt of the additional information, the insurer shall pay the greater of fifteen dollars (\$15) per year or interest at the rate of 10 percent per annum beginning with the first calendar day after the 30-working-day period. An insurer shall automatically include the fifteen dollars (\$15) per year or interest due in the payment made to the claimant, without requiring a request therefor.

(f) An insurer shall not delay payment on a claim from a physician or other provider to await the submission of a claim from a hospital or other provider, without citing specific rationale as to why the delay was necessary and providing a monthly update regarding the status of the claim and the insurer's actions to resolve the claim, to the provider that submitted the claim.

(g) An insurer shall not request or require that a provider waive its rights pursuant to this section.

(h) This section shall apply only to claims for services rendered to a patient who was provided emergency services and care as defined in Section 1317.1 of the Health and Safety Code in the United States on or after September 1, 1999.

(i) This section shall not be construed to affect the rights or obligations of any person pursuant to Section 10123.13.

(j) This section shall not be construed to affect a written agreement, if any, of a provider to submit bills within a specified time period.

SEC. 6. Section 10133.66 is added to the Insurance Code, to read:

10133.66. On or before July 1, 2006, the commissioner, pursuant to his or her authority under Section 12921.1, shall also complete all of the following duties:

(a) Provide announcements that inform health insurance consumers and their health care providers of the department's toll-free telephone number that is dedicated to the handling of complaints and of the availability of the Internet Web page established under this section, and the process to register a complaint with the department and to submit an inquiry to it.

(b) Establish an Internet Web page located on the department's public Internet Web site dedicated exclusively to processing complaints and inquiries relating to health insurance issues from insureds and their health care providers. The Web page shall provide insureds and their health care providers with information concerning filing a complaint and making an inquiry concerning a health insurer and, at a minimum, shall provide the following information:

(1) The department's toll-free telephone number.

(2) A list of all health insurers licensed by the department.

(3) Educational and informational guides for health insurance consumers and health care providers describing their rights under this code. The guides shall be easy to read and understand and shall be made

available to the public, including access on the department's Internet Web site.

(4) A separate, standardized complaint form for health care providers to file a complaint.

(c) An insured or health care provider may file a written complaint with the department with respect to the handling of a claim or other obligation under a health insurance policy by a health insurer or production agency, or with respect to the alleged misconduct by a health insurer or production agency. The commissioner shall notify the complainant of the receipt of the complaint within 10 business days of its receipt. The commissioner shall make a determination on the complaint within 60 calendar days of the date of its receipt, unless the commissioner, in his or her discretion, determines that additional time is reasonably necessary to fully and fairly evaluate the complaint. The commissioner shall notify the complainant of the final action taken on his or her complaint within 30 days of the final action. The notification shall include a summary explaining the commissioner's reasons for the final action.

SEC. 7. Section 10133.67 is added to the Insurance Code, to read:

10133.67. Pursuant to Section 12921, the commissioner may also agree to payment to a health care provider who submitted a claim for health care benefits provided to an insured that are covered under the insured's health insurance policy.

SEC. 8. Section 12921.1 of the Insurance Code is amended to read:

12921.1. (a) The commissioner shall establish a program on or before July 1, 1991, to investigate complaints and respond to inquiries received pursuant to Section 12921.3, to comply with Section 12921.4, and, when warranted, to bring enforcement actions against insurers. The program shall include, but not be limited to, the following:

(1) A toll-free telephone number published in telephone books throughout the state, dedicated to the handling of complaints and inquiries.

(2) Public service announcements to inform consumers of the toll-free telephone number and how to register a complaint or make an inquiry to the department.

(3) A simple, standardized complaint form designed to assure that complaints will be properly registered and tracked.

(4) Retention of records on complaints for at least three years after the complaint has been closed.

(5) Guidelines to disseminate complaint and enforcement information on individual insurers to the public, that shall include, but not be limited to, the following:

(A) License status.

(B) Number and type of complaints closed within the last full calendar year, with analogous statistics from the prior two years for comparison. The proportion of those complaints determined by the department to require that corrective action be taken against the insurer, or leading to insurer compromise, or other remedy for the complainant, as compared to those that are found to be without merit. This information shall be

disseminated in a fashion that will facilitate identification of meritless complaints and discourage their consideration by consumers and others interested in the records of insurers.

(C) Number and type of violations found, by reference to the line of insurance and the law violated. For the purposes of this subparagraph, the department shall separately report this information for health insurers.

(D) Number and type of enforcement actions taken.

(E) Ratio of complaints received to total policies in force, or premium dollars paid in a given line, or both. Private passenger automobile insurance ratios shall be calculated as the number of complaints received to total car years earned in the period studied.

(F) Any other information the department deems is appropriate public information regarding the complaint record of the insurer that will assist the public in selecting an insurer. However, nothing in this section shall be construed to permit disclosure of information or documents in the possession of the department to the extent that the information and those documents are protected from disclosure under any other provision of law.

(6) Procedures and average processing times for each step of complaint mediation, investigation, and enforcement. These procedures shall be consistent with those in Article 6.5 (commencing with Section 790) of Chapter 1 of Part 2 of Division 1 for complaints within the purview of that article, consistent with those in Article 7 (commencing with Section 1858) of Chapter 9 of Part 2 of Division 1 for complaints within the purview of that article, and consistent with any other provisions of law requiring certain procedures to be followed by the department in investigating or prosecuting complaints against insurers.

(7) A list of criteria to determine which violations should be pursued through enforcement action, and enforcement guidelines that set forth appropriate penalties for violations based on the nature, severity, and frequency of the violations.

(8) Referral of complaints not within the department's jurisdiction to appropriate public and private agencies.

(9) Complaint handling goals that can be tested against surveys carried out pursuant to subdivision (a) of Section 12921.4.

(10) Inclusion in its annual report to the Governor, required by Section 12922, detailed information regarding the program required by this section, that shall include, but not be limited to: a description of the operation of the complaint handling process, listing civil, criminal, and administrative actions taken pursuant to complaints received; the percentage of the department's personnel years devoted to the handling and resolution of complaints; and suggestions for legislation to improve the complaint handling apparatus and to increase the amount of enforcement action undertaken by the department pursuant to complaints if further enforcement is deemed necessary to ensure proper compliance by insurers with the law.

(b) The commissioner shall promulgate a regulation that sets forth the criteria that the department shall apply to determine if a complaint is

deemed to be justified prior to the public release of a complaint against a specifically named insurer.

(c) The commissioner shall provide to the insurer a description of any complaint against the insurer that the commissioner has received and has deemed to be justified at least 30 days prior to public release of a report summarizing the information required by this section. This description shall include all of the following:

- (1) The name of the complainant.
- (2) The date the complaint was filed.
- (3) A succinct description of the facts of the complaint.

(4) A statement of the department's rationale for determining that the complaint was justified that applies the department's criteria to the facts of the complaint.

(d) An insurer shall provide to the department the name, mailing address, telephone number, and facsimile number of a person whom the insurer designates as the recipient of all notices, correspondence, and other contacts from the department concerning complaints described in this section. The insurer may change the designation at any time by providing written notice to the Consumer Services Division of the department.

(e) For the purposes of this section, notices, correspondence, and other contacts with the designated person shall be deemed contact with the insurer.

SEC. 8.5: Section 12921.1 of the Insurance Code is amended to read:

12921.1. (a) The commissioner shall establish a program on or before July 1, 1991, to investigate complaints and respond to inquiries received pursuant to Section 12921.3, to comply with Section 12921.4, and, when warranted, to bring enforcement actions against insurers or production agencies, as those terms are defined in subdivision (a) of Section 1748.5. The program shall include, but not be limited to, the following:

(1) A toll-free telephone number published in telephone books throughout the state, dedicated to the handling of complaints and inquiries.

(2) Public service announcements to inform consumers of the toll-free telephone number and how to register a complaint or make an inquiry to the department.

(3) A simple, standardized complaint form designed to assure that complaints will be properly registered and tracked.

(4) Retention of records on complaints for at least three years after the complaint has been closed.

(5) Guidelines to disseminate complaint and enforcement information on individual insurers to the public, that shall include, but not be limited to, the following:

(A) License status.

(B) Number and type of complaints closed within the last full calendar year, with analogous statistics from the prior two years for comparison. The proportion of those complaints determined by the department to require that corrective action be taken against the insurer, or leading to insurer compromise, or other remedy for the complainant, as compared to

those that are found to be without merit. This information shall be disseminated in a fashion that will facilitate identification of meritless complaints and discourage their consideration by consumers and others interested in the records of insurers.

(C) Number and type of violations found, by reference to the line of insurance and the law violated. For the purposes of this subparagraph, the department shall separately report this information for health insurers.

(D) Number and type of enforcement actions taken.

(E) Ratio of complaints received to total policies in force, or premium dollars paid in a given line, or both. Private passenger automobile insurance ratios shall be calculated as the number of complaints received to total car years earned in the period studied.

(F) Any other information the department deems is appropriate public information regarding the complaint record of the insurer that will assist the public in selecting an insurer. However, nothing in this section shall be construed to permit disclosure of information or documents in the possession of the department to the extent that the information and those documents are protected from disclosure under any other provision of law.

(6) Procedures and average processing times for each step of complaint mediation, investigation, and enforcement. These procedures shall be consistent with those in Article 6.5 (commencing with Section 790) of Chapter 1 of Part 2 of Division 1 for complaints within the purview of that article, consistent with those in Article 7 (commencing with Section 1858) of Chapter 9 of Part 2 of Division 1 for complaints within the purview of that article, and consistent with any other provisions of law requiring certain procedures to be followed by the department in investigating or prosecuting complaints against insurers or production agencies.

(7) A list of criteria to determine which violations should be pursued through enforcement action, and enforcement guidelines that set forth appropriate penalties for violations based on the nature, severity, and frequency of the violations.

(8) Referral of complaints not within the department's jurisdiction to appropriate public and private agencies.

(9) Complaint handling goals that can be tested against surveys carried out pursuant to subdivision (a) of Section 12921.4.

(10) Inclusion in its annual report to the Governor, required by Section 12922, detailed information regarding the program required by this section, that shall include, but not be limited to: a description of the operation of the complaint handling process, listing civil, criminal, and administrative actions taken pursuant to complaints received; the percentage of the department's personnel years devoted to the handling and resolution of complaints; and suggestions for legislation to improve the complaint handling apparatus and to increase the amount of enforcement action undertaken by the department pursuant to complaints if further enforcement is deemed necessary to ensure proper compliance by insurers or production agencies with the law.

(b) The commissioner shall promulgate a regulation that sets forth the criteria that the department shall apply to determine if a complaint is deemed to be justified prior to the public release of a complaint against a specifically named insurer or production agency.

(c) The commissioner shall provide to the insurer or production agency a description of any complaint against the insurer or production agency that the commissioner has received and has deemed to be justified at least 30 days prior to public release of a report summarizing the information required by this section. This description shall include all of the following:

- (1) The name of the complainant.
- (2) The date the complaint was filed.
- (3) A succinct description of the facts of the complaint.

(4) A statement of the department's rationale for determining that the complaint was justified that applies the department's criteria to the facts of the complaint.

(d) An insurer shall provide to the department the name, mailing address, telephone number, and facsimile number of a person whom the insurer designates as the recipient of all notices, correspondence, and other contacts from the department concerning complaints described in this section. The insurer may change the designation at any time by providing written notice to the Consumer Services Division of the department.

(e) For the purposes of this section, notices, correspondence, and other contacts with the designated person shall be deemed contact with the insurer.

SEC. 9. Section 12921.3 of the Insurance Code is amended to read:

12921.3. (a) The commissioner, in person or through employees of the department, shall receive complaints and inquiries, investigate complaints, prosecute insurers when appropriate and according to guidelines determined pursuant to Section 12921.1, and respond to complaints and inquiries by members of the public concerning the handling of insurance claims, including, but not limited to, violations of Article 10 (commencing with Section 1861) of Chapter 9 of Part 2 of Division 1, by insurers, or alleged misconduct by insurers or production agencies.

(b) The commissioner shall not decline to investigate complaints for any of the following reasons:

(1) The insured is represented by an attorney in a dispute with an insurer, or is in mediation or arbitration.

(2) The insured has a civil action against an insurer.

(3) The complaint is from an attorney, if the complaint is based upon evidence or reasonable beliefs about violations of law known to an attorney because of a civil action.

(c) The commissioner may defer the investigation until the finality of a dispute, mediation, arbitration, or civil action involving the claim is known.

(d) The commissioner, as he or she deems appropriate, and pursuant to Section 12921.1, shall provide for the education of, and dissemination of

information to, members of the general public or licensees of the department concerning insurance matters.

SEC. 9.5. Section 12921.3 of the Insurance Code is amended to read:

12921.3. (a) The commissioner, in person or through employees of the department, shall receive complaints and inquiries, investigate complaints, prosecute insurers or production agencies when appropriate and according to guidelines determined pursuant to Section 12921.1, and respond to complaints and inquiries by members of the public concerning the handling of insurance claims, including, but not limited to, violations of Article 10 (commencing with Section 1861) of Chapter 9 of Part 2 of Division 1, by insurers or production agencies, or alleged misconduct by insurers or production agencies.

(b) The commissioner shall not decline to investigate complaints for any of the following reasons:

(1) The insured is represented by an attorney in a dispute with an insurer, or is in mediation or arbitration.

(2) The insured has a civil action against an insurer.

(3) The complaint is from an attorney, if the complaint is based upon evidence or reasonable beliefs about violations of law known to an attorney because of a civil action.

(c) The commissioner may defer the investigation until the finality of a dispute, mediation, arbitration, or civil action involving the claim is known.

(d) The commissioner, as he or she deems appropriate, and pursuant to Section 12921.1, shall provide for the education of, and dissemination of information to, members of the general public or licensees of the department concerning insurance matters.

SEC. 10. Section 8.5 of this bill incorporates amendments to Section 12921.1 of the Insurance Code proposed by both this bill and AB 729. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2006, (2) each bill amends Section 12921.1 of the Insurance Code, and (3) this bill is enacted after AB 729, in which case Section 8 of this bill shall not become operative.

SEC. 11. Section 9.5 of this bill incorporates amendments to Section 12921.3 of the Insurance Code proposed by both this bill and AB 729. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2006, (2) each bill amends Section 12921.3 of the Insurance Code, and (3) this bill is enacted after AB 729, in which case Section 9 of this bill shall not become operative.

EXHIBIT I

CHAPTER 957

An act to amend Section 1375.1 of, and to add Section 1371 to, the Health and Safety Code, and to add Sections 10123.13 and 11512.180 to the Insurance Code, relating to insurance.

[Approved by Governor September 20, 1986. Filed with Secretary of State September 22, 1986.]

LEGISLATIVE COUNSEL'S DIGEST

AB 4206, Peace. Health insurance: claim reimbursement.

Existing 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, except that for a health care service plan that is a health maintenance organization reimbursement would be required no later than 45 working days after receipt of the claim. These provisions would apply to any claim, whether in state or out of state, unless contested by the insurer or plan.

The people of the State of California do enact as follows:

SECTION 1. Section 1371 is added to the Health and Safety Code, to read:

1371. A health care service plan which covers hospital, medical, or surgical expenses 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 health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan, unless the claim or portion thereof is contested by the plan in which case the claimant shall be notified, in writing, within 30 working days.

As used in this section, a contested claim, or portion thereof, includes situations in which the plan has not received the completed claim and all information necessary to determine payer liability for the claim, including but not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, or a claim on appeal.

SEC. 2. Section 1375.1 of the Health and Safety Code is amended to read:

1375.1. (a) Every plan shall have and shall demonstrate to the

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commissioner that it has all of the following:

- (1) A fiscally sound operation and adequate provision against the risk of insolvency.
- (2) Assumed full financial risk on a prospective basis for the provision of covered health care services, except that a plan may obtain insurance or make other arrangements for the cost of providing to any subscriber or enrollee covered health care services, the aggregate value of which exceeds five thousand dollars (\$5,000) in any year, for the cost of covered health care services provided to its members other than through the plan because medical necessity required their provision before they could be secured through the plan, and for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for that fiscal year.

(3) A procedure for prompt payment or denial of provider and subscriber or enrollee claims. Except as provided in Section 1371, a procedure meeting the requirements of Subchapter C of the regulations (29 C.F.R. Part 2560) under Public Law 93-406 (88 Stats. 829-1035, 29 U.S.C. Secs. 1001 et seq.) shall satisfy this requirement.

(b) In determining whether the conditions of this section have been met, the commissioner shall consider, but not be limited to, the following:

- (1) The financial soundness of the plan's arrangements for health care services and the schedule of rates and charges used by the plan.
- (2) The adequacy of working capital.
- (3) Agreements with providers for the provision of health care services.

(c) For the purposes of this section, "covered health care services" means health care services provided under all plan contracts.

SEC. 3. Section 10123.13 is added to the Insurance Code, to read: 10123.13. Every insurer issuing group or individual policies of disability insurance and every self-insured employee welfare benefit plan which covers hospital, medical, or surgical expenses shall reimburse claims or any portion of any claim, whether in state or out of state, for such expenses, as soon as practical, but no later than 30 working days after receipt of the claim by the insurer or plan unless the claim or portion thereof is contested by the insurer in which case the claimant shall be notified, in writing, within 30 working days.

As used in this section, a contested claim, or portion thereof, includes situations in which the insurer or plan has not received a completed claim and all information necessary to determine payer liability for the claim, including but not limited to, reports of investigations concerning fraud or misrepresentation, and necessary consents, releases, and assignments, or a claim on appeal.

SEC. 4. Section 11512.180 is added to the Insurance Code, to read: 11512.180. Every nonprofit hospital service plan that covers hospital, medical, or surgical expenses on a group or individual basis

shall reimburse claims or any portion of any claim, whether in state or out of state, for such expenses, as soon as practical, but no later than 30 working days after receipt of the claim by the hospital service plan, or if the plan is a health maintenance organization, 45 working days after receipt of the claim by the hospital service plan, unless the claim or portion thereof is contested by the plan in which case the claimant shall be notified, in writing, within 30 working days.

As used in this section, a contested claim, or portion thereof, includes situations in which the plan has not received the completed claim and all information necessary to determine payer liability for the claim, including but not limited to, reports of investigations concerning fraud or misrepresentation, and necessary consents, releases, and assignments, or a claim on appeal.

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PROOF OF SERVICE

Re: *In the Matter of PacifiCare Life and Health Insurance Company*
File No. UPA 2007-00004

I am employed in the County of Los Angeles, State of California. I am over the age of 18 and not a party to the within action. My business address is 10940 Wilshire Boulevard, Suite 2000, Los Angeles, California 90024.

On, **May 31, 2012**, I served the foregoing document(s) described as **CALIFORNIA DEPARTMENT OF INSURANCE'S REQUEST FOR OFFICIAL NOTICE** on all appropriate parties in this action, as listed, by the method stated.

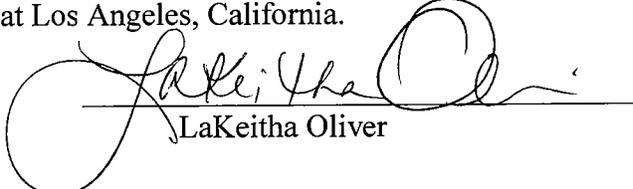
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If electronic-mail service is indicated, by causing a true copy to be sent via electronic transmission from Strumwasser & Woocher LLP's computer network in Portable Document Format (PDF) to the this date to the e-mail address(es) stated, to the attention of the person(s) named.

If U.S. Mail service is indicated, by placing this date for collection for mailing true copies in sealed envelopes, first-class postage prepaid, addressed to each person as indicated, pursuant to Code of Civil Procedure section 1013a(3). I am readily familiar with the firm's practice of collection and processing correspondence for mailing. Under that practice, it would be deposited with the U.S. Postal Service on that same day with postage thereon fully prepaid at Los Angeles, California, in the ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after date of deposit for mailing contained in the affidavit.

I declare under penalty of perjury under the laws of the State of California that the above is true and correct. Executed on **May 31, 2012**, at Los Angeles, California.


LaKeitha Oliver