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BEFORE THE INSURANCE COMMISSIONER

OF THE STATE OF CALIFORNIA

SAN FRANCISCO

In the Matter of the Certificate of Authority of: BLUE SHIELD OF CALIFORNIA LIFE & HEALTH INSURANCE COMPANY, Respondent.	CDI File No. OSC-2007-00067 OAH No.: 2008020772 SECOND AMENDED ORDER TO SHOW CAUSE (Insurance Code §§790.03, 790.05, and 790.06 and California Code of Regulations, Title 10, §§2695.1 et seq.; ACCUSATION (Insurance Code §§700(c), 704(b), 790.03, 790.05, 790.06, 796.04, 10113, 10123.13, 10123.131, 10169, 10380, 10381.5, 10384, and 10400 and California Code of Regulations, Title 10, §§2695.1 et seq.; NOTICE OF NONCOMPLIANCE AND HEARING (Insurance Code §§700(c), 704(b), 790.03, 790.05, 790.06, 796.04, 10113, 10123.13, 10123.131, 10169, 10380, 10381.5, 10384, and 10400 and California Code of Regulations, Title 10, §§2695.1 et seq.; and, DEMAND FOR MONETARY PENALTY (Insurance Code §§790.035, 790.08, and 12976).

The Insurance Commissioner of the State of California ("Insurance Commissioner") in his official capacity alleges that:

JURISDICTION AND PARTIES

1. From July 1, 1954 to the present, Respondent, BLUE SHIELD OF CALIFORNIA LIFE & HEALTH INSURANCE COMPANY ("BLUE SHIELD"), has been the holder of a Certificate of Authority issued by the Insurance Commissioner authorizing Respondent to transact the business of life and disability insurance in the State of California, pursuant to §700 et seq. of the California Insurance Code.[1]

2. Respondent, BLUE SHIELD, is a California corporation and a wholly-owned subsidiary of Blue Shield of California.

3. On or about August 2005, the California Department of Insurance's ("Department") Field Claims Bureau commenced a routine Market Conduct examination of BLUE SHIELD'S claims practices and procedures in California, pursuant to §§730, 733 and 735.5, to determine whether BLUE SHIELD'S denial of claims and claims handling practices during the twelve-month period from June 1, 2004 through May 31, 2005 conformed to its contractual obligations and applicable law. The examination occurred in BLUE SHIELD'S corporate offices in San Francisco. The investigation included an examination of claims files and related records involving Group and Individual Preferred Provider Organization product lines, Individual Short-Term Health products, and Group and Individual life insurance product lines; and an examination of BLUE SHIELD'S guidelines, policies and procedures, training plans, and forms adopted by BLUE SHIELD for use in California. The examination also covered the work practices of BLUE SHIELD'S third-party administrator for BLUE SHIELD'S Short-Term Health product, Comprehensive Benefits and Claims Administrators, located in Minneapolis, Minnesota.

[1] All citations are to the California Insurance Code unless otherwise indicated.

4. Concurrent with the Department's initial routine examination of BLUE SHIELD'S claims handling practices, the Department conducted a targeted Market Conduct examination focusing on BLUE SHIELD'S rescission practices during the same twelve-month period from June 1, 2004 through May 31, 2005. The targeted examination regarding rescissions covered Individual and Family Plan health insurance products to determine whether such rescission practices and related claims settlement practices conformed to contractual obligations and applicable law.

5. The Department's Public Report of the Market Conduct Examination As of May 31, 2005 stated the manner and extent to which BLUE SHIELD'S noncompliance with Insurance Code §790.03 and California Code of Regulations, title 10, §§2695.1 et seq. (attached hereto as Exhibit 1),[2] and specified a reasonable time thereafter in which such noncompliance may be corrected.

6. The Department's Report of the Market Conduct Examination As of May 31, 2005 stated the manner and extent to which BLUE SHIELD'S noncompliance with violations of laws other than §790.03 and California Code of Regulations, title 10, §§2695.1 et seq., is alleged (attached hereto as Exhibit 2),[3] and specified a reasonable time thereafter in which such noncompliance may be corrected.

7. California Insurance Code §700(c) provides that, after the issuance of a certificate of authority, the holder must continue to comply with all requirements set forth in the Insurance Code and all other applicable laws of this State.

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[2] The Public Report of the Market Conduct Examination As of May 31, 2005, attached as Exhibit 1, contains only alleged violations of Cal. Ins. Code §790.03 and Cal. Code Regs. , tit. 10, §§2695 et seq. identified in the combined initial and targeted examinations.

[3] The Report of the Market Conduct Examination As of May 31, 2005, attached as Exhibit 2, contains only alleged violations of laws other than Cal. Ins. Code §790.03 and Cal. Code Regs., tit.10, §2695 et seq. identified in the combined initial and targeted examinations.

8. California Insurance Code §704(b) provides that the Commissioner may suspend an insurer's certificate of authority, after hearing, for not carrying out its contracts in good faith.

9. California Insurance Code §10400 provides, in pertinent part, that the Commissioner may suspend an insurer's certificate of authority for willfully engaging in postclaims underwriting, in violation of Insurance Code §10384, or willfully violating any other provision of Chapter 4, Part 2, Division 2 of the Insurance Code.

10. California Insurance Code §§730, 733, 734, and 790.04 authorize the Commissioner access to all records of an insurer and the power to examine the affairs of every person engaged in the business of insurance to determine whether such insurer or person has complied with all laws applicable to insurance transactions.

11. California Insurance Code §790.02 prohibits any insurer from engaging in this State "in any trade practice which is … an unfair method of competition or an unfair or deceptive act or practice in the business of insurance."

12. California Insurance Code §790.03 defines unfair methods of competition and unfair and deceptive acts or practices in the business of insurance. Section 790.03(h) enumerates sixteen (16) claims settlement practices that, when either knowingly committed on a single occasion, or performed with such frequency as to indicate a general business practice, are considered to be unfair claims settlement practices, and are thus prohibited.

13. California Code of Regulations ("CCR"), Title 10, Chapter 5, Subchapter 7.5, Article 1 contains Fair Claims Settlement Practices Regulations "to promote the good faith, prompt, efficient and equitable settlement of claims." These regulations delineate certain minimum standards for the settlement of claims which, when violated knowingly on a single occasion or performed with such frequency as to indicate a general business practice shall constitute an unfair claims settlement practice within the meaning of Insurance Code §790.03(h).

Other acts or practices not specifically delineated in this set of regulations may also be unfair claims settlement practices subject to Insurance Code §790.03. All licensees are required to have thorough knowledge of such regulations.

14. CCR, title 10, §2695.1(g) provides that failure of a licensee to provide the commissioner with requested information sufficient to examine the licensee's claims handling practices may justify a finding that the licensee was in noncompliance with these regulations or California Insurance Code §790.03.

15. CCR, title 10, §2695.3(a) requires all insurers to maintain all documents, notes and work papers, including copies of all correspondence, pertaining to each claim in such detail that pertinent events and the dates of the events can be reconstructed and the licensee's actions pertaining to the claim can be determined.

16. CCR, title 10, §2695.5(a) requires a licensee to respond immediately to an inquiry from the Department concerning a claim, but in no event more than twenty-one (21) calendar days of receipt of that inquiry. This section is not intended to permit delay in responding to inquiries by Department personnel conducting an examination on the insurer's premises.

17. CCR, title 10, §2695.7(b) (1) requires a licensee to provide to a claimant, in writing, the factual and legal basis for denial of a claim. Section 2695.7(b) (3) further requires a licensee to include a statement in its claim denial that, if the claimant believes the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance, and must include the address and telephone number of the unit of the Department which reviews claims practices.

18. CCR, title 10, §2695.7(d) provides that every insurer must conduct and diligently pursue a thorough, fair and objective investigation and shall not persist in seeking information not reasonably required or material to the resolution of a claim dispute.

19. California Insurance Code §790.035 provides that "any person who engages in any unfair method of competition or any unfair or deceptive act or practice defined in §790.03 is liable to the state for a civil penalty to be fixed by the commissioner, not to exceed five thousand dollars ($5,000) for each act, or, if the act or practice was willful, a civil penalty not to exceed ten thousand dollars ($10,000) for each act. The commissioner shall have the discretion to establish what constitutes an act."

20. California Insurance Code §790.06 provides for the prosecution of unfair methods of competition and unfair and deceptive acts or practices in the business of insurance that are not defined in §790.03.

21. California Insurance Code §790.08 states that "The powers vested in the commissioner in this article shall be additional to any other powers to enforce any penalties, fines or forfeitures, denials, suspensions or revocations of licenses or certificates authorized by law with respect to the methods, acts and practices hereby declared to be unfair or deceptive."

22. California Insurance Code §796.04 provides that a health insurer "that authorizes a specific type of treatment for services covered under a policyholder's contract by a provider shall not rescind or modify this authorization after the provider renders the health care service in good faith and pursuant to the authorization for any reason, including, but not limited to, the insurer's subsequent rescission, cancellation, or modification of the insured's or policyholder's contract...."

23. California Insurance Code §10113 provides that "Every policy of life, disability, or life and disability insurance issued or delivered within this State... shall contain and be deemed to constitute the entire contract between the parties and nothing shall be incorporated therein by reference to any constitution, by-laws, rules, application or other writings, of either of the parties thereto or of any other person, unless the same are indorsed upon or attached to the policy...."

24. California Insurance Code §10169 provides, in pertinent part, that, under the Legislature's establishment of an Independent Medical Review System in the Department of Insurance, commencing January 1, 2001, every disability insurer must provide an insured with the opportunity to seek an independent medical review whenever health care services have been denied, modified, or delayed by the insurer...if the decision was based in whole or in part on a finding that the proposed health care services are not medically necessary. Subsection (i) of §10169 requires that "every disability insurer shall prominently display in every ...insurance contract, ...on copies of insurer procedures for resolving grievances, on letters of denials issued by either the insurer or its contracting organization, and on all written responses to grievances, information concerning the right of an insured to request an independent medical review" from the Department of Insurance "in cases where the insured believes that health care services have been improperly denied, modified, or delayed by the insurer or by one of its contracting providers."

25. California Insurance Code §10123.13 requires that "Every insurer issuing group or individual policies of health insurance that covers hospital, medical, or surgical expenses...shall reimburse claims..., whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the claim by the insurer." If the claim is contested or denied by the insurer, the claimant shall be notified in writing within 30 working days after receipt of the claim. Such notice must identify the portion of the claim that is contested or denied and the specific reasons including the factual and legal basis for contesting or denying the claim. The insurer shall provide a copy of such notice to the insured's health care provider that provided the services at issue. If an uncontested claim is not reimbursed within 30 working days after receipt, or if the insurer has received all of the information necessary to determine payer liability for a contested claim that is determined to be payable and has not reimbursed the claim within 30 working days

of receipt of that information, 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.

26. California Insurance Code §10123.131 provides, in pertinent part, that an insurer shall not request information that is not reasonably necessary to determine liability for payment of a claim.

27. California Insurance Code §10380 provides that the falsity of any statement in the application for insurance shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insured.

28. California Insurance Code §10381.5 provides, in pertinent part, that "the insured shall not be bound by any statement made in an application for a policy unless a copy of such application is attached to or endorsed on the policy when issued as a part thereof."

29. California Insurance Code §10384 prohibits an insurer issuing any policy of disability insurance covering hospital, medical, or surgical expenses from engaging in the practice of postclaims underwriting. "Postclaims underwriting" is defined as "rescinding, canceling, or limiting of a policy or certificate due to the insurer's failure to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application *before* issuing the policy or certificate."

FACTUAL ALLEGATIONS

30. On or about August 2005, the Department conducted a routine Market Conduct examination of BLUE SHIELD'S claims handling practices during the period of June 1, 2004 through May 31, 2005. The examination focused primarily on whether BLUE SHIELD'S claims handling and claims settlement practices were effectuated promptly, fairly, and equitably, in conformance with contractual obligations and California law.

31. Concurrently, the Department conducted a targeted examination of Blue Shield's rescission practices during the same twelve month period from June 1, 2004 through May 31, 2005. The targeted examination covered only Individual and Family Plan health insurance policies.

32. Between June 1, 2004 and May 31, 2005, Blue Shield rescinded one hundred eighty-five (185) Short-Term-Health insurance policies and forty-four (44) Individual and Family Plan health insurance policies, totaling two hundred twenty-nine (229) policies.

33. During the initial Market Conduct examination, the examiners reviewed two hundred eighty-six (286) claims files involving various Blue Shield lines of business, including Group and Individual Preferred Provider Organization health insurance products, Individual Short-Term Health products, and Group and Individual life insurance products. The initial examination included ten (10) rescinded and cancelled Individual and Family Plan health insurance policies. During the concurrent targeted examination, the examiners reviewed the remaining thirty-four (34) rescinded Individual and Family Plan health insurance policies during that time period. In sum, the examiners reviewed three hundred twenty (320) files.

34. Based on the combined examinations, the Department alleges that BLUE SHIELD has engaged in the following five hundred seventy-five (575) unfair or deceptive acts or practices,[4] in violation of California Insurance Code §790.03 and/or the Fair Claims Settlement Practices Regulations, as more fully described in the attached Market Conduct reports:

Failure to Act Reasonably Promptly Upon Communications Regarding Claims

(a) In one hundred seventy-six (176) instances, BLUE SHIELD failed to respond to an inquiry by the Department's examiners within 21 calendar days, in violation of CCR, title 10,

§2695.5(a). In many of those instances, BLUE SHIELD took 22 to 100 days to respond.

(b) In at least one (1) instance, BLUE SHIELD failed to acknowledge and act reasonably promptly to a provider appeal with respect to claims arising under insurance policies, in violation of California Insurance Code §790.03(h)(2).

(c) In two (2) instances, BLUE SHIELD failed to acknowledge to the claimant receipt of a notice of claim within fifteen calendar days, in violation of CCR, title 10, §2695.5(e)(1).

(d) In three (3) instances, BLUE SHIELD failed to act reasonably promptly in providing and/or maintaining all documents and records requested by Department examiners, as required by California Insurance Code §734, in violation of California Insurance Code §790.03(h)(2).

Failure to Adopt and Implement Reasonable Standards for the Prompt Investigation and Processing of Claims

(e) In one hundred twenty-five (125) instances, BLUE SHIELD failed to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under its insurance policies, in violation of California Insurance Code §790.03(h)(3).

(f) In fifty-eight (58) instances, BLUE SHIELD failed to maintain all documents, notes, correspondence, and work papers which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed and the licensee's actions pertaining to the claim can be determined, in violation of CCR, title 10, §2695.3(a).

(g) In seventeen (17) instances, BLUE SHIELD failed to respond at all or failed to properly evaluate responses from policyholders who appealed rescission of their coverage and denial of their claims, in violation of California Insurance Code §§790.02 and 790.03(h)(3). In one instance, an insured who applied for a plan transfer was underwritten and thereafter rescinded

[4] Of the 531 claims handling violations cited in the Market Conduct Examination Reports, 519 were identified in the initial examination and 12 in the targeted examination.

when he should not have been underwritten at all. In three instances, points that led to a rescission were assigned for symptoms in which there was no evidence of the underlying diagnosis that generated the points. In seven instances, policyholders appealed rescission of their coverage attaching statements from their health care providers refuting BLUE SHIELD'S basis for rescission, which BLUE SHIELD did not address.

Misrepresentation of Pertinent Facts or Insurance Policy Provisions to Claimants

(h) In sixty-one (61) instances, BLUE SHIELD failed to represent correctly to claimants pertinent facts or insurance policy provisions relating to a coverage at issue, in violation of California Insurance Code §790.03(h)(1). Four of these instances involved life insurance products, in which BLUE SHIELD notified claimants of life insurance benefits that a beneficiary was not designated yet BLUE SHIELD could not locate a copy of the application in the files to support such a statement.

(i) In five (5) instances, BLUE SHIELD failed to advise policyholders of their right to seek an Independent Medical Review from the Department of Insurance on letters of denials and other written materials, as required by California Insurance Code §10169(i), in violation of California Insurance Code §790.03(h)(1).

Not Attempting in Good Faith to Effectuate Prompt, Fair and Equitable Settlements

(j) In thirty-five (35) instances, BLUE SHIELD failed to include a statement in its claim denial that, if the claimant believes the claim has been wrongly denied or rejected, he or she may have the matter reviewed by the California Department of Insurance, along with the address and telephone number of the unit of the Department which reviews claims practices, in violation of CCR, title 10, §2695.7(b)(3). BLUE SHIELD was previously cited for violation of this section in the Department's Market Conduct Examination Report As of August 31, 2002.

(k) In twenty-six (26) instances, BLUE SHIELD failed to conduct and diligently pursue a thorough, fair and objective investigation by persisting in seeking information not reasonably required for or material to the resolution of a claim dispute, in violation of CCR, title 10, §2695.7(d) (prior to 10/04 CCR revision).

(l) In three (3) instances, BLUE SHIELD failed to conduct and diligently pursue a thorough, fair and objective investigation of a claim, in violation of CCR, title 10, §2695.7(d)(after 10/04 CCR revision).

(m) In seventeen (17) instances, BLUE SHIELD did not attempt in good faith to effectuate prompt, fair and equitable settlements of claims in which liability had become reasonably clear, in violation of California Insurance Code §790.03(h)(5). BLUE SHIELD agreed to these findings and, at the insistence of the Department, conducted a survey of claims during 2004-2006, resulting in payment of an additional $986,401.93 to claimants.

(n) In thirteen (13) instances, BLUE SHIELD failed to provide to the claimant an explanation of benefits for each claim payment including, if applicable, the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits, in violation of CCR, title 10, §2695.11(b).

(o) In five (5) instances, BLUE SHIELD failed to provide to the claimant, in writing, the factual and legal bases of the reason for the denial of a claim, in violation of CCR, title 10, §2695.7(b)(1).

(p) In four (4) instances, BLUE SHIELD failed to affirm or deny coverage of claims within a reasonable time after proof of loss requirements had been completed and submitted by the insured, in violation of California Insurance Code §790.03(h)(4).

(q) In at least one (1) instance, BLUE SHIELD attempted to settle a claim by making a settlement offer that is unreasonably low despite evidence submitted by the claimant to support the value of the claim, in violation of CCR, title 10, §2695.7(g).

(r) In at least one (1) instance, BLUE SHIELD failed to reimburse the insured or medical service provider for reasonable expenses incurred in copying medical records requested by the insurer, in violation of CCR, title 10, §2695.11(g). BLUE SHIELD agreed to this finding and, at the insistence of the Department, conducted a survey of claims paid during 2003-2006, resulting in payment of an additional $974.65 to claimants and/or medical service providers.

(s) In three (3) instances, BLUE SHIELD failed to return premium to beneficiaries at the time of claims settlement, as required by California Insurance Code §481, in violation of California Insurance Code §790.03(h)(5). BLUE SHIELD agreed to these findings and, at the insistence of the Department, conducted a survey of claims during 2004-2006, resulting in payment of an additional $15,104.24 to claimants.

(t) In seven (7) instances, BLUE SHIELD failed to pay interest on an *uncontested* claim after thirty working days, as required by California Insurance Code §10123.13((b), in violation of California Insurance Code §790.03(h)(5). BLUE SHIELD was previously cited for violation of this section in the Department's Market Conduct Examination Report As of August 31, 2002.

(u) In five (5) instances, BLUE SHIELD failed to pay interest on a contested claim that had not been paid within thirty days of a determination of payer liability, as required by California Insurance Code §10123.13(c), in violation of California Insurance Code §790.03(h)(5). BLUE SHIELD agreed with these findings and paid the interest due.

(v) In four (4) instances, BLUE SHIELD failed to reimburse or notify insureds that BLUE SHIELD was contesting or denying the claim within thirty working days, as required by

California Insurance Code §10123.13(a), in violation of California Insurance Code §790.03(h)(4). BLUE SHIELD was previously cited for noncompliance with California Insurance Code §10123.13(a) in the Department's Market Conduct Examination Report As of August 31, 2002.

Failure to Certify Adequate Training of Claims Agents

(w) In one (1) instance, BLUE SHIELD failed to maintain a copy of the certification that the company had provided thorough and adequate training of its claims agents regarding the Fair Claims Settlement Practices Regulations, in violation of CCR, title 10, §2695.6(b)(4).

Failure to Disclose Policy Provisions and Benefits

(x) In two (2) instances, BLUE SHIELD failed to disclose to a claimant or beneficiary all benefits, coverage, time limits or other provisions of an insurance policy that may apply to the claim presented, in violation of CCR, title 10, §2695.4(a).

35. The Commissioner has alleged that each act identified in paragraph 34 constitutes an unfair method of competition or unfair or deceptive act or practice within the meaning of California Insurance Code §790.03; and,

36. As a result of the combined examinations, the Department also alleges that BLUE SHIELD has engaged in activities related to rescissions in violation of the following provisions of the Insurance Code, as more fully described in the Market Conduct Reports:

Failure to Attach or Endorse the Application to the Insurance Policy When Issued

In two hundred twenty-nine (229) instances, BLUE SHIELD failed to attach or endorse the application on the policy when it was issued yet used statements in the application as the basis for all forty-four (44) Individual and Family Plan rescissions and cancellations and one hundred eighty-five (185) Short-Term Health policy rescissions, in violation of California Insurance Code §10113.

In two hundred twenty-nine (229) instances, BLUE SHIELD used insured's statements in an application for a health insurance policy as the basis for rescission without attaching or endorsing such application on the policy when it was issued in all of the Individual and Family Plan and Short-Term Health insurance policies rescinded between June 1, 2004 through May 31, 2005, in violation of California Insurance Code §10381.5.

Failure to Establish Material Misrepresentation to Bar Recovery Under the Policy

In two hundred twenty-nine (229) instances, BLUE SHIELD failed to establish that an incorrect or incomplete response on the application constituted material misrepresentation or intent to deceive, under applicable law, in each of the forty-four (44) Individual and Family Plan policies and one hundred eighty-five (185) Short-Term Health insurance policies rescinded between June 1, 2004 through May 31, 2005 to bar recovery under the policies, in violation of California Insurance Code §10380. The Department's examiners found no evidence that BLUE SHIELD made a good faith effort to determine whether the policyholder was aware of the true facts of his or her medical history and appreciated the significance of information related to him or her or contacted the agent to determine all the facts surrounding any alleged misrepresentation in a rescission investigation.

BLUE SHIELD Engaged in Prohibited Postclaims Underwriting

In two hundred twenty-nine (229) instances, BLUE SHIELD engaged in postclaims underwriting in each of the forty-four (44) Individual and Family Plan policies and one hundred eighty-five (185) Short-Term health insurance policies rescinded between June 1, 2004 through May 31, 2005, in violation of California Insurance Code §10384, by failing to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application *before* issuing the policy. As examples,

(1) YV's health insurance policy was rescinded after a request for prior authorization of medical care and claims were received by BLUE SHIELD. BLUE SHIELD'S postclaims investigation revealed inconsistencies in YV's application when compared to medical records which were only obtained *after* issuance of the policy for the postclaims investigation. Specifically, YV's application reported treatment for a bladder infection on 2/1/04 in Part 7 of the application, which was an incorrect section of the application for reporting this information. In spite of the bladder infection and bladder pain reported in Part 7, YV provided conflicting information in Part 4 when she answered "no" to the following question: "Have you ever received any professional advice or treatment for or had any of the symptoms pertaining to any of the following:...Question 6: Urinary Tract: Such as: renal,...bladder...infections." Further, YV did not list any medication she presumably would have taken for a bladder infection. YV's application also provided no information on details of her medical condition in Part 5 even though she reported it in Part 7, making this application incomplete. BLUE SHIELD failed to contact the applicant or take any other steps to obtain the missing responses. Thus, BLUE SHIELD was put on notice that the applicant had suffered bladder pain and a bladder infection but chose not to complete medical underwriting and resolve the obvious inconsistencies prior to issuing the policy.

Further, the structure of the question in Part 7, which inquires about the Last Physician Visit, provides no opportunity for the applicant to supply information about visits prior to the last physician visit and is confusing and difficult to understand. It would be difficult for an applicant to report recurring visits or problems when the question asks only about the last physician visit. Yet BLUE SHIELD would need this information to properly apply its own underwriting guidelines and to complete medical underwriting.

BLUE SHIELD failed to consistently apply its underwriting guidelines and processed YV's incomplete application as a "clean" application. Had BLUE SHIELD ordered a copy of

medical records from the doctor who treated her bladder infection *prior* to issuing coverage, it would have obtained the additional information needed to complete medical underwriting to determine eligibility. Instead, BLUE SHIELD waited until medical services were needed and provided to conduct a postclaims investigation that resulted in rescinding the policy. During the postclaims investigation, BLUE SHIELD obtained the medical records at no cost within four days of its request.

(2) VH completed an application for health insurance and BLUE SHIELD issued the policy without reviewing or requesting medical records during the pre-enrollment medical underwriting process. BLUE SHIELD asked the insurance agent (holding an appointment from BLUE SHIELD) involved in selling the policy to obtain two pieces of missing information regarding applicant's cigarette smoking and last menstrual period. In a large handwritten note, initialed at the bottom of VH's application, the agent wrote "Suggest APS." An "APS" is an Attending Physician Statement and is an important part of the medical underwriting process when there is any question about the applicant's medical information which is self-reported. In Part 11 of the application, the agent is required to provide written yes or no answers to a series of questions. On VH's application, in the section where the agent signs, every single "YES" response had clearly been scratched out and replaced with a "NO" response. By failing to contact its appointed agent to inquire about the changed answers and the agent's recommendation to obtain an Attending Physician Statement, BLUE SHIELD failed to complete medical underwriting. The Department could find no evidence of an Attending Physician Statement or documentation of an inquiry to the agent regarding the recommendation in the pre-enrollment underwriting file.

(3) MQ submitted an application for individual health insurance on October 2, 2004. The application showed a "NO" response in Part 4 to the following question: "Have

you...EVER...received any professional advice or treatment for or had any symptoms pertaining to any of the following?... Question 19. Counseling or treatment for symptoms of depression, manic depression, anxiety, ...or for any other reason?" In Part 6, MQ indicated ongoing use of the medication Propanolol as of 2/27/04. MQ reported using this medication for anxiety and indicated no end date for use of this medication. In Part 7, which asked to List your Last Physician Visit, MQ reported the same 2/27/04 visit to her physician with the finding of Anxiety and Present Status of "None." The information provided by MQ in these three different parts of the application produced clear conflicts. In two answers, she reported anxiety but answered "NO" to a direct question about anxiety in her Medical History. She provided no information in Part 5 asking for Medical Condition Details. The Department's examiners did not find any evidence that BLUE SHIELD requested additional information from the applicant or medical records in the pre-enrollment underwriting file to resolve these apparent conflicts and inconsistencies in the application before issuing the policy.

MQ also indicated on the application that she drank five alcoholic beverages per week for five years with a stop date of 9/26/04, which was only *five* days prior to the date of her application for health coverage. These contradictory and inconsistent responses to an experienced underwriter clearly call for additional information to complete medical underwriting and resolve apparent questions. Nothing was done. However, once health care providers requested prior authorization for medical care and claims for medical services were submitted for payment, BLUE SHIELD immediately initiated a postclaims investigation during which it obtained underwriting information that led to rescission of MQ's coverage.

(4) NB submitted her application for individual health insurance on 8/25/04. Even though her application was incomplete due to the omission of the diagnosis that led to her surgery in 2002, BLUE SHIELD issued a policy. NB's application also contained obvious

inconsistencies that were not resolved prior to issuance of coverage. In the part asking about Medical Conditions, NB listed treatment for stress due to a divorce from 7/03 and ending 9/03. However, in the part asking about her Last Physician Visit, NB listed a referral to counseling on 03/10/04, that her present status was "good," and that the reason for the physician visit was "follow up." BLUE SHIELD did not comply with its own guidelines that call for the applicant to provide written documentation of missing information such as a diagnosis. The Department's examiners could find no evidence that BLUE SHIELD sought medical records or took other measures to properly complete medical underwriting and resolve the patent inconsistencies in NB's application *prior* to issuing a policy.

(5) FH applied for health coverage, requesting an effective date of 4/1/04. She answered "YES" to the question "Have you...EVER received any professional advice or treatment for or had any symptoms pertaining to any of the following? Question 1: Brain or nervous system – such as: dizziness, headache, etc.?" FH reported, in Part 5, a diagnosis of hormonal migraines that was ongoing and that she was continuing to take a medication for this diagnosis. FH did not complete the question regarding frequency of her migraines nor did she complete the application's inquiry regarding the Present Status of her migraines. BLUE SHIELD did not follow up to obtain the missing information and issued a policy. Five months after the effective date, a prior authorization request triggered a postclaims investigation. Thereupon, BLUE SHIELD requested medical records and received them within **three** days. FH also filed a complaint with the Department stating that she had fully disclosed her medical history but her coverage was still rescinded.

(6) MM, KD, BZR, and JC reported prior coverage with BLUE SHIELD or one of its affiliates. Nonetheless, in spite of easy access to claims history and medical information detail for these four individuals, there was no record that BLUE SHIELD reviewed such information to

complete medical underwriting *before* issuing the policies to assure that the responses were accurate and complete. BLUE SHIELD processed MM's application as a "clean" application, yet it had prior claims history to show that it had paid claims for treatment of conditions that were not reported on the application. BLUE SHIELD ignored its own guidelines which instruct that an application should not be treated as "clean" if there is prior BLUE SHIELD health coverage.

(7) CC submitted an online application to BLUE SHIELD requesting a plan change, from a PPO plan with a $5,000 deductible to a PPO plan with a $750 deductible. BLUE SHIELD issued coverage under the new plan on 8/15/04, but shortly thereafter initiated a postclaims investigation on 9/9/04. On his transfer application, CC reported a normal healthy routine exam on 7/29/02, followed by an emergency room visit seven days later and a one-week hospitalization for the diagnosis of hyperhydrosis on 8/6/02. BLUE SHIELD'S underwriting guidelines call for additional underwriting if a diagnosis is not on its "clean application" list. CC's diagnosis of hyperhydrosis was **not** on this list, yet BLUE SHIELD failed to complete such underwriting before issuing coverage on 8/15/04 under the new PPO plan. BLUE SHIELD rescinded CC's coverage on 9/19/04.

STATUTORY ALLEGATIONS

37. The facts alleged in Paragraph 34 herein demonstrate that BLUE SHIELD has engaged in acts which constitute an unfair method of competition and/or unfair or deceptive acts or practices in this State, in violation of California Insurance Code §790.03 and/or the Fair Claims Settlement Practices Regulations. BLUE SHIELD'S conduct constitutes grounds for the Insurance Commissioner to assess a monetary penalty pursuant to California Insurance Code §790.035.

38. The facts alleged in Paragraphs 34 and 36 herein demonstrate that BLUE SHIELD has not carried out its contracts in good faith, and constitute grounds for the Insurance

Commissioner to suspend BLUE SHIELD'S Certificate of Authority pursuant to Insurance Code §704(b).

39. The facts alleged in Paragraph 36 herein demonstrate that BLUE SHIELD has engaged in postclaims underwriting, in direct contravention of California Insurance Code §10384, and, if willful, constitute grounds for the Insurance Commissioner to suspend or revoke BLUE SHIELD'S Certificate of Authority pursuant to California Insurance Code §10400.

40. The facts alleged in Paragraph 36 herein demonstrate that BLUE SHIELD has engaged in conduct that violates California Insurance Code §§10380 and 10381.5, and, if willful, constitute grounds for the Insurance Commissioner to suspend or revoke BLUE SHIELD'S Certificate of Authority pursuant to California Insurance Code §10400.

41. The facts alleged in Paragraph 36 herein demonstrate that BLUE SHIELD has engaged in activities related to rescission practices which constitute an unfair method of competition and/or unfair or deceptive acts or practices in the marketplace affecting consumers and disability insurance competitors in this State that are not defined in California Insurance Code §790.03, in violation of §790.06(a) of the California Insurance Code. BLUE SHIELD'S conduct constitutes grounds for the Insurance Commissioner to enjoin such practices if not discontinued.

42. The Insurance Commissioner hereby notifies BLUE SHIELD that, based upon the facts alleged herein, BLUE SHIELD is in violation of California Insurance Code §§700(c), 704(b), 790.02, 790.03, 790.06, 796.04, 10113, 10123.13, 10123.131, 10169, 10380, 10381.5, and 10384, and the Fair Claims Settlement Regulations contained in California Code of Regulations, Title 10, Chapter 5, Subchapter 7.5, commencing with §2695.1.

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DEMAND PURSUANT TO CALIFORNIA INSURANCE CODE §§790.035, 790.05, 790.08, and 12976

43. PLEASE TAKE NOTICE that the Insurance Commissioner may, as a result of BLUE SHIELD'S actions as set forth hereinabove, and pursuant to California Insurance Code §790.035, seek monetary penalties up to:

a. Two million eight hundred seventy-five thousand dollars ($2,875,000.00), if each of the five hundred seventy-five (575) acts of unfair competition or unfair or deceptive practices alleged above is established and such acts are non-willful, based on a penalty of five thousand dollars ($5,000.00) for each act; or

b. Five million seven hundred fifty thousand dollars ($5,750,000.00), if each of the five hundred seventy-five (575) acts of unfair competition or unfair or deceptive practices alleged above is established and such acts are willful, based on a penalty of ten thousand dollars ($10,000.00) for each act.

44. PLEASE TAKE FURTHER NOTICE that, as a result of the actions of BLUE SHIELD as set forth hereinabove, and pursuant to California Insurance Code §§790.06, 790.08, 10380, 10113, 10381.5, and 10384, demand is hereby made for such other equitable relief, including restitution, as may be necessary to redress BLUE SHIELD'S violations of enumerated California statutory law and regulations and for such other and further relief as may be just and proper.

ORDER TO SHOW CAUSE PURSUANT TO CALIFORNIA INSURANCE CODE §§790.03, 790.05 and 790.06

45. WHEREAS, the Insurance Commissioner has reason to believe, based upon the facts set forth herein, that BLUE SHIELD has engaged in or is engaging in unfair methods of competition and/or unfair or deceptive acts or practices in this State as defined in California Insurance Code §790.03(h) and/or the Fair Claims Settlement Practices Regulations; and,

46. WHEREAS, the Insurance Commissioner has reason to believe, based upon the facts set forth herein, that BLUE SHIELD has engaged in or is engaging in a method of competition and/or an act or practice in the conduct of its business in this State that is not defined in California Insurance Code §790.03, and that the method is unfair and/or the act or practice is unfair or deceptive pursuant to California Insurance Code §790.06; and,

47. WHEREAS, the Insurance Commissioner has reason to believe that a proceeding by the Insurance Commissioner would be in the public interest, he hereby issues the herein Order to Show Cause, pursuant to California Insurance Code §790.05, containing a statement of the charges and BLUE SHIELD'S potential liability; and,

48. WHEREAS, the Insurance Commissioner has reason to believe that a proceeding by the Insurance Commissioner would be in the public interest, he hereby issues the herein Order to Show Cause, pursuant to California Insurance Code §790.06, containing a statement of the methods, acts or practices alleged to be unfair or deceptive; and,

49. THEREFORE, the Insurance Commissioner hereby notifies BLUE SHIELD that a hearing shall be held at a time and place to be determined by the Commissioner which shall not be less than 30 days after service of the herein Order to Show Cause to determine whether the alleged methods, acts or practices set forth herein should be declared to be unfair or deceptive and whether the Commissioner should issue an Order to pay the penalty imposed by California Insurance Code §790.035 and to cease and desist from such acts or practices.

50. THEREFORE, the Insurance Commissioner hereby notifies BLUE SHIELD that a hearing shall be held at a time and place to be determined by the Commissioner which shall not be less than 30 days after service of the herein Order to Show Cause to determine whether the alleged methods, acts or practices set forth herein should be declared to be unfair or deceptive and whether the Commissioner should issue a report so declaring.

WHEREFORE, the Insurance Commissioner prays for the following:

1. An Order to Cease and Desist against BLUE SHIELD from engaging in unfair methods of competition and unfair and deceptive acts or practices in the business of life and disability insurance in violation of California Insurance Code §§790.03 and 790.06; and,

2. An Order to Cease and Desist against BLUE SHIELD from engaging in activities in the business of life and disability insurance in violation of California Insurance Code §§700(c), 704(b), 796.04, 10113, 10123.13, 10123.131, 10169, 10380, 10381.5, and 10384; and

3. The suspension of BLUE SHIELD'S Certificate of Authority to act as a Life and Disability insurer in the State of California for not exceeding one year, pursuant to California Insurance Code §704(b); and,

4. The suspension or revocation of BLUE SHIELD'S Certificate of Authority to act as a Life and Disability insurer in the State of California, pursuant to California Insurance Code §10400; and,

5. The imposition of Notice on BLUE SHIELD that, after conclusion of the hearing, upon a finding of violation of California Insurance Code §700(c), BLUE SHIELD will be subject to the possible revocation of its Certificate of Authority pursuant to California Insurance Code §701; and,

6. The imposition of monetary penalties as provided by law, pursuant to California Insurance Code §790.035, of up to (a) two million eight hundred seventy-five thousand dollars ($2,875,000.00) if each of the five hundred seventy-five (575) acts of unfair competition or unfair or deceptive practices alleged above is established and such acts are non-willful, based on a penalty of five thousand dollars ($5,000.00) for each act; or (b) five million seven hundred fifty thousand dollars ($5,750,000.00) if each of the five hundred seventy-five (575) acts of unfair

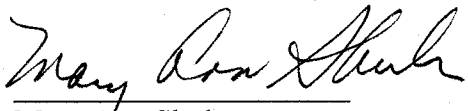
competition or unfair or deceptive practices alleged above is established and such acts are willful, based on a penalty of ten thousand dollars ($10,000.00) for each act; and,

7. The imposition of such other equitable relief, including restitution, as may be necessary to redress BLUE SHIELD'S violations as set forth above; and

8. The imposition of such further relief as may be just and proper.

Dated: October 2, 2008

STEVE POIZNER
Insurance Commissioner

By: 

Mary Ann Shulman
Senior Staff Counsel

PROOF OF SERVICE
Blue Shield of California Life & Health Insurance Company
Case No. OSC-2007-00067

I am over the age of eighteen years and am not a party to the within action. I am an employee of the Department of Insurance, State of California, employed at 45 Fremont Street, 19th Floor, San Francisco, California 94105. On October 2, 2008, I served the following document(s):

CALIFORNIA DEPARTMENT OF INSURANCE'S SECOND AMENDED ORDER TO SHOW CAUSE AND STRIKEOUT VERSION

on all persons named on the attached Service List, by the method of service indicated, as follows:

If **U.S. MAIL** is indicated, by placing on this date, true copies in sealed envelopes, addressed to each person indicated, in this office's facility for collection of outgoing items to be sent by mail, pursuant to Code of Civil Procedure Section 1013. I am familiar with this office's practice of collecting and processing documents placed for mailing by U.S. Mail. Under that practice, outgoing items are deposited, in the ordinary course of business, with the U.S. Postal Service on that same day, with postage fully prepaid, in the city and county of San Francisco, California.

If **OVERNIGHT SERVICE** is indicated, by placing on this date, true copies in sealed envelopes, addressed to each person indicated, in this office's facility for collection of outgoing items for overnight delivery, pursuant to Code of Civil Procedure Section 1013. I am familiar with this office's practice of collecting and processing documents placed for overnight delivery. Under that practice, outgoing items are deposited, in the ordinary course of business, with an authorized courier or a facility regularly maintained by one of the following overnight services in the city and county of San Francisco, California: Express Mail, UPS, Federal Express, or Golden State overnight service, with an active account number shown for payment.

If **FAX SERVICE** is indicated, by facsimile transmission this date to fax number stated for the person(s) so marked.

If **PERSONAL SERVICE** is indicated, by hand delivery this date.

If **INTRA-AGENCY MAIL** is indicated, by placing this date in a place designated for collection for delivery by Department of Insurance intra-agency mail.

If **EMAIL**, by electronic mail transmission this date to the email address(es) listed.

Executed this date at San Francisco, California. I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Jean Hipon

SERVICE LIST
Blue Shield of California Life & Health Insurance Company
Case No. OSC-2007-00067

Name/Address	Phone/Fax Numbers	Method of Service
Cheryl R. Tompkin Administrative Law Judge OFFICE OF ADMINISTRATIVE HEARINGS 1515 Clay Street, Suite 206 Oakland, CA 94612	Tel.: (510) 622-2722 Fax: (510) 622-2743	U. S. MAIL
John C. Holmes BARGER & WOLEN LLP 633 W. Fifth Street, 47th Floor Los Angeles, CA 90071 jholmes@barwol.com	Tel.: (213) 680-2800 Fax: (213) 614-7399	U. S. MAIL
Gregory N. Pimstone MANATT, PHELPS & PHILLIPS, LLP 11355 W. Olympic Boulevard Los Angeles, CA 90064 gpimstone@manatt.com	Tel.: (310) 312-4000 Fax: (310) 312-4224	U. S. MAIL