



**CALIFORNIA DEPARTMENT OF INSURANCE**  
**2008 ANNUAL REPORT**  
**OF THE INSURANCE COMMISSIONER**

**DEPARTMENT OF INSURANCE**

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July 31, 2009

The Honorable Arnold Schwarzenegger  
Governor of California  
State Capitol Building  
Sacramento, CA 95814

Dear Governor Schwarzenegger:

I am pleased to provide you the *2008 Annual Report of the Insurance Commissioner* as required by California Insurance Code ("CIC") section 12922.

To benefit California's insurance consumers, I have collected and analyzed as much information as possible. Accordingly, this *Annual Report* includes the information mandated by the following CIC statutes:

- §1060 - insurer insolvency and delinquency proceedings;
- §1872.83(h) - workers' compensation fraud-fighting efforts and results;
- §1872.85(d) – activities of the Fraud Division investigating and prosecuting fraudulent disability insurance claims;
- §1872.9 - activities undertaken to reduce fraud under the Insurance Frauds Prevention Act;
- §1874.8(f) - results of the Organized Automobile Fraud Activity Interdiction Program;
- §10089.83(a) - program statistics about the Department's mediation of claims disputes;
- §12921.1(a)(10) – information about the Department's investigations of consumer complaints about claims handling by insurers;
- §12921.4(b) – evaluation of complaint patterns and actions taken with respect to those complaints;
- §12962 - analysis of programs to: ensure the availability of liability insurance, and prevent arbitrary rates and practices.

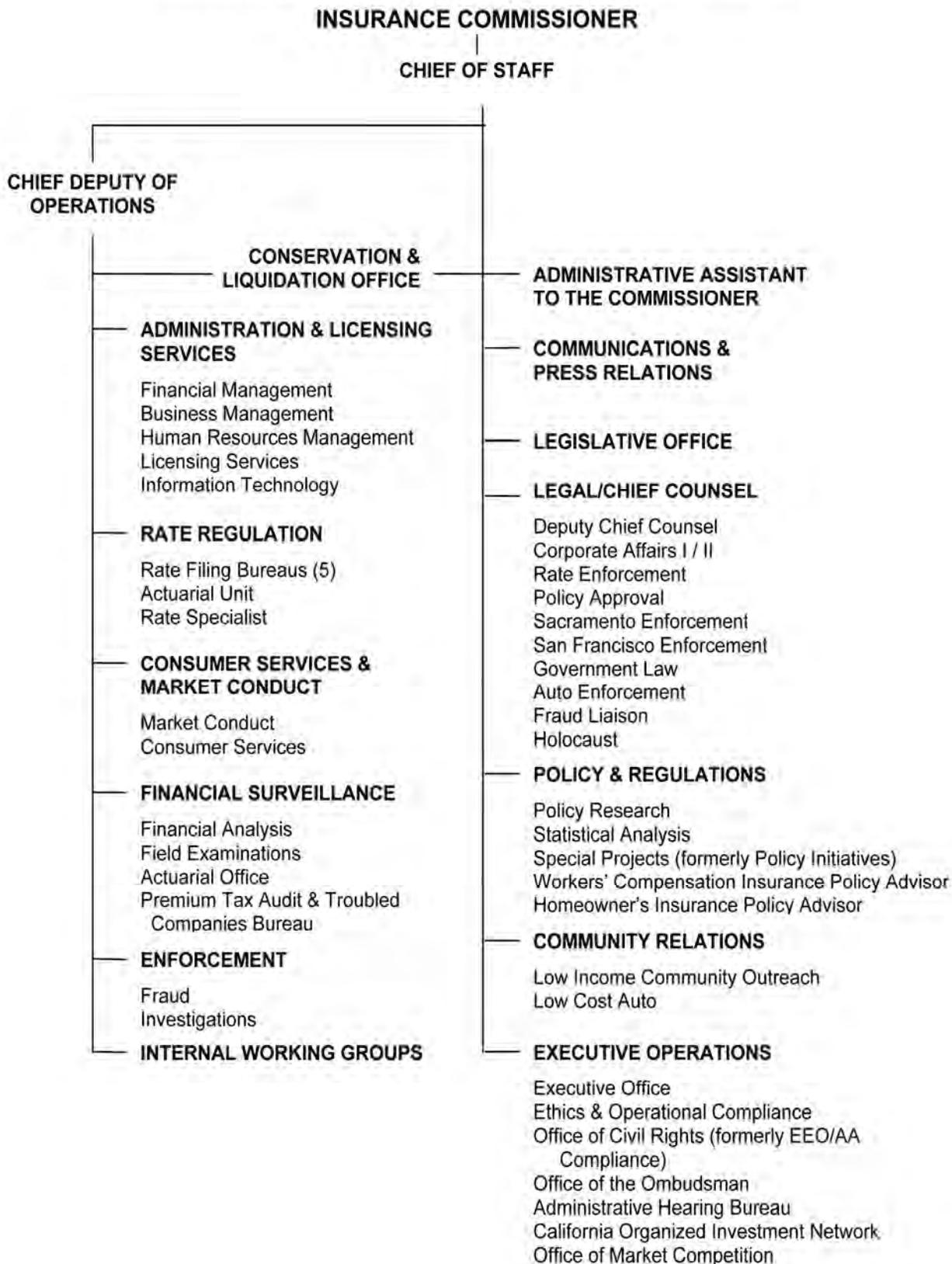
Finally, the report presents synopses of various reports filed with the Department, an overview of the Department's activities by branch and a summary of California's insurance industry and interests.

Sincerely,

A handwritten signature in cursive script that reads "Steve Poizner".

STEVE POIZNER  
Insurance Commissioner

# California Department of Insurance 2008 Organizational Chart (Graphical Version)



California Department of Insurance  
2008 Organizational Chart (Accessible Text Version)

**INSURANCE COMMISSIONER**

- CHIEF OF STAFF
- CHIEF DEPUTY OF OPERATIONS
  - CONSERVATION & LIQUIDATION OFFICE

**CHIEF OF STAFF**

ADMINISTRATIVE ASSISTANT TO THE COMMISSIONER

COMMUNICATIONS & PRESS RELATIONS

LEGISLATIVE

LEGAL/GENERAL COUNSEL

- Deputy Chief Counsel
- Corporate Affairs I/II
- Rate Enforcement
- Policy Approval
- Sacramento Enforcement
- San Francisco Enforcement
- Government Law
- Auto Enforcement
- Fraud Liaison
- Holocaust

POLICY & REGULATIONS

- Policy Research
- Statistical Analysis
- Special Projects Division (formerly Policy Initiatives Office)
- Workers' Compensation Insurance Policy Advisor
- Homeowner's Insurance Policy Advisor

COMMUNITY RELATIONS

- Low Income Community Outreach
- Low Cost Auto

EXECUTIVE OPERATIONS

- Executive Office
- Ethics & Operational Compliance

- Office of Civil Rights (formerly EEO/AA Compliance)
- Office of Ombudsman
- Administrative Hearing Bureau
- California Organized Investment Network
- Office of Market Competition
- Office of Strategic Planning

**CHIEF DEPUTY OF OPERATIONS**

ADMINISTRATION & LICENSING SERVICES

- Financial Management
- Business Management
- Human Resources Management
- Licensing Services
- Information Technology

RATE REGULATION

- Rate Filing Bureaus (5)
- Actuarial Unit
- Rate Specialist

CONSUMER SERVICES & MARKET CONDUCT

- Market Conduct
- Consumer Services

FINANCIAL SURVEILLANCE

- Financial Analysis
- Field Examinations
- Actuarial Office
- Premium Tax Audit & Troubled Companies Bureau

ENFORCEMENT

- Fraud
- Investigations

INTERNAL WORKING GROUP

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**2008 ANNUAL REPORT**  
**CONSUMER SERVICES AND MARKET  
CONDUCT BRANCH**

## CONSUMER SERVICES & MARKET CONDUCT BRANCH

The Consumer Services and Market Conduct Branch's (CSMCB) focus is consumer protection, and it accomplishes this by educating consumers, mediating consumer complaints, and enforcing insurance laws. CSMCB enforces insurance laws during the investigation of individual consumer complaints against insurers and agents/brokers and through on-site examinations of insurer claims and underwriting files.

CSMCB consists of two divisions and five bureaus:

### Consumer Services Division (CSD)

- Consumer Communications Bureau (CCB)
- Claims Services Bureau
- Rating and Underwriting Services Bureau (RUSB)

### Market Conduct Division (MCD)

- Field Claims Bureau (FCB)
- Field Rating and Underwriting Bureau (FRUB)

**Table A: CSMCB 2008 Calendar Year Results**

Consumer Telephone Calls Received (automated call-center calls).....	222,405
Complaint Cases Opened.....	37,513
Complaint Cases Closed.....	35,952
Total Amount of Consumer Dollars Recovered.....	\$50,414,024
Number of Exams Adopted by the Commissioner.....	176
Total Amount of Claims Dollars Recovered or Premium Returned to Consumers.....	\$11,993,673
Penalties Resulting from MCD Legal Actions in 2008.....	\$4,700,000
<b>CSMCB Grand Total Amount</b> (Consumer Dollars Recovered, Claims Dollars Recovered or Premium Returned to Consumers, and Penalties Resulting from Legal Actions in 2008).....	<b>\$75,013,009</b>

## CONSUMER SERVICES DIVISION

The Consumer Services Division (CSD) is responsible for responding to consumer inquiries and complaints regarding insurance company or producer activities. CSD maintains separate bureaus to handle telephone inquiries and provide education to the public, respond to consumer complaints on claims handling practices, respond to rating and underwriting based consumer complaints, and to provide education to the public on insurance issues. The goal of CSD is primarily to protect California insurance consumers through enforcement of the California Insurance Code and related laws and regulations.

The CSD is responsible for administering the program described in California Insurance Code (CIC) Section 12921.1(a), for investigating complaints, responding to consumer inquiries and bringing enforcement actions against insurers and production agencies. In accordance with California Insurance Code (CIC) Section 12921.1(a)(10), the Department is reporting 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 (if any) 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.

Complaints and inquiries are handled by three bureaus within the division: the Consumer Communication Bureau (CCB), the Claims Services Bureau (CSB) and the Rating & Underwriting Services Bureau (RUSB). CCB is often referred to as the Hotline, and its staff responds to telephone calls received through the Department's toll-free phone line. In 2008, 106 fulltime staff are devoted to the complaint handling operation. This represents 8% of the 1336 total authorized positions in the Department.

The Hotline staff answers questions on insurance claims and underwriting practices, administers the CDI Residential, Earthquake and Automobile Mediation Programs, and handles time sensitive complaints. CSB is responsible for investigating, evaluating, and resolving written consumer complaints involving claims issues for all lines of insurance except Worker's Compensation, which are regulated by the Department of Industrial Relations in California. RUSB is responsible for investigating, evaluating, and resolving written consumer complaints involving rating and underwriting issues for all lines of insurance (including Worker's Compensation). Consumers may file complaints via telephone, Internet or in written correspondence. The review and initiation of the investigation of complaints occurs within three days of receipt, and the CDI contacts the appropriate licensees (insurers or agents). The time needed to resolve a complaint varies in accordance with the type of case and the complexity of the issues to be evaluated and resolved. The average time among all cases is about 45 days from open to close. Complex cases involve analysis of conflicting facts and applicable laws. Resolution in such cases may require more lengthy investigation. Conversely, cases involving less complex issues may be resolved within hours, days, or a few weeks. Consumers are informed about the final resolution of complaints as quickly as possible, but no later than 30 days after the final action.

## Consumer Services & Market Conduct Branch

The CSD retains records on all consumer complaints involving rating, underwriting and claims issues. This information is gathered and trend reports are developed with the goal of determining whether further action against the licensee should be taken. The Division collects and maintains a wide range of statistical information on complaints. On an annual basis it tracks: the number of complaints open and closed, types of alleged violations, amount of recoveries, number of complaints against insurers, etc. Additionally, the Division prepares complaint comparison studies for automobile, homeowner's and life products in order to rank insurers based on their frequency of complaints and whether those complaints were justified. A Justified Complaint Ratio is used to determine which insurers are the worst performers. These statistics can lead to a number of actions, such as: enforcement action; referral of case to the CDI Legal Division for formal legal action; and initiation of a request for a market conduct examination. All legal actions taken by CDI are public information and are posted on the department's website. Insurers can appeal enforcement actions taken against them through the civil court system.

**Disaster Response:** In addition to the complaint handling operation of the Department, the Consumer Services Division also coordinates the Department's response to natural and other disasters that impact insurance consumers and businesses in California. This response includes administration of the Emergency Damage Assessment function described in CIC Section 16000. In 2008, several natural disasters occurred in the state.

A series of Southern California wildfires began in March and continued through November of 2008. At one point, 1500 fires were burning during a single 24 hour period between June 20<sup>th</sup> and the morning of June 21<sup>st</sup>, 2008. Some of the most notable fires included the Tea, Sayre-Sylmar, Ophir, Summit, Triangle, and Sesnon/Merek fires. Insurers have reported that there were about **6,238** claims filed, **\$640,037,525 Million** in potential insurer exposure, and about **\$447,239,383 Million** paid by insurers through April 2009. The Consumer Services Divisions responded in several areas. CSD dispatched more than 35 professional staff that spent 48 days at 11 Disaster Recovery Centers and workshops to assist survivors with insurance questions and helping to get insurers to pay claims as quickly as possible. CSD also investigates complaints received from fire survivors. The Division has received approximately 110 complaints and recovered \$1,169,949 for consumers.

Additionally, CDS staff continued to work on the 2007 fire storm complaints and issues and conducted workshops in San Diego County, meeting with total loss survivors and assisting them with technical insurance questions and issues. The division assisted approximately 626 consumers and recovered \$29,258,228 on their behalf.

The Division will continue to assist all wild fire survivors to help effect positive resolution of their claims and related issues.

## Consumer Complaint Trends

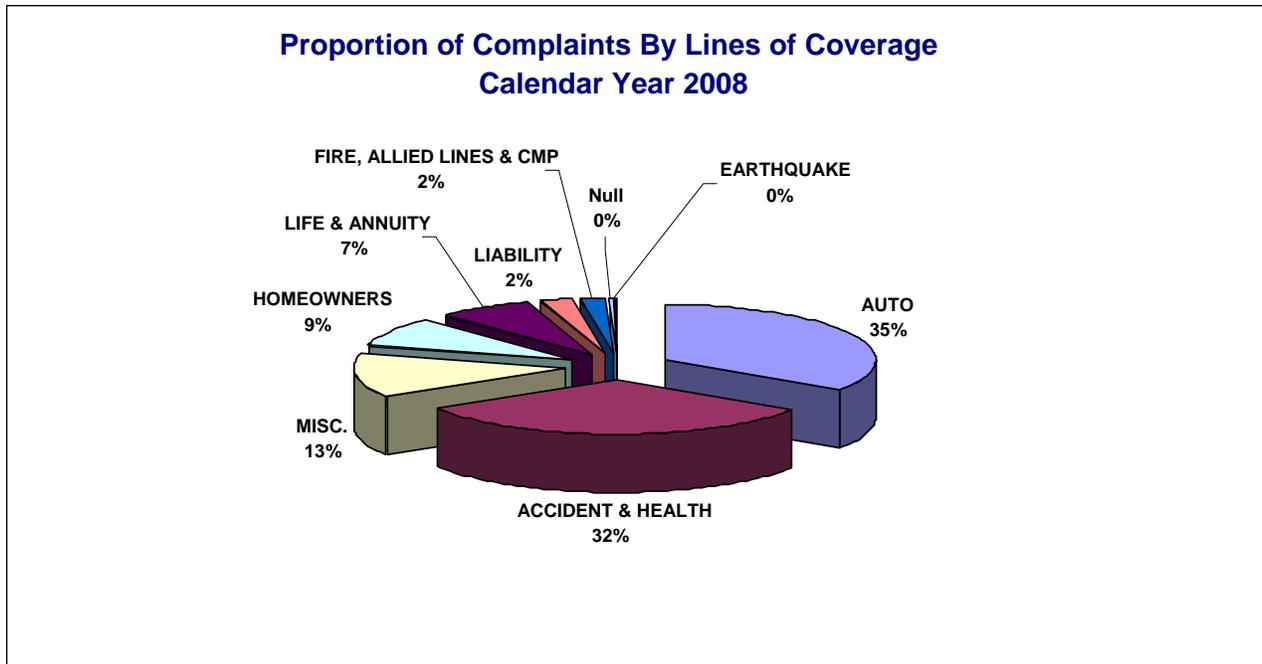
The following tables identify notable complaint trends by line of coverage:

**Table B: Trends in Percentage of Complaints by Lines of Coverage**

Coverage Type	2006	2007	2008
AUTO	40.13%	37.77%	34.43%
ACCIDENT & HEALTH	25.91%	30.42%	31.76%
MISC.	13.93%	13.12%	12.90%
HOMEOWNERS	7.41%	7.16%	8.80%
LIFE & ANNUITY	7.23%	6.80%	7.23%
LIABILITY	2.82%	2.34%	2.43%
FIRE, ALLIED LINES & CMP	1.90%	1.61%	1.82%
Null	0.27%	0.28%	0.36%
EARTHQUAKE	0.40%	0.49%	0.27%

The overall percentage of accident & health complaints has been increasing slightly over past years, while the percentage of auto complaints has been decreasing over the past years.

## Consumer Services & Market Conduct Branch



The pie graph above shows the proportion of complaints by lines of coverage for calendar year 2008.

Auto	35%
Accident & Health	32%
Miscellaneous	13%
Homeowners	9%
Life and Annuity	7%
Liability	2%
Fire, Allied Lines & CMP	2%
Null	0%
Earthquake	0%

**Table C: Top Ten Types of Complaint Reasons (2006-2008)**

#	Types of Complaint Reasons	2006	2007	2008
1	Denial of Claim	17%	14%	17%
2	Claim Handling Delay	4%	6%	10%
3	Unsatisfactory Settlement Offer	5%	5%	6%
4	Other - Claim Handling	6%	5%	5%
5	Premium & Rating / Misquotes	4%	5%	5%
6	Premium Refund	8%	7%	5%
7	Coverage Question	2%	3%	5%
8	Cancellation	5%	6%	5%
9	Premium Notice/Billing Problem	5%	5%	5%
10	Agent Handling	6%	6%	5%
	<b>Total:</b>	<b>61%</b>	<b>63%</b>	<b>68%</b>

**CONSUMER COMMUNICATIONS BUREAU**

The Consumer Communications Bureau (CCB) Consumer Hotline is often referred to as the Commissioner's "eyes & ears" on the issues and concerns that affect California's insurance consumer. CCB officers respond to phone calls received through the California Department of Insurance's (CDI) statewide toll-free Consumer Hotline: 800-927-HELP (4357) to provide callers with immediate access to constantly updated information on insurance related issues. The Hotline is staffed by knowledgeable insurance professionals whose years of expertise, combined with their dedication to consumers, enables them to provide immediate assistance on time sensitive issues. CCB also responds to inquiries received through the Consumer "Contact Us" Web site; coordinates responses to inquiries addressed to the Commissioner through its Commissioner's Correspondence Unit; responds to "walk-in" inquiries at the Department's Los Angeles public counter; leads the CSD Health Triage Team; chairs the CSD Inter-Agency Health Team; analyzes and provides input on proposed legislation; manages the Division's Disaster Response Program, and leads or participates in various task forces.

**Residential Property, Earthquake, and Automobile Physical Damage Mediation Program**

CCB administers the Department's Residential Property, Earthquake Claims, and Automobile Physical Damage Mediation Program. The program was established in 1995 in response to earthquake claims resulting from the Northridge Earthquake of January 17, 1994. The legislature has since expanded to program to include automobile physical damage and residential property disputes subject to specific guidelines. Since the program's inception in 1996 through December 31, 2008, the Mediation Program has recovered \$15,323,050 for consumers. In accordance with CIC 10089.83, the following is a report of the results of the program for the calendar year 2008:

**Table D: 2008 Residential Property, Earthquake, and Automobile Mediation Program Results**

	<b>Residential</b>	<b>Earthquake</b>	<b>Automobile</b>	<b>Totals</b>
Number of mediation cases eligible	28	0	3	31
Number settled within 28 day settlement period	4	0	1	5
Number sent to mediation	12	0	2	14
Number of cases rejected by insurer	9	0	0	9
Number accepted by insurer	12	0	2	14
Number of settlements rejected within 3 day waiting period	0	0	1	1
Amount initially claimed	\$829,731	0	\$33,374	\$863,105
Amount of settlements	\$409,950	0	\$22,333	\$432,283

**CLAIMS SERVICES BUREAU**

The Claims Services Bureau (CSB) investigates consumer allegations of improper claims handling by insurers. These written requests for assistance include, but are not limited to, wrongful denial of claims, payments less than amounts claimed, and delays in claims handling. If its investigation indicates a violation of an insurance law or regulation has occurred, CSB pursues payment of claims that were improperly denied or delayed, when applicable.

In addition to assisting consumers with a variety of issues involving all lines of insurance except worker’s compensation, CSB also participates on the Senior Issues Task Force, The Inter-agency Health Forum, and assists people impacted by wildfires and other catastrophic events at local assistance centers and work shops.

**RATING AND UNDERWRITING SERVICES BUREAU**

The Rating and Underwriting Services Bureau (RUSB) investigates consumer complaints of improper or inequitable rating and underwriting transactions performed by insurance companies and agent-brokers. RUSB works with the affected parties to clarify issues and reach a resolution. If its investigation shows that an insurance violation or a policy breach has occurred, RUSB enforces the code or policy contract and requires the reinstatement of coverage and the refunding of premiums and broker fees, when applicable.

Consumer Services and Market Conduct Branch

In addition to assisting consumers with a variety of issues involving all lines of insurance, RUSB also participates on the Senior Issues Task Force and the Disability Advisory Committee, and assists people impacted by wildfires and other catastrophic events at local assistance centers and work shops. RUSB produces detailed trend and hot topics reports on insurance company and agent-broker violations identified from its review of consumer complaint files which CSMCB and others within the Department find valuable for identifying and monitoring non-compliant activity by licensees.

**(CIC) Section 1858.35 Report**

In accordance with California Insurance Code (CIC) Section 1858.35, the Department is reporting the number and type of complaints received by the Department from any person aggrieved by any rate charged, rating plan, rating system or underwriting rule; and the disposition of these complaints.

**Table E: (CIC) Section 1858.35 Complaints by Type/Reason 2008**

<b>Rank</b>	<b>Complaint Type/Reason</b>	<b># of Complaints</b>
1	Premium & Rating / Misquotes	700
2	Coverage Question	470
3	Premium Refund	290
4	Cancellation	287
5	Premium Notice/Billing Problem	276
6	Surcharge	263
7	Nonrenewal	261
8	Agent Handling	113
9	Other - Policyholder Service	74
10	Other - Underwriting	56
11	Policyholder Service Delays no response	20
12	Information Requested	15
13	Policy Audit Dispute	15
14	Misrepresentation	14
15	Refusal to Insure	12
16	All Other Reasons	132
	<b>Total:</b>	<b>2,998</b>

**Table F: (CIC) Section 1858.35 Complaints by Final Disposition: 2008**

<b>Rank</b>	<b>Final Disposition</b>	<b># of Complaints</b>	<b>Recovery Amount *</b>
1	Company Position Upheld	1794	\$314,834
2	Premium Refund	196	\$607,598
3	Advised Complainant	153	\$11,964
4	Question Of Fact	139	\$26,298
5	Other	113	\$2,268
6	Premium Problem Resolved	98	\$66,175
7	Policy Issued/Restored	61	\$64,471
8	Underwriting Practice Resolved	61	\$29,477
9	Information Furnished/Expanded	52	\$0
10	Non-renewal Notice Rescinded	45	\$0
	All Other Reason Codes	286	\$614,635
	<b>Total:</b>	<b>2,998</b>	<b>\$1,737,720</b>

\* Recovery Amount to Consumers

## MARKET CONDUCT DIVISION

The Market Conduct Division (MCD) is responsible for the examination of insurance company practices on behalf of the California Insurance Department. These examinations are generally based on a fixed schedule of examinations, scheduled re-examinations and targeted examinations due to special circumstances or the results of market analysis of consumer complaints and other data. Exams are generally conducted in the insurers' offices, located nationwide.

MCD maintains separate bureaus to conduct claims handling practices exams and rating and underwriting exams, a reflection of a division of operations in the insurance industry and in the laws regulating claims from rating practices. Also in MCD, the Market Analysis Unit evaluates consumer complaints, enforcement actions, exam activity, and other data on a national basis to identify issues that may be of regulatory concern in California. The goal of any market conduct examination is to evaluate compliance with statutes and regulations relative to the business of insurance and to initiate corrective actions or enforcement actions when necessary.

The following is a summary of MCD's accomplishments for the year 2008. The list covers different areas of accomplishment, including exams completed, dollars returned to consumers, industry and community interactions, and legal actions taken.

**Table G: Market Conduct Division Results for 2008**

<b>Examination Results Category</b>	<b>FCB</b>	<b>FRUB</b>	<b>MCD Totals</b>
Number of Exams Adopted by the Commissioner	69	107	176
Amount of Claims Dollars Recovered or Premium Returned to Consumers	\$3,696,898	\$8,296,775	\$11,993,673

<b>Legal Actions &amp; Penalties</b>	<b>FCB</b>	<b>FRUB</b>	<b>MCD Totals</b>
No. of Actions Finalized by Legal Branch due to MCD Exam Findings	6	1	7
Penalties Resulting from Legal Branch in 2008	\$4,450,000	\$250,000	\$4,700,000

*FCB: Field Claims Bureau*

*FRUB: Field Rating & Underwriting Bureaus*

## **FIELD CLAIMS BUREAU**

The Field Claims Bureau (FCB) conducts market conduct examinations of the claims practices of all licensed California insurers. The focus of each exam is on compliance with the California Insurance Code and the California Fair Claims Settlement Practices regulations. FCB seeks to ensure equitable treatment of policyholders and claimants in accordance with insurance contracts and California law. The California Insurance Code sections cited in FCB examinations vary by line of insurance. However, those that are common to both life & disability and property & casualty insurance involve delay, documentation, and improper handling, which may include improper settlement, failure to pursue investigation, and improper denial. FCB obtains thousands of remedial claim actions from insurers each year as a result of the examinations it conducts. Many of the issues which lead to these actions are displayed in its reports which are published in the Department's website.

## **FIELD RATING AND UNDERWRITING BUREAU**

The Field Rating and Underwriting Bureau (FRUB) conducts market conduct examinations of insurer rating and underwriting practices. FRUB reviews the advertising, marketing, risk selection and declination, underwriting, pricing, and policy termination practices of life, health, property, and casualty insurers. FRUB examinations focus on compliance with rate filing requirements, consistency within the insurer's adopted rating processes, and overall conformity of rating and underwriting with California law. FRUB examiners verify that the insurer's adopted rates have been filed and approved, and are applied consistently. This requires that underwriting be adequately documented and not unfairly discriminatory.

**California Insurance Code (CIC) § 12921.4(b):**

In accordance with California Insurance Code (CIC) § 12921.4(b), the Market Analysis Unit reviewed the complaint data of each insurance carrier that was authorized to transact business in the State of California during the year 2008. Specifically, the analysis of complaint data focused on the following areas: insurer, insurance line of business, and type of violation.

Complaint totals by insurer is a primary criteria for determining the Market Conduct Division's examination schedule. The ten insurers with the most complaints in 2007 (ranging from 715 at the top to 303 at number 10) have been examined in the last 3 years or will be examined in the next 2 years (3 completed, 6 in progress, 1 on schedule). Additionally, several of the insurers identified with high complaint totals are scheduled for examination more than once during this 5 year timeframe. Five of the ten have been the subject of enforcement actions within the last 3 years and 2 are under consideration for further action.

Complaints by line of business continue to be an important area for focusing Market Conduct Division examination resources. The Department received 37,513 complaints in 2008. The top five lines of business which generated the most complaints were the following: private passenger auto (12,624), group accident and health (7,962), (3,187), homeowners, individual accident and health (2,834), and individual life (2,122). These lines of business were the most frequently examined by both the Field Claims Bureau and the Field Rating and Underwriting Bureau during 2008. Within each line of business, the Market Conduct Division also prioritizes those insurers with the most complaints. All insurers in the top 10 of complaints in each line have been examined in the last 3 years or are scheduled to be examined in the next two years. Thus, the lines of business most impacted by complaints, and the insurers that generated the most complaints within those lines of business, are prioritized for examination by the Market Conduct Division.

An analysis of complaints sorted by the type of violation is completed for each examination initiated for the Market Conduct Division. The results of this analysis allow the examiners in charge to identify areas of their review that they should scrutinize more closely. Whenever a trend or pattern in violation data is observed, the information is shared with those department employees that have a use or need for the data. Of those 10 insurers, each has been examined within the last 3 years or is scheduled for examination by the Market Conduct Division within the next 2 years.

A geographic analysis of consumer complaints was conducted for the year 2008. Complaints within those geographic regions identified as having high concentrations of complaints relative to the population of the region will be the subject of further analysis during 2009.

PATIENT AND PROVIDER PROTECTION ACT UNIT

Item 0845-001-0217—California Department of Insurance

1. **Patient and Provider Protection Act Unit.** *The California Department of Insurance (CDI) shall submit calendar-year annual reports on or before July 1, 2007, July 1, 2008, and July 1, 2009, to the Senate Health Committee, the Assembly Health Committee, and the Joint Legislative Budget Committee concerning the number, types, and status of health care provider, consumer, and other complaints processed each year under the provisions of Chapter 441, Statutes of 2005 (SB 634, Speier), and Chapter 723, Statutes of 2005 (SB 367, Speier). To the extent possible, CDI should provide this report in a format similar to that used by the Department of Managed Health Care in similar reports.*

SB 367 and SB 634 became effective January 1, 2006. SB 367 amended and adopted various sections of the California Insurance Code (CIC) to create the Patient and Provider Protection Act. In order to implement SB 367 and SB 634, the Department: (1) developed a Request for Assistance form specific to providers to be used by providers in filing complaints with the CDI; (2) developed a web page, located on the CDI’s public web site, which is specific to health insurance and health care providers; (3) developed and posted a list of all insurers providing health insurance coverage on our public web site; (4) developed and published a Health Care Provider’s information guide to the Complaint Process; (5) sent out a notice to all health insurers advising each of the dispute resolution process reporting requirement, as per Insurance Code Section 10123.137(d); and hired and trained CDI staff on the handling of provider complaints.

**I. Total Numbers and Types of Complaints handled under SB 634 and SB 367**

For Calendar Year 2008, CDI received more than 6,712 complaints relating to health insurance related matters. In addition to the complaints received and investigated in CY 2008, CDI’s Consumer Services Division staff handled several cases involving several health insurers, which affected more than 2,807 providers and thousands of patients.

Table A describes the types of healthcare provider complaints received by the CDI.

**Table A: SB 367 Healthcare Complaint Types (Calendar Year 2008)**

Reason Description	Percentage of all Healthcare Provider Complaints Received by the CDI
Denial of Claim	33%
Unsatisfactory Settlement Offer	18%
Claim Handling Delay	12%
Other - Claim Handling	7%
Usual, Customary Reasonable	6%
*All Other Reasons Combined	25%

*\*CDI tracks all complaints using a coding system standardized through the National Association of Insurance Commissioners (NAIC). Other Reasons may include prompt pay, forced placement audit dispute health status, unfair discrimination, rescission, etc*

## **II. Other Regulatory Actively Related to SB 367 and SB 634**

### **A. Market Conduct Examination of Health Insurers**

For Calendar Year 2008, the CDI's Market Conduct Division, Field Claims Bureau completed 18 market conduct examinations of Health Insurers. Twelve of these exams have resulted in a referral to the CDI's Legal Division for potential enforcement action for violations of the various health insurance laws. However, until such time as an order or enforcement action is filed, the names of the insurers and the substance of the actions cannot be made public. The Field Rating and Underwriting Bureau completed 20 insurer market conduct examinations of Health Insurers. Further action is pending upon review.

### **B. Legal Division, Health Enforcement Bureau Activities**

As a result of SB 367, in September 2006, the CDI recruited and hired a staff counsel with special expertise in health insurance and health care provider issues. The CDI created the Health Enforcement Bureau to provide legal assistance to the Consumer Services and Market Conduct functions, undertake health enforcement actions under a range of insurance statutes pertaining to claims settlement practices and provider protections, prepare proposed regulations to clarify and make specific statutes governing health insurance rescissions, and research legal questions concerning statutes governing individual and small group health insurance.

In 2008, the Health Enforcement Bureau handled more than 23 separate legal matters including key enforcement actions against the State's largest health insurers. In 2008, three significant settlements were reached involving alleged illegal health insurance rescissions and related improper claims handling. These actions resulted in \$4.6 million in up front penalties paid to the State as well as recoupment of legal fees incurred in prosecuting these actions. An additional \$10.6 million in penalties may be due to the Department if these companies fail to meet the requirements set forth on the corrective action plans to be approved by the Department and called for in the settlements.

More importantly, as a result of these three key enforcement actions, more than 4,000 individuals whose insurance was rescinded between January 1, 2004 and December 31, 2008 will receive offers of health insurance coverage in 2009 without regard to their possible pre-existing conditions. These former insureds can also request reimbursement of out of pocket medical expenses they incurred as a result of the rescission of their health insurance coverage. The health insurers who settled these enforcement actions - Health Net Life, Blue Shield Life and Anthem Blue Cross Life and Health - are barred from using the validity of the rescission as a defense in their adjudication of the reimbursement requests. These no-fault restitution agreements which include both an offer of money paid to former insureds and an offer of health insurance coverage are unprecedented in the history of the Department.

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In addition, each of these three health insurers, who represent approximately 85% of the individual health insurance market's covered lives, were required in these settlements to submit corrective action plans which cover a wide range of detailed procedures critical to how the companies conduct medical underwriting of health insurance applications, claims handling, rescission investigations and related matters in a compliant manner. All have agreed to install an Independent Third Party organization to review proposed rescissions and to abide by the reviewing organization's recommendation.

In 2008 the Commissioner's Health Enforcement Bureau filed a major action against PacifiCare Life and Health Insurance Company alleging many thousands of claims handling violations and allegations related to failure to properly resolve provider disputes, failure to manage provider contracting processes and improper management of pre-existing condition exclusions in health insurance policies. This case and others are still pending.

In 2008 the Health Enforcement Bureau staff analyzed many important pieces of health related legislation and rendered several key legal opinions and responses regarding matters brought by agents, insurers, consumers and providers to the Department for interpretation and resolution. Some of these matters were resolved through negotiation thereby avoiding non compliance with the Insurance Code and the cost to the Department of filing a formal enforcement action.

This Bureau has also provided information to health insurers to help them better comply with consumer protections within certain health insurance statutes. As a direct result of the investigation of provider complaints handled by the Consumer Services and Market Conduct divisions several Legal Services Requests were submitted to the Health Enforcement Bureau for legal opinions and/or enforcement actions. As of the writing of this report, more than eight (8) enforcement actions have been filed against health insurers. All of these actions are pending. Also, the Health Enforcement Bureau works collaboratively with legal counsel at the Department of Managed Health Care (DMHC) in coordinating legal issues, public policy matters and enforcement activities to increase consistency for organizations offering both DMHC and CDI regulated products.

### **C. Independent Medical Review Program (IMR)**

The IMR program became effective in 2001, with the passage of AB55 (1999), and Insurance Code Section 10169. Table A, below describes the number of potential IMR cases received by the CDI from CY 2001 through CY 2008.

**Table B: IMR Activity by CDI**

<b>Calendar Year</b>	<b>Cases Received</b>
2001	120
2002	300
2003	323
2004	365
2005	390
2006	520
2007	975
2008	1287