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PACIFICARE LIFE AND HEALTH
INSURANCE COMPANY

BEFORE THE INSURANCE COMMISSIONER
OF THE STATE OF CALIFORNIA

In the Matter of

PACIFICARE LIFE AND HEALTH
INSURANCE COMPANY,
Respondent.

File No. UPA 2007-00004

OAH No. 2009061395

**PACIFICARE'S PROPOSED
CONCLUSIONS OF LAW**

Judge: Hon. Ruth S. Astle

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1 **PROPOSED LEGAL CONCLUSIONS**

2 **I. SUMMARY OF ARGUMENT.**

3 No legal conclusions are sought in connection with this section of the brief.

4

5 **II. FACTUAL AND PROCEDURAL BACKGROUND.**

6 No legal conclusions are sought in connection with this section.

7

8 **III. THE BURDEN OF PROOF.**

9 1. CDI has the burden of proof as to each fact the existence or nonexistence of which is
10 essential to the claim for relief that it is asserting. (Evid. Code, §§ 500, 520.) CDI also bears the
11 burden of proving each fact essential to an award of penalties, including the amount of the penalty.

12 2. PacifiCare, as a respondent, does not bear the burden of proof and therefore need not
13 prove the absence of violations.

14 **IV. CDI'S INTERPRETATIONS OF THE RELEVANT STATUTES AND REGULATIONS.**

15

16 3. CDI's proposed interpretations of statutes and regulations are not binding
17 interpretations unless adopted in the form of a regulation in compliance with the procedures of the
18 Administrative Procedure Act, and even then the regulation must be consistent and not in conflict
19 with the statute under which it was adopted in order to be valid. (Gov. Code, § 11342.2.)

20 4. Further, “[b]ecause an [agency’s] interpretation [of a statute or regulation] is an
21 agency’s legal opinion, . . . rather than the exercise of a delegated legislative power to make law, it
22 commands a commensurably lesser degree of judicial deference.” (*Yamaha Corp. of America v. State*
23 *Board of Equalization* (1998) 19 Cal.4th 1, 11 (*Yamaha*).)

24 5. The amount of deference that should be afforded to agency interpretations of statutes
25 and regulations can be determined under the following criteria: (1) whether an agency has a potential
26 advantage over the courts in interpreting the relevant statute (where, for example, the legal text to be
27 interpreted is highly technical or complex); and (2) whether its interpretation is “‘probably correct,’”
28 which entails evidence of “careful consideration by senior agency officials” (rather than a single staff
member), “evidence that the agency ‘has consistently maintained the interpretation in question,

1 especially if [it] is long-standing,” and “indications that the agency’s interpretation was
2 contemporaneous with legislative enactment of the statute being interpreted.” (*Yamaha, supra*, 19
3 Cal.4th at pp. 12-13.)

4 6. The statutory and regulatory interpretations of CDI’s witnesses, upon which CDI
5 relies and which were announced for the first time during the prosecution of PacifiCare, reflect
6 nothing more than the Department’s litigation position in this case and are entitled to no deference.

7 7. Mr. Cignarale’s opinions regarding the size of the penalty in this case, and the
8 application of the penalty factors set forth in [Regulation 2695.12](#), were inadmissible and incompetent
9 because they are hearsay (premised on the advice of other unidentified lawyers who did not testify as
10 expert witnesses), lack foundation for an expert legal opinion, and are impermissible opinions of law,
11 which is a matter within the province of this Court. Accordingly, they can be afforded no weight by
12 the Court.

13 **V. DUE PROCESS CONSTRAINTS ON THE SCOPE OF ANY PENALTY AGAINST**
14 **PACIFICARE.**

15 8. The Federal Due Process Clause dictates that a person receive fair notice of the
16 *conduct* that will subject him to punishment, and also of the *severity* of the penalty that a State may
17 impose. (*BMW of North America, Inc. v. Gore* (1996) [517 U.S. 559, 574](#); accord, *State Farm Mut.*
18 *Auto. Ins. Co. v. Campbell* (2003) [538 U.S. 408, 417](#).)

19 9. Fair notice of the severity of the penalty requires that the size of the penalty be
20 reasonable and proportionate to the amount of harm, the reprehensibility of the conduct, and to the
21 civil penalties authorized or imposed in comparable cases. (*State Farm, supra*, [538 U.S. at 426](#);
22 *Gore, supra*, [517 U.S. at pp. 574-575](#).)

23 10. The factors for determining whether a fine is excessive or a violation of due process
24 are essentially the same regardless of whether an excessive fine is examined under the Excessive
25 Fines clause or the Due Process Clause.

26 11. These constitutional limitations of the proposed penalties are properly raised in this
27 administrative proceeding.
28

1 **A. Lack of Harm.**

2 12. The Due Process Clause prohibits the Court from affording any deference to CDI’s
3 recommended penalty because the size of the penalty is wholly disproportionate to the level of harm.

4 13. A penalty is excessive where its amount is substantially greater than the amount of
5 harm caused by the penalized action(s).

6 14. The revised claims amounts paid by PacifiCare as a result of its alleged violations
7 were under \$1 million; \$1 million is a substantial sum, suggesting under the case authorities that a
8 penalty of under \$1 million would reach the constitutional maximum.

9 15. The lack of proof with respect to any harm beyond the revised claim amounts also
10 militates against CDI’s recommended penalty.

11 **B. Lack of Reprehensibility.**

12 16. The nature of the vast majority, if not all, of the alleged violations – e.g., omission of
13 language in two forms, failing to send acknowledgement letters for properly processed claims, failing
14 to pay 3% of the claims within 30 working days, or untimely seeking reimbursement for
15 overpayments – is hardly reprehensible: There was no evidence of physical harm, no denial of
16 medical care, no conscious disregard for safety, and no intentional malice, trickery, or deceit.
17 PacifiCare’s lack of culpability counsels against the imposition of the exorbitant penalty CDI seeks
18 here.

19 **C. CDI’s Prior Penalties.**

20 17. CDI’s prior penalties set a maximum of \$655,000 in the context of significantly more
21 egregious conduct.

22 18. It makes no difference whether the prior penalties were awarded by a court or in a
23 settlement approved as fair by the government agency.

24 **D. Mr. Cignarale’s Penalty Methodology.**

25 19. Due process further prohibits this Court from giving any deference to Mr. Cignarale’s
26 recommended penalties because they are purely arbitrary and the product of unprincipled
27
28

1 methodologies devoid of any standards. (*Bell v. Farmers Ins. Exch.* (2004) 115 Cal.App.4th 715,
2 751-757, citing *Connecticut v. Doebr* (1991) 501 U.S. 1, 11.)

3
4 **VI. CDI'S ARBITRARY AND STANDARDLESS HANDLING OF THE ENFORCEMENT ACTION.**

5 20. CDI's departure from historical standards and unique treatment of PacifiCare violates
6 the Equal Protection Clause of the U.S. Constitution. (See *U.S. Const. amend. XIV, § 1.*)

7 21. PacifiCare has established the three elements necessary to make out a "class of one"
8 equal protection claim: (1) PacifiCare was treated differently from other similarly situated insurance
9 companies; (2) CDI's differential treatment of PacifiCare was intentional; and (3) there was no
10 rational basis for the difference in treatment. (See *Genesis Env'tl. Servs. v. San Joaquin Valley*
11 *Unified Air Pollution Control Dist.* (2003) 113 Cal.App.4th 597, 605.)

12 22. CDI's arbitrary enforcement action also violated PacifiCare's right to due process of
13 law because it was permeated with an unwillingness to follow established rules and a lack of
14 objectivity.

15
16 **VII. THE RELEVANT STATUTORY AND REGULATORY FRAMEWORK.**

17 **A. Section 790.03(h).**

18 23. A violation of [section 790.03\(h\)](#) cannot be based solely upon the violation of another
19 non-penal statute – particularly, a subsequently enacted statute – which does not reference [section](#)
20 [790.03](#).

21 24. Instead, acts barred elsewhere in the Insurance Code, such as those subject to non-
22 penal statutes, must first be determined to be unfair and deceptive under [section 790.06](#) and an order
23 so issued and violated before the insurer can be held liable for penalties for that statute's violation.

24 25. Treating a violation of a non-penal statute as an unfair claims settlement practice
25 would also violate due process.

26 26. Under the plain language of [section 790.03\(h\)](#), which is supported by case law,
27 violations may be premised only upon a "practice," *not a single act*, and that practice must be
28 "knowingly committed or performed with such frequency as to indicate a general business practice."
([§ 790.03\(h\)](#).)

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1. “Practice.”

27. A “practice” is “[a] habitual or customary action,” and in the context of a business practice, a “[a] habitual act or action.” ([Webster’s II New College Dict. \(2001\) p. 867](#); see also [2 Shorter Oxford English Dict. \(6th ed. 2007\) p. 2311](#) [“The habitual doing or carrying out of something; usual or customary action or performance”].)

28. [Regulation 2695.1, subdivision \(a\)](#) may not be used to construe “practice” under [section 790.03\(h\)](#) as a single act because such an interpretation is contrary to the plain language of [section 790.03\(h\)](#).

29. [Regulation 2695.1, subdivision \(a\)](#) provides: “[Section 790.03\(h\)](#) of the California Insurance Code enumerates sixteen 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” ([Cal. Code Regs., tit. 10, § 2695.1, subd. \(a\)](#).) To the extent that the commission of a single act is treated as a “practice,” [Regulation 2695.1, subdivision \(a\)](#) contradicts the plain language of [section 790.03\(h\)](#) – which uses the term “practice” – and is therefore invalid. ([Gov. Code, § 11342.2](#).)

2. “Knowingly Committed.”

30. Any unfair claims settlement practice must be “knowingly” committed or performed, and committed or performed with such frequency to be a general business practice.

31. Under the case law and the plain meaning of “knowingly,” “knowingly” requires that the insurer act deliberately, which requires awareness of the conduct and its consequences. Implied or “constructive knowledge” is not sufficient to establish an unfair claims settlement practice.

32. In order to commit such a practice “knowingly,” the insurer must “deliberately” commit a claims-handling practice that falls within one of the enumerated and prohibited practices.

33. [Regulation 2695.2, subdivision \(l\)](#) defines “knowingly committed” to mean “performed with actual, implied, or constructive knowledge, including, but not limited to, that which is implied by operation of law.” This definition is in direct conflict with the Supreme Court’s pronouncement in *Royal Globe Ins. Co. v. Superior Court* (1979) [23 Cal.3d 880](#) (*Royal Globe*), and

1 its plain meaning. Accordingly, the definition of “knowingly” in [Regulation 2695.2, subdivision \(l\)](#)
2 can be given no weight.

3 34. [Section 790.03\(h\)](#) requires that the insurer “[k]nowingly commit[]” the prohibited
4 practice, not that it knew of the conditions that created a risk of the commission of a subsequent
5 prohibited practice.

6 3. “General Business Practice.”

7
8 35. A “general business practice” must be more frequent, systematic, and pervasive than
9 the “claims settlement practices” specified in [section 790.03\(h\)](#).

10 36. The “frequency” requirement in [section 790.03\(h\)](#) ensures that an insurer is not subject
11 to penalties when a number of occasional acts have not occurred with enough frequency to be
12 considered a “general business practice.”

13 37. The frequency of the acts must exceed specific tolerance thresholds to constitute a
14 “practice” or a “general business practice.”

15 38. Under [section 733, subdivision \(f\)](#), when conducting an examination of an insurer’s
16 claims-handling performance, CDI is legally obligated to “observe those guidelines and procedures
17 set forth in the Examiner’s Handbook adopted by” the NAIC, which has strongly encouraged States
18 to utilize a benchmark error rate of at least 7% for establishing a general business practice for
19 purposes of a State’s unfair claims practices.

20 **B. The Specific Prohibited Practices Under Section 790.03(h).**

21 1. [Section 790.03\(h\)\(1\)](#).

22
23 39. [Section 790.03\(h\)\(1\)](#) prohibits “[m]isrepresenting to claimants pertinent facts or
24 insurance policy provisions relating to any coverages at issue.”

25 40. By definition, a “misrepresentation” requires an assertion—some affirmative
26 misstatement; it cannot just be an omission of a material fact. (See 1 Witkin, Summary of Cal. Law
27 (2005) [Contracts § 287](#) [“There can be no misrepresentation unless there is a *representation . . .*”],
28 italics in original]; Rest. (Second) Torts (1977) [§ 525, com. b](#) [defining misrepresentation as an
“*assertion not in accordance with the truth*”], italics added.)

1 41. CDI’s attempt to incorporate an “omission” standard into the term “misrepresentation”
2 in [section 790.03\(h\)\(1\)](#) is contrary to law because it (1) contradicts the plain meaning of
3 misrepresentation, (2) contrasts with other Insurance Code provisions, which separately specify
4 omissions when they are intended to be covered, and (3) finds no support in the case law or
5 regulations.

6 2. Section [790.03\(h\)\(2\)](#).

7 42. Section [790.03\(h\)\(2\)](#) prohibits “[f]ailing to acknowledge and act reasonably promptly
8 upon communications with respect to claims arising under insurance policies.”

9 43. The plain language of [section 790.03\(h\)\(2\)](#) does not require an acknowledgement of
10 *the receipt of a claim*, but rather a “communication with respect to claims.”

11 44. Section [790.03\(h\)\(2\)](#) does not require an affirmative effort to contact members or
12 providers, absent a communication from a member or provider prompting the insurer to do so.

13 45. Nothing in subdivision (h)(2) mandates that the “acknowledge[ment]” be in any
14 particular form.

15 46. Section [10133.66](#) does not define the standard for “reasonably prompt”
16 acknowledgment of a claim under [section 790.03\(h\)\(2\)](#). Section [10133.66](#), subdivision (c) refers to
17 acknowledgements of “[r]eceipt of each claim,” which is not a “communication with respect to
18 claims.”

19 47. Regulation [2695.5](#), subdivision (e) does not define the standard for “reasonably
20 prompt” acknowledgment of a claim under [section 790.03\(h\)\(2\)](#). This regulation addresses the
21 obligation to act upon a *claim*—not the obligation to acknowledge and act upon *communications* with
22 respect to that claim.

23 3. Section [790.03\(h\)\(3\)](#).

24 48. Section [790.03\(h\)\(3\)](#) prohibits “[f]ailing to adopt and implement reasonable standards
25 for the prompt investigation and processing of claims arising under insurance policies.”
26

1 49. By the statute’s plain language, if the insurer has adopted and implemented such
2 standards, then there can be no violation of [section 790.03\(h\)\(3\)](#), even if CDI can point to specific
3 claims that were not promptly investigated and processed.

4 50. [Sections 10123.137, 10169, and 10133.66, subdivision \(c\)](#) do not define what
5 constitute “reasonable standards” for prompt investigation and processing under [section 790.03\(h\)\(3\)](#).

6 51. [Regulations 2695.3, subdivision \(a\), 2695.5, subdivision \(b\), and 2695.7, subdivision](#)
7 [\(d\)](#) do not interpret “reasonable standards for the prompt investigation and processing of claims” and
8 are therefore irrelevant to [section 790.03\(h\)\(3\)](#).

9 4. [Section 790.03\(h\)\(4\)](#).

10 52. An insurer is in violation of [section 790.03\(h\)\(4\)](#) only if it knowingly commits or
11 performs with sufficient frequency to constitute a general business practice the “failure to affirm or
12 deny coverage of claims within a reasonable time.”

13 53. [Section 10123.13](#) does not establish that affirming or denying coverage in more than
14 30 working days is unreasonable under [section 790.03\(h\)\(4\)](#).

15 54. [Regulation 2695.7, subdivision \(c\)\(1\)](#) contemplates the right to take additional time to
16 accept or deny a claim in providing that “[i]f more time is required than is allotted in [subsection](#)
17 [2695.7\(b\)](#) [which refers to the time to affirm or deny a claim]. . . . to determine whether a claim
18 should be accepted and/or denied . . . , every insurer shall provide the claimant, within the time frame
19 specified in [Regulation 2695.7, subdivision \(b\)](#), with written notice of the need for additional time.”

20 55. [Section 790.03\(h\)\(4\)](#) cannot be construed to limit the time period to affirm or deny
21 coverage of claims to 30 working days.

22 5. [Section 790.03\(h\)\(5\)](#).

23 56. [Section 790.03\(h\)\(5\)](#) prohibits “[n]ot attempting in good faith to effectuate prompt,
24 fair, and equitable settlements of claims in which liability has become reasonably clear.”

25 57. [Section 790.03\(h\)\(5\)](#) does not define “good faith,” and case authorities hold that the
26 concept of “good faith” is subjective only—not objective.
27
28

1 58. CDI has the burden of proving that PacifiCare lacked good faith in order to prove a
2 violation of [section 790.03\(h\)\(5\)](#).

3 59. Statutes outside article 6.5 of the Insurance Code, which defines unfair practices,
4 cannot be invoked to construe [section 790.03](#) and thereby attach penalties for violations of non-penal
5 statutes.

6 **C. Section 790.035’s Restrictions On The Amount Of Any Penalty.**

7
8 60. The two-tiered penalty structure and language of [Section 790.035\(a\)](#), along with its
9 legislative history, analogous Insurance Code provisions, and judicial decisions collectively
10 demonstrate that the term “willful,” as used in the statute, requires that the insurer have actual
11 knowledge that its conduct violated the law – that is, that its conduct constituted an unfair practice
12 defined in [section 790.03\(h\)](#) – and that it harbored a specific intent to commit the violation.

13 61. Under [790.035, subdivision \(a\)](#), “willful” requires more than a mere willingness or
14 purpose to commit the conduct that happens to be unlawful.

15 62. The definition of “willfully” found in Penal Code section 7 is irrelevant because it is
16 not part of the Insurance Code and does not contain the two-tiered penalty system in [section 790.035](#)
17 or anything like it.

18 63. [Regulation 2695.2, subdivision \(y\)](#), which purports to eliminate the specific intent and
19 actual knowledge requirements for “willful” is invalid and unenforceable because it conflicts with the
20 two-tiered penalty system in [section 790.035](#) and therefore exceeds CDI’s statutory authority.

21 64. The definition of “willful” provided in [Regulation 2695.2, subdivision \(y\)](#) ignores the
22 legislative history, is inconsistent with the meaning of “willful” in other Insurance Code provisions,
23 is contrary to law, does not deserve any deference, and should be invalidated.

24 65. [Section 790.035](#) authorizes a penalty for each act and the statute grants the
25 Commissioner “discretion to establish what constitutes an act.”

26 66. If an “act,” as defined by [Regulation 2695.2, subdivision \(v\)](#), is a “commission or
27 omission which in and of itself constitutes a violation” of [section 790.03](#) (Cal. Code Regs., tit. 10, §
28 [2695.2, subd. \(v\)](#)), then the “act” here must be the unfair claims settlement practice under [section](#)
[790.03\(h\)](#).

1 67. The Commissioner can only impose a penalty for each “practice” prohibited under
2 [section 790.03](#) – not each act that collectively forms the “practice.”

3 68. [Section 790.035](#) requires that inadvertent acts in the servicing of a policy be treated as
4 a single act.

5 69. Inadvertence is defined as “[a]n accidental oversight; a result of carelessness,” “lack of
6 heedfulness or attentiveness, inattention, fault from negligence.” ([Black’s Law Dict. \(8th ed. 1990\)](#),
7 [p. 744](#); [Kooper v. King \(1961\) 195 Cal.App.2d 621, 626.](#))

8 70. An act is inadvertent if the violation resulted from a lack of heedfulness or
9 attentiveness even if the insurer knew that it was engaging in conduct that ultimately contributed to
10 the occurrence of a prohibited act.

11 71. Even if an insurer’s specific actions were volitional, they are nonetheless
12 “inadvertent” if they were performed through inattention or carelessness. In such a case, all acts are
13 deemed a single act for purposes of any penalty.

14 **D. Regulation 2695.12’s Penalty Factors.**

15 72. [Regulation 2695.12](#) specifies factors that should guide the Court in determining any
16 penalty assessment. (See Cal. Code Regs., tit. 10, [§ 2695.12.](#))

17 **a) Regulation 2695.12, Subdivisions (a)(10), (a)(12): The Degree Of
18 Harm.**

19 73. The most important factor in setting a penalty is “the degree of harm occasioned by
20 the noncompliance” (see Cal. Code Regs., tit. 10, [§2695.12, subd. \(a\)\(10\), \(a\)\(12\)](#)), as is required by
21 due process.

22 74. Speculation about harm is not sufficient to satisfy either [Regulation 2695.12](#),
23 [subdivisions \(a\)\(10\), \(a\)\(12\)](#) or due process, and cannot serve as a basis for any penalty against
24 PacifiCare.

25 **b) Regulation 2695.12, Subdivision (a)(8): PacifiCare’s Remedial
26 Measures.**

27 75. A factor that may be considered in fixing the proper penalty is “whether the licensee
28 has taken remedial measures with respect to the noncomplying act(s).” (Cal. Code Regs., tit. 10, [§
2695.12, subd. \(a\)\(8\).](#))

1 the licensee failed to take any remedial measures.” (Cal. Code Regs., tit. 10, § 2695.12, subd.
2 (a)(13).)

3 85. PacifiCare’s remedial measures should warrant any penalty at the low end of the
4 applicable range, because it is undisputed that PacifiCare remedied each of the alleged violations.

5 86. Management’s knowledge of its integration strategies does not equate with knowledge
6 of the alleged violations of the insurance laws, particularly when CDI has failed to establish any
7 causal link or nexus between the specific integration-related issues alleged in this proceeding and any
8 of the charged violations.

9
10 **f) Regulation 2695.12, Subdivision (a)(7): Relative Number Of
Claims.**

11 87. Regulation 2695.12 allows the Court to consider “the relative number of claims where
12 the noncomplying act(s) are found to exist, the total number of claims handled by the licensee and the
13 total number of claims reviewed by the Department during the relevant time period.” (Cal. Code
14 Regs., tit. 10, § 2695.12, subd. (a)(7).)

15 88. Application of this factor requires the Court to compare the number of alleged
16 violations to the total volume of the claims processed by PacifiCare.

17 89. Individual errors should not be penalized where PacifiCare’s general business practice
18 is compliant with applicable law.

19 **VIII. ALLEGED VIOLATIONS OF SECTION 790.03.**

20 **A. The Failure To Provide Notice Of IMR Rights In EOBs.**

21 90. A member does not have an IMR right upon receipt of an EOB. A member is entitled
22 to an IMR only in limited instances defined in sections 10169, subdivisions (d), (j), and (k).
23

24 91. Section 10169, subdivision (i) specifies the materials that must inform members about
25 IMR rights, but nowhere requires that notice of IMR rights be included in EOBs.

26 92. The EOB is not a “letter of denial” as that term is used in section 10169.

27 93. An EOB does not constitute “copies of insurer procedures for resolving grievances,”
28 which must include notice of the right to an IMR under section 10169, subdivision (i).

1 94. Nothing in the [Regulation 2695.4](#) requires the disclosure of statutory rights; instead, it
2 mandates disclosure of benefits or other provisions of the insurance policy.

3 95. [Regulation 2595.4](#) does not require that IMR language be disclosed in any specific
4 place and does not provide a basis for penalizing PacifiCare for not including IMR language in its
5 EOBs.

6 96. Even if [section 10169, subdivision \(i\)](#) or [Regulation 2695.4](#) required IMR language in
7 EOBs, CDI could not premise an unfair claims settlement practice on the omission of IMR language
8 in EOBs. Neither [section 10169, subdivision \(i\)](#) nor the regulation authorizes CDI to impose
9 penalties on PacifiCare.

10 97. CDI has the burden of proving that PacifiCare’s omission of IMR language from
11 EOBs constituted a violation of [section 790.03\(h\)\(1\)](#) and [\(h\)\(3\)](#). CDI has failed to meet this burden
12 of proof.

13 98. The omission of a purported statutory notice of IMR rights in EOBs does not
14 constitute a misrepresentation of fact or of insurance policy provisions under [section 790.03\(h\)\(1\)](#).

15 99. The failure to include a notice of a purported statutory right cannot be a
16 misrepresentation of fact. A statutory right is not a fact.

17 100. A “misrepresentation” requires an affirmative misstatement; it cannot just be an
18 omission of a material fact.

19 101. Even if the omission of a material fact could be a misrepresentation, an omission of a
20 notice of a statutory right cannot be a misrepresentation where the omitted statutory right has not yet
21 been triggered by the action taken in the EOB.

22 102. The alleged failure to include IMR language in EOB forms does not violate [section](#)
23 [790.03\(h\)\(3\)](#), because omitting language from a form is not, in and of itself, a “fail[ure] to adopt [a]
24 reasonable standard” for promptly investigating and processing claims. Further, informing members
25 about IMR rights in an EOB – before the right to an IMR is triggered – is unrelated to “the prompt
26 investigation and processing of claims.”

27 103. As a matter of due process, PacifiCare lacked fair notice that [section 790.03\(h\)](#)’s
28 prohibitions against misrepresentation or the failure to adopt and implement reasonable standards for

1 investigation and processing claims would also include a purported delay in finding acceptable
2 language for informing members of their right to an IMR in an EOB.

3 104. The over 320,000 alleged violations at issue were inadvertent and constituted no more
4 than one act, warranting a single penalty within the meaning of [section 790.035](#).

5 105. PacifiCare’s omission of IMR language from EOBs was not willful and thus the
6 maximum potential penalty is \$5,000 per act, of which there is only one because the failure to
7 incorporate IMR language in EOBs was inadvertent.

8 106. The failure to restate information about the right for an IMR in an EOB did not cause
9 any conceivable harm, and any penalty against PacifiCare would therefore need to be at the lowest
10 end of any penalty range.

11 **B. Failure To Give Notice Of The Right To Review In EOP Claims.**

12 107. The omission from EOPs of statutory notice to providers of their right to have
13 contested or denied claims reviewed by CDI does not constitute an unfair claims settlement practice
14 under [section 790.03](#).

15 108. [Regulation 2695.7, subdivision \(b\)\(3\)](#) is irrelevant because it requires that notice of
16 CDI review rights be provided to “the claimant,” and EOPs are issued to “providers,” not claimants.
17 (Cal. Code Regs., tit. 10, [§ 2695.7, subd. \(b\)\(3\)](#); *id.*, [§ 2695.2, subd. \(c\)](#).)

18 109. Notice regarding the right to seek CDI review is not required for every EOP. Instead,
19 the plain language of [sections 10123.13, subdivision \(a\)](#) and [10123.147, subdivision \(a\)](#) requires
20 notice to providers of their CDI review rights only for a claim that is “contested or denied.”

21 110. CDI’s expansive interpretation of “contested or denied” to include any claim that is
22 not paid at billed charges is not supported by any statute, internal regulation, manual, or external
23 guidelines.

24 111. There was no fair notice to PacifiCare that claims paid in full under the contract terms
25 would still be deemed denied and thus required notice of CDI review.

26 112. Penalties may not be imposed with respect to those EOPs that did not expressly
27 “contest” or “deny” a claim.
28

1 113. The failure to provide statutory notice of review rights to “providers” does not violate
2 790.03(h)(1).

3 114. Because section 790.03(h)(1) penalizes “[m]isrepresenting *to claimants* pertinent facts
4 or insurance policy provisions,” and a “provider” is not a “claimant,” (see Cal Code Regs., tit. 10, §
5 2695.2, subd. (c), italics added), the failure to provide statutory notice of review rights to “providers”
6 cannot be a misrepresentation “to claimants.”

7 115. The obligation to notify providers of the right to CDI review comes from a statute, not
8 a policy provision relating to coverage; therefore, the omission of a notice regarding a statutory right
9 to review is not a misrepresentation of “fact . . . relating to *coverage*” under section 790.03(h)(1).
10 (Italics added.)

11 116. The omission of a statutory notice does not constitute a misrepresentation, because the
12 plain terms of section 790.03(h)(1) apply only to a “misrepresent[ation],” not a mere omission.

13 117. The omission of the requisite statutory notice language in an EOP does not relate to
14 the investigation of claims, nor does it mean that PacifiCare failed to adopt reasonable standards for
15 the prompt processing of claims under section 790.03(h)(3).

16 118. Any penalties issued under section 790.03(h) premised on violations of sections
17 10123.13, subdivision (a) and 10123.147, subdivision (a) – which do not provide for penalties –
18 would violate well established due process principles because PacifiCare did not have fair notice that
19 non-compliant EOP forms could be charged as violations of section 790.03(h) and subject it to
20 penalties.

21 119. Even if an unfair claims settlement practice could be established, the transmittal of the
22 deficient EOPs was inadvertent and must be considered a single act, warranting a single penalty
23 under section 790.035.

24 120. Because any harm resulting from PacifiCare’s failure to include the statutory notice in
25 EOPs is speculative at best, such harm cannot, consistent with due process, serve as the basis for
26 penalties.

27 121. PacifiCare’s issuance of deficient EOPs was not “willful” for purposes of 790.035
28 because there was no willingness to continue to issue incomplete EOPs once PacifiCare became

1 aware of CDI's interpretation of the statute. Therefore, the maximum penalty must be \$5,000 per act,
2 of which there is only one because PacifiCare's failure to include a statutory notice in EOPs was
3 inadvertent.

4 **C. The Failure To Timely Acknowledge Claims.**

5 122. [Section 10133.66, subdivision \(c\)](#) does not require that a letter be sent to providers,
6 acknowledging receipt of a paper claim.

7 123. [Section 10133.66, subdivision \(c\)](#) authorizes multiple methods of claims
8 acknowledgement. It requires receipt be "identified and acknowledged," but permits disclosure of
9 the recorded date of receipt by three general methods: (1) acknowledgement "in the same manner as
10 the claim was submitted"; (2) acknowledgement through electronic means, by telephone, web site, or
11 another mutually agreeable method of notification, "by which the provider may readily confirm the
12 insurer's receipt of the claim and the recorded date of receipt"; or (3) acknowledgement to the claims
13 clearinghouse, if the claimant uses the clearinghouse.

14 124. [Section 10133.66, subdivision \(c\)](#) imposes no additional obligation to affirmatively
15 send out confirmation letters or similar notices in order to "acknowledge" a claim simply because the
16 claim was submitted by mail.

17 125. PacifiCare's claim acknowledgement procedures comply with the requirements of
18 [section 10133.66, subdivision \(c\)](#). Both providers and claimants can confirm the status of their
19 claims, including the date on which they were received, by telephone; or for contracted providers, on
20 PacifiCare's website; or for claims submitted electronically, through a clearinghouse.

21 126. The failure to send an acknowledgment letter does not constitute the unfair claims
22 settlement practice of "[f]ailing to acknowledge and act reasonably promptly *upon* communications
23 with respect to claims arising under insurance policies" under [section 790.03\(h\)\(2\)](#).

24 127. Nothing in [section 790.03\(h\)\(2\)](#) mandates that the acknowledgment be in any
25 particular form. CDI's claim – which is premised *solely* on the failure to send acknowledgement
26 letters – therefore fails.

27 128. PacifiCare did not violate [section 790.03\(h\)\(2\)](#) for the additional reason that a failure
28 to send a written letter is not a failure to "acknowledge and act upon *communications*" regarding

1 claims. [Section 790.03\(h\)\(2\)](#) does not require an affirmative effort to contact members or providers
2 to acknowledge receipt of a claim absent a communication from a member or provider to do so.

3 129. CDI’s reliance on Regulation 2695, subdivision (e)(1) to further define [section](#)
4 [790.03\(h\)\(2\)](#)’s claims acknowledgment requirement is misplaced. [Regulation 2695.5, subdivision](#)
5 [\(e\)\(1\)](#) does not even concern *providers* – which is the basis for the vast majority of CDI’s
6 acknowledgement claims – *and* does not require that acknowledgement letters be sent even to
7 members. (Cal. Code Regs., tit. 10, § [2695.5, subd. \(e\)\(1\)](#).)

8 130. The failure to send a written acknowledgment letter in a paperless age does not
9 constitute a failure to implement reasonable standards in violation of [section 790.03\(h\)\(3\)](#), and CDI
10 has wholly failed to show that PacifiCare’s standards for processing claims are not reasonable.

11 131. There is no evidence that PacifiCare “knowingly” – i.e., deliberately – engaged in a
12 “practice” of failing “to acknowledge and act reasonably promptly upon communications with
13 respect to claims” ([section 790.03\(h\)\(2\)](#)) or deliberately failed “to adopt and implement reasonable
14 standards for the prompt investigation and processing of claims” ([section 790.03\(h\)\(3\)](#)).

15 132. PacifiCare’s failure to send acknowledgement letters did not occur with sufficient
16 frequency to be deemed a “general business practice,” since 95% of claims during the 2007 MCE
17 period received some form of written acknowledgment within 15 working days from receipt of the
18 claim.

19 133. PacifiCare plainly lacked any fair notice that its practice of acknowledging receipt of
20 claims electronically, by telephone, and by website, rather than by letter, could give rise to
21 punishment. The imposition of any penalties based on PacifiCare’s failure to acknowledge receipt of
22 claims by snail-mail is therefore unconstitutional.

23 134. PacifiCare’s alleged failure to send written acknowledgment letters was non-willful,
24 and therefore the maximum penalty is \$5,000 per act.

25 135. Any alleged violation for failure to send written acknowledgment letters resulted from
26 the inadvertent insertion of an “N” in the RIMS system that turned off the sending of
27 acknowledgement letters. Accordingly, PacifiCare’s failure to send acknowledgment letters was
28

1 inadvertent under [Section 790.035, subdivision \(a\)](#), and thus constituted, at most, a single act,
2 warranting a single penalty.

3 136. The failure to send acknowledgement letters did not cause any conceivable harm, and
4 any penalty against PacifiCare would therefore need to be at the lowest end of any penalty range.

5 137. The failure to send acknowledgement letters did not violate [section 790.03\(h\)](#), and
6 even if it did, a single penalty of no more than \$5,000 is the statutory maximum.

7
8 **D. Alleged Failure To Timely Pay Uncontested Claims.**

9 138. [Section 10123.13](#) expressly acknowledges that some claims will be paid beyond the
10 “30 working days” timeliness threshold provided therein. ([§ 10123.13, subd. \(a\)](#); see also
11 [§ 10123.147, subd. \(a\)](#).) Because [Section 10123.13](#) does not provide for penalties for late-paid
12 claims, but instead provides for the payment of 10% interest as the remedy, the failure to meet the 30
13 working day claim deadline is not an unfair claims settlement practice. ([§ 10123.13, subd. \(b\)](#).)

14 139. Multiple violations of the non-penal provisions of [sections 10123.13, subdivision \(a\)](#)
15 and [10123.147, subdivision \(a\)](#) cannot constitute the basis for penalties under [section 790.03\(h\)](#).

16 140. The failure to pay claims within 30 working days is not itself a violation of [section](#)
17 [790.03\(h\)\(2\)](#), because the prohibited practice involves the failures to acknowledge and act “upon
18 communications” from a member or provider, not a failure to pay a claim.

19 141. Failure to pay within 30 working days does not mean there was a failure to adopt and
20 implement “reasonable standards for the prompt processing of claims” under [section 790.03\(h\)\(3\)](#).

21 142. PacifiCare adopted and implemented “reasonable standards” for the prompt processing
22 of claims, as evidenced by the minor percentage of claims that PacifiCare paid beyond 30 working
23 days, thereby precluding the finding of a [section 790.03\(h\)\(3\)](#) violation.

24 143. The failure to pay only 3% of uncontested claims within 30 working days is different
25 from, and cannot constitute, a failure to *affirm* or deny *coverage* of claims within a *reasonable time*”
26 under [section 790.03\(h\)\(4\)](#). (Italics added.)

27 144. The failure to pay uncontested claims within the 30 working day period of [section](#)
28 [10123.13, subdivision \(a\)](#) or [section 10123.147, subdivision \(a\)](#)—which do not take into account the
reasons for, the length of, or the good faith regarding the delay—does not mean that there was any

1 failure to “attempt” in “good faith” to effectuate the prompt, fair, and equitable settlements of claims
2 under [section 790.03\(h\)\(5\)](#).

3 145. Even assuming arguendo that PacifiCare violated [section 790.03\(h\)](#) by failing to pay
4 some claims within 30 working days, PacifiCare did not *knowingly* commit or perform the violations
5 with such frequency as to constitute a general business practice.

6 146. By definition, a practice that is engaged in only 3% of the time cannot be a “general
7 business practice.”

8 147. CDI is estopped from claiming that PacifiCare’s 97% timely payment rate, which
9 exceeded the tolerance rate provided in Undertaking 19, constitutes an unfair claims settlement
10 practice.

11 148. Due process prohibits any punishment against PacifiCare for conduct that complied
12 with the standards set forth in the Undertakings.

13 149. Any penalty—in addition to the 10% interest penalty prescribed by statute—violates
14 due process because PacifiCare lacked fair notice that failure to comply with section 10123,
15 subdivision (a)’s 30-working-days standard would subject it to penalties under [section 790.03](#).

16 150. PacifiCare did not have a specific intent to violate either [section 10123.13, subdivision](#)
17 [\(a\)](#) or [section 10123.147, subdivision \(a\)](#)—let alone [section 790.03\(h\)](#). Consequently, the alleged
18 violations cannot be deemed “willful,” and the maximum potential penalty is \$5,000 per act.

19 151. The lack of harm weighs in favor of minimal penalties for the supposed violations of
20 [section 790.03](#). (Cal. Code Regs., tit. 10, § 2695.12, subd. (a)(10).)

21 **E. The Alleged Failure To Pay Statutory Interest On Late-Paid Claims.**

22 152. The failure to pay statutory interest on a claim that was not timely paid – i.e., a
23 violation of [section 10123.13, subdivision \(a\)](#) – cannot itself be a separate “unfair claims settlement
24 practice” under [section 790.03\(h\)](#) because none of the sixteen “unfair claims settlement practices”
25 enumerated in [section 790.03\(h\)](#) makes any reference to the failure to pay statutory interest on a
26 claim and because the payment (or nonpayment) of interest is not a “claims settlement practice” at
27 all. A “claims settlement practice” is a practice regarding the processing and payment of claims for
28 benefits *under an insurance policy*. The interest payment mandated by [section 10123.13, subdivision](#)

1 (b) is not a policy benefit, but a *remedy* imposed by *statute* for failure to pay within the time set by
2 another statute.

3 153. Imposing a penalty on top of the 10% penalty/remedy for the same non-penal
4 infraction – failing to pay within 30 working days – creates an excessive fine.

5 154. A failure to pay statutory interest has nothing to do with a representation of a fact
6 relating to coverage or a policy provision relating to coverage and, therefore, cannot constitute a
7 misrepresentation of fact or a policy provision in violation of [section 790.03\(h\)\(1\)](#).

8 155. The failure to pay statutory interest cannot constitute a violation of [section](#)
9 [790.03\(h\)\(2\)](#), because there is no connection between the failure to pay statutory interest and the
10 failure to acknowledge and act upon “communications” with respect to a claim.

11 156. The failure to pay *statutory* interest on some untimely paid claims cannot itself
12 constitute a failure to adopt reasonable *standards* for the processing of policy benefits for claims
13 under [section 790.03\(h\)\(3\)](#). While the repeated failure to promptly process claims *might*
14 *circumstantially evidence* a failure to adopt reasonable standards, CDI would have the burden of
15 proving (1) the insurer’s standards and (2) how the standards were unreasonable. However, CDI has
16 not met this burden.

17 157. PacifiCare adopted reasonable standards for prompt payment of claims, including the
18 payment of any interest due, precluding the finding of any violation of [section 790.03\(h\)\(3\)](#).

19 158. The failure to pay statutory interest does not constitute a failure to affirm or deny
20 coverage of claims within a reasonable time under [section 790.03\(h\)\(4\)](#). “Affirming” coverage for a
21 claim, as required by [section 790.03\(h\)\(4\)](#), is different from the actual *payment* of a claim. And
22 *affirming coverage* is even further removed from the issue of *paying statutory interest* on a late-paid
23 claim.

24 159. There is no evidence that any failure to pay statutory interest on the part of PacifiCare
25 was not in good faith; any such failure was the result of human error. Accordingly, PacifiCare’s
26 failure to pay statutory interest does not constitute a failure to “attempt” in “good faith” to effectuate
27 the prompt and fair settlement of claims, which is all subdivision (h)(5) requires.
28

1 160. Given the absence of fair notice that the failure to pay statutory interest could warrant
2 penalties as an unfair claims settlement practice under [section 790.03](#), the Due Process Clause
3 prevents the imposition of any penalties based thereon.

4 161. PacifiCare’s failure to pay interest was not “willful” as that term is used in [section](#)
5 [790.035](#). Thus, the maximum potential penalty is \$5,000 per act.

6 162. The lack of harm resulting from the failure to pay 10% statutory interest on top of a
7 fully-paid claim weighs in favor of minimal penalties for the supposed violations of [section 790.03](#).
8 (Cal. Code Regs., tit. 10, § [2695.12](#), subd. (a)(10).)

9
10 **F. The Denial Of Claims Based On The Exclusionary Period For Pre-Existing**
11 **Conditions.**

12 163. [Sections 10708, subdivision \(a\)](#) and [10198.7, subdivision \(a\)](#) are non-penal statutes
13 that cannot serve as the basis for penalties under [section 790.03\(h\)](#).

14 164. Enforcement of an unlawful policy provision (12-month exclusionary period for pre-
15 existing conditions) is not a misrepresentation of “pertinent facts or insurance policy provisions”
16 under [section 790.03\(h\)\(1\)](#). The denial of a claim based on the unlawful policy provision cannot be a
17 misrepresentation of a fact or of a policy provision when the denial conforms with the terms of the
18 policy.

19 165. CDI’s “misrepresentation by implication” theory is contrary to law, because, by
20 definition, a “misrepresentation” requires an assertion—some affirmative misstatement. There can be
21 no “misrepresentation by implication.” Simply issuing a document that contains an error is not a
22 misrepresentation.

23 166. PacifiCare’s adoption of the wrong exclusionary policy was a reasonable mistake and
24 does not mean, in and of itself, that it failed to adopt “reasonable standards for the prompt
25 investigation and processing of claims . . .” under [section 790.03\(h\)\(3\)](#). Further, while PacifiCare’s
26 adoption of erroneous policy language yielded some incorrect claims-processing results, it had
27 nothing to do with the investigation and processing of claims arising under the insurance policy.
28 Accordingly, PacifiCare did not violate [section 790.03\(h\)\(3\)](#) on account of its adoption of an
erroneous exclusionary policy.

1 167. By applying a policy (the 12-month exclusionary period) that CDI authorized,
2 PacifiCare was acting in good faith in settling claims under it. This alone precludes any unfair claims
3 settlement practice under [section 790.03\(h\)\(5\)](#). An insurer need only “attempt[] in good faith” to
4 effectuate an equitable settlement of a claim in order to avoid any unfair claims settlement practice
5 under [section 790.03\(h\)\(5\)](#).

6 168. Because PacifiCare did not have actual knowledge that it was applying the wrong
7 exclusionary period, PacifiCare did not “knowingly” engage in an unfair claims settlement practice
8 under [section 790.03\(h\)](#).

9 169. It cannot be established that PacifiCare engaged in a general business practice when it
10 only incorrectly denied claims based on a 12-month exclusionary period 0.28% of the time during the
11 relevant period.

12 170. CDI’s penalty assessment violates PacifiCare’s due process rights because PacifiCare
13 did not have fair notice that a violation of [sections 10708, subdivision \(a\)](#) or [10198.7, subdivision \(a\)](#),
14 based on a certificate of insurance approved by CDI, could possibly subject it to penalties.

15 171. Because PacifiCare’s denials of claims based on an erroneous exclusionary period
16 were the result of a single, inadvertent error by PacifiCare, CDI must treat all of the 3,862 improperly
17 denied claims as a single act for purposes of any penalty. ([§ 790.035, subd. \(a\)](#).)

18 172. The maximum penalty is thus \$5,000, as CDI concedes the improper denials were not
19 “willful.”

20 173. CDI has presented no evidence of actual harm resulting from this erroneous
21 exclusionary period.

22 174. Speculation about potential harm is not sufficient to satisfy either [regulation 2695.12,](#)
23 [subdivisions \(a\)\(10\), \(a\)\(12\)](#), or due process.

24 175. CDI’s assertion that “[p]atients facing liability for thousands of dollars in medical care
25 suffer tremendous anxiety,” ([CDI Br. 129](#)), is inadmissible hearsay evidence based on a CDI
26 employee trying to recall written complaints that CDI received from patients.

27
28

1 **G. The Denial Of Claims Due To Failure To Maintain COCCs.**

2 176. The erroneous denial of claims due to failure to maintain COCCs is not an unfair
3 claims settlement practice under [section 790.03\(h\)](#).

4 177. CDI has failed to carry its burden of proof that PacifiCare misrepresented the facts or
5 insurance policy provisions under [section 790.03\(h\)\(1\)](#). No evidence supports CDI’s position that
6 any of the 1,799 claims were denied based on missing COCCs, so there is no evidence of a
7 misrepresentation to that effect regarding those claims.

8 178. Even if PacifiCare had received a COCC but nonetheless denied the claim in an EOB,
9 there are no misrepresentations of fact or of policy provisions under [section 790.03\(h\)\(1\)](#), because a
10 typical EOB states that a claim is being denied due to a lack of information, and asks the claimant to
11 submit a COCC.

12 179. To the extent PacifiCare mishandled any COCCs, it was the result of processing errors
13 in converting to an automated system, not any failure to adopt reasonable standards for processing
14 claims in violation [section 790.03\(h\)\(3\)](#).

15 180. CDI has failed to carry its burden of proof that PacifiCare violated [section](#)
16 [790.03\(h\)\(5\)](#); there is no evidence that PacifiCare lacked good faith in “attempting” to effectuate a
17 prompt, fair, and equitable settlement of any COCC-related claim, and there is no evidence that
18 PacifiCare acted in bad faith when it denied a claim because it could not locate the COCC. To the
19 contrary, PacifiCare attempted in good faith to process COCCs.

20 181. [Regulation 2695.7, subdivision \(d\)](#) is inapplicable here because a COCC is reasonably
21 required and material for the resolution of a claim involving a pre-existing condition.

22 182. PacifiCare did not “knowingly” commit any practice of denying claims, based on the
23 failure to provide a COCC, when a COCC had been submitted.

24 183. CDI has failed to establish that the alleged mishandling of 1,799 claims was done with
25 sufficient frequency to constitute a general business practice of PacifiCare.

26 184. CDI cannot show that PacifiCare’s denial of any claims due to the mishandling of
27 COCCs was “willful” for purposes of [section 790.035](#). Thus, the maximum potential penalty is
28 \$5,000 per act.

1 185. The lack of harm resulting from any mishandling of COCCs here militates in favor of
2 a minimal penalty for the alleged violation of [section 790.03](#). (See Cal. Code Regs., tit. 10, [2695.12](#),
3 [subd. \(a\)\(10\)](#).)

4 186. The due process and excessive fines clauses limit any penalty based on the
5 mishandling of COCCs because PacifiCare’s conduct was not reprehensible and any harm is
6 speculative.

7
8 **H. The Failure To Correctly Pay Claims**

9 187. [Regulations 2695.7, subdivision \(g\)](#) provides that “No insurer shall attempt to settle a
10 claim by making a settlement offer that is unreasonably low.” CDI has failed to show that (1) the
11 incorrect payment was a “settlement offer,” and that (2) the payment was “unreasonably low,”
12 meaning that there was some substantial difference between what PacifiCare offered to pay and how
13 much it should have offered. CDI thus cannot establish a violation of [Regulation 2695.7, subdivision](#)
14 [\(g\)](#).

15 188. Because CDI cannot establish a violation of [Regulation 2695.7, subdivision \(g\)](#), this
16 regulation is irrelevant to this proceeding, and in any event does not give rise to an unfair claims
17 settlement practice under [section 790.03](#).

18 189. PacifiCare’s inadvertent errors in payment cannot be a misrepresentation of a fact or
19 of a policy provision under [section 790.03\(h\)\(1\)](#). A payment does not make a representation of any
20 fact or of any policy provision, but is merely a determination of the amount that the insurer has
21 calculated is owed under the policy.

22 190. An inadvertent error in the amount of payment does not mean that PacifiCare failed to
23 “adopt and implement reasonable standards” for processing claims under [section 790.03\(h\)\(3\)](#). CDI
24 has failed to meet its burden of showing that any of the 2,662 reworks resulted from the failure to
25 adopt or implement reasonable standards.

26 191. PacifiCare unquestionably did adopt reasonable standards in this case. The very fact
27 that PacifiCare voluntarily reworked the claims demonstrates the reasonable nature of PacifiCare’s
28 standards for the investigation and processing of claims under [section 790.03\(h\)\(3\)](#).

1 192. CDI has failed to carry its burden of proving a violation of [section 790.03\(h\)\(5\)](#)
2 because inadvertent errors do not support a finding that PacifiCare did not “attempt[] in good faith to
3 effectuate prompt, fair, and equitable settlements of claims.”

4 193. These incorrect payments were not “knowingly” committed as required under [section](#)
5 [790.03\(h\)](#) because there is no evidence that PacifiCare was aware that it was paying any of the claims
6 incorrectly. CDI has also failed to carry its burden of proof of showing that PacifiCare had
7 constructive knowledge that it was committing one of the unfair practices at issue.

8 194. The 2,662 allegedly incorrect payments constitute a mere 0.15% of the total claims
9 processed. Accordingly, the errors that led to the incorrect payments here did not occur with
10 sufficient frequency “as to indicate a general business practice” under [section 790.03\(h\)](#).

11 195. Application of due process and regulatory principles requires that any penalty be
12 minimal, because there is no evidence that the incorrect payments caused any harm to the providers
13 who received one of the 2,662 reworked payments. (Cal. Code Regs., [§ 2695.12, subd. \(a\)\(10\)](#).)

14 196. PacifiCare’s incorrectly paid claims, which were reworked and fully paid with interest,
15 do not constitute a willful act under [section 790.035, subdivision \(a\)](#).

16 **I. 58 Alleged Violations For Closing Or Denying Claims When Requesting**
17 **Additional Information.**

18 197. PacifiCare’s policy of denying claims pending receipt of additional information is not
19 an unfair business practice under [section 790.03](#), and it is not prohibited by any other section of the
20 Insurance Code.

21 198. [Section 10123.13, subdivision \(a\)](#) states that when an insurer “contest[s]” a claim, “the
22 claimant shall be notified, in writing, that the claim is contested *or denied*.” (Italics added). (See also
23 [§ 10123.147, subd. \(a\)](#) “[A]n insurer may contest or deny a claim...by notifying the claimant, in
24 writing, that the claim is contested or denied”].) Therefore, the Insurance Code expressly permits
25 the insurer to send an EOB that denies the claim and indicates, with a remark code, the reason for the
26 denial and requesting the additional information.

27 199. CDI’s list of 43 alleged violations in [Exhibit 127](#), a CDI-generated list of randomly
28 sampled claims files, cannot form the basis for a factual finding by the Court, because this Court has

1 already held that [Exhibit 127](#) may not be admitted “for the proof of any matter.” ([Tr. 2833:3-7](#)
2 [[Astle, J.](#)].) Therefore, it may not be relied on as evidence in support of any alleged violations.

3 200. The closure letters CDI relies on to establish two alleged violations are administrative
4 hearsay that cannot form the basis for a factual finding without other competent evidence, which CDI
5 failed to submit. (See Gov. Code, [§ 11513, subd. \(d\)](#).) Accordingly, CDI has no evidence to support
6 these 2 allegations.

7 201. The allegations based on claims that were handled before or after the MCE period
8 should be dismissed because they are based on conduct outside of the MCE period.

9 202. When PacifiCare informed the claimant that the claim was closed or denied,
10 PacifiCare *did* close or deny these claims, and thus did not misrepresent any fact of policy provision
11 in violation of [section 790.03\(h\)\(1\)](#).

12 203. CDI has failed to prove a violation of [section 790.03\(h\)\(3\)](#) because no delay has
13 occurred merely due to the practice of temporarily closing or denying the claim.

14 204. Any penalty must be minimal, because there is no proof of harm caused by
15 PacifiCare’s practice of closing or denying claims when requesting additional information, and
16 speculation over potential harm is not sufficient to satisfy either [Regulation 2695.12, subdivisions](#)
17 [\(a\)\(10\), \(a\)\(12\)](#) or due process. (Cal. Code Regs., tit. 10, [§ 2695.12, subd. \(a\)\(10\), \(a\)\(12\)](#).)

18 **J. The Untimely Overpayment Demands To Providers.**

19 205. CDI cannot premise an unfair claims settlement practice on a violation of [section](#)
20 [10133.66, subdivision \(b\)](#). [Section 10133.66, subdivision \(b\)](#) is, in effect, a statute of limitations for
21 seeking reimbursement from a provider. Nothing in the text of [section 10133.66, subdivision \(b\)](#)
22 suggests that the failure to abide by this statute results in an unfair claims settlement practice.
23

24 206. There were not enough missing first-request letters to show a general business practice
25 or that untimely overpayment demands were done knowingly.

26 207. It was PacifiCare’s general business practice to send timely overpayment recovery
27 letters.

28 208. Because any untimely collection notices correctly represented the fact that there had
been an overpayment, there was no misrepresentation of facts under [section 790.03\(h\)\(1\)](#).

1 209. An untimely overpayment demand does not constitute a misrepresentation of
2 insurance policy provisions under [section 790.03\(h\)\(1\)](#). The limitations period for sending
3 overpayment demands comes from a statute, not a policy provision relating to coverage.

4 210. The mistaken transmittal of untimely overpayment demands do not, in and of
5 themselves, translate into a failure to adopt prompt processing standards in violation of [section](#)
6 [790.03\(h\)\(3\)](#). Indeed, the issuance of a demand for recovery of overpayments – mistaken or not –
7 shows that the claim was previously and promptly processed.

8 211. CDI wholly fails to meet its burden of proof to show that PacifiCare’s “standards” for
9 the prompt investigation and processing of claims were not reasonable.

10 212. A penalty imposed here would not comport with due process because CDI’s assertion
11 that PacifiCare’s issuance of untimely overpayment demands created significant administrative
12 burdens on claimant is wholly speculative.

13 213. The Rawling record purporting to account for patients’ psychological harm is
14 administrative hearsay and cannot form the basis for a factual finding, absent competent,
15 corroborating evidence. (Gov. Code, [§ 11513, subd. \(d\)](#).)

16 **K. The Failure To Maintain Complete Claims Files.**

17 214. Consideration of these allegations, which, with one exception, CDI did not assert until
18 after the close of evidence, denies PacifiCare due process.

19 215. CDI failed to establish any violations of [Regulations 2695.3, subdivisions \(a\) and \(b\)](#)
20 for failure to maintain complete claim files.

21 216. The closure letters that CDI relies solely upon as evidence for six of the alleged
22 violations are conclusory, do not prove the alleged violations, and are administrative hearsay that
23 cannot form the basis for a factual finding without other competent evidence, which CDI failed to
24 submit. (Gov. Code, [§ 11513, subd. \(d\)](#)).

25 217. Neither the 2007 MCE Examination Report nor PacifiCare’s cited response provides
26 sufficient information from which the Court may make a finding regarding the nature or extent of the
27 missing documents or the nature as to PacifiCare’s practice in maintaining its claim files.
28

1 218. Even if PacifiCare did violate [Regulation 2695.3, subdivisions \(a\) and \(b\)](#) by failing to
2 maintain complete claim files in 15 instances, CDI could not premise an unfair claims practice on
3 such a failure.

4 219. A failure to maintain a document in a claim file is not a failure to “acknowledge” or
5 “act reasonably promptly upon communications” regarding claims within the meaning of [section](#)
6 [790.02\(h\)\(2\)](#).

7 220. CDI has offered no competent evidence that any failure to maintain a complete claim
8 file in the 15 cited instances resulted in any failure “to acknowledge and act reasonably promptly
9 upon communications” regarding claims. Accordingly, CDI has failed to prove a violation of [section](#)
10 [790.02\(h\)\(2\)](#).

11 221. The omission of some materials from a small number of claims file does not mean that
12 there was a failure to adopt and implement reasonable standards for promptly investigating and
13 processing claims under [section 790.03\(h\)\(3\)](#).

14 222. CDI has not presented evidence that PacifiCare “knowingly” failed to maintain a
15 complete claim file.

16 223. The small percentage of instances in which CDI charges PacifiCare with a failure to
17 maintain complete claim files does not suggest that PacifiCare had a practice of failing to maintain
18 complete claim files, let alone a “general business practice.”

19 224. Any penalty cannot exceed \$5,000 – the maximum penalty for non-willful acts.

20 225. The harm that allegedly stems from PacifiCare’s failure to maintain complete claim
21 files is sheer speculation and cannot, consistent with due process and applicable regulations, form the
22 basis of a penalty assessment.

23 **L. The Alleged Failures To Pursue A Thorough Investigation.**

24 226. CDI has not introduced any competent evidence for 37 of the 52 alleged violations in
25 this category. The closure letters, upon which CDI relies, are administrative hearsay that cannot form
26 the basis for a factual finding without other competent evidence, which CDI failed to submit. (See
27 Gov. Code, [§ 11513, subd. \(d\)](#).)
28

1 227. CDI’s remaining allegations arise from two claimants, based on an inadequate
2 evidentiary foundation.

3 228. The failure to thoroughly investigate a claim is not a misrepresentation of fact or of a
4 policy provision by [section 790.03\(h\)\(1\)](#)’s text because a “misrepresentation” requires an assertion –
5 some affirmative misstatement.

6 229. The failure to thoroughly investigate a claim is not a violation of [section 790.03\(h\)\(3\)](#).
7 By the statute’s plain language, if the insurer has adopted and implemented reasonable standards,
8 then there can be no violation of [section 790.03\(h\)\(3\)](#), even if CDI can point to specific claims that
9 were not promptly investigated and processed.

10 230. CDI’s wholesale failure to argue or show that PacifiCare failed to adopt and
11 implement reasonable standards requires dismissal of its [section 790.03\(h\)\(3\)](#) claim.

12 231. CDI has failed to prove that PacifiCare actually failed to affirm or deny any of the
13 claims at issue here within a reasonable time under [section 790.03\(h\)\(4\)](#). The two claims cited by
14 CDI – Mr. R’s and Mrs. W’s – were affirmed within a reasonable time.

15 232. CDI has not demonstrated that PacifiCare’s failure to thoroughly investigate a claim
16 constituted the unfair claims settlement practice of “[n]ot attempting in good faith to effectuate
17 prompt, fair, and equitable settlements” under [section 790.03\(h\)\(5\)](#). Indeed, the evidence supports a
18 finding that PacifiCare acted in good faith in the two cases cited by CDI.

19 233. Even if CDI could establish an unfair claims settlement practice under [section](#)
20 [790.03\(h\)](#), it cannot establish that it was knowingly – i.e., deliberately – committed or a general
21 business practice. CDI only alleges 52 instances out of approximately 2,689,832 claims that
22 PacifiCare processed during the relevant period; these 52 instances cannot constitute a general
23 business practice.

24 234. The maximum penalty per act is \$5,000 because CDI has not charged the alleged
25 violations as willful acts.

26 235. Any penalty must be nominal because CDI has failed to prove harm and speculation of
27 harm is not sufficient to satisfy either [Regulation 2695.12, subdivision \(a\)\(10\)](#) or due process.
28

1 **M. The Failure To Transact Business In PacifiCare’s Name.**

2 236. Section 880 merely requires an insurance company to conduct business “in its own
3 name” and does not specify how precise a company must be in describing its name. Section 880 does
4 not require use of the name “as set forth in the license.” Accordingly, PacifiCare’s failure to
5 reference its full legal name is not even a technical violation of section 880.

6 237. PacifiCare’s failure to state its full legal name is *not* the misrepresentation of
7 “pertinent facts or insurance policy provisions relating to any coverages at issue,” as prohibited by
8 [section 790.03\(h\)\(1\)](#). PacifiCare’s use of its shortened name does not constitute a misrepresentation
9 because there is nothing “false” about these assertions.

10 238. The two alleged instances PacifiCare represented that the underwriting carrier was
11 “PacifiCare Life Assurance Company” instead of PacifiCare Life and Health Insurance Company” do
12 not concern “pertinent facts or insurance policy provisions relating to any coverages at issue,” and
13 therefore, cannot be violations of [section 790.03\(h\)\(1\)](#).

14 239. With 119,648 PPO members in California and hundreds of thousands of pieces of
15 correspondence sent to members each year, 29 instances of purportedly noncompliant
16 correspondence do not constitute a “practice” for purposes of [section 790.03](#).

17 240. [Section 790.03](#) requires that the “practice” be knowingly committed, and PacifiCare
18 did not knowingly make a when it conducted business under its shortened name.

19 241. CDI’s penalty assessment violates PacifiCare’s due process rights because PacifiCare
20 did not have fair notice that penalties could be assessed for violations of section 880, which contains
21 no penalty provision.

22 242. Even if CDI could establish a violation of [section 790.03\(h\)\(1\)](#), any penalty would
23 have to be nominal because of the lack of evidence regarding the requisite acts and the absence of
24 evidence of harm.

25 **N. The Alleged Failures To Train Claims Agents Regarding Fair Claims Settlement**
26 **Practices.**

27 243. CDI failed to meet its burden of proving that each of the 23 individuals qualify as
28 “claims agents” as defined in [regulation 2695.2\(d\)](#). (Cal Code Regs., tit. 10, § 2695.2(d).)

1 244. Even if CDI could establish a violation of [Regulation 2695.6, subdivision \(b\)](#) based on
2 PacifiCare’s alleged failure to provide formal training regarding Fair Claims Settlement Practice
3 regulations, this failure would not constitute an unfair claims settlement practice under [section](#)
4 [790.03\(h\)\(3\)](#).

5 245. The plain language of the regulations distinguishes between the communication of
6 processing standards (which may be relevant to their implementation) and training regarding the
7 unfair claims settlement regulations themselves. (Cal. Code Regs., tit. 10, [§ 2695.6, subd. \(a\), \(b\).](#))

8 246. Any penalty would violate due process because PacifiCare lacked fair notice that
9 failure to train a few claims agents about Fair Claims Settlement practices could possibly subject it to
10 penalties under [section 790.03\(h\)](#).

11 247. CDI did not present any testimony as to any alleged impact, harm, or denial of
12 medical care resulting from PacifiCare’s purported failure to train these 23 individuals about the Fair
13 Claims Settlement practices. Under [Regulation 2695.12, subdivision \(a\)\(10\)](#), and under due process
14 principles, the lack of harm weighs in favor of minimal penalties for the supposed violations of
15 [section 790.03\(h\)](#).

16 **O. The Failure To Timely Respond To Provider Disputes.**

17 248. [Section 10123.137](#) does not purport to define “reasonably promptly” under [section](#)
18 [790.03\(h\)\(2\)](#) or “prompt[ness]” under [section 790.03\(h\)\(3\)](#).

19 249. The failure to respond within 45 working days to a relatively small percentage of
20 provider dispute claims cannot constitute an unfair claims settlement practice under [section](#)
21 [790.03\(h\)\(2\)](#).

22 250. [Section 790.03\(h\)\(2\)](#) only requires that an insurer “act reasonably promptly upon
23 communications with respect to claims.” It does not require a final determination or a written
24 determination.

25 251. The transmittal of a determination in more than 45 working days, due to document
26 routing and outsourcing issues, is not “knowingly” committed.

27 252. CDI has also failed to establish that the alleged prohibited conduct, if any, occurred
28 with enough frequency to constitute a general business practice under [section 790.03](#). PacifiCare

1 acted reasonably promptly approximately 91% of the time and had a practice of timely responding to
2 PDR requests.

3 253. Evidence of the failure to process a relatively small percentage of claims within 45
4 working days at a time of transition does not establish that PacifiCare failed to adopt and implement
5 “reasonable standards” under [section 790.03\(h\)\(3\)](#).

6 254. The minimal harm of provider “frustration” entitles CDI to only a minimal penalty, if
7 any, as a matter of due process and under the applicable penalty regulations.

8 255. Any penalty cannot exceed \$5,000, because the violations were not willful.

9 **P. The Failure To Timely Respond To CDI Inquiries.**

10 256. CDI has failed to carry its burden of proof that PacifiCare violated [section](#)
11 [790.03\(h\)\(2\)](#).

12 257. If the 21 day time period in [regulation 2695.5, subdivision \(a\)](#) is the correct measure of
13 “reasonably prompt” under [790.03\(h\)\(2\)](#), the 21 days must be measured from the date the CDI
14 inquiry was received. Without proof of receipt, CDI cannot establish that any of the 29 responses
15 were untimely under its 21-day rule. (Cal Code Regs., tit. 10, [§ 2695.5\(a\)](#).)

16 258. CDI cannot use the date that its inquiry was sent as the basis for calculating the
17 response time, given that the regulation provides that the period begins to run from date of receipt of
18 the inquiry.

19 259. The conclusory statements in closure letters, upon which CDI relies, are administrative
20 hearsay that cannot form the basis for a factual finding that PacifiCare’s responses were incomplete
21 without other competent evidence, which CDI failed to submit. (Gov. Code, [§ 11513, subd. \(d\)](#).)

22 260. CDI has not established that PacifiCare failed to provide a complete written response
23 within 21 calendar days of receipt of CDI’s inquiry on enough of the 29 occasions to constitute a
24 practice, let alone, a general business practice under [section 790.03](#).

25 261. In light of the admitted lack of willfulness, the lack of any harm associated with them,
26 the remedial measures taken, and the low frequency of only 4% in untimely responses, any penalty
27 should not exceed \$100.
28

1 **Q. The Failure To Timely Respond To Claimants.**

2 262. Regulation 2695.5, subdivision (b) applies to communications from “claimants.”

3 Given that the seven communications that CDI has cited are from providers, the definition in
4 regulation 2695.5(b) is inapplicable here. CDI has also not shown that a formal member appeal is a
5 “communication” from a claimant to which the 15-day response period in regulation 2695.5,
6 subdivision (b) applies. As such, PacifiCare was under no obligation to completely respond to the
7 two member appeals, or any of the nine cited communications, within the 15-day period.

8 263. CDI cannot establish a violation of 790.03(h)(2) because CDI has not provided the
9 dates on which the communications at issue were received, if ever, by PacifiCare, and thus there is
10 not sufficient evidence to establish that PacifiCare failed to respond reasonably promptly.

11 264. CDI relies solely on closure letters sent by its compliance officers, without any
12 supporting documentary evidence, as the basis for claiming that PacifiCare did not respond promptly.
13 The closure letters are administrative hearsay that cannot form the basis for a factual finding without
14 other competent evidence, which CDI failed to submit. (Gov. Code, § 11513, subd. (d).)

15 265. The purported failure to respond to two claimants within 15 days cannot constitute a
16 practice or a general business practice under section 790.03.

17 266. CDI has failed to establish that any failure to timely respond to two (or even nine)
18 claimants was knowing. Knowledge of response time, or knowledge of untimely response on a few
19 occasions, is not equivalent to knowingly committing a prohibited practice of failing to act
20 reasonably promptly upon communications.

21 267. CDI has not shown sufficient harm to justify the recommended excessive penalty
22 under the circumstances, violating due process.

23 268. CDI’s own regulation 2695.2(v) provides that a single act for purposes of determining
24 the penalty is the violation itself, which is the prohibited practice here. Since the practice, therefore,
25 is the punishable event, not each individual act, only a single penalty based on a single practice is
26 warranted.

1 **R. The Alleged Failure To Implement A Policy Regarding Recording The Date Of**
2 **Receipt Of Claims.**

3 269. CDI has failed to prove a single violation of [Regulation 2695.3](#) based on PacifiCare’s
4 alleged failure to implement a policy regarding recording the date of receipt of claims.

5 270. If CDI did successfully demonstrate PacifiCare’s failure to record the received date on
6 two claims in a single appeal, in violation of [Regulation 2695.3](#), this would not amount to an unfair
7 claims settlement practice under [section 790.03\(h\)\(3\)](#), because PacifiCare indisputably adopted and
8 implemented reasonable standards to record the “received” date of all claims (both paper and
9 electronic).

10 271. At all times relevant to this proceeding, PacifiCare had (and continues to have) a
11 general business practice of accurately recording the receipt date of claims.

12 272. There is no evidence that the two alleged violations were knowing violations and done
13 with such frequency as to constitute a general business practice under [section 790.03\(h\)](#).

14 273. Due process prevents the imposition of any penalties here because CDI points to only
15 speculative harm.

16 **S. The Alleged Misrepresentations To CDI**

17 274. The alleged misrepresentations concerning acknowledgement letters and employee
18 turnover should not be a factor in assessing any penalties because CDI admittedly cannot prove a
19 violation of [section 790.03, subdivision \(e\)](#) or [regulation 2695.5, subdivision \(a\)](#)

20 275. Any aggravation of the penalty based on violations of [section 790.03\(e\)](#) or [Regulation](#)
21 [2695.5, subdivision \(a\)](#) is unwarranted because the alleged misstatements about acknowledgement
22 letters and employee attrition were, at worst, instances of confusion and good-faith mistakes about
23 issues that were later remedied. These statements were not misrepresentations.

24 **T. The Misrepresentations Of Pertinent Facts To Claimants.**

25 276. [Section 790.3\(h\)\(1\)](#) and [Regulation 2695.4, subdivision \(a\)](#) refer only to misstatements
26 made to “claimants” and therefore cannot support a penalty for misrepresenting policy provisions to
27 providers.
28

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277. For 80 of the allegations, CDI relies solely on closure letters that are administrative hearsay that cannot form the basis for a factual finding without other competent evidence, which CDI failed to submit. (Gov. Code, § 11513, subd. (d).)

278. The alleged misrepresentations were not knowing or a general business practice.

279. CDI has failed to provide evidence supporting its claim that the misstatements to claimants alleged on the closure letters constitute violations of section 790.3(h)(1) or Regulation 2695.4, subdivision (a).

Dated: August 31, 2012

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By _____
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