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6
7 BEFORE THE INSURANCE COMMISSIONER
8 OF THE STATE OF CALIFORNIA
9

10 In the Matter of the Licenses and Licensing
11 Rights of
12 RIVERSOURCE LIFE INSURANCE
13 COMPANY,

14 Respondent.

File No: UPA 2009 - 00003

ORDER TO SHOW CAUSE, NOTICE OF
HEARING, RE SUSPENSION OR
REVOCATION OF CERTIFICATE OF
AUTHORITY AND NOTICE OF
MONETARY PENALTY

(Ins. Code §§700, 704, 790.035, 790.05,
10234.2, 10234.3, 10234.4 and 10234.5)

STATEMENT OF CHARGES/ACCUSATION

(Ins. Code §§700, 717, 790.03, 10111.2,
10172.5, 10232.97, 10234.8, 10235.9, and
10237.1)

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21 The California Department of Insurance (CDI) brings this matter pursuant to the
22 provisions of California Insurance Code §§700, 704, 790.035, 790.05, 10234.2, 10234.3, 10234.4
23 and 10234.5. As set forth herein, the CDI alleges violations of Insurance Code §§700, 717,
24 790.03, 10111.2, 10172.5, 10232.97, 10234.8, 10235.9 and 10237.1 and California Code of
25 Regulations, Title 10, Chapter 5, Subchapter 7.5, Article 1, §§2695.4(a), 2695.5(b), 2695.5(e)(1),
26 2695.5(e)(2), 2695.5(e)(3), 2695.6, 2695.7(b)(1), 2695.7(b)(3), 2695.7(c)(1), 2695.7(d),
27 2695.7(g), 2695.7(h), and 2695.11(b) (sections of the Fair Claims Settlement Practices
28 Regulations, and hereafter, the "Fair Claims Regulations.")

1 I

2 PARTIES

3 Respondent RiverSource Life Insurance Company ("RiverSource") holds, and at all times
4 relevant hereto held, a Certificate of Authority issued by the Insurance Commissioner of the State
5 of California (Commissioner) to issue life and disability insurance policies, including disability
6 policies providing long term care coverage.

7 II

8 BACKGROUND

9 Pursuant to Insurance Code §§730, 733, and 790.04 and Regulation §2695.3(a), the CDI
10 conducted a market examination (Market Conduct Examination) of RiverSources's operating
11 procedures and claims handling practices for life insurance policies (Life Policy), accident and
12 disability/disability income policies (Disability Policy), and disability policies providing long
13 term care coverage (LTC Policy.) The examination reviewed prior market conduct examinations,
14 consumer complaints and claims files for claims that were closed between June 1, 2007 and May
15 31, 2008 (Review Period.) The Market Conduct Examination was conducted at the CDI's offices
16 and at RiverSources's offices in Minneapolis, Minnesota. The Market Conduct Examination was
17 made to discover, in general, whether RiverSources's claims handling practices and operating
18 procedures conform to the contractual obligations in its insurance policy forms, the Insurance
19 Code, the Fair Claims Regulations, and federal and state law.

20 The Market Conduct Examination was conducted by a random sampling of files closed
21 during the Review Period. The CDI examined 55 of 294 LTC Policy files, 20 of 332 Disability
22 Policy claim files, and 35 of 222 Life Policy claims files.

23 As set forth herein, the Market Conduct Examination cited numerous violations of the
24 Insurance Code and the Fair Claims Regulations. The CDI believes that the violations are
25 indicative and representative of violations that exist in the entire population of claims and policies
26 handled by RiverSource during the Review Period. The CDI therefore asserts that the violations
27 cited in the Market Conduct Examination can be reasonably and reliably extrapolated to the entire
28 population of Life, Disability and LTC Polices and claims during the Review Period.

1 Accordingly, the CDI will seek penalties herein based upon the number of violations set forth in
2 the Market Conduct Examination reports, plus the number of violations that are extrapolated from
3 the Market Conduct Examination (without duplication.) The extrapolated number of violations
4 will also be considered by the CDI in seeking the relief set forth herein as to matters other than
5 penalties.

6 As the result of the Market Conduct Examination, the CDI prepared and issued reports to
7 RiverSource containing the CDI's findings and containing RiverSource's responses thereto. The
8 Market Conduct Examination findings are summarized in Sections IV through VI hereof. The
9 Market Conduct Examination contains findings indicate that RiverSource engaged in a pattern
10 and practice of violating the provisions of Insurance Code §§700, 717, 790.03, 10111.2, 10172.5,
11 10232.97, 10234.8, 10235.9 and 10237.1 and Fair Claims Regulations §§ 2695.4(a), 2695.5(b),
12 2695.5(e)(1), 2695.5(e)(2), 2695.5(e)(3), 2695.6, 2695.7(b)(1), 2695.7(b)(3), 2695.7(c)(1),
13 2695.7(d), 2695.7(g), 2695.7(h), and 2695.11(b). The Market Conduct Examination found that
14 RiverSource failed to adhere to, and breached, its duties of good faith and fair dealing to its
15 policyholders.

16 III

17 FAIR CLAIMS REGULATIONS

18 As set forth in Articles IV, V and VI, the CDI alleges that RiverSource violated the
19 following provisions of the Fair Claims Regulations.

20 A. Fair Claims Regulation §2695.4(a).

21 Every insurer shall disclose to a first party claimant or beneficiary all benefits, coverages,
22 time limits or other provisions of any insurance policy issued by that insurer that may
23 apply to the claim presented by the claimant. When additional benefits might reasonably
24 be payable under an insured's policy upon receipt of additional proofs of claim, the insurer
25 shall immediately communicate this fact to the insured and cooperate and assist the insured
26 in determining the extent of the insured's additional liability.

25 B. Fair Claims Regulation §2695.5.

26 (b) Upon receiving any communication from a claimant, regarding a claim, that
27 reasonably suggests that a response is expected, every licensee shall immediately, but in
28 no event more than fifteen (15) calendar days after receipt of that communication, furnish
the claimant with a complete response based on the facts as then known by the licensee.
This subsection shall not apply to require communication with a claimant subsequent to
receipt by the licensee of a notice of legal action by that claimant.

1
2 (e) Upon receiving notice of a claim, every insurer shall immediately, but in no even more
3 than fifteen (15) calendar days alter, do the following unless the notice of claim received
4 is a notice of legal action:

5 (1) acknowledge receipt of such notice to the claimant unless payment is made
6 within that time period. If the acknowledgement is not in writing, a notation of
7 acknowledgement shall be made in the insurer's claim file and dated. ...

8 (2) provide to the claimant necessary forms, instructions, and reasonable
9 assistance, including but not limited to, specifying the information the claimant
10 must provide for proof of claim;

11 (3) begin any necessary investigation of the claim.

12 C. Fair Claims Regulation §2695.6.

13 (b) All licensees shall provide thorough and adequate training regarding the regulations to
14 all their claims agents. Licensees shall certify that their claims agents have been trained
15 regarding these regulations and any revisions thereto. ...

16 A licensee shall demonstrate compliance with this subsection by the following
17 methods:

18 ...

19 (3) where the licensee retains insurance adjusters ..., the licensee must ... annually
20 certify, in a declaration under penalty of perjury, that such training is provided.
21 Alternatively, the insurance adjuster may annually certify ... that he or she has read
22 and understands these regulations and all amendments thereto or has successfully
23 completed a training seminar which explains these regulations;

24 ...

25 (5) the annual certification required by this subsection shall be completed on or
26 before September 1 of each calendar year.

27 D. Fair Claims Regulation §2695.7.

28 (b) Upon receiving proof of claim, every insurer, except as specified in subsection
29 2695.7(b)(4) below, shall immediately, but in no even more than forty (40) calendar days
30 later, accept or deny the claim, in whole or in part. The amounts accepted or denied shall
31 be clearly documented in the claim file unless the claim has been denied in its entirety.

32 (1) Where an insurer denies or rejects a first party claim, in whole or in part, it
33 shall do so in writing and shall provide to the claimant a statement listing all the
34 bases for such rejection or denial and the factual and legal bases for each reason
35 given for such rejection or denial which is then within the insurer's knowledge.
36 Where an insurer's denial of a first party claim, in whole or in part, is based on a
37 specific statute, applicable law or policy provision, condition or exclusion, the
38 written denial shall include reference thereto and provide an explanation of the
39 application of the statute, applicable law or policy provision, condition or
40 exclusion to the claim.

41 ...

42 (3) Written notification pursuant to this subsection shall include a statement that,

1 if the claimant believes all or part of the claim has been wrongfully denied or
2 rejected, he or she may have the matter reviewed by the California Department of
3 Insurance, and shall include the address and telephone number of the unit of the
4 Department which reviews claims practices.

5 (c)(1) If more time is required than is allotted in subsection 2695.7(b) to determine
6 whether a claim should be accepted and/or denied in whole or in part, every insurer shall
7 provide the claimant, within the time frame specified in subsection 2695.7(b), with written
8 notice of the need for additional time. This written notice shall specify any additional
9 information the insurer requires in order to make a determination and state any continuing
10 reasons for the insurer's inability to make a determination. Thereafter, the written notice
11 shall be provided every thirty (30) calendar days until a determination is made or notice of
12 legal action is served. If the determination cannot be made until some future event occurs,
13 then the insurer shall comply with this continuing notice requirement by advising the
14 claimant of the situation and providing an estimate as to when the determination can be
15 made.

16 (d) Every insurer shall conduct and diligently pursue a thorough, fair and objective
17 investigation and shall not persist in seeking information not reasonably required for or
18 material to the resolution of a claim dispute.

19 (g) No insurer shall attempt to settle a claim by making a settlement offer that is
20 unreasonably low. The Commissioner shall consider any admissible evidence offered
21 regarding the following factors in determining whether or not a settlement offer is
22 unreasonably low:

23 (1) the extent to which the insurer considered evidence submitted by the claimant
24 to support the value of the claim;

25 (2) the extent to which the insurer considered legal authority or evidence made
26 known to it or reasonably available;

27 (3) the extent to which the insurer considered the advice of its claim adjust as to
28 the amount of damages;

(4) the extent to which the insurer considered the advice of its counsel that there
was a substantial likelihood of recovery in excess of policy limits;

(5) the procedures used by the insurer in determining the dollar amount of
property damage;

(6) the extent to which the insurer considered the probable liability of the insured
and the likely jury verdict or other final determination of the matter;

(7) any other credible evidence presented to the Commissioner that demonstrates
that (i) any amount offered by the insurer in settlement to a first-party claim to an
insured not represented by counsel, or (ii) the final amount offered in settlement of
a first-party claim to an insured who is represented by counsel, or ...

(h) Upon acceptance of the claim, in whole or in part and, when necessary, upon receipt
of a properly executed release, every insurer, except as specified in subsection
2695.7(h)(1) and (2) below, shall immediately, but in no event more than thirty (3)
calendar days later, tender payment or otherwise take action to perform its claim
obligation. The amount of the claim to be tendered is the amount that has been accepted
by the insurer as specified in subsection 2695.7(b). ...

1 (1) The time frame specified in subsection 2695.7(h) shall not apply to claims
2 arising from policies of disability insurance subject to Section 10123.13 of the
3 California Insurance Code, disability income insurance subject to Section 10111.2
4 of the California Insurance Code, or

5 E. Regulation §2695.11(b).

6 With each claim payment, the insurer shall provide to the claimant and assignee, if any, an
7 explanation of benefits which shall include, if applicable, the name of the provider or
8 services covered, dates of service, and a clean explanation of the computation of benefits.

9 IV

10 MARKET CONDUCT EXAMINATION - LONG TERM CARE POLICIES

11 A. RiverSource Policies and Practices - General Findings.

12 The Market Conduct Examination determined that RiverSources's claims handling
13 practices and procedures violated Insurance Code §§790.03(h)(1), 790.03(h)(2), 790.03(h)(3),
14 790.03(h)(5), 790.03(h)(13), 10111.2(a), 10111.2(c), 10172.5(c), 10232.97, 10234.8, 10235.9(b),
15 and 10237.1 and the Fair Claims Regulations. Claimants under RiverSources's LTC Policies are
16 a vulnerable population. They are typically in their late 70's and 80's, and in many instances are
17 in their 90's, and they are frail, unable to perform activities of daily living (as defined in Insurance
18 Code §10232.8), suffering from Alzheimer's Disease or other cognitive impairment, and in need
19 of medical or other assistance. The CDI alleges that the Market Conduct Examination shows that
20 RiverSource engaged in patterns and practices violating the Insurance Code and Fair Claim
21 Regulations, including through general business practices, and violated its duties of honesty, good
22 faith and fair dealing, including the duty of good faith and fair dealing specified in Insurance
23 Code §10234.8, in delaying investigation of claims, imposing burdens on its insureds, requiring
24 unneeded assessments and documents, improper interpretation of its policies, and engaging in the
25 other acts set forth herein for the purpose of minimizing or avoiding paying claims under its
26 policies.

27 1. Denial of Coverage Based on Outdated Care Facility Requirement.

28 RiverSource issued "nursing home" LTC Policies to insureds between 1989 and 1993
prior to the enactment of statutes pertaining to long term care coverage, including Insurance Code
§10232.92 which requires every LTC policy issued in California to include care provided in a

1 residential care facility. The CDI is informed and believes that RiverSources's nursing home
2 LTC Policies were issued when long term care was more commonly provided in skilled nursing
3 facilities and other facilities that provided nursing services. RiverSources's LTC Policies, though,
4 provide for care other than nursing care. Over time, the practices of providing long term care
5 have shifted to utilizing care facilities that provide assistive care that is appropriate to the needs of
6 the patient, and which may include nursing care, but which are not skilled nursing or other
7 nursing facilities. Although such change has occurred, RiverSource did not amend its in force
8 LTC Policies to reflect or accommodate those changes. Instead, RiverSource strictly interpreted
9 and misinterpreted the terms in its policies which predate the industry changes, and which are
10 outdated, to deny coverage.

11 RiverSources's nursing home LTC Policy form states that long term care must be provided
12 in a Nursing Home, which the policy defines as follows:

13 A facility ... which is licensed by the appropriate licensing agency to engage primarily in
14 providing nursing care and related care to inpatients and

- 15 - Provides 24 hour a day nursing service under a planned program of policies and
16 procedures which was developed with the advice of, and is periodically reviewed and
17 executed by, a professional group of at least one Doctor and one Nurse; and
- 18 - Has a Doctor available to furnish medical care in case of an emergency; and
- 19 - Has at least one Nurse who is employed there full time (or at least 24 hours per week if
20 the facility has less than 10 beds); and
- 21 - Has a Nurse on duty or on call at all times; and
- 22 - Maintains clinical records for all patients; and
- 23 - Has appropriate methods and procedures for handling and administering of drugs and
24 biologicals.

25 NOTE: The above requirements are typically met by licensed skilled nursing facilities,
26 comprehensive nursing care facilities and intermediate nursing care facilities ... Those
27 requirements are generally NOT met by; rest homes, homes for the aged, sheltered living
28 accommodations, residence homes; or similar living arrangements.

The foregoing factors are hereafter referred to as the "6 Factors" and the second factor is
hereafter referred to as the "Doctor/Nurse Factor."

When RiverSource sold the nursing home LTC Policies, the 6 Factors, including
Doctor/Nurse Factor, may have been useful in distinguishing appropriate long term care facilities

1 from facilities that did not offer the level professional care contemplated for coverage by the
2 Policies. At the time of the Review Period, the State of California and other states licensed
3 skilled nursing facilities, residential care facilities and other facilities, and those licensing
4 requirements supplanted the purpose of the 6 Factors as to assuring that a facility could provide
5 the long term care covered by the LTC Policies. Accordingly, to effectuate the purpose of its
6 LTC Policies and provide the benefits reasonably expected by its policyholders, RiverSource
7 should have permitted its insureds to obtain covered care at a licensed care facility that provided
8 the appropriate level of care.

9 As set forth herein, however, RiverSource maintained a policy and practice of requiring
10 that benefits could only be provided in care facilities that strictly comply with the 6 Factors,
11 including the Doctor/Nurse Factor. RiverSource enforced this policy and practice, regardless
12 whether its insured qualified for benefits, regardless whether the facility provided the level of care
13 needed by the insured and was covered by the LTC Policy, and regardless whether the facility
14 was licensed.

15 Particularly, requiring compliance with the Doctor/Nurse Factor was unreasonable and
16 improper. To the extent that the Doctor/Nurse Factor was once a reasonable requirement for
17 assuring the nature and quality of long term care when the LTC Policies were issued, or to the
18 extent that it served some other purpose, the changes in long term care industry made the
19 requirement no longer necessary or reasonable, or consonant with long term care practice, by the
20 time of the Review Period. Requiring compliance with the Doctor/Nurse Factor is the equivalent
21 of requiring the use of an ice box, if that were specified in a policy, in an age of refrigeration.

22 The CDI is informed and believes, and thereon alleges, that RiverSource required strict
23 compliance with the 6 Factors, and particularly the Doctor/Nurse Factor, for the purpose of
24 denying coverage under its LTC policies to its insureds.

25 The foregoing policies and practices constitute an unreasonable and improper
26 interpretation of its LTC Policy, unfair acts or practices in the business of insurance and
27 violations of Insurance Code §790.03(h)(3) regarding the adoption and implementation of
28 reasonable standards for processing claims, violations of Insurance Code §790.03(h)(5) in not

1 attempting in good faith to effectuate prompt, fair and equitable settlements of claim in which
2 liability has become reasonably clear, a general business practice referred to in Insurance Code
3 §10234.3(b), and a breach of the duty of good faith and fair dealing specified in Insurance Code
4 §10234.8.

5 2. Denial of Coverage Based on Unreasonable Interpretation of Policy Provisions.

6 RiverSources's nursing home LTC Policies provide long term care benefits under
7 circumstances where the insured did not require nursing care. The Policies provide as follows:

8 No Specific Level of Care Required. This Policy makes no distinction, in the duration or
9 amount of benefits You will be paid, *for different levels of care (whether skilled,*
10 *intermediate or custodial)* as long as Your Nursing Home Stay is Necessary. [emphasis
added]

11 As set forth in Paragraph IV(A), however, RiverSource denied coverage to its insureds
12 who qualified for benefits under LTC Policies and who required custodial care on the grounds
13 that the facility selected by the insured did not meet the 6 Factors, including Doctor/Nurse Factor.
14 The denial on such grounds is an unreasonable and improper interpretation of the LTC Policy
15 because the Policy provides for "custodial" care, as opposed to nursing care. Further, to the
16 extent that the LTC Policy provisions are ambiguous, RiverSource may not interpret them to the
17 detriment of its insureds and by doing so, make the "custodial" care provision an illusory promise.

18 The foregoing policies and practices constitute an unreasonable and improper
19 interpretation of its LTC Policy terms, unfair act or practices in the business of insurance and
20 violations of Insurance Code §790.03(h)(3) regarding adoption and implementation of reasonable
21 standards for processing claims, violations of Insurance Code §790.03(h)(5) in not attempting in
22 good faith to effectuate prompt, fair and equitable settlements of claim in which liability has
23 become reasonably clear, a general business practice referred to in Insurance Code §10234.3(b),
24 and a breach of the duty of good faith and fair dealing specified in Insurance Code §10234.8.

25 3. Failure to Provide Reasonable Assistance.

26 Upon being notified that an insured wishes to arrange for care in a facility, including in
27 cases in which RiverSource is advised that the insured will be leaving a hospital, skilled nursing
28 facility or other care facility, RiverSource will not provide the insured with a list of eligible

1 facilities and requires the insured to locate, on his or her own, a facility that meets the
2 requirements of RiverSources's LTC Policy, including the 6 Factors. RiverSource requires the
3 insured to select a facility and then submit information, or have the facility submit information, to
4 RiverSource. Only at that time will RiverSource commence its process of determining whether
5 the facility qualifies for coverage and meets the 6 Factors. This practice is followed by
6 RiverSource even in cases in which the insured needs to immediately or imminently enter or be
7 transferred to a facility. In some instances, RiverSource provides the insured with the assistance
8 of a contractor who may identify possible care facilities, but the contractor will not assure that the
9 facilities it identifies meet RiverSources's requirements.

10 RiverSources's practice improperly places the burden of finding an acceptable facility on
11 its insureds and in doing so, fails to provide reasonable assistance to its insureds. The process
12 creates unreasonable and unnecessary delay and is particularly detrimental to an insured that
13 needs to obtain care and it penalizes an insured that, regardless of his or her best effort, selects a
14 facility that provides the care contemplated by the LTC Policy, but which RiverSource eventually
15 determines is ineligible. The insured is not only denied coverage for his or her stay in the care
16 facility, the deductible period ("elimination period") -- the period in which the insured she must
17 absorb all long term care costs before the policy provides benefits -- is not considered by
18 RiverSource to have commenced. Finally, the insured must then recommence the process of
19 attempting to find an eligible facility, again without the reasonable assistance of RiverSource.

20 The foregoing policy and practices constitute violations of Fair Claims Regulation
21 §2695.5(e)(2), unfair acts or practices in the business of insurance and violations of Insurance
22 Code §790.03(h)(3) regarding adoption and implementation of reasonable standards for
23 processing claims, a general business practice referred to in Insurance Code §10234.3(b), and a
24 breach of the duty of good faith and fair dealing specified in Insurance Code §10234.8.

25 4. Failure to Investigate - Burden of Ascertainning Qualification of Care Facility.

26 Upon being notified by an insured of a facility in the insured wishes to receive care,
27 RiverSource requires the insured to commence the process of determining whether the facility
28 complies with the 6 Factors set forth in the LTC Policy. RiverSource sends a facility inquiry

1 form to the insured and requires the insured to submit the form to the facility. The information
2 sought by RiverSource can be obtained or satisfied, in many instances, by determining whether
3 the facility is licensed. Through its practice of sending the facility inquiry form to the insured,
4 RiverSource improperly places on its own duty to investigate claims and to provide assistance on
5 its insured.

6 The foregoing policy and practices constitute violations of Fair Claims Regulation
7 §2695.5(e)(2), unfair acts or practices in the business of insurance and violations of Insurance
8 Code violations of Insurance Code §790.03(h)(3) regarding adoption and implementation of
9 reasonable standards for processing claims, a general business practice referred to in Insurance
10 Code §10234.3(b), and a breach of the duty of good faith and fair dealing specified in Insurance
11 Code §10234.8.

12 5. Inspection of Long Term Care Facility.

13 RiverSource has a policy and practice of making inspections of long term care facilities
14 selected by its insureds and examining a facility's staff training, security, staffing ratios and other
15 matters. Its LTC Policy, however, only requires facilities to be "licensed by the appropriate
16 licensing agency" and meet the 6 Factors. RiverSource may not disallow coverage for care in a
17 licensed care facility on grounds that are not specified in the LTC Policy and, specifically, on
18 grounds that are the subject of licensing by the State of California. The CDI is informed and
19 believes that the purpose of RiverSource's inspections is to disqualify facilities and deny benefits
20 under its LTC policies.

21 The foregoing policy and practice constitutes unfair acts or practices in the business of
22 insurance and violations of Insurance Code §790.03(h)(3) regarding adoption and implementation
23 of reasonable standards for processing claims, a general business practice referred to in Insurance
24 Code §10234.3(b), and a breach of the duty of good faith and fair dealing specified in Insurance
25 Code §10234.8.

26 6. Failure to Commence Investigation.

27 RiverSource fails to commence timely or adequate investigation of claims. Upon
28 receiving notice of a claim or notice that an insured intends to enter a facility and utilize his or

1 policy benefits, RiverSources's policy and practice is to send claim forms to the insured and, in
2 general, to take no further action until the claim forms, care facility forms, and other forms are
3 fully completed and returned. RiverSource does not consider that a claim has been made until
4 such time. Further, RiverSource does not consider a claim to commence until the insured enters a
5 facility, which RiverSource may later reject as being an unacceptable under its Policy (again,
6 including the 6 Factors.) Further still, RiverSource does not schedule a health assessment of its
7 insured, including when RiverSource has been advised that its insured is seeking benefits due to
8 cognitive impairment, and thus determine the insured's eligibility for policy benefits, until the
9 insured physically enters a care facility. RiverSources's policy and practices cause unreasonable
10 delay and hardship for a generally elderly and dependent population.

11 The foregoing policy and practices constitutes violations of Fair Claims Regulation
12 §2695.7(d), unfair acts or practices in the business of insurance and violations of Insurance Code
13 §790.03(h)(3) regarding adoption and implementation of reasonable standards for processing
14 claims, a general business practice referred to in Insurance Code §10234.3(b), and a breach of the
15 duty of good faith and fair dealing specified in Insurance Code §10234.8.

16 7. Failure to Disclose Additional Benefits When Medicare Provides Coverage.

17 RiverSource issued LTC Policies that were "tax-qualified" pursuant to 26 U.S.C.A.
18 §7702B and which therefore do not pay benefits that are duplicated, as defined in 26 U.S.C.A.
19 §7702B, by the limited long term care benefits that Medicare covers. Whenever it is advised that
20 an insured is being provided long term care coverage by Medicare, RiverSource denies the
21 insured's claim and does not communicate to the insured that he or she may be entitled to benefits
22 under the LTC Policy that are in addition to, and do not duplicate, the coverage provided by
23 Medicare. RiverSources's insureds are therefore denied the ability to obtain other benefits that
24 are provided by their LTC Policies.

25 The foregoing policy and practice constitutes violations of Fair Claims Regulations
26 §§2695.4(a) and §2695.59(e)(2), unfair acts or practices in the business of insurance and
27 violations of Insurance Code §790.03(h)(3) regarding adoption and implementation of reasonable
28 standards for processing claims, a general business practice referred to in Insurance Code

1 §10234.3(b), and a breach of the duty of good faith and fair dealing specified in Insurance Code
2 §10234.8.

3 8. Failure to Provide Written Basis for Denial of Coverage When Medicare Provides
4 Coverage.

5 In denying a claim under an LTC Policy on the grounds that coverage is being provided
6 by Medicare, RiverSource does not communicate the reason for denial to the insured.

7 The foregoing policy and practices constitutes violations of Fair Claims Regulations
8 §§2695.4(a) and §2695.59(e)(2), unfair acts or practices in the business of insurance and
9 violations of Insurance Code §790.03(h)(3) regarding adoption and implementation of reasonable
10 standards for processing claims, violations of Insurance Code §790.03(h)(13) regarding
11 explanation of the basis for denial of a claim, a general business practice referred to in Insurance
12 Code §10234.3(b), and a breach of the duty of good faith and fair dealing specified in Insurance
13 Code §10234.8.

14 9. Use of Eligibility Standards in Violation of Insurance Code §10232.97.

15 Insurance Code §10232.97 provides as follows:

16 In every long-term care policy or certificate that covers care in a nursing facility, the
17 threshold establishing eligibility for nursing facility care shall be no more restrictive than
18 a provision that the insured will qualify if either one of two criteria are met: (a)
19 Impairment in *two* activities of daily living, or (b) Impairment in cognitive ability.
[emphasis added]

20 RiverSource's LTC policies predate the enactment of Insurance Code §10232.97 in 1999
21 and provide a different threshold for eligibility for nursing facility care. Between February 14,
22 1992 and December 31, 1992, however, RiverSource added an endorsement to some of its LTC
23 Policies, which was approved by the Commissioner, which provide that RiverSource would
24 determine eligibility based on impairment in three activities of daily living (ADL's) as defined in
25 Insurance Code §10232.8. Although the endorsement was only made a part of some policies,
26 RiverSource used the three ADL impairment standard to adjudicate claims under 94 Policies to
27 which the endorsement had not been added. The use of a three ADL impairment standard
28 conflicts with the policy of the State of California, as expressed in Insurance Code §10232.97,
and was not provided for by the RiverSource policies.

1 The foregoing policy and practices constitutes unfair acts or practices in the business of
2 insurance and violations of Insurance Code §790.03(h)(3) regarding adoption and implementation
3 of reasonable standards for processing claims, violations of Insurance Code §790.03(h)(5)
4 regarding not attempting in good faith to effectuate prompt, fair and equitable settlement of
5 claims in which liability has become reasonably clear, a general business practice referred to in
6 Insurance Code §10234.3(b) and a breach of the duty of good faith and fair dealing specified in
7 Insurance Code §10234.8.

8 10. Failure to Pay Costs of Investigation.

9 RiverSource pays for the cost of obtaining Attending Physician Statements, medical
10 records, facility statements and other information that it requires or seeks in connection with
11 reviewing claims, but it imposed a maximum payment of \$100 for the cost of obtaining Attending
12 Physician Statements. No maximum is set forth in the LTC Policies and there is no other basis
13 for imposing a maximum.

14 The foregoing policy and practices constitutes unfair acts or practices in the business of
15 insurance and violations of Insurance Code §790.03(h)(3) regarding adoption and implementation
16 of reasonable standards for processing claims, a general business practice referred to in Insurance
17 Code §10234.3(b) and a breach of the duty of good faith and fair dealing specified in Insurance
18 Code §10234.8.

19 11. Failure to Comply with Training Regulation.

20 RiverSource uses a third party administrator to adjust claims under LTC Policies. An
21 annual certification for that administrator was not completed for September 1, 2007, in violation
22 of Fair Claims Regulation §2695.6(b).

23 B. Market Conduct Examination - Specific Findings.

24 The matters described in Paragraph IV(A) above are set forth with greater specificity in
25 the reports of the Market Conduct Examination and are further summarized as follows.

26 1. Fair Claims Regulation §2695.4(a).

27 In 21 instances, upon receiving notice that a claim would be or was being made,
28 RiverSource failed to advise its insureds of all the terms of its LTC Policies that were, or may

1 have been, pertinent. RiverSource failed to advised its insureds of covered services, deductible
2 periods, benefit maximums, institutional or non-institutional benefits, provisions on functional
3 dependency, limitation and exclusions as to facilities and providers, and other provisions that
4 limit, exclude, reduce or delay providing of benefits under its policies. In 3 instances,
5 RiverSource failed to advise its insureds who were receiving long term care coverage under
6 Medicare provisions of other or excess benefits that the RiverSource policy would pay. In 1
7 instance, RiverSource incorrectly advised its insured that the policy had a 100 day elimination
8 period instead of the correct period, which was 20 days.

9 The foregoing constitutes 24 acts in violation of Fair Claims Regulation §2695.4(a) and
10 Insurance Code §§790.03(h)(3) and 10234.8.

11 2. Insurance Code §§ 790.03(h)(3).

12 RiverSource delayed health evaluations and assessments of its insureds for eligibility for
13 long term care benefits under its LTC Policies, required extra functional assessments for coverage
14 in cases of cognitive impairment, delayed determining qualification of facilities (both as to the 6
15 Factors and otherwise), delayed requesting medical records, delay in obtaining Attending
16 Physician Statements, failed to duly consider physician statements, failed to duly consider prior
17 services and benefits provided to its insureds, failed to timely seek information, and required the
18 insured to obtain facility information and other information that RiverSource should have
19 obtained.

20 The specific instances of the foregoing matters are set forth in the Market Conduct
21 Examination reports and they include the following: In 1 instance involving a 92 year old
22 insured, RiverSource did not request a health assessment until two months after the claim was
23 made and over one month after it had received a plan of care from care facility, it did not review
24 the care facility for months, and RiverSource did not deny the claim based on the Doctor/Nurse
25 Factor until two months after it knew that the care facility did not meet that factor.
26 RiverSources's unreasonably delayed investigation resulted in the claim being denied more than
27 four months after it was made. In 1 instance involving a 64 year old insured, RiverSource
28 delayed obtaining a health assessment for approximately one month and delayed seeking medical

1 records for approximately one month. In 1 instance, RiverSource sent a letter to the insured's
2 representative the day after RiverSource received the claim stating that thirty days had elapsed
3 without a response. In 1 instance involving a 72 year old insured that suffers from Alzheimer's
4 Disease, RiverSource failed to investigate the applicability of home health services. In 1 instance
5 involving a 92 year old insured, RiverSource waited approximately two months after it received
6 notice of a claim before requesting a health assessment and waited for all claim forms to be
7 submitted before investigating. In 1 instance involving a 91 year old insured, RiverSource relied
8 on a health assessment that was performed before the insured notified RiverSource of an
9 additional impairment in the ability to perform an ADL. RiverSource failed to investigate the
10 insured's changed condition before denying her claim. In 1 instance involving a 74 year old
11 insured, RiverSource took four months to investigate the claim, after which RiverSource denied
12 the claim contending that the insured did not suffer from cognitive impairment or an inability to
13 perform ADL's. The insured later submitted a second claim based on the same matters, which
14 RiverSource approved retroactive to the date of the prior health assessment which it contended
15 did not show qualification for benefits. RiverSource approved the claim 422 days after receiving
16 notice of the first claim. RiverSource failed to adequately investigate this matter. In 1 instance
17 involving an 83 year old insured, RiverSource waited two months after receiving notice of a
18 claim to request medical records, resulting in unnecessary delay, and RiverSource failed to
19 investigate until claims materials were received. In 1 instance involving an 80 year old insured,
20 RiverSource was advised that the insured was in a care facility but it did not schedule a health
21 assessment for 44 days and did not actively investigate until claims forms were returned. In 1
22 instance involving a 94 year old insured, RiverSource delayed sending a facility inquiry form for
23 10 days, despite being given advance notice that the insured would go to the care facility,
24 RiverSource does not commence its investigation until all forms are received, and RiverSource
25 did not conduct an assessment of insured until she had been in the care facility for 75 days. In 1
26 instance involving an 87 year old insured, RiverSource waited until it received completed claim
27 forms before scheduling an assessment of the insured, who had been in a care facility for two
28 months, and RiverSource required multiple forms and duplicative information. In 1 instance

1 involving an 84 year old insured, RiverSource delayed denial of the insured's claim for home
2 health for approximately three months. In 1 instance involving a 75 year old insured suffering
3 from dementia, the insured inquired about three possible care facilities but RiverSource undertook
4 no investigation of the facilities and RiverSource did not schedule an assessment of the insured
5 for approximately five months. In 1 instance involving an 86 year old insured, RiverSource had
6 an assessment that the insured suffered from dementia and qualified for policy benefits, but it
7 required an additional dementia examination and it required submission of additional care plans
8 and evaluations. In 1 instance involving an 84 year old insured, RiverSource did not deny the
9 claim based on the Doctor/Nurse Factor and other of the 6 Factors until more than two months
10 after it knew that the care facility did not meet the factors. In 1 instance involving an 86 year old
11 insured suffering from Alzheimer's Disease, RiverSource provided confusing information as to
12 the dates for which coverage was provided, necessitating numerous inquiries, and resulting in a
13 follow up communication from RiverSource which exacerbated the confusion. Further, as to that
14 insured, RiverSource required a dementia assessment despite having received the Alzheimer's
15 diagnosis, contrary to the terms of the LTC Policy.

16 The foregoing constitutes 17 acts in violation of Insurance Code §§790.03(h)(3) and
17 10234.8.

18 3. Fair Claims Regulation §2695.7(d).

19 In 15 instances, RiverSource failed to diligently pursue a fair and objective investigation
20 and RiverSource failed to seek information that was not reasonably required for, or material to,
21 the resolution of claims under long term care policies. The specific instances of the foregoing
22 matters are set forth in the Market Conduct Examination reports, and they include the following.

23 In one instance involving a 72 year old insured suffering from Alzheimer's Disease,
24 RiverSource misrepresented whether it would review a claim for prior services and RiverSource
25 advised the insured that a plan of care would have to be established, even though RiverSource
26 knew of the Alzheimer's. In 1 instance involving an 81 year old insured, RiverSource required a
27 facility statement even though it had already determined that the facility qualified for coverage.
28 In another instance involving the same insured, RiverSource required the submission of medical

1 records that it already had and required another Attending Physician's Statement despite the fact
2 that RiverSource had already conducted an evaluation of the insured. In 1 instance, involving an
3 80 year old insured, RiverSource imposed numerous forms and processes on the insured and
4 failed to identify care facilities, after being advised that the insured needed care. In 1 instance
5 involving a 64 year old insured, RiverSource failed to pay on-going monthly claim expense
6 because it was waiting for a physician report regarding the patient, even though RiverSource had
7 recently conducted a health assessment of the insured. Further, in that instance, RiverSource
8 sought a new facility statement from the facility where the insured had continued to receive care.
9 In 1 instance involving an 83 year old insured suffering from dementia, RiverSource sought
10 repeated submission of forms, sought duplicate information, and placed its burden of obtaining
11 information on the insured. In 1 instance involving an 84 year old insured, RiverSource sought a
12 facility license, which it had already received two months earlier and which it could have readily
13 obtained through its own investigation. In 1 instance involving a 74 year old insured suffering
14 cognitive impairment, RiverSource required a physician's statement even though it had an
15 assessment of cognitive impairment, delaying its investigation of the claim by approximately
16 three months. In 1 instance involving a 75 year old insured suffering from dementia, RiverSource
17 periodically requested facility statements despite the diagnosis of cognitive impairment and
18 continuous care at the facility. In 1 instance involving an 86 year old insured suffering from
19 dementia, RiverSource sought care plans, evaluations, care notes and other materials despite
20 having an assessment that the insured qualified for coverage. In 2 instances involving an 84 year
21 old insured and a 79 year old insured, RiverSource placed its investigation obligation on the
22 insured to obtain information regarding the care facility, sought unnecessary medical information
23 and care facility information, and sought multiple claim forms. In 1 instance involving an 86 year
24 old insured, RiverSource failed to commence its investigation until all claims forms were
25 received, it required excessive processes to qualify for coverage, it imposed duplicative and
26 unnecessary requirements, and it placed its burden of investigation on the insured. In one
27 instance involving a 74 year old insured, RiverSource required the submission of a facility
28 statement even though it already had a copy of the facility's licenses, a "facility environment"

1 description, a physician's operative letter, a letter of medical necessity, and an assessment of the
2 insured's health. In 1 instance involving a 78 year old insured, RiverSource had already received
3 a facility statement from the care facility when it sent a "cognitive questionnaire" to the facility,
4 requiring the submission of information that was not specified in the LTC Policy.

5 The foregoing constitutes 15 acts in violation of Fair Claims Regulation §2695.7(d) and
6 Insurance Code §§790.03(h)(3), 790.03(h)(4), 790.03(h)(5) and 10234.8.

7 4. Fair Claims Regulation §2695.7(c)(1).

8 In 7 instances, RiverSource failed to provide notice to claimants of its need for additional
9 time to determine whether a claim should be accepted or rejected, and failed to advise the insured
10 of the reason for needing additional time or failed to advise the insured of additional information
11 that RiverSource needed to determine whether to accept or deny the claim. The foregoing
12 constitutes 7 acts in violation of Fair Claims Regulation §2695.7(c)(1) and Insurance Code
13 §§790.03(h)(5) and 10234.8.

14 5. Insurance Code §790.05(h)(5).

15 In 4 instances, RiverSource did not attempt in good faith to effectuate prompt, fair and
16 equitable settlements of claims in which liability had become reasonably clear. In 1 instance
17 involving an 81 year old insured, RiverSource denied a claim where the insured had obtained
18 Attending Physician Statements from her doctors that certified her need for placement in a care
19 facility, it failed to consider medical reports including reports as to her impairment in performing
20 ADL's, it delayed its claim review by placing its burden of investigation on the insured, and it
21 waited until all claim forms were returned to commence its investigation. In another instance
22 involving a second claim by the same insured, RiverSource required resubmission of claim forms
23 seeking information that it already had, it unnecessarily required a new health assessment, it
24 delayed approving the claim, and it failed to validate the dates for which coverage should be
25 provided. In 1 instance involving a 78 year old insured, RiverSource received medical records in
26 June 2007, did not seek a facility statement from a care facility until September 2007, failed to
27 actively pursue an investigation, and eventually determined that coverage would not be provided
28 due to Medicare duplication. In 1 instance involving a 78 year old insured, RiverSource received

1 a review of the care facility in which the insured was residing in November 2007, but it did not
2 reject the facility, based on the 6 Factors, until February 2008. The delayed rejection of the
3 facility resulted in, among other detriment, depriving the insured of counting 188 days toward
4 satisfying her deductible. The foregoing constitutes 4 acts in violation of Insurance Code
5 §§790.03(h)(5) and 10234.8.

6 6. Fair Claims Regulation §2695.7(g).

7 In 6 instances, RiverSource attempted to settle long term care claims by making
8 settlement offers that were unreasonably low. In 1 instance involving an 81 year old insured,
9 RiverSource underpaid a claim by \$900, in another instance for the same insured, RiverSource
10 failed to commence the waiver of premium period by approximately two months, resulting in an
11 underpayment of the claim by \$253.21. In 1 instance involving an 86 year old insured,
12 RiverSource failed to pay home health benefits for four days of coverage in the amount of \$100.
13 In 1 instance involving an 80 year old insured, RiverSource failed to apply the insured's stay in a
14 convalescent home to the waiver of premium period, causing an underpayment of \$1,950.00. In 1
15 instance involving an 83 year old insured who was cognitively impaired, RiverSource failed to
16 determine that the cognitive impairment had existed for approximately two years and it paid the
17 claim, after an appeal, from an unsupported starting date for the impairment. Based on the
18 Market Conduct Examination, RiverSource agreed to pay benefits for an additional two years in
19 the amount of \$44,245.85. In 1 instance, RiverSource underpaid a claim by entering an incorrect
20 claim date into its system. The foregoing constitutes 6 violations of Fair Claims Regulation
21 §2695.7(g) and Insurance Code §§790.03(h)(3), 790.03(h)(5) and 10234.8.

22 7. Fair Claims Regulation §2695.5(e)(2).

23 In 3 instances, RiverSource failed to advise insureds that were receiving long term care
24 coverage through Medicare as to other benefits that may have been available under their LTC
25 Policies. In 1 instance involving a 78 year old insured, RiverSource failed to assist the insured in
26 locating and qualifying a facility that met RiverSources's policy requirements. Further,
27 RiverSource denied the insured's claim on the basis of the ineligibility of the facility more than
28 six months after the insured entered the facility. In 1 instance involving a 79 year old insured,

1 RiverSource failed to assist the insured in locating and qualifying a facility and RiverSource
2 denied the insured's claim as to one facility seven months after the insured entered that facility
3 based on its failure to meet the 6 Factors. In 1 instance involving a 72 year old insured,
4 RiverSource failed to assist the insured in filing a claim for a supportive equipment benefit. The
5 foregoing constitutes 6 acts in violation of Fair Claims Regulation §2695.11(b) and Insurance
6 Code §§790.03(h), 790.03(h)(5) and 10234.8.

7 8. Fair Claims Regulation §2695.11(b).

8 In 4 instances, RiverSource failed to adequately provide an explanation of the benefits that
9 it accepted or denied under LTC Policies. In 1 instance involving an 86 year old insured,
10 RiverSources's explanation of benefits failed to identify the start and end dates for which payment
11 was made. In 1 instance involving a 74 year old insured, RiverSources's explanation of benefits
12 failed to identify the start and end dates of the policy elimination period, failed to state the daily
13 benefit amount and failed to state how the elimination period applied. In 1 instance involving an
14 80 year old insured, RiverSources's explanation of benefits failed to indicate the daily benefit
15 amount. In 1 instance involving a 78 year old insured, RiverSources's explanation of benefits
16 failed to show the daily benefit amount, the number of days paid, and the specific dates of
17 payment. The foregoing constitutes 4 acts in violation of Fair Claims Regulation §2695.11(b)
18 and constitute 4 acts in violation of Insurance Code §§790.03(h) (5), 790.03(h)(13) and 10234.8.

19 9. Fair Claims Regulation §2695.7(b)(3).

20 In 4 instances, RiverSource failed to provide the insured with written notice that if he or
21 she believed that all or part of a claim has been wrongfully denied or rejected, he or she could
22 have the matter reviewed by the CDI. The foregoing constitutes 4 acts in violation of Fair Claims
23 Regulation §2695.7(b)(3) and Insurance Code §§790.03(h)(3) and 10234.8.

24 10. Fair Claims Regulation §2695.7(h).

25 In 3 instances, RiverSource failed to tender payment within 30 calendar days of
26 acceptance of a claim in whole or in part. In 1 instance, RiverSource did not pay the claim for
27 approximately 2 months after the 30 day period. In 2 instances, RiverSource did not pay the
28 claim for one month after the 30 day period. The foregoing constitutes 3 acts in violation of Fair

1 Claims Regulation §2695.7(h) and Insurance Code §§790.03(h)(3) and 10234.8.

2 11. Fair Claims Regulation §2695.5(e)(3).

3 In 3 instances, RiverSource failed to commence an investigation within 15 calendar days.

4 In 1 instance involving an 87 year old insured, RiverSource was aware that the insured was
5 transferring to a care facility from a rehabilitation facility, but it failed to investigate whether the
6 stay in the rehabilitation facility was covered by the LTC Policy. In 1 instance involving an 86
7 year old insured, RiverSource failed to begin an investigation within 15 days, failed to seek an
8 assessment of the insured in a timely manner, and failed to conduct an investigation until claim
9 forms were received. In 1 instance involving a 92 year old insured, RiverSource was advised of
10 the claim, but its only action within 15 calendar days was to mail claim forms to the insured.

11 RiverSource did not schedule a health assessment for more than two months and did not
12 otherwise take timely, reasonable actions to investigate. The foregoing constitute 3 acts in
13 violation of Fair Claims Regulation §2695.5(e)(3) and Insurance Code §§790.03(h)(3) and
14 10234.8.

15 12. Insurance Code §790.03(h)(1).

16 In 1 instance, RiverSource misrepresented the licensing requirements for home health care
17 providers and in 1 instance involving an 86 year old insured, RiverSource misrepresented that
18 benefits were not payable when the policy in fact included "bed reservation benefits." The
19 foregoing constitute 2 acts in violation of Insurance Code §§790.03(h)(1) and 10234.8.

20 13. Fair Claims Regulation §2695.5(b).

21 In 1 instance involving a 78 year old insured, RiverSource failed to respond to the
22 insured's inquiry within 15 calendar days in circumstances where the communication reasonably
23 suggested that a response was expected. RiverSource failed to respond for approximately 4
24 months. The foregoing constitutes 1 act in violation of Fair Claims Regulation §2695.5(b) and
25 Insurance Code §§790.03(h)(2) and 10234.8.

26 14. Fair Claims Regulation §2695.7(b)(1) and Insurance Code §10235.9(b).

27 In 3 instances, RiverSource failed to provide a written denial letter to its insureds within
28 forty days. The foregoing constitutes 3 violations of Fair Claims Regulation §2695.7(b)(1) and

1 Insurance Code §§790.03(h)(3), 790.03(h)(13), 10234.8 and 10235.9(b)

2 15. Insurance Code §10235.97.

3 In 3 instances, RiverSource determined the insured's qualification for benefits by using an
4 endorsement that was not part of the LTC Policy and which based coverage on the insured's
5 inability to perform three ADL's. As a result of the Market Conduct Examination, RiverSource
6 advised the Commissioner that the endorsement and three ADL standard was applied 94 times
7 during the Review Period to policies that do not have the endorsement. The foregoing constitute
8 94 acts in violation of Insurance Code §§790.03(h)(5) and 10235.97.

9 16. Insurance Code §10237.1.

10 In 1 instance, RiverSource failed to offer that the insured that could purchase an inflation
11 protection feature as provided for by Insurance Code §10237.1. The matter constitutes 1 act in
12 violation of Insurance Code §§790.03(h)(3) and 10237.1.

13 V

14 **MARKET CONDUCT EXAMINATION - LIFE INSURANCE POLICIES**

15 As set forth in Article II, the Market Conduct Examination determined that RiverSources's
16 claims handling practices and procedures violated provisions of Insurance Code sections 790.03,
17 and 10172.5(c) and the Fair Claims Regulations. The Market Conduct Examination indicates that
18 RiverSource engaged in a pattern and practice of violating the foregoing Insurance Code sections
19 and regulations and it violated its duties of honesty, good faith and fair dealing. The Market
20 Conduct Examination reports identified the following violations.

21 A. Fair Claims Regulation §2695.11(b).

22 In 7 instances concerning payment of death benefits, RiverSource did not provide an
23 adequate explanation of the death benefit option that was used to calculate the benefit and
24 RiverSource did not explain the calculation of its payment. In 1 of these instances, RiverSource
25 returned excess premium as part of the death benefit, failing to properly identify the nature of the
26 payment. The foregoing constitutes acts in 7 acts in violation of Fair Claims Regulation
27 §2695.11(b) and Insurance Code §790.03(h)(3).

28 ///

1 B. Fair Claims Regulation §2695.5(e)(1) and §2695.7(b)(3).

2 In 1 instance, RiverSource failed to acknowledge notice of receipt of a claim within 15
3 days and in 1 instance, RiverSource failed to advise the claimant that if he or she believed that the
4 claim had been wrongfully denied or rejected, he or she could have the matter reviewed by the
5 CDI. The foregoing constitutes 1 act in violation of Fair Claims Regulation §2695.5(e)(1), 1 act
6 in violation of Fair Claims Regulation §2695.7(b)(3) and 2 acts in violation of Insurance Code
7 §§790.03(h)(2).

8 C. Insurance Code §10172.5(c).

9 In 3 instances, RiverSource failed to advise beneficiaries of the interest rate that it paid on
10 death claims. The foregoing constitutes 3 acts in violation of Insurance Code §§790.03(h)(3) and
11 10172.5(c).

12 D. Insurance Code §790.03(h)(3).

13 In 2 instances, RiverSource failed to apply waiver of premium provisions for insureds
14 who were receiving benefits under disability policies. The foregoing constitutes 2 acts in
15 violation of Insurance Code §790.03(h)(3).

16 VI

17 **MARKET CONDUCT EXAMINATION - DISABILITY INCOME**

18 As set forth in Article II, the Market Conduct Examination determined that RiverSource's
19 claims handling practices and procedures violated provisions of Insurance Code sections 790.03,
20 10111.2(a), and 10111.2(c) and the Fair Claims Regulations. The Market Conduct Examination
21 indicates that RiverSource engaged in a pattern and practice of violating the foregoing Insurance
22 Code sections and regulations and it violated its duties of honesty, good faith and fair dealing.
23 The Market Conduct Examination reports identified the following violations.

24 A. Fair Claims Regulation §2695.7(b)(3).

25 In 3 instances, RiverSource failed to advise the claimant that if he or she believed that the
26 claim had been wrongfully denied or rejected, he or she could have the matter reviewed by the
27 CDI. The foregoing constitutes 3 acts in violation of Regulation §2695.7(b)(3) and Insurance
28 Code §790.03(h)(3).

1 B. Fair Claims Regulation §2695.4(a).

2 In 2 instances, RiverSource failed to advise its insured under a disability policy of all
3 benefits available under the policy. In 1 of these matters, the insured became 85% blind,
4 qualified for benefits under a disability income policy titled "Business Expense Protection Plan"
5 and qualified as having a "Presumptive Total Disability" under the terms of that policy.
6 RiverSource failed to advise the insured that blindness qualified as presumptively disabled. In 1
7 of these instances, RiverSource notified the insured that a benefit period was expiring but failed
8 to correctly advise the insured of policy provisions as to "total disability" which could provide an
9 additional benefit period. The foregoing constitutes 2 acts in violation of Regulation §2695.4(a),
10 Insurance Code §§790.03(h)(3) and 790.03(h)(5).

11 C. Insurance Code §790.03(h)(5).

12 In 2 instances, RiverSource refused to reimburse its insureds for the expense incurred in
13 obtaining Attending Physician's Reports that RiverSource required. RiverSource is required to
14 pay for the reasonable costs of investigating claims under its policies, including the costs of
15 obtaining forms that it requires to process and evaluate claims. The foregoing constitutes 2 acts
16 in violation of Insurance Code §790.03(h)(5).

17 D. Insurance Code §790.03(h)(3).

18 In 1 instance, RiverSource determined that disability benefits under its policy would cease
19 because the insured was able to perform his customary occupation, or other occupation, without
20 investigating whether it had sufficient grounds to make that determination. The foregoing
21 constitutes 1 act in violation of Insurance Code §790.03(h)(3).

22 E. Regulation §§2695.7(c)(1), 2695.7(d) and 2695.7(g).

23 In 1 instance, RiverSource failed to provide written notice to its insured every 30 days,
24 over a period of approximately 68 days, of the reasons for its inability to make a determination on
25 the claim. In 1 instance, RiverSource paid disability benefits at an incorrect rate and as a result of
26 the Market Conduct Examination, paid the insured an additional \$567.71. In 1 instance,
27 RiverSource requested that the insured provide a further statement from his physician attesting, in
28 essence, that he was still blind. The foregoing constitutes 3 acts in violation of, respectively,

1 Regulation §§ 2695.7(c)(1), 2695.7(g) and 2695.7(d) and 3 acts in violation of Insurance Code
2 §§790.03(h)(3) and 790.03(h)(5).

3 F. Insurance Code §790.03(h)(1).

4 In 1 instance, RiverSource incorrectly advised its insured of the date on which the insured
5 would satisfy the elimination period in the disability policy. The foregoing constitutes 1 act in
6 violation of Insurance Code §790.03(h)(1).

7 G. Insurance Code §§10111.2(a) and 10111.2(c).

8 In 1 instance, RiverSource failed to pay disability income under its policy for over two
9 months although it had all information needed to determine liability for the claim. RiverSource
10 made the payment after the insured made an inquiry, but it failed to pay interest on the claim.
11 The foregoing constitutes 1 act in violation of Insurance Code §§790.03(h)(5), 10111.2(a) and
12 Insurance Code §10111.2(c.)

13 **VII**

14 **ACCUSATION - STATEMENT OF GENERAL CHARGES**

15 A. The practices, acts and violations determined in the Market Conduct Examination, as
16 stated in the reports thereof and as set summarized in Articles IV through VI above, and the
17 pattern and frequency of such practices, acts and violations, indicate that RiverSource knowingly
18 committed and performed such matters with such frequency as to indicate general business
19 practices of unfair claims settlement practices and violation of its duty of good faith and fair
20 dealing, and its duties of honesty, good faith and fair dealing as to long term care insurance.

21 B. The matters set forth in Paragraph A above and in Articles IV through VI indicate that
22 RiverSource failed to comply with the requirements of Insurance Code §700 as to complying with
23 the provisions of the Insurance Code, §717(e) as to the competency, character and integrity of
24 management, and §717(g) as to whether claims are promptly and fairly adjusted and are promptly
25 and fully paid in accordance with the law and the terms of the policies.

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1 VIII

2 ORDER TO SHOW CAUSE

3 WHEREAS, the CDI has reason to believe that RiverSource engaged in or is engaging in
4 the unfair or deceptive acts or practices and other unfair or unlawful acts set forth in Articles IV
5 through VI (collectively, "Acts"); and

6 WHEREAS, the CDI has reason to believe that a proceeding with respect to
7 RiverSources's Acts is in the public interest;

8 NOW, THEREFORE, pursuant to Insurance Code §§790.05 and 10234.4, RiverSource is
9 ordered to appear before the Commissioner, as set forth in Article XII below, and show cause
10 why the Commissioner should not issue an order requiring RiverSource to:

11 A. Cease and desist from engaging in the methods, acts, and practices set forth in Articles
12 IV through VI hereof that are in violation of Insurance Code §790.03 and the Fair Claims
13 Regulations;

14 B. Take all actions necessary to comply with the requirements of Insurance Code
15 §10234.8; and

16 C. Cease marketing long term care insurance in California.

17 IX

18 SUSPENSION OF CERTIFICATE OF AUTHORITY

19 A. Based on the matters set forth in Articles IV through VI, the CDI alleges that
20 RiverSource has not carried out its contracts in good faith and has habitually and as a matter of
21 ordinary practice and custom compelled claimants under policies to accept less than the amounts
22 due under the terms of the policies and pursuant to Insurance Code §704, its Certificate of
23 Authority should be suspended for a period not exceeding one year.

24 B. Based on the matters set forth in Articles IV through VI, the CDI alleges that
25 RiverSource has violated the provisions of Division 2, Part 2, Chapter 2.6 of the Insurance Code
26 (hereafter, Chapter 2.6) and pursuant to Insurance Code §10234.4(b), its Certificate of Authority
27 to transact disability insurance should be suspended.

28 C. An order of suspension of RiverSources's Certificate of Authority shall provide for

1 protection of RiverSources's current policyholders.

2 X

3 **REVOCATION OF CERTIFICATE OF AUTHORITY**

4 A. Based on the matters set forth in Articles IV through VI, the CDI alleges that
5 RiverSource has failed, and continues to fail, to comply with the requirements as to its business
6 set forth in the Insurance Code and in other laws of the State of California as required by
7 Insurance Code §700(c). RiverSource has failed to comply with the requirements of Insurance
8 Code §§700, 717, 790.03, 10111.2, 10172.5, 10232.97, 10234.8, 10235.9, and 10237.1 and the
9 Fair Claims Regulations and accordingly, RiverSources's Certificate of Authority should be
10 revoked.

11 B. An order of revocation of RiverSources's Certificate of Authority shall provide for
12 protection of RiverSources's current policyholders.

13 XI

14 **NOTICE OF PENALTIES**

15 The CDI seeks the imposition of penalties as follows:

16 1. Pursuant to Insurance Code §790.035, for unfair acts or deceptive acts or practices as
17 set forth in Articles IV through VI, and as reasonably and reliably extrapolated to the policies and
18 claims during the Review Period (without duplication), a penalty in an amount to be fixed by the
19 Commissioner not to exceed \$10,000 for each unfair or deceptive act or practice found to be
20 willful, and a penalty in an amount to be fixed by the Commissioner not to exceed \$5,000 for
21 each unfair or deceptive act or practice found not to be willful.

22 2. Pursuant to Insurance Code §§10234.2 and 10234.3(b), for unfair acts or deceptive acts
23 or practices and for violations of Chapter 2.6 as set forth in Article IV, and as reasonably and
24 reliably extrapolated to the policies and claims during the Review Period (without duplication),
25 penalties in an amount not less than \$5,000 for each first violation, penalties in an amount not less
26 than \$10,000 for each subsequent or knowing violation, and penalties in an amount of not less
27 than \$10,000 and not more than \$500,000 for each general business practice set forth in Article
28 IV, Paragraphs 1 through 10.

1 3. As to the matters set forth herein pertaining to long term care insurance, RiverSource
2 may elect to accept the penalties determined by the Commissioner, respond to the charges set
3 forth herein in writing, or request a hearing within 10 days of receipt hereof.

4 XII

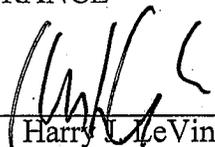
5 NOTICE OF HEARING

6 Pursuant to California Insurance Code §§700, 704, 790.05 and 10234.5, RiverSource is
7 ordered to appear before the Commissioner on a date and time to be set by the Office of
8 Administrative Hearings located at 1515 Clay Street, Suite 206, Oakland, California 94612 and
9 show cause why the Commissioner should not issue the orders set forth in Article VIII and a
10 hearing shall be held as to the suspension of RiverSources's Certificate of Authority as set forth in
11 Article IX, the revocation of RiverSources's Certificate of Authority as set forth in Article X, and
12 the penalties to be imposed on RiverSource as set forth in Article XI.

13 Date: September 21, 2011

CALIFORNIA DEPARTMENT OF
INSURANCE

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16 By



Harry Levine
Senior Staff Counsel