BEFORE THE
DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA



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| In the Matter of the Accusation Against:<br><br>Universal Care, Inc.,<br><br>Respondent. | No. 07-358<br><br>OAH No. 2010090785 |

## DECISION

The attached Proposed Decision of the Administrative Law Judge of the Office of Administrative Hearings, dated July 11, 2011, is hereby adopted by the Department of Managed Health Care as its Decision in the above-entitled manner with the following technical and minor changes pursuant to Government Code Section 11517(c)(2)(C).

1. On page 2, paragraph 1, change the word "Medi-Care" to "Medicare."

2. On page 2, paragraph 2, revise the second sentence to read: "In her confidential report dated June 20, 1997, Ms. Larsen noted "substantial delays in payment of claims of up to 305 working days after receipt of the claim [includes Point-of-Service claims]."

3. On page 2, paragraph 4, in the second sentence, change the word "reports" to "exams."

4. On pages 2-3, paragraph 4, strike the entire third and fourth sentences.

5. On page 3, paragraph 6, change the word "ensure" to "insure [sic]" in the first sentence and add "[sic]" behind the word "insure" in that same sentence.

6. On page 3, paragraph 7, strike "in that respondent was required to implement corrective actions to remediate interest payments in claims during the April 2004 examination" from the last sentence and add "from the April 2004 examination" following the phrase "repeat deficiency."

7. On page 4, paragraph 9, strike "in that respondent was required to implement corrective actions to remediate interest payments on claims during the September 2004 exam" from the last sentence and add "from the April 2004 examination" following the phrase "repeat deficiency."

8. On page 4, paragraph 11, revise the second sentence to read: "In UC's Response to the DMHC's Final Report, submitted August 25, 2008, UC identified 5,911 late claims that did not include interest and penalties."

9. On page 4, paragraph 11, revise the last sentence to read: "The final spreadsheets and final remediation reports were completed by respondent in August 2008 and filed with the DMHC prior to its August 25, 2008 Response to the DMHC's Final Report."

10. On page 4, footnote 3, change "DMHC's" to "UC's"

11. On page 4, footnote 4, change "DMHC's" to "UC's."

12. On page 5, paragraph 14, in the first sentence insert the word "the" between the words "for" and "DMHC."

13. On pages 6-7, paragraph 3, strike the following:

    "(2) Failure of a plan to comply with the requirements of sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections combination deemed advisable by the Director to enforce the provisions of this regulation"

    and replace it with the following:

    "(2) Failure of a plan to comply with the requirements of sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections 1300.71, 1300.71.38, 1300.71.4, and 1300.77.4 of title 28 may constitute a basis for disciplinary action against the plan. The civil, criminal, and administrative remedies available to the Director under the Health and Safety Code and this regulation are not exclusive, and may be sought and employed in any combination deemed advisable by the Director to enforce the provisions of this regulation."

14. On page 8, paragraph 8, strike the following:

    "(c) An "unfair payment pattern," as used in this section, means any of the following:

    (1) Engaging in a demonstrable and unjust pattern, as defined by the department, of reviewing or processing complete and accurate claims that results in payment delays."

15. On page 9, paragraph 10, in the first sentence, change the word "September" to "April."

16. On page 9, paragraph 10, in the first sentence, insert the phrase "late-paid" between the words "uncontested" and "claims."

17. On page 10, paragraph 12, in the first sentence, change the word "Assessing" to "Applying."

18. On pages 10-11, paragraph 12, in the last sentence, change the word "department" to "DMHC."

19. On page 11, paragraph 1 of the Order, change the "Department of Managed Health Care" to "DMHC."

This Decision shall become effective immediately.

Pursuant to Government Code section 11521(a), the Department of Managed Health Care's power to order reconsideration of this Decision expires thirty (30) days after service of the Decision or the effective date of the Decision, whichever occurs earlier.

IT IS SO ORDERED.

By _____
Brent Barnhart
Director
Department of Managed Health Care

Dated: 10/13/11

BEFORE THE
DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA



| | |
|---|---|
| In the Matter of the Accusation Against:<br><br>UNIVERSAL CARE, INC.,<br><br>Health Care Service Plan<br>License Number 933 0209<br><br>Respondent. | Enforcement Matter No. 07-358<br><br>OAH No. 2010090785 |

**PROPOSED DECISION**

This matter was heard before Rebecca M. Westmore, Administrative Law Judge, Office of Administrative Hearings, State of California, on May 16, and May 17, 2011, in Sacramento, California.

Drew Brereton, Senior Counsel, represented Michael D. McClelland, Assistant Deputy Director of the Office of Enforcement for the Department of Managed Health Care (DMHC).

Curtis S. Leavitt, Attorney at Law, represented respondent, Universal Care, Inc. (UC), by and through its Chief Executive Officer (CEO), Jeffrey V. Davis.

Evidence was received, and the record remained open to permit the parties to submit closing briefs. On June 6, 2011, the parties simultaneously submitted closing briefs, and on June 24, 2011, complainant submitted a rebuttal to respondent's closing brief. The record was closed, and the matter was submitted for decision on June 24, 2011.

ISSUES

1. Did respondent fail to timely pay interest and penalties on late-paid claims and health care provider disputes?

2. Did respondent engage in an unfair payment pattern?

3. Is a $100,000 penalty appropriate to ensure respondent's future compliance with the Knox-Keene Act's interest and penalty provisions?

## FACTUAL FINDINGS

1. Universal Care has been licensed as a for-profit health care service plan[1] under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) since October 15, 1985. UC is a mixed-model HMO which manages health care services for 16,000 members who are predominantly Medi-Care and Medi-Cal beneficiaries. In California, the DMHC is the agency charged with regulating and ensuring compliance with this state program.[2]

*Prior Routine Examinations of Universal Care*

2. In or about September 1996, the DMHC conducted a routine examination of UC and issued a report identifying 12 areas of deficiencies, including the failure to comply with claim payment requirements. In her confidential report dated June 20, 1997, Ms. Larsen noted "substantial delays in payment of claims of up to 305 working days after receipt of the claim. This is a repeat deficiency from our prior examination dated November 24, 1992." In addition, Ms. Larsen noted "[o]ur examination also disclosed that the Plan was not paying interest for the claims paid in excess of 45 working days."

3. In or about March 2002, the DMHC conducted a routine examination of UC and issued a report identifying four areas of deficiencies, including the failure to comply with claim payment requirements for emergency and non-emergency services, and the failure to "calculate and pay interest on payments made after the statutory 45 working day requirement." In her report dated September 13, 2002, Ms. Larsen identified 4,874 claims for non-emergency services which were paid beyond the 45 working day requirement between July 1, 2000 and August 31, 2001, and did not include the requisite interest and penalty payments. In addition, there were 4,773 claims for emergency services that were paid beyond the 45 working day requirement, and did not include the requisite interest. Ms. Larsen deemed these to be repeat deficiencies from the DMHC's September 1996 confidential report. According to Ms. Larsen, in 2002 the DMHC did not require health care service plans to remediate claims.

4. In or about April 2004, the DMHC conducted a routine examination of UC and issued a report identifying six areas of deficiencies, including the failure to timely pay claims for emergency and non-emergency services, and the failure to automatically include interest on those late-paid claims. In her final report dated September 16, 2004, Ms. Larsen deemed these to be repeat deficiencies from the DMHC's September 1996 and March 2002 reports. As part of its corrective action plan, respondent submitted spreadsheets to the DMHC identifying 14,584 claims that were not timely paid, and in which interest was paid in

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[1] Health Care Service Plans are commonly referred to as Health Maintenance Organizations (HMOs).

[2] The Knox-Keene Act became effective in 1975, and was originally administered by the California Department of Corporations. On July 1, 2000, the Health Care Service Plan Division was placed under the charge of the DMHC.

interest on those late-paid claims. In her final report dated September 16, 2004, Ms. Larsen deemed these to be repeat deficiencies from the DMHC's September 1996 and March 2002 reports. As part of its corrective action plan, respondent submitted spreadsheets to the DMHC identifying 14,584 claims that were not timely paid, and in which interest was paid in the amount of $288,632.18 and penalties were paid in the amount of $145,440, for a total of $434,072.18. According to Ms. Larsen, in 2004 the DMHC required health care service plans to remediate claims, and respondent remediated these claims in good faith.

*Routine Examination of Universal Care – September 2007*

5. In or about September 2007, the DMHC's Division of Financial Oversight (DFO) conducted a routine examination of respondent's finances. The DFO is responsible for monitoring and evaluating the financial soundness of and statutory and regulatory compliance by health care service plans; reviewing financial statements filed by licensees; reviewing filings; performing financial examinations of books and records; reviewing compliance issues; and reviewing claim payments and provider dispute resolutions. Joan Larsen is a certified public accountant, who serves as a supervising examiner for the DMHC. She testified at hearing as an expert for the DMHC. Her duties include overseeing financial examinations; overseeing the team of examiners; reviewing the financial viability of health care service plans; and reviewing compliance issues. Ms. Larsen has performed 112 routine examinations and 16 non-routine focused examinations.

6. According to Ms. Larsen, "it's very important to ... ensure that the providers are ... paid timely for their services, to insure that the providers are willing to stay in the plan's network for the provision of services to the enrollees." To that end, the Knox-Keene Act requires health care service plans to reimburse uncontested claims within 45 working days from receipt of the claim. Health care service plans which fail to do so must automatically include in the claim payment interest at the rate of 15 percent beginning from the 46th working day, plus a $10 penalty fee.

7. During the September 2007 examination, Ms. Larsen and her team of auditors randomly selected 20 late-paid claims and determined that 10 of the claims (50 percent) were not paid with interest at all or interest was underpaid. In her Final Report, Ms. Larsen deemed UC's failure to automatically pay interest and penalties on late-paid claims in 2007 as a repeat deficiency, in that respondent was required to implement corrective actions to remediate interest payments on claims during the April 2004 examination.

8. In its response to the DMHC, UC's CEO, Jeffrey V. Davis, asserted that the software for UC's interest calculator was inadvertently programmed to exclude holidays from the number of days used to calculate interest payments, but that the program has since been corrected to include holidays. The interest calculator was corrected on October 18, 2007.

9. DFO's team of auditors also randomly selected 25 provider disputes and determined that in two of the disputes (eight percent), UC had not paid interest at all or interest was underpaid. According to Ms. Larsen, this deficiency resulted from respondent's incorrect use of the date of receipt of the dispute, as opposed to the date of receipt of the original claim, to determine the timeliness of the claim payment. In her Final Report, Ms. Larsen deemed UC's failure to pay interest as a repeat deficiency, in that respondent was required to implement corrective actions to remediate interest payments on claims during the September 2004 examination.

10. In its response to the DMHC, Mr. Davis asserted that the software for UC's interest calculator was inadvertently programmed to use the date of the dispute, as opposed to the date of the original claim, to determine the timeliness of the claim payment. The interest calculator was corrected on October 18, 2007.

11. Based on these findings, respondent proposed in its corrective action plan to, inter alia, produce a report identifying all late claims in which interest was incorrectly paid from September 1, 2004 through October 18, 2007. In its report, UC identified 5,911 late claims that did not include interest and penalties. Interest owed amounted to $50,732, and penalties owed amounted to $59,110, for a total of $109,842.[3] UC also identified 239 provider disputes that did not include interest and penalties. Interest owed amounted to $10,851, and penalties owed amounted to $2,390, for a total of $13,241.[4] The final spreadsheets and final remediation reports were completed by respondent in August 2008.

12. At hearing, Ms. Larsen admitted that respondent was cooperative throughout the examination and forthcoming during the remediation process. She could not opine whether or not respondent's claims payment deficiencies were intentional or willful, but admitted that if she believed the claims payment deficiencies in 2007 were intentional or willful, she would have included that information in her final report.

*Respondent's Defenses*

13. At hearing, Mr. Davis admitted that of the 1.3 million claims paid by UC during the DMHC's September 2007 audit, 13,467 claims were paid more than 45 working days from the date of receipt by UC. Of those 13,467 late-paid claims, UC failed to pay the correct amount of interest or pay interest at all on 5,912 claims. Mr. Davis also admitted that UC failed to correctly pay interest on 239 provider disputes. Mr. Davis pointed out however, that UC timely and correctly paid 7,555 claims, and confirmed that UC's interest calculator has since been fixed. According to Mr. Davis, UC underpaid an average of $8.58 in interest.

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[3] The DMHC's final remediation report identified 5,912 late claims, with interest owed in the amount of $50,731 and penalties owed in the amount of $59,120, for a total of $109,851.

[4] The DMHC's final remediation report agreed with respondent's assessment of the number of incorrectly paid provider disputes, and the resulting amounts due for interest and penalties.

14. Respondent contends that because UC remediated all of the underpaid interest and penalty payments prior to the DMHC's filing of the Accusation, they were in full compliance with the Knox-Keene Act, and there were no violations for DMHC to charge. However, as set forth in Legal Conclusion 3, California Code of Regulations, title 28, section 1300.71, subdivision (s)(3), specifically provides the DMHC with authority to bring an enforcement action against a health care service plan whether or not the violations have been remediated. Therefore, respondent's argument is without merit.

15. Finally, respondent contends that in order for the DMHC to maintain a cause of action for an "unfair payment pattern," it must first prove that UC's conduct was a "demonstrable and unjust pattern." Respondent's argument is without merit. As set forth in Legal Conclusion 8, Health and Safety Code section 1371.37, subdivision (c), identifies four separate and distinct definitions of "unfair payment pattern." Two of the definitions do require a showing of a "demonstrable and unjust pattern" (subdivisions (c)(1) and (c)(2)); however, one involves the repeated failure to pay claims within the requisite timeframes (subdivision (c)(3)), and the other involves the repeated failure to automatically include interest on late-paid claims (subdivision (c)(4).). The DMHC has alleged an unfair payment pattern based on Health and Safety Code section 1371.37, subdivisions (c)(3) and (c)(4), and therefore is not required to demonstrate that UC's failures to pay claims within the requisite timeframes or to automatically include interest on late-paid claims also constituted a "demonstrable and unjust pattern."

*Proposed Penalty Assessment*

16. The DMHC has proposed a $100,000 penalty against UC to deter similar violations in the future. According to Ms. Larsen, the DMHC has never assessed an administrative penalty against UC in spite of the repeat deficiencies identified in prior routine examinations. Ms. Larsen reviewed respondent's June 2010 through March 2011 financial statements to determine respondent's financial viability, including its financial trends, cash position, working capital, cash flows, net income, footnote disclosures, and increasing enrollment, premiums and medical costs, and determined that respondent's tangible net equity as of March 31, 2011 was "roughly $2.1 million," which is "about $1.1 million in excess of the required amount" for financial viability. Based on her review, Ms. Larsen opined that respondent "will be able to pay the fine" in four quarterly payments beginning at the end of the second quarter of 2011 and continuing through the end of the first quarter of 2012, and she is confident that payment of the penalty in four quarterly installments will not have a negative impact on the health care service plan, and will not impair the health care service plan's ability to pay its enrollees. Ms. Larsen admitted, however, that a lump sum payment of $100,000 would jeopardize UC's financial status.

17. At hearing, Mr. Davis described UC as a "very small" health care service plan, with $5 million in assets, and monthly revenues of $3 million. Respondent submitted financial statements from June 2008, June 2009, and June 2010 showing net losses to the company. Mr. Davis denied any willful conduct on the part of UC. He disputed the DMHC's characterization of UC's September 2007 deficiencies as repeat deficiencies from prior examinations, and contended that the prior examinations either involved distinctly

different deficiencies, or involved findings which UC disagreed with, and therefore should not be considered in assessing the penalty. Mr. Davis believes that the September 2007 deficiencies resulted from an "isolated event" involving an improperly programmed interest calculator, and that no additional corrective action is necessary to avoid reoccurrence of these deficiencies in the future. Mr. Davis believes that the proposed fine is excessive, and asserted that "we think a fine of five or ten thousand dollars would have made the same point ...."

## LEGAL CONCLUSIONS

*Applicable Statutes and Regulations*

1. In license disciplinary proceedings, the burden of proof is on complainant to show that grounds exist to discipline the license. In the absence of any law to the contrary, the required standard of proof is a preponderance of the evidence. (Evidence Code section 115. See also, *Martin v. Alcohol Beverage Control Appeals Bd.* (1959) 52 Cal.2d 265.)

2. Health and Safety Code section 1386 provides, in pertinent part, that:

> (a) The director may, after appropriate notice and opportunity for a hearing, by order suspend or revoke any license issued under this chapter to a health care service plan or assess administrative penalties if the director determines that the licensee has committed any of the acts or omissions constituting grounds for disciplinary action.
>
> (b) The following acts or omissions constitute grounds for disciplinary action by the director:
>
> [¶] ... [¶]
>
> (6) The plan has violated or attempted to violate, or conspired to violate, directly or indirectly, or assisted in or abetted a violation or conspiracy to violate any provision of this chapter, any rule or regulation adopted by the director pursuant to this chapter, or any order issued by the director pursuant to this chapter.

3. California Code of Regulations, title 28, section 1300.71, subdivision (s), provides, in pertinent part, that:

> [¶] ... [¶]
>
> (2) Failure of a plan to comply with the requirements of sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4, and 1371.8 of the Health and Safety Code and sections

combination deemed advisable by the Director to enforce the provisions of this regulation.

(3) Violations of the Health and Safety Code and this regulation are subject to enforcement action whether or not remediated, although a plan's identification and self-initiated remediation of deficiencies may be considered in determining the appropriate penalty.

[¶] ... [¶]

*Cause for Discipline – Failure to Automatically Pay Interest and Penalties on Claims*

4. Health and Safety Code section 1371 provides, in pertinent part, that:

A health care service plan ... shall reimburse claims ... as soon as practicable, but no later than 30 working days after receipt of the claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the claim by the health care service plan .... If an uncontested claim is not reimbursed by delivery to the claimants' address of record within the respective 30 or 45 working days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 30- or 45-working-day period. A health care service plan shall automatically include in its payment of the claim all interest that has accrued pursuant to this section without requiring the claimant to submit a request for the interest amount. Any plan failing to comply with this requirement shall pay the claimant a ten dollar ($10) fee.

5. Health and Safety Code section 1371.35 provides, in pertinent part, that:

(a) A health care service plan ... shall reimburse each complete claim ... as soon as practical, but no later than 30 working days after receipt of the complete claim by the health care service plan, or if the health care service plan is a health maintenance organization, 45 working days after receipt of the complete claim by the health care service plan ....

(b) If a complete claim, or portion thereof, that is neither contested nor denied, is not reimbursed by delivery to the claimant's address of record within the respective 30 or 45 working days after receipt, the plan shall pay the greater of fifteen dollars ($15) per year or interest at the rate of 15 percent per annum beginning with the first calendar day after the 30- or

45-working-day period. A health care service plan shall automatically include the fifteen dollars ($15) per year or interest due in the payment made to the claimant, without requiring a request therefor.

[¶] ... [¶]

6. California Code of Regulations, Title 28, section 1300.71.38, subdivision (g), defines "past due payments" as follows:

> If the provider dispute or amended provider dispute involves a claim and is determined in whole or in part in favor of the provider, the plan or the plan's capitated provider shall pay any outstanding monies determined to be due, and all interest and penalties required under sections 1371 and 1371.35 of the Health and Safety Code and section 1300.71 of title 28, within five (5) working days of the issuance of the Written Determination. Accrual of interest and penalties for the payment of these resolved provider disputes shall commence on the day following the expiration of "Time for Reimbursement" as forth in section 1300.71(g).

7. As set forth in Factual Findings 7 through 11, and 13, respondent admitted that UC failed to automatically include interest and penalties on 5,912 late-paid claims and 239 provider disputes. Therefore, cause exists to discipline respondent's license pursuant to Health and Safety Code sections 1386, subdivisions (a) and (b)(6), 1371, and 1371.35, subdivisions (a) and (b), in conjunction with California Code of Regulations, title 28, sections 1300.71, subdivisions (s)(2) and (s)(3), and 1300.71.38, subdivision (g).

*Cause for Discipline – Unfair Payment Pattern*

8. Health and Safety Code section 1371.37 provides, in pertinent part, that:

> (a) A health care service plan is prohibited from engaging in an unfair payment pattern, as defined in this section.
>
> [¶] ... [¶]
>
> (c) An "unfair payment pattern," as used in this section, means any of the following:
>
> (1) Engaging in a demonstrable and unjust pattern, as defined by the department, of reviewing or processing complete and accurate claims that results in payment delays.

(c) An "unfair payment pattern," as used in this section, means any of the following:

(1) Engaging in a demonstrable and unjust pattern, as defined by the department, of reviewing or processing complete and accurate claims that results in payment delays.

(2) Engaging in a demonstrable and unjust pattern, as defined by the department, of reducing the amount of payment or denying complete and accurate claims.

(3) Failing on a repeated basis to pay the uncontested portions of a claim within the timeframes specified in Section 1371, 1371.1, or 1371.35.

(4) Failing on a repeated basis to automatically include the interest due on claims pursuant to Section 1371.

(d)(1) Upon a final determination by the director that a health care service plan has engaged in an unfair payment pattern, the director may:

(A) Impose monetary penalties as permitted under this chapter.

[ ¶ ] ... [ ¶ ]

9. California Code of Regulations, Title 28, section 1300.71, subdivision (a)(8), provides, in pertinent part, that:

> A "demonstrable and unjust payment pattern" or "unfair payment pattern" means any practice, policy or procedure that results in repeated delays in the adjudication and correct reimbursement of provider claims.

10. As set forth in Factual Findings 7 through 11, 13 and 15, respondent's practice and procedures between September 1, 2004 and October 18, 2007, resulted in repeated failures to automatically include interest on payment of uncontested claims. Therefore, cause exists to discipline respondent's license pursuant to Health and Safety Code sections 1386, subdivisions (a) and (b)(6), and 1371.37, subdivisions (a), (c)(3), (c)(4) and (d)(1)(A), in conjunction with California Code of Regulations, title 28, sections 1300.71, subdivisions (a)(8), (s)(2) and (s)(3).

*Proposed Assessment of $100,000 Penalty*

11. California Code of Regulations, title 28, section 1300.86, provides that:

> (a) When assessing administrative penalties against a health plan the Director shall determine the appropriate amount of the penalty for each violation of the Act based upon one or more of the factors set forth in subsection (b).
>
> (b) The factors referred to in subsection (a) include, but are not limited to the following:
>
> (1) The nature, scope, and gravity of the violation;
>
> (2) The good or bad faith of the plan;
>
> (3) The plan's history of violations;
>
> (4) The willfulness of the violation;
>
> (5) The nature and extent to which the plan cooperated with the Department's investigation;
>
> (6) The nature and extent to which the plan aggravated or mitigated any injury or damage caused by the violation;
>
> (7) The nature and extent to which the plan has taken corrective action to ensure the violation will not recur;
>
> (8) The financial status of the plan;
>
> (9) The financial cost of the health care service that was denied, delayed, or modified;
>
> (10) Whether the violation is an isolated incident; and/or
>
> (11) The amount of the penalty necessary to deter similar violations in the future.

12. Assessing these criteria, respondent's repeated failures to automatically include interest and penalties on late-paid claims are serious, and over time may jeopardize the willingness of providers to stay with the plan. No evidence was presented to demonstrate that respondent's repeated failures were willful, however. To the contrary, respondent's interest calculator was inadvertently programmed to exclude holidays from the interest calculation, and to calculate interest from the date of receipt of a dispute, rather than the required date of receipt of the original claim. (Factual Findings 8 and 10.) Respondent

cooperated with the department during their investigation, and acted in good faith in developing a corrective action plan and remediating the late-paid claims and provider disputes. (Factual Findings 11, 12 and 14.)

13. Pivotal to this case, however, is the plan's history of violations involving claim payment requirements dating back to November 24, 1992, which demonstrates that respondent's current violations are not an isolated incident. Since March 2002, over 30,000 late-paid claims have been identified as claims that did not include the requisite interest and penalty payments. Routine examinations have not deterred respondent from engaging in claim payment violations, and have not encouraged respondent to actively ensure full compliance with the claim payment provisions of the Knox-Keene Act. According to Ms. Larsen, respondent's financial status demonstrates that they have the ability to pay a $100,000 penalty in four quarterly installments. Respondent did not present evidence to rebut Ms. Larsen's opinion. Therefore, a $100,000 penalty payable in four quarterly installments is appropriate in this matter.

## ORDER

1. Respondent, Universal Care, Inc., shall pay to the Department of Managed Health Care, an administrative penalty in the amount of $100,000, payable in four quarterly installments.

2. The administrative penalty shall be paid to the DMHC in accordance with a payment schedule agreed to by the parties. If respondent fails to make a payment when such payment becomes due and payable, the DMHC may, at its sole discretion, declare the balance of the administrative penalty due.

DATED: July 11, 2011

REBECCA M. WESTMORE
Administrative Law Judge
Office of Administrative Hearings

## PROOF OF SERVICE

*In the Matter of the Accusation Against Universal Care, Inc.*

I, Erin E. Weber, declare:

I am employed in the County of Sacramento, State of California, with the Department of Managed Health Care. I am over the age of eighteen (18) and not a party to this matter. My business address is:

980 Ninth Street, Suite 500
Sacramento, CA 95814

I am readily familiar with the business practice at the place of my business for collection and processing of correspondence for mailing with the United States Postal Service. In accordance with that practice, correspondence placed in the internal mail collection system is deposited with the United States Postal Service that same day in the ordinary course of business.

On October 13, 2011, I served a copy of the Decision of the Department of Managed Health Care regarding the Proposed Decision of the Administrative Law Judge in *In the Matter of the Accusation Against Universal Care, Inc*, Office of Administrative Hearings Case No. 2010090785, on the interested parties in this action by registered mail, First Class mail, or by hand delivery, with postage fully prepaid, addressed as follows:

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Executed on October 13, 2011 at Sacramento, California. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Erin Weber