BEFORE THE UTAH INSURANCE COMMISSIONER

UTAH INSURANCE DEPARTMENT, Complainant, vs. **PEDRO DAVID BARCENAS,** Respondent	**FINDINGS OF FACT, CONCLUSION OF LAW and ORDER** Docket No. 2023-4531 Donald H. Hansen Administrative Law Judge/Presiding Officer

PROCEDURAL BACKGROUND

Before the commencement of this administrative action, Respondent Pedro David Barcenas ("Respondent") was licensed by the Utah Insurance Department (the "Department") as a nonresident individual insurance producer with an accident and health or sickness line of authority. The Department issued its Notice of Formal Agency Action and Complaint on July 31, 2023, seeking revocation of Respondent's license.

Respondent timely filed a request for an evidentiary hearing. A prehearing conference was conducted telephonically on September 1, 2023. Respondent was represented in this action by attorney Kenneth Parkinson, Esq., who appeared at the prehearing conference. The Department was represented by Shelley A. Coudreaut, Assistant Utah Attorney General. A Scheduling Order and Notice of Evidentiary Hearing was entered on September 1, 2023.

The Presiding Officer conducted an evidentiary hearing on December 14, 2023. All parties, witnesses and counsel appeared via Google Meet video teleconferencing. All testifying witnesses were first duly placed under oath or affirmation. The Department was represented by

Ms. Coudreaut, and Respondent was represented by Mr. Parkinson.

Based on the record evidence presented in this matter, the Presiding Officer enters the following.

FINDINGS OF FACT

1. At all relevant times, Respondent was licensed by the Department as a nonresident insurance producer with an accident and health or sickness line of authority, Utah Insurance Department license number 782751.

2. Respondent resides in [redacted].

3. At certain times relevant to this action, Respondent was employed as a tele-sales agent for Cigna Insurance Group (Cigna). Among other duties, Respondent enrolled insurance consumers in Medicare Advantage plans.

4. Cigna considers Medicare consumers to be vulnerable to scams and misrepresentation in insurance sales because they are usually elderly. Consequently, Cigna closely regulates and audits the conduct of its Medicare Advantage sales agents.

5. Open enrollment for Medicare Advantage plans occurs annually between October 15 and December 5. However, "special election periods" (SEPs) are available outside the open enrollment period for enrollees who meet certain special circumstances such as moving outside the enrollee's previous service area. In such cases, a SEP is available during the month before the month in which the enrollee moves, and for two months after the enrollee's move.

6. Cigna uses a script for tele-sales agents to use to confirm whether a potential enrollee meets eligibility requirements for a SEP enrollment.

7. Cigna tele-sales agents are also required to complete annual training and pass a

written exam regarding current Medicare eligibility regulations.

8. Cigna routinely conducts compliance audits of its tele-sales agents' customer interactions with prospective Medicare enrollees to assure compliance with Medicare regulations including confirmation of SEP eligibility.

9. Cigna compliance personnel audited numerous sales calls conducted by Respondent and concluded that he had misused the Medicare SEP standard applicable to an enrollee who had moved to a new service market.

10. Respondent was among a group of more than 25 tele-sales agents whose customer calls were subjected to compliance audits between January and May 2022. Compliance personnel listened to recordings of agents' sales calls three times each.

11. Cigna sales agents are made aware that their sales calls are recorded and subject to audits by compliance personnel.

12. Prior to the above-described audits, Respondent had been recognized by Cigna as a top sales performer for several years.

13. Audits of six sales calls conducted by Respondent led Cigna to conclude that Respondent had repeatedly acted out of compliance with Medicare SEP eligibility rules (the six audited sales calls are described individually below). Cigna undertook an internal ethics review of the alleged violations, during which Respondent argued that his compliance failures were due to mistakes or misunderstandings on his part. Respondent was one of 22 agents specifically investigated by a Cigna "sales integrity group" for improper use of SEPs, including the "move" SEP.

14. Nonetheless, Cigna concluded that Respondent had used fraudulent practices to

secure enrollment of customers using the SEP "move" eligibility exception or had demonstrated incompetence. Accordingly, Cigna terminated Respondent's employment.

15. On January 11, 2022, Respondent enrolled a Medicare customer who had relocated to a new service area, but the enrollment was outside the one-month-before or two-months-after-the move limitation period.

16. On March 10, 2022, Respondent again enrolled a Medicare customer who had relocated to a new service area, but the enrollment was outside the one-month-before or two-months-after-the-move limitation period.

17. On March 23, 2022, Respondent again enrolled a Medicare customer who had not relocated to a new service area but incorrectly applied the SEP "move" exception.

18. On April 6, 2022, Respondent again enrolled a Medicare customer who had not relocated to a new service area but incorrectly applied the SEP "move" exception.

19. On April 18, 2022, Respondent again enrolled a Medicare customer who had not relocated to a new service area but incorrectly applied the SEP "move" exception.

20. On May 2, 2022, Respondent again enrolled a Medicare customer who had not relocated to a new service area but incorrectly applied the SEP "move" exception.

21. Respondent asserts that he was "scapegoated" by Cigna because the U.S. Department of Justice (DOJ) was investigating Cigna concerning alleged wrongful business practices. The investigation was in progress about one month prior to Respondent's termination by Cigna.

22. Respondent had no prior disciplinary history with Cigna before his termination.

23. During his employment with Cigna, Respondent typically fielded some 20 to 30

sales calls per day.

24. Respondent blames his errors on lack of product training by Cigna specifically regarding use of the "move" SEP in cases of temporary "snowbird" relocations by customers. He also faults the Cigna computer program for Medicare enrollment which does not use a secondary "confirm" button following entry of a particular eligibility code or data. A confirm option is often used in computer programs to ensure that user's entry was intentional. Thus, he asserts, if he made an erroneous code entry, he was not able to correct it.

25. Respondent's six repeated improper uses of the "move" SEP identified by Cigna as the basis for his termination represent material breaches of the professional ethical and competency requirements set forth in the Utah Insurance Code.

ANALYSIS AND CONCLUSIONS OF LAW

The Presiding Officer is not persuaded by Respondent's assertions that his multiple erroneous uses of the relocation SEP exception was due to lack of training or were mere mistakes that were impossible to correct because of the lack of a "confirm" button on his computer screen. There is also no credence given to Respondent's theory that he was scapegoated by Cigna because of a pending DOJ investigation. Respondent has not shown a clear causal nexus between the DOJ investigation and his termination by Cigna. It is thus uncontested that the errors were repetitious and were the result of either intentional misrepresentation or avoidable mistakes. Weighing in Respondent's favor, however, is the fact that while there were six cases in which he improperly used the SEP exception, these cases were among several hundred sales calls he handled – based on an estimated 20 to 30 per day – during the period in which the Cigna audits were taking place.

The Department's argument that the evidence establishes either intentional misconduct by Respondent or at least incompetency and financial irresponsibility is compelling, although there is another explanation for the Respondent's repeated improper conduct: simple carelessness and neglect. Utah insurance law expects a substantially higher degree of attention, caution and diligence than that which Respondent has demonstrated in this case.

Thus, there is no question that Respondent's misconduct in the Cigna cases warrants administrative disciplinary action. The only issue is what degree of disciplinary action by the Department is justified. While it is a close call, the Presiding Officer concludes that the remedy of license revocation is somewhat excessive under the facts presented here. The Insurance Code provides for a licensee to be placed on probation status in appropriate situations, and this is one such situation.

Accordingly, the Presiding Officer enters the following Conclusions of Law.

1. Respondent violated Utah Code Sec. 31A-23a-111(5)(b)(xvi) when in the conduct of insurance business he used practices that demonstrated incompetence and financial irresponsibility.

2. Respondent violated Utah Code Sec. 31A-23a-111(5)(b)(xxiv) when in the conduct of insurance business he used methods or practices that endangered the legitimate interests of customers and the public.

3. Respondent violated Utah Code Sec. 31A-23a-402(1)(a)(i) by making or causing to be made communications containing false or misleading information relating to an insurance product or contract.

4. Utah Code Section 31A-23a-112 provides that a licensee may be placed on

probation for a period not to exceed 24 months under certain circumstances, including where the licensee has been involved in an administrative proceeding regarding a professional or occupational license, and subject to reasonable terms and conditions to be specified in the order of probation. *See* Section 31A-23a-112(1)(C) and 112(3).

ORDER

1. The Department's petition for revocation of Respondent's licensure is DENIED.

2. Respondent is hereby placed on probation for a period of 24 months, starting the day this Order is issued. Respondent's terms and conditions of probation shall include the following:

A. Respondent shall not commit any act or omission of the kinds described in the Department's Complaint and in the foregoing Findings of Fact, or any other violation of the Utah Insurance Code.

B. Respondent shall pay to the Department a forfeiture of $1,000.00 within thirty (30) days after the date of this Order.

C. Respondent shall report each quarter to the Market Conduct Examiner ("Examiner") who investigated this matter. Respondent's quarterly probation reports will address Respondent's employment and activities in the insurance business during the previous quarter, and may be conducted telephonically or by other electronic means. The Examiner will contact Respondent soon after entry of this Order to establish a schedule and protocol for conducting the quarterly reports, and otherwise supervising Respondent's probation.

D. Respondent will comply with such other reasonable conditions of probation as the Examiner may require.

E. Respondent's failure to comply with the terms and conditions of his probation will result in revocation of his Utah insurance licensure.

DATED this 17th day of January 2024.

JONATHAN T. PIKE
UTAH INSURANCE COMMISSIONER

/s/ Donald H. Hansen
Donald H. Hansen
Administrative Law Judge/Presiding Officer
Utah Insurance Department
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801-957-9321
Email: uidadmincases@utah.gov

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on this date a true and correct copy of the foregoing **FINDINGS OF FACT, CONCLUSION OF LAW and ORDER to:**

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Shelley A. Coudreaut, Esq.
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Salt Lake City, UT 84114-0874

DATED this 17th day of January 2024.

/s/ Jeanine Couser
Jeanine Couser
Utah Insurance Department
4315 South 2700 West, Suite 2300
Taylorsville, UT 84129
801-957-9321

Right to Agency Review

Any party may request agency review of an order in an adjudicative proceeding within 30 days of the date of the order to be reviewed. The request should be sent to uidadmincases@utah.gov. Utah Insurance Department Rule R590-160-8 provides as follows:

(1)(a) Agency review of an adjudicative proceeding, except an informal adjudicative proceeding that becomes final without a request for a hearing under Subsection R590-160-7(1), is available to a party to a proceeding by filing a request for agency review with the commissioner within 30 days of the date of the order.
(b) Failure to seek agency review is a failure to exhaust administrative remedies.
(2) Agency review shall comply with Section 63G-4-301.
(3)(a) The commissioner or the commissioner's designee shall conduct the review.
(b) A designee may not be the presiding officer who issued the decision under review.
(c) If a designee conducts a review, the designee shall recommend a disposition to the commissioner.
(d) The commissioner will make the final decision and sign the order.
(4) Content of a request for agency review.
(a) A request for agency review shall comply with Subsection 63G-4-301(1)(b), and shall include the following:
(i) a copy of the order that is the subject of the request;
(ii) the factual basis for the request, including:
(A) citation to the record of the formal adjudicative proceeding; and
(B) clear reference to evidence or a proffer of evidence in an informal adjudicative proceeding;
(iii) the legal basis for the request, including citation to supporting authority;
(iv) for a challenge to a finding of fact in a formal adjudicative proceeding, the reason that the finding is not supported by substantial evidence based on the entire record; and
(v) for a challenge to a finding of fact in an informal adjudicative proceeding, the reason that the finding is not supported by substantial evidence based on the evidence received or proffered.
(b) A party challenging a finding of fact in a formal adjudicative proceeding shall:
(i) order a transcript of the recording relevant to the finding;
(ii) certify that a transcript is ordered;
(iii) file the transcript with the commissioner or the commissioner's designee;
(iv) serve a copy of the transcript on each party; and
(v) pay the cost of preparing the transcript.
(c) The commissioner or commissioner's designee may waive the transcript requirement on motion for good cause shown.
(5) Memoranda.
(a)(i) A party requesting agency review shall submit a supporting memorandum with the request.
(ii) If a transcript is necessary to conduct agency review, a supporting memorandum shall be filed no later than 15 days after the service of the transcript on the opposing party.
(b) An opposing memorandum shall be filed no later than 15 days after the supporting memorandum is filed.
(c) A reply memorandum shall be filed no later than five days after the opposing memorandum is filed.

(d) The commissioner or the commissioner's designee may order a party to submit additional memoranda to assist in conducting agency review.
(6) Request for a stay.
(a) On motion by a party and for good cause, the commissioner or commissioner's designee may stay the presiding officer's order during the pendency of agency review.
(b) A motion for a stay shall be made in writing and may be made at any time during the pendency of agency review.
(c) An opposition to a motion for a stay shall be made in writing within ten days from the date the motion is filed.
(7)(a) A party may request oral argument in the party's initial pleading.
(b) The commissioner or the commissioner's designee may grant oral argument if requested in a party's initial pleading.
(8) Failure to comply with Section R590-160-8 may result in the commissioner or the commissioner's designee dismissing the request for agency review.