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BEFORE THE INSURANCE COMMISSIONER
OF THE STATE OF CALIFORNIA

In the Matter of the Accusation Against:

**PACIFICARE LIFE AND HEALTH
INSURANCE COMPANY**

Respondent.

Case No. UPA 2007-00004

OAH No. 2009061395

**OPENING BRIEF ON THE MERITS
OF THE CALIFORNIA
DEPARTMENT OF INSURANCE**

Judge: Hon. Ruth Astle

Hrg. Date: December 7, 2009,
continuing from day to day

Arg. Date: November 14-15, 2012

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1 **I. INTRODUCTION**

2 Nearly 1 million violations of law. The vast majority of them committed with the
3 company’s full contemporaneous knowledge of their illegality. Nearly all of them admitted,
4 at one time or another, to have been committed in violation of the law.

5 Such a record of noncompliance does not happen by accident. When Respondent
6 PacifiCare Life and Health Insurance Company (“PLHIC” or “PacifiCare”) — a company
7 with a good record of compliance and a good reputation for service — was acquired by
8 UnitedHealth Group (“United”¹), the new owners embarked on a relentless pursuit of
9 “synergies,” demanding cost-cutting measures well understood at the time to be likely to lead
10 to the violations that followed, in order to satisfy the expectations of “Wall Street” that
11 United itself had seeded. And, by United’s lights, the strategy was wildly successful, reaping
12 several times the promised savings. The fact that the process literally ran PLHIC into the
13 ground, leaving behind a trail of violations and substantially eliminating the company as an
14 insurance provider in California, has not diminished United’s expressed satisfaction with this
15 history. Meanwhile, with PacifiCare having about \$700 million in the bank, United stands
16 poised quite literally to take the money and run.

17 In this Opening Brief, the California Department of Insurance (“CDI” or “the
18 Department”) first chronicles PLHIC’s descent from a well-functioning health insurer, its
19 decimation at the hands of United, the explosion of complaints from consumers and
20 healthcare providers, and the discovery of manifold violations of law. (See pp. 5-63, *infra*.)
21 The Department then explicates the general legal principles governing the determination of
22 violations of law and the imposition of penalties. (See pp. 63-104, *infra*.) Those principles
23 are then applied to the evidence regarding each category of violations charged to determine
24
25
26

27 ¹ “United” is used here to refer generally to the parent, UnitedHealth Group, and the
28 various subsidiaries that managed PLHIC. Where the identity of a specific subsidiary of
UnitedHealth Group is relevant to the discussion, it is cited by name.

1 whether Insurance Code section 790.03² has been violated and, if it has, how many acts were
2 committed in violation of that section and the appropriate penalty to impose.³

3 Under the Unfair Insurance Practices Act (“UIPA,” §§ 790-790.15), this analysis is
4 necessarily categorical and, in this case, ranges 20 categories comprising the 908,654 acts
5 charged in violation of section 790.03. However, while the penal focus of the UIPA is the
6 individual act, the multitude of these trees should not obscure the forest: At bottom, these
7 violations were not accidental, were not the product of bad luck, were not the result of low-
8 level employees having thousands of bad days. These violations were the predictable and
9 predicted consequences of decisions made at the very top of the organization by people
10 unfamiliar with PacifiCare’s business and uninterested in maintaining its quality service or
11 legal compliance. The record traces the violations back to the most basic policy decisions:

- 12 • As soon as the PacifiCare acquisition closed, United embarked on a relentless
13 program of cost-cutting, imposed over warnings of the consequences that would and,
14 indeed, did follow. (See pp. 7-9, *infra.*) Staffing ratios were cut, forcing each officer,
15 director, and manager to oversee more people and more activities. (See pp. 9-12,
16 *infra.*) Whole departments were eliminated, their work hastily outsourced to ill-
17 prepared, inadequately supervised vendors. (See pp. 12-36, *infra.*) “In the name of
18 synergies, it was speed to move then clean.” (Exh. 5265, p. 1939.) Within 18
19 months, over a third of PacifiCare’s staff was gone and, with them, indispensable
20 institutional knowledge. (See p. 11, *infra.*) Capital budgets were slashed, systems
21 were not adequately maintained, and staff was denied the tools to do its job properly,
22 as the rushed conversion of PLHIC was replaced by a “keep the lights on” policy of
23 running off the business at minimum cost. (See pp. 36-42, *infra.*) From the outset,

24
25 ² Citations to section numbers not identified by code are to the Insurance Code.

26 ³ This Opening Brief is accompanied by Proposed Findings and Conclusions
27 (“Proposed Findings” or “PF”), comprised of findings of fact and legal conclusions that the
28 Department requests be made. In general, this Opening Brief addresses the applicable legal
principles in greater detail and the evidentiary record in less detail than the Proposed
Findings.

1 when management was warned that it was cutting too deeply, the response was that
2 the predicted “bumps in the road” had to be tolerated in order to achieve synergy
3 commitments the company had made to Wall Street. (See pp. 32-32, *infra.*)

- 4 • This fundamental policy resulted in precisely the weak management one would
5 expect. Among the thinned-out ranks, there was inadequate coordination among the
6 various silos where pieces of major programs were being cobbled together. Lines of
7 responsibility were ill-defined, and accountability was either unallocated or evaded.
8 Changes were inadequately planned, insufficiently tested, poorly documented, and
9 hastily implemented. Resulting processes were inadequately monitored, and routine
10 audits — for example, to ensure that a transaction that enters a given system comes
11 out the other end — were omitted or neglected. Unsurprisingly, documents were lost
12 or misdirected, claims and documents languished in untended corners of haphazardly
13 implemented systems, legal deadlines were missed and other obligations went unmet.
14 (See pp. 36-57, *infra.*)

- 15 • The Department would expect a licensee to respond to the earliest signs of
16 noncompliance with dissatisfaction and an aggressive program to promptly identify
17 root causes, swiftly correct errors, and immediately prevent their continuation. That
18 did not happen in this case, and it did not happen for an obvious reason: The
19 violations were entirely expected and accepted. United had replaced PacifiCare’s
20 culture of compliance with a policy of failure and correction. In some parts of the
21 organization, they even had a name for it: “fall forward,” failures affirmatively
22 expected and willingly tolerated. (Exh. 897, p. 1591; Exh. 898, p. 4764; Exh. 899,
23 p. 8015; RT 15354:17-15356:2 (Soliman); RT 17323:2-21; 17335:3-13 (Lippincott);
24 see also Exh. 945 [Wichmann e-mail referring to “fail forwards” as “our leading
25 cause of defects”]; RT 15945:16-15946:16 (Wichmann).) This is a pernicious policy
26 in any organization, but it is vastly more dangerous where new management has
27 imposed an ethos of relentless cost-cutting and has embarked on a sweeping program
28 to hastily replace employees, systems, and processes in pursuit of synergies. And it is

1 a policy that negates any claim of a good-faith intention to comply with the law.
2 Under United’s management, PacifiCare’s policy went from avoiding violations to
3 expecting them and just correcting them on a failure-by-failure basis as they
4 happened. Proof of this policy can be found in the fact that no officer or employee
5 was ever held accountable. Numerous executives were asked whether anyone was
6 ever fired, demoted, or denied a promotion for these events, and none of the witnesses
7 was aware of a single person who had suffered any adverse career consequences.
8 (E.g., RT 6721:4-17 (Bugiel); RT 10559:11-10561:8;10562:14-10564:2 (Berkel);
9 RT 17629:24-17630:10 (McMahon); RT 16029:23-16033:9 (Wichmann) [“I wouldn’t
10 go around trying to find out who was to blame for what”].) That is not evidence of
11 inadvertence in personnel-management. Nobody suffered any adverse consequences
12 because the actions and the results were entirely consistent with company policy. The
13 violations were just the expected bumps in the road, so nobody got blamed for the
14 potholes. As long as costs were cut and synergies realized, no one’s career was in
15 jeopardy because, in United’s view, nobody did anything wrong — at least as long as
16 they eventually took corrective action.

- 17 • These policies and actions were accompanied by a disturbing lack of candor from the
18 company, starting with the solicitation of approval for United to acquire PacifiCare’s
19 license. Weeks after the two companies’ executives personally appeared before the
20 Commissioner and assured him that PLHIC would remain in the market and that there
21 would be minimal changes to personnel, orders were given for the reductions in staff,
22 and within a few months whole departments had been eliminated. Internal documents
23 revealed the recognition that commitments to regulators had not been kept, but the
24 company would not even acknowledge as much until it met with the new
25 Commissioner a year and a half later, after the CDI investigation was in process. (See
26 pp. 5-7, *infra*.) Meanwhile, in the course of that investigation, PLHIC staff was
27 repeatedly concealing evidence of the extent of, and reasons for, the noncompliance
28 and the date the company would come into compliance. (See pp. 58-62, *infra*.)

1 This enforcement action will write the final chapter of the saga, and with it the lesson
2 of the PacifiCare acquisition, integration, and virtual elimination from the market — a lesson
3 that is still very much in doubt. As far as the company is concerned, it is a success story.
4 (E.g., RT 15872:24-15873:12 (Wichmann) [“satisfied with the way United executed the
5 PacifiCare integration,” which was “a success” from shareholder, member, and provider
6 standpoints].) If the story ends there, with PLHIC sending United as profits the now-
7 unneeded bulk of the \$700 million PLHIC has in the bank as profits, the pronouncement of
8 success will be vindicated, professions of self-satisfaction justified. But if instead it ends
9 with the imposition of a substantial penalty — one that is a small fraction of the maximum
10 authorized by statute but large enough that it cannot simply be dismissed as the cost of doing
11 business, a small offset on hundreds of millions of dollars booked in synergies — that will be
12 a very different lesson, and one not lost on this licensee or its peers.

13 **II. BACKGROUND**

14 **A. Acquisition of PacifiCare by United**

15 In 2005, PLHIC served approximately 148,000 members under a license issued by the
16 California Insurance Commissioner.⁴ At that time, the company enjoyed a reputation for
17 providing excellent customer service (RT 2317:23-2318:2 (Norket); RT 8266:15-18
18 (Berkel)), and had no significant compliance issues. (RT 597:21-598:6 (Vandepas); RT
19 124:21-125:5 (Smith); RT 1208:17-21 (Black); Exh. 1184, p. 8; see also Exh. 1184, p. 8:2-8
20 [Cignarale unaware of any particular problems with PLHIC before 2006, “no exceptional
21 findings of concern”].)

22 In July 2005, UnitedHealth Group announced its intention to acquire PacifiCare
23 Health Systems (“PHS”), PLHIC’s holding company. (Exh. 5252, p. 6927; RT 7320:2-6
24

25 ⁴PacifiCare had another subsidiary, PacifiCare of California, that was a provider of
26 health maintenance organization (“HMO”) service and was subject to the jurisdiction of the
27 California Department of Managed Health Care (“DMHC”). DMHC also had jurisdiction
28 over an HMO-related product, point of service (“POS”). PLHIC’s non-HMO insurance
(called on this record “PPO” for “preferred provider organization”) was regulated by the
Commissioner.

1 (Berkel); Exh. 5265, p. 1941.) The acquisition, which was valued at roughly \$8.2 billion
2 (Exh. 625, p. 7042), required the approval of several regulators, including the California
3 Insurance Commissioner (§ 1215, subd. (d)). In contrast to PacifiCare, United’s PPO carrier
4 had a record of claims-related compliance issues. (Exh. 5292; Exh. 1184, p. 27:12-13.)

5 On November 1, 2005, then-Commissioner John Garamendi conducted an
6 investigatory public hearing into the acquisition, at which he expressed concerns about
7 complaints regarding the claims-handling performance of United’s insurance subsidiaries
8 around the country. The United executives who attended the hearing assured the
9 Commissioner that the company had put those problems behind it and would not repeat them
10 with PacifiCare. (Exh. 625, pp. 7145-7149.)

11 The executives also promised to maintain PacifiCare’s extensive operations in
12 California and to expand the insurance company’s business in the state. Although the
13 merged company would lay off approximately 200 California staff, according to PacifiCare
14 executives, “the vast majority of our employees in California will remain with the company”
15 and “the overall employee population for PacifiCare in California [would] remain relatively
16 constant.” (Exh. 625, pp. 7072, 7096-7097; Exh. 5265, p. 1939; RT 9018:17-25 (Monk).)
17 The company stressed the importance of local leadership and “local market expertise.”
18 (Exh. 625, pp. 7078-7079; RT 7943:22-7944:6 (Berkel).) PacifiCare executives also touted
19 the additional resources and technology that United would bring to benefit California
20 consumers and providers. (Exh. 625, pp. 7075-7076.) These representations were made with
21 the expectation that the Commissioner would rely on them in deciding whether to approve
22 the merger. (RT 8997:7-8998:8 (Monk).)

23 The Commissioner agreed to the acquisition, subject to certain conditions, which
24 were memorialized in Undertakings United and PacifiCare executed. (Exh. 5191.) The deal
25 closed on December 20, 2005. (Exh. 630, p. 114; Exh. 430; RT 4448:21-4449:10
26 (Burghoff); RT 10593:23-24 (McFann).)

27 The promises made in the 2005 hearings, however, were not kept. (Exh. 5265,
28 p. 1939.) Rather than increased capital investment and improved technology, the acquisition

1 resulted in “a technology mess.” (Exh. 627, p. 0409; Exh. 5265, p. 1939; RT 8005:4-15
2 (Berkel).) The company laid off 600 employees in 2006, triple the 200 promised at the
3 hearing. (RT 7947:7-16 (Berkel); Exh. 5265, p. 1939.) The promise to promote local
4 leadership was followed by the failure to retain knowledgeable staff and management and a
5 “lack of local decision making.” (Exh. 627, p. 0407.)

6 **B. The Immediate Push for Synergies**

7 Even before the acquisition closed, the two companies committed to quickly
8 integrating PacifiCare’s operations into United’s. (Exhibit 5265, p. 1941 (“Integrate
9 ASAP!”); Exh. 943, p. 8907; RT 7810:1; 10383:8-19 (Berkel).) These plans ignored the
10 “brutal fact” that “prior [United] acquisitions had not been integrated or migrated.” (Exh.
11 5265, p. 1939.) Executives also overlooked the fact that, compared to previous acquisitions
12 by United, the PacifiCare integration was one of “unprecedented scope and complexity.”
13 (RT 15062:19-25 (Lippincott); Exh. 914.)

14 The two companies established an aggregate synergy goal of \$100 million to be
15 “achieved 6 to 9 months after closing.” (Exh. 943, p. 8907.) “Synergies” include “revenue
16 upside” as well as “cost reduction” in “FTE’s (full-time equivalents), vendor contracting,
17 platform synergies, wage rate savings, infrastructure, etc.” (Exh. 434, p. 3044.) This
18 synergy projection was based on an “incomplete” due diligence process that did not include a
19 “robust understanding” of integration costs. (Exh. 5265, p. 1941.)

20 Shortly after the December 21, 2005 closing, United told investors that it expected to
21 achieve between \$50 million and \$75 million in synergies during the first year of the
22 integration, net of any integration costs, and up to \$350 million total synergies over the
23 course of two to three years. (Exh. 5265, p. 1942; Exh. 457, p. 9242; Exh. 433, p. 0621; RT
24 18395:20-24 (Wichmann).)

25 In late 2005, less than two months after the executives’ public appearance before
26 Commissioner Garamendi, PacifiCare formed teams to plan and execute the integration.
27 (RT 5350:8-19 (Labuhn); RT 5997:3-11 (Vonderhaar); RT 17647:23-17649:10 (Watson).)
28 One team, led by Scott Burghoff, focused on “business integration,” meaning “bringing two

1 organizations together as one, organizationally and through common business processes.”
2 (RT 4401:3-12 (Burghoff).) United Vice President of Operations A.J. Labuhn headed
3 another team that focused on operational integration, including Group Services (also known
4 as Membership Accounting Services or “MAS”), Claims (“Transactions”), and Customer
5 Service. (RT 6000:6-7 (Vonderhaar); RT 17655:2-5 (Watson); RT 5349:19-5350:3
6 (Labuhn).) A third team, led by Jason Greenberg, was in charge of planning “system
7 migration” — the movement of PacifiCare members to a United claims processing platform
8 (RT 5412:16-20 (Labuhn); RT 11955:13-11956:5 (Greenberg).) PacifiCare’s counsel went
9 to great pains to emphasize that no one person was “most knowledgeable” about the
10 integration.” (RT 4393:14-19 [“Mr. Burghoff is being tendered in response to the
11 Department’s request for the person most knowledgeable regarding integration. [¶] We’ve
12 advised the Department that, in our view, there is no single witness who could provide that
13 testimony.”]; see also RT 4419:7-13 (Burghoff) [agreeing with counsel].)

14 Each of these teams was tasked with “establish[ing] synergies” “[b]ecause promises
15 had been made to Wall Street.” (RT 17652:13-17653:9; 17648:14-17 (Watson).) The
16 “corporate initiative to drive down operating costs” imposed “internal operating income”
17 (“IOI”) benchmarks and synergy “commitments that each of the segments had to achieve.”
18 (Exh. 546, p. 8116; RT 15551:14-15552:12 (McMahon).) The company pursued these
19 synergies with knowledge that the changes it was making would create operational
20 disruption, which it planned to clean up later. (Exh. 5265, p. 1939 [“In the name of
21 synergies, it was speed to move then clean . . .”].)

22 The programmatic implications of the cost-cutting were easier to ignore because the
23 organization of the synergy drive insulated those giving the orders from those carrying them
24 out. Rigid silos between operational areas hampered the integration effort. (Exh. 437;
25 Exh. 440; Exh. 448, p. 8700; Exh. 644, p. 5643.) None of the integration team leaders took
26 an active role in managing the projects within their jurisdictions. (Exh. 1093, pp. 7:12-8:2.)
27 Mr. Labuhn described his role as simply dictating “the mechanics of the numbers related to
28 the budget rules of the road for transitioning FTEs as we had been instructed to follow.” (RT

1 5537:1-5.) Mr. Burghoff testified that “it was my role within UnitedHealthcare to collect and
2 report” synergy estimates (RT 4478:10-17) and that the risks associated with platform
3 migration, a program he was managing, were not within his jurisdiction to address. (RT
4 4489:6-23.) The different integration teams did not meet regularly and were ignorant of the
5 plans being pursued by the other teams. (Exh. 1093, p. 6:20-25.) For example, Mr. Labuhn
6 was unaware of the plan to migrate PLHIC claims to UNET, the United claims platform.
7 (RT 5413:18-5414:5.) Mr. Burghoff regarded the process of integrating claims functions as
8 “a separate integration process” “outside of my scope of responsibility.” (RT 4456:5-14.)

9 **C. Cypress Layoffs and Operation Closures**

10 A “big part” of the integration teams’ responsibilities was to “identify people to
11 eliminate to meet our synergies.” (RT 17652:17-23 (Watson).) To that end, one of the main
12 integration projects was closing several operations that had historically been performed at
13 PacifiCare’s Cypress office and transferring those functions to outside vendors or other
14 United offices. (RT 17655:19-17656:8 (Watson).) The planning for these layoffs and
15 closures began shortly after the acquisition closed. (RT 17657:12-17; 17675:13-21
16 (Watson); RT 3165:5-11 (Murray).)

17 United instructed the Group Services, Transactions, and Customer Care operational
18 teams to “align” their staff to United’s standardized staffing ratios, which increased the
19 number of staff reporting to each manager and supervisor. (RT 17652:17-23; 17653:10-
20 17655:1 (Watson); RT 6006:14-6008:6; 6285:10-19 (Vonderhaar); Exh. 457, pp. 9243,
21 9274.) For example, each Claims manager went from supervising 35 staff to supervising 65.
22 (Exh. 550, p. 6321; RT 5394:12-17 (Labuhn); RT 17653:10-17655:1 (Watson); RT 6285:10-
23 19 (Vonderhaar).) This staffing ratio exercise was designed to achieve synergy targets
24 (Exh. 805, p. 3760 [row 7]) and was one way the integration teams determined how many
25 PacifiCare employees would be laid off. (RT 17657:18-17658:12 (Watson).)

26 In late March 2006, PacifiCare told the DMHC that it intended to lay off 600
27 California staff. (RT 8824:19-8827:7; 9006:14-9007:16; 9019:8-11 (Monk).) The company
28 did not divulge this information to CDI. (RT 9007:17-23 (Monk).) The company soon

1 announced its intent to close Claims and Customer Service operations in Cypress and
2 transfer those functions to vendors and to other PacifiCare offices. The company also
3 announced its intent to close the Cypress Mail Room, Quality, and Training departments.
4 (Exh. 283, p. 3656; RT 2498:15-24 (Sing); RT 5365:2-20 (Labuhn).) These announcements
5 came less than five months after the executives' appearance before Commissioner
6 Garamendi (Exh. 625).

7 Over the spring and summer of 2006, PacifiCare outsourced several key functions
8 performed by the staff being laid off or by vendors under contracts with PacifiCare. Sorting
9 of paper mail, scanning and data-entry of paper claims, and scanning and routing of claim-
10 related documents was outsourced to Lason, which performed the work in Utah and India,
11 for an annual savings of \$1.1 million. (Exh. 5443; Exh. 283, p. 3659; Exh. 517, p. 1847
12 [number 28]; RT 3602:13-15 (Murray).) The company laid off all 22 Cypress-based PLHIC
13 claims examiners (Exh. 283; Exh. 805, p. 3786; Exh. 5348, p. 8455; RT 6774:18-21
14 (Vonderhaar); RT 11333:13-19; 10280:21-23 (Berkel)) and transitioned the bulk of PPO
15 claim processing, including some reworks, to a vendor called MedPlans. (Exh. 5348, p.
16 8455; Exh. 528, p. 2687; RT 6216:23-6217:8 (Vonderhaar); RT 3468:18-24 (Norket) [all but
17 stop loss and transplant].) The company transferred the telephone customer service function
18 to West Corporation in Huntsville, Alabama and to PacifiCare's San Antonio office.
19 (RT 2482:14-25 (Sing).) The printing and mailing of checks, Explanations of Benefits
20 ("EOBs"), and letters, which had been performed for PacifiCare by the IDC unit of IBM, was
21 transferred to Duncan, a United subsidiary located in South Carolina, for an annual savings
22 of \$3 million. (RT 4268:8-20; 4281:11-16; 4270:23-4271:1 (Oczkowski); Exh. 406.) Other
23 functions handled by IDC, including mail distribution, were transferred to Xerox. (RT
24 6879:10-17 (Vonderhaar).) The company outsourced processing of eligibility forms to
25 Accenture, resulting in the layoffs of 124 FTEs and savings of \$4.4 million each year. (Exh.
26 514, p. 3617 [number 3]; Exh. 540, p. 3760.)

27 These layoffs were executed "for synergies and the integration process" (RT 17659:1-
28 9 (Watson)) and, indeed, achieved synergies (RT 18117:19-18118:2 (Monk)). PacifiCare

1 Regulator Affairs Senior Vice President Nancy Monk testified that the timing of the layoffs
2 was driven by higher-than-expected turnover among customer service and operations staff in
3 Cypress. She testified that the uncertainty following the acquisition and “poaching” by
4 PacifiCare’s competitors was affecting service levels. (RT 8820:22-8823:8; 18113:18-25.)
5 These post-hoc explanations do not appear in the contemporaneous talking points explaining
6 the layoffs, which emphasize the need to “improve operating efficiency.” (Exh. 283,
7 p. 3661; Exh. 5296; RT 12353:10-12354:19 (Monk).) And even Ms. Monk conceded that
8 the desire to lower costs played a role in the changes. (RT 12388:7-21.)

9 **D. Diminished Staff Unable to Successfully Execute Simultaneous Sweeping**
10 **Changes in Systems and Procedures**

11 The rush to achieve synergies during the first year after the acquisition resulted in
12 simultaneous implementation of many complicated operational changes. PacifiCare
13 experienced dramatic internal upheaval, with frequent leadership changes (Exh. 5265,
14 p. 1943 [all executives have changed roles]; Exh. 699, p. 4120), a “considerable knowledge
15 drain caused by high turnover” (Exh. 465, p. 6550), and entire departments gone, their work
16 transferred to United staff without additional resources or training on PacifiCare-specific
17 practices (Exh. 678, pp. 3120, 3066). PacifiCare staff and functions were reallocated from
18 one department to another, resulting in a loss of “control or visibility to who is doing what.”
19 (Exh. 596, p. 7917 [Nakashoji 7:58 a.m.].) By April 2007, 39% of the PacifiCare employees
20 had terminated, by lay-off or voluntary departure. (Exh. 455.)

21 Many of the acts in violation at issue in this action were directly attributable to
22 United’s deliberate decisions to implement cost-cutting strategies for PacifiCare operations
23 immediately after the acquisition with the full expectation of the consequences that followed.
24 Indeed, in internal memoranda and correspondence, legacy PacifiCare officers and staff
25 complained that United’s corporate culture consistently prioritized “managing to Wall Street
26 in the short-term” rather than “appropriately investing in the business.” (Exh. 678, pp. 3071,
27 2864, 2888, 3069, 3158, 2844, 2852, 2875, 2916, 3077, 3084.)

1 The transition from PacifiCare’s traditional business model to United’s low-budget
2 approach “damaged focus, staffing models, and core operational effectiveness.” (Exh. 465,
3 p. 6552.) The resulting “deficiencies led to the large number of complaints made to state
4 regulators” (Exh. 465, p. 6550; Exh. 749; RT 10306:18-10307:3 (Berkel)) and what
5 employees characterized as “disgraceful” service to PacifiCare members and providers (Exh.
6 678, p. 2856).

7 PacifiCare later acknowledged that the implementation of United’s “standard staffing
8 and management ratios” left the company “understaffed in several critical areas.” (Exh. 753,
9 p. 4220.) The excessive layoffs executed in connection with the staffing ratios and
10 outsourcing contributed to the alleged violations and delayed remediation of mis-paid and
11 wrongly denied claims. (Exh. 528, p. 2688; Exh. 527, p. 2690; Exh. 5258, p. 7106.) In the
12 summer of 2007, David Wichmann, the Executive President and Chief Operating Officer of
13 UnitedHealth Group, told employees at PacifiCare’s Cypress office that the company had
14 “cut too deep” and apologized for laying off so many legacy PacifiCare employees. (RT
15 15341:7-15342:6 (Soliman); RT 9737:21-9738:9 (Berkel).) Although he promised to “build
16 up in California again,” the company continued to implement layoffs. (RT 15342:7-19
17 (Soliman).)

18 **E. Botched Transition of Critical Process to Outside Vendors**

19 The company planned and executed the transition of several key functions to outside
20 vendors in the midst of this internal restructuring. The rigid centralization of functions
21 within United left important decisions in the hands of people without knowledge of
22 PacifiCare’s business. (Exh. 762, p. 7481 [Sheppard 6:03 p.m.].) The vendor transitions
23 were riddled with deficiencies. Whether it was something as simple as opening the mail or
24 as complex as processing provider disputes, PacifiCare’s transition of critical functions to
25 outside vendors proved to be case studies in mismanagement, under-funding, lack of
26 coordination, inadequate documentation, poor planning, insufficient testing, and negligent
27 monitoring.

1 **1. Outsourcing of Mail Routing, Claims Keying, Document Storage,**
2 **and Preprocessing to Lason**

3 Nowhere were these deficiencies on more conspicuous display than in the transition
4 of the functions from PacifiCare staff and vendors to Lason.

5 Between May and October of 2006, PacifiCare transferred several “particularly
6 critical” mail processing functions to Lason (RT 6316:22-24 (Vonderhaar)), including
7 sorting paper mail between “keyable” claims and “non-keyable” correspondence
8 (RT 3188:22-3189:6 (Murray), “keying” or data entry of paper claims into RIMS,
9 PacifiCare’s PPO claims platform, scanning and routing non-keyable correspondence, and
10 scanning secondary documents (correspondence that had been used to process a claim) for
11 storage in PacifiCare’s FileNet system. (Exh. 283, p. 3659; Exh. 5046, p. 2236; RT 3180:9-
12 3181:25; 3201:22-3202:13; 14308:24-14309:14 (Murray).) The company also outsourced
13 some claim pre-processing functions to Lason, including manual member eligibility and
14 provider matching. (Exh. 517, p. 1847; RT 3217:19-3218:6; 14290:21-24 (Murray); RT
15 14837:19-14838:5 (Vavra).)

16 **a. DocDNA**

17 Each week, PacifiCare received between 70,000 and 80,000 pieces of “nonkeyable
18 correspondence” or mail other than claims. (RT 3189:11-24; 3691:12-20 (Murray).) The
19 majority of this correspondence related to requests to reprocess or “rework” claims.
20 (RT 3197:15-22 (Murray).) This rework correspondence had to be routed from post office
21 boxes to PacifiCare’s PPO rework teams. (RT 3190:6-3191:4 (Murray).) Because California
22 law requires insurers to respond to provider disputes, member appeals, and other
23 correspondence within a reasonable time (see, e.g., §§ 790.03, subd. (h)(2), 10123.137,
24 subd. (c); Reg. 2695.5), the routing of these documents is highly time-sensitive.

25 The PacifiCare mail room received a “very wide range of documents” so it was “a
26 very complex process” to sort and route them properly. (RT 13682:12-15; 13699:23-25
27 (Murray); RT 13898:1-6 (Vavra).) Before the acquisition, this correspondence was sorted
28 and routed by an experienced mail handler who, after many years with the company, “was
able to recognize a document and know where it needed to be delivered.” (RT 13743:15-16;

1 14314:15-16 (Murray).) In 2005, PacifiCare was working with a vendor called ACS to
2 develop an automated mail routing application to replace this manual process. After the
3 acquisition, in February 2006, the company decided to use Lason, United's vendor instead.
4 (Exh. 5443; RT 3164:19-3166:13; 13690:10-16 (Murray); RT 6316:4-24 (Vonderhaar).)

5 Beginning in July 2006, documents were shipped from PacifiCare's post office box to
6 Lason's Salt Lake City Regional Mail Operation ("RMO") where the correspondence was
7 separated from keyable claims, scanned, and e-mailed to Lason's facilities in India.
8 (Exh. 5443; Exh. 5446; RT 13700:19-13701:14 (Murray).) To replace the institutional
9 knowledge of the appropriate destination of each document possessed by the seasoned mail
10 sorter and her supervisor, PacifiCare designated a manager, Jonathan Murray, to work with
11 Lason to customize DocDNA, Lason's proprietary document routing software.
12 (RT 13679:20-13680:2; 13691:23-13692:13 (Murray).)

13 Mr. Murray decided that the routing system should be based upon an analysis of
14 "what a document is." (RT 13682:11-23.) To that end, the Lason India staff was required to
15 categorize each document according to one of 65 "document types," eight states, and four
16 lines of business. (RT 13725:16-25 (Murray).) The categorization, or "doc typing" decision,
17 directed each document to one of dozens of "queues" from which it was supposed to be
18 retrieved and processed by PacifiCare staff. (RT 3197:23-3198:6; 13701:6-13702:5
19 (Murray); Exh. 5445, p. 3776.) Some of those queues fed into the REVA system, which
20 routed rework related documents, by generating a prompt for a rework examiner who could
21 then access DocDNA to review the document related to the rework request. (RT 3199:5-23
22 (Murray).)

23 The document routing instructions developed by Mr. Murray were "fragmented and
24 complex" (Exh. 373, p. 0560; Exh. 577) and required intensive scrutiny of each document
25 combined with a high level of familiarity with American health systems. The instructions
26 required determination of whether, for example, a document "impact[s] the eligibility of a
27 member;" "is a response to information requested by PacifiCare;" or contained "info
28 necessary for first time claims processing." (Exh. 5445, pp. 3781, 3789, 3793.) Even Mr.

1 Murray, the system’s architect, struggled to use it to properly categorize a document.⁵ (RT
2 14371:21-14373:10 (Murray).)

3 PacifiCare created a 350 page binder for Lason staff to consult in selecting a
4 document type. (Exh. 5444.) The binder, which was the only instructional material provided
5 to Lason’s document routing staff (RT 13749:1-6 (Murray)), contained examples of some of
6 the correspondence that fell within each category. Many of the exemplars were virtually
7 indistinguishable from exemplars illustrating different document types. (E.g., Exh. 5444,
8 compare pp. 4297 [Doc Type A4.1.1a] with 7500 [Doc Type B2.4.1a], 7512 [Doc Type
9 B2.5.3a], and 7547 [Doc Type B3.4.2a]; compare pp. 4413 [Doc Type D3.3.1] with 4424
10 [Doc Type D4.2.1a].) Throughout 2006 and 2007, Lason staff expressed confusion about the
11 doc typing rules, and Mr. Murray had to revise the binder repeatedly. (RT 13749:21-
12 13750:16; 13715:9-25 (Murray); Exh. 373, p. 0560.)

13 Accurate routing also depended on proper identification by Lason staff of each
14 document’s state of origin and line of business (“LOB”) (e.g., PPO, HMO, Medicare). The
15 LOB determination was based on the post office box to which the correspondence was sent,
16 even though PacifiCare knew that post office boxes were highly unreliable indicators of
17 LOB. (RT 13773:21-13774:3 (Murray); RT 14823:12-14 (Vavra); Exh. 710, p. 0017
18 [number 1].) State of origin information was not always available to Lason staff. (RT
19 3193:20-25 (Murray).) PacifiCare’s Cypress staff had had access to the RIMS and NICE
20 claims platforms to help determine LOB and state, but Lason did not. (Exh. 710; Exh. 711;
21 RT 14315:6-19 (Murray).)

22 PacifiCare witnesses have admitted that the DocDNA system implemented in July
23 2006 made it virtually impossible for Lason to properly route the mail. (RT 3207:15-17
24

25 ⁵Mr. Murray, who created the document routing rules and binder, was asked on the
26 stand to doc-type Exhibit 296, to illustrate whether, as PacifiCare counsel stated, “it really
27 isn’t that complicated.” (RT 14371:4-5.) He categorized Exhibit 296 as falling within the
28 category for “provider profile updates,” “because it’s referencing a CPT code.” (RT
14371:21-14373:10 (Murray).) In fact, Exhibit 296 was a request to negotiate a new
contract. (RT 2660:3-2661:9 (Griffin).)

1 (Murray); RT 6801:23-6802:14; 6317:18-20; 6805:4-12 (Vonderhaar.) Eventually, in 2008,
2 PacifiCare vastly simplified the doc-typing rules by asking Lason staff to make two initial
3 determinations: whether the document was sent by a member, and whether it related to a
4 claim. Those choices led to a much smaller and clearer decision tree, which “made it
5 significantly easier” to route the document correctly. (RT 3206:7-25; 14384:18-14385:8
6 (Murray).)

7 From its implementation in July 2006 until its redesign in mid-2008, many documents
8 were routed late, routed to the wrong queues, or simply went “missing.” (Exh. 361; Exh 277;
9 Exh. 577, p. 8646; Exh. 367, p. 7465; Exh. 912.) The delays in document routing caused
10 delays in claim adjudication, caused PacifiCare to fail to timely respond to appeals and
11 provider disputes, and led PacifiCare to improperly deny claims while requesting documents
12 it had already received. (Exh. 342, p. 8514; Exh. 747, p. 7115; Exh. 577, p. 8646; Exh. 116,
13 p. 1298; Exh. 882, p. 7641.)

14 Even after documents arrived in the proper work queue, “there were buildups of
15 inventory” in the queues because PacifiCare did not dedicate sufficient staff to process the
16 documents with “a turnaround time that would keep documents moving.” (RT 13784:1-25
17 (Murray).) Thousands of documents languished in queues for 30 days or more. (Exh. 526,
18 p. 2770; Exh. 666, p. 1103.) A “huge cleanup effort” of two queues in July 2007 revealed
19 “files going back to 2006.” (Exh. 277, p. 8717 [Morris 7:32 a.m.] .) The inventory of aged
20 documents sitting in DocDNA remained high throughout 2007. (Exh. 526, p. 2770;
21 Exh. 666, p. 1103; Exh. 370, p. 8617.) A year after its implementation, Susan Berkel, a
22 Senior Vice President of Operations Integration, characterized claim-dependent
23 correspondence routing as “broken.” (Exh. 5265, p. 1939.)

24 **b. Processing of Paper Claims**

25 At the time of the acquisition, PacifiCare’s Cypress mail room was the entry point for
26 paper claims, which comprised almost half of PLHIC’s claims. (RT 7419:17-24 (Berkel);
27 RT 3189:25-3190:10 (Murray).) These claims were sorted and scanned by the RMO and
28

1 routed to Mexico for entry into the appropriate claims engine — RIMS for PPO and POS
2 claims, and NICE or ILIAD for HMO claims. (Exh. 5446.)

3 Before entering RIMS, PPO claims were to go through several preliminary processing
4 steps in Claims Exchange, RIMS’ “front end,” including eligibility matching (to ascertain
5 whether the member was covered by that insurance product on that date of service, and
6 whether the service was covered by the policy) and provider matching (to link the provider
7 listed on the claim to a provider name, tax identification number, and address in the claim
8 platform). (Exh. 5223; RT 7407:21-7409:22 (Berkel).) If Claims Exchange did not
9 automatically match the claim to an eligible member, covered service, and provider, the
10 claim fell into a “matching queue,” and a human had to research and resolve the matching
11 issue before the claim could be uploaded to RIMS. (RT 7408:10-7409:22 (Berkel);
12 Exh. 5223; Exh. 5252, p. 6930.)

13 In May 2006 PacifiCare transferred to Lason the function of entering data from paper
14 claims into RIMS (Exh. 5446; Exh. 5046, p. 2236), and in October 2006 the company
15 outsourced the work of researching claims that had fallen into Claims Exchange work queues
16 (Exh. 512, p. 1282; Exh. 365, p. 6870). PacifiCare failed, however, to give Lason the means
17 to determine whether claims should be keyed into RIMS, NICE, or ILIAD. Prior to
18 outsourcing, the Cypress mail room staff succeeded in routing claims to the proper platform
19 by looking up members in the claims engines when eligibility was unclear. Lason’s RMO
20 staff did not have access to the claims platforms, and their default instruction was to route
21 claims to NICE. (Exh. 573, p. 2770; Exh. 711; RT 14315:6-19 (Murray).) PPO claims
22 “rejected” from NICE because the system could not match the claim to an eligible HMO
23 member. (RT 6117:14-22; 6352:3-9 (Vonderhaar).) PacifiCare also failed to give Lason
24 proper instructions for separating keyable claims from nonkeyable documents or correct
25 keying guidelines. (Exh. 885.)

26 In late 2006, PacifiCare discovered that Lason had not been “working” several Claims
27 Exchange queues. According to Lason, PacifiCare had failed to provide sufficient access to
28 Claims Exchange and instructions for processing the claims. (Exh. 572.) In 2006 and again

1 in 2007, PacifiCare, dissatisfied with Lason’s performance of this function, proposed to bring
2 the work back in-house. (Exh. 572, p. 5064; Exh. 710; Exh. 911; RT 13947:13-20 (Vavra).)
3 It never did so.

4 As a result of this mismanagement, an “inordinate amount” of paper claims were
5 “rejected” from PacifiCare claims systems and could not be adjudicated. (Exh. 410, p. 7401;
6 Exh. 339; Exh. 885.) Through the summer and fall of 2006, the rejected hard copy claims
7 had to be mailed back to PacifiCare offices for research and then returned to Lason for a
8 second attempt at data entry. (Exh. 410, p. 7401; Exh. 896.) Many claims were several
9 weeks old by the time they were corrected and returned to Lason. (Exh. 339, p. 2462;
10 Exh. 366, p. 7266.)

11 PacifiCare addressed the “reject” problem in October 2006 by instructing Lason staff
12 to enter “dummy” values in necessary claim fields “to force the claims into the system.”
13 (Exh. 885, p. 4881.) This merely shifted the locus of the problem: once forced into Claims
14 Exchange, the formerly rejected claims would “error out” to a work queue for manual
15 research. (Exh. 885, p. 4881; RT 17456:20-17457:8 (Vavra); RT 14296:9-16 (Murray).)
16 Because Lason had no way to “look up individual members and determine into which PHS
17 platform the claims should be keyed” (Exh. 573), claims that had been errored out from one
18 platform would be sent to another platform. Claims sometimes “bounced” or “looped”
19 between platforms up to eight or nine times before being adjudicated. (RT 13958:1-13959:5
20 (Vavra); Exh. 881.) This “looping” remained a “very big issue” throughout 2007.
21 (Exh. 881.)

22 In late 2007, “a huge 62%” of paper claims were erroring out of the autoadjudication
23 process because of “match issues,” including approximately one-third of paper claims that
24 failed to match with an eligible member. (Exh. 554, p. 0310 [Berkel 1:09 p.m.].) In
25 December 2007, noting that this problem was causing PacifiCare to “fail the prompt pay
26 laws of California,” Ms. Berkel urged that it was “imperative to come up with a solution.”
27 (Exh. 554, p. 0310.)
28

1 The proposed solution, FETrain, was already in place at RMOs serving other United
2 subsidiaries. FETrain allowed users to perform an eligibility search across all United and
3 PacifiCare platforms, and testing showed that it would significantly improve eligibility
4 matching for PacifiCare claims. (Exh. 573, p. 2770 [Hinrichs 1:45 p.m.].) The proposal met
5 “resistance” from PacifiCare’s finance department, despite the fact that, at roughly \$65,000,
6 the project was “relatively low cost and high value.” (Exh. 554, p. 0310 [Parsons
7 2:08 p.m.].) FETrain was not implemented until “late 2008, early 2009.” (RT 6118:7-11
8 (Vonderhaar); Exh. 711.)

9 **c. Storage of Secondary Documents**

10 After a document was used in processing a claim, it became a “secondary document”
11 which had to be scanned and retained. Many secondary documents, such as certificates of
12 creditable coverage “COCCs” and medical records, are needed to properly adjudicate future
13 claims and must be readily retrievable. (Exh. 6, p. 7566; RT 2469:4-21 (Norket); RT
14 14311:13-14312:11 (Murray); RT 20482:3-11 (McNabb).)

15 The task of scanning and logging these documents into FileNet, PacifiCare’s long-
16 term storage system, was outsourced to Lason’s operations in Mexico. (Exh. 365, p. 6872;
17 RT 3690:25-3691:3 (Murray).) PacifiCare sent secondary documents to Lason with a cover
18 sheet indicating the member or claim number, “and it was presumed they were entering the
19 [member]/claim # on the image” so PacifiCare staff could “systematically retrieve the
20 document when needed.” (Exh. 575, p. 4004.) However, PacifiCare completely failed to
21 oversee the secondary document storage function. PacifiCare did not give Lason clear
22 instructions for processing these secondary documents or for returning documents that could
23 not be imaged. Different departments within PacifiCare used different cover sheets to send
24 their secondary documents for indexing, amplifying the confusion. (Exh. 365, p. 6872;
25 RT 14901:25-14902:17; 14908:25-14910:15 (Vavra).)

26 Because there was no oversight of this process (Exh. 365, p. 6872), PacifiCare did not
27 realize until August 2007, a full year after outsourcing this function, that secondary
28 documents were “in a black hole”: Lason was not indexing all documents. (Exh. 342,

1 p. 8514.) Thousands of documents were sitting in FileNet, unattached to a claim or member,
2 and “could not be retrieved” by PacifiCare staff. (Exh. 574; Exh. 355, p. 8503; Exh. 365,
3 p. 6872; RT 6353:7-14 (Vonderhaar).)

4 After this discovery, PacifiCare assigned “ownership” of the secondary document
5 function to Kelly Vavra’s Data Capture team (Exh. 365, p. 6872) and created a common
6 cover sheet to be used throughout the company when sending secondary documents to Lason
7 that would “ensure they were being indexed appropriately in Imaging.” (Exh. 355, p. 8503.)
8 However, even that simple remedial measure had not yet been implemented six months later
9 (Exh. 355, p. 8503), nor had the lost secondary documents been indexed (Exh. 365, p. 6873;
10 Exh. 376, p. 8233). In March 2008, PacifiCare staff remained confused about who was
11 responsible for overseeing Lason’s indexing and use of the new cover-sheet convention.
12 (Exh. 1031; RT 17432:7-17433:12 (Vavra).)

13 **d. Routing of Mail**

14 Even a matter as simple as distributing the mail in Cypress was thrown into chaos by
15 the poorly managed transition. During the transition of mail services to Xerox, IBM was
16 “bombarded with changes from [United] with little, if any, notice or planning.” (Exh. 595,
17 p. 7920 [Badalamenti 5:45 p.m.].) Employees sympathized with vendors, who complained
18 that United had “made things more difficult” for them “with many changes and several
19 people providing ‘direction.’” (Exh. 596, p. 7917 [Nakashoji 7:58 a.m.].)

20 After Xerox took over, mail was “just dumped in a room.” (Exh. 401, p. 4853
21 [Switzer 8:13 p.m.].) Ruth Watson, a PacifiCare Vice President of Membership Accounting,
22 related how her unit had suddenly stopped receiving premium checks because the mail was
23 no longer being delivered.

24 “I had a manager that went in her pickup truck and loaded the back of her
25 pickup truck with the mail for the entire building. And then we spent three
26 people full time for three days sorting through the mail, and we identified \$5
27 million in premium checks and the mail for the rest of the building.”
(RT 17704:22-17705:2.)

1 While not all of the mail mishaps were as severe as the incident Ms. Watson reported, the
2 mishandling of the mail room transition contributed to mail routing issues that lasted into
3 Spring 2007. (Exh. 5258, p. 7105 [See “Claims Integration Issues”]; Exh. 410, p. 7401
4 [number 6].)

5 **e. PacifiCare’s Overall Mismanagement of the Lason**
6 **Outsourcing**

7 The poor performance of the Lason document routing, secondary document indexing,
8 claims data entry, and preprocessing functions caused or contributed to PacifiCare’s failure
9 to timely pay claims and respond to provider disputes and to PacifiCare’s practices of
10 wrongly denying claims and requesting information claimants had already submitted.
11 (Exh. 116, p. 1298; Exh. 882, p. 7641; RT 8474:11-17 (Berkel); Exh. 342, p. 8514; Exh. 666,
12 pp. 1103-1104.) Despite its awareness that the problems with Lason’s performance were
13 causing violations of law, PacifiCare tolerated what it considered “broken” processes
14 (Exh. 5265, p. 1939) until the middle of 2008. The Lason debacle put on display a wide
15 range of the PacifiCare management deficiencies and illustrates many of the dysfunctional
16 traits encountered in PacifiCare’s mishandling of critical functions driven by the search for
17 synergies.

18 *Relentless Pursuit of Synergies Forced an Unrealistic, Inflexible Implementation*
19 *Schedule*

20 First and most obviously, these breakdowns were the harvest of errors planted with
21 the cost-cutting imperatives of the drive for synergies. The rushed implementation of
22 DocDNA reflects how United’s “corporate initiative to drive down operating costs” (Exh.
23 546, p. 8116) produced inflexible, unrealistic timelines for major operational changes. When
24 in 2004 PacifiCare created the REVA system for managing reworks, it phased the system in
25 slowly, achieving stability with HMO reworks before expanding to PPO. (RT 3199:5-11;
26 RT 13670:20-13671:5 (Murray).) When PacifiCare began planning to automate mail routing
27 before the acquisition, the company intended to phase it in with similar caution, to allow the
28 vendor to develop a better understanding of PacifiCare’s processes and operational needs

1 before assuming the full set of mail routing and claim processing functions. (RT 3655:6-13;
2 13670:20-13671:5 (Murray).)

3 Two months after the United takeover, in February 2006, Lason was selected as the
4 vendor and PacifiCare-wide implementation of DocDNA was targeted for July 1, 2006.
5 (Exh. 5446.) Because the synergy targets were predicated on expectations of when the work
6 would be transferred (Exh. 517, p. 1848), the timeline was “not negotiable.” (Exh. 678,
7 p. 2846.) Mr. Murray began to work on DocDNA “in earnest” in March 2006.
8 (RT 13695:19 (Murray).) He testified it was “a challenge” to design and test DocDNA in
9 that time, as he “didn’t have a lot of time to spare” and “couldn’t think about it for a long
10 period.” (RT 13695:4-15 (Murray).) The company ignored protests from PacifiCare staff
11 that “it was a pretty fast transition for the kind of work that we were moving forward.” (RT
12 6326:1-7 (Vonderhaar).)

13 The implementation timeframe proved profoundly unrealistic. Mr. Murray predicted
14 that Lason would not be able to deliver a completed routing system by July 2006, as the
15 process was “not yet at a conceptual design phase” in April 2006. (Exh. 889, p. 7286
16 [Murray 10:31 a.m.].) Indeed, Lason soon confirmed that it would be unable to provide a
17 fully functional document routing system by July because it could not train its staff in time.
18 Lason asked PacifiCare to keep the work internal until staff could be trained or to send a
19 trainer to India. (Exh. 377, p. 7283; 3659:20-3660:16 (Murray).) PacifiCare refused both to
20 postpone the layoffs of Cypress mail room staff and to send a trainer to assist Lason in India.
21 (RT 3656:25-3657:5; 3659:11-14 (Murray); RT 14052:10-18 (Vavra).)

22 Although PacifiCare recognized that “Lason’s team [was] too inexperienced to
23 accurately route hard copies” and that distributing mail-routing work to remaining PacifiCare
24 staff “would likely result in more accurate distribution in the short term,” PacifiCare insisted
25 that Lason “[f]ind a way to get [its staff] trained on document recognition and distribution”
26 so that Lason could take over mail routing by July 1. (Exh. 377, p. 7282-7283; RT 3661:21-
27 3662:12 (Murray).) From that implementation date until October 2006, DocDNA could not
28 route mail at all. (RT 3657:14-3658:2 (Murray).) It was “essentially just a holding container

1 of images that we needed to run reports and pull specifically from based on the document
2 number.” (RT 3200:3-18 (Murray).)

3 *In Its Haste, PacifiCare Failed to Provide for Proper Planning, Testing, and*
4 *Implementation*

5 DocDNA, a system intended to direct time-sensitive claim-related documents with
6 significant implications for consumers, was ill-conceived, barely analyzed prior to
7 implementation, and poorly tested. PacifiCare’s reckless and hasty implementation of this
8 system illustrates the organizational dysfunction at the root of many violations in this case.

9 PacifiCare maintains that it had no choice but to implement a flawed process and use
10 the data from the resulting chaos to design “a more effective solution going forward.”
11 (RT 13726:22-13727:8 (Murray).) Yet the flaws in the document routing system were
12 apparent from the beginning. Had PacifiCare subjected its plan to a modicum of scrutiny,
13 the company would have realized that asking Lason staff to leaf through an enormous binder
14 filled with opaque instructions and paper exemplars would not result in accurate routing of
15 the “very wide range of documents” PacifiCare received each week. (RT 13682:12-15;
16 13699:23-25 (Murray).) The company’s failure to do so exemplifies PacifiCare’s fall-
17 forward doctrine: “let the system fail and then fix the specific failure points” “rather than
18 spend too much time predicting the errors.” (Exh. 566; RT 15354:17-15356:22 (Soliman);
19 RT 10359:16-19 (Berkel); Exh. 678, p. 3005; Exh. 897, p. 1591; Exh. 898, p. 4764;
20 Exh. 899, p. 8015.)

21 The DocDNA transition also illustrates PacifiCare’s failure to thoroughly review
22 existing processes or conduct “detailed business and system analysis” before eliminating
23 staff and outsourcing business functions. (Exh. 466, p. 0888; Exh. 448, p. 8705; RT
24 8497:19-8498:7 (Berkel).) Due to the abbreviated implementation schedule, the company
25 did not adequately analyze and document the pre-outsourcing mail routing process (RT
26 6328:19-6329:3 (Vonderhaar)) or fully evaluate the proposed DocDNA system (Exh. 5258,
27 p. 7105.) Before implementation of DocDNA, PacifiCare conducted “a couple rounds” of
28 testing, with 70 or 80 documents in each round. (RT 13772:8-13773:4 (Murray).) In light of

1 the complexity of document routing and the wide variety of documents received via mail, the
2 testing conducted for DocDNA before implementation was inadequate.

3 The refusal to allocate sufficient time for careful analysis and testing of the proposed
4 document routing system was not just negligent but willfully reckless. Before PacifiCare
5 implemented DocDNA, other vendors warned of the risks inherent in overly complex mail
6 routing processes: “[A]ny deviation to the address on the mail piece is an opportunity for
7 error. If the instructions are not clear, or they vary based on the type of mail piece, the risk
8 increases.” (Exh. 596, p. 7918.) ACS, PHS’ chosen vendor, had balked at designing a
9 system with 65 document types, informing PacifiCare that most routing systems had only
10 five or six types. (RT 13767:2-13769:9 (Murray).) If common sense were not sufficient to
11 alert PacifiCare to the risks of misrouted mail, these explicit warnings surely were.

12 Although PacifiCare had anticipated that some documents would be misrouted, it
13 designed DocDNA with “no method of systematically locating a document within a
14 DocDNA queue.” (Exh. 574; Exh. 709; RT 13712:4-8 (Murray).) As a result of this
15 “ridiculous” “integration mistake” (Exh. 709), documents could only be found by searching
16 for a unique document identifier number “DCN” to which claims examiners and customer
17 service staff did not have access. (RT 3275:2-17; 3620:25-3621:7 (Murray).) In late 2007,
18 Ms. Berkel sought approval for adding the ability to search DocDNA by member number but
19 was told that the \$40,000 expense “isn’t in the budget.” (Exh. 709; Exh. 632, p. 9282.) This
20 response exemplified, in her view, how the obsession with synergies “drives irrational
21 answers.” (Exh. 632, p. 9282.)

22 *Lason Exemplifies PacifiCare’s Lack of Proper Management of Vendors*

23 A principal reason for Lason’s poor performance and why it was not promptly
24 identified and corrected was PacifiCare’s failure to appropriately manage the functions it had
25 outsourced. (RT 6317:18-20 (Vonderhaar) [PacifiCare “didn’t give [Lason] the best
26 direction”]; RT 6805:4-12 (Vonderhaar) [“we designed something so complicated it was
27 difficult to manage”]; RT 17469:17-17470:7 (Vavra) [claim rejection was a result of
28 PacifiCare giving Lason inaccurate instructions].) PacifiCare management gave little

1 thought to the details of how Lason was to accomplish the tasks it had been assigned.
2 (Exh. 711, p. 6591 [PacifiCare was “finding out more things about [Lason’s] procedures we
3 didn’t know about” in 2008].) On several different occasions, PacifiCare completely failed
4 to give Lason instructions for handling the work it had assigned or gave inaccurate
5 instructions, resulting in serious operational problems. (Exh. 577; Exh. 365, p. 6872; Exh.
6 885; Exh. 572.)

7 No one at PacifiCare had overall responsibility for the functions outsourced to Lason.
8 (Exh. 5255; Exh. 911, Exh. 711; RT 14885:8-16 (Vavra).) The dispersed distribution of
9 responsibilities led to confusion among PacifiCare managers about “who had oversight for
10 what component.” (RT 14865:4-15 (Vavra).) Many serious operational deficiencies can be
11 traced to the “gap[s]” in “the Lason oversight process.” (Exh. 706 [Auerbach 4:53 p.m].)
12 PacifiCare has admitted that its relationship with Lason exemplified the “partner
13 management breakdowns” that plagued PacifiCare after its acquisition by United. (Exh. 662,
14 p. 3221.)

15 In late 2007, Ms. Berkel began calling for a “single point of contact for
16 Lason/DocDNA.” (Exh. 705, p. 1679.) She was informed that Ms. Vavra, a United
17 Operations Director, was the “single owner over the Lason relationship” and “should be
18 driving the controls and remediation efforts.” (Exh. 706 [Auerbach 4:53 p.m].) According
19 to Ms. Vavra, however, she was merely the “relationship owner” for Lason. She was not the
20 “single point of contact,” nor did she “own” the contract under which Lason’s work was
21 performed. (RT 14872:25-14873:14; 14839:9-20; 14864:5-8.) Indeed, she knew very little
22 about the correspondence routing work Lason performed. (RT 14892:4-25; 14894:22-
23 14895:11 (Vavra).) This “silo mentality” (Exh. 678, p. 2833; Exh. 288, p. 5466; RT
24 8486:18-8487:6 (Berkel)) delayed effective issue identification and remediation of
25 operational defects. Indeed, the silos and lack of a single overall owner explain why
26 secondary document indexing operated without any supervision by PacifiCare for over a
27 year. (Exh. 365, p. 6872.)

1 Failure to Monitor Lason's Work Led to the Explosion of Unprocessed Documents

2 Lason exemplifies the recurring PacifiCare practice of ignoring queues and orphaning
3 business processes. The individual queues and overall inventory of DocDNA were, by
4 PacifiCare's admission, "poorly managed." (Exh. 342, p. 8514.) PacifiCare did not ensure
5 that there was an "owner" responsible for working each queue until the company was
6 required to do so by regulators, a year after outsourcing the work. (RT 7466:11-23 (Berkel);
7 Exh. 365, p. 6877; Exh. 601, p. 9158; Exh. 118, p. 3418; Exh. 606, p. 1820.) Until May
8 2008, no one had centralized responsibility for monitoring DocDNA inventory or exercised
9 overall responsibility for the document routing function. (RT 3613:14-23 (Murray); RT
10 13988:5-11; 14879:6-17 (Vavra).)

11 As in other areas of PacifiCare's operations, data reconciliation, reporting of
12 performance metrics, and quality audits governing Lason's work were nonexistent or
13 inadequate. (Exh. 370, p. 8617; RT 3627:19-22 (Murray); RT 10313:11-17 (Berkel).) The
14 company consequently failed to detect serious operational breakdowns for months, allowing
15 violations of law to mount.

16 As soon as DocDNA went live, documents began getting "locked" in DocDNA
17 queues instead of being transmitted to REVA, so claims were not reprocessed and provider
18 disputes were not responded to, in some cases for many months. (Exh. 341, p. 3979;
19 RT 3273:7-19; RT 3286:9-13; RT 3288:16-22; RT 3292:19-3293:3 (Murray).) The company
20 did not discover the problem until January 2007 because it had no reconciliation report to
21 ensure that the number of documents deposited in the REVA-designated DocDNA queues
22 matched the number uploaded to REVA each day. (RT 3286:18-3287:2; RT 3289:3-5;
23 RT 3292:2-4 (Murray).)

24 The reconciliation report created after this fiasco should, as Mr. Murray conceded,
25 have been "in place from the beginning." (RT 3286:18-25 (Murray).) After the REVA
26 "locking" experience, PacifiCare should have promptly imposed reconciliation controls for
27 each step of the document routing process. In late 2007, however, there were still "issue[s]
28 with not being aware of volume of REVA files coming from Lason" (Exh. 594, p. 4022

1 [number 1A].) and significant “reconciliation gaps” between the RMO, DocDNA, REVA,
2 and FileNet. (Exh. 365, p. 6878; RT 14328:17-20 (Murray).)

3 Similarly, PacifiCare did not discover that secondary documents were falling into the
4 “black hole” of FileNet without any means of retrieval until August 2007 because there was
5 “no file reconciliation between Lason Mexico and Imaging Team.” (Exh. 365, p. 6872.) In
6 March 2008, there was still no one at PacifiCare auditing Lason’s performance of this
7 function. (Exh. 1031, p. 0037; RT 17432:7-17433:12 (Vavra).)

8 PacifiCare delayed establishing quality, reporting, and reconciliation measures for
9 DocDNA long after the unreliability of the document routing system was known to be
10 affecting claims payment. The company repeatedly noted in late 2007 that reporting around
11 Lason’s activities was “not adequate” and that the company needed “additional resources”
12 for quality audits and reports. (Exh. 370, p. 8617; Exh. 365, p. 6879.) Yet in April 2008,
13 reporting and quality assurance for DocDNA remained “minimal” and “ad hoc.” (Exh. 226,
14 p. 7651; RT 14330:9-11 (Murray).)

15 *PacifiCare Persistently Failed to Hold Lason Accountable for Its Performance*

16 In May 2006, Lason and PacifiCare executed a “Statement of Work” for PacifiCare
17 functions as an addendum to Lason’s existing contract with United. (Exh. 336.) The
18 Statement of Work contained “service level agreements” (“SLAs,” also called “performance
19 guarantees”) whereby Lason would forfeit a percentage of each month’s invoice if it failed to
20 meet certain quality standards. (Exh. 336, pp. 5258-5259; RT 13908:15-23 (Vavra).)

21 PacifiCare has vaunted these quality standards, and the fact that PacifiCare, rather than
22 Lason, measured performance against these standards, as indicating PacifiCare’s appropriate
23 management of the outsourced work. (RT 13907:21-13908:14 (Vavra).) That is not a story
24 that can survive examination of the record.

25 The SLAs were wholly inadequate. The standards only governed the accuracy of
26 sorting between nonkeyable correspondence and keyable claims, and the speed by which the
27 documents were forwarded from the RMO to Lason’s offshore offices. (Exh. 336, pp. 5256,
28 5258; RT 13904:15-24; 13967:24-13968:6 (Vavra).) Once the mail arrived in Mexico or

1 India, the performance standards evaporated. There were no SLAs governing the timeliness
2 or accuracy of correspondence routing (Exh. 336; RT 13936:25-13937:7; 14848:8-12
3 (Vavra)), keying of PLHIC claims (RT 13937:8-12; 14841:14-22; 14847:22-14848:7
4 (Vavra)), or indexing of secondary documents (RT 14915:7-10 (Vavra)). Dirk McMahon,
5 the Chief Operating Officer of UnitedHealthcare (RT 15482:7-15483:4 (McMahon)), agreed
6 this omission was troubling. (RT 17573:5-14.)

7 Consequently, despite Lason’s dismal performance in 2006, 2007, and the first half of
8 2008, it was assessed no penalties for failing to meet standards in that time. (RT 3673:12-
9 3674:7 (Murray); RT 13986:1-20 (Vavra).) Nor was Lason audited or held to any standards,
10 whether by monetary penalties or otherwise, for the crucial functions it performed. (Exh.
11 707, p. 9970 [Akahoshi 5:23 p.m. (number 25): Lason not held to PacifiCare standards for
12 claims keying]; Exh. 370, p. 8617 [no metrics for Claims Exchange]; Exh. 1030 [auditing of
13 doc-typing work began in January 2008]; RT 9813:22-9814:6 (Berkel); RT 17416:15-25
14 (Vavra); RT 14330:12-20 (Murray) [no regular sampling of nonkeyable correspondence
15 function].)

16 In September 2007, well over a year after Lason had taken over the critical Cypress
17 functions, Mr. McMahon demanded that Lason “be absolutely micro-managed into the
18 ground” and observed that, if Lason was “going along fat, dumb and happy not paying out on
19 service guarantees with their performance,” PacifiCare needed to “re-jigger” the SLAs as
20 soon as possible. (Exh. 575, p. 4003 [McMahon 8:49 a.m.].) Six months later, PacifiCare
21 renegotiated their SLAs with Lason. (Exh. 5458.) This agreement required the company to
22 route 96% of mail within 72 hours of receipt and all mail within 96 hours. (Exh. 5458,
23 p. 2732; RT 17387:3-22 (Vavra).)

24 The new SLA was not enforced. Lason did not meet the turnaround time standard in
25 May, June, July, or August of 2008. (Exh. 369, pp. 9186, 9187.) Lason should have
26 incurred a penalty for those months (RT 17389:12-18 (Vavra)), but PacifiCare did not
27 impose one. (RT 17437:4-11 (Vavra); Exh. 1028, p. 2.)

1 Lason Exemplifies PacifiCare's Hasty Cost-Cutting and Slow Remediation

2 As with so many of the integration projects, the outsourcing to Lason was
3 characterized by haste in implementing cost-cutting measures followed by slothful inaction
4 to correct the preordained problems. Grave problems with Lason's performance arose as
5 soon as the outsourcing took effect. (Exh. 339; Exh. 340; Exh. 366; Exh. 571, p. 2532;
6 RT 6317:5-6318:21 (Vonderhaar).) Throughout 2006 and into 2007, PacifiCare's
7 management complained about continued "issues" with Lason and "unacceptable" delays in
8 correspondence routing, reciting the obvious: that the problems "wouldn't be happening if
9 we hadn't outsourced" the work. (Exh. 572, p. 5064 [Vonderhaar 4:23 p.m.].) Yet
10 PacifiCare did not implement meaningful remedial measures until 2008.

11 The company noted the same issues month after month without taking action.
12 PacifiCare's failure to address the problems with DocDNA is particularly egregious. In late
13 2006, PacifiCare knew that it was having problems routing and storing COCCs it received
14 from members, as well as medical records and other documents received from providers.
15 (Exh. 5009; Exh. 884, p. 5066 [Nakashoji 3:52 p.m.].) Nine months later, the company again
16 observed "a significant issue of missing documents" and noted that PacifiCare's own
17 Network Management and Transactions departments had reported mailing documents to the
18 RMO multiple times "and the documents don't show up indexed to claims." (Exh. 577.)

19 By mid-2007, PacifiCare knew that the problems with DocDNA were serious and
20 intractable. (Exh. 5265, p. 1939 [July 2007: Berkel calls correspondence routing "broken"];
21 Exh. 361 [July 2007: Failure to timely process reworks attributed to Lason delays]; Exh. 526,
22 p. 2771 [August 2007: "Issues again with aging in Lason queues."]; Exh. 575, p. 4003
23 ["Everytime we turn around there are issues with Lason and DocDNA."].) PacifiCare
24 promised DMHC that it would review and update its policies related to mail intake and
25 DocDNA by November 30, 2007 (Exh. 5290, Attachment D, pp. 21, 24) and told CDI it
26 would "completely update" its DocDNA policies by the end of 2007. (Exh. 161, p. 13) Yet
27 in February 2008, the company's corrective action plan for Lason was only 50% complete.
28

1 (Exh. 376, p. 8233.) PacifiCare did not begin work on the DocDNA redesign until May
2 2008. (Exh. 376, p. 8233; Exh. 367, p. 7466.)

3 PacifiCare repeatedly failed to timely implement even the simplest and most obvious
4 corrective actions. In August 2007, for example, the company discovered that thousands of
5 secondary documents related to PPO claims were floating around “unattached” in FileNet.
6 (Exh. 575, pp. 4003, 4004.) PacifiCare committed to having all of those secondary
7 documents indexed by October 19, 2007 (Exh. 710, p. 0018 [number 10].), but the task
8 remained incomplete in February 2008. (Exh. 365, p. 6873; Exh. 376, p. 8233.) Even the
9 basic step of implementing a company-wide cover sheet to ensure that the secondary
10 documents would be properly indexed going forward was not executed until February 2008.
11 (Exh. 355, p. 8503.) The relatively low-cost project of modifying FETrain to halt the claims-
12 looping issue that was resulting in late-paid claims was implemented a year after the fix was
13 proposed. (Exh. 554; RT 6118:7-11 (Vonderhaar); Exh. 711; Exh. 881.)

14 PacifiCare was well aware that Lason was contributing to violations of law.
15 (Exh. 882, p. 7641; Exh. 750, p. 7699; Exh. 554.) Yet the company sought cheap, one-time
16 fixes and “workarounds” rather than analyzing and attacking the root causes. (RT 6801:23-
17 6802:14 (Vonderhaar).) PacifiCare did not dedicate sufficient resources to analyze and
18 remediate a process that it considered “broken” (Exh. 5265, p. 1939) and that was resulting
19 in violations of law.

20 **2. Outsourcing of Claims Processing to MedPlans**

21 Before the acquisition, PacifiCare used a vendor called MedPlans (later acquired by
22 First Source) on a limited basis to add back-up claim processing capacity when claim
23 volumes rose. (RT 6193:19-6194:10; 6216:15-22 (Vonderhaar).) From the beginning of its
24 relationship with MedPlans, PacifiCare was dissatisfied with the quality of the vendor’s
25 work. (Exh. 560, p. 4878.) Nevertheless, shortly after the acquisition, PacifiCare decided to
26 lay off its Cypress claims staff in order to “migrate claim processing from higher cost offices
27 to lower cost vendors,” specifically MedPlans. (Exh. 550, p. 6321 [number 54]; RT
28 6188:16-24; 6197:4-8 (Vonderhaar).) PacifiCare transferred the bulk of its PPO claims

1 processing, including complicated rework claims, to MedPlans (Exh. 528, p. 2687;
2 Exh. 5348, p. 8455; RT 6216:23-6217:8 (Vonderhaar); RT 3468:18-24 (Norket)), and
3 oversight of PPO claims processing was transferred to the company's San Antonio office.
4 (Exh. 5046, p. 2236; Exh. 560; Exh. 5348, p. 8455.)

5 After the acquisition of PacifiCare, supervision of MedPlans was transferred to
6 United's Vendor Management staff, who "didn't really understand the PacifiCare legacy
7 business," which undermined management of MedPlans performance with respect to PLHIC
8 claims. (RT 6197:9-6198:10 (Vonderhaar); Exh. 558.) PacifiCare initially believed its
9 reliance on MedPlans would be short lived in light of the anticipated platform migration that
10 would allow it to sunset RIMS. (Exh. 560, p. 4878.) By September 2006, the company had
11 abandoned those migration plans and was facing several more years on RIMS. (Exh. 5399.)
12 Yet, although PacifiCare's concerns with the quality of MedPlans adjudication decisions
13 quickly escalated after September (Exh. 558; RT 6200:4-11 (Vonderhaar)), the insurer did
14 not revisit its dependency on MedPlans.

15 In late 2006, PacifiCare told the vendor that "the quality levels we are seeing are
16 really a cause for termination." (Exh. 1032.) MedPlans' errors in contract interpretations
17 and erroneous denials required PacifiCare to rework these claims. (Exh. 560, p. 4878; RT
18 6226:25-6227:4 (Vonderhaar).) In September 2007, PacifiCare was "frustrated" with
19 MedPlans because the "same conversations [about quality] have been had over the past two
20 or three years" and threatened that "if fixes are not made, [PacifiCare would] have to bring
21 [the work] back in house." (Exh. 560, p. 4878; RT 6225:1-18 (Vonderhaar).) This threat
22 was hollow: PacifiCare simultaneously told MedPlans that it regarded itself as "absolutely
23 dependent on MedPlans for all the work" and felt it "ha[d] to work with them" despite grave
24 concerns about the quality of MedPlans' performance. (Exh. 560, p. 4878; RT 6223:14-
25 6224:3 (Vonderhaar).) Since the threat to withdraw its business was not credible, there was
26 no incentive for MedPlans to improve quality. Nor did PacifiCare assist its vendor in
27 meeting quality expectations; PacifiCare staff told MedPlans they had neither time to revise
28 instructions nor resources to help train MedPlans processors. (Exh. 560, p. 4879.)

1 PacifiCare suspected that one threat to the integrity of MedPlans claims processing
2 was its policy of paying its staff “piece rate” — based on the number of claims they
3 processed. (Exh. 560, pp. 4878-4879; RT 6227:15-6228:7 (Vonderhaar).) PacifiCare’s
4 Claims managers rightly believed that this payment structure encouraged processors to “take
5 the ‘easy way out’ and deny instead of process.” (Exh. 560, pp. 4878-4879.) PacifiCare was
6 “concerned about [MedPlans’] financial model” and decided it needed to correct this
7 irrational payment structure. (RT 6219:18-23; 6227:5-14 (Vonderhaar).) But PacifiCare
8 never altered the piece-rate system. (RT 6233:25-6234:3 (Vonderhaar).)

9 As discussed below, the outsourcing to MedPlans caused serious claim-processing
10 errors, which resulted in many of the acts in violation being charged here.

11 **3. Outsourcing of Eligibility to Accenture**

12 PacifiCare announced a pilot program to transfer PacifiCare paper eligibility data
13 entry functions to Accenture in the Philippines in March 2006 and completed the outsourcing
14 in May. (Exh. 283, pp. 3656, 3658; Exh. 540; RT 17672:19-17673:5 (Watson); RT 5365:21-
15 5366:5 (Labuhn).) PacifiCare had “a lot of special processes” set up for certain employer
16 groups (Exh. 541, p. 3728 [Madden 5:07 p.m.]), but the transition plan did not include
17 retaining any Cypress-based eligibility staff to troubleshoot after the work was outsourced.
18 (Exh. 542; RT 17683:7-17684:24 (Watson); Exh. 1093, p. 23:24-27.) Ms. Watson told Mr.
19 Labuhn, who headed the integration team over Group Services, that eliminating the entire
20 eligibility team at once was too risky. (RT 17700:1-14 (Watson).) He dismissed her
21 concerns, explaining “that there would be some bumps in the road, but ‘we’d work through
22 them’” to arrive at a “more efficient” process. (RT 17700:14-20 (Watson).)

23 There were “countless” problems with the enrollment process following the
24 outsourcing to Accenture. (Exh. 544, p. 6724; RT 17684:3-10 (Watson).) For example, due
25 to insufficient testing before the transition, Accenture caused termination letters accidentally
26 to be sent to enrolled members. (Exh. 5265, pp. 1945-1946; RT 10412:23-10413:12
27 (Berkel); RT 17701:20-17702:17 (Watson).) More generally, the transition to Accenture
28

1 involved a wholesale change in PacifiCare’s processing of eligibility information,
2 implemented without informing employer groups.

3 Before the acquisition, PacifiCare’s enrollment staff was available to employer
4 groups to resolve any errors they detected on eligibility forms. (RT 17679:13-17680:13
5 (Watson). PacifiCare decided to abandon this “high touch” practice when it outsourced the
6 work to Accenture; the company simply mailed back any form that contained an error
7 without entering the member’s data. (RT 18432:20-18433:18 (Wichmann); RT 17685:9-16
8 (Watson); Exh. 542.) On several occasions Accenture returned incomplete eligibility forms
9 to the wrong employer group. (RT 17685:22-25 (Watson).)

10 It took approximately two weeks for the returned forms to reach employers after
11 being mailed from the Philippines. In the meantime, the members were deemed ineligible
12 and denied care. (RT 17681:21-17682:23 (Watson).) PacifiCare did not inform employer
13 groups that Accenture would not perform the outreach to fill gaps in enrollment forms that
14 PacifiCare had done prior to the acquisition. (Exh. 1093, p. 23:15-21.) As a result, 40% of
15 eligibility forms were rejected by Accenture, leading providers to turn away new members,
16 some of whom remained unenrolled for up to two months. (Exh. 542, p.4911; Exh. 1065;
17 Exh. 678, pp. 2784, 2829, 2857, 2879, 3016; RT 10417:19-10419:15 (Berkel).)

18 Ms. Watson referred to the transition to Accenture as “one of the most difficult
19 service breakdowns I’ve ever experienced” in a 30-year career. (RT 17683:25-17684:14.)
20 Other executives agreed that the organization failed in its execution of this transition and that
21 the process to “escalate” the resulting problems for members was “extremely weak.”
22 (Exh. 1064 [Frey 10:56 a.m.]; RT 18420:4-14 (Wichmann) [confirming that Exh. 1064 refers
23 to enrollment]; Exh. 5265, p. 1945 [“deteriorating. . . service around eligibility issues” after
24 the eligibility function was removed from Cypress].)

25 **4. Outsourcing of Customer Care to West**

26 Prior to the acquisition by United, PacifiCare’s customer service model was “Promise
27 Made, Promise Kept” — customer service staff retained responsibility for the caller’s issue
28 until it was resolved. After the acquisition this model was abandoned as the focus shifted to

1 “improving efficiencies” and reducing “handle time” (call duration). (Exh. 352; RT 3392:3-
2 3393:5 (Sing); RT 13558:8-11 (Murphy).) Performance was measured and raises awarded
3 based on “handle time” rather than the service provided to the caller, resulting in pressure to
4 terminate calls even if the caller’s concern was left unresolved. (Exh. 678, pp. 2819, 2775,
5 2784, 2786, 2807, 2811, 2815, 2817, 2849, 2859, 2957, 2964, 2968, 2987, 2988, 3052, 3053,
6 3088, 3126, 3152, 3158, 3164, 3167, 3169, 3158, 3173.) Customer service representatives
7 (“CSRs”) who sought to “make that extra effort for the customer [were] penalized for extra
8 call time and/or low production numbers.” (Exh. 678, pp. 2770-2771.) As one CSR
9 reported:

10 “[T]he difference in a customer service center and a call center is that a
11 customer service center strives to provide their customers with the best service
12 for there [sic] needs. A call center simply takes the call As I was
13 advised by a supervisor, we are not a not customer service center, we are a call
14 center. While we may meet our stats, our customer service has been left in the
15 dust.” (Exh. 678, p. 3006.)

16 The company did not provide customer serve staff with adequate tools or training to
17 furnish responses to callers’ concerns. PacifiCare had “multiple phone numbers” and no
18 interactive voice response (“IVR”) system to help route calls to the proper department, so it
19 was “hard to get [calls] to the right place.” (Exh. 546, p. 8117; RT 2510:4-8 (Sing).) And
20 because CSRs were not properly trained to route callers to staff qualified to respond to their
21 concerns, “promises of call backs and corrections [were] not followed up on.” (Exh. 678, p.
22 2771; Exh. 289, p. 6599; Exh. 627, p. 0408; RT 2564:24-2565:25; 2574:17-2575:15 (Sing.)
23 Members “very commonly” reported calling up to ten different times about the same issue.
24 (Exh. 678, pp. 2886, 2958.) One member requested to speak to a customer service
25 supervisor on five different occasions and was promised that he would be called back within
26 24 hours, but never received a call back. (RT 1727:21-1728:7 (Mr. R).)

27 The customer service department was supposed to scan any documents it received by
28 fax and forward them to the appropriate department using the Online Routing System
29 (“ORS”). (RT 2542:20-23; 2544:9-2545:22 (Sing).) Customer service staff was also
30 supposed to record the issue in IDT, a tracking system (RT 2490:4-12; 3359:17-3361:3

1 (Sing)), but were “not trained on how to route correctly,” which contributed to provider and
2 member calls going “unaddressed.” (Exh. 289, p. 6599; RT 2565:13-2566:25; 2573:11-19
3 (Sing).)

4 The new CSRs had far less expertise than their legacy PacifiCare predecessors and
5 were unable to assist with “a high percentage of calls,” even those asking “simple questions
6 as to how a claim is paid.” (Exh. 286; Exh. 287, p. 6168 [Mimick 5:05 p.m.].) Members,
7 providers, and employer groups experienced “horrible,” “incompetent” customer service,
8 including wait times of up to an hour and a half, provision of inaccurate information, and
9 “outright rudeness.” (Exh. 1065, p. 1102, ¶ 5 [“outright rudeness”]; Exh. 287, p. 6168
10 [inaccurate information]); Exh. 349, p. 6624 [inaccurate information]); Exh. 702; Exh. 717,
11 p. 5404; Exh. 678, pp. 2771, 2797, 2801, 2805, 2831, 2836, 2838 [“horrible”], 2839, 2848,
12 2855, 2864, 2871, 2876; 2882, 2891; 2894 [1.5-hour wait], 2912, 2917 [“incompetent”];
13 3028, 3071; RT 1726:2-1727:20 (Mr. R); RT 3378:21-3379:4 (Sing); RT 2674:15-21;
14 2668:14-2669:12 (K. Griffin).)

15 PacifiCare’s focus on efficiencies led to a deterioration in customer service (Exh. 352;
16 RT 3392:3-3393:5 (Sing)) that harmed consumers, providers, and employers. Providers
17 could not obtain accurate information about the status of claim disputes and were often
18 instructed to resubmit the disputes. (Exh. 5320, p. 8939; Exh. 1033, p. 5468.) One member
19 testified that he spent considerable time and money taken from his work day to repeatedly
20 fax, and call regarding, the same two claims over a period of several months. (RT 1741:24-
21 1742:8 (Mr. R).)

22 PacifiCare did not remediate its flawed customer service for almost two years. The
23 company noted a “high level of customer service issues” in early 2007 (Exh. 285, p. 7085
24 [Berkel 7:27 p.m.].); shortly afterward, California brokers ranked PacifiCare as having “the
25 least effective and courteous member services department.” This survey was discussed at the
26 highest levels of the company (Exh. 803, p. 9189 [Greenberg 3:37 p.m.]; RT 15967:15-
27 15968:18 (Wichmann)), but apparently did not spark a change in the model. Finally, in the
28

1 spring of 2008, PacifiCare decided to bring some outsourced customer service functions back
2 in-house. (Exh. 352.)

3 **F. Mismanagement of Internal Systems and Processes**

4 The functions that PacifiCare did not outsource depended on systems and processes
5 that were working satisfactorily, but which United was determined to abandon in favor of
6 moving the work to United platforms. Once again, the effort was characterized by
7 mismanagement, under-funding, lack of coordination, poor planning, inadequate
8 documentation, insufficient testing, and negligent monitoring.

9 **1. Refusal to Invest in Infrastructure Necessary for Compliance**

10 PacifiCare and United's due diligence process was "incomplete," did "not include
11 robust understanding of PHS integration/migration costs," and did "not outline a 5 year
12 capital plan." (Exh. 5265, p. 1941.) The company's "going in positions" and synergy targets
13 were therefore based on "very preliminary information." (RT 4430:19-23 (Burghoff).)
14 Throughout 2006 and 2007, investment in PacifiCare's operational infrastructure was
15 "significantly limited given the desire to immediately recognize synergies," and, indeed,
16 permitted PacifiCare to achieve synergies in excess of Wall Street expectations. (Exh. 342, p.
17 8532; Exh. 450, p. 5416; Exh. 1058; Exh. 1059; RT 18264:11-19 (Way).) The integration
18 was therefore characterized by "difficulty securing and remaining committed to
19 capital/resources for legacy systems maintenance and integration execution." (Exh. 699, p.
20 4118.)

21 **a. Changed Migration Plans**

22 Once the company broadcast its synergy expectations to the public, it refused to make
23 adjustments that would require significant investment, even when its "going in positions"
24 proved untenable. (Exh. 1093, p. 17:28-18:3.) This was most strikingly illustrated by the
25 plans for adjudicating RIMS claims on United's claim platform, plans that were abandoned
26 less than a year after the acquisition closed.

27 At the time of the acquisition, the two companies planned to migrate claims
28 processing off PacifiCare legacy claims platforms and onto United's platform, UNET (RT

1 11956:11-21 (Greenberg).), permitting the company to “sunset” PacifiCare’s systems and
2 save millions of dollars (Exh. 653, p. 3159; Exh. 523, p. 7765; Exh 647, p. 5875). PacifiCare
3 based its budgets and long-term operational plans on the assumption that PLHIC claims
4 would be migrated to UNET by June 2007. (Exh 531, p. 11 (number 1); Exh. 523, p. 7765;
5 RT 12031:24-12032:3 (Greenberg).) This timeline was “confirmed without involving all
6 areas of service,” “without adequate capital and resource planning” (Exh. 662, p. 3221; Exh.
7 5265, p. 1939; RT 8326:20-25; 8010:9-13 (Berkel).), and despite recognition that the plan’s
8 “significantly accelerated timeline,” “increased complexity,” and large scope made it “risky.”
9 (Exh. 653, p. 3165.)

10 Through the Spring of 2006, PacifiCare continued to assume that PPO claims would
11 migrate to UNET by June 2007 (Exh. 647, p. 5875; Exh. 651, p. 2655; RT 8347:21-24
12 (Berkel).), but the head of the systems migration integration team warned his superiors that it
13 “may not be realistic” to migrate all business over to UNET within a year or two.
14 (Exh. 5395, p. 1649.) In September 2006, PacifiCare formally abandoned its platform
15 migration plans (Exh. 5399); but did not make any decisions about alternative plans for
16 RIMS because “resources were diverted” to focus on NICE. (Exh. 5397, p. 0679; RT
17 11979:22-11980:11; RT 11981:25-11982:16 (Greenberg).) Eventually PacifiCare decided to
18 gradually sunset RIMS by encouraging PLHIC members to “voluntarily migrate” to United
19 PPO products. (RT 7789:5-9; 7841:4-9 (Berkel).)

20 PacifiCare executives recognized by late 2006 that it would be using RIMS to
21 adjudicate claims for several years. (Exh. 526, p. 2770; RT 8418:17-8419:1; RT 7841:14-
22 7842:1 (Berkel).) By offering employer groups the opportunity to “make a choice
23 voluntarily” to switch from PLHIC to United PPO (RT 7841:14-7842:1 (Berkel)), PacifiCare
24 knew that some would choose to remain with PLHIC, as many did. (RT 8418:17-8419:1;
25 7841:14-7842:1 (Berkel).) Indeed, PacifiCare did not begin “the official discontinuation of
26 PPO products on the PLHIC license” until 2010. (RT 7841:12-13 (Berkel).) As of 2010,
27 there were no plans to cease writing individual PLHIC policies and there was no official date
28 set to sunset RIMS. (RT 7962:8-14; 7963:1-5 (Berkel).)

1 RIMS that lacked NPI capability, but to “minimize PHS build efforts for NPI.” (Exh. 392, p.
2 2162 [number 140].) Throughout 2006 and 2007, a significant number of RIMS claims had
3 provider “match issues” that would have been prevented or reduced by the use of NPI. (Exh.
4 554; RT 19673:3-10; 19711:3-7 (Boeving).) These provider match errors caused PacifiCare
5 to “fail the prompt pay laws of California.” (Exh. 554, p. 0310 [Berkel 1:09 p.m.]; Exh. 365,
6 p. 6870.)

7 In the summer of 2007, just as PacifiCare was acknowledging that it would be
8 running RIMS for several more years (Exh. 526, p. 2770), Ms. Berkel told United executives
9 that PacifiCare systems had “not had adequate support since August 2005.” (Exh. 460,
10 p. 5410; RT 8126:21-8127:13.) United admitted to its board that its focus on getting
11 “business off PHS legacy systems” had caused the company to neglect the “existing
12 operating environment” and that “reinvestment in IT infrastructure and maintenance efforts
13 is required to support the business.” (Exh. 457, p. 9245; Exh. 753, p. 4220.) Several months
14 later, senior leaders again noted that “the legacy PacifiCare platform has not been adequately
15 maintained . . . to support ongoing operations, including regulatory requirements.”
16 (Exh. 342, p. 8532.) By 2008, the vendors who leased RIMS and its associated software to
17 PacifiCare no longer supported the versions PacifiCare was running and threatened to
18 withdraw support. (Exh. 655, p. 1630; Exh. 656, p. 0208; Exh. 1093, pp. 28-29;
19 RT 8431:15-19 (Berkel).)

20 In 2008 and again in 2009, the company reaffirmed the decision not to upgrade to a
21 more current version of RIMS (Exh. 654, p. 3952; Exh. 655, pp. 1627, 1630; Exh. 695,
22 p. 5777), even as it acknowledged that “appropriate maintenance has continually been
23 deferred from 2005” and that maintenance of the claims platform remained “inadequate.”
24 (Exh. 553, pp. 5385, 5387.) PLHIC claims continued to be processed on the version of
25 RIMS that the company regarded as “antiquated” in 2005. (RT 12145:10-15 (Greenberg).)

26 The company neglected RIMS in other ways. RIMS was classified as a “Tier 2”
27 application, meaning that the company tolerated a higher level of malfunctions and did not
28 budget for an “on site manager” to coordinate responses to those malfunctions. (Exh. 1054,

1 p. 5230.) In 2007, there were several RIMS outages and malfunctions, during which claims
2 could not be processed (Exh. 1049, p. 5224; Exh. 1055; Exh. 1056, p. 5030; Exh. 1044, p.
3 5206 [Dufek 2:54 p.m.]; Exh. 1054, p. 5230), leading PacifiCare Vice President of Claims
4 Ellen Vonderhaar and other leaders to express significant concern about RIMS' stability.
5 (Exh. 1049, p. 5224 [Vonderhaar 5:14 p.m.]; Exh. 1044, p. 5206 [Dufek 2:54 p.m.].) The
6 most serious RIMS outage lasted four days. (Exh. 744; Exh. 1046, p. 5211.)

7 After the acquisition, PacifiCare stopped performing full backups of RIMS, relying
8 on incremental backups that saved only the data that had been entered that day. (Exh. 1046,
9 p. 5211 (number 19).) Full backups would have permitted prompt recovery after the 2007
10 outages. IT sought funding for full backups of RIMS soon after that outage, emphasizing
11 that the existing incremental backups placed RIMS at high risk. (Exh. 1044; Exh. 1045; RT
12 17977:20-17978:4 (Way).) Five months later, the request was "stalled"; eventually, it was
13 abandoned. (Exh. 1048, p. 3773 [Dufek 8:56 p.m.]; Exh. 5558.)

14 **c. Conscious Neglect of Operational Infrastructure**

15 The funding allocated for PacifiCare operations was "minimal given the expectation
16 that [PacifiCare] would begin migration by June of [2007]." (Exh. 524, p. 7482 [Ness 9:45
17 a.m.].) That allocation was not revisited after the company realized migration was
18 "obviously not going to happen now." (Exh. 524, p. 7482 [Ness 9:45 a.m.]; Exh. 1093,
19 p. 17:22-18:27.)⁶ When serious problems arose, United leaders were "indifferent" to
20 whether the resources that had been allocated were adequate to meet operational needs.
21 (Exh. 543, p. 4755; Exh. 546, p. 8119; RT 8085:7-17 (Berkel).) Decisions were "based on
22 what systems and operations can do with minimal expense" rather than what was needed to
23 process claims adequately. (Exh. 678, p. 3077.) Business leaders were told that expecting
24

25 ⁶While decisions to migrate to United platforms were "broadly communicated" (Exh.
26 5265, p. 1939), and decisions terminating a migration would ordinarily be widely distributed
27 to a large number of people (RT 12067:7-24, 12071:8-12972:5 (Greenberg); but see RT
28 17501:19-17502:14 (McMahon) [no specific mechanism at United for announcing a
decision]), there is no evidence in this record of any written communication going out
announcing to the people on the migration project that it had been terminated.

1 additional capital to solve operational problems was “a sucker’s bet.” (Exh. 636, p. 3619, ¶
2 3.) For example, when it was discovered that it would cost \$40,000 to fix a “ridiculous”
3 “integration mistake,” the response was simply, “we don’t have budget to fix that.” (Exh.
4 632, p. 9282; Exh. 709.)

5 PacifiCare’s “Keep The Lights On” Committee, which sought to “do just the
6 minimum” to keep PacifiCare systems running (Exh. 462; see also Exh. 525; Exh. 901,
7 p. 4202; RT 5422:2-6 (Labuhn)), exemplifies the company’s approach to supporting
8 PacifiCare’s infrastructure. In 2007, United allocated just \$4 million to cover all PacifiCare
9 operational and capital needs, as well as “investments to generate synergies.” (Exh. 900,
10 p. 7283 [Stringer 9:45 a.m.]; Exh. 524, p. 7480 7480 [Labuhn 9:27 a.m.].) Ms. Berkel called
11 the 2008 PacifiCare capital budget of \$7 million “wholly inadequate” to support PacifiCare’s
12 claim engines (Exh. 552, p. 0862.) and implored her superiors to “get real on what it takes to
13 ‘keep the lights on’.” (Exh. 632, p. 9282.)

14 Despite the representations to the Commissioner at the 2005 hearing about United’s
15 superior investment in technology, resources for technological solutions to operational
16 problems were persistently scarce. (Exh. 929; Exh. 901, p. 4202, ¶ 2; Exh. 657, p. 7436;
17 Exh. 524, p. 7486; RT 15351:4-15352:7 (Soliman).) Because United did not establish a
18 budget for integration-related IT development, PacifiCare’s 2006 IT budget had to be
19 “rationed and reallocated to Integration work.” (Exh. 929 [Soliman 4:54 p.m.]; Exh. 657, p.
20 7433.) The ongoing lack of funding for system upgrades, including claim-dependent
21 processes (Exh. 524, pp. 7483 [Dufek 6:50 a.m.], 7485 [Dufek 7:39 a.m.]), put key
22 operational areas at risk. (Exh. 524, pp. 7483 [Dufek 6:50 a.m.], 7483-7484 [Way 9:35
23 p.m.].) The IT department was instructed to put all work orders on hold (Exh. 524, pp. 7483
24 [Dufek 6:50 a.m.], 7483-7484 [Way 9:35 p.m.]), as only “break/fix” technology
25 enhancements — those required to fix a programming error — were approved for funding.
26 (Exh. 901, p. 4202, ¶ 2; Exh. 657, p. 7436; RT 16238:18-16239:6 (Lippincott).) The IT
27 department could not obtain funding for system upgrades, including claim-dependent
28

1 processes like fee schedules and corrections to RIMS data, “despite many attempts.” (Exh.
2 524, pp. 7483 [Dufek 6:50 a.m.], p. 7485 [Dufek 7:39 a.m.])

3 **2. CTN, Recontracting, Consolidation and Corruption of Provider** 4 **Data**

5 At the time that United was considering acquiring PacifiCare, it provided services to
6 its California members through the Care Trust Network (“CTN”), a provider network leased
7 from Blue Shield. To address antitrust concerns, the U.S. Department of Justice (“DOJ”)
8 required United to terminate the CTN lease within a year after the close of the merger.
9 (RT 10596:4-19 (McFann).) The lease itself, however, permitted Blue Shield to give notice
10 of termination within a month of the close of the merger, effective six months later. (Exh.
11 758, p. 9291, fns. 7 & 8.) Blue Shield exercised this option immediately after the merger
12 closed in late December 2005, terminating United’s access to CTN providers as of June 23,
13 2006. (Exh. 5344.)

14 Before the acquisition closed, United knew that the CTN lease could be terminated as
15 soon as six months after close and was planning to replace the CTN network within that
16 time. (Exh. 5343, p. 7737; RT 10791:19-10792:1; 10793:3-9; 10799:7-12 (McFann).) One
17 of the attractions for PacifiCare of acquiring PacifiCare lay in obtaining the PacifiCare
18 provider network. (Exh. 426, pp. 8997, 8999, 9004 [“particularly in California”];
19 RT 10836:22-10837:1 (McFann).) In late 2005, United began planning to replace CTN with
20 PacifiCare’s network, to contract with high volume CTN providers not already contracted
21 with PacifiCare, and to “remediate” any PacifiCare contracts that did not allow access by
22 PacifiCare affiliates, by June 2006 “or by termination date of the Network Access Agreement
23 with CTN, whichever is first.” (Exh. 5343, p. 7736.)

24 This termination did not affect PacifiCare members, who were already being served
25 by PacifiCare’s provider network, which became available to United with the acquisition.
26 (Exh. 5252, p. 6928; RT 8046:3-8; RT 10348:4-14 (Berkel).) However, United deemed there
27 to be “gaps” in the PacifiCare network’s coverage that disadvantaged United members, so
28 United embarked on a program to recontract CTN providers. The ensuing recontracting

1 effort was not, however, limited to executing contracts with high volume “gap” providers
2 (those who had served United members through CTN but were not contracted with
3 PacifiCare). Instead, the company also sought to “remediate” existing PacifiCare contracts
4 with “unfavorable economics” (Exh. 5343, p. 7736; RT 5070:6-12 (McFann).), encouraged
5 all PacifiCare physicians to sign United contracts (Exh. 467, p. 1356, [number 11].), and
6 targeted physicians who had previously belonged to neither network. (Exh. 629, p. 1966[3rd
7 bullet in first paragraph].) As a result, United signed new contracts with over 9,000
8 providers in 2006 and early 2007 (Exh. 5252, pp. 6928, 6929), double the number necessary
9 to fill the CTN “gap.” (Exh. 622, p. 0677.)

10 **a. Contract Loading Delays**

11 More than two-thirds of the contracts that PacifiCare/United executed in 2006 and
12 early 2007 were loaded into its claims systems more than 30 days after the effective date of
13 the contract. (Exh. 5252, p. 6929.) PacifiCare insisted that the providers agree to “hold”
14 claims indefinitely until the new rates were loaded and forgo any interest to which they
15 would be legally entitled for late payment. (Exh. 862, p. 5500 [number 2]; Exh. 5352; RT
16 2206:19-2207:14; 2208:8-16; 12885:15-25 (McFann).) Ms. Berkel testified that the
17 company programmed RIMS to “hold” claims for existing providers until the new rates were
18 loaded, but internal documents showed that claims were paid and then reworked later
19 because the “hold” function was too “manual” to be reliable. (Exh. 528, p. 2688 [see first
20 bullet under “CA Retro Contracts/RIMS Re-work projects –Ellen”].) Moreover, RIMS could
21 not be adjusted to hold claims for newly contracted providers. Their claims were therefore
22 processed as out-of-network despite having executed a contract. (RT 9931:24-9932:14
23 (Berkel).) In any event, many providers submitted claims before their new contracts were
24 loaded and were paid at outdated or out-of-network rates. (RT 2209:22-2210:9 (McFann).)

25 The contract uploading process was plagued with errors and miscommunication
26 between staff in Network Management (“NM”), who negotiated and executed the contracts,
27 and Contract Control and Installation (“CCI”), who reviewed and uploaded the contract data.
28 (RT 2214:1-16; 2215:22-2216:6; 2221:7-10 (McFann).) The staff responsible for uploading

1 the fee schedules were inexperienced, and PacifiCare did not have adequate server space to
2 upload a significant number of fee schedules at once. (Exh. 962 [Smith 3:28 p.m.];
3 Exh. 963; RT 16294:22-16925:13 (Lippincott).)

4 **b. EPDE**

5 In the midst of its ambitious recontracting effort, PacifiCare decided to stop directly
6 maintaining provider data in its RIMS PPO claims platform. Beginning June 23, 2006, the
7 same day as the CTN “cutover,” the company used a “data bridge,” called the Electronic
8 Provider Data Exchange (“EPDE”), to transfer provider demographic and contract data from
9 a United database to RIMS. This decision was driven by the desire to realize cost reductions
10 from avoiding maintenance of RIMS data. (Exh. 395, pp. 1146, 1173; RT 15222:17-22
11 (Lippincott).)

12 Because CTN was a “rental network,” United did not own or maintain the data. (RT
13 14990:1-20 (Lippincott).) Adjudicating claims for United Health Insurance Co. (“UHIC”)
14 after the CTN cutover therefore required importing all the CTN and PacifiCare demographic
15 and fee schedule data into United’s Network Database (“NDB”), on which the United claims
16 engine, UNET, relied. (Exh. 5486, p. 1; RT 2172:10-16; 2257:19-23 (McFann).) United
17 decided to capitalize on this data upload to NDB by eliminating the work involved in
18 manually maintaining RIMS, which resulted in significant cost-savings. (Exh. 395, p. 1146.)

19 There was no technical or operational imperative to use EPDE. (RT 15257:17-25
20 (Lippincott); RT 21336:3-10 (McNabb).) PacifiCare continued to “dually maintain”
21 (separately update) provider data for the remaining legacy PacifiCare states until late 2007,
22 and for PacifiCare’s other platforms long thereafter. (RT 15056:24-15058:6 (Lippincott).)
23 PacifiCare’s representation that termination of the CTN lease “necessitated creating a single
24 source of truth” (Exh. 5615, p. 4) is simply false. The decision to launch EPDE in California
25 on June 23, 2006 was a strategic choice.

26 It was also, as PacifiCare knew, fraught with risk. During each nightly EPDE feed,
27 every record that had been changed since the last feed was transmitted to RIMS and
28 overwrote RIMS records. Because every data transfer presents risk of erroneously changing

1 thousands of records, data bridges are generally regarded as a temporary tool that is usually
2 not employed when the user has control over both the source and destination databases, as
3 PacifiCare did in this case. (Exh. 1093, p. 27:16-19; RT 16067:8-20 (Lippincott).) Indeed, a
4 Network Data Management executive noted that EPDE was a “band aid” and that the
5 company should “establish a direct connect [from NDB] if a platform will be with us for a
6 little while.” (Exh. 947, p. 0396.) PacifiCare never considered building a “direct
7 connection” to allow RIMS to access the data in NDB necessary to adjudicate each claim,
8 which it deemed too expensive. (RT 16067:21-16068:6 (Lippincott).)

9 PacifiCare was aware that using a data bridge created risks that it was unprepared to
10 mitigate (Exh. 395, pp. 1149, 1222) and that it was “moving through uncharted waters.”
11 (Exh. 914.) The company had no previous experience using EPDE in an integration with
12 PacifiCare’s “unprecedented scope and complexity.” (RT 15062:19-25 (Lippincott).) But
13 rather than resolving these risks, PacifiCare’s hasty implementation of EPDE exacerbated
14 them.

15 High level executives ignored internal warnings about the “questionable data”
16 acquired from CTN and “the potential to overwrite clean records in RIMS with bad NDB
17 data.” (Exh. 773, p. 2319; RT 10998:23-11000:14; 11002:3-11003:18 (McFann).) Twenty
18 percent of California data in NDB was incorrect when EPDE launched. (Exh. 767, p. 3316.)
19 But the company failed to assess and reconcile data discrepancies between RIMS and NDB
20 before implementing the feed (Exh. 769, p. 6084; Exh. 713, p. 9518; RT 12766:8-12767:14
21 (McFann)) and only later recognized that the CTN data it was using to overwrite RIMS
22 records was “awful” (Exh. 774, p. 1293).

23 Before writing the programs that comprised EPDE, PacifiCare did not analyze how
24 the two companies’ divergent contracting practices and the many structural differences
25 between RIMS and NDB would affect the flow of data. (Exh. 759, p. 6084; Exh. 917,
26 p. 6488; RT 10845:3-12; 10991:8-12; 12774:5-12; 12765:6-23 (McFann).) The resulting
27 code, unsurprisingly, wreaked havoc with provider data. (E.g., RT 12774:5-12 (McFann);
28 Exh. 771, p. 5859 [Congleton 12:04 p.m.]; Exh. 917; Exh. 954, p. 2782 [Mimick 11:36

1 a.m.].) For example, when a hospital and a medical group shared a similar name, EPDE
2 erroneously “matched” the records and caused the medical group data to overwrite the
3 hospital data, a phenomenon known as the “HSP/MDG overwrite.” (Exh. 921, p. 5189 [Rao
4 5:40 p.m.]; RT 16157:24-16158:3 (Lippincott).)

5 This error should have been, but was not, identified in the planning and testing stage.
6 (RT 16158:7-16 (Lippincott).) The company did not adequately test the EPDE process
7 before implementing it. (Exh. 921; Exh. 759, p. 6084; RT 8231:3-9 (Berkel).) The company
8 devoted a single day to system testing and user acceptance testing, and skipped the
9 “integration testing” necessary to assess the impact of changes on all systems involved in the
10 feed. (Exh. 388, p. 4954; RT 4036:2-20 (Barbati).) Even United Vice President
11 Ross Lippincott recognized, after the fact, the need for testing such processes further
12 upstream and downstream than they did in this case. (Exh. 921, p. 1 [Lippincott 12:39 am].)
13 PacifiCare conducted such minimal training that the EPDE team itself did not understand the
14 basics of how the process worked. (Exh. 602, pp. 1240 -1241; Exh. 898, p. 4739; RT
15 10993:9-10994:17; 12841:1-19 (McFann); 16481:23-16482:15 (Lippincott).) A full year
16 after implementation, the staff attempting to solve data corruption caused by the EPDE feed
17 remained baffled by fundamental elements of the process. (Exh. 948, p. 5403; RT
18 15022:24:15023:6; 16089:7-20 (Lippincott).)

19 Starting when it launched in June 2006, and continuing into 2008, EPDE corrupted
20 provider data in RIMS, causing contracted providers to be paid as non-participating and vice-
21 versa (Exh. 8, p. 1869; Exh. 480; Exh. 481; Exh. 501; Exh. 954, p. 2782 [Mimick 11:36
22 a.m.]; Exh. 354, p. 7184,) and erasing entire data fields, resulting in significant mispayment
23 of claims. (Exh. 475; Exh. 476; Exh. 477; RT 4935:1-4936:17 (McFann); Exh. 479 [result
24 was underpayment]; RT 4950:14-23; 4952:1-3 (McFann); Exh. 481 [provider terminated, not
25 discovered for 4 months].) RIMS data was so corrupted by August 2006 that the idea of
26 using RIMS to generate provider directories was dismissed as “crazy talk.” (Exh. 775, p.
27 2803 [McFann 7:35 p.m.]; RT 11015:6-22 (McFann).) Nine months later, RIMS data was
28

1 still so riddled with errors that PacifiCare *again* could not rely on RIMS to print directories.
2 (Exh. 957, p. 8305.)

3 PacifiCare had originally planned to add all other legacy PacifiCare states to the
4 RIMS EPDE feed in August 2006, but postponed implementation in the other states because
5 the effect on California data was so disastrous. (Exh. 392, p. 2150; Exh. 953, p. 4704
6 [Berkel 9:44 a.m.]; RT 5042:2-18 (McFann).) When the company finally implemented the
7 other states in October 2006, it caused “a huge mess” — providers were “paid non-
8 contracted and to wrong addresses,” just as they were in California. (Exh. 507, pp. 3923-
9 3924.) PacifiCare discontinued the EPDE feed for these states and continued to dually
10 maintain their RIMS data for at least another year. (Exh. 5539.) There is no indication that
11 PacifiCare even considered doing the same for California provider data.

12 **c. Failure to Maintain Fee Schedules**

13 As United was well aware before the acquisition, PacifiCare’s “thousands” of
14 nonstandard fee schedules “take[] time and effort to [build] correctly.” (RT 10674:20-24;
15 10681:7-10; 12961:12-13 (McFann).) For months following the acquisition, PacifiCare
16 failed to maintain RIMS fee schedules and the “crosswalks” that linked fee schedules in
17 RIMS to the corresponding fee schedules in NDB. In March 2007, PacifiCare realized that
18 no one had been maintaining the nonstandard fee schedule crosswalk, which housed the
19 majority of PacifiCare fee schedules, and that dozens of the standard fee schedules were also
20 incorrectly linked. (Exh. 497, pp. 9764-9765; RT 10861:7-9 (McFann).) This
21 “embarrassing” and “avoidable” situation would have been prevented by “much more rigor”
22 around “operational flows.” (Exh. 497, p. 9763 [McFann 9:21 p.m.]; RT 16266:5-16268:2
23 (Lippincott).) As Mr. Lippincott, the “owner” of the end-to-end EPDE process, observed, it
24 was “hard to believe it’s mid-March and we are just now realizing a key operational process
25 hasn’t been followed this entire time.” (Exh. 959, p. 8289 [Lippincott 1:16 p.m.]; RT
26 15185:24-15186:2 (Lippincott).)

1 [limited]”).) And the problem could have been detected by appropriate end-to-end audit
2 processes (RT 15369:21-15370:2) or at least remedied after the fact had anybody been
3 monitoring the transactions:

4 “[C]ertainly if we had tested more rigorously and on a wider scale, we could
5 have cut the damage. But the fact that nobody was tending or watching or
6 looking for the rejects, neither automated nor manually, was a problem as
well.” (RT 15370:10-14.)

7 She confirmed that the error caused claims to be lost. (RT 15369:17-20.)

8 Ms. Soliman also testified to the deleterious effects of United’s fall-forward policy
9 (RT 15354:17-15358:25; 15361:3-15362:19; 15375:18-15378:3) and on the problems created
10 by the budget cuts and loss of personnel (RT 15351:4-15352:16; 15377:21-15379:2;
11 15382:18-15383:6). So in the UFE breakdown we find yet another case study in PacifiCare
12 mismanagement, combining again many of the recurring deficiencies: synergy-driven budget
13 and personnel cuts, hastily implemented new processes and systems insufficiently
14 understood, inadequate testing, and inadequate monitoring.

15 **e. Corruption of Provider Data in RIMS and Claim-Payment**
16 **Errors Confirm the Mismanagement of the Integration**

17 If Lason is the poster-program for PacifiCare’s mismanagement of outsourcing and
18 vendor management, EPDE and the associated corruption of provider data is the emblem of
19 PacifiCare’s for mismanagement of internal programs.

20 Like the Lason fiasco, the root causes of the inaccurate provider data in RIMS
21 illustrate PacifiCare’s culpability and disregard for compliance. Provider contract data is
22 extremely complex, and timely and accurate claims payment depends on skillful
23 management of that complexity. (RT 19812:1-6 (McNabb).) Yet the company neglected to
24 establish and implement even the most rudimentary standards or risk-mitigation strategies for
25 handling contracts and provider data. PacifiCare’s provider data deficiencies were the
26 inevitable result of its refusal to invest in adequate staff and quality-control resources, its
27 failure to promptly analyze defects and address their root causes, its willingness to let the
28

1 provider community bear the brunt of known data corruption, and its siloed organizational
2 culture in which avoidance of blame was paramount to problem-solving.

3 *Failure to Manage the Process and Personnel for Handling Contracts*

4 PacifiCare provided its staff with “no documented process flows” for loading
5 contracts or physician rosters or for linking doctors to the right fee schedules. Staff was
6 given conflicting instructions for contract loading and no path for resolving problems that
7 arose in the contract loading process. (Exh. 787.) Legacy PacifiCare Network Management
8 staff submitted incorrectly configured contracts because they were not trained to use
9 Emptoris, the contract-generating and loading tool that fed data to NDB. (Exh. 342,
10 p. 8526.) The months-long neglect of the fee schedule crosswalks was attributed to the lack
11 of “a clear process on loading fee schedules [and] updating crosswalks” (Exh. 497, p. 9764
12 [Feng 1:04 p.m.:number 2].) and the failure to properly audit fee schedules after they were
13 constructed (Exh. 491, p. 1252; RT 10296:4-12 (Berkel)).

14 *Failure to Timely Remediate Defects*

15 Shortly after the EPDE feed began, PacifiCare staff began complaining of the
16 “widespread impact” of “questionable data” (Exh. 773, p. 2319) and expressed “frustration”
17 that the “data integrity issue” was not being investigated. (Exh. 775, p. 2803 [Gates 4:34
18 p.m.].) By early 2007, EPDE had contributed to an “all time high” of aged RIMS inventory
19 and rework. (Exh. 544, p. 6721 [Berkel 7:27 p.m.:4th paragraph].) Yet the company failed to
20 take corrective action for months.

21 By August 2006, PacifiCare realized that the EPDE process had serious problems—
22 sufficiently serious that the company postponed expanding it to other states (Exh. 953,
23 p. 4704 [McFann 9:58 a.m.]; Exh. 775, p. 2803 [McFann 7:35 p.m.]) — and that changes to
24 the feed were required. (Exh. 435, p. 3699 [date of 8-8-06, “changes to EPDE required” (See
25 bullet “CTN Migration”).]) In January 2007, the company conducted an “all day deep dive”
26 to review EPDE logic and identify corrective actions. (Exh. 950 [Rao 10:04 a.m.].) Yet the
27 first coding adjustment to fix known logic errors, euphemistically known as an
28 “enhancement,” was not implemented until March 2007. (Exh. 921, p. 5189; Exh. 916, p.

1 9427 [number 4].) Logic fixes were rolled out in a sporadic and piecemeal fashion
2 throughout 2007 and 2008. (Exh. 958, p. 0540 [number 2.7]; Exh. 505, p. 1589 [Mimick
3 7:38 a.m.]; Exh. 506, pp. 3785; Exh. 677, p. 4417.) These “enhancements” often introduced
4 new data errors (Exh. 677, p. 4417 [number 2]; Exh. 505, p. 1589 [Mimick 7:38 a.m.]),
5 indicating that PacifiCare had not taken to heart to its “lessons learned” about
6 comprehensively testing the code before implementation. (Exh. 921, p. 5189 [Lippincott
7 12:39 a.m.].)

8 PacifiCare promised to remedy its contract-loading deficiencies following the market
9 conduct exam. (Exh. 118, p. 3423.) A year later, however, Ms. Berkel predicted that
10 reworks and provider appeals “will increase” “because we have not corrected our internal
11 control framework” for contract loading. (Exh. 637 [Berkel 9:52 a.m.].) In March 2009, Mr.
12 McMahon called an assessment of PacifiCare’s progress on these corrective actions “brutal,”
13 observing that “there are no quantitative measures of success and we are behind on all”
14 corrective actions for contract loading. (Exh. 715, p. 3204 [McMahon 9:59 a.m.]; Exh. 714,
15 p. 1635; RT 9909:3-12 (Berkel).)

16 PacifiCare did not timely or voluntarily rework provider claims that had been paid
17 improperly as a result of late contract loading. (Exh. 5265, p. 1945; Exh. 118, p. 3423.) The
18 company was committed to “eliminating retros” and pressured providers to accept lump-sum
19 settlements rather than reprocessing claims, as PacifiCare was required to do. (Exh. 264,
20 p. 5470 [McKinley 10:27 a.m.]; Exh. 116, p. 1301; RT 2226:2-5 (McFann).)

21 Lack of Data Reconciliation and Reporting

22 PacifiCare fixed individual data errors when frustrated providers complained about
23 them, but did not attempt to identify the full scope of corrupted data, did not analyze root
24 causes, and did not allocate resources to fixing all the errors causing inaccurate claims
25 payments. Records that had been fixed were therefore often corrupted again by the next
26 feed, requiring staff to “correct[] provider records over and over again.” (Exh. 501, p. 5935
27 [Chan 2:27 p.m.].) Even after the fee schedule crosswalk was found to have been neglected
28 for months, a deficiency United Vice President Elena McFann called “avoidable” and

1 “embarrassing” (Exh. 497, p. 9763 [McFann 9:21 p.m.]), the company did not swiftly
2 remediate it, and the company failed to maintain fee schedules on several later occasions.
3 (Exh. 266, p. 6987; Exh. 970, p. 9675 [Mimick 7:18 a.m.]; Exh. 808, Exh. 763; RT 2260:2-9
4 (McFann).)

5 The company’s failure to analyze the root cause of billing address errors exemplifies
6 its indifference to large scale data corruption in RIMS. Shortly after EPDE went live,
7 providers began complaining that reimbursement checks were being sent to outdated
8 addresses, even though PacifiCare had previously been sending payment to the proper
9 address. (Exh. 1021, p. 0280 [Black 3:53 p.m.]) In late 2006, several PacifiCare employees
10 noted this phenomenon, and one suggested, to no avail, that a report be run to identify all the
11 providers affected. (Exh. 495.) CDI and the California Medical Association (“CMA”)
12 independently raised the issue with PacifiCare in early 2007. (Exh. 1021; Exh. 5, p. 0705.)
13 The company continued to receive internal indications that an EPDE error was changing
14 provider addresses in RIMS but refused to investigate the root cause because NDB was the
15 “source of truth,” “so regardless of what was previously in RIMS, it’s good now.” (Exh.
16 850, p. 8067; Exh. 354, p. 7184 [number 17].) This glib tautology was unconscionable in
17 light of the company’s awareness that inaccurate data in NDB had, and was continuing to,
18 corrupt RIMS data (RT 15129:18-15130:3 (Lippincott)). The company did not identify the
19 structural defect causing returned checks, which were not paid within 30 working days, until
20 April 2007. (Exh. 917.)

21 By late 2006, PacifiCare had recognized the need for stronger quality controls to
22 prevent data defects from being introduced at the various handoff points between contract
23 loading, NDB, and RIMS, yet the company took no action to tighten controls. (Exh. 759, p.
24 6084; RT 16305:17-20; 16332:21-16333:22 (Lippincott).) In April 2007, the company again
25 acknowledged the acute absence of quality measures for the transmission of data from
26 Emptoris to NDB and for the EPDE feed from NDB to RIMS. (Exh. 965, pp. 5838, 5840.)
27 Yet PacifiCare did not establish a “war room” to track data corruption problems related to
28 EPDE until June 2007, a year after the feed began (Exh. 602, p. 1241), and did not begin

1 regularly reviewing “EPDE quality metrics” until September 2007. (Exh. 602, pp. 1238,
2 1245.) The need for these reconciliation and reporting activities was foreseeable in June
3 2006; if PacifiCare had implemented at that time and consistently applied them thereafter,
4 many mispaid claims could have been avoided. (RT 8247:8-13; 8253:25-8253:-25 (Berkel).)

5 The sporadic, ad hoc reconciliation reports that PacifiCare used before September
6 2007 were often ignored because the company did not establish standards or allocate
7 responsibility for monitoring the reports. (Exh. 968, p. 8487 [Lippincott 11:09 a.m.];
8 Exh. 970, p. 9675 [Mimick 7:18 a.m.]; Exh. 665, p. 4133 [“who owns the report?” (See
9 “Business Requirements”)]; RT 16381:14-15 (Lippincott).) Even reports created to monitor
10 specific logic flaws known to be corrupting provider records, or brand-new code that had just
11 been put into production, were not monitored. (Exh. 503, p. 1380 [Mimick 3:29 p.m.]; Exh.
12 969, pp. 4808- 4809 [Rao 3:07 p.m.]; RT 16376:12-23 (Lippincott).)

13 Moreover, the enhanced reports that PacifiCare developed in August 2007 were
14 inadequate. (Exh. 977 [Mimick 7:40 a.m.]; RT 16432:6-21 (Lippincott).) In October 2008,
15 and again in March 2009, the company lamented the inadequacy of the reconciliation reports
16 and quality controls to prevent demographic and contract data defects. (Exh. 699, p. 4154;
17 Exh. 714, p. 1635 [number 5].) The company never developed proper controls or testing
18 capacity for Emptoris, despite having acknowledged for years the need for enhanced testing.
19 (Exh. 966, pp. 2470, 2471 [McDonnell 6:47 a.m.]; Exh. 771, p. 5858 [Kaja 10:21 p.m.].)

20 The company also failed to correct data errors promptly, allowing them to languish
21 for months while claims were incorrectly paid. (Exh. 8, pp. 1865-1868; Exh. 497; Exh. 509;
22 Exh. 5354, pp. 8205 (Dr. Sun), 8206 (Dr. Castellanos), 8207 (Dr. Borok and Women’s
23 Healthcare); Exh. 477; Exh. 481 [provider terminated, not discovered for four months].) The
24 company did not attempt to systematically assess the accuracy of RIMS data until August
25 2007. (Exh. 602, p. 1239.) By that time, PacifiCare employees had been begging their
26 superiors for months to undertake a “rigorous audit process to ensure the integrity of data”
27 (Exh. 789, p. 7224) rather than “continue to rely on the provider community to discover our
28 issues for us” (Exh. 956, p. 5196 [Mimick 10:02 a.m.]). The company had also, months

1 earlier, acknowledged that “dated provider demographic data in NDB needs extensive
2 cleaning.” (Exh. 965, p. 5840 [5th bullet under “Lowlights”].)

3 *Silos and Lack of Accountability*

4 Management of the contract loading process and EPDE was characterized by hostility
5 among departments whose cooperation was crucial to success. The refusal to transcend
6 organizational boundaries hindered resolution of serious problems. Because PacifiCare
7 never established a “dedicated single point of contact” to supervise and coordinate the
8 activities involved in contract loading and provider data, all process improvements were
9 “transactional or reactionary” rather than proactive. (Exh. 699, p. 4152.)

10 The company failed to designate responsibility for researching the root causes of
11 errors. (Exh. 856, pp. 1709 [See “Current Process Controls”] Exh. 665, p. 4133;
12 RT 12834:25-12835:7; 12837:23-12838:6; 12839:10-14 (McFann).) As a result, the
13 company faced a backlog of almost a thousand unresolved provider data inquiries in January
14 2007, most of them over two months old. (Exh. 767, p. 3323.) A year later, there were still
15 provider data issues that had “been on a list for 6 months or more with no traction,” due to “a
16 gap in the organizational structure” and unwillingness by staff to “step out of their roles to
17 engage the UHC organization.” (Exh. 979, p. 3701.)

18 The obstacles posed by United’s silo mentality are most strikingly illustrated by the
19 IT department’s refusal to meaningfully assist the effort to resolve EPDE problems, and
20 Mr. Lippincott’s failure to challenge that refusal. IT refused to make Probir Datta, the
21 programmer who created much of the EPDE logic (RT 15095:16-23; 15197:9-11; 16485:11-
22 16486:1 (Lippincott)), available to help the EPDE team even after the other person most
23 knowledgeable on the topic had left the company. (Exh. 985, p. 2512 [Mimick 4:32 p.m].)
24 IT was continually ineffective in supporting efforts to resolve EPDE problems; resisted
25 participating in the war room; refused to investigate EPDE issues unless there was
26 “evidence” that the error was IT’s fault; and ignored requests for assistance for weeks.
27 (Exh. 948, p. 5402 [Feng 6:43 a.m.]; Exh. 665, p. 4133; Exh. 987, p. 0597; Exh. 985,
28 p. 2513; Exh. 986, p. 2487; RT 16500:2-9 (Lippincott).) Mr. Lippincott was responsible for

1 demanding the IT resources necessary to quickly resolve EPDE problems, but he saw no
2 problem with IT “following their by-the-book procedures,” even though those procedures
3 were “not meeting needs.” (RT 16518:9-25; 16502:17-16503:8; Exh. 1093, p. 21:8-21.)

4 United executives also focused on avoiding blame for data corruption rather than
5 taking ownership and fixing problems. The director of CCI fumed that others “put the
6 accountability on me to try and figure out what the root cause is when the people who
7 created/implemented this process should be explaining to me what they are doing to corrupt
8 my records in RIMS.” (Exh. 501, p. 5933 [Chan 9:40 a.m.].) Mr. Lippincott was
9 preoccupied with “trying to clear EPDE’s name” by attributing problems to the legacy
10 PacifiCare Autoload program, although modifications to that program fell within his area of
11 accountability. (Exh. 919, p. 5200 [Lippincott 12:42 a.m.]; Exh. 1093, pp. 9:11-10:23.) He
12 dismissed criticisms as “EPDE lore” (RT 15030:7-15032:4 (Lippincott)) and insisted that
13 “EPDE isn’t the root cause of X problem” even before the root cause could be determined.
14 (Exh. 953, p. 4704 [McFann 9:58 a.m.].) During the hearing, Mr. Lippincott continued to
15 insist that he bore no responsibility for the data corruption detected in the market conduct
16 exam. (RT 15191:23-15193:12; 15195:17-25; 15199:21-15201:5.)

17 Layoffs and Inadequate Resources

18 Many of these operational deficiencies, and the glacial pace of remediation, can be
19 traced to PacifiCare’s excessive layoffs, failure to retain knowledgeable staff, and refusal to
20 devote adequate resources to maintaining PacifiCare’s claims payment infrastructure.

21 Every department involved in contract loading and maintenance of provider data was
22 understaffed. Network Management, which negotiated contracts and managed many of the
23 provider data issues, had been “reduced through attrition” (Exh. 717, p. 5404 [See 3d bullet
24 in “Background”]) and “had triple work load [sic] with the same staff.” (Exh. 5265, p.
25 1948.) CCI, which reviewed contracts and uploaded the data into NDB, was
26 “overwhelmed,” “backlogged” and “overloaded due to layoffs.” (Exh. 510, pp. 1301-1302,
27 1304.) CCI was “at least 6 weeks behind” in loading contract information because the
28

1 company did not replace CCI staff that had left, even as the “floodgates [were] opening for
2 remediated contracts.” (Exh. 510, p. 1304; Exh. 760 [Stewart 9:36 a.m.])

3 The Integration and Technology Operations (“ITO”) unit, which was responsible for
4 EPDE, did not increase staffing despite “continued aggressive acquisition activities” that it
5 knew would “stretch resources beyond capacity.” (Exh. 984, pp. 9814, 9827.) The
6 company’s failure to undertake data reconciliation efforts until late in 2007 is likely
7 attributable to the absence of “resources to perform historical clean-up or structured, pro-
8 active ‘true-up.’” (Exh. 699, p. 4152; RT 9897:3-17 (Berkel).) Even after the fee schedule
9 debacle, the company did not allocate sufficient resources to thoroughly examining each fee
10 schedule. (Exh. 491, p. 1255.)

11 The company also shed legacy PacifiCare employees at a time when detailed
12 knowledge of RIMS and of PacifiCare’s nonstandard contracts was most crucial. The
13 contract loading staff did “not have historical knowledge of PHS process, systems or
14 provider contracts” and the practice of “simply apply[ing] UHC standards across the board”
15 “created huge regulatory, financial and legal risk for PHS legacy business.” (Exh. 762,
16 p. 1481 [Sheppard 6:03 p.m.])

17 PacifiCare made no effort to retain the single employee who understood the different
18 file structures of both NDB and RIMS. (RT 15149:6-15150:1 (Lippincott); Exh. 1093,
19 p. 21:1-7.) The delay in reworking mispaid claims was due in part to the “limited RIMS
20 rework claims adjudicators” remaining after the layoffs. (Exh. 408, p. 7620 [2nd bullet under
21 “Overview”].)

22 The refusal to budget for maintenance of legacy PacifiCare systems and for
23 technology development necessary for integration significantly delayed remediation of
24 known EPDE errors. The strict limit on funding for technology fixes prevented needed code
25 enhancements “from being operationalized.” (Exh. 984, p. 9827; Exh. 524, p. 7482.) When
26 PacifiCare first began assessing the logic flaws in EPDE in January 2007, there was no
27 funding for EPDE updates (Exh. 950 [Rao 10:04 a.m.]; Exh. 447, p. 6385.) As a result, the
28 first “enhancements” did not occur until March and April of 2007. Projects planned for 2008

1 to improve data accuracy were sacrificed to budget limits. (Exh. 981, p. 9023; Exh. 982,
2 p. 6087; Exh. 983, p. 1316.)

3 **G. The Result: “Integration Speed, Savings, Quality — Pick Two. We Missed**
4 **on Quality”**

5 In 2006, Uniprise, the operations arm of United that “paid the claims and answered
6 most of the phone calls” (RT 15485:8-19 (McMahon)) “hit its IOI based upon the fine work
7 to drive cost out of PHS.” (Exh. 546, p. 8116 [Auerbach 9:02 a.m.].) As of June 30, 2007,
8 United had achieved a total of \$950 million in integration run rate synergies — \$365 million
9 of which was attributable to “operating efficiencies.” (Exh. 457, p. 9242.⁷) The “operating
10 efficiencies” included reduced costs of corporate infrastructure and information technology.
11 (RT 11245:13-22 (Berkel).) That figure does not include any “growth synergies” or
12 increased revenue. (RT 18407:9-18408:19 (Wichmann).) Compared to the

13 As United sees it, the integration is a success story. (E.g., RT 15872:24-15873:12
14 (Wichmann) [“satisfied with the way United executed the PacifiCare integration,” which was
15 “a success” from shareholder, member, and provider standpoints].) Apparently inspired by
16 the comparison to the initial aggregate synergy goal of \$100 million (Exh. 943, p. 8907) —
17 which was supposed to include both cost reductions and business growth (Exh. 434, p. 3044)
18 —United has given itself repeated pats on the back. (E.g., RT 15920:11-15921:5
19 (Wichmann) [problems encountered “sit inside a very broad-based, complicated integration,
20 which by most every measure, independent or otherwise, people would say was highly
21 successful”]; RT 17418:22-17419:12 (Vavra) [Lason successful]; RT 19859:14-21
22 (McNabb) [both acquisition and integration were success]; RT 7818:7-15 (Berkel)
23 [Accenture very successful]; RT 8230:14-16 (Berkel) [implementation of EPDE successful];
24 RT 9788:18-21 (Berkel) [Lason a success]; RT 2092:1-3 (McFann) [CTN transition
25 “considered a success at United”]; RT 17302:12-22 (Lippincott) [EPDE was a “successful
26 deployment”].)

27 _____
28 ⁷“Annualized run rate’ refers to, once an integration project has been completed, for
the following 12 months or any annualized basis, that those would be the savings realized.”
(RT 4458:10-13 (Burghoff).)

1 Forgotten (or simply denied) is the fact that these synergies were achieved “at the cost
2 of excellent customer service and claims payment.” (Exh. 450, p. 5417.) As United
3 executive Mr. McMahon observed, the company’s “overzealous” pursuit of synergies drove
4 PacifiCare’s numerous operational problems. (Exh. 662, p. 3216 [McMahon 11:48 a.m.]
5 Ms. Berkel testified that resource scarcity contributed to violations in this case. (RT
6 8074:18-8075:11.) Her 2007 lessons-learned appraisal remains the most pithy summary of
7 the integration: “Integration Speed, Savings, Quality — Pick Two. We missed on Quality.”
8 (Exh. 5265, p. 1939.) The record thus contains a complete explanation of how so sweeping a
9 breakdown in a previously functioning insurance company occurred. From the initial staff
10 and budget cuts to the hastily implemented changes in systems and processes, PacifiCare
11 reaped the inevitable harvest of inadequate management of the resulting explosion of
12 violations. While it is unnecessary to trace these roots in order to confirm the violations
13 themselves, they cast a clarifying light on the appropriate regulatory response to those
14 violations, as discussed below.

15 **H. Complaints, Regulatory Response, Company Evasion**

16 In October 2006, CDI began noticing a spike in complaints from consumers and
17 providers about PacifiCare’s claims-handling practices, primarily focused on mispaid claims
18 and claims that had been wrongly denied based on pre-existing conditions. (RT 52:22-53:16;
19 58:14-59:2 (Smith); Exh. 5003.) Consumers also complained, and the company has
20 confirmed, that for a period phone calls to the company went completely unanswered. (RT
21 57:15-20 (Smith); Exh. 5265, p. 1945.) When CDI compliance officer Nicoleta Smith
22 repeatedly attempted to reach someone in PacifiCare’s claims department to discuss the
23 complaints, no one answered the telephone and she was unable to leave a message. (RT
24 54:3-56:8 (Smith).) Ms. Smith finally received a return phone call from a PacifiCare
25 representative, Sharon Hulbert, with whom she initiated a discussion about the complaints
26 the Department had received. (RT 55:24-57:25 (Smith).)

27 The number of complaints continued to increase dramatically in the following
28 months. (RT 195:14-23 (Smith).) In early 2007, CDI’s Claim Services Bureau (“CSB”), a

1 unit within the Consumer Services Division, assigned several experienced compliance
2 officers to systematically investigate the complaints it was receiving about PacifiCare’s
3 claim-handling practices. (RT 69:17-70:3; 181:16-19; 224:13-17 (Smith).) The Department
4 notified PacifiCare at that time that its investigation of consumer complaints had revealed
5 troubling patterns of noncompliance. CDI requested a detailed corrective action plan and a
6 timeline for its completion. (Exh. 5004.) Over the course of 2006 and 2007, CDI
7 compliance officers issued numerous violation letters confirming the results of their
8 complaint investigations and citing the company for hundreds of violations. (Exh. 36;
9 Exh. 39; Exh. 46; Exh. 47; Exh. 48; Exh. 49; Exh. 54; Exh. 55; Exh. 57; Exh. 59; Exh. 61;
10 Exh. 63; Exh. 68; Exh. 70; Exh. 72; Exh. 74; Exh. 75.)

11 At PacifiCare’s request, representatives of the company participated in a conference
12 call with CDI compliance staff at the end of January (RT 71:4-10 (Smith); Exh. 4, p. 7940),
13 but did not answer the Department’s questions or furnish timelines for completing corrective
14 actions. (RT 77:21-79:7; 82:11-83:5 (Smith).) In early March 2007, several high level
15 PacifiCare executives gave a presentation to CDI staff about “challenges” the company was
16 “overcoming” in connection with the “integration” of PacifiCare into United, and their
17 relationship to the complaints CDI was receiving from consumers and providers. The
18 company identified United’s loss of the leased Care Trust Network (CTN) as the primary
19 cause of claims-processing problems. (Exh. 8, p. 1865; Exh. 5013, p. 9677 [Masters 9:52
20 a.m.]; RT 122:23-123:2 (Smith).)

21 Nor was the company forthright with the regulators about the role that the Lason
22 outsourcing played in the service breakdowns that triggered so many complaints. During the
23 March 2007 PacifiCare-CDI meeting to address consumer complaints and integration issues,
24 the company was aware that serious errors in the transition of mail routing to Lason were
25 affecting claims, appeals, customer service, and provider disputes. (Exh. 5258, p. 7105.) Yet
26 PacifiCare chose not to reveal this information to CDI in the course of the meeting. (RT
27 7568:20-7569:3 (Berkel).)

1 Throughout the first half of 2007, the CSB PacifiCare team met regularly with
2 PacifiCare staff to discuss the claim-handling practices revealed by consumer and provider
3 complaints. (RT 112:14; 118:18-22; 153:3-7; 162:2-13; 177:10-25 (Smith).) CDI asked
4 PacifiCare to identify the extent and root causes of noncompliance and requested detailed
5 corrective actions, including reprocessing of wrongly denied and mispaid claims. (Exh. 3;
6 Exh. 4; Exh. 5; Exh. 6; Exh. 7; Exh. 11; Exh. 17; Exh. 5017; RT 84:18-21; 106:21-108:22;
7 110:4-115:8; 153:3-7 (Smith).) PacifiCare expert Susan Stead, a former regulator with the
8 Ohio Department of Insurance testifying on behalf of PacifiCare, lauded CDI's efforts to
9 address PacifiCare's noncompliance. (RT 24510:13-25; 24484:1-24487:20; 24493:1-14;
10 24495:15-24996:11 (Stead).)

11 PacifiCare periodically provided responses to the Department's inquiries and updated
12 the Department on its corrective action efforts. (E.g., Exh. 5006; Exh. 5007; Exh. 5008.)
13 However, the company frequently failed to meet deadlines it had established for completing
14 corrective actions. (E.g., Exh. 17, p. 7377 [number 1]; Exh. 15, p. 0477 [number 8]; RT
15 173:19-25 (Smith).) While PacifiCare was "responsive" in terms of its willingness to meet
16 with CDI, "the meetings did not really result in substantive resolutions" to the issues CDI
17 raised. (RT 464:10-19 (Smith).) Laura Henggler, CDI's primary contact at PacifiCare, was
18 "not very helpful" and appeared uninformed about basic claims-processing matters. (RT
19 153:9-154:4 (Smith).) Over the course of CSB's investigation, PacifiCare made several
20 misrepresentations about its integration activities and their causes. For example, PacifiCare
21 deliberately obfuscated the circumstances around the corruption of fee schedules (compare
22 Exh. 623, p. 3205, with Exh. 622, p. 0678) and misrepresented the circumstances and
23 consequences of the termination of the CTN lease.

24 CDI compliance officers grew frustrated that the noncompliance they had brought to
25 the company's attention was not promptly addressed. (RT 112:8-16; 115:9-22; 159:3-160:1
26 (Smith).) Compared to other health insurers with whom Ms. Smith had worked on
27 compliance issues, PacifiCare's progress on corrective action plans was "very slow" and the
28 volume of compliance issues grew rather than shrinking over time. (RT 178:21-179:23

1 (Smith.) In Spring 2007, the CMA, an organization representing independent physicians
2 and physician groups (RT 1243:18-23 (Black)), and the University of California Medical
3 Centers filed complaints with the Insurance Commissioner calling for an investigation of
4 PacifiCare’s claim-handling practices. (Exh. 165; Exh. 5155.) These complaints indicated
5 that PacifiCare had not addressed the compliance problems CDI had been discussing with the
6 company for several months. When a compliance officer asked PacifiCare about the
7 estimated timeframe for resolving the compliance issues that CDI had addressed, Ms.
8 Hulbert responded that it would take three to five years to resolve these acquisition-related
9 problems, and that it would be “cost prohibitive” to do so more quickly. (RT 118:11-17
10 (Smith).)

11 The large volume of consumer and provider complaints and the compliance issues the
12 CSB investigation had uncovered prompted CDI to consider a targeted exam. (Exh. 5171,
13 p. 4289; RT 267:19-268:6 (Smith); RT 600:9-20 (Vandepas); RT 14067:24-14068:16
14 (Laucher).) Around April 2007, CDI and the DMHC began planning coordinated targeted
15 examinations of the PacifiCare legal companies within their respective jurisdictions
16 (Exh. 5408; RT 11451:6-10 (David)), and notified the company of the planned exam shortly
17 thereafter (Exh. 891).

18 During the course of the examination, CDI sent PLHIC several “referrals” to clarify
19 the circumstances of particular transactions, practices, or data. (RT 619:1-13 (Vandepas);
20 Exh. 106; Exh. 107; Exh. 108; Exh. 110; Exh. 111; Exh. 121.) PacifiCare sometimes
21 provided only partial responses to these referrals, which the examiner in charge, Coleen
22 Vandepas, testified was unusual. (Exh. 109; RT 628:1-629:1 (Vandepas); see also RT
23 14074:1-12 (Laucher).) In several responses to referrals, the company deliberately
24 suppressed or distorted information. For example, when the Department asked about staffing
25 trends for claims-processing staff, PacifiCare deliberately withheld the primary reason for
26 turnover, which was dissatisfaction with benefits and overtime. (Exh. 363; RT 3509:17-
27 3510:4 (Norket).) In another referral, CDI asked about the root cause of the company’s
28 failure to timely process provider disputes. PacifiCare acknowledged internally that its

1 noncompliance in this area was due to the document routing system it implemented after the
2 acquisition, but decided not to share this information with the Department. (Exh. 358, p.
3 9596.)

4 In accordance with section 734.1, CDI transmitted to PacifiCare the verified written
5 reports of the MCE on or about November 9, 2007. (Exh. 116; RT 907:1-16 (Vandepas).)
6 PacifiCare was given 30 days to make a written submission or rebuttal to the reports, as
7 provided for by section 734.1, subdivision (a). (Exh. 116, p. 1411.) On or about December
8 7, 2007, PacifiCare issued its responses to the verified written reports of the MCE, admitting
9 to approximately 130,000 violations of law, and disputing other findings. (Exh. 117;
10 Exh. 118; RT 662:15-663:18 (Vandepas); RT 7778:21-7779:1 (Berkel).) Where PacifiCare
11 disagreed with the number of violations cited in the draft report, the final report was revised
12 to accept PacifiCare's figure. (RT 666:10-669:6 (Vandepas); compare Exh. 1 with Exh. 117,
13 Exh. 118.)

14 The Department rated the findings "severe." (Exh. 892; RT 14076:12-20 (Laucher).)
15 This rating, as Joel Laucher, then head of the Market Conduct Division, testified, "generally
16 means that we would expect to do a referral for an enforcement action." (RT 14076:12-14.)
17 Mr. Laucher testified that the Department was alarmed by the "pervasiveness" of the
18 noncompliance and the fact that unfair practices persisted long after they had been brought to
19 the company's attention. (RT 14077:13-24.)

20 PacifiCare was served with the Order to Show Cause; Statement of Charges /
21 Accusation; Notice of Monetary Penalty on January 25, 2008. The Department subsequently
22 filed four Supplemental Accusations and a First Amended Accusation, in which it alleged
23 additional violations discovered in the course of the hearing. (Exh. 290; Exh. 597; Exh. 664;
24 Exh. 1177; Exh. 1209.) The Administrative Law Judge ("ALJ") ruled that her decision in
25 this case would not include findings on the allegations pled in the Fourth Supplemental
26 Accusation (RT 25716:10-25719:2), which have accordingly been omitted from the briefing
27 and the Proposed Findings.

1 In the next part of this brief (pp. 63-104, *infra*), the Department reviews the legal
2 principles applicable to the determination of violations and assessment of penalty, and in the
3 following part each category of charged violations is specifically addressed (pp. 105-309,
4 *infra*). The discussion immediately above of the integration of PacifiCare into United, the
5 manifold systems and process failures, and the mismanagement of PacifiCare’s PPO business
6 is offered for factual context, to explain how the violations arose, to identify the general
7 business practices of the licensee, and to provide the evidence necessary to assess the
8 appropriate penalties.

9 **III. LEGAL FRAMEWORK**

10 **A. History of Sections 790.03 and 790.035**

11 To protect consumers from dilatory and unfair practices by insurers, the Legislature
12 enacted the UIPA. (§ 790 et seq.) Adopted in 1959 by Assembly Bill No. 1530 and
13 amended several times since, the purpose of the act is

14 “to regulate trade practices in the business of insurance . . . by defining, or
15 providing for the determination of, . . . all such practices . . . which constitute
16 unfair methods of competition or unfair or deceptive acts or practices and by
prohibiting the trade practices so defined or determined.” (§ 790.)

17 In so doing, the Legislature sought “to regulate further in areas of perceived lacunae in the
18 state control of insurance business” to preempt federal regulation, in accordance with
19 passage of the McCarran-Ferguson Act (15 U.S.C. §§ 1011-1015) giving states control over
20 the business of insurance. (*Karlin v. Zalta* (1984) 154 Cal.App.3d 953, 972; 15 U.S.C. §§
21 1011-1015 [McCarran-Ferguson Act].) Section 790.02 prohibits any person from engaging
22 in “an unfair or deceptive act or practice in the business of insurance” as defined in section
23 790.03 or determined pursuant to this article (§ 790.04).

24 Section 790.03 defines “unfair methods of competition and unfair and deceptive acts
25 or practices in the business of insurance,” forming the framework of the Commissioner’s
26 authority to protect consumers from a broad spectrum of unfair insurance practices.
27 Prohibited acts extend to such diverse practices as misrepresenting policies, dividends, or the
28 financial condition of an insurer; false, deceptive, or misleading advertising; anti-competitive

1 behavior; discriminatory rating; and canceling or refusing to renew a policy in violation of
2 code provisions protecting religious and other non-profit institutions. (§ 790.03, subds. (a)-
3 (g) & (i).)

4 In 1972, the Legislature enacted Assembly Bill No. 459, adding subdivision (h).
5 Subdivision (h) added a specific set of prohibited unfair claims settlement practices,
6 patterned after a similar, but not identical, amendment to the National Association of
7 Insurance Commissioners (“NAIC”) model act.⁸ The proscribed practices relevant to this
8 proceeding include:

9 “(1) Misrepresenting to claimants pertinent facts or insurance policy
10 provisions relating to any coverages at issue.” (§ 790.03, subd. (h)(1).)

11 “(2) Failing to acknowledge and act reasonably promptly upon
12 communications with respect to claims arising under insurance policies.” (§
13 790.03, subd. (h)(2).)

14 “(3) Failing to adopt and implement reasonable standards for the prompt
15 investigation and processing of claims arising under insurance policies.” (§
16 790.03, subd. (h)(3).)

17 “(4) Failing to affirm or deny coverage of claims within a reasonable time
18 after proof of loss requirements have been completed and submitted by the
19 insured.” (§ 790.03, subd. (h)(4).)

20 “(5) Not attempting in good faith to effectuate prompt, fair, and equitable
21 settlements of claims in which liability has become reasonably clear.” (§
22 790.03, subd. (h)(5).)

23 The legislation prohibits insurers from “knowingly committing or performing with
24 such frequency as to indicate a general business practice” any of the enumerated unfair
25 claims settlement practices (§ 790.03, subd. (h)(1)-(h)(16)). However, to enforce subdivision
26 (h), as originally enacted, the Commissioner had to first issue an order to show cause and
27 then, upon a finding at hearing that the alleged acts were unfair or deceptive, issue a cease-
28 and-desist order pursuant to section 790.05. If the unfair practices continued, the

⁸For an example of a difference between the NAIC model act and California’s UIPA, the NAIC model act did not state that a single act could trigger liability until modified by the association in 1990.

1 Commissioner could seek penalties, but only for violation of the cease and desist order. (See
2 Stats. 1972, ch. 725.) The Commissioner did not yet have authority to assess penalties for
3 committing the underlying unfair or deceptive practices.

4 Insureds and third party claimants, however, could bring actions in the courts to seek
5 damages against insurers for claims-handling misconduct in violation of section 790.03,
6 subdivision (h). The private right of action for unfair insurance practices was recognized by
7 *Royal Globe Ins. Co. v. Superior Court* (1979) 23 Cal.3d 880 (“*Royal Globe*”). The *Royal*
8 *Globe* Court also held that a single violation knowingly committed was sufficient to bring an
9 action, reasoning that an individual claimant would not be able to prove a pattern of
10 wrongdoing. (*Royal Globe*, 23 Cal.3d at p. 891.) Concurrent jurisdiction (private lawsuits
11 and administrative enforcement) of section 790.03, subdivision (h) ended in 1988 when the
12 California Supreme Court eliminated the private right of action in *Moradi-Shalal v.*
13 *Fireman’s Fund Ins. Co.* (1988) 46 Cal.3d 287 (“*Moradi-Shalal*”), reversing its ruling in
14 *Royal Globe*. Although the *Moradi* Court discussed whether a single act was sufficient to
15 bring an administrative enforcement action, the Court did not decide that issue. Rather than
16 “allowing ourselves to be swept deeper into the developing interpretative whirlpool it [*Royal*
17 *Globe*] has created,” the *Moradi-Shalal* Court limited its decision to abrogating the private
18 right of action against insurers for violation of section 790.03. (*Moradi-Shalal*, 46 Cal.3d at
19 p. 304.)

20 In 1989, the Legislature adopted section 790.035 in Senate Bill No. 1363, which
21 dramatically broadened the scope of the Commissioner’s enforcement powers by authorizing
22 the Commissioner to impose penalties of up to \$5,000 per act, or \$10,000 for each willful
23 act, in violation of section 790.03 and authorizing such penalties without any prior cease-
24 and-desist order. The legislative history indicates that the statute was enacted in direct
25 response to the *Moradi-Shalal* decision eliminating a private right of action under section
26 790.03, subdivision (h) and was intended to provide the Commissioner with an equivalent
27 tool to deter insurers from engaging in unfair and deceptive claims-handling practices.

1 In 1992, pursuant to the express grant of quasi-legislative authority, the Insurance
2 Commissioner promulgated the Fair Claims Settlement Practices Regulations to “delineate
3 certain minimum standards for the settlement of claims which, when violated . . . shall
4 constitute an unfair claims settlement practice.” (Reg. 2695.1, subd. (a).) Reinforcing the
5 Legislature’s intent to liberally interpret what constitutes an unfair or deceptive act (§§ 790,
6 790.02, 790.04), the Preamble states:

7 “These regulations are not meant to provide the exclusive definition of all
8 unfair claims settlement practices. Other methods, act(s), or practices not
9 specifically delineated in this set of regulations may also be unfair claims
10 settlement practices and subject to California Insurance Code Section
11 790.03(h)...” (Reg. 2695.1, subd. (b).)

12 To accomplish its objectives, the Regulations define statutory terms and set standards
13 for determining penalties. (Reg. 2695.1 et seq.) In relevant part, the Regulations make it
14 clear that the practices proscribed in section 790.03, subdivision (h) are considered to be
15 unfair claims settlement practices when “*either* knowingly committed on a single occasion,
16 *or* performed with such frequency as to indicate a general business practice.” (Reg. 2695.1,
17 subd. (a) (emphasis supplied).) An act is “knowingly committed,” within the meaning of
18 subdivision (h), if “performed with actual, implied or constructive knowledge, including, but
19 not limited to, that which is implied by operation of law.” (Reg. 2695.2, subd. (l).)
20 Consistent with the legislative intent to provide an incentive to the insurance industry to
21 refrain from unfair practices, the Regulations also make it clear that the “commission or
22 *omission*” of a proscription of section 790.03 or this subchapter is subject to penalties under
23 section 790.035. (Reg. 2965.1, subd. (v) (emphasis supplied).)

24 The Legislature has twice amended section 790.03 since adoption of the Regulations
25 in 1992, expressing no disagreement with the definitions of statutory terms or substantive
26 standards set forth in the Regulations. (Stats. 2001, ch. 253 (Assem. Bill No. 1193), § 2;
27 Stats. 2011, ch. 426 (Sen. Bill No. 712), § 1.) Indeed, pursuant to amendments of section
28 790.03 in 2001 — almost a decade after the Commissioner first promulgated the Regulations
— the Legislature required that, upon receipt of a claim, an insurer must provide the

1 policyholder with a written notice stating that “Fair Claims Settlement Practices Regulations
2 govern how insurance claims must be processed in this state,” and must explain to the
3 claimant how to obtain a copy of the Regulations. (§ 790.034, subd. (b)(1).)

4 **B. Standards for Liability Under Section 790.03**

5 As part of the UIPA, section 790.03 prohibits certain acts considered to be “unfair
6 methods of competition or unfair or deceptive acts or practices in the business of insurance.”
7 Standards for determining liability are found in the language of the UIPA and statutes found
8 elsewhere in the Insurance Code, and are further augmented by regulations, including the
9 Fair Claims Settlement Practices Regulations.

10 **1. Subdivision (h)**

11 With the enactment of subdivision (h), the Legislature added a specific set of unfair
12 claims settlement practices to the regulatory framework of the UIPA, expressly designed to
13 ensure fairness in the claims process and investigation and resolution of claims. The
14 legislative intent was to deter insurers from engaging in unfair insurance practices and to
15 create incentives for insurers to comply with the law. Therefore, the standards should be
16 interpreted liberally with fidelity to promoting the consumer protections they were intended
17 to provide. (*Cole v. California Ins. Guarantee Assoc.* (2004) 122 Cal.App.4th 552, 558 [“A
18 remedial or protective statute should be liberally construed to promote the underlying public
19 policy.”].)

20 **a. Either a Single Act or a General Business Practice**

21 To establish a violation of section 790.03, subdivision (h), the legal standard requires
22 that an unfair claims settlement practice must be either “knowingly committed *or* performed
23 with such frequency as to indicate a general business practice.” (§ 790.03, subd. (h)
24 (emphasis supplied).) The use of the disjunctive establishes that there are two ways to prove
25 a violation: a single act knowingly committed or an indication of a general business practice.
26 (*Zorich v. Long Beach Fire & Amb. Serv.* (9th Cir. 1997) 118 F.3d 682, 684 [disjunctive “or”
27 means that only one of the listed requirements need be satisfied].)

1 Other language in section 790.03, subdivision (h) confirms that a single act can
2 establish an unfair claims settlement violation. As examples, subdivision (h)(7) prohibits
3 “attempting to settle *a* claim by *an* insured”; subdivision (h)(7) proscribes “failing, after
4 payment of *a* claim”; subdivision (h)(13) proscribes “failing to provide . . . for the denial of *a*
5 claim”; subdivision (h)(14) prohibits “directly advising *a* claimant”; subdivision (h)(15)
6 prohibits “misleading *a* claimant”; and subdivision (h)(16) proscribes “delaying . . . after the
7 insurer has received *a* claim.” (§ 790.03, subd. (h) (emphases supplied).)

8 The Regulations likewise make it clear that a single isolated act knowingly committed
9 can constitute a constitute violation of section 790.03, subdivision (h):

10 “Section 790.03(h) enumerates sixteen claims settlement practices that, when
11 *either* knowingly committed on a *single* occasion, *or* performed with such
12 frequency as to indicate a general business practice, are considered to be unfair
13 claims settlement practices and are, thus, prohibited by this section of the
California Insurance Code.” (Reg. 2695.1, subd. (a) (emphasis supplied).)

14 The Regulations are based on the Department’s expertise in both the technical and
15 practical implications of the claims-handling issues involved in section 790.03, subdivision
16 (h), after careful consideration by the Commissioner, in accordance with Administrative
17 Procedure Act notice-and-comment provisions. Like CDI Deputy Commissioner
18 Tony Cignarale (RT 22839:19-22840:1-11), Ms. Stead agreed that a single act could subject
19 an insurer to a penalty under section 790.035. (RT 25356:9-11 [“I do understand that a
20 single act could be enough, under some circumstances possibly, to establish the existence of
21 an unlawful trade practice.”]; Exh. 5717 [showing two proof standards for section 790.03,
22 subd. (h)].)

23 **b. Knowingly Committed**

24 The legal standard for “knowingly committed” is “performed with actual, implied or
25 constructive knowledge, including but not limited to, that which is implied by operation of
26 law.” (Reg. 2695.2, subd. (l).) Constructive knowledge means that “[i]f one by exercise of
27 reasonable care would have known a fact, he is deemed to have had constructive knowledge
28 of such fact.” (Black’s Law Dict. (abridged 6th ed. 1991) p. 217.) As an example, PLHIC

1 improperly denied claims on pre-existing-condition grounds, despite having certificates of
2 creditable coverage in its possession.

3 **c. Performed with Such Frequency as to Indicate a General**
4 **Business Practice**

5 Having made clear in the preceding clause that even a single act may violate the
6 statute, the Legislature provided the second clause to prohibit as well any unfair general
7 business practice. It is important to recognize that the function of “frequency” is not as a
8 condition of liability but as an indicator of a general business practice, supporting an
9 inference of general practice from frequent acts. It is the practice — not the frequency of
10 acts itself — that is addressed in the second clause, and, of course, the general business
11 practice may be established by other means than frequent act, such as by affirmative
12 statement of policy or by the use of a standardized form containing illegal provisions.

13 The Insurance Code does not define the term “general business practice,” or explain
14 what frequency suffices to “indicate a general business practice.” (§ 790.03, subd. (h).)

15 Frequency, as a threshold number, will vary according to the circumstances and can
16 be as small as one when the circumstances support an inference of practice from the single
17 act. (See Reg. 2695.1, subd. (a); see RT 22850:10-13 (Cignarale).) For example,
18 Mr. Cignarale viewed 30 instances of PLHIC’s failure to timely respond to Department
19 inquiries as a high frequency (Exh. 1184, p. 161:11); 1,333 instances of PLHIC incorrectly
20 paying claims over the course of one year and two months as high frequency (Exh. 1184,
21 p. 78:1-2); and 100% frequency during a certain period of PLHIC’s failure to include a
22 notice in its EOBs to insureds of the right to an Independent Medical Review (“IMR”) (Exh.
23 1184, p. 59:16-18) sufficient to indicate a general business practice.

24 **2. Specific Proscriptions**

25 **a. Subdivision (h)(1): Misrepresenting to Claimants Pertinent**
26 **Facts or Insurance Policy Provisions Relating to Any**
27 **Coverages at Issue**

28 Section 790.03, subdivision (h)(1) prohibits insurers from “misrepresenting to
claimants pertinent facts or insurance policy provisions relating to any coverages at issue.”

1 (§ 790.03, subd. (h)(1).) “Misrepresentation” means anything not true. (Black’s Law Dict.
2 (abridged 6th ed. 1991) p. 692.) Its synonyms are “misstate, misrelate, slant, distort,
3 misinterpret.” (Merriam-Webster Online Dict. <<http://www.merriam-webster.com> >[as of
4 May 11, 2012].) In addition, it is well established that an omission of a material fact by a
5 person under duty to disclose it is equally as fraudulent as an affirmative misstatement. (See,
6 e.g., *Chiarella v. United States* (1980) 455 U.S. 222, 230.) The ordinary meaning of
7 “omission” is “something neglected or left undone, neglect of duty . . . specifically a failing
8 to perform a duty or expected action.” (455 U.S. at p. 230; Merriam-Webster Online Dict.
9 [as of May 11, 2012].) By its plain language, subdivision (h)(1) imposes a duty on insurers
10 to truthfully disclose to claimants pertinent facts or policy provisions related to the coverage
11 at issue. Moreover, the Regulations confirm the inclusive nature of “misrepresentation” by
12 making clear that, for purposes of determining a penalty under section 790.035, a single act
13 may be “*any commission or omission* which in and of itself constitutes a violation of . . .
14 Section 790.03 or this subchapter.” (Reg. 2695.2, subd. (v) (emphasis supplied).) The
15 Legislature intended to regulate the trade practices of insurers to protect consumers.
16 (§ 790.02.) The Department has interpreted the proscriptions of subdivision (h)(1) to mean
17 misrepresentation by affirmatively making false statements as well as misrepresentation by
18 omission. (Exh. 1184, p. 39:14-17, 39:20-40:3, 51:6-24.) The standard governing insurers in
19 subdivision (h)(1) is properly interpreted broadly to mean any communication sent to a
20 claimant with information that is incorrect due to affirmative representation or omission.

21 The Regulations further interpret subdivision (h)(1). In detailing what policy
22 provisions are pertinent, Regulation 2695.4 requires insurers to disclose to a first party
23 claimant or beneficiary all benefits, coverages, time limits or other provisions of the policy
24 that may apply to the claim presented. (Reg. 2695.4, subd. (a).) In addition, Regulation
25 2695.7 imposes the obligation to notify claimants of their right to have the Department
26 review a denial of all or part of a claim. (Reg. 2695.7, subd. (b).) By defining certain
27 statutory terms, the Regulations make it clear that the protections of subdivision (h)(1) must
28

1 be broadly applied to include insureds as well as providers making claims on behalf of
2 insureds.

3 A “claimant” means a first or third party claimant. (Reg. 2695.2, subd. (c).) A “first
4 party claimant” means any person asserting a right under an insurance policy as a named
5 insured, other insured or beneficiary under the terms of the insurance policy. (Reg. 2695.2,
6 subd. (f).) For purposes of health insurance (see § 106 [health insurance included in
7 “disability insurance”]), “beneficiary” means “the party or parties entitled to receive the
8 proceeds or benefits occurring under the policy in lieu of the insured” (Reg. 2695.2,
9 subd. (a)), confirming that a provider is a “first party claimant.” A “third party claimant”
10 means any person asserting a claim against the interests insured under the insurance policy.
11 (Reg. 2695.2, subd. (x).) “Insurance policy” is also broadly defined to mean “the written
12 instrument in which any certificate of group insurance, contract of insurance, or non-profit
13 hospital service plan is set forth.” (Reg. 2695.2, subd. (j).)

14 **b. Subdivision (h)(2): Failing to Acknowledge and Act**
15 **Reasonably Promptly upon Communications with Respect**
16 **to Claims Arising Under Insurance Policies**

17 Section 790.03, subdivision (h)(2) prohibits insurers from “[f]ailing to acknowledge
18 and act reasonably promptly upon communications with respect to claims arising under
19 insurance policies.” (§ 790.03, subd. (h)(2).)

20 Delineation of the standards for “reasonably promptly” have been provided by the
21 Legislature in other statutes and in the Regulations authorized by the Legislature. For health
22 insurance, the standard for “reasonably prompt” acknowledgment of a claim are defined by
23 section 10133.66, namely 15 working days from the date of receipt of the claim.

24 (§ 10113.66, subd. (c).) The Regulations further interpret the requisite “reasonably prompt”
25 actions required of an insurer upon receipt of a claim. Thus, in addition to acknowledging
26 receipt of a claim within 15 calendar days, an insurer must also

27 “provide to the claimant necessary forms, instructions, and reasonable
28 assistance, including . . . specifying the information the claimant must provide
for proof of claim [and] begin any necessary investigation of the claim [within
the same period]. (Reg. 2695.5, subd. (e).)

1 Standards for “reasonably prompt” payment of an uncontested claim are set forth in
2 section 10123.13 as no later than 30 working days after receipt of the claim. (§ 10123.13,
3 subd. (a).) Should a claim be contested, the “reasonably prompt” time for notifying the
4 claimant and provider is set forth in section 10123.13 as 30 working days from receipt of the
5 claim. Additional standards for “reasonably prompt” actions associated with a claim are
6 further provided in section 10123.13, requiring that an insurer must also identify what
7 portion of the claim is contested or denied and provide the specific factual and legal basis for
8 contesting or denying the claim. (§ 10123.13, subd. (a).) Section 10123.147 also provides
9 standards for a “reasonably prompt” response to health insurance claims, requiring an insurer
10 to notify both the insured and the provider of their rights to have the claim denial reviewed
11 by the Department. (§ 10123.147, subd. (a).)

12 **c. Subdivision (h)(3): Failing to Adopt and Implement**
13 **Reasonable Standards for the Prompt Investigation and**
14 **Processing of Claims Arising Under Insurance Policies**

15 Section 790.03, subdivision (h)(3) proscribes “[f]ailing to adopt and implement
16 reasonable standards for the prompt investigation and processing of claims arising under
17 insurance policies” as an unfair claims settlement practice. (§ 790.03, subd. (h)(3).) It is
18 important to note that the language of the statute shows the intent that merely penning
19 procedures for investigating and processing claims is insufficient, that such standards must
20 actually be effectively implemented. To “adopt” requires a sustained effort, “to accept . . .
21 and put into effective operation.” (Black’s Law Dict. (abridged 6th ed.1991) p. 32.)

22 What constitutes “reasonable standards” for processing a claim is made specific in
23 various other statutes. Again, for health insurance, section 10123.13 defines a reasonable
24 standard for reimbursement of a claim as no later than 30 working days from receipt of the
25 claim. (§ 10123.13, subd. (a).) That statute also sets forth a reasonable standard for notice of
26 a contested or denied claim as 30 working days from receipt of the claim and, further,
27 specifies what information must be included — identification of “the portion of the claim
28 that is contested or denied and the specific reasons including for each reason the factual and
legal basis.” Section 10123.47 reinforces that 30 working days is a reasonable standard for

1 reimbursement of a claim as well as a reasonable standard for notification to both the insured
2 and provider that a claim is contested or denied. (§ 10123.147, subd. (a).) That statute also
3 defines a reasonable standard for investigating and processing a claim to mean that insurers
4 are required to notify insureds and providers of their right to have the Department review any
5 claim denial.

6 Section 10123.137 fleshes out the statutory policy to regulate insurer practices in the
7 investigation and processing of claims by defining what are reasonable standards in handling
8 provider disputes: “Each contract between a health insurer and a provider shall contain
9 provisions requiring a fast, fair, and cost-effective dispute resolution mechanism under which
10 providers may submit disputes to the insurer” (§ 10123.137, subd. (a).) The statute
11 further specifies what information must be submitted and sets a reasonable standard for
12 resolving the dispute as 45 working days from the date of receipt of the provider dispute.
13 (§ 10123.137, subd. (c).)

14 Section 10169 amplifies what constitutes reasonable standards for investigating and
15 processing a claim by requiring that insurers provide notice of an insured’s right to request
16 an IMR in informational brochures, contracts, grievance procedures, EOBs and a wide
17 variety of other communication vehicles. Section 10133.66, subdivision (c) sets forth
18 additional reasonable standards for claims processing by requiring insurers to acknowledge
19 to providers receipt of a claim within 15 working days and to specify the recorded date of
20 receipt of the claim.

21 The Regulations also interpret the provisions of section 790.03, subdivision (h)(3).
22 Regulation 2695.3 delineates what constitutes reasonable standards with regard to
23 maintaining claims files to document the actions taken by insurers to investigate and process
24 claims. The Regulation requires that claims files “shall contain all documents, notes and
25 work papers (including copies of all correspondence) which reasonably pertain to each claim
26 in such detail that pertinent events and the dates of the events can be reconstructed.”
27 (Reg. 2695.3, subd. (a).) Further, the Regulation sets forth certain information that must be
28 maintained as a reasonable standard in processing claims: “. . . the claim number, line of

1 coverage, date of loss and date of payment of the claim, date of acceptance, denial or date
2 closed without payment.” (Reg. 2695.3, subd. (b).) It stands to reason that if the insurer
3 cannot produce records showing how it reached its determination about a claim, that it has
4 failed to adopt and implement reasonable standards for the investigation and processing of
5 claims. In addition, Regulation 2695.5 sets forth a reasonable standard of 15 calendar days
6 from receipt of a communication as to what constitutes a reasonable time to respond to a
7 claimant regarding communication about a claim. (Reg. 2695.5, subd. (b).)

8 Regulation 2695.7 delineates “Standards for Prompt, Fair and Equitable Settlements”
9 that interprets section 790.03, subdivision (h)(3). A subsection pertinent to what constitutes
10 reasonable standards in the investigation of a claim requires that “[e]very insurer shall
11 conduct and diligently pursue a thorough, fair and objective investigation and shall not
12 persist in seeking information not reasonably required for or material to the resolution of a
13 claim dispute.” (Reg. 2695.7, subd. (d).) The Regulations define “investigation” broadly to
14 mean “all activities of an insurer or its claims agent related to the determination of coverage,
15 liabilities, or nature and extent of loss or damage for which benefits are afforded by an
16 insurance policy . . . and other obligations or duties arising from an insurance policy or
17 bond.” (Reg. 2695.2, subd. (k).)

18 The overriding purpose of the regulatory scheme is to foster fairness and equity in the
19 settlement of claims. (*Spray, Gould & Bowers v. Associated Internat. Ins. Co.* (1999) 71
20 Cal.App.4th 1260, 1269 (“*Spray*”).) An underlying proscription is that “[n]o insurer shall
21 attempt to settle a claim by making a settlement offer that is unreasonably low.”
22 (Reg. 2695.7, subd. (g).) To determine whether or not a settlement offer is unreasonably
23 low, Regulation 2695.7 sets forth factors to consider in determining whether a settlement
24 offer is reasonable.

25 The Regulations further interpret what constitutes reasonable standards in processing
26 claims by requiring an insurer to disclose to the insured specific policy provisions and
27 benefits applicable to the claim and, further, “[w]hen additional benefits might reasonably
28 be payable under an insured’s policy . . . , the insurer shall immediately communicate this fact

1 to the insured and cooperate with and assist the insured in determining the extent of the
2 insurer’s additional liability.” (Reg. 2695.4, subd. (a).)

3 **d. Subdivision (h)(4): Failing to Affirm or Deny Coverage of**
4 **Claims Within a Reasonable Time After Proof of Loss**
5 **Requirements Have Been Completed and Submitted by the**
6 **Insured**

7 Section 790.03, subdivision (h)(4) prohibits insurers from “failing to affirm or deny
8 coverage of claims within a reasonable time after proof of loss requirements have been
9 completed and submitted by the insured.” (§ 790.03, subd. (h)(4).) Black’s Law Dictionary
10 defines “affirm” as an affirmative act “to ratify, uphold, approve, make firm, confirm,
11 establish, reassert.” (Black’s Law Dict. (abridged 6th ed.1991) p. 37.) To deny means to
12 “refuse to grant or accept.” (*Id.*, p. 300.) Denials may be made in whole or in part. (E.g.,
13 § 10169, subd. (b) [“denied . . . in whole or in part”]; Reg. 2695.7, subd. (b) [“accept or deny
14 the claim, in whole or in part”].) For health insurance, the standard for what constitutes a
15 reasonable time is defined as being no more than 30 working days. (§ 10123.13, subd. (a).)
16 The 30-day period for reimbursement of an uncontested claim is reiterated in
17 section 10123.147, subdivision (a). If an insurer needs more time to determine whether to
18 accept or deny the claim, Regulation 2695.7 requires the insurer to provide written notice of
19 the need for additional time, within the specified time frame, and to specify any additional
20 information that is needed and the reason for the insurer’s inability to make the determination
21 timely. The Regulation requires that such notice be provided every 30 days thereafter.
22 (Reg. 2695.7, subd. (c)(1).) Regulation 2695.7 sets additional standards for an insurer
23 denying a claim, requiring that insurers provide a written statement to the claimant listing all
24 bases for denial of a claim, in whole or in part, and the factual and legal bases for each
25 reason given for the denial. (Reg. 2695.7, subd. (b)(1).) The Regulations further implement
26 subdivision (h)(3) by defining “proof of claim” to mean any evidence or documentation in
27 the possession of the insurer, regardless of whether it was submitted by the claimant or
28 obtained by the insurer in the course of its investigation, that provides any evidence of the
claim and that “reasonably supports the magnitude or the amount of the claimed loss.”

1 (Reg. 2695.2, subd. (s).) Additionally, Regulation 2695.7 requires that the insurer notify the
2 claimant of his or her statutory right to ask the Department to review any claim that was
3 denied or rejected. (Reg. 2695.7, subd. (b)(3).)

4 **e. Subdivisions (h)(5): Not Attempting in Good Faith to**
5 **Effectuate Prompt, Fair, and Equitable Settlements of**
6 **Claims in Which Liability Has Become Reasonably Clear**

7 Section 790.03, subdivision (h)(5) proscribes “[n]ot attempting in good faith to
8 effectuate prompt, fair, and equitable settlements of claims in which liability has become
9 reasonably clear.” (§ 790.03, subd. (h)(5).) In enacting subdivision (h), the overriding
10 legislative intent was to protect consumers from delays and imbalance in power in settling
11 claims. Section 790.03, subdivision (h)(5) sets standards to accomplish this public policy
12 objective. To complement the statute, the Regulations flesh out the public policy to “foster
13 equity, fairness, and plain-dealing in claims handling.” (*Spray*, 71 Cal.App.4th 1260 at p.
14 1269.)

15 The phrase “good faith” typically requires that the actor have harbored a belief that it
16 was complying with the law (e.g., *Neal v. Farmers Ins. Exch.* (1978) 21 Cal.3d 910, 921;
17 *People v. Maddox* (1956) 46 Cal.2d 301, 306–307), and that that belief is both subjectively
18 real and objectively reasonable (*Ojavan Investors, Inc. v. California Coastal Com.* (1997) 54
19 Cal.App.4th 373, 389; *Careau & Co. v. Sec. Pac. Bus. Credit, Inc.* (1990) 222 Cal.App.3d
20 1371, 1401-02). Absence of candor, intent to deceive, and desire to gain improper advantage
21 are inconsistent with a claim of good faith. (E.g., *Egan v. Mut. of Omaha Ins. Co.* (1979) 24
22 Cal.3d 809, 818; *Engalla v. Permanente Med. Group, Inc.* (1977) 15 Cal.4th 951, 974-75;
23 *Whitlow v. Bd. of Med. Examiners* (1967) 248 Cal.App.2d 478, 487.) The acts in question
24 must have been taken with intent to comply with the actor’s legal obligations and without
25 purpose of evading those obligations. (*George Arakelian Farms, Inc. v. Agric. Labor*
26 *Relations Bd.* (1985) 40 Cal.3d 654, 667; *Fox v. Federated Dep’t Stores, Inc.* (1979) 94
27 Cal.App.3d 867, 877.)

28 Various statutes provide detail as to what constitutes “prompt” settlement of claims
for health insurance. Sections 10123.13 and 10123.47 set the standard of 30 working days

1 after receipt of a claim as the timeframe for “prompt” reimbursement of a claim.
2 (§§10123.13, subd. (a), 10123.47, subd. (a).) Standards for prompt settlement of claims also
3 impose the duty on insurers to acknowledge receipt of a claim from a provider within 15
4 working days and inform the provider of the date of receipt of the claim, as set forth in
5 section 10133.66. (§ 10133.66, subd. (c).) With respect to an insurer’s duties upon receipt of
6 communications concerning a claim, the Regulations interpret “prompt” to mean that
7 insurers must respond to a claimant within 15 calendar days. (Reg. 2695.5, subd. (b).)
8 Further, the Regulations set the standard of 21 calendar days for insurers to respond to the
9 Department concerning an inquiry about a claim. (Reg. 2695.5, subd. (a).)

10 “Fair” is defined as “having the qualities of impartiality and honesty; free from . . .
11 self-interest; . . . even-handed.” (Black’s Law Dict. (abridged 6th ed.1991) p. 412 .) To
12 promote fairness, section 10123.13 imposes a standard on insurers to provide notice to the
13 claimant, in circumstances of a denied or contested claim, of the specific reason for
14 contesting or denying a claim, including the factual and legal basis for doing so.
15 (§ 10123.13, subd. (a).) Similarly, section 10123.147 establishes the standard that an insurer
16 must provide notice to both the insured and provider identifying the portion of the claim that
17 is contested or denied, by revenue code, and providing specific reasons for the denial,
18 including the factual and legal basis. (§ 10123.147, subd. (a).) In addition, to promote
19 fairness, the statute sets the standard that the insurer must provide a statement both to the
20 insured and provider of their right to seek review by the Department of a contested or denied
21 claim, together with the name and contact information of the unit within the Department that
22 performs the review function. (§ 10123.147, subd. (a).)

23 Section 10708 contains a “fairness” standard prohibiting exclusion of coverage for
24 pre-existing conditions in policies covering three or more persons beyond six months of the
25 effective date of coverage. (§ 10708, subd. (a)(1).) Further limitations on such pre-existing
26 condition clauses are also specified. (§ 10198.7, subd. (a); § 10708, subd. (a)(1).) The
27 Regulations complement section 790.03, subdivision (h)(5) by setting standards that insurers
28 “conduct and diligently pursue a thorough, fair and objective investigation.” (Reg. 2695.7,

1 subd. (d).) The Regulation augments what constitutes a fair investigation by prohibiting
2 insurers from persisting in seeking information not reasonably required for or material to the
3 resolution of a claim dispute.

4 Section 10123.13 sets equitable standards for insurers in requiring the payment of
5 interest for an uncontested claim unpaid after 30 days of receipt of the claim. (§ 10123.13,
6 subd. (b).) In promoting fairness and equity, section 10133.66 prohibits an insurer from
7 requesting reimbursement from providers for overpayment of a claim after 365 days from the
8 date of payment of the overpaid claim. (§ 10133.66, subd. (b).) Further, the statute also
9 requires that an insurer acknowledge the receipt of each claim so that the provider may know
10 the recorded date of receipt of the claim. (§ 10133.66, subd. (c).)

11 The Regulations further interpret section 790.03, subdivision (h)(5) as to what
12 constitutes “good faith, prompt, efficient and equitable settlement of claims.” (Reg. 2695.1,
13 subd. (a)(2).) Regulation 2695.4 sets standards for insurers to disclose all benefits,
14 coverages, time limits or other provisions of any insurance policy that may apply to the claim
15 presented by the insured. (Reg. 2695.4, subd. (a).) The Regulations also interpret “fairness
16 and equity” to require that insurers immediately communicate to the insured when
17 “additional benefits might reasonably be payable under an insured’s policy” and, further, to
18 “assist the insured in determining the extent of the insurer’s additional liability.”
19 (Reg. 2695.4, subd. (a).) To ensure accomplishing the objectives of section 790.03,
20 subdivision (h)(5), the Regulations set standards that every insurer provide thorough and
21 adequate training regarding the Regulations to all of its claims agents, and annually certify so
22 in writing. (Reg. 2695.6, subd. (b).)

23 **3. Relationship of Section 790.03 to Other Laws**

24 The source of administrative enforcement of unfair insurance claims practices is the
25 UIPA, and sections 790.03 and 790.035 are its underpinnings. As authorized by the
26 Legislature, the Regulations further the public policy purpose of the UIPA by delineating
27 minimum standards for the settlement of claims that complement section 790.03,
28 subdivision (h), violations of which are also deemed violations of the UIPA. (Reg. 2695.1;

1 Reg. 2695.2, subd. (v).) Other statutes in the Insurance Code additionally set standards for
2 claims settlement practices in specific lines of insurance, including health insurance, that
3 determine violations of section 790.03.

4 **a. Relationship to Other Statutes**

5 In addition to the UIPA, other Insurance Code provisions set standards for some
6 aspects of claims settlement practices in specific lines of insurance. (See, e.g., §11583
7 [partial payment from liability policy must be accompanied with notice of statute of
8 limitations applicable to case]; § 10123.13 [certain disability payments required to be
9 tendered within 30 days of receipt of claim; interest penalty on later payment if claim
10 undisputed]; § 10172.5 [life insurance benefits required to be paid within 30 days of death or
11 interest penalty imposed]; § 560 [payment for car repair required to be paid within 10 days of
12 receipt of itemized bill].) Several such statutes are alleged to have been violated here. (See,
13 e.g., §§ 880 [conduct business in own name], 10123.13, subds. (a) & (b) [timely
14 reimbursement of claims], 10123.13, subd. (a) [interest payment on untimely
15 reimbursement]; 10123.137, subds. (a) & (c) [requirements for provider dispute resolution],
16 10123.137, subd. (a) & (c) [additional PDR requirements], 10123.147, subd. (a) [prompt
17 payment of claims], 10169, subd. (i) [notice of IMR rights], 10198.7, subd. (a) [preexisting
18 conditions], 10708, subd. (a) [preexisting conditions].)

19 Thus, many statutes outside the UIPA will be found to prohibit conduct also
20 proscribed in section 790.03, and many violations of the enumerated unfair claims settlement
21 practices of subdivision (h) also amount to breaches of specific duties set out elsewhere in
22 the Insurance Code. In some cases the subsequent statutes provide guidance on how a
23 general term in section 790.03 should be interpreted. For example, subdivision (h)(4)
24 prohibits the insurer from “[f]ailing to affirm or deny coverage of claims within a reasonable
25 time.” Where the claim is made under a health insurance policy covered by
26 section 10123.13, that section’s 30-working-day deadline for reimbursing claims informs
27 what constitutes a reasonable time under section 790.03, subdivision (h)(4).

1 It is not uncommon for a licensee’s noncompliant acts to violate more than one
2 provision of the Insurance Code. In recognition of that fact, section 790.08 explicitly vests
3 power in the commissioner to seek cumulative remedies, including monetary penalties
4 pursuant to section 790.035, for unfair or deceptive acts that may also violate other statutes:

5 “The powers vested in the commissioner in this article [Article 6.5 Unfair
6 Practices] shall be additional to any other powers to enforce any penalties,
7 fines or forfeitures, denials, suspensions or revocation of licenses or
8 certificates authorized by law with respect to methods, acts and practices
hereby declared to be unfair or deceptive.” (§ 790.08.)

9 When read together, these other provisions make explicit the general proscriptions of section
10 790.03, subdivision (h). (See *Kotler v. Alma Lodge* (1998) 63 Cal.App.4th 1381, 1394
11 [“Statutory sections relating to the same subject must be read together and harmonized.”].)
12 Whether section 790.03, subdivision (h) explicitly references the other sections of the
13 Insurance Code is not relevant. The interaction of subdivision (h) and the other statutes is
14 obvious. “Every statute should be construed with reference to the whole system of law of
15 which it is a part, so that all may be harmonized and have effect.” (*Katz v. Los Gatos-
16 Saratoga Joint Union High School Dist.* (2004) 117 Cal.App.4th 47, 54.)

17 **b. Relationship to Fair Claims Settlement Practices**
18 **Regulations**

19 The Legislature contemplated the need for promulgation of rules and regulations to
20 augment and enforce section 790.03:

21 “The commissioner shall, from time to time as conditions warrant, after notice
22 and public hearing, promulgate reasonable rules and regulations, and
23 amendments and additions thereto, as are necessary to administer this article
[Art. 6.5 Unfair Practices].” (§ 790.10.)

24 The Commissioner’s authority to translate general prohibitions of section 790.03,
25 subdivision (h) into specific, proscribed claims-handling practices is well established. “An
26 administrative agency is not limited to the exact provisions of a statute in adopting
27 regulations to enforce its mandate. “[T]he absence of any specific [statutory] provisions
28 regarding the regulation of [an issue] does not mean that such a regulation exceeds statutory

1 authority.” (*Ford Dealers Assn. v. Department of Motor Vehicles* (1982) 32 Cal.3d 347,
2 362.) The agency is authorized to “fill up the details” of the statutory scheme. (*Mineral*
3 *Associations Coalition v. State Mining & Geology Bd.* (2006) 138 Cal.App.4th 574, 589; see
4 also *Credit Ins. Gen. Agents Assn. v. Payne* (1976) 16 Cal.3d 651, 656 [“Courts have long
5 recognized that the Legislature may elect to defer to and rely upon the expertise of
6 administrative agencies.”].)

7 The Regulations set standards for the settlement of claims that complement section
8 790.03, subdivision (h), violations of which are deemed violations of the UIPA and subject
9 to monetary penalties pursuant to section 790.035. An act, for the purpose of determining
10 any penalty pursuant to section 790.035, is “any commission or omission which in and of
11 itself constitutes a violation of California Insurance Code Section 790.03 or the Regulations.”
12 (Reg. 2695.2, subd. (v).) This aligns with the legislative intent of section 790.035 to create
13 economic sanctions as an incentive to the insurance industry to refrain from unfair practices.
14 The purpose of the Regulations “is salutary, designed to alert insureds to their insurance
15 policy obligations, and to foster equity, fairness, and plain-dealing in claims handling.”
16 (*Spray*, 71 Cal.App.4th at p. 1269.)

17 While the Commissioner has enacted regulations, both interpreting the words of the
18 UIPA and exercising his grant of legislative authority to declare enumerated conduct
19 unlawful, rulemaking cannot and should not be expected to enumerate every specific act that
20 has been proscribed in general terms in the text of section 790.03. For example, the
21 prohibition against “[m]isrepresenting . . . pertinent facts” in subdivision (h)(1) need not be
22 augmented by a regulation enumerating each specific facts that may not misrepresented or
23 each specific form of representation to which the prohibition applies. Nor need there be a
24 regulation listing every kind of acknowledgment for the failure to acknowledge a paper claim
25 be recognized as “[f]ailing to acknowledge and act reasonably promptly upon [a]
26 communication[] with respect to [a] claim[]” under subdivision (h)(2).

27 The Regulations “flesh out the statutory public policy” of the UIPA, the purpose of
28 which is to regulate trade practices in the business of insurance. (*Spray*, 71 Cal.App.4th at p.

1 1269.) “In sum, the Fair Claims Settlement Practices Regulations represent the considered
2 and duly promulgated public policy appropriate to the processing of . . . insurance claims in
3 California.” (71 Cal.App.4th at p. 2169.)

4 **C. Penalty Provisions of Section 790.035**

5 Section 790.035, subdivision (a) provides:

6 “Any person who engages in any unfair method of competition or any unfair
7 or deceptive act or practice defined in Section 790.03 is liable to the state for a
8 civil penalty to be fixed by the commissioner, not to exceed five thousand
9 dollars (\$5,000) for each act, or, if the act or practice was willful, a civil
10 penalty not to exceed ten thousand dollars (\$10,000) for each act. The
11 commissioner shall have the discretion to establish what constitutes an act.
12 However, when the issuance, amendment, or servicing of a policy or
13 endorsement is inadvertent, all of those acts shall be a single act for the
14 purpose of this section.”

15 Pursuant to this authority, the Department is recommending that the Commissioner assess a
16 penalty for each of the 908,654 acts in violation of law in the First Amended Accusation that
17 are to be decided here.

18 Section 790.035 was enacted in 1989 by Senate Bill No. 1363. Its purpose is
19 repeatedly defined in the legislative history in these terms:

20 “Under current law, insurers cannot be fined for practices determined by the
21 Commissioner to be unfair and deceptive unless the practices continue after a
22 cease and desist order has been issued. This measure will allow the
23 Commissioner to impose charges for the initial acts which prompt regulator
24 action. The author expresses the belief that such authority will serve as a more
25 effective and flexible regulatory tool than restricting penalties to violations of
26 cease and desist orders only.” (Assem. Com. on Finance and Insurance, Rep.
27 on Sen. Bill No. 1363 (1989-1990 Reg. Sess.) as amended July 6, 1989
28 (Department’s Request for Official Notice (“RON”), Exh. A, p. 01).)

The bill was enacted in direct response to *Moradi-Shalal*’s abrogation abrogated of the *Royal
Globe* private right of action for unfair insurance practices. Addressing claims that existing
administrative enforcement of the UIPA was inadequate, the *Moradi* Court separately
“urge[d] the Insurance Commissioner and the courts to continue to enforce the laws
forbidding such practices to the full extent consistent with our opinion” and noted the

1 absence of anything in its holding that “would prevent the Legislature from creating
2 additional civil or administrative remedies.” (46 Cal.3d at pp. 304, 305.) The staff of the
3 Insurance, Claims and Corporations Committee quoted this call to effective enforcement,
4 noting that:

5 “[w]ith the repeal of the Royal Globe decision . . . and the present structure of
6 not fining for the illegal act but the violation of a cease-and-desist order, there
7 is little incentive for insurance companies to refrain from unfair or deceptive
8 practices.” (Sen. Insurance, Claims and Corporations Com., Rep. Sen. Bill
9 No. 1363 (1989-1990 Reg. Sess.) as amended March 9, 1989 (RON, Exh. B,
10 p. 05).)

11 Accordingly, the Committee concluded that Senate Bill Number 1363 “is consistent with the
12 spirit of *Moradi-Shalal* by giving adequate power to the Commissioner to dissuade insurers
13 from unfair practices, and by providing an incentive to the insurance industry to refrain from
14 such practices.” (*Ibid.*)

15 Committee and agency analyses of the bill as it worked its way through the
16 Legislature repeatedly noted as a deficiency of then-current law the absence of penal
17 authority until a cease-and-desist order had been violated and asserted that the intent of the
18 bill was to “discourage insurance companies from violating” the statutes prohibiting unfair
19 acts and practices. (E.g., Cal. Dept. Finance Analysis of Sen. Bill No. 1363 (1989-1990 Reg.
20 Sess.) as amended May 9, 1989 (RON, Exh. C, p. 06); see also Sen. Rules Com., Off. Of
21 Sen. Floor Analyses, 3d reading analysis of Sen. Bill No. 1363 (1989-1990 Reg. Sess.) as
22 amended September 11, 1989 (RON, Exh. D, p. 09) [present provision for a fine “doesn’t
23 allow it to be used as a deterrent . . . [with] the present structure of not fining for the illegal
24 act but the violations of a cease-and-desist order, there is little incentive for insurance
25 companies to refrain from unfair and deceptive practices”]; Cal. Dept. Finance, Enrolled Bill
26 Rpt. on Sen. Bill No. 1363 (1989-1990 Reg. Sess.), September 20, 1989 (RON, Exh. E,
27 pp. 11-12); Cal. Dept. Insurance, Enrolled Bill Report on Sen. Bill No. 1363 (1989-1990
28 Reg. Sess.), September 20, 1989 (RON, Exh. F, p. 13) [“Under current law, the
commissioner has no power to impose a penalty until an insurer violates a cease and desist
order, thus there is no meaningful deterrent against a violation of the Unfair Practices Act

1 itself.”].) In the Assembly Finance and Insurance Committee, the “Background Information
2 Request” on S.B. 1363 posed the question, “What is the problem or deficiency in the present
3 law which the bill seeks to remedy,” which was answered:

4 “Under present law, insurance companies committing unfair or deceptive
5 practices cannot be fined unless they continue the practice after the Insurance
6 Commissioner issues a cease-and-desist order. This bill will make the
7 insurance companies liable for the initial act.” (Assem. Ctee. on Finance &
8 Ins., June 23, 1989 (RON, Exh. G, p. 15).)

9 The legislative imperative to strengthen enforcement of the UIPA is reflected by the
10 fact that section 790.035 was adopted as an urgency statute and by the Legislature’s findings
11 of urgency:

12 “This act is an urgency statute necessary for the immediate preservation of the
13 public peace, health, or safety within the meaning of Article IV of the
14 Constitution and shall go into immediate effect. The facts constituting the
15 necessity are: In order to effectively protect consumers from deceptive
16 insurance practices and to ensure marketplace stability it is necessary for this
17 act to take effect immediately.” (Stats. 1989, ch. 725, § 4.)

18 Construction of section 790.035 is disputed by the parties, and the Department
19 addresses those disputes below. But the first observation to be made about the statute is that
20 it was intended to be broadly remedial, to create incentives for insurers to comply with the
21 law, and to deter them from engaging in unfair acts and practices. Interpretation of the
22 statute’s individual terms must be faithful to these purposes.

23 **1. Act or Practice**

24 Section 790.035 makes it clear that its basic unit of law enforcement is the *act* in
25 violation of the law. While section 790.03, subdivision (h) prohibits both acts and practices
26 (see pp. 67-68, *supra*), section 790.035, subdivision (a) is explicit that the event subject to
27 penalty is the act:

28 “Any person who engages in any unfair method of competition or any unfair
or deceptive *act* or practice defined in Section 790.03 is liable to the state for a
civil penalty to be fixed by the commissioner, not to exceed five thousand
dollars (\$5,000) for *each act*, or, if the act or practice was willful, a civil
penalty not to exceed ten thousand dollars (\$10,000) for *each act*.” (Emphasis
supplied.)

1 By its use of the disjunctive, section 790.035 makes it clear that both acts and practices are
2 prohibited, but the imposition of penalties on a per-act basis establishes that specific,
3 individual acts are subject to the penal sanction without proof of any associated practice.

4 Reflecting the pivotal role the illegal “act” plays in the UIPA, subdivision (a) goes on
5 to grant the Commissioner “discretion to establish what constitutes an act.” The provision
6 confirms both the importance of the Commissioner’s subject-matter expertise and the crucial
7 implications of this determination in effective law enforcement policy.

8 **2. Inadvertent Issuance, Amendment, or Servicing of a Policy or**
9 **Endorsement**

10 The penalty-per-act-in-violation mandate of section 790.035, subdivision (a) is
11 adjusted by the following sentence: “However, when the issuance, amendment, or servicing
12 of a policy or endorsement is inadvertent, all of those acts shall be a single act for the
13 purpose of this section.”

14 The phrase “when the issuance, amendment, or servicing of a policy or endorsement
15 is inadvertent” was added to the bill in its final amendment before passage and was not
16 thought by Legislative Counsel to require any revision to his digest of the bill’s provisions.
17 (Assem. Amend. to Sen. Bill No. 1363 (1989-1990 Reg. Sess.) September 11, 1989, pp. 1, 2;
18 compare Assem. Amend. to Sen. Bill No. 1363 (1989-1990 Reg. Sess.) July 17, 1989, pp. 1,
19 2.) The final bill analysis makes no reference to the amending language. (Sen. Rules Com.,
20 Off. Of Sen. Floor Analyses, 3d reading analysis of Sen. Bill No. 1363 (1989-1990 Reg.
21 Sess.) as amended September 11, 1989.)

22 The wording singles out three actions an insurer might take with regard to a policy —
23 its issuance, amendment, or servicing — but omits other actions such as cancellation,
24 rescission, or refusal to issue or renew. Since “servicing” does not include “issuance” or
25 “amendment,” it is plainly not the case that everything an insurer may do with respect to a
26 policy is the “servicing” of the policy. This sentence does not simply collapse all violations
27 arising from an error in *how* the insurer services a policy into a single act. The antecedent of
28 “those acts” is the issuance, amendment, or servicing of the policy. It is inadvertence in the

1 act of servicing itself, not an error in the way in which the servicing was carried out, for
2 which the consolidation of violations is prescribed.

3 In his Pre-Filed Direct Testimony, Mr. Cignarale explained the Department’s
4 construction of this language initially in the context of the category of violations consisting
5 of COCC-related wrongful claim denials:

6 “Obviously, there was no issuance or amendment here. By denying a claim —
7 that is to say by sending out a denial letter or an EOB that denies the claim —
8 PacifiCare was ‘servicing’ the policy, but there is no evidence that that act of
9 servicing was inadvertent. When the insurer intends to process and deny a
10 claim but does so wrongfully or incorrectly, that does not constitute the
11 inadvertent servicing of a policy for purposes of determining the number of
12 acts in violation. In this instance, PacifiCare did not inadvertently send out
13 these denial letters or EOBs.” (Exh. 1184, p. 23.)

14 He then applied this definition of what constitutes inadvertent servicing in each of the
15 successive categories of violations.

16 Even in those cases where servicing may be said to have been inadvertent, Mr.
17 Cignarale points out a logical limit to the principle: If the error was repeated, or persisted for
18 so long that it should have been identified by the company, the deficiency cannot be
19 dismissed as mere “inadvertence,” but rather constitutes gross neglect or conscious disregard
20 of the deficiency. (Exh. 1184, p. 127:3-13.) A similar limiting principle has long been
21 employed by the courts in deciding whether relief from default was warranted under Code of
22 Civil Procedure section 473 by an attorney’s inadvertence. (See, e.g., *Henderson v. Pacific*
23 *Gas & Elec. Co.* (2010) 187 Cal.App.4th 215, 230 [“inadvertence” under section 473 “does
24 not mean mere inadvertence in the abstract. If it is wholly inexcusable it does not justify
25 relief.”], quoting *Hearn v. Howard* (2009) 177 Cal.App.4th 1193, 1206; *Daher v. American*
26 *Pipe & Const. Co.* (1968) 257 Cal.App.2d 816, 820-821 [“courts are liberal in relieving
27 parties of defaults caused by inadvertence or excusable neglect ... yet they do not act as
28 guardians for incompetent parties or parties who are grossly careless as to their own affairs”],
quoting *Gillingham v. Lawrence* (1909) 11 Cal.App. 231, 233-234.)

1 The very absence of any explanation of the sentence in the legislative history is itself
2 important. As noted above, the sentence was added in the last few days of the Legislature’s
3 consideration of the bill, was not found by Legislative Counsel to require mention in his
4 digest, and was not thereafter referenced in the final bill report. (Assem. Amend. to Sen. Bill
5 No. 1363 (1989-1990 Reg. Sess.) September 11, 1989, pp. 1, 2; Sen. Rules Com., Off. Of
6 Sen. Floor Analyses, 3d reading analysis of Sen. Bill No. 1363 (1989-1990 Reg. Sess.) as
7 amended September 11, 1989.) The obvious inference is that the added language neither
8 solved a major problem nor was understood by the voting legislators to significantly alter its
9 law-enforcement objectives or means.

10 Another absence is worth noting here: the absence of any evidence from PacifiCare
11 showing colorable inadvertence. It is, of course, PacifiCare’s burden to establish its
12 entitlement to the collapsing of a multitude of committed acts into a single penalized act. In
13 two and a half years, the company has yet to utter the phrase “inadvertent servicing,” much
14 less tendered any evidence of entitlement to its benefits.

15 That omission may be attributable to the fact that construction of the inadvertent-
16 servicing phrase could not, under even the most fanciful definition, affect more than a small
17 percentage of the violations alleged in this case. In the vast majority of the categories, there
18 is no evidence of anything other than purposeful, knowing advertence — most of the actions
19 were intentionally taken, often after the ongoing violations had been called to the company’s
20 attention. However, in other enforcement cases the term may be more significant, so proper
21 construction of these terms is important to the long-term enforcement program.

22 **3. Willful**

23 Section 790.035 makes the insurer liable for a penalty not to exceed \$5,000 per act or,
24 if the action is willful, not to exceed \$10,000 per act. The Fair Claim Settlement Practices
25 Regulations contain the operative definition of “willful”:

26 “‘Willful’ or ‘Willfully’ when applied to the intent with which an act is done
27 or omitted means simply a purpose or willingness to commit the act, or make
28 the omission referred to in the California Insurance Code or this subchapter. It

1 does not require any intent to violate law, or to injure another, or to acquire
2 any advantage.” (Reg. 2695.2, subd. (y).)

3 This definition mirrors the standard definition found in numerous statutes and literally
4 hundreds of cases. For example, Penal Code section 7, subdivision (1) states:

5 “The word ‘willfully,’ when applied to the intent with which an act is done or
6 omitted, implies simply a purpose or willingness to commit the act, or make
7 the omission referred to. It does not require any intent to violate law, or to
8 injure another, or to acquire any advantage.”

9 Among the hundreds of cases following this definition in a wide range of settings are, e.g.,
10 *Patarak v. Williams* (2001) 91 Cal.App.4th 826, 829 [civil penalties for each willful violation
11 of Mobilehome Residency Law]; *Prudential Home Mortgage Co. v. Superior Court* (1998)
12 66 Cal.App.4th 1236, 1248 [fine for violation of Civ. Code, § 2941]; *Ibrahim v. Ford Motor*
13 *Co.* (1989) 214 Cal.App.3d 878, 893 [civil penalties under Song-Beverly Act]; *May v. New*
14 *York Motion Picture Corp.* (1920) 45 Cal.App. 396, 404 [“In civil cases, the word ‘willful,’
15 . . . [implies] merely that the thing done or omitted to be done was done or omitted
16 intentionally. It amounts to nothing more than this: That the person knows what he is doing,
17 intends to do what he is doing, and is a free agent.”].)

18 Mr. Cignarale cited the definition in the Fair Claim Settlement Practices Regulations
19 and applied it in formulating his recommended penalties:

20 “Thus, an insurer must willfully — with a purpose or willingness — commit
21 an act or make an omission proscribed by section 790.03, though it is not
22 necessary for PacifiCare to have intended to violate the law, to injure anyone,
23 or to acquire any advantage in denying these claims.” (Exh. 1184, p. 24.)

24 **4. Penalty Range**

25 Section 790.035 leaves to the Commissioner’s discretion where in the zero-to-\$5,000
26 or zero-to-\$10,000 range to fix the penalty for a given violation. By itself, the statute is like
27 the vast number of laws authorizing a penalty range, commending the fixing of the proper
28 point within that range to the sound discretion of the administrator, whose discretion is
limited only by the requirement that he or she not act arbitrarily or capriciously. (E.g.,
Flippin v. Los Angeles City Bd. of Civil Serv. Com’rs (2007) 148 Cal.App.4th 272, 279;

1 *Kazensky v. City of Merced* (1998) 65 Cal.App.4th 44, 74; *Lake v. Civil Serv. Comm'n*, 47
2 Cal.App.3d 224, 228 (1975).)

3 In the case of section 790.035, the exercise of that discretion is informed by the
4 Regulations, which discuss the factors the Commissioner takes into consideration in setting a
5 penalty. However, neither those Regulations nor any other law specifies how the
6 Regulations' qualitative factors lead to the quantitative penalty that section 790.035 requires.
7 Generally, administrators cross that bridge without explicating any analytic process.
8 However, in this case Mr. Cignarale laid out his analysis in an explicit methodology: First,
9 he examined the violations by category according to the violation charged. (Exh. 1184,
10 p. 4:15-19.) Then, after determining whether the alleged acts do in fact constitute violations
11 of section 790.03, he assessed the severity of such violations categorically, according to how
12 severe such conduct is, simply based on the fact of the violation and the harm that flows from
13 such conduct, without the specific circumstances of the PacifiCare violations. (Exh. 1184,
14 p. 4:20-26; see Reg. 2695.12, subd. (a)(10).) This assessment compared the acts in question
15 to the range of acts that could constitute a violation of section 790.03, subdivision (h),
16 expressing his conclusion as a percentage of the maximum permissible penalty. (Exh. 1184,
17 p. 4:20-26.) He then reviewed the evidence of the specific violations making up the category
18 in this case, as summarized in assumptions he was asked to make, in order to determine
19 whether the violations were willful (to determine whether the applicable range was \$0 to
20 \$5,000 or \$0 to \$10,000) and whether they constituted the inadvertent issuance, amendment,
21 or servicing of a policy. (Exh. 1184, p. 4:26-5:1.) Mr. Cignarale next reviewed the evidence
22 of the specific violations PacifiCare is alleged to have committed to adjust the generic
23 starting point, evaluating the evidence in light of the factors enumerated in
24 Regulation 2695.12. (Exh. 1184, p. 5:1-4.) That yielded a recommended penalty per act in
25 violation of the law ("unit penalty" (Exh. 1184, p. 5:1-3)). Then, at the end of the process, he
26 made a final review of the resulting penalties individually and in the aggregate to assess
27 whether they "represent appropriate amounts to achieve the regulatory purposes of punishing
28 the violations and deterring similar conduct in the future . . . [and] whether the aggregate

1 penalty is appropriate in light of the licensee’s financial condition and history.” (Exh. 1184,
2 p. 5:5-9.)

3 In assessing Mr. Cignarale’s recommendations, it is important to recognize his 20
4 years of experience in enforcement and compliance for the Department in positions of
5 increasing responsibility. (Exh. 1184, pp. 2:18-4:5; Exh. 1184A.) Over the entirety of that
6 period, he has been enforcing the Regulations adopted to implement the UIPA in both health
7 insurance and other lines of business, giving him an understanding of claim-processing and
8 other workings of insurance companies. (Exh. 1184, p. 3:3-10, 3:21-4:5.) His duties have
9 regularly called upon him to provide guidance to CDI staff and advice to the highest levels of
10 the agency. (Exh. 1184, pp. 2:26-3:2, 3:15-20.) In the course of these duties, he has become
11 a leading repository for what the courts have referred to as the ““sophisticated bodies of
12 expertise”” that ““the Insurance Commissioner and the Department of Insurance possess.””
13 (*Karlin v. Zalta* (1984) 154 Cal.App.3d 953, 985, quoting *County of Los Angeles v. Farmers*
14 *Insurance Exchange* (1982) 132 Cal.App.3d 77, 87.)

15 Mr. Cignarale’s approach represents a sensible, careful, explicit approach to the
16 balancing of the statutory and regulatory factors upon which penalties are to be assessed
17 under section 790.035. It brings his and the Department’s experience in enforcing the UIPA
18 to bear on the task of evaluating the violations in this case.

19 **5. Penalty Factors Under Regulation 2695.12**

20 Regulation 2695.12, subdivision (a) requires the Commissioner to “consider
21 admissible evidence” on 14 factors when “determining whether to assess penalties and if so
22 the appropriate amount to be assessed.” While all of the 14 factors that are pertinent to the
23 violations in question must be considered when applicable (“shall”), nothing in
24 section 2695.12 makes these 14 factors exhaustive of the matters the Commissioner may
25 consider. Mr. Cignarale was careful to point out that while the regulation necessarily
26 “informed” his assessment of the proper penalty, he was not necessarily limited to the 14
27
28

1 enumerated factors. (Exh. 1184, p. 5:3-4.) In fact, his category-by-category analysis did not
2 address any factor other than the 2695.12 factors. (See Exh. 1184, pp. 17:1-172:19.)⁹

3 Not all of the 14 factors of Regulation 2695.12, subdivision (a) apply to the health
4 insurance claims at issue in this case. Mr. Cignarale considered eight of the factors:
5 extraordinary circumstances (subd. (a)(1)), complexity of claims (subd. (a)(3)), relative
6 number of claims (subd. (a)(7)), remedial measures (subd. (a)(8)), previous violations (subd.
7 (a)(9)), harm (subd. (a)(10)), good-faith attempt to comply (subd. (a)(11)), frequency and
8 severity (subd. (a)(12)), and management awareness (subd. (a)(13)). What follows is a
9 general discussion of each factor, which is further addressed where applicable in the
10 category-by-category analysis in this brief and in the accompanying Proposed Findings of
11 Fact and Legal Conclusions.

12 **a. Regulation 2695.12, subdivision (a)(1): extraordinary**
13 **circumstances**

14 Regulation 2695.12, subdivision (a)(1) identifies as a factor to be considered in
15 setting a penalty “the existence of extraordinary circumstances.” The term “extraordinary
16 circumstances” is defined in the Regulations:

17 ““Extraordinary circumstances means circumstances outside of the control of
18 the licensee which severely and materially affect the licensee’s ability to
19 conduct normal business operations.” (Reg. 2695.2, subd. (e).)

20 This definition is taken verbatim from the Insurance Code. (See § 12926.2.) If extraordinary
21 circumstances are shown, then they operate as a mitigating factor.

22 The Regulation requires two elements for extraordinary circumstances to qualify as
23 mitigation. First, they must be beyond the licensee’s control. And second, they must
24 severely and materially affect the licensee’s ability to conduct normal business operations.
25 Those two conditions allow for such events as a natural disaster that disables a wide range of

26 ⁹ However, he did not necessarily limit himself to the 2695.12 factors in the final step
27 of his analysis, the adjustment to the aggregate penalty. (RT 23577:12-23578:25 [applied
28 solely the aggravating and mitigating factors in 2965.12 for the adjustment of generic starting
point in each category].)

1 businesses notwithstanding prudently planned emergency measures. They would not allow
2 for contingencies of the insurer’s own making, nor for an event in which most of the
3 insurer’s normal business operations are unaffected, nor for developments that a prudently
4 managed insurance company can be expected to weather without major interruption.

5 PacifiCare has not identified any circumstances that would be extraordinary under
6 Regulation 2695.12, subdivision (a)(1).

7 **b. Regulation 2695.12, subdivision (a)(3): complexity of claims**

8 Subdivision (a)(3) of Regulation 2695.12 calls for the Commissioner to consider “the
9 complexity of the claims involved” when assessing penalties.

10 There is no statutory or regulatory definition of “complexity” under this regulation,
11 but its context makes it clear that the standard is a comparative one. If a licensee violates the
12 law in the course of processing a claim, subdivision (a)(3) says that the Commissioner should
13 consider the complexity of that claim in setting the penalty. That consideration is necessarily
14 comparative, and the comparison is properly to the kinds of claims an insurer should expect
15 to receive when writing the kind of business the licensee has chosen to write — in this case,
16 to the kinds of claims a health insurer normally receives. As Mr. Cignarale explained,
17 “PacifiCare is a health insurer in the business of paying claims, and the process of paying
18 claims according to the correct fee schedules should not be complex for the company.”
19 (Exh. 1184, p. 68:1-4.) The regulation is limited to the complexity “of the claims involved,”
20 not of the company or industry more generally, and not of claims other than those associated
21 with the violation that has been found.

22 Mr. Cignarale’s category-by-category analysis led him to recognize complexity as a
23 slightly mitigating factor in a number of categories and to find no basis for complexity-
24 mitigation in the rest. And in no category did he cite the absence of complexity with respect
25 to the nature of the violation (e.g., absence of complexity in acknowledging a claim) as an
26 aggravating factor.

1 **c. Regulation 2695.12, subdivision (a)(7): relative number of**
2 **claims**

3 Regulation 2695.12, subdivision (a)(7) says the Commissioner shall consider:

4 “the relative number of claims where the noncomplying act(s) are found to
5 exist, the total number of claims handled by the licensee and the total number
6 of claims reviewed by the Department during the relevant time period.”

7 As Mr. Cignarale testified, this factor “requires consideration of the number of claims where
8 violations have been found compared to the number of claims reviewed by the Department.”
9 (Exh. 1184, pp. 26:28-27:2.) That conforms to the Statement of Reasons explaining that the
10 Regulation was amended into its present language because, “in order to determine the
11 appropriate penalties to be assessed, the Department must consider the number of claims
12 where violations have been found as compared to the number of claims examined by the
13 Department.” (Exh. 1200, p. 38.) The Statement of Reasons further explained that before
14 the amendment, the “current ratio using the number of claims handled by the insurer is not
15 relevant in determining appropriate penalties as the Department does not examine all claims
16 handled by insurers and would have no way of knowing whether violations would be found
17 in those claim files not reviewed.” (Exh. 1200, p. 38.)

18 This consideration is critical for CDI, which employs a report-by-exception method of
19 examination, where it simply reports the violations found and not the number of compliant
20 acts, rather than report-by-test, where a department would report both the number of non-
21 compliant files and compliant files examined. (RT 13431:14-13433:8 (Laucher); see Exh. 1,
22 pp. 3508 [“This report is written in a ‘report by exception’ format.”], 3530 [same].) It would
23 be a mistake to assume that the unreviewed claims had been given a clean bill of health.

24 It is also true that compliance is sometimes properly measured by examining the total
25 population — not the total population of claims but the total population of claims to which
26 the law applies. Thus, for example, if the question is whether the insurer complied with the
27 requirement to process provider disputes within 45 working days (§ 10123.137, subd. (c)), it
28 may be possible to examine every dispute resolution request and calculate the noncompliance
rate by dividing the number of noncompliant claims by the total population of claims to

1 which the requirement applies. Similarly, if the question is whether the insurer failed to pay
2 interest on late payments, the relevant calculation is the noncompliant percentage of claims
3 on which interest is due, not the total number of claims, the vast majority of which may have
4 been timely paid or received no payment. On this, Ms. Stead and Mr. Cignarale appear to
5 agree. (RT 24934:10-24936:16 (Stead) [proper comparison is unacknowledged claims to
6 claims requiring acknowledgment, late claims without interest payment to late-paid claims];
7 Exh. 1184, p. 128:10-13 [comparing number of claims not acknowledged to the number of
8 claims requiring acknowledgment], 117:16-24 [comparing failures to pay interest on late
9 claims to total number of late-paid claims where interest was due].)

10 However, it would also be erroneous to assume that claims examined using a 100%
11 sample were compliant in all respects if they were not found in an electronic analysis to be
12 noncompliant. Such assessments tend, as in this case, to test solely for compliance with one
13 or a small number of criteria — namely the criteria that can be reasonably readily tested by
14 computer. So in this case it was possible (assuming the completeness and accuracy of the
15 data the Department was given) to determine which claims were paid late or not timely
16 acknowledged, but not which claims were paid incorrectly under the applicable contract, or
17 which claims were improperly denied. The Department did not employ an electronic
18 analysis to detect those violations, and it would be an obvious mistake to assume that the
19 files that do not have a late-pay or acknowledgment violation were processed in compliance
20 with all laws for claim processing.

21 In implementing subdivision (a)(7), Mr. Cignarale compared the evidence of
22 noncompliance to the relevant denominator where the appropriate information was available.
23 (Exh. 1184, pp. 46:11-14 [EOP], 59:16-18 [EOB], 111:15-21 [late pays], 117:16-24 [failure
24 to pay interest], 128:10-18 [acknowledgment], 135:23-25 [late response to PDR].) Where
25 the appropriate quantity for comparison was unavailable, he was unable to apply this factor.
26 (Exh. 1184, pp. 26:27-27:4 [COCC violations], 36:14-16 [pre-ex], 141:7-11 [claim denial
27 with request for additional information], 151:7-13 [untimely collection of overpaid claims],
28

1 155:25-28 [failure to maintain complete claim files].) In doing so, he was faithful to the
2 logic and the purpose of the regulation.

3 **d. Regulation 2695.12, subdivision (a)(8): remedial measures**

4 Subdivision (a)(8) of Regulation 2695.12 prescribes consideration of “whether the
5 licensee has taken remedial measures with respect to the noncomplying act(s).” For purposes
6 of this regulation, the Department understands “remedial” and “corrective” to be
7 interchangeable terms as used in the industry. An affirmative answer to the “whether”
8 question would make this a factor in mitigation, and a negative answer would make it a
9 factor in aggravation.

10 In Mr. Cignarale’s application of this factor, he recognized remedial action to be a
11 mitigating factor where effective action was taken, correcting the deficiency both
12 prospectively (to stanch future violations) and retrospectively (to compensate those injured
13 by past violations). (See Exh. 1184, pp. 27:5-10 [absence of adequate prospective measures],
14 36:17-24 [crediting PacifiCare for prospective and retrospective action, despite failure to
15 promptly implement some measures], 46:15-21 [noting unexplained delay], 59:19-24 [slight
16 mitigation despite delay], 68:15-24 [lump-sum settlement with provider but failure to
17 reprocess claims and failure to correct claims platform result in slight aggravating factor],
18 76:13-20 [lump-sum settlement and corrective work with provider mitigating factor despite
19 failure to rework claims, since provider didn’t request rework], 83:4-8 [slight mitigating
20 factor in reprocessing claims but only doing so after provider testified in hearing], 96:10-21
21 [some self-reporting, some identification of root cause, inadequate corrective action result in
22 slight mitigation], 111:22-26 [corrective actions slight mitigating factor even though they
23 should have been put in place much sooner and were implemented much later than
24 PacifiCare assured CDI], 117:25-118:3 [belated corrective actions, reprocessing with
25 interest, company erring on side of overpayment credited as mitigating factor], 128:19-26
26 [remedial actions slight mitigating factor, disregarding delay in implementation], 156:1-9
27 [some retrospective remedial measures but no evidence of corrective prospective action
28 neither aggravating nor mitigating].)

1 But more fundamentally, the credit one might normally give remedial actions as
2 mitigating factors must be significantly reduced in this case because here the company *relied*
3 on remedial actions not as a complement to an effective prospective compliance program but
4 as a *substitute* for one.

5 The Department agrees that taking remedial action remains pertinent to the fixing of
6 penalties, even in this case. Even where PacifiCare has taken knowing, affirmative actions to
7 create the noncompliance, it is still entitled to some credit for eventually taking whatever
8 remedial action it took — at least as compared to a hypothetical company that did not do
9 even that. But there is very little room for such credit when the noncompliance was
10 occasioned by the company’s reliance on a policy not of preventing violations but merely
11 fixing them when they occur.

12 **e. Regulation 2695.12, subdivision (a)(9): previous violations**

13 Under Regulation 2695.12, subdivision (a)(9) the Commissioner is to consider “the
14 existence or nonexistence of previous violations by the licensee.” As Mr. Cignarale noted,
15 before its acquisition by United, PacifiCare “did not have a record of significant previous
16 violations.” (Exh. 1184, p. 27:12-13.) United, on the other hand, did. (Exh. 1184, p. 27:14-
17 17; see, e.g., Exh. 5292.) The question raised by this case is whether United’s prior record
18 has any relevance here under subdivision (a)(9).

19 If the question were simply whether the subsidiary should be punished for the sins of
20 the parent, the answer obviously would be that it should not. But that is not the question
21 here. When United acquired PacifiCare, it took over complete management of the company
22 and integrated its operations into the United operations that, with regard to claim processing,
23 had a record of previous violations. The question posed by subdivision (a)(9) is whether
24 penalties of the licensee should reflect past violations *by the licensee’s management* in
25 managing another insurance company.

26 In general, the law contemplates attributing the acts of an employee to the corporate
27 principal or employer, even for penal purposes, when the principal was aware of, and
28 consciously disregarded, the employee’s prior conduct. (Civ. Code, § 3294, subd. (b))

1 [knowledge and conscious disregard, or ratification of acts, by an officer, director, or
2 managing agent].) The reason is that ““if a person acting in a managerial capacity . . .
3 approves of the act by a subordinate, the imposition of punitive damages upon the employer
4 serves as a deterrent to the employment of unfit persons for important positions.”” (*Weeks v.*
5 *Baker & McKenzie* (1998) 63 Cal.App.4th 1128, 1149, quoting Rest.2d Torts, § 909, com. b,
6 at p. 468.)

7 This is a question of special importance for a regulator in this industry. Historically,
8 insurance companies have been allowed to organize themselves in a variety of ways, some of
9 which result in the “licensee” being an empty shell and all of its actions being taken by
10 managers and personnel of an outside entity that is not itself the licensed insurer. (See, e.g.,
11 §§ 769.8-769.87 [Managing General Agents Act, under which carrier is managed by outside
12 entity], 1280-1560.19 [reciprocal and interinsurance exchanges managed by attorney-in-fact;
13 see generally *Industrial Indem. Co. v. Golden State Co.* (1953) 117 Cal.App.2d 519, 522-
14 523]. This has led to some difficulty in the courts deciding whether, for example, to pierce
15 the corporate veil to make the assets of the outside entity available to pay judgments against
16 an undercapitalized insurer. (Compare *Delos v. Farmers Group, Inc.* (1979) 93 Cal.App.3d
17 642 with *Filippo Industries, Inc. v. Sun Ins. Co. of New York* (1999) 74 Cal.App.4th 1429.¹⁰)
18 The issue here is simpler than that. The Department is not looking here to the funds of the
19 parent company to pay the penalty assessed against the licensee. The issue here is simply
20 whether, in considering a licensee’s compliance history for purposes of possible mitigation
21

22 ¹⁰ Many of the cases addressing corporate veil-piercing involve punitive-damages
23 claims for breach of the duty of good faith and fair dealing. Thus, the *Delos* case cited above
24 found an insurer’s attorney-in-fact liable for the carrier’s bad faith under *Royal Globe* (93
25 Cal.App.3d at p. 653), while *Filippo Industries* found no liability in the insurer’s underwriter
26 and agent pursuant to *Moradi-Shalal* (74 Cal.App.4th at p. 1444). Such cases turn on
27 whether the attorney-in-fact or agent could be held liable, and whether its assets could be
28 reached, for breach of a contract to which it was not a party. These questions of contract law
and standing to bring an action for breach are not presented here. The question here is
whether the licensee’s knowledge of the history of the new management it was bringing in
may also be considered when assessing the performance of the those new managers who are
now responsible for the company’s current violations.

1 of penalties for current violations, the Commissioner must be blind to the regulatory history
2 of the new management the licensee's owners have brought in to take over the formerly
3 compliant company. The Department submits that the Commissioner need not and should
4 not ignore the new managers' history, that the regulatory consequences of a different answer
5 would impair enforcement, and that the Commissioner should not be understood to have
6 intended, in enacting subdivision (a)(9), to have created such a regulatory loophole.

7 In applying subdivision (a)(9) to this case, Mr. Cignarale found United's history of
8 prior violations not to militate in favor of a higher or lower penalty for any category:

9 "The existence or nonexistence of previous violations is inapplicable in this
10 case. (Reg. § 2695.12, subd. (a)(9).) PacifiCare, before it was acquired by
11 United, did not have a record of significant previous violations, which I
12 normally would regard as a moderately mitigating factor. However, United,
13 which after the acquisition controlled and made decisions on behalf of
14 PacifiCare, including the operational integration decisions that led to many of
15 the violations being charged in this matter, has a poor record of previous
16 violations relating to claims handling. Giving PacifiCare credit for its pre-
17 acquisition performance would reward United for continuing its practices that
18 result in violations of law. That would be inconsistent with this Regulation
19 section and with the regulatory scheme as a whole." (Exh. 1184, p. 27:11-19.)

20 However, where there were similar, uncharged violations by PacifiCare since the acquisition,
21 Mr. Cignarale considered that fact to be aggravating under subdivision (a)(9). (Exh. 1184,
22 pp. 45:22-25, 59:25-60:5.)

23 **f. Regulation 2695.12, subdivision (a)(10): harm**

24 Regulation 2695.12, subdivision (a)(10) provides that the Commissioner shall
25 consider "the degree of harm occasioned by the noncompliance."

26 It cannot be seriously disputed that an assessment of harm was at the core of
27 Mr. Cignarale's penalty recommendations. The starting point of his analysis under each
28 category was an "assessment of the severity of [each] category of violations." (Exh. 1184,
p. 4:21-24.) He was explicit that this assessment of severity involved the degree of harm
associated with the kind of act prohibited. (RT 23230:20-23232:1; 23235:20-23236:1;
23590:6-12; 24154:6-21.) He then adjusted his recommended penalty by applying

1 subdivision (a)(10), along with the other applicable factors, to the facts of the specific
2 violations. (See Exh. 1184, pp. 27:20-28:3, 37:3-10, 46:26-47:10, 60:6-13, 68:27-69:17,
3 76:23-77:8, 83:11-84:4, 96:24-97:5, 112:1-4, 118:6-17, 129:1-9, 136:6-18, 156:12-157:6,
4 160:6-8, 164:3-10.)

5 Consistent with the purposes of section 790.035, the “harm” that he weighed, and that
6 this factor calls on the Commissioner to consider, is properly interpreted broadly to include
7 all forms of harm that an insurance company can cause in violating section 790.03 and that
8 should be prevented. This, of course, would include not just financial harm but also non-
9 pecuniary harm, such as pain and suffering, inconvenience, and regulatory harm that the law
10 routinely recognizes in such assessments, and would not be limited to harm that can be
11 readily measured in dollar terms. “A penalty statute presupposes that its violation produces
12 damage beyond that which is compensable.” (*City & County of San Francisco v. Sainez*
13 (2000) 77 Cal.App.4th 1302, 1315, quoting *State of California v. City & County of San*
14 *Francisco* (1979) 94 Cal.App.3d 522, 531.) The harms that the law recognizes will flow
15 from violations of such statutes range well beyond dollar losses fixed with precision to such
16 forms of harm as pain and suffering that are inherently difficult to quantify but nonetheless
17 recognized in the law. (E.g., *Capelouto v. Kaiser Found. Hospitals* (1972) 7 Cal.3d 889,
18 895-96 [“even in the absence of any explicit evidence showing pain, the jury may infer such
19 pain, if the injury is such that the jury in its common experience knows it is normally
20 accompanied by pain”]; *Duarte v. Zachariah* (1994) 22 Cal.App.4th 1652, 1664 [“General
21 damages may be awarded for the form of emotional distress called pain or suffering where it
22 is a natural concomitant of a physical injury, inferable from the fact of the injury and the
23 common experience of humanity.”].) And specifically in setting penalties, courts readily
24 recognize such harms as inconvenience, both to members of the public and to the
25 government.

26 “[Defendants] inconvenienced the purchasers of the vehicles; they caused the
27 DMV to incur costs in enforcing the certification requirement for registration;
28 and they have caused the Board to incur no end of enforcement costs. All these
are damages borne by the taxpaying citizens of this state as a result of the

1 defendants' decision to flout the proscriptions of the Health and Safety Code."
2 (People ex rel. State Air Res. Bd. v. Wilmshurst (1999) 68 Cal.App.4th 1332,
3 1351.)

4 Often, penal statutes are enacted in part because the kind of harm engendered by the
5 prohibited conduct is inherently difficult to quantify. "Regulatory statutes would have little
6 deterrent effect if violators could be penalized only where a plaintiff demonstrated
7 quantifiable damages." (68 Cal.App.4th at p. 1351; *State of California v. City & County of*
8 *San Francisco, supra*, 94 Cal.App.3d 522, 531 [no deterrent effect if the defendant were
9 penalized only when the plaintiff could demonstrate "quantifiable damage"].) Consideration
10 solely of quantifiable, out-of-pocket expenses would obviously be an incomplete
11 measurement of the harm caused by an offending act.

12 CDI expert Henry Zaretsky reviewed the violations alleged and confirmed that, from
13 an economic perspective, there were cognizable categories of harm to providers and
14 consumers that were not fully offset by remedial payments, including administrative costs
15 from having to rebill claims, lost business opportunities, incorrect calculation of patient
16 liability, injury to the physician-patient relationship, delay in treatment, and patient anxiety.
17 (Exh. 1082, pp. 16:6-18:11.)

18 Dr. Zaretsky also testified that the allegations of United striving to save money by
19 limiting the planning and testing of systems, using actual production processes to identify
20 system deficiencies, failing to comprehensively analyze new programs and processes, and
21 relying on customers to identify errors that were only then addressed is a form of harm
22 identified by economists as "externalization of costs," "when an entity inflicts indirect costs
23 onto third parties who experience negative, uncompensated effects." (Exh. 1082, pp. 18:12-
24 19:24.) This testimony was uncontradicted.

25 While the law is clear that proof of harm is not required in a penalty action (*City and*
26 *County of San Francisco v. Sainez, supra*, 77 Cal.App.4th 1302, 1315), the Commissioner
27 has chosen, by enacting Regulation 2695.12, subdivision (a)(10), to require consideration of
28 harm in assessing penalties under section 790.035. But it is not a one-dimensional, green-
eyeshade depiction of "harm" to which the regulation calls attention. It is the full range of

1 harms an insurance company’s noncompliance is capable of causing. Mr. Cignarale has
2 addressed that full range here, and PacifiCare has been given every opportunity to do the
3 same.

4 **g. Regulation 2695.12, subdivision (a)(11): good faith attempt**
5 **to comply**

6 Subdivision (a)(11) of Regulation 2695.12 calls on the Commissioner to consider
7 “whether, under the totality of circumstances, the licensee made a good faith attempt to
8 comply with the provisions of this subchapter.” Cast in terms of “whether,” which is
9 susceptible of an affirmative or negative determination, subdivision (a)(11) can function as
10 either a mitigating factor, if determined in the affirmative, or an aggravating factor, if
11 determined in the negative.

12 As noted above (p. 76, *supra*), the indicia of “good faith” include an objectively
13 reasonable subjective belief that the actor was complying with the law (e.g., *Neal v. Farmers*
14 *Ins. Exch.*, *supra*, 21 Cal.3d 910, 921; *People v. Maddox*, *supra*, 46 Cal.2d 301, 306-307;
15 *Ojavan Investors, Inc. v. California Coastal Com.*, *supra*, 54 Cal.App.4th 373, 389; *Careau*
16 *& Co. v. Sec. Pac. Bus. Credit, Inc.*, *supra*, 222 Cal.App.3d 1371, 1401-02). It also implies
17 candor, no intent to deceive, and no attempt to gain improper advantage. (E.g., *Egan v. Mut.*
18 *of Omaha Ins. Co.*, *supra*, 24 Cal.3d 809, 818; *Engalla v. Permanente Med. Group, Inc.*,
19 *supra*, 15 Cal.4th 951, 974-75; *Whitlow v. Bd. of Med. Examiners*, *supra*, 248 Cal.App.2d
20 478, 487.) And actions taken in “good faith” must have been motivated by an intent to
21 comply with the actor’s legal obligations and without purpose of evading those obligations.
22 (*George Arakelian Farms, Inc. v. Agric. Labor Relations Bd.* *supra*, 40 Cal.3d 654, 667; *Fox*
23 *v. Federated Dep’t Stores, Inc.*, *supra*, 94 Cal.App.3d 867, 877.)

24 The presence or absence of good faith in the individual acts in violation of
25 section 790.03 is addressed in the discussion of each category of violations below and in the
26 Proposed Findings. This violation-by-violation evidence, however, should be viewed against
27 the backdrop of the evidence of an overall, systemic absence of good faith. The departure
28 from PacifiCare’s historic culture of compliance to the relentless pursuit of synergies with

1 full anticipation of the likely adverse consequences, the reliance on remediation in lieu of
2 preventing noncompliance, the widespread absence of adequate planning and testing, and the
3 absence of candor and affirmative attempts to conceal the extent and nature of
4 noncompliance (pp. 59-62, *supra*) must be recognized as negating any claim of good faith.

5 **h. Regulation 2695.12, subdivision (a)(12): frequency, severity**

6 Subdivision (a)(12) of Regulation 2695.12 calls for consideration of “the frequency of
7 occurrence and/or severity of the detriment to the public caused by the violation of a
8 particular subsection of this subchapter.” This factor relates to attributes of the violations
9 already specified in earlier subdivisions: the numerosity of the acts in violation (see
10 Reg. 2695.12, subd. (a)(7) [“relative number of claims”]) and the severity of harm from the
11 acts (see Reg. 2695.12, subd. (a)(10) [“degree of harm”]). The “and/or” confirms that
12 numerosity and severity are aggravating factors separately or together. And subdivision
13 (a)(12) is clear that the focus is on the specific category of violations, the “particular
14 subsection” violated.

15 With respect to numerosity, subdivision (a)(12) invites consideration of the frequency
16 of occurrence. Like subdivision (a)(7), which refers to the “*relative* number,”
17 subdivision (a)(12) calls for the quantity of violations to be related to other quantities by its
18 reference to “frequency.” It has been pointed out that the dictionary definition of frequency
19 ““is the number of occurrences of a repeating event per a unit of time.”” (RT 25254:6-
20 25254:7 [ALJ quoting Webster’s dictionary].) In insurance parlance “frequency” (often used
21 by actuaries in the phrase “frequency and severity”) generally refers to the number of claims
22 per policy or other unit of exposure. The Department reads “frequency of occurrence” in
23 subdivision (a)(12) to refer to a high number of violations when related to any meaningful
24 variable — time, exposures, units of work, whatever makes the resulting measure relevant to
25 the law-enforcement purpose of the regulation.

26 The reference to the “severity of the detriment to the public” makes it clear that the
27 measure of severity covers not just the harm to the immediate victim, such as the
28 policyholder (as a member of the public) but also the harm to the general public. The term

1 certainly embraces what Prof. Kessler referred to as “harm to the process” (RT 21743:23-
2 21744:7, 21773:22-21774:4, 21815:24-21817:1), as well as other forms of injury to the
3 public interest. Similarly, harm to the healthcare delivery system should be recognized as a
4 form of detriment to the public.

5 In general, Mr. Cignarale focused in formulating his penalty recommendations on the
6 detriment to those members of the public who were most immediately affected — consumers
7 and providers — but took note of violations particularly detrimental to the regulatory
8 process. (E.g., Exh. 1184, pp. 129:10-18, 154:15-18, 159:4-7, 165:11-20.)

9 **i. Regulation 2695.12, subdivision (a)(13): management**
10 **awareness, failure to take remedial action**

11 Pursuant to Regulation 2695.12, subdivision (a)(13), the Commissioner shall consider
12 “whether the licensee’s management was aware of facts that apprised or should have
13 apprised the licensee of the act(s) and the licensee failed to take any remedial measures.”
14 Again, the word “whether” indicates the factor may be aggravating or mitigating.

15 The presence or absence of remedial measures is already identified as a factor under
16 subdivision (a)(9). The text of this subdivision differs from that factor in several ways. First
17 and most obviously, it calls for a determination whether management was aware of facts that
18 should have, or actually did, put it on notice of the noncompliant acts. If the licensee failed
19 to take remedial measures (an aggravating factor) but the need for remedial measures was not
20 known to management, those facts would be aggravating under subdivision (a)(9) but not
21 under subdivision (a)(13). In addition, as Mr. Cignarale applied subdivisions (a)(9) and
22 (a)(13), effective remedial measures were recognized to be mitigating evidence even if
23 belatedly taken; unreasonable delay was reflected in his assessment under
24 subdivision (a)(13). (See Exh. 1184, pp. 28:21-23 [delayed correction of COCC violations],
25 61:18-20 [delayed correction to EOBs], 98:16-20 [belated corrections to systems incorrectly
26 paying claims], 130:5-21 [delayed correction of failures to send acknowledgment letters].)

27 In this case, the knowledge of management will be clear for most of the violations.
28 Many of the violations were occasioned by the merger and the directions given by

1 management itself for the integration — the emphasis on cost-cutting, the directives to cut
2 staff and outsource functions, the drive for speed and attendant inadequacy in execution, and
3 the priority assigned to achieving synergies. Furthermore, the inevitable problems quickly
4 materialized and became known to management. The integration teams themselves
5 contained officers at the vice-president level. (E.g., RT 4456:18-4457:9 (Burghoff)
6 [common leadership of integration teams was Dave Astar, who reported directly to Steve
7 Hemsley]; RT 4395:15-21 (Burghoff) [Mr. Burghoff was Vice President of Integration
8 Services]; RT 5343:11-5343:25 (Labuhn) [Vice President of Operations].) When staff
9 expressed concerns about the pace of integration, they were assured that the course had been
10 charted by management to meet Wall Street expectations. (E.g., Exh. 5265, p. 1942;
11 RT 17652:13-17653:10; 17659:1-5; 17700:9-20 (Watson).) For many categories,
12 management wasn't just aware of the problems, they were the source of the problems.

13 If notice is found, then subdivision (a)(13) asks whether the company failed to take
14 any remedial measures with respect to the act or acts in question. This is necessarily an act-
15 by-act inquiry (or category-by-category when the evidence is uniform regarding a
16 homogeneous set of acts). The Department does not read “any remedial measures” in
17 subdivision (a)(13) to say that if management took some measures with respect to one act in
18 violation then this factor necessarily militates in favor of mitigation no matter how many
19 other noncompliant acts management ignored or how ineffectual the actions taken were.

20 Accordingly, Mr. Cignarale examined each category under subdivision (a)(13) and
21 reported his conclusions in his testimony. (See, e.g., Exh. 1184, pp. 28:17-23, 61:18-20,
22 70:20-25, 78:6-16, 98:6-20, 112:16-25, 119:3-9, 130:5-21, 142:11-15, 152:26-153:6, 157:25-
23 158:3, 161:16-19, 164:17-19.) Full consideration has been given to this factor in his penalty
24 recommendation.

1 **IV. VIOLATIONS OF LAW AND RECOMMENDED PENALTIES**

2 **A. Incorrect Denial of Claims Due to Failure to Maintain Certificates of**
3 **Creditable Coverage on File**

4 **1. Applicable Legal Requirements**

5 The Insurance Code and the Regulations, of course, contain many provisions that
6 require that claims be correctly processed and not be improperly denied. They also set forth
7 the circumstances under which claims may and may not be denied.

8 For instance, the law allows insurers to exclude coverage for pre-existing medical
9 conditions for up to six months after a new group insurance policy takes effect if the member
10 does not have evidence of prior coverage.¹¹ (§ 10708.) But if the insured submits evidence
11 of continuous prior coverage by another insurance policy, coverage of any pre-existing
12 conditions may not be denied. (§ 10198.7, subd. (e).) This evidence, which may take
13 various forms, is commonly referred to as a certificate of creditable coverage (“COCC”).
14 And once the member (or her employer or prior insurer) has submitted a COCC, the insurer
15 is required to keep it on file so that it is readily retrievable (Reg. 2695.3, subd. (b);
16 Exh. 5348, p. 8454), and it is not permitted to deny claims on this ground. PacifiCare does
17 not appear to contest these requirements.

18 Therefore, the denial of a claim based on a pre-existing condition exclusion *after* a
19 COCC has been submitted is illegal. First, each such denial violates section 790.03,
20 subdivision (h)(1), if knowingly committed or performed with such frequency as to indicate a
21 general business practice, because it falsely represents: (1) that the member had not yet
22 submitted and the insurer had not yet received evidence of prior coverage; and (2) that the
23 insurer is not obligated to cover treatments for a pre-existing condition when it is in fact
24 legally required to do so.

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¹¹For plans that cover one or two individuals, the applicable period may be up to
12 months. (§ 10198.7, subd. (b).)

1 Claims denied on this basis are also violations of section 790.03, subdivision (h)(3)
2 because they reflect failures to adopt and implement reasonable standards for prompt
3 investigation and processing of claims arising under insurance policies.

4 Such denials further violate section 790.03, subdivision (h)(5) because they are
5 instances in which the company is not attempting in good faith to effectuate prompt, fair, and
6 equitable settlements of claims in which liability has become reasonably clear. When an
7 insurer has a COCC in its possession, its liability for claims that would otherwise trigger a
8 pre-existing condition denial is reasonably clear. A violation of this section occurs when the
9 insurer nonetheless denies the claim because it has not made a good faith effort to maintain
10 that COCC, or the information it contains, in a retrievable location.

11 Similarly, requiring members to resubmit COCCs multiple times also violates
12 Regulation 2695.7, subdivision (d), which requires insurers to diligently investigate claims
13 and not persist in seeking information not reasonably required for resolution of the claim.

14 Sections 10123.13, subdivision (a) and 10123.147, subdivision (a) also require
15 insurers to reimburse uncontested claims within 30 working days. A claim is “reasonably
16 contested when the insurer has not received a completed claim and all information necessary
17 to determine payer liability for the claim.” (§ 10123.13, subd. (c).) Claims submitted on
18 behalf of members for whom the insurer has received evidence of prior coverage should be
19 treated as uncontested and promptly reimbursed because the company has sufficient
20 information to adjudicate the claim. Denying or “closing” a claim on the ground that the
21 treatment is for a pre-existing condition and requesting that the member submit a COCC,
22 when the COCC was already in the possession of the insurer, therefore violates this
23 provision.

24 **2. PacifiCare’s Violations of Law**

25 **a. PacifiCare’s Policy for Processing COCCs**

26 As far back as 2005, PacifiCare’s practice when it received a claim from a new
27 member with a treatment code that corresponded to a potential pre-existing condition was to
28 automatically close or deny the claim and to issue a denial letter requesting a copy of the

1 COCC.¹² (E.g., Exh. 128, p. 5109; RT 8090:18-8091:16; 9914:3-18 (Berkel); RT 6371:15-
2 25 (Vonderhaar).) In fact, PacifiCare EOBs had a specific remark code “px” that stated:

3 “This claim is being denied due to lack of required information. Please
4 forward the Certificate of Creditable Coverage from your prior carrier. If
5 unavailable, please submit names and addresses of doctors who have treated
6 you in the past year. Refer to your Certificate, ‘Exclusionary period for pre-
existing conditions.’” (Exh. 128, p. 5109.)

7 PacifiCare would accept COCCs by both facsimile and mail. (RT 14322:25-14323:17
8 (Murray).) COCCs were often sent to the Customer Service department but were also
9 received by Appeals (if the COCC was sent in relation to a denied claim) or Member
10 Account Services (“MAS”). (Exh. 6, p. 7566; RT 14311:19-25 (Murray).) Whatever
11 PacifiCare department received the COCC was supposed to forward it to the Claims
12 department, where staff were “supposed to go into the claim engine and indicate that there
13 was prior coverage” so that future claims that would otherwise be categorized as pre-existing
14 conditions would be properly paid. (RT 8088:5-10 (Berkel); RT 14312:1-4 (Murray).) The
15 COCC was then supposed to be forwarded to Lason, the vendor that had assumed mailroom
16 and document routing functions in mid-2006, to be scanned as a “secondary document,”
17 indexed by claim number, and permanently stored in FileNet, PacifiCare’s long-term filing
18 system. (Exh. 348, p. 0679; RT 14311:13-14312:11 (Murray); RT 8094:10-25 (Berkel).)
19 Indexing these claims by their claim number was, of course, a vital step to ensure that these
20 claim-dependent COCCs could be later retrieved from FileNet if necessary. (RT 3200:2-
21 3201:12; 14311:13-14312:16 (Murray); RT 8094:10-25 (Berkel).)

22 **b. Complaints Against PacifiCare**

23 Within months of the acquisition, virtually every step in the process of receiving,
24 routing, processing, and storing COCCs broke down. Around October 2006, consumers
25 began complaining to CDI that they had submitted COCCs to PacifiCare multiple times but
26 that the company was continuing to deny their claims on the basis of pre-existing conditions

27 _____
28 ¹²As discussed below in part IV.J, *infra*, PLHIC’s practice of automatically closing or
denying such a claim also represents a separate and independent violation of the law.

1 and instructing them to re-submit the COCCs. (RT 58:14-59:2; 62:14-24 (Smith);
2 RT 352:11-22 (Masters).) Beyond the obvious unnecessary burdens imposed on them in
3 submitting and re-submitting these documents, these consumers reported feeling worried and
4 frustrated by these denials because of the “threat of financial responsibility” for needed
5 treatments, compounded by PacifiCare’s lack of responsiveness to phone calls. (RT 352:11-
6 353:1 (Masters).) CDI’s investigation of these complaints revealed a general and widespread
7 practice of continuing to request COCCs after they had already been received. (Exh. 41,
8 p. 9455; Exh. 76; Exh. 5004, p. 7576.) Around the same time, regulators from Washington
9 and Oregon independently began investigating the company’s COCC maintenance
10 procedures. (Exh. 5265, pp. 1946-1947.)

11 In late 2006, CDI raised the COCC issue with PacifiCare, and PacifiCare admitted it
12 too had received complaints about COCC handling from consumers. As reported by Ms.
13 Smith in November 2006, “I have also been in contact with the company and the company
14 contact has confirmed that she has also seen an influx of this type of situation in the past few
15 weeks.” (Exh. 5009.) Internal documents confirm PacifiCare’s awareness of problems with
16 its COCC process. In an early 2007 e-mail, a PacifiCare account executive reported to Marty
17 Sing, Christopher Byrnes, Ms. Vonderhaar, and others:

18 “Regarding the COCC submission process: Over and over members complain
19 that as soon as . . . they are prompted to send in the COCC document they do
20 so, and end up submitting it 4 or 5 times, with our still not confirming receipt.
21 In the meantime, claims are denied for processing during this hang up.”
(Exh. 1041, p. 3269 [Drago 2:36 p.m.]; see also Exh. 702, p. 5475 [Hill
22 9:47 a.m.])

23 Other internal documents reflected similar accounts of PacifiCare’s broken COCC
24 process: “The members consistently report sending in the certificates on several occasions
25 and for one reason or another, there is no way for claims or MAS to cross share the
26 certificates or keep them entered into a central location for all staff to review. Or they are
27 simply ‘lost’. In any event, the members[‘] claims end up being denied for lack of
28 information and a failure to provide the requested certificate of creditable coverage, although
the member can show sending it in several times.” (Exh. 6, p. 7566.)

1 PacifiCare further admitted that the issue was “[l]ack of a consistent process to house,
2 track and/or retrieve COCCs received from members,” a problem that “results in claim
3 denials for pre-existing coverage condition due to lack of the receipt of a COCC. . . . even
4 though members report mailing and/or faxing their COCCs on one or more occasions.
5 (Exh. 687, p. 2813.)

6 PacifiCare does not appear to have taken any actions to remediate these systemic
7 problems until after CDI demanded, in January 2007, that the company initiate a
8 comprehensive corrective action plan, including review of the processes for handling
9 incoming COCCs and confirming whether the certificates were accessible to the staff who
10 needed them. (Exh. 5004, p. 7577.) To remediate these improperly denied claims, the
11 Department further requested that PacifiCare review “all denials made in 2006 related to the
12 non-receipt of a certificate of creditable coverage.” (Exh. 5004, p. 7577 [number 5].)

13 In June 2007, PacifiCare disclosed that it had incorrectly denied 1,799 claims on the
14 basis of pre-existing conditions due to its failure to track COCCs. (Exh. 5314, p. 7378
15 [number 5]; Exh. 5016; RT 452:7-24 (Smith).) When the company reprocessed those
16 illegally denied claims, it issued additional payment on 689 claims but contended that no
17 additional payment was owed for the remaining 1,110 claims because, the company claimed,
18 the covered amount was within the member’s deductible. (Exh. 103; RT 451:16-24; 452:7-
19 455:5 (Smith); Exh. 5016; Exh. 5015, p. 7765 [number 2]; Exh. 5348, p. 8453 [see number
20 10].)

21 PacifiCare does not seem to have ever fully remediated its improper denials of those
22 1,110 claims. If the full amount owed on these 1,110 claims was applicable to the member’s
23 deductible as PacifiCare contends, then PacifiCare should have determined whether later
24 claims for the affected members that had been applied to the deductible should have been
25 paid instead. Despite repeated requests by CDI to do so, PacifiCare did not appear to have
26 reprocessed those subsequent claims:

27 “It appears that the re-work was not properly completed. Consumers were
28 given credit towards their deductible for that claim but we are unsure if
subsequent unrelated claims have also been taken into account when applying

1 the benefits toward the deductible. If the deductible would have been met
2 after other claims are also taken into account, then a check should have gone
3 out to the member/consumer to also include interest. The company has not
4 addressed this issue.” (Exh. 5015, p. 7765; see also RT 250:15-252:16
5 (Smith).)

6 As Ms. Smith further testified at the hearing, “[t]his was one of the questions we kept raising
7 with the company,” but “I never really got an answer to that question from the company.”
8 (RT 252:24-253:5; see also Exh. 5022, p. 3044.)

9 **c. Root Causes of PacifiCare’s Violations**

10 The COCC tracking issues can be traced to several flaws in the integration of
11 PacifiCare into United. In the chaos that followed the layoff of claims staff and the transfer
12 of claim processing tasks to San Antonio, PacifiCare stopped consistently updating RIMS to
13 reflect the receipt of COCCs. And when PacifiCare’s Cypress staff were laid off, many
14 facsimile machines were left unattended. (RT 17695:10-17697:11 (Watson).) PacifiCare did
15 not, and still does not, employ a consistent method for handling incoming faxes. (RT
16 3177:14-3178:14 (Murray).) COCCs that were faxed to Customer Service should have been
17 scanned, forwarded to the Claims department through ORS, and documented in the IDT
18 tracking system. (RT 2542:20-23; 2490:4-12; 3359:17-3361:3 (Sing).) But since, as
19 PacifiCare has admitted, Customer Service personnel were “not trained on how to route
20 correctly though IDT,” COCCs were not routed appropriately and therefore went
21 “unaddressed.” (Exh. 289, p. 6599; RT 2565:13-2566:5; 2573:11-19 (Sing).)

22 PacifiCare’s poorly planned and recklessly implemented transition of document
23 routing and storage functions to Lason also contributed to its COCC-related violations of
24 law. Ms. Berkel acknowledged that the COCC problems occurred because of the transition
25 to Lason and the DocDNA program used by that vendor. (RT 11250:14-18 (Berkel);
26 Exh. 5370, p. 2.)

27 First, the document routing instructions for COCCs that were provided to Lason were
28 almost unintelligible. Mr. Murray, the PacifiCare employee who designed these routing
instructions, acknowledged that they were “fragmented” and “complex.” (RT 14354:10-17;
Exh. 373, p. 0560 [“Lason doc typing business rules are fragmented and complex.”].) And

1 when PacifiCare counsel attempted to demonstrate that this process “isn’t that complicated”
2 by having Mr. Murray walk through the steps to categorize a particular piece of
3 correspondence while on the stand (RT 14371:2-7), Mr. Murray made several mistakes, first
4 testifying that the flow chart he was using was “backwards” (RT 14372:1-7), then after
5 miscategorizing the document using the wrong column, changed his testimony and said “I
6 think I corrected you incorrectly. . . . The original [flow chart] was correct” (RT 14375:2-9).
7 Mr. Murray couldn’t categorize the document until after CDI counsel and the ALJ corrected
8 him. (RT 14374:20-7.)

9 To properly categorize a COCC as the correct document type, a Lason worker in
10 India would have to go through several even more complicated steps and make many
11 difficult determinations that are not apparent from the face of the document. First, that
12 worker would need to determine that the source of the COCC was from a “Member or PHS
13 Employee,” even though COCCs are often sent by other insurance carriers; no instructions
14 were provided for how to categorize the source when a document comes from another
15 insurer. (Exh. 5445, pp. 3776-3778.) If the Lason worker correctly categorized the COCC
16 as coming from a member or a PHS employee, the worker would then turn to the “Member
17 & PHS Employee Correspondence” section of the binder, and have to make a determination
18 of whether the COCC related to “Appeals,” “Eligibility Info,” “Member Correspondence,” or
19 “PHS Employee Correspondence.” (Exh. 5445, p. 3779.) Finally, if the Lason worker
20 successfully got through these steps, he or she would arrive at the document typing page,
21 which provides as the complete description of a COCC:

22 “Typically a letter from another Health Plan indicating when the member
23 terminated coverage.

24 “May also be a hand-written form testifying to the date.” (Exh. 5445, p. 3781;
25 Exh. 5444, p. 4244.)

26 Such a vague description provides almost no guidance, and fails to account for various other
27 documents that PacifiCare accepts as evidence of creditable coverage, such as bills or EOBs
28 from the insured’s previous insurer, a “HIPAA certification” form, insurance plan ID cards,
or payroll stubs (Exh. 17, p. 7390).

1 PacifiCare also admitted that its DocDNA queues and inventory, where documents
2 like COCCs were stored before being processed, were “poorly managed.” (Exh. 342,
3 p. 8514.) It sometimes took weeks for a document to reach its destination, with thousands of
4 documents languishing inexplicably in DocDNA queues for over a month. (Exh. 361;
5 Exh. 526, p. 2770; Exh. 666, p. 1103 [Berkel 8:47 p.m.].) And while COCCs were in
6 DocDNA queues waiting to be processed, there was no way to search for them (RT 9823:22-
7 9824:15 (Berkel)), a circumstance that Ms. Berkel called “ridiculous” and “an integration
8 mistake” (Exh. 709, p. 1684 [Berkel 8:26 p.m.]; RT 9825:5-8 (Berkel)). The cost of making
9 documents searchable within DocDNA was only \$40,000 (Exh. 709 [Nakashoji 4:18 p.m.]),
10 but this improvement was initially rejected because “it isn’t in the budget.” (Exh. 632,
11 p. 9282.) Therefore, if a particular COCC was misrouted to the wrong DocDNA queue — a
12 likely circumstance given the fragmented and complex routing rules given to Lason and one
13 affirmatively anticipated by the company (RT 13715:13-14 (Murray)) — PacifiCare would
14 have no way to locate that document until whoever was assigned to the queue where the
15 COCC was misrouted to happened to stumble upon it. As a result, when the member called
16 PacifiCare and explained that he or she had already sent it, the customer service
17 representative would have no way to search in DocDNA to confirm it, so the member would
18 be forced to send it again. (RT 8093:12-8097:6 (Berkel); RT 6371:15-6372:22
19 (Vonderhaar).)

20 Even after reaching the appropriate DocDNA queue, documents were often not timely
21 processed. (RT 9824:18-9825:4; 8095:14-8096:3 (Berkel); RT 3269:17-3270:12 (Murray).)
22 In one instance, 14,000 documents that should have been transmitted to PacifiCare’s claims
23 rework staff, which likely included member COCCs, were “locked” in DocDNA and not
24 processed for more than a four-month period. (Exh. 341, pp. 3978-3979.) And no one at
25 PacifiCare detected this pile up because the company lacked basic reconciliation
26 mechanisms. (RT 3286:1-3287:2 (Murray).)

27 And even after a COCC worked its way through this obstacle course, Lason still had
28 problems properly storing these documents so that they would be available for future use. As

1 PacifiCare has acknowledged, it must maintain COCCs in a retrievable manner under the
2 Regulations. (Exh. 5348, p. 8454.) The maintenance of hard copy or imaged COCCs is
3 particularly important when an insurer fails, as PacifiCare systemically did here, to update its
4 claim system to reflect receipt of the evidence of creditable coverage. In drafting its
5 corrective action plan in March 2007, PacifiCare noted the importance of ensuring that
6 COCCs were “retrievable by using member ID#.” (Exh. 348, p. 0679.) But in practice,
7 Lason was not consistently indexing documents by member ID number prior to storage in
8 FileNet, so many COCCs continued to be irretrievable after receipt. (Exh. 574; Exh. 342,
9 p. 8514; Exh. 355, p. 8503; Exh. 365, p. 6872; RT 6353:7-14 (Vonderhaar).) PacifiCare only
10 discovered that “secondary document indexing was in a black hole” in August 2007.
11 (Exh. 342, p. 8514; Exh. 574.)

12 These document handling problems are traceable to the following business practices
13 associated with the transition to Lason. Implementation of DocDNA was rushed and
14 accompanied by inadequate testing and training (Exh. 377; RT 6325:7-6326:7; 6328:19-
15 6329:3 (Vonderhaar); RT 3655:6-13; 13695:4-22; 13699:19-13700:2; 13771:19-13773:4
16 (Murray)) and insufficient quality control and reconciliation measures. (RT 14327:4-8;
17 14329:25-14331:9; Exh. 226, p. 7651; Exh. 594, p. 4022 [see number 5]; Exh. 707, p. 9970.)
18 In creating DocDNA, PacifiCare “designed something so complicated it was difficult to
19 manage” and “didn’t give [Lason] the best direction.” (RT 6317:18-20; 6805:4-12
20 (Vonderhaar).) Accountability within PacifiCare for functions outsourced to Lason was
21 fractured and incomplete, with no oversight of the secondary document indexing function.
22 (Exh. 365, p. 6872; Exh. 577; Exh. 705; Exh. 711; Exh. 1031; RT 3613:21-23 (Murray);
23 RT 14865:4-15; 14900:23-14901:4 (Vavra).) Even worse, PacifiCare neither established nor
24 held Lason accountable for quality metrics in service level agreements (RT 13936:25-
25 13938:10; 14840:24-14841:22; 14915:3-10 (Vavra); Exh. 575, p. 4003 [McMahon
26 8:49 a.m.]), which allowed these problems to persist for unreasonable lengths of time.
27
28

1 **d. PacifiCare’s Failure to Promptly Remediate Its Violations**

2 As discussed above, PacifiCare was forced to reprocess claims that had been
3 improperly denied during 2006 because of its failure to manage COCCs. While PacifiCare
4 appears to claim that it “self-initiated” these reworks, in fact, it was CDI that demanded that
5 the company review these claims. (Exh. 5004, p. 7576; RT 163:1-5 (Smith).)

6 PacifiCare’s other remedial efforts, also undertaken at CDI’s behest, were pursued
7 without urgency. PacifiCare was aware of problems with its COCC processes at least as
8 early as October 2006 (Exh. 5009), yet it did not begin analyzing its processes for handling
9 COCCs until around March 2007. (Exh. 687, p. 2813 [“First workgroup meeting on
10 3/1/07.”].)

11 Other corrective actions were cursory or incomplete. PacifiCare’s corrective action
12 plan in March 2007 called for storing COCCs in FileNet where they would be “retrievable by
13 using member ID#.” (Exh. 348, p. 0679.) However, PacifiCare did nothing to verify that all
14 COCCs could in fact be retrievable by member ID number, and its failure to do so resulted in
15 COCCs and other documents continuing to be “lost” in FileNet for many more months.
16 (Exh. 574; Exh. 342, p. 8514; Exh. 355, p. 8503; Exh. 365, p. 6872; RT 6353:7-14
17 (Vonderhaar).) The process of reviewing already adjudicated claims when a COCC was
18 received to ensure no prior claims were denied for pre-existing conditions should have been
19 standard protocol. It was implemented in April 2007, approximately six months after CDI
20 first urged the company to address the COCC issue. (Exh. 740, pp. 1404, 1408.) PacifiCare
21 did not begin requesting COCCs at the time of enrollment, to ensure proper processing of
22 future claims, until late 2007. (Exh. 601, p. 9156.)

23 The most urgent problems causing COCC violations were not remedied for years after
24 the company first became aware of the deficiencies in its processes. As of March 2007,
25 PacifiCare was aware that remediating its COCC deficiencies required re-examination of
26 DocDNA routing. (Exh. 348, pp. 0678-0679.) The company internally acknowledged that
27 the problems with DocDNA were severe (Exh. 5265, p. 1939 [July 2007 memo in which Ms.
28 Berkel reports that “claim dependent correspondence routing” was “broken”]; Exh. 575, p.

1 4003 [Berkel 6:24 p.m.: “everytime [sic] we turn around there are issues with Lason and
2 DocDNA”]; Exh. 361 [July 2007: Failure to timely process reworks attributed to Lason
3 delays]; Exh. 526, p. 2771 [August 2007: “Issues again with aging in Lason queues.”]) but
4 did not begin discussing the idea of redesigning the document routing process until February
5 2008, and did not begin work on that redesign until May 2008 (Exh. 376, p. 8233; Exh. 367,
6 p. 7466).

7 There is no evidence that PacifiCare ever remediated its haphazard handling of
8 incoming faxes. (RT 3177:14-3178:14 (Murray).) The concern that “faxes go to [a] black
9 hole” was a “common theme” in 2007 (Exh. 795, p. 2072) and documents submitted through
10 customer service fax lines continued to be lost into 2008. (Exh. 351; Exh. 352.) PacifiCare
11 was aware that it had not fully remediated its practice of requesting information it had
12 already received. In September 2007, PacifiCare observed a high volume of letters
13 “requesting additional information” which “could be related to claims being denied
14 incorrectly.” (Exh. 371, p. 4008 [see number 12].) There is no evidence that PacifiCare took
15 steps to address this continued noncompliance.

16 As a consequence of these delayed and ineffectual corrective actions, CDI continued
17 to detect violations of law stemming from the failure to manage COCCs long after
18 April 2007, when PacifiCare claimed to have completed its corrective actions. (E.g.,
19 Exh. 79, p. 6318.) Had PacifiCare diligently sought to address the root causes of its COCC-
20 related violations in early 2007 when asked to do so by the Department, the company could
21 have avoided many of the violations related to its egregious mismanagement of claim-related
22 documents.

23 **e. Harm Caused by PacifiCare’s Violations**

24 Improper denials on the basis of pre-existing conditions have very serious
25 consequences. As Mr. Cignarale testified, the consumers likely to submit a claim for
26 medical care for which they were treated or diagnosed in the six months prior to coverage are
27 those suffering from acute or chronic illnesses or injuries for which treatment is often
28 expensive. (Exh. 1184, p. 18:16-18.) Patients may be denied medical care by providers who

1 are frustrated with the insurer’s denial (Exh. 144; RT 1034:23-1035:5; 1038:2-1039:10 (Ms.
2 W)), or may delay or forgo needed care because of fears of being required to pay for the
3 treatment. These violations therefore present a risk of bodily injury or degradation of health.

4 In addition, patients facing liability for thousands of dollars in medical care suffer
5 tremendous anxiety. (RT 352:11-353:1 (Masters); RT 1024:13-17; 1041:6-20 (Ms. W.))
6 The total payment PacifiCare made for the claims denied as a result of its mishandling of
7 COCCs amounted to approximately \$765,157. (Exh. 5015, p. 7765; RT 250:3-11 (Smith).)
8 This represents over \$1,000 per claim, a significant sum and one that would burden the
9 average California family. (Exh. 1184, p. 27:22-26.) Further, PacifiCare has failed to
10 provide any evidence (either to CDI during the investigation or at the hearing) that it ever
11 remediated the full effects of the 1,110 improperly denied claims on which it asserts no
12 additional payment was owed. These claims therefore represent harm never remediated,
13 which is a serious concern. (RT 252:9-253:5 (Smith); Exh. 5022, p. 3044.)

14 Separate from the serious financial strain PacifiCare imposed on members, an EOB
15 explaining that a claim is not covered on pre-existing condition grounds can be terrifying to
16 consumers. The deductible represents a finite, and usually relatively modest, sum that the
17 consumer expects to pay each year. PacifiCare’s EOBs denying claims on pre-existing
18 condition grounds, however, communicate that *all* claims incurred in the next six (or twelve)
19 months for a given condition will be denied and not applied to the deductible, at ever
20 increasing cost to the member.

21 The harm in this case was exacerbated by customer service that PacifiCare’s own
22 employees described as “horrible” and “incompetent.” (Exh. 678, pp. 2838 [“horrible”],
23 2917 [“incompetent”].) Consumers who contacted PacifiCare to inquire about COCCs that
24 they had already sent and that the company had lost encountered wait times of up to an hour
25 and a half, and when they did finally get a hold of a PacifiCare representative they were often
26 given inaccurate information and treated with “outright rudeness.” (Exh. 1065, p. 1102, ¶ 5
27 [“outright rudeness”]; Exh. 287, p. 6168 [incorrect information]; Exh. 702; Exh. 717, p.
28 5404; Exh. 678, pp. 2771, 2797, 2801, 2805, 2831, 2836, 2839, 2848, 2855, 2864, 2871,

1 2876; 2882, 2891, 2894 [1.5 hour wait], 2912, 2917, 3028, 3071; RT 1726:2-1727:20 (Mr.
2 R); RT 3378:21-3379:4 (Sing).) As discussed above, PacifiCare customer service
3 representatives were also unable to help consumers because COCCs were not retrievable
4 from within PacifiCare’s systems.

5 **3. Number of Acts in Violation**

6 Each of the 1,799 claims that PacifiCare has acknowledged were denied because of
7 the company’s improper handling of COCCs represents an act in violation of section 790.03,
8 subdivisions (h)(1), (h)(3), and (h)(5), as well as a violation of section 10123.13, subdivision
9 (a) and Regulation 2695.7, subdivision (d).

10 In each instance, PacifiCare falsely represented to consumers that their claims were
11 excluded from coverage because of a pre-existing condition, thereby misrepresenting
12 pertinent facts. Each improper denial and request that the claimant submit a COCC form
13 also represents an unnecessary and unreasonable demand for information that the company
14 already possessed in order to adjudicate a claim for which liability was clear, in violation of
15 Regulation 2695.7, subdivision (d).

16 **4. PacifiCare Knowingly Committed the Acts in Violation, and**
17 **Performed Them with Such Frequency as to Indicate a General**
18 **Business Practice**

19 As discussed above, to establish a violation of section 790.03, subdivision (h), it is
20 sufficient to demonstrate that an act or practice was “either knowingly committed on a single
21 occasion, or performed with such frequency as to indicate a general business practice.”

(Reg. 2695.1, subd. (a).)

22 “Knowingly committed” as defined by Regulation 2695.2, subdivision (l), means
23 “performed with actual, implied or constructive knowledge, including, but not limited to, that
24 which is implied by operation of law.” This requirement is easily satisfied for these
25 violations. PacifiCare knew or should have known that it was misrepresenting to claimants
26 pertinent facts relating to coverage, i.e., it knew or should have known that the claim denials
27 were incorrect. PacifiCare is chargeable with constructive knowledge of documents it has
28 received from claimants, so failures to act on the basis of those documents are knowingly

1 committed. An insurer has little excuse for not knowing that a claimant has sent in
2 documents, particularly claim-dependent documents like COCCs. Such an expectation
3 underlies many of the requirements of the UIPA and the Regulations, such as the prohibition
4 on insurers requesting unnecessary information (Reg. 2695.7, subd. (d)), and the requirement
5 that insurers acknowledge and act reasonably promptly upon communications with respect to
6 claims (§ 790.03, subd. (h)(2)).

7 Therefore, PacifiCare “knowingly” committed these acts in violation: its incorrect
8 denial of these claims constituted a knowing misrepresentation of pertinent facts when it
9 incorrectly denied the claims and a knowing failure to attempt in good faith to effectuate
10 prompt, fair, and equitable settlement of claims. (Exh. 1184, p. 23:8-11.)

11 PacifiCare also had sufficient information to be chargeable with knowledge that it
12 needed to have in place sufficient processes to ensure that important documents like COCCs
13 would be adequately routed, maintained, and stored. By failing to implement adequate
14 procedures, and failing to ensure that its vendor implemented such procedures, PacifiCare
15 thus knowingly failed to adopt and implement reasonable standards for the prompt
16 investigation and processing of claims. (Exh. 1184, p. 23:11-16.)

17 **5. The Acts in Violation Were Willful**

18 These are willful acts in violation. As discussed above, Regulation 2695.2,
19 subdivision (y) defines “willful” and “willfully” as:

20 “simply a purpose or willingness to commit the act, or make the
21 omission referred to in the California Insurance Code or this
22 subchapter. It does not require any intent to violate law, or to injure
another, or to acquire any advantage.”

23 Thus, an insurer must willfully — with a purpose or willingness — commit an act or make
24 an omission proscribed by section 790.03. It is not necessary for PacifiCare to have intended
25 to violate the law, to injure anyone, or to acquire any advantage in denying these claims.
26 (Exh. 1184, p. 24:21-24.)

27 As Mr. Cignarale observed, there are several unfair practices that PacifiCare
28 committed with “purpose or willingness” in connection with the COCC-based denials.

1 (Exh. 1184, p. 24:25-26.) First, these wrongfully denied claims are the result of PacifiCare’s
2 purposeful or willing failure to adopt and implement reasonable standards for the prompt
3 investigation and processing of claims. (§ 790.03, subd. (h)(3).) Such reasonable standards
4 include careful consideration when designing operational systems of possible claims-
5 handling and regulatory consequences; comprehensive testing, error detection and quality
6 control; close supervision of vendors performing outsourced work; and rapid responses to
7 indications that systems are not performing as expected. Any reasonable insurer would know
8 that it must have processes in place to assure accurate and consistent handling of COCCs,
9 given such documents’ importance to claim processing. In fact, PacifiCare admitted that it
10 knew that it did not implement a system for keeping COCCs in a central location where staff
11 could access them, which resulted in these illegal claims denials. (Exh. 6, p. 7566.)

12 Further demonstrating PacifiCare’s purposeful or willing failure to adopt and
13 implement reasonable standards for the prompt investigation and processing of claims is the
14 company’s actions (and omissions) with respect to Lason. In transferring responsibility for
15 crucial documents to that vendor, PacifiCare designed a process that, in PacifiCare’s own
16 words, was “so complicated it was difficult to manage” (RT 6805:4-12 (Vonderhaar)) and
17 the company then failed to adequately monitor the work outsourced to Lason (e.g., Exh. 365,
18 p. 6872 [“There has been no consistent oversight of this function by PHS/United.”]). The
19 company provided Lason with admittedly inadequate instructions or no instructions at all;
20 did not timely implement basic quality control mechanisms that obviously were necessary,
21 such as simple reconciliation reports, audits, and performance payment guarantees; and
22 routed the documents through a system that could not be searched despite knowing or having
23 reason to know such searches were required to process claims correctly. These failures,
24 which led to the violations being charged here, were clearly “willfully” committed.

25 PacifiCare also — with purpose and willingness — misrepresented pertinent facts, as
26 proscribed by section 790.03, subdivision (h)(1). (Exh. 1184, p. 25:17-18.) As more fully
27 discussed below, PacifiCare has an institutional policy of denying claims for what it believes
28 to be pre-existing conditions, unless the claims examiner is aware that a COCC has been

1 received. (See in part IV.J, *infra*.) By October 2006 at the latest, PacifiCare’s top leaders
2 were aware of a “systemic problem” processing COCCs (RT 17605:16-17 (McMahon)) and
3 should have known that RIMS did not reliably reflect whether a COCC had or had not been
4 sent. Each time it issued, through its claim examiners, an EOB denying the claim as a pre-
5 existing condition, the company exhibited a willingness to misrepresent pertinent facts to
6 providers and members. (Exh. 1184, p. 25:22-24.)

7 **6. The Issuance, Amendment, or Servicing of the Policy or**
8 **Endorsement Was Not Inadvertent**

9 As Mr. Cignarale concluded, these claim denials do not constitute the inadvertent
10 “issuance, amendment, or servicing of a policy or endorsement,” as that phrase is used in
11 section 790.035, subdivision (a). (Exh. 1184, p. 23:21-28.) Obviously, there was no
12 issuance or amendment here. By denying a claim — that is to say by sending out a denial
13 letter or an EOB that denies the claim — PacifiCare was “servicing” the policy, but there is
14 no evidence that that act of servicing was inadvertent. When the insurer intends to process
15 and deny a claim but does so wrongfully or incorrectly, that does not constitute the
16 inadvertent servicing of a policy for purposes of determining the number of acts in violation.
17 In this instance, there is no evidence that PacifiCare inadvertently sent out any of these denial
18 letters or EOBs. (Exh. 1184, p. 23:25-28.)

19 **7. Applicable Unit-Penalty**

20 Mr. Cignarale began his analysis of the appropriate unit-penalty by evaluating the
21 general harm and severity of this kind of violation, which he deemed “very serious”:

22 “Inappropriate claim denials can cause a patient to be denied medical care or to avoid
23 needed care because the patient cannot afford to pay for the treatment. These
24 violations therefore present a risk of bodily injury or degradation of health. In my
25 experience, the members who are most likely to experience a claim denial related to a
26 failure to maintain COCCs are those with significant chronic health problems, and
those consumers are the ones who are most vulnerable to the denial or postponement
of medical care.” (Exh. 1184, p. 18:11-18.)

27 Consistent with his “very serious” assessment, Mr. Cignarale opined that the starting
28 point for determining the unit-penalty should be 65% above the bottom of the range from

1 zero to the maximum, or \$6,500 for each willful act in violation. (Exh. 1184, p. 18:19-22.)
2 For violations where no money was owed, he recommended a starting point at 50% above
3 the bottom of the range, or \$5,000 for each willful act in violation. (Exh. 1184, pp. 18:23-
4 19:3.)

5 Mr. Cignarale then evaluated the evidence on specific violations in this case, which
6 were provided to him in the form of assumptions. He found five factors under which there
7 were grounds for adjustment of his starting point based on evidence of the specific COCC-
8 related claim denials charged here, one mitigating and three aggravating. (Exh. 1184,
9 pp. 26:1-28:23.) He found the evidence that PacifiCare undertook remedial measures (Reg.
10 2695.12, subd. (a)(8)) mitigating, although he noted evidence that the company still had not
11 established a consistent practice for handling faxes. (Exh. 1184, p. 27:5-10.) He concluded
12 that the harm that flowed from these violations was more extensive than in the typical
13 violation (Reg. 2695.12, subd. (a)(10)) because the inability to retrieve COCCs from
14 PacifiCare's systems resulted in members spending "time and effort mailing or faxing
15 multiple copies of their COCCs that they had already submitted." (Exh. 1184, p. 27:27-28.)
16 Mr. Cignarale found the absence of a good faith attempt to comply (Reg. 2695.12,
17 subd. (a)(11)) to be a factor in aggravation because "PacifiCare neglected to assure that basic
18 functions essential to the operation of any insurance company – monitoring incoming
19 correspondence – were maintained during the integration" and because the company
20 "resisted implementing cost-effective solutions because they weren't 'in the budget.'" (Exh. 1184, p. 28:4-12.) He viewed the 1,799 claims denied based on mishandling of
21 COCCs during 2006 to be an unusually high frequency (Reg. 2695.12, subd. (a)(12)) and an
22 aggravating factor. Finally, he concluded that PacifiCare was aware of facts that apprised it
23 of the violations in late 2006 (Reg. 2695.12, subd. (a)(13)) but failed to remediate the
24 problems until 2008. (Exh. 1184, p. 28:17-23.)

26 Based on this analysis, Mr. Cignarale recommended an increase of 10% for the
27 charged violations, from \$5,000 to \$5,500 for the 1,110 denials for which the full amount
28 was applied to the deductible, and from \$6,500 to \$7,150 for the 689 denials for which

1 payment was owed. (Exh. 1184, p. 28:24-29:2.) This results in an aggregate penalty for this
2 category of \$11,031,350 for these 1799 acts in violation.

3 **B. Incorrect Denial of Claims Based on an Illegal Pre-Existing Condition**
4 **Exclusionary Period**

5 **1. Applicable Legal Requirements**

6 As discussed in the previous section, insurers may exclude coverage for pre-existing
7 conditions under certain circumstances for a limited period of time after a new group
8 insurance policy takes effect. (§ 10708.) For health plans covering one or two individuals,
9 the maximum pre-existing conditions exclusion period is 12 months after the insured's
10 effective date of coverage. (§ 10198.7, subd. (b).) For plans covering three or more
11 individuals, however, that period is no more than 6 months after the insured's effective date
12 of coverage. (§ 10198.7, subd. (a).)

13 An insurer that denies a claim based on a pre-existing condition exclusion after those
14 maximum 6- or 12-month periods is illegally denying that claim. Each such denial, if
15 knowingly committed or performed with such frequency as to indicate a general business
16 practice, constitutes a violation of section 790.03, subdivision (h)(1) because the insurer is
17 falsely representing that the service for which reimbursement is requested is not covered by
18 the member's policy. A claim denial based on the improper application of a 12-month
19 exclusionary period also violates an insurer's obligation to disclose to claimants and
20 beneficiaries "all benefits, coverage, time limits or other provisions" of the insurance policy.
21 (Reg. 2695.4, subd. (a).)

22 Claims denied on this basis are also violations of section 790.03, subdivision (h)(3)
23 because they reflect failures to adopt and implement reasonable standards for prompt
24 investigation and processing of claims arising under insurance policies.

25 They further violate section 790.03, subdivision (h)(5) because they are instances in
26 which the company is not attempting in good faith to effectuate prompt, fair, and equitable
27 settlements of claims in which liability has become reasonably clear. After the 6-month
28 exclusionary period has expired, the insurer's liability for claims for pre-existing conditions

1 is reasonably clear, and an insurer’s determination that the claim is to be denied reflects a
2 failure to make a good faith effort to apply the proper exclusionary period.

3 Sections 10123.13, subdivision (a) and 10123.147, subdivision (a) further require
4 insurers to reimburse uncontested claims within 30 working days. A claim is “reasonably
5 contested when the insurer has not received a completed claim and all information necessary
6 to determine payer liability for the claim.” (§ 10123.13, subd. (c).) Claims submitted after
7 the member’s pre-existing condition exclusionary period has expired are uncontested claims
8 that must be promptly reimbursed because the company has sufficient information to
9 adjudicate the claim. Denying a claim on the basis that the treatment is for a pre-existing
10 condition when that pre-existing condition is no longer a valid basis for excluding coverage
11 therefore violates this provision.

12 **2. PacifiCare’s Violations of Law**

13 **a. PacifiCare’s Illegal Denials**

14 Around January 2004, PacifiCare submitted, and CDI authorized, a certificate of
15 insurance for a group plan that contained a 12-month exclusionary period, instead of the 6-
16 month period permitted by law. (Exh. 5299, pp. 7549, 7559; RT 8906:1-15; 9216:15-
17 9217:11 (Monk).) Ms. Monk testified that PacifiCare’s product filer made “a mistake” in
18 copying the certificate from “an already-drafted template” and “conforming it to the product
19 that was being filed on behalf of the company.” (RT 8906:16-20; 9222:1-7.) She further
20 testified that the company did not, and still does not, require product filing staff to submit
21 their products to a control person for review, either before or after submission to the
22 approving regulator. (RT 9223:12-25; 9224:14-9225:8.)

23 While CDI did not “catch the mistake” when it authorized the certificate
24 (RT 8909:20-22 (Monk)), the company, of course, always remains responsible for ensuring
25 its own compliance with the law. CDI’s approval of a form policy does not immunize
26 PacifiCare from violations of law arising from the company’s *application* of an illegal pre-
27 existing condition period. Even PacifiCare does not make that contention. (RT 9218:4-
28 9219:2 (Monk).) Indeed, PacifiCare is not being charged for violations — though it could be

1 — for issuing and disseminating an illegal form policy; rather, it is being charged for
2 illegally denying claims for pre-existing conditions after the maximum exclusionary period
3 had elapsed.

4 Throughout 2004, 2005 and 2006, PacifiCare illegally denied thousands of claims
5 based on its application of the 12-month exclusionary period to policies with more than two
6 insureds. (RT 8906:1-15; 9216:23-9217:5; 9227:25-9228:22 (Monk).) Beginning in mid-
7 2006, many of these denials were issued by claims examiners employed by a vendor called
8 MedPlans. These examiners — as well as the claims examiners at PacifiCare — had
9 supposedly been trained on the Insurance Code and Fair Claims Settlement Practices
10 Regulations (RT 9227:25-9229:6 (Monk)), but none of them noticed in the processing of
11 these thousands of claims that application of a 12-month period was illegal.

12 In late 2006, CDI began receiving an alarming number of complaints from consumers
13 regarding claim denials on the basis of pre-existing conditions. (RT 57:21-25 (Smith).)
14 Shortly after CDI contacted PacifiCare to investigate these reports, a company representative
15 disclosed to Ms. Smith that the company was using a 12-month exclusionary period that was
16 not legally permitted for group policies. (RT 63:20-64:10 (Smith).) PacifiCare claimed that
17 it later updated RIMS to reflect the 6-month exclusionary period and asserted that it had re-
18 trained its claims examiners to recognize plans to which the 6-month period was applicable.
19 (Exh. 6, p. 7567; Exh. 740, p. 1405.) Several months later, PacifiCare amended its group
20 plan certificate to reflect the legally permissible 6-month exclusionary period and
21 disseminated a letter to brokers and employer groups notifying them of the change.
22 (Exh. 740, p. 1405; Exh. 11, pp. 7550-7551.)

23 **b. PacifiCare's Inadequate Remediation Efforts**

24 In the Fall of 2006, CDI demanded that PacifiCare reprocess these illegally denied
25 claims and pay to claimants any additional amounts owed. (RT 10225:1-12 (Berkel).) Yet it
26 wasn't until many months later, in April 2007, that PacifiCare actually completed its rework
27 project. (RT 10225:8-12 (Berkel).) PacifiCare reported that it had reworked 3,862 PLHIC
28 claims that it had illegally denied in 2006 based on pre-existing conditions grounds outside

1 the 6-month exclusionary period. (Exh. 354, p. 7184, line 20; RT 3460:11-23 (Norket).)
2 PacifiCare determined that it owed additional payment and interest to claimants for 3,019 of
3 these claims. (Exh. 740, pp. 1405-1406; Exh. 601, p. 9162; RT 6928:20-6929:6
4 (Vonderhaar); RT 10225:8-12 (Berkel).)

5 No additional amounts were paid on the remaining 843 claims likely because the full
6 amount owed was applicable to the member's deductible. PacifiCare's wrongful denial of
7 these claims, therefore, may have prevented affected members from meeting their
8 deductibles and may have resulted in members having to pay out-of-pocket subsequent
9 claims that should have been paid by PacifiCare.

10 In addition, although PacifiCare knew at that time it was reworking these claims that
11 the company's illegal policy had been in effect since early 2004, it chose to reprocess only
12 those claims that it illegally denied in 2006. (Exh. 354, p. 7184; Exh. 740, p. 1405; RT
13 8910:16-20 (Monk); RT 10225:5-19 (Berkel).) It was not until CDI discovered during the
14 MCE that the company had failed to reprocess all 2004 and 2005 illegally denied claims that
15 PacifiCare agreed to rework them and to pay additional amounts owed. (RT 10225:13-19
16 (Berkel).) PacifiCare finally reprocessed those claims in February 2008 — three to four
17 years after they had initially been denied. (Exh. 740, p. 1405; RT 10225:13-19 (Berkel).)
18 This delay is inexcusable. The company could and should have remediated these claims
19 earlier, as even Ms. Berkel recognized. (RT 10225:1-19 (Berkel).) The total number of
20 claims wrongly denied in 2004 and 2005 is unknown, but PacifiCare owed payment to
21 claimants for at least 626 claims. (Exh. 601, pp. 9161- 9162; Exh. 740, p. 1406; RT 6930:5-
22 10 (Vonderhaar).) In total, PacifiCare reported that it owed \$99,615 on these 626 claims.
23 (Exh. 601, p. 9162; Exh. 740, p. 1406.) PacifiCare's practice of denying claims for pre-
24 existing conditions beyond the legally permissible 6-month period affected at least 2,020
25 PLHIC members. (Exh. 356.)

26 PacifiCare also asserted that it took a number of remediation measures to ensure that
27 further pre-existing condition claims would be processed correctly and in accordance with
28 the law. Those measures were ineffective. For instance, the company claimed to have

1 updated its claims engine to reflect the correct 6-month period and to have re-trained claims
2 examiners on these issues in December 2006. (Exh. 740, p. 1405.) But CDI's 2007 MCE
3 revealed that PacifiCare's handling of claims involving pre-existing conditions continued to
4 be deficient. CDI made a number of serious findings that reflected a company that simply
5 didn't know how to correctly process these types of claims:

- 6 • "PacifiCare does not have a procedure in place to accurately document the
7 proper application of a health policy pre-existing condition exclusion."
- 8 • "None of the claims files reviewed documented how the pre-existing period
9 was determined by the Company."
- 10 • "There is no documentation in the claims files confirming member date of hire
11 — a necessary element to apply the pre-existing period — as the pre-existing
12 exclusion applies only to conditions for which medical advice, diagnosis, care
13 or treatment was recommended or received within a six month period ending
14 on the day before the date of hire."
- 15 • "There is no documentation that employer waiting periods were reviewed and
16 included in the six month exclusionary period applied to the members who did
17 not have creditable coverage."
- 18 • "There is no documentation that the benefit effective date supplied by the
19 employer has been correctly entered or verified by the Company."
- 20 • "The Company fails to adequately document their basis for determining a
21 condition is pre-existing when medical records have been provided and they
22 do not support prior medical advice, diagnosis, care or treatment." (Exh. 118,
23 pp. 3423-3424.)

24 PacifiCare admitted that its failures in documenting hire dates "prevents accurate
25 determination of the pre-existing waiting period." (Exh. 118, p. 3424; RT 6930:22-
26 6931:1(Vonderhaar); RT 9233:8-15 (Monk).)

27 Well into 2008, over a year after CDI initially brought to the company's attention
28 problems with its pre-existing condition procedures, PacifiCare was still failing to correctly

1 process these claims, as the company’s own reports reflect. For instance, a January 2008
2 focused audit, initiated at CDI’s request, revealed that PacifiCare was still incorrectly
3 denying over 10% of claims on the basis of a pre-existing condition exclusion. (Exh. 355,
4 p. 8498; RT 3467:15-25 (Norket).) An April 2008 audit reported a similarly unsatisfactory
5 error rate for pre-existing condition denials. (Exh. 741, pp. 6725-6726 [“89.61% vs. 97.00%
6 requirement”].)

7 In July 2008, PacifiCare had to rework an additional 3,030 claims that it had denied
8 on the basis of pre-existing conditions between October 2006 and March 2008. (Exh. 601,
9 p. 9161.) The company owed additional payment of \$147,414 on 826 of these claims.
10 (Exh. 601, pp. 9161-9162; RT 6930:5-10 (Vonderhaar).)

11 Given PacifiCare’s admitted inability to correctly process these claims, CDI made a
12 request in the first half of 2008 that the company cease applying the pre-existing condition
13 exclusionary period for certain members until it could process those claims appropriately.
14 (Exh. 742; RT 10241:9-18 (Berkel).) The company estimated that this remedial measure
15 would cost it roughly \$800,000 (Exh. 808) and ultimately refused to implement the measure.
16 (RT 10245:22-23 (Berkel).)

17 Many of these illegal claim denials were attributable to PacifiCare’s decision to
18 outsource claim processing to MedPlans — a vendor it knew to be incompetent and
19 unconcerned about quality. (See pp. 30-32, *supra*.) After the acquisition by United,
20 PacifiCare nevertheless laid off the Cypress claims staff and transferred their work to
21 MedPlans and other “lower cost vendors.” (Exh. 550, p. 6321; RT 6188:16-24; 6193:19-
22 6194:10; 6197:4-8; 6216:15-22 (Vonderhaar).) PacifiCare made this move not to improve
23 quality or increase operating efficiencies, but rather to maximize synergies that could be
24 reported to Wall Street. As company synergy tracking documents reported, the goal was to
25 “[m]igrate claims processing out of the Cypress, CA transaction center to lower cost
26 transaction processing locations and vendors.” (Exh. 515, p. 3072 [line 27]; see also
27 Exh. 550, p. 6321 [line 54].)

1 PacifiCare transferred the bulk of its PPO claims-processing to MedPlans, including
2 “extremely complicated” claims such as those involving the application of pre-existing
3 condition exclusions (RT 6850:11-12 (Vonderhaar); Exh. 740, p. 1410), even though
4 PacifiCare’s contemporaneous documents reflected serious dissatisfaction with that vendor’s
5 performance. In October 2006, for instance, a PacifiCare employee complained that
6 MedPlans’s quality levels at the time were “really a cause for termination.” (Exh. 1032.) In
7 a September 2007 meeting with MedPlans, PacifiCare representatives again complained
8 about the vendor’s performance lamenting that the “same conversations have been had over
9 the past two or three years” (Exh. 560, p. 4878) but “[s]imilar errors keep repeating”
10 (Exh. 560, p. 4879). And despite PacifiCare’s understandable concern that MedPlans was
11 paying its processors on a per-claim basis — which PacifiCare itself complained created an
12 incentive for them to “take the ‘easy way out’ and deny instead of process” the claims so
13 they could get paid more (Exh. 560, pp. 4878-4879; RT 6227:15-6228:7 (Vonderhaar)) —
14 PacifiCare nevertheless failed to insist that MedPlans change its payment structure
15 (RT 6219:18-23; 6227:5-14 (Vonderhaar)).

16 PacifiCare’s quality audits further confirmed MedPlans’s poor performance
17 specifically with respect to the processing of pre-existing condition claims. The company’s
18 January 2008 report, for instance, attributed the failures to MedPlans, finding that “[i]ssues
19 identified were MedPlans’ examiners,” that its examiners were continuing to use the
20 incorrect pre-existing denial codes, and that they had not correctly applied the training it had
21 received. (Exh. 355, p. 8498; RT 3467:8-14 (Norket); RT 10234:9-18 (Berkel).)

22 Because PacifiCare had laid off its own claims staff, however, it was, in PacifiCare’s
23 own words, “absolutely dependent on MedPlans for all the work and has to work with them.”
24 (Exh. 560, p. 4878.) Thus, despite its serious dissatisfaction with MedPlans and the known
25 performance problems, it continued to send more and more work to that vendor, which
26 resulted in claims continuing to be illegally denied.

1 RT 10225:8-12 (Berkel.) PacifiCare contends that the remaining 843 incorrectly denied
2 claims were owed no additional amounts. These were likely claims for which the amount
3 owed was applicable to the member's deductible.

4 Whether or not additional money was owed, each of the 3,862 claims that PacifiCare
5 has acknowledged were incorrectly denied because of the company's improper application of
6 a 12-month exclusionary period represents an act in violation of section 790.03, subdivisions
7 (h)(1), (h)(3), and (h)(5), as well as a violation of section 10123.13, subdivision (a) and
8 Regulation 2695.7, subdivision (d). In each of these claim denials, PacifiCare misinformed
9 consumers that their claims were excluded from coverage because of a pre-existing condition
10 and that such claims would not be covered for the entire 12-month period.

11 There are additional, known violations committed by PacifiCare that are not being
12 charged in this action. The evidence establishes — and PacifiCare has admitted — that the
13 company illegally denied at least 626 pre-existing claims in 2004 and 2005, and failed to
14 reprocess them until 2008. (Exh. 601, p. 9162.) PacifiCare has further admitted that it
15 illegally denied at least 826 pre-existing claims from 2006 to 2008. (Exh. 601, pp. 9161-
16 9162; RT 6930:5-10 (Vonderhaar.) While these claims are not charged in this action, they
17 should be considered aggravating circumstances when setting the penalty. (E.g., *Grim v.*
18 *State Bar* (1991) 53 Cal.3d 21, 33-34; *Ralph Williams Ford v. New Car Dealers Policy &*
19 *Appeals Bd.* (1973) 30 Cal.App.3d 494, 499-500; see RT 10450:7-22.) They reflect, at a
20 minimum, PacifiCare's failure to fully and promptly remediate its known violations of law
21 and its continued indifference to the proper application of pre-existing condition provisions
22 — plainly relevant considerations for determining the penalty for the charged violations.

23 **4. PacifiCare Knowingly Committed the Acts in Violation, and**
24 **Performed Them with Such Frequency as to Indicate a General**
25 **Business Practice**

26 These acts were knowingly committed. PacifiCare knew or should have known that
27 these were wrongful denials. It, of course, is chargeable with knowledge that the law
28 permitted only a 6-month pre-existing exclusionary period on these policies. It is expected to
know that these claims arose more than six months after the member's expected date and that

1 the claims should not have been denied based on a pre-existing condition exclusion.
2 (Exh. 1184, p. 34:16-19.)

3 PacifiCare is also chargeable, when adjudicating a claim on the basis of pre-existing
4 condition exclusion, with knowledge that its files were inadequate to make such a
5 determination. (Exh. 1184, p. 34:19-21.)

6 Separately, the 3,862 acts in violation being charged are of sufficient frequency to
7 indicate a general business practice. Indeed, that frequency *must* be sufficient to indicate a
8 general business practice, because they are the result of PacifiCare's admitted general
9 business practice of incorrectly denying claims based on an illegal 12-month pre-existing
10 condition exclusionary period. According to PacifiCare's representations, those 3,862 claims
11 represent all the claims incorrectly denied on this basis in 2006.

12 **5. The Acts in Violation Are Not Being Charged As Willful**

13 CDI is not charging these violations as willful acts in violation.

14 **6. The Issuance, Amendment, or Servicing of the Policy or** 15 **Endorsement Was Not Inadvertent**

16 The servicing of the policy relevant to the charged acts in violation was PacifiCare's
17 sending of the claim denials. There is no evidence that PacifiCare inadvertently sent those
18 claim denials.

19 **7. Applicable Unit-Penalty**

20 Mr. Cignarale began his analysis of the appropriate unit-penalty by evaluating the
21 severity of this kind of violation, concluding that it is "very serious" compared to the range
22 of violations to which section 790.035 applies:

23 "Inappropriate claim denials directly harm claimants, and can even lead to patients
24 deferring needed medical care because the financial burden of paying for the care is
25 beyond the patient's means. These violations therefore carry a serious risk of bodily
26 injury or deterioration in health. Moreover, in my experience the members most
27 frequently affected by such denials are those with chronic or serious health
28 conditions, for whom such inappropriate denials may result in the most harm."
(Exh. 1184, p. 29:24-30:4.)

1 Consistent with his “very serious” assessment, Mr. Cignarale opined that the starting
2 point for determining the unit-penalty should be 65% above the bottom of the range from
3 zero to the maximum, or \$3,250 for each non-willful act in violation. (Exh. 1184, p. 30:5-9.)
4 For violations where no money was owed, he recommended a starting point at 50% above
5 the bottom of the range, or \$2,500 for each non-willful act in violation. (Exh. 1184,
6 p. 30:10-28.)

7 Mr. Cignarale then evaluated the evidence on specific violations in this case. He
8 identified six factors under which there were grounds for adjustment of his starting point
9 based on evidence of the specific pre-existing condition violations charged here, three
10 mitigating and three aggravating. While acknowledging that adjudication of pre-existing
11 conditions claims is complex (Reg. 2695.12, subd. (a)(3)), he found that complexity
12 irrelevant to the violations caused by the inclusion of the wrong exclusionary period in the
13 form policy. (Exh. 1184, p. 36:11-13.) Mr. Cignarale saw insufficient evidence to conclude
14 whether the relative frequency of the violations (Reg. 2695.12, subd. (a)(7)) was mitigating
15 or aggravating. (Exh. 1184, p. 36:14-16.) He regarded the company’s remedial measures
16 (Reg. 2695.12, subd. (a)(8)), including revising the policy and reprocessing the incorrectly
17 denied claims, as a factor in mitigation, despite the company’s reluctance to adopt further
18 measures to address deficiencies in its processing of pre-existing condition claims that were
19 identified in the MCE. (Exh. 1184, p. 36:17-24.)

20 Mr. Cignarale concluded that the harm occasioned by the violations was greater than
21 that usually associated with pre-existing condition denials (Reg. 2695.12, subd. (a)(10))
22 because of the unknown number of violations where the amount of the improperly denied
23 claim was applied to the member’s deductible. He also noted that inclusion of the 12-month
24 exclusionary period in the policy form may have dissuaded members from seeking medical
25 care. (Exh. 1184, p. 37:3-10.) He credited PacifiCare for making a good faith attempt to
26 comply with the law. (Reg. 2695.12, subd. (a)(11).) Although PacifiCare did not have
27 process controls for drafting and filing form policies, he did not regard this as aggravating in
28 light of CDI’s own failure to detect the error. (Exh. 1184, p. 37:11-20.) The large number of

1 affected members and the severity of the detriment to the public (Reg. 2695.12, subd.
2 (a)(12)) was, in Mr. Cignarale’s view, an aggravating factor. (Exh. 1184, p. 38:1-4.) Finally,
3 Mr. Cignarale viewed the company’s failure to detect the error in the form policy for two
4 years (Reg. 2695.12, subd. (a)(13)), as evidence in aggravation, in light of the company’s
5 obligation to train its claim examiners on the appropriate exclusionary period. He opined
6 that this factor was only slightly aggravating, as CDI also failed to ascertain the illegality of
7 the policy. (Exh. 1184, p. 38:6-11.)

8 On balance, Mr. Cignarale determined that the evidence supported reducing the unit-
9 penalty by 50% for the violations associated with the illegal 12-month exclusionary period.
10 He recommended that the unit-penalty for claims where payment was owed be reduced from
11 \$3,250 to \$1,625, and that the unit penalty for claims where no payment was owed by
12 reduced from \$2,500 to \$1,250. (Exh. 1184, p. 38:17-21.)

13 The existence and circumstances of the uncharged violations from 2004 and 2005
14 related to the illegal 12-month exclusionary period, and the uncharged violations related to
15 ongoing failures to properly apply the law governing pre-existing conditions identified
16 during the MCE, warrant a departure from Mr. Cignarale’s recommended penalty for the
17 charged violations. Mr. Cignarale did not consider those uncharged violations in his
18 analysis. For example, Mr. Cignarale viewed the absence of prior violations of this nature
19 (Reg. 2695.12, subd. (a)(9)) to be a slightly mitigating factor (Exh. 1184, p. 36:25-27);
20 however, that opinion assumed that the hundreds of violations in 2004 and 2005 would be
21 charged in this case. As discussed above, the ALJ is permitted to consider such uncharged
22 violations as aggravating circumstances when setting the penalty. (E.g., *Grim, supra*, 53
23 Cal.3d at pp. 33-34; *Ralph Williams Ford, supra*, 30 Cal.App.3d at pp. 499-500; see
24 RT 10450:7-22.)

25 Evidence of PacifiCare’s continued indifference to proper application of pre-existing
26 condition provisions remains relevant and is an aggravating factor. The ALJ is “entitled to
27 consider related deficiencies in order to evaluate” PacifiCare’s good faith attempt to comply
28 with the statute and “in order to determine what administrative penalty . . . would be

1 suitable.” (*Ralph Williams Ford, supra*, 30 Cal.App.3d at 499-500.) When the company
2 investigated the laws governing pre-existing conditions in late 2005, it should have realized
3 the necessity of tracking member hire dates to properly measure the beginning of the
4 exclusionary period. It denied claims without this information until March 2008. (Exh. 118,
5 pp. 3423-3424; Exh. 740, p. 1405; RT 6930:22-6931:1 (Vonderhaar).)

6 By late 2006, PacifiCare knew that entrusting its “extremely complicated” pre-ex
7 claims (RT 6850:11-12 (Vonderhaar)) to MedPlans, whose quality levels were so low as to
8 be “cause for termination” (Exh. 1032), created an unnecessary risk of erroneous claim
9 denials. The company threatened to move this “complex work” in house in light of concerns
10 expressed by regulators, but it did not do so. (Exh. 560, p. 4878.) The fact that PacifiCare
11 considered itself “completely dependent” on MedPlans despite its dissatisfaction accounts for
12 the vendor’s failure to “hold itself accountable” for the work it performed on PLHIC claims:
13 MedPlans faced no consequences for its dismal performance. (Exh. 560.)

14 PacifiCare did not even audit MedPlans’s performance on claims denied for pre-
15 existing conditions until early 2008, when requested to do so by CDI. (Exh. 740, p. 1409;
16 RT 10234:9-18 (Berkel).) Moreover, even though PacifiCare recognized that MedPlans’s
17 piece rate payment structure created an incentive for improper denials, PacifiCare did not
18 force its vendor to apply a more rational wage scheme for PacifiCare claims. (Exh. 560,
19 p. 4878-4879; RT 6233:25-6234:3 (Vonderhaar).)

20 While the company trained claim examiners on pre-ex in late 2006, that training
21 consisted solely of differentiating between a 6-month and a 12-month exclusionary period.
22 (Exh. 740, p. 1405; RT 6965:9-11 (Vonderhaar).) The company conducted no further
23 training on a “complicated process” that “requires above level understanding” and benefit
24 interpretation skills until it revised its remark codes in late 2007, following the market
25 conduct exam, when it trained processers on the use of new remark codes. (Exh. 740,
26 pp. 1405, 1411; RT 6965:9-11 (Vonderhaar).) Moreover, the training provided to MedPlans
27 in both instances was inadequate. (Exh. 740 pp. 1405, 1409; Exh. 355, p. 8498; RT 3467:8-
28 14; 3468:1-11 (Norket).)

1 Ms. Vonderhaar testified that PacifiCare provided “ongoing training” to MedPlans
2 after its “focused audits” shed light on the “root cause” of errors. (RT 6965:14-17.) Yet the
3 April 2008 audit results revealed the same rate of erroneous pre-ex denials—10%—as when
4 the audits began in January. (Exh. 355, p. 8498; Exh. 741, pp. 6725-6726; RT 10239:12-14
5 (Berkel).)

6 Some of the remedial measures the company eventually adopted could have been
7 implemented far earlier. PacifiCare did not begin tracking hire date information until
8 March 2008, four months after the market conduct exam report reminded the company that
9 this information was necessary to properly adjudicate pre-ex claims. (Exh. 116, pp. 1301-
10 1302; Exh. 740, p. 1405.) In the Summer of 2008, PacifiCare began using AS400 to verify
11 whether PLHIC members had prior coverage in another PacifiCare plan, but the tool had
12 been in use within PacifiCare for some time and surely could have been utilized earlier.
13 (RT 11227:13-11228:3 (Berkel).)

14 The existence of these additional uncharged violations, and the aggravating
15 circumstances relevant to those uncharged acts in violation that occurred in 2006-2008,
16 warrant a 10% increase over Mr. Cignarale’s adjusted unit-penalty recommendation. A 40%
17 reduction in the unit penalty, rather than 50%, is therefore appropriate, resulting in a unit-
18 penalty of \$1,950 for the 3019 claim denials for which money was owed, and a \$1,500 unit-
19 penalty for the 843 improper claim denials for which no money was owed. This would result
20 in an aggregate penalty for this category of violations of \$7,151,550.

21 **C. Failure to Give Notice to Providers of Their Right to Appeal to CDI**

22 **1. Applicable Legal Requirements**

23 Sections 10123.13, subdivision (a) and 10123.147, subdivision (a)¹³ specifically
24 require inclusion of a notice that providers may seek review by the Department of any claim
25 that is contested or denied, and that the notice must include contact information for the
26 Department. In 2005, existing law required insurers to either remit payment for health care
27

28 ¹³For convenience, subsequent citations are to 10123.13.

1 claims within 30 working days of receipt, or to deny or contest the claim in that time,
2 explaining its reasons for doing so. Senate Bill 367 (“SB 367”), enacted that year, required
3 CDI to establish a program to investigate provider complaints regarding denied and contested
4 claims. (§ 10133.661, subd. (c).) It also required an insurer, in all communications notifying
5 providers that it was contesting or denying a claim “or portion thereof,” to (i) inform them of
6 their right to seek review by CDI and (ii) provide them with CDI’s address, website address,
7 and telephone number:

8 “The notice shall advise the provider who submitted the claim . . . and the
9 insured that either may seek review by the department of a claim that the
10 insurer contested or denied, and the notice shall include the address, Internet
11 Web site address, and telephone number of the unit within the department that
performs this review function.” (§ 10123, subd. (a).)

12 In enacting this law, the Legislature found and declared that “[h]ealth care services must be
13 available to Californians without unnecessary administrative procedures, interruptions, or
14 delays.” (Legis. Counsel’s Dig., Sen. Bill No. 367 (2005-2006 Reg. Sess.) (RON, Exh. H,
15 p. 17).) It further explained the rule requiring insurers to notify members and providers of
16 their right to request review from CDI and to provide CDI’s contact information was
17 intended to “reduce confusion about the identity of the appropriate regulator,” and ultimately
18 sought to “assure the public that the law is properly implemented”:

19 “With two separate departments responsible for regulating entities that provide
20 health care coverage, patients and their health care providers are often
21 confused about the identity of the appropriate regulator.

22 “It is the intent of the Legislature to reduce confusion about the identity of the
23 appropriate regulator, to provide all patients who have health care coverage
24 and their health care providers with an easy and effective mechanism within
25 the Department of Insurance to effectively resolve complaints as already
26 intended for health care providers through the Department of Managed Health
27 Care, and to assure the public that the law is properly implemented.” (Legis.
28 Counsel’s Dig., Sen. Bill No. 367 (2005-2006 Reg. Sess.) (RON, Exh. H,
p. 17).)

1 This law, known as the Patient and Provider Protection Act, thus was viewed broadly by the
2 Legislature as an addition of rights for patients and providers necessary to instill public
3 confidence in the just application of the laws.

4 Section 10123.13, subdivision (a) further required that the notice that contains the
5 CDI review rights and CDI's contact information may be included on EOBs and must also
6 advise the provider of its right to file a dispute with the insurer:

7 "The notice to the provider may be included on either the explanation of
8 benefits or remittance advice and shall also contain a statement advising the
9 provider of its right to enter into the dispute resolution process described in
Section 10123.137."

10 Thus, the law required that insurers notify providers of their right to request review by
11 CDI and their right to submit a dispute with the insurer.

12 In practice, nearly all Explanations of Payment ("EOPs")¹⁴ will require such
13 notification of the right to seek review to CDI and to file a dispute with the insurance
14 company. Since, as PacifiCare's own expert has admitted, very few claims are paid at
15 the full billed amount, virtually all EOBs or EOPs deny or contest a claim or a portion
16 of a claim. (Exh. 1184, p. 41:19-20; RT 24344:7-11 (Stead).) For purposes of an
17 insurer's notification requirements, the law treats equally claims that are denied in
18 their entirety and claims of which a portion is paid and a portion denied.

19 Regulation 2695.7, subdivision (b), for instance, requires insurers, upon
20 receipt of a claim, to:

21 "accept or deny the claim, in whole or *in part*. The amounts accepted or denied
22 shall be clearly documented in the claim file unless the claim has been denied
23 in its entirety." (Reg. 2695.7, subd. (b) (emphasis supplied).)

24 That section goes on to require insurers to notify the claimant that if he or she "believes all or
25 *part* of the claim has been wrongfully denied or rejected, he or she may have the matter
26 reviewed by the California Department of Insurance" and to "include the address and

27
28 ¹⁴The Department uses the term Explanation of Payments or EOPs to refer to
Explanation of Benefits or EOBs that are sent to providers.

1 telephone number of the unit of the Department which reviews claims practices.”
2 (Reg. 2695.7, subd. (b)(3) (emphasis supplied).)

3 Section 10123.13, subdivision (a) similarly treats claims a portion of which is
4 contested or denied as “contested or denied” claims, requiring that if “the claim or *portion*
5 *thereof* is contested by the insurer . . . the claimant shall be notified, in writing, that the claim
6 is contested or denied, within 30 working days after receipt of the claim by the insurer.”
7 (Emphasis supplied.) That subdivision further provides that the “notice that a claim is being
8 contested or denied shall identify the *portion of the claim* that is contested or denied”
9 (emphasis supplied) and then requires that that notice inform the member or provider of their
10 right to seek CDI review.

11 PacifiCare was therefore required to include information about providers’ right to
12 contact CDI to dispute all EOPs beginning on January 1, 2006, when that requirement of
13 section 10123.13, subdivision (a) was enacted. Until June 2007, however, all PLHIC EOPs
14 omitted that information and failed to indicate that the claim fell within CDI’s jurisdiction.
15 This failure to include notice of CDI-review rights in each EOP constitutes an act in violation
16 of section 10123.13, subdivision (a).

17 Each knowing issuance of a defective EOP also constitutes an act in violation of
18 section 790.03, subdivision (h)(1), which prohibits “misrepresenting to claimants pertinent
19 facts or insurance policy provisions relating to any coverages at issue.” These EOPs
20 purported to represent the recipients’ dispute rights if they disagreed with PacifiCare’s
21 adjudication of their claim, but omitted mention of an avenue of appeal deemed essential by
22 the Legislature.

23 Each deficient EOP also violates section 790.03, subdivision (h)(3) because it reflects
24 a knowing failure to adopt and implement reasonable standards for prompt investigation and
25 processing of claims arising under insurance policies.

26 These deficient EOPs further violated Regulation 2695.7, subdivision (b), which as
27 described above specifically requires notification of CDI review rights.

1 **2. PacifiCare’s Violations of Law**

2 **a. PacifiCare’s Admissions of Violations and Delays in**
3 **Remediating**

4 Section 10123.13, subdivision (a)’s requirement that insurers notify providers of their
5 right to request CDI review and to advise them of their right to enter into a dispute resolution
6 process with the insurer became effective on January 1, 2006.

7 Throughout 2006 and 2007, PLHIC’s EOPs contained a page titled “Provider Dispute
8 Information” that purported to “notify you of your dispute rights.” (E.g., Exh. 24, p. 3088.)
9 It informed providers that:

10 “Per California law, PacifiCare is obligated to notify you of your dispute
11 rights. If you would like to submit a provider dispute, please submit a request
12 to:

13 PacifiCare
14 Provider Dispute
15 P.O. Box 6098
16 Cypress, CA 90630” (E.g., Exh. 24, p. 3088.)

17 But these PacifiCare EOPs failed to notify providers of their statutory right to seek
18 review by CDI. For well over one year after section 10123.13, subdivision (a) became law,
19 every single PLHIC EOP omitted the vital notification language that the Legislature had
20 deemed necessary “to reduce confusion about the identity of the appropriate regulator” and
21 “to assure the public that the law is properly implemented.” (Legis. Counsel’s Dig., Sen. Bill
22 No. 367 (2005-2006 Reg. Sess.) (RON, Exh. H, p. 17).)

23 PacifiCare apparently had inadequate controls in place, because it was unaware of
24 these failures until CDI notified it on February 21, 2007, that the company’s EOPs illegally
25 omitted this right-to-CDI review language. In a violation letter of that date, CDI informed
26 PacifiCare that the “EOB[is issued by your company to the provider on 9/11/06 and 12/25/06
27 failed to include the required notice advising the provider of the right to have the contested or
28 denied claim reviewed by our Department.” (Exh. 683, p. 9289.) CDI therefore cited
PacifiCare for violating the law. (Exh. 683, pp. 9289-9290.)

Over a month later, on March 23, 2007, PacifiCare forwarded to CDI a sample of a
revised EOP that included this notice of the providers’ right to seek review by CDI and

1 CDI's contact information. (Exh. 11, pp. 7542-7543.) For some reason it took PacifiCare
2 over a month to draft a single sentence to be added to its EOPs that read: "If you feel that all
3 or part of this claim has been wrongfully denied or rejected, you may have the matter
4 reviewed by the California Department of Insurance at: [contact information for CDI's
5 Consumer Services Division]." (Exh. 11, p. 7543.)

6 PacifiCare further represented to CDI at that time that these language changes "are in
7 progress and will be included on EOBs as of 4/8/07." (Exh. 11, p. 7542.) That
8 representation was false. In fact, PacifiCare failed to include the statutorily required CDI-
9 review language on its EOPs for group claims until June 15, 2007, almost four months after
10 CDI notified PacifiCare of the noncompliant EOPs. (Exh. 118, p. 3415.) EOPs issued for
11 individual claims continued to omit CDI-review-right language for approximately five
12 months after that, until November 4, 2007. (Exh. 118, p. 3415; Exh. 823; RT 12527:1-
13 12528:5 (Monk).) During this same period, PacifiCare knowingly disseminated hundreds of
14 thousands of misleading EOPs.

15 During the MCE, CDI again cited PacifiCare multiple times for its failures to include
16 the statutorily required language on its EOPs, and PacifiCare in every instance admitted that
17 it had violated the law. In an August 30, 2007, referral, CDI cited PacifiCare for failing to
18 include in an EOP notice of the "right to contest a claim with DOI" and "the CDI website."
19 (Exh. 1206, p. 4272.) PacifiCare responded by agreeing with CDI's finding and promising
20 that the corrective action plan would "provide changes to the EOB/EOP language" and
21 would add a reference to the CDI website. (Exh. 1206, p. 4273.)

22 Similarly, in CDI's MCE reports, it cited PacifiCare for failing to include in its EOPs
23 the right to CDI review language and CDI's contact information. (Exh. 118, p. 3415.) In the
24 company's official response to those reports, PacifiCare again agreed with the finding that it
25 "failed to include required wording in the EOB and Explanation of Payment (EOP)
26 correspondence." (Exh. 118, p. 3415; see also RT 8897:2-7 (Monk).)

1 The legislative history of SB 367 — which PacifiCare’s legislative staff purportedly
2 follows and reviews (RT 12397:23-12398:12 (Monk)) — makes absolutely clear that the
3 reference to “department” in the statute is to the California Department of Insurance:

4 “The bill . . . [r]equires notice in #1 above to include a statement advising the
5 provider and the insured of the following: (a) that either may seek review by
6 DOI of a claim that the insurer contested or denied, (b) the address, an Internet
7 web address, and telephone number of the unit within the DOI that conducts
8 such reviews, and (c) that the provider has a right to enter into the insurer’s
9 dispute resolution process under #2 above.” (Exh. 680, p. 2 [number 9, Senate
10 Floor Analyses for SB 367] (emphasis supplied); see also Exh. 681, p. 2
11 [number 9, Assembly Floor Analyses for SB 367].)

12 “DOI,” as Ms. Monk acknowledged, refers to the Department of Insurance. (RT 9282:5-7.)

13 And when certain PacifiCare’s regulatory staff analyzed SB 367, they similarly
14 interpreted the term “department” in section 10123.13, subdivision (a) to refer to CDI.
15 PacifiCare’s implementation log for that bill stated that section 10123.13, subdivision (a)
16 required that “Notice to provider and insured shall advise them that either may seek review
17 by the Dept. of *Insurance* of a claim that the insurer contested or denied.” (E.g., Exh. 5316,
18 p. 7528 [last row] (emphasis supplied).)¹⁵ Ms. Monk, in fact, acknowledged that the
19 implementation log for SB 367 reflected that the staff understood the reference in the statute
20 to the “department” to be the Department of Insurance. (RT 9272:8-9273:1 (Monk).)

21 The notion that PacifiCare’s omission of the notice from EOPs was “understandable”
22 is simply untenable. Of course, it is also irrelevant, as all of the charged violations occurred
23 *after* PacifiCare was indisputably on notice of its obligation to include CDI-review language.
24

25 ¹⁵Also making this interpretation unreasonable is the fact that the Fair Claims
26 Settlement Practices Regulations explicitly require that insurers notify claimants of their
27 right to have matters “reviewed by the California Department of Insurance.” (Reg. 2695.7,
28 subd. (b)(3).) This regulation has been on the books since the 1990s. (Exh. 1184, p. 47:24-
25.)

1 Meaning of “Contested or Denied” Claim

2 PacifiCare next suggests that claims in which it remitted the amount purportedly
3 owed under its contract with the provider cannot be “contested or denied” claims.¹⁶ There
4 are two ways in which such claims may be denied or contested: First, as PacifiCare’s
5 witness testified, a claim is often composed of several claim lines seeking payment for
6 different services. If one or more of those claim lines is paid in full, but another claim line is
7 denied, the claim is “considered denied because there are portions of that claim particular
8 services of which benefits have not been made available.” (RT 25535:17-25536:2 (Stead).)
9 Second, when an insurer communicates its intent to pay for each covered service, but to pay
10 less than the amount billed by the provider, the insurer is contesting its obligation to pay the
11 billed amount. It is this latter category of claims that PacifiCare contends does not require
12 notice of provider rights to appeal to CDI.

13 In determining the meaning of “a claim that the insurer contested or denied” in
14 section 10123.13, subdivision (a), the words should be accorded “their usual, ordinary, and
15 common sense meaning based on the language used and the evident purpose for which the
16 statute was adopted.” (*People v. Vincelli* (2005) 132 Cal.App.4th 646, 651.) The statute
17 must be construed “with reference to the entire scheme of law of which it is a part so that the
18 whole may be harmonized and retain its effectiveness.” (*In re Marriage of Harris* (2004) 34
19 Cal.4th 210, 222.) The construction chosen must be the one “that comports most closely
20 with the Legislature’s apparent intent.” (*Smith v. Superior Court* (2006) 39 Cal.4th 77, 83.)
21 “Where uncertainty exists consideration should be given to the consequences that will flow
22 from a particular interpretation,” and results contrary to the legislative purpose should be
23 avoided. (*Western Oil & Gas Ass’n v. Monterey Bay Unified Air Pollution Control Dist.*
24 (1989) 49 Cal.3d 408, 425.)

25
26 ¹⁶This argument amounts to a post-hoc effort to limit the company’s exposure to
27 fines, not an explanation for its noncompliance. There is no indication that PacifiCare
28 adopted this view before the hearing, or relied on it in omitting the required language from
its EOPs. Today, PacifiCare’s EOPs contain the same required disclosures for all claims,
whether they are paid or denied, in full or part.

1 The common sense meaning of the verbs “contest” and “deny” supports the view that
2 all EOPs indicating payment of less than billed charges must advise providers of CDI-review
3 rights. To “contest” a claim is to “dispute” or “challenge” the claim being asserted.
4 (Merriam-Webster’s Online Dict. (2012) < <http://www.merriam-webster.com/dictionary>> [as
5 of May 15, 2012] “contest,” synonyms.) To “deny” a claim is to “declare untrue” or “refuse
6 to admit or acknowledge” the contention represented by the claim. (Merriam-Webster’s
7 Online Dict. (2012) < <http://www.merriam-webster.com/dictionary>> [as of May 15, 2012]
8 “deny,” definition.) When an insurer asserts that, instead of paying the \$100 billed by a
9 physician, it is remitting \$50, it is disputing its obligation to pay the full billed amount and
10 declaring untrue the provider’s assertion that the billed amount is owed. Whether or not such
11 a dispute is well-founded is irrelevant to the act of contesting. Whether the insurer *believes*
12 that its contract with the provider authorizes it to pay less than the full billed amount is also
13 irrelevant.

14 When it enacted SB 367, the Legislature was aware that the majority of health care
15 claims are governed by contract. It was also aware that many disputes arising under these
16 contracts concern not whether the insurer was obligated to pay the claim, but how much the
17 payment should be. It would make no sense for the Legislature to create regulatory relief for
18 wholly rejected claims but not for payment accuracy complaints. An insurer that believes it
19 is entitled by virtue of its contract with a provider to contest a portion of the claim may —
20 because of errors of the very kind PacifiCare repeatedly committed here, such as failing to
21 maintain fee schedules and the fee schedule crosswalk, failing to build and load provider fee
22 schedules, failing to timely load provider contracts, linking providers to the wrong fee
23 schedule, paying non-contracted providers according to a contracted rate, and paying
24 contracted providers according to a non-contracted rate — be illegally withholding money
25 owed to the provider. In the case of a claim submitted by non-contracted providers, where
26 the parties have not agreed on a reimbursement rate, the right to contest the insurer’s

1 unilateral evaluation of the claim’s worth is clearly crucial. In either scenario, the right to
2 seek Department review of such a contestation remains vitally important.¹⁷

3 In fact, the requirement that insurers notify claimants of their right to seek CDI
4 review is triggered not by whether the *insurer* believes it is entitled, whether by contract or
5 otherwise, to pay less than the full billed amount, but by whether the “*claimant* believes all
6 or part of the claim has been wrongfully denied or rejected.” (Reg. 2695.7, subd. (b)(3)
7 (emphasis supplied).) PacifiCare itself acknowledges this point. In its corrected EOPs, it
8 notifies providers that “[i]f *you feel* that all or part of this claim has been wrongfully denied
9 or rejected, you may have the matter reviewed by the California Department of Insurance at:
10 [contact information for CDI’s Consumer Services Division].” (Exh. 11, p. 7543 (emphasis
11 supplied).)

12 Implementation Delay

13 Although CDI had notified PacifiCare of the deficiencies in its EOPs in
14 February 2007, and the company had promised that it would include the statutorily required
15 language on its EOPs beginning on April 8, 2007, the company inexplicably delayed
16 implementing compliant EOPs for many more months, in willful noncompliance with the
17 law.

18
19
20 ¹⁷ Section 10123.137, which describes the provider dispute resolution mechanism
21 insurers were required to implement as part of SB 367, further demonstrates the Legislature’s
22 recognition that legitimate provider disputes often arise from claims for which the insurer has
23 remitted partial payment. Among the data providers must include in written disputes
24 submitted to insurers are a “description of the dispute, and, if applicable, billed and paid
25 amounts.” (§ 10123.137, subd. (c).) Having mandated an insurer-sponsored remedy for
26 provider disputes regarding discrepancies between amounts billed and amounts paid, the
27 Legislature cannot logically have intended to exclude those disputes from the purview of the
28 Department’s review. Nor could the Legislature have intended to exclude notice of such
review from EOPs from which such disputes might arise. When examined in light of the
plain meaning of the words, the manifest legislative purpose, and the entire regulatory
program, it is clear that the phrase “contested or denied claim” in section 10123.13,
subdivision (a) encompasses claims for which payment in less than the billed amount is
remitted.

1 PacifiCare’s sole excuse for this delay is that it was waiting to implement these
2 changes on its EOPs until it had developed compliant IMR language to be included on its
3 EOBs. This explanation makes no sense. Though Ms. Monk contended that the company
4 was treating the EOP and EOB changes as a “single corrective action project,” she
5 acknowledged that there was no reason they had to be implemented together. (RT 9304:8-
6 9305:25.) She further admitted that the company should have implemented these changes to
7 the EOPs earlier: “I mean, honestly, in hindsight, we could have implemented this earlier
8 than we did the IMR language.” (RT 9305:13-15.)

9 **c. Harm Caused by PacifiCare’s Violations**

10 Disseminating EOPs that misrepresent provider appeal rights by omitting CDI-review
11 notification harms providers. Although providers typically know more about their legal
12 rights with respect to insurers than do consumers (Exh. 1184, p. 52:8), the statutory right to
13 have complaints reviewed by CDI was newly enacted in 2006 (RT 25320:15-25321:12
14 (Stead)), and awareness likely had not spread throughout the medical community. Moreover,
15 even those providers who were aware of their right to complain to regulators could not
16 discern from a PLHIC EOP which regulator such complaints should be addressed to.
17 Provider “confusion about the identity of the appropriate regulator” was one of the problems
18 that prompted SB 367 (Legis. Counsel’s Dig., Sen. Bill No. 367 (2005-2006 Reg. Sess.)
19 (RON, Exh. H, p. 17)), and that confusion continued unabated among PLHIC providers until
20 June 2007 when the statutory language was finally added. (Exh. 1025, p. 731; RT 17180:23-
21 17182:4 (Wetzel).) The increase in justified complaints received by the Department after the
22 company began issuing compliant EOPs (Exh. 5621, pp. 35-38; Exh. 5622, p. 15;
23 RT 22110:22-22111:11 (Kessler)), at a time when PacifiCare was allegedly undertaking
24 corrective action to reduce claims-handling errors and the company’s business volume was
25 declining, suggests that inclusion of the notice had an effect.

26 PacifiCare’s failure to adequately respond to both informal phone calls and formal
27 provider disputes during this time (e.g., Exh. 289, p. 6599; Exh. 286; Exh. 287, p. 6168
28 [Mimick 5:05 p.m.]; Exh. 1019; RT 2564:24-2565:25 (Sing); RT 2674:15-21; 2668:14-

1 2669:12 (K. Griffin)) made notification of the right to CDI review all the more crucial.
2 Many claim denials and mispayments could have been remedied, or addressed in a manner
3 less costly to providers, if they had known to complain to the Department.

4 The right to seek CDI review of a contested claim also involves the right to petition
5 the government, and impediments to the exercise of that right is itself a form of harm.
6 (RT 21055:24-20156:23 (Kessler); Exh. 1184, p. 40:19-24.) And even providers who would
7 not have filed a complaint with the Department may have been more assertive in their
8 interactions with the insurer, and more likely to participate in the insurer's dispute resolution
9 process, if they knew that the insurer's determination is subject to governmental review.
10 (Exh. 1184, p. 40:19-24.) Indeed, in enacting the requirement that insurers notify insureds
11 and providers of this right, the Legislature declared that it was necessary "to assure the public
12 that the law is properly implemented." (Legis. Counsel's Dig., Sen. Bill No. 367 (2005-2006
13 Reg. Sess.) (RON, Exh. H, p. 17).)

14 That these harms cannot be readily calculated does not mean they can be ignored. "A
15 penalty statute pre-supposes that its violation produces damage beyond that which is
16 compensable." (*City & County of San Francisco v. Sainez* (2000) 77 Cal.App.4th 1302,
17 1315.) PacifiCare's attempt to belittle these violations (see RT 25058:15-16 (Stead)) should
18 be firmly rejected. While the lack of notice is less serious than some other conduct
19 punishable under section 790.035 (Exh. 1184, p. 40:11-14), it is an important component of
20 the Legislature's carefully crafted program to ensure the prompt and accurate payment that is
21 key to maintaining a reliable health care system. That the insurance laws "safeguard public
22 safety as a collective whole and compliance with the entire regulatory scheme, and not just
23 the rules governing matters that have an immediate and direct effect on life and limb, is
24 presumed." (*U.S. v. Emerson* (1st Cir. 1997) 107 F.3d 77, 80 (citation omitted).)

25 **3. Number of Acts in Violation**

26 Between February 22 and June 15, 2007, PacifiCare issued at least 462,805 illegal
27 EOPs. (Exh. 549; Exh. 1182; Exh. 1180.)
28

1 As reflected in claim data prepared by PacifiCare and produced at the hearing, it
2 issued 443,055 illegal EOPs for group claims that failed to contain the statutory right-to-
3 CDI-review language from February 22, 2007, to June 15, 2007. (Exh. 549; RT 5984:24-
4 5985:14; 5986:23-5987:4; 5995:5-12 (Vonderhaar).) Based on a claims database produced
5 by PacifiCare and in evidence (Exh. 1180), from February 22, 2007, through May 31, 2007,
6 there were 19,548 individual claims submitted by providers for which they received a
7 deficient EOP (Exh. 1180; Exh. 1182, p. 1), and 202 individual claims originally submitted
8 by members for which providers received a deficient EOP (Exh. 1180; Exh. 1182, p. 2.)

9 PacifiCare has not submitted claims data to determine the number of deficient EOPs
10 on individual claims it issued from June 1, 2007, until November 4, 2007. There were also
11 many hundreds of thousands more deficient EOPs that failed to include CDI-review language
12 that PacifiCare issued before February 21, 2007, which are not being charged here.

13 **4. PacifiCare Knowingly Committed the Acts in Violation, and**
14 **Performed Them with Such Frequency as to Indicate a General**
15 **Business Practice**

16 PacifiCare had actual knowledge at least as of February 21, 2007, that its EOPs were
17 illegally omitting the CDI-review language. Thus, PacifiCare knew as of that date that all
18 EOPs being sent were misrepresenting provider dispute rights, and it knew that as of that
19 date it had not implemented reasonable standards for claims processing because it was failing
20 to include this notice in outgoing EOPs. On that basis alone, each of the EOPs sent
21 thereafter was a knowing act in violation of the law.

22 When section 10123.13 became law, PacifiCare made an intentional decision to
23 include on its EOPs information about its internal dispute resolution mechanism but not the
24 right to seek review by CDI. It reaffirmed that decision after it was told unambiguously that
25 such notice was required. Pursuant to that business practice, PacifiCare issued hundreds of
26 thousands of illegal EOPs — every EOP the company issued for several months. So
27 independent of these acts being knowing, they also were committed with a frequency that
28 makes unmistakable the company's general business practice. Indeed, where, as here, the

1 illegality is embedded in the insurer’s standard form, the illegal general business practice is
2 established directly by that form, without the need to refer to the frequency of acts.

3 **5. The Acts in Violation Were Willful**

4 From February 22, 2007 forward, PacifiCare willingly and purposefully
5 misrepresented providers’ options for challenging contested or denied claims. PacifiCare
6 deliberately chose to continue issuing EOPs that it knew misrepresented providers’ rights for
7 months after it had been informed that its EOPs were illegally omitting this language. There
8 can be no doubt that the act of issuing each of the EOPs was done with “a purpose or
9 willingness to commit the act.” (Reg. 2695.2, subd. (y).)

10 **6. The Issuance, Amendment, or Servicing of the Policy or**
11 **Endorsement Was Not Inadvertent**

12 PacifiCare intended to service each of these policies when it mailed the EOPs in
13 question. There was no inadvertence in servicing. (§ 790.035, subd. (a).)

14 PacifiCare’s initial failure to correctly implement SB 367 to include notice of right-to-
15 CDI-review language is irrelevant to the “single act” language in section 790.035. But even
16 if the company began sending noncompliant EOPs through a single inadvertent act in years
17 past, and even if one ignores the gross negligence of that action and of the failure for years to
18 discover the noncompliance, once the deficiency had been brought to PacifiCare’s attention
19 in 2007, the ongoing decision to send out noncompliant EOPs for months thereafter cannot
20 be dismissed as inadvertent. Rather, the decision to continue issuing misleading and
21 noncompliant EOPs when PacifiCare had already composed compliant language was
22 intentional and advertent.

23 **7. Applicable Unit-Penalty**

24 Mr. Cignarale began his analysis of the appropriate unit-penalty with an assessment
25 of the severity of this kind of violation, concluding that it is “moderately serious”:

26 “In comparison to the range of violations to which section 790.035 applies, I
27 view the EOP-notice violation as moderately serious. It is not, for example, as
28 serious as a violation that, by its nature, would cause a patient to be denied
medical care or that presents a serious risk of bodily injury. On the other
hand, it is a significant concern.

1 “The prompt and accurate payment of claims is, of course, critical to the
2 provider, the patient, the insurer, and the healthcare system. The notice
3 prescribed in Insurance Code section 10123.13 is an important part of the
4 system the Legislature has established for resolution of disputes about claim
5 processing.

6 “I also believe that the right to Department review should be viewed as an
7 opportunity to petition government and that this violation represents the denial
8 of a mandatory notice to inform affected persons of that right. So beyond
9 value the notice may have in correcting improper practices by the insurer, the
10 absence of the required notice should be recognized as denying some people
11 the knowledge of their right to petition their government, which I view as
12 serious.” (Exh. 1184, p. 40:11-24.)

13 Consistent with his “moderately serious” assessment, Mr. Cignarale opined that the
14 starting point for determining the unit-penalty should be 30% above the bottom of the range
15 from zero to the maximum, or \$3,000 for willful acts in violation. (Exh. 1184, p. 42:3-7.)

16 Mr. Cignarale then evaluated the evidence on the specific violations in this case. He
17 found significant aggravation. He also found the “fact that every single EOP for group
18 claims issued during the period of February 22, 2007, and June 15, 2007, and every EOP for
19 individual claims issued from February 22, 2007, and November 4, 2007, were
20 noncompliant” to be an aggravating factor (Reg. 2695.12, subd. (a)(7)). (Exh. 1184, p. 46:11-
21 14.) The same evidence indicated a high frequency of violations for purposes of subdivision
22 (a)(12), but he did not see clear evidence of a detriment to the public any greater than would
23 typically be encountered in such violations. (Exh. 1184, p. 48:3-10.)

24 Mr. Cignarale testified that the harm occasioned by these violations (Reg. 2695.12,
25 subd. (a)(10)) was greater than would be encountered in the usual case. He noted that the
26 noncompliant EOPs were issued at the very time of deficiencies in PacifiCare’s telephone-
27 inquiry system and provider dispute resolution process, and at a time of an unusually high
28 rate of other violations, when appeal to CDI might have been particularly useful to quickly
remedy the underlying deficiencies in the company’s processing. Omission of this
information also exacerbated provider confusion about which regulator had jurisdiction over
the claim. Mr. Cignarale also noted the evidence that the rate of complaints to the

1 Department rose after inclusion of the missing information, and inferred that its omission
2 may have suppressed the rate of appeals to CDI. (Exh. 1184, p. 46:26-47:10.)

3 Mr. Cignarale found an absence of a good faith attempt to comply with the law
4 (Reg. 2695.12, subd. (a)(11)) in these violations. He did not credit the claim that PacifiCare
5 misunderstood the statutory reference to “department” to be to anything other than the
6 Department of Insurance — which in any event would be irrelevant to these violations,
7 which all occurred after CDI had called the company’s attention to the noncompliance.
8 (Exh. 1184, p. 47:11-48:2.)

9 Taking note of the hundreds of thousands of noncompliant EOPs preceding the period
10 of the acts charged, Mr. Cignarale found a history of previous violations of this kind
11 (Reg. 2695.12, subd. (a)(9)) and deemed it to be a slight aggravating factor. (Exh. 1184,
12 p. 46:22-25.)

13 He found no evidence of extraordinary circumstances (Reg. 2695.12, subd. (a)(1))
14 and no evidence that the violations were related to the complexity of the underlying claims
15 (Reg. 2695.12, subd. (a)(3)). (Exh. 1184, p. 46:5-10.) And Mr. Cignarale took note of the
16 eventual remedial measures — eventual correction of the noncompliant notices — but also of
17 the fact that correction took four to eight months (Reg. 2695.12, subd. (a)(8) and (a)(13)).
18 (Exh. 1184, pp. 46:15-21, 48:11-15.) He found no other evidence that would operate to
19 mitigate the penalty.

20 Taking these mostly aggravating circumstances into account, Mr. Cignarale opined
21 that an increase in the unit-penalty of 10% was in order, from \$3,000 to \$3,300.

22 However, Mr. Cignarale proposed an additional adjustment in this and other
23 categories in which there is a very large number of acts in violation.

24 “Ordinarily we assume each violation is of equal gravity so we simply
25 pick a single per-violation penalty and multiply that by the number of acts in
26 violation to identify a reasonable penalty for the entire category, and that
27 approach normally yields appropriate penalties. However, it is not necessarily
28 the case that every act in violation is of equal severity and needs to be given
the same penalty, and that is not the case here.

1 “To illustrate, if this case had come to me with just a single EOP in
2 violation and all of the other factors the same, I would have no hesitation in
3 saying that the company should be penalized \$3,300 for that single act, and I
4 would view a reduction from that amount as inappropriate. However, I do not
view it necessary to penalize the 400,000th identical act as severely as the
first.” (Exh. 1184, pp. 48:23-49:5.)

5 He therefore recommended that the unit-penalty be gradually reduced in 50,000-act blocks,
6 with the penalty for each successive block of acts reduced by 50%, subject to four
7 limitations: (1) where victims have been harmed, the punishment for each act should exceed
8 that harm; (2) the penalty for each act should be greater than any benefit the company may
9 have realized from committing that act; (3) the aggregate penalty for the category must
10 suffice to deter such violations in the future; and (4) no act should receive a penalty less than
11 a minimum that recognizes the systemic harm from violating the law. (Exh. 1184, p. 49:5-
12 10.) For this category, he proposed that the unit-penalty decline in 50% increments but level
13 off at \$50. The resulting schedule of unit-penalties is:

Acts in Violation		Penalty per Act in Violation
From	To	
1	50,000	\$3,300
50,001	100,000	\$1,650
100,001	150,000	\$825
150,001	200,000	\$412
200,001	250,000	\$206
250,001	300,000	\$103
300,001	350,000	\$51
350,001	400,000	\$50
400,001	450,000	\$50
450,001	500,000	\$50

14
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23 (Exh. 1184, p. 49:13-25.) This results in an aggregate penalty for the EOP violations of
24 \$332,990,250. (Exh. 1184, p. 49:26-28.) That yields an average unit-penalty for this
25 category of $\$332,990,250 / 462,805 = \719.50 per act in violation, 7% from the bottom of the
26 penalty range for willful acts.
27
28

1 **D. Failure to Provide Notice to Insureds of Their Right to Request an**
2 **Independent Medical Review**

3 **1. Applicable Legal Requirements**

4 In 1999, the Legislature enacted Assembly Bill 55 (“AB 55”), which created within
5 the Department an IMR system. The IMR system guarantees patients the opportunity to seek
6 an independent review whenever health care services have been denied, modified, or delayed
7 based, in whole or in part, on consideration of medical necessity. (§ 10169, subds. (a), (d).)
8 It further required the Department to treat IMR requests that do not meet the requirements for
9 review as a request for the Department to review the grievance. (§ 10169, subd. (d)(1).)

10 To make consumers aware of this important safeguard, the Legislature required
11 insurers to “prominently display” information concerning the right of an insured to request
12 an IMR on a broad range of communications to members: “in every insurer member
13 handbook or relevant informational brochure, in every insurance contract, on insured
14 evidence of coverage forms, on copies of insurer procedures for resolving grievances, on
15 letters of denial issued by either the insurer or its contracting organization, and on all written
16 responses to grievances.” (§ 10169, subd. (i).) Because PacifiCare’s EOBs constitute
17 “letters of denial” and include “copies of insurer procedures for resolving grievances,” they
18 were required to include information about the right to request an IMR. Until June 2007,
19 however, they omitted any mention of an insured’s IMR rights.

20 An EOB constitutes a “letter of denial,” as that phrase is used in section 10169,
21 subdivision (i), whenever the EOB notifies the insured that the insurer intends to pay less
22 than the amount billed by the provider; in those instances, the insurer is denying some
23 portion of the claim. The law treats equally claims that are denied entirely and claims of
24 which a portion is paid and a portion denied. As discussed above, Regulation 2695.7,
25 subdivision (b) requires insurers, upon receipt of a claim, to:

26 “accept or deny the claim, *in whole or in part*. The amounts accepted or denied
27 shall be clearly documented in the claim file unless the claim has been denied
28 in its entirety.” (Emphasis supplied).

1 Each claim therefore consists of “amounts accepted” and “amounts denied.” If any amounts
2 are denied, the communication regarding the intent to deny a portion of the claim is a letter
3 of denial.

4 Section 10123.13 similarly reflects this principle that a communication regarding a
5 partially paid and partially denied claim is a “letter of denial”:

6 “unless the claim *or portion thereof* is contested by the insurer, . . . the
7 claimant shall be notified, in writing, that the *claim is contested or denied*.
8 The notice that a claim is being contested or denied shall identify *the portion*
9 *of the claim* that is contested or denied and the specific reasons . . . for
10 contesting or denying the claim.” (§ 10123.13, subd. (a) (emphasis supplied).)

11 This language makes clear that an insurer’s notice to a member that any portion of the claim
12 is being denied constitutes a denial.

13 The fact that an insurer may have a right to deny portions of the claim pursuant to its
14 contract with a provider does not negate the fact that it is denying a portion of that claim.
15 Moreover, the fact that many claims — even those denied in full — are not denied on the
16 basis of medical necessity has no bearing on the meaning of “letter of denial” in section
17 10169, subdivision (i). That subdivision sets forth a notification requirement, identifying a
18 plethora of materials on which the IMR notification language must appear, including those
19 that will be seen by insureds long before there is any possibility that they will receive a letter
20 of denial, let alone one based on medical necessity. The legislative intent is clear: to ensure
21 consumer awareness of an important right by including information about that right on a
22 number of insurance-related documents so that consumers would be sure to see it.

23 In addition to being “letters of denials,” PacifiCare’s EOBs constitute “copies of
24 insurer procedures for resolving grievances,” which represents an independent basis for
25 requiring that IMR language appear on the company’s EOBs. The fourth page of each
26 PacifiCare EOB was titled “Know Your Rights” and described the means by which an
27 insured may challenge the insurer’s determinations. It informed consumers that they could
28 appeal adverse decisions, including decisions regarding medical necessity, to PacifiCare’s
internal appeals department. (E.g., Exh. 23, p. 3093.) The “Know Your Rights” page further

1 referred to “other voluntary alternative dispute resolution options, such as mediation” that
2 might be available to consumers, as well as the right to file a civil action under the Employee
3 Retirement Income Security Act (“ERISA”), and it also listed CDI’s contact information.
4 (E.g., Exh. 23, p. 3093.) Because PacifiCare chose to include on its EOBs these various
5 means by which an insured may resolve grievances relating to the company’s claim
6 adjudications, it was then required to notify the insured of his or her right to an IMR pursuant
7 to section 10169, subdivision (i).

8 PacifiCare’s issuance of EOBs without IMR notification language therefore
9 constitutes acts in violation of section 10169, subdivision (i).

10 The knowing issuance of defective EOBs also constitutes acts in violation of
11 section 790.03, subdivision (h)(1), which prohibits “misrepresenting to claimants pertinent
12 facts or insurance policy provisions relating to any coverages at issue.” By requiring that
13 insurers include it on various insurance communications, the Legislature has determined that
14 notification of IMR rights is a pertinent fact that must be disclosed to members.

15 PacifiCare’s deficient EOBs also violate section 790.03, subdivision (h)(3) because
16 they reflect failures to adopt and implement reasonable standards for prompt investigation
17 and processing of claims arising under insurance policies.

18 They also violate Regulation 2695.4, subdivision (a), which requires the insurer to
19 disclose “all benefits, coverage, time limits or other provisions of any insurance policy” that
20 may apply to the claim. By omitting the required IMR notification language, PacifiCare
21 failed to disclose an important statutorily created benefit and provision of the insurance
22 policy.

23 **2. PacifiCare’s Violations of Law**

24 **a. PacifiCare Admits, Then Disclaims, Its Obligation to** 25 **Include IMR Language on EOBs**

26 Section 10169, subdivision (i)’s requirement regarding notification of IMR rights
27 became effective on January 1, 2001.

1 At least as early as 2006, the PacifiCare’s EOBs contained a “Know Your Rights”
2 page that informed consumers of various ways in which they could challenge PacifiCare’s
3 claim adjudication, including their right to appeal adverse decisions to the company itself,
4 and the dispute resolution rights under ERISA. (E.g., Exh. 23, p. 3093.) PacifiCare’s EOBs,
5 however, conspicuously failed to include the IMR notification language that section 10169,
6 subdivision (i) required be “prominently display[ed].” (E.g., Exh. 23, p. 3093.) In fact,
7 PacifiCare EOBs for group claims omitted this statutorily required language throughout 2006
8 until June 15, 2007, and its EOBs for individual claims omitted this language from 2006 until
9 November 4, 2007. (Exh. 118, p. 3415.)

10 During the MCE and CDI’s investigation of consumer complaints against PacifiCare,
11 the company admitted on multiple occasions that it was required — but had failed — to
12 include on its EOBs language notifying the insured of his or her right to request an IMR. As
13 CDI Senior Compliance Officer Robert Masters testified, when CDI initially brought this
14 omission to PacifiCare’s attention in March 2007, the company acknowledged that the
15 omission was in error and promised to include the required language in its EOBs.
16 (RT 1957:22-1958:15.)

17 Then, during the MCE, CDI issued a number of referrals citing the company for
18 failing to include IMR notification language on its EOBs, and in response after response,
19 PacifiCare agreed with CDI’s citations, and promised that the omission would be remediated.
20 For example, in a September 14, 2007, referral about a specific member claim, CDI found:
21 “The adjusted EOB does not meet the requirements of CIC § 10123.13(a), CIC § 10169(i).”
22 (Exh. 1205, p. 7639.) PacifiCare responded by agreeing with that finding:

23 “Agree with finding. Corrective action plan will provide changes to the
24 EOB/EOP language to include the right to enter into the dispute resolution
25 process, reference their right to an IMR and reference the Plan website. See
attached Plan’s Corrective Action Plan.” (Exh. 1205, p. 7639.)

26 Similarly, in an August 30, 2007, referral, CDI posed the question to PacifiCare: “Do you
27 agree the EOB(s) sent to the provider on 9/23/06 did not comply with the requirements of
28 CIC 10123.13(a) or 10169(i)?” (Exh. 1206, p. 4272.) The referral further specified that the

1 EOB was deficient because it “does not include reference to the right to IMR.” (Exh. 1206,
2 p. 4272.) PacifiCare responded to that question “Agree with finding,” and it again promised
3 that its corrective action plan would provide changes to the EOB/EOP language to include
4 right to IMR language. (Exh. 1184, p. 4273.)

5 In addition to these company admissions, PacifiCare’s official response to CDI’s
6 MCE reports further admitted that “[t]he Company failed to include required wording in the
7 EOB and Explanation of Payment (EOP) correspondence” and represented that the company
8 had implemented a corrective action plan to add the requirement language on its EOBs and
9 EOPs. (Exh. 118, pp. 3415, 3419.)

10 But PacifiCare then did an about-face at the hearing, contending there that its
11 longstanding view has been — has always been — that the law actually does not require such
12 language on EOBs. In fact, Ms. Monk testified that at the time section 10169, subdivision (i)
13 was enacted, PacifiCare analyzed that bill and affirmatively decided that IMR notification
14 was not required to be included on EOBs. (RT 9257:2-13.) Rather, Ms. Monk testified that
15 IMR language wasn’t included on PacifiCare EOBs because “at the point in time that a
16 member receives an EOB, they are not eligible to request an IMR, and notice at that point is
17 potentially confusing.” (RT 8860:18-8861:2; 8852:6-8853:20.)¹⁸

18
19 ¹⁸PacifiCare apparently contends that an EOB that denies all or part of a claim does
20 not constitute a “letter of denial” as that term is used in section 10169, subdivision (i). That
21 interpretation is unreasonable and not consistent with industry practice. Logically, an EOB
22 that denies a claim in whole or in part is no different in substance from a document, which
23 happens to be put into a letter format, that informs the claimant that the claim is being
24 denied. The insurance industry similarly treats EOBs and denial letters equivalently. The
25 ICE organization — which in other contexts PacifiCare has claimed to rely upon for training
26 and interpretations of law (RT 7679:6-21 (Berkel); RT 18035:1-5 (Monk)) — has published
27 training materials that specifically define a “denial letter” or “denial notice” as:

28 “A document notifying a patient that an adverse coverage decision has been
made as a result of adjudication of a provider claim for reimbursement. It
identifies the billing provider, the services, the financial liability, the deciding
organization, the reason for the decision, the appeal process and where to
direct written or verbal appeals or to request additional information and the
time limit to do so. This notice may comprise a letter or a properly formatted

1 Yet PacifiCare’s inclusion of notification language on certain other materials at the
2 same time contradicts PacifiCare’s supposed rationale for omitting it from its EOBs. For
3 instance, as Ms. Monk testified, PacifiCare includes IMR language on its certificates of
4 coverage, appeal resolution letters, and denial letters. (RT 8855:16-21 (Monk); Exh. 5299,
5 p. 7604; Exh. 5300, pp. 7515-7516; Exh. 5302, p. 7527.) Many of these documents, as Ms.
6 Monk acknowledged on cross examination, are sent to insureds before they are eligible for
7 an IMR. (RT 9207:15-9208:15.) For example, PacifiCare interpreted section 10169,
8 subdivision (i) to require IMR language on letters denying preauthorization requests on
9 coverage grounds, determinations for which IMR is not available. (Exh. 5301, p. 7524;
10 RT 9234:25-9236:3 (Monk); § 10169, subd. (c).) PacifiCare’s implementation log for
11 AB 55, produced after Ms. Monk’s direct testimony,¹⁹ also contradicts her testimony. It
12 reflected that the decision was made to include IMR language on all “pre-service and claim
13 delay, denial and modification letters” (Exh. 819, p. 7674); pre-service letters, Ms. Monk
14 acknowledged on cross, are sent at a time before the member is entitled to an IMR.
15 (RT 12514:20-1251:16.)

16 In formulating its after-the-fact excuses for failing to include the required IMR
17 language on EOBs, PacifiCare has apparently confused an insured’s eligibility for an IMR,
18

19 *explanation of benefits form (EOB), remittance advice (RA) or payment advice*
20 *(PA). Proper notices will meet 19 requirements for content, accuracy and*
21 *timeliness (discussed in detail, below).” (Exh. 821, p. 1 of 8 (emphasis*
22 *supplied).)*

23 Thus, even PacifiCare’s own sources recognize EOBs as “letters of denials.”

24 ¹⁹Ms. Monk testified that in her search for documents, she had located copies of the
25 company’s AB 55 implementation log; she testified that although she had turned that
26 documentation over to her counsel, it had not been produced to CDI (RT 12509:1-5;
27 9056:11-9056:21; 9058:3-14), even though plainly relevant and responsive to CDI document
28 requests. It was only produced after CDI learned of this improper withholding and requested
on the record that it be produced. (RT 12509:6-10; 12510:12-21; 9056:11-9056:21; 9058:3-
14 (Monk).)

1 set forth in section 10169, subdivision (j), with an insurer's separate statutory obligation to
2 *notify* an insured of his or her right to request an IMR, set forth in a separate provision,
3 subdivision (i). Simply because an insured may or may not be eligible for an IMR at a
4 particular time, does not mean that he or she need not be notified of the right to request one,
5 as the statute makes clear. It is antithetical to such notification requirements to so narrowly
6 (and incorrectly) limit their scope. As Mr. Cignarale testified, the intent of this notification
7 requirement is to inform claimants at several points in the claims adjudication process of
8 their right to request an IMR so they are aware of and can avail themselves of these rights if
9 necessary:

10 "I believe it's one of the many intents of providing disclosure at several points
11 in the process of the insurance transaction of the right to the IMR so that, in
12 the event it is needed down the road, the consumer and the provider are aware
13 of those rights and can avail themselves of those rights." (RT 22823:7-12
(Cignarale).)

14 It is, of course, not up to PacifiCare to decide whether a requirement imposed by the
15 Legislature makes sense to comply with.

16 **b. PacifiCare Delays Implementation of IMR Language**

17 The Department informed PacifiCare on March 23, 2007, at the latest, that the
18 company's EOBs unlawfully omitted IMR notification language. (Exh. 13, p. 8208;
19 Exh. 5303, p. 8208.) In a letter to PacifiCare dated March 27, 2007, Mr. Masters described a
20 March 23, 2007, teleconference between CDI and PacifiCare at which PacifiCare was
21 informed of the missing IMR language in its EOBs. (Exh. 5303, p. 8208.) As discussed
22 above, Mr. Master further testified that PacifiCare admitted on that call that it was required
23 to include such language on its EOBs. (RT 1957:22-1958:15.) Indeed, Mr. Masters's
24 March 27 letter was written in response to the company's request at that meeting for "a
25 sample of the required Independent Medical Review notification language." (Exh. 5303,
26 p. 8208.) CDI offered its assistance, but made clear, in no uncertain terms, that "[i]t is your
27 company's responsibility to compose IMR language that complies with California law."
28 (Exh. 5303, p. 8208.)

1 Mr. Masters’s letter included copies of PacifiCare’s existing IMR application form
2 and portions of its certificate of coverage, both of which CDI informed PacifiCare included
3 compliant language, including an indication that a request for IMR is to be made to CDI.
4 (Exh. 5303, pp. 8208, 8210; RT 9241:21-9242:16 (Monk).) In addition, CDI provided
5 PacifiCare sample language that tracked the requirements of section 10169, subdivision (i),
6 informing the insureds of their right to request an IMR from CDI if they believed that health
7 care services have been improperly denied, modified, or delayed by the insurer. (Exh. 5303,
8 p. 8208.) CDI reminded PacifiCare that “[a]cceptable IMR notification must be included on
9 all denials, appeals, and all copies of the insurer’s procedures for resolving appeals and
10 grievances” (Exh. 5303, p. 8208) and further warned the company that “[f]ailure to provide
11 the insureds with their legal rights is a violation of 10169 and could have had a chilling effect
12 on the filing of IMR applications by the insureds currently and in the past” (Exh. 5303,
13 p. 8210).

14 PacifiCare chose not to avail itself of its already existing compliant language or the
15 sample language provided by CDI in its March 27 letter. Instead, the company decided to
16 draft entirely new IMR language for its EOBs because it was determined to fit all the “Know
17 Your Rights” material onto a single page to avoid incurring additional cost. (RT 11138:18-
18 11139:14; 11144:16-11145:3 (Smith); Exh. 5311, p. 4405 [“Once I get your feedback, I will
19 then send to our claims department to determine if it all fits on one page . . .”].)

20 Almost a month later, on April 20, 2007, PacifiCare informed CDI that it had
21 developed a draft IMR disclosure and represented that “outgoing EOBs . . . will contain this
22 language as of April 30, 2007.” (Exh. 5357, p. 0597; RT 11041:4-14 (Smith).) PacifiCare
23 asked CDI to review its draft language. (RT 11044:23-11045:2; 11072:5-11 (Smith); RT
24 9246:19-23 (Monk).) Ms. Smith promptly informed the company that its new EOB was
25 deficient: it failed to explain the circumstances under which an IMR could be requested and
26 gave no indication from whom it could be requested (Exh. 5357, p. 0598; Exh. 5358,
27 p. 8792; RT 11041:15-11042:6 (Smith); RT 9247:25-92486 (Monk)) — basic information
28

1 plainly required by the statute and obviously necessary in order for the notification to have
2 any meaning.

3 Weeks later, on May 8, PacifiCare sent a new draft. (Exh. 5307, pp. 4391-4392.) In a
4 telephone conference the same day, CDI advised the company that this draft, too, was legally
5 deficient. (Exh. 5308.) This draft again failed to tell insureds with what entity they may file
6 requests for IMRs. (Exh. 5307, p. 4392.) CDI again urged the company “to refer to the
7 existing language in PLHIC’s appeal responses, Certificates of Insurance, and CDI’s website
8 to facilitate a quicker and more compliant version of the required notice. Corrective action
9 must be a priority and accomplished expeditiously.” (Exh. 5308.)

10 On May 11, PacifiCare sent CDI a paragraph of IMR language (excerpted into the
11 text of an e-mail rather than in the full context of an EOB). (Exh. 5309, pp. 0173-0174.)
12 Ms. Smith reviewed the language the same day and informed PacifiCare that the language
13 itself appeared to be compliant and asked the company to “start implementing as soon as
14 possible.” (Exh. 5309, p. 0173.) PacifiCare thanked Ms. Smith for her “fast review of the
15 draft language” and promised to get back to her on the effective date of the new language.
16 (Exh. 5309, p. 0173.) PacifiCare did not implement this language on its EOBs, as it had
17 promised to do.

18 On May 15, PacifiCare sent CDI a copy of the full draft EOB containing the revised
19 language. This version placed the IMR language in the same paragraph that discussed rights
20 available under ERISA and enforced by the Department of Labor (“DOL”), immediately
21 before instructions for using PacifiCare’s internal appeal process. (Exh. 5360, p. 4399; RT
22 11105:23-25; 11106:25-11107:25 (Smith).) In full context — as opposed to excerpted out in
23 an e-mail, as PacifiCare had previously provided it to CDI on May 11 (Exh. 5309, pp. 0173-
24 0174) — it was clear that consumers would be confused about where to file a request for
25 IMR, likely believing that the program was administered either by PacifiCare or DOL, rather
26 than by CDI. (RT 11105:13-11106:8; 11127:2-14 (Smith); RT 12230:2-14; 12262:7-15
27 (Roy).)

1 The following day, compliance officer Janelle Roy circulated to her colleagues a
2 version of PacifiCare’s EOB that she had revised to include compliant IMR language.
3 (Exh. 5364, pp. 7859-7860.) CDI made further suggestions to PacifiCare based on this
4 revised language. (RT 11135:17-20; 11136:10-17; 11138:18-23; 11140:6-24 (Smith).)
5 While the Department does not ordinarily provide suggested language to insurers, it did so in
6 this case in order to expedite compliance while accommodating PacifiCare’s insistence on
7 fitting the company’s required disclosures on a single “Know Your Rights” page.
8 (RT 11146:7-12; 11127:15-25 (Smith).)

9 After PacifiCare had received this input from CDI, it made changes and submitted
10 additional drafts to CDI on May 23 (Exh. 5311) and May 29 (Exh. 5312). PacifiCare finally
11 began disseminating the revised EOBs for claims filed under group policies on June 15,
12 2007, almost three months after CDI brought the noncompliant EOBs to PLHIC’s attention.
13 (Exh. 5366, p. 7874; Exh. 118, p. 3415.) Inexplicably, the company failed to implement
14 compliant EOBs for claims filed under individual policies until November 4, 2007, over six
15 months after CDI raised the issue and urged prompt compliance. (Exh. 118, p. 3415;
16 Exh. 822; RT 12523:16-12525:9 (Monk).) Ms. Monk, in fact, incorrectly testified that all
17 EOBs contained compliant IMR language as of June 2007 (RT 12522:6-23), and was
18 unaware that individual claims EOBs lacked this required language for several months after
19 (RT 12524:13-24).

20 **c. PacifiCare’s Excuses for Violating the Law**

21 *Notice of Noncompliance*

22 PacifiCare contends that it had no notice of its obligation to include IMR information
23 on EOBs. (RT 8863:9-14 (Monk).) That contention is absurd on its face, as even
24 PacifiCare’s expert was forced to acknowledge: CDI is only charging PacifiCare with
25 violations that occurred *after* CDI explicitly told the company that the law required IMR
26 notification on all EOBs. (RT 24985:11-24986:8 (Stead).)

1 compliant language was the company’s responsibility and that the misrepresentation must be
2 promptly remediated. (Exh. 5303, p. 8208; Exh. 5308; RT 11045:3-6 (Smith).) PacifiCare
3 knew that CDI was not legally obligated to review its proposed language and was doing so as
4 a courtesy. (RT 11141:10-11142:2 (Smith); RT 9239:17-21 (Monk).) As Ms. Smith
5 testified:

6 “I have instructed the company on many occasions over the phone almost
7 every time we had conversations that we do not approve language, and we do
8 not give any — any sort of — I guess, the blessing that they were looking for.
9 We had — I had personally told the company we were doing this as a
10 courtesy.” (RT 11141:19-24.)

11 The Department expended considerable resources assisting PacifiCare to come into
12 compliance with section 10169. PacifiCare’s attempt to hold CDI responsible for its own
13 disregard for the law should be roundly rejected.

14 **d. Harm Caused by PacifiCare’s Violations**

15 The potential consequences of the omitted IMR notice are serious. Consumers are
16 typically unaware of their legal rights to appeal health care determinations outside of the
17 insurer-administered appeal process. (Exh. 1184, p. 52:8.) This ignorance, which the notice
18 required by section 10169, subdivision (i) is intended to remedy, could lead a patient to be
19 denied needed medical care.

20 Many consumers who petition for an IMR review and are found to be ineligible for
21 the service in question may nonetheless have meritorious complaints of other kinds. As
22 required by law, the Department performs a full regulatory review of such claims regardless
23 of whether or not they are eligible for a formal IMR. (See § 10169, subd. (d)(1); Exh. 1184,
24 p. 52:13-18.) Thus, PacifiCare’s failure to notify claimants of their IMR rights likely denied
25 them of the opportunity to obtain assistance from CDI. It is impossible to ascertain how
26 many consumers could have obtained assistance, either by obtaining an IMR or by other
27 regulatory intercession, if PacifiCare had issued compliant EOBs before June 2007.

28 PacifiCare’s failure to adequately respond to both informal phone calls and to formal
disputes in 2006 and 2007 (e.g., Exh. 289, p. 6599; Exh. 286; Exh. 287, p. 6168; Exh. 1019;

1 RT 2564:24-2565:25 (Sing); RT 1726:2-1728:7 (Mr. R)) made access to the Department all
2 the more crucial. It is therefore likely that many claim denials could have been remedied, or
3 remedied more quickly, if consumers had more information about the Department.

4 The right to seek an IMR also involves the right to petition one's government. There
5 is an intangible harm from the denial of access to that right. Part of the purpose of section
6 10169 was to restore confidence in the health care system by assuring consumers that critical
7 decisions about their care would not be left solely to profit-seeking insurers with an incentive
8 to minimize benefits. (Sen. Com. on Health, 3d reading analysis of AB 55 as amended April
9 27, 2009, p. 3.) Even consumers who never avail themselves of the IMR process benefit
10 from knowing that the government guarantees a neutral review of claim denials that could
11 stand in the way of needed medical care.

12 PacifiCare's attempt to belittle these violations as "just not putting, you know, notice
13 on an EOB form" (RT 25058:15-17 (Stead)) misses the point and, more generally, reflects
14 the company's overall dismissive attitude toward compliance with laws it finds unimportant.
15 While the lack of IMR notice may be less serious than some other conduct punishable under
16 section 790.035 (Exh. 1184, p. 52:3-9), it is an important component of the Legislature's
17 carefully crafted program of insurance regulation that PacifiCare cannot choose to ignore.

18 **3. Number of Acts in Violation**

19 Between March 24 and June 15, 2007, PacifiCare issued at least 336,085 illegal
20 EOBs. (Exh. 549; Exh. 1183, Exh. 1180.)

21 As reflected in claim data prepared by PacifiCare and produced at the hearing, it
22 issued 322,423 illegal EOBs for group claims that failed to contain the statutory IMR
23 notification language from March 24 to June 15, 2007. (Exh. 549; RT 5984:24-5985:14;
24 5986:23-5987:4; 5995:5-12 (Vonderhaar).) Based on a claims database produced by
25 PacifiCare and in evidence (Exh. 1180), from March 24, 2007, through May 31, 2007, there
26 were 13,537 individual claims submitted by providers for which members received a
27 deficient EOB (Exh. 1180; Exh. 1183, p. 1), and 125 individual claims submitted by
28 members for which they received a deficient EOB (Exh. 1180; Exh. 1183, p. 2.)

1 PacifiCare has not submitted claims data to determine the number of deficient EOBs
2 on individual claims it issued from June 1, 2007, until November 4, 2007. There were also
3 millions more deficient EOBs that failed to include IMR notification language that
4 PacifiCare issued from January 1, 2001, when the statute became effective, until March 23,
5 2007, which are not being charged here.

6 **4. PacifiCare Knowingly Committed the Acts in Violation, and**
7 **Performed Them with Such Frequency as to Indicate a General**
8 **Business Practice**

9 PacifiCare had actual knowledge of its illegal practice at least as of March 23, 2007,
10 when the Department notified the company that its EOBs were illegally omitting the IMR
11 notification language. Thus, PacifiCare knew as of that date that all EOBs being sent were
12 misrepresenting pertinent facts, and it knew that as of that date it had not implemented
13 reasonable standards for claims processing because it was failing to include the statutorily
14 required notice in outgoing EOBs.

15 Given PacifiCare's actual knowledge, proof of a general business practice is
16 unnecessary but plainly evident. When section 10169 was enacted, PacifiCare made an
17 intentional decision to omit IMR language from all of its EOBs. (RT 9257:2-13 (Monk).) It
18 reaffirmed that decision after it was told unambiguously that the language was required.
19 Pursuant to that business practice, PacifiCare issued hundreds of thousands of illegal EOBs.

20 **5. The Acts in Violation Were Willful**

21 From March 24, 2007, and forward, PacifiCare willingly and purposely
22 misrepresented consumers' rights to appeal and failed to implement a reasonable EOB as
23 soon as practicable. The Department provided PacifiCare with three examples of compliant
24 language just days after the initial conversation regarding EOBs, including two that
25 PacifiCare was already using on other documents. PacifiCare was entitled to develop
26 alternative legally compliant language, but it was not entitled to continue to issue misleading
27 EOBs while it was doing so. PacifiCare deliberately chose to continue issuing EOBs that it
28 knew misrepresented consumers' rights.

1 **6. The Issuance, Amendment, or Servicing of the Policy or**
2 **Endorsement Was Not Inadvertent**

3 PacifiCare intended to service each of these policies when it mailed the EOBs in
4 question. Moreover, PacifiCare knowingly and intentionally excluded IMR language from
5 its EOBs. (RT 8866:16-20; 9257:2-13 (Monk).) Even were section 790.035 read to
6 authorize treating thousands of past noncompliant EOBs as a single act in violation on the
7 basis of an initial inadvertent decision, PacifiCare’s omission of IMR language from EOBs
8 after receiving notice of the noncompliance was not inadvertent.

9 **7. Applicable Unit-Penalty**

10 Mr. Cignarale began his analysis of the appropriate unit-penalty by evaluating the
11 severity of this kind of violation, concluding that it is “moderately serious”:

12 “In comparison to the range of violations to which section 790.035 applies, I
13 view the EOP-notice violation as moderately serious. I view the failure to
14 provide notice of IMR rights as slightly more serious than the omission of
15 providers’ rights to appeal to the Department, because in my experience
16 consumers are less aware of their rights than providers. This omission is
17 therefore more harmful.

18 “An IMR review is only available when the denial of a claim is based
19 on a finding that the service was not medically necessary, and is therefore
20 inapplicable to many denials. The potential consequences of the omitted IMR
21 notice, however, are more serious than in the case of provider EOPs, because it
22 could lead a patient to be denied needed medical care. In addition, in my
23 experience many consumers who petition for an IMR review and are not
24 eligible do have meritorious complaints of other kinds, and benefit from the
25 Department’s investigation of their claim denial. (See Ins. Code, § 10169,
26 subd. (d)(1).) Accordingly, even if a request for an IMR is not eligible for such
27 review, the Department treats that request as a complaint against the insurer
28 and performs a full regulatory review of the claim at issue.

 “The right to seek an IMR involves the right to petition government.
This violation represents the denial of a mandatory notice to inform affected
persons of that right. So beyond the value the notice may have in correcting
improper practices by the insurer, the absence of the required notice should be
recognized as denying some people the knowledge of their right to petition
their government, which I view as serious.” (Exh. 1184, p. 52:5-23.)

1 Consistent with his “moderately serious” assessment, Mr. Cignarale opined that the
2 starting point for determining the unit-penalty should be 35% above the bottom of the range
3 from zero to the maximum, or \$3,500 for willful acts in violation. (Exh. 1184, p. 52:24-28.)

4 Mr. Cignarale then evaluated the evidence of the specific violations in this case. He
5 found only four factors under which there were grounds for adjustment of his starting point
6 under the evidence of the specific EOB violations charged here, two aggravating and two
7 mitigating. (Exh. 1184, pp. 59:1-61:20.) He found the relative number of claims where the
8 noncomplying facts were found (Reg. 2695.12, subd. (a)(7)) to be an aggravating factor,
9 since “every single group claim EOB issued during the period of March 24, 2007, and
10 June 15, 2007, and every individual claim EOB from March 24 to November 4, 2007, was
11 noncompliant.” (Exh. 1184, p. 59:16-18.) He considered the presence of previous violations
12 (Reg. 2695.12, subd. (a)(9)) — namely the hundreds of thousands of noncompliant EOBs
13 issued before the first charged violations — to be slightly aggravating. (Exh. 1184, pp.
14 59:25-60:5.) Mr. Cignarale credited PacifiCare for undertaking remedial measures to correct
15 its EOBs (Reg. 2695.12, subd. (a)(8)), but recognized only slight mitigation due to the failure
16 to promptly revise the form, even in the interim, while developing its one-page language.
17 (Exh. 1184, p. 59:19-24.) But he found significant mitigation in the company’s good faith in
18 attempting to comply (Reg. 2695.12, subd. (a)(11)), recognizing the quick submission of
19 revisions after receiving CDI-staff comments and PacifiCare’s evident belief at the time that
20 it was entitled to await staff “approval” of its proposed language. (Exh. 1184, pp. 60:22-
21 61:6.)

22 Largely based on this latter factor, the apparent, albeit unjustified, reliance on its
23 exchanges with CDI over language of the IMR notice, Mr. Cignarale substantially reduced
24 his recommended unit-penalty by 35%, from the \$3,500 starting-point to \$2,275 per act in
25 violation. (Exh. 1184, p. 61:21-25.)

26 As he did with the EOP violations, Mr. Cignarale recognized the grounds for reducing
27 the unit-penalty for increasingly numerous acts in violation, adopting the same 50%

1 reduction in 50,000-act blocks, resulting in the following unit-penalties for the EOB
2 violations:

Acts in Violation		Penalty per Act in Violation
From	To	
1	50,000	\$ 2,275
50,001	100,000	\$ 1,138
100,001	150,000	\$ 569
150,001	200,000	\$ 284
200,001	250,000	\$ 142
250,001	300,000	\$ 71
300,001	350,000	\$ 50

3
4
5
6
7
8
9
10 (Exh. 1184, p. 62:1-19.) This results in an aggregate penalty for the EOB violations of
11 \$225,749,563. That yields an average unit-penalty for this category of
12 $\$225,749,563/336,085 = \671.70 per act in violation, less than 7% from the bottom of the
13 penalty range for willful acts.

14 **E. Failure to Timely Pay Claims**

15 **1. Applicable Legal Requirements**

16 The UIPA contains various provisions pertaining to the timely payment of claims.
17 Section 790.03, subdivision (h), enacted in 1972, sets forth certain requirements for claims
18 handling. For instance, section 790.03, subdivision (h)(4) requires insurers “to affirm or
19 deny coverage of claims within a reasonable time” after the claims are submitted.
20 Section 790.03, subdivision (h)(2) similarly requires insurers to “acknowledge and act
21 reasonably promptly upon communications with respect to claims.” These provisions did not
22 set a specific time limit for insurers to affirm or deny claims, or for insurers to acknowledge
23 and act upon claims; rather, they required that insurers do so “within a reasonable time” and
24 “reasonably promptly.”

25 Section 790.03, subdivision (h)(3) requires insurers to “adopt and implement
26 reasonable standards for the prompt investigation and processing of claims,” and
27 section 790.03, subdivision (h)(5) requires insurers to “attempt[] in good faith to effectuate
28 prompt, fair, and equitable settlements of claims in which liability has become reasonable

1 clear.” Again, neither of these provisions set a specific time limit for insurers to investigate
2 and process claims, or for insurers to effectuate settlements of claims, instead requiring
3 “prompt” investigation and processing of claims, and “prompt, fair, and equitable”
4 settlements of claims.

5 In 1986, the Legislature enacted Assembly Bill 4206 (“AB 4206”) with the stated
6 purpose of adding to the existing UIPA (also referred to as the Unfair Trade Practices Act)
7 specific time limits for the processing of claims. As the Legislative Counsel’s Digest for the
8 chaptered bill stated: “Existing law, with respect to policies of disability insurance, self-
9 insured employee welfare benefit plans, nonprofit hospital service plans, and health care
10 service plans does not set a specific time limit for reimbursement of claims made pursuant to
11 the policy or plan. This bill would provide for reimbursement as soon as practical but no
12 later than 30 working days after receipt of the claim” (Legis. Counsel’s Dig., Assem.
13 Bill No. 4206 (1985-1986 Reg. Sess.) (RON, Exh. I, p. 28).)

14 The Senate Floor Analyses before the Legislature when it passed the bill similarly
15 stated: “Existing law does not specify a time period during which a claim must be paid.”
16 (Exh. 1201, p. LIS-9b.) In further describing the then-existing law, the Analyses noted: “The
17 Unfair Trade Practices Act requires insurers to adopt standards for prompt investigation and
18 processing of claims; failure to do so constitutes an unfair practice subject to administrative,
19 civil or criminal penalties.” (Exh. 1201, p. LIS-9b.) The Analyses then explained that
20 AB 4206 set forth a specific time limit for insurers to pay or dispute claims:

21 “This bill requires all disability insurers, self-insured employee welfare plans,
22 health care service plans and nonprofit hospital service plans to pay all
23 nondisputed claims or portions of claims as soon as practical but within 30
24 working days of submission of the claim. . . . If a claim or portion of a claim
25 is disputed, the claimant shall be notified in writing within 30 working days.”
26 (Exh. 1201, p. LIS-9b.)²⁰

27 ²⁰Nothing in the law or legislative history indicates any intention for AB 4206 to
28 supersede or repeal the UIPA’s provisions relating to the timely processing of health claims
by insurers.

1 Specifically, AB 4206 added section 10123.13, subdivision (a), which requires
2 insurers to reimburse, contest, or deny claims within 30 working days after receipt of the
3 claim by the insurer:

4 “Every insurer issuing group or individual policies of health insurance that
5 covers hospital, medical, or surgical expenses, including those telemedicine
6 services covered by the insurer as defined in subdivision (a) of Section 2290.5
7 of the Business and Professions Code, shall reimburse claims or any portion of
8 any claim, whether in state or out of state, for those expenses as soon as
9 practical, but no later than 30 working days after receipt of the claim by the
insurer unless the claim or portion thereof is contested by the insurer, in which
case the claimant shall be notified, in writing, that the claim is contested or
denied, within 30 working days after receipt of the claim by the insurer. . . .”²¹

10 Section 10123.13, subdivision (a) thus reflects the Legislature’s determination of what
11 constitutes “a reasonable time” to affirm or deny health claims, and what constitutes acting
12 “reasonably promptly” upon communications with respect to claims. (§ 790.03,
13 subds. (h)(4), (h)(2).) If any insurer does not reimburse, contest, or deny a claim within 30
14 working days, it has not affirmed or denied claims within a reasonable time and has not acted
15 reasonably promptly with respect to claims. Likewise, in enacting section 10123.13,
16 subdivision (a), the Legislature has determined that an insurer must reimburse, contest, or
17 deny a claim within 30 working days in order to constitute “prompt” investigation,
18 processing, and settlements of claims. (§ 790.03, subds. (h)(3), (h)(5).)

19 **2. PacifiCare’s Violations of Law**

20 **a. CDI Market Conduct Examination Findings**

21 During the 2007 MCE of PacifiCare, CDI uncovered tens of thousands of acts in
22 violation of the laws relating to timely payment of claims.

23 In an August 18, 2007, referral to PacifiCare, CDI requested that PacifiCare self-
24 report the number of claims paid over 45 calendar days because of the volume of claims
25 processed during the MCE review period. PacifiCare produced data indicating a total of 207
26

27 _____
28 ²¹Section 10123.147, subdivision (a) imposes a substantively similar requirement on
claims for emergency services and care. (See § 10123.147, subd. (h).)

1 claims that were paid late during the MCE period, but CDI noted inconsistencies in those
2 data:

3 “Due to the claims volume, the Company was asked to self-report the number
4 of claims paid over 45 days. We received data in ‘Access’ and Text’ formats
5 indicating a total of 207 claims that were paid late. However, as indicated
6 above, the data received is inconsistent.” (Exh. 106, p. 5073.)

7 In fact, PacifiCare further admitted that the original claims spreadsheet submitted to
8 CDI contained incorrect dates. (Exh. 106, p. 5072.) Based on revised claims data PacifiCare
9 subsequently produced, CDI detected 37,238 group claims that were paid more than 30
10 working days after receipt — far more than the 207 claims reflected when PacifiCare was
11 asked to self-report the number. (Compare Exh. 108, p. 4758, with Exh. 106, p. 5073.)

12 After examining data for PacifiCare’s individual claims, CDI cited the company for a
13 total of 42,137 violations for failing to timely reimburse claims. (Exh. 116, p. 1302 [“The
14 results of the computerized data analysis revealed that 40,808 group paid claims and 1329
15 individual paid claims were not reimbursed as soon as practical, but no later than 30 working
16 days of receipt of the claim by the company.”].) On November 9, 2007, CDI served
17 PacifiCare with verified written MCE reports containing these citations. The company
18 December 7, 2007, response to those reports “acknowledge[d] that 42,137 claims or 3.7%
19 were paid after 30 working days.” (Exh. 118, p. 3426.)

20 **b. Member and Provider Complaints About Late Payments**

21 In late 2006, CDI began receiving a large number of consumer complaints against
22 PacifiCare relating to late and incorrect claims payments:

23 “The providers were complaining about undue delays, improper denials,
24 underpayments fee schedule reimbursement errors, underpayments, um, and
25 frustration of trying to work with PLHIC and their provider dispute program
26 and not being able to get a resolution.” (RT 351:21-352:2 (Masters); see also
27 RT 349:24-350:4; 352:12-353:1 (Masters); RT 52:22-53:16 (Smith);
28 Exh. 1128, p. 2127; Exh. 1129, p. 2159; Exh. 1185, p. 7881; Exh. 1186;
RT 24017:15-18 (Cignarale).)

In general, when CDI receives such a complaint from a member or provider, the complaint
goes through an in-take process and is assigned to a CDI compliance officer. (RT 353:6-17

1 (Masters).) That officer will typically ask that the insurer re-review the complaint itself, and
2 will also request that the insurer produce the complete file pertaining to the complaint for
3 CDI's review. (RT 355:12-356:8 (Masters).) In this review, the CDI officer will seek to
4 determine whether the particular complaint has merit and will also perform a full regulatory
5 review citing any noncompliance with the Insurance Code or the Regulations in the file.
6 (RT 356:11-21 (Masters).) If citations are made, CDI will issue a closing violation letter
7 identifying the violations being charged against the company and providing the company the
8 opportunity to contest those citations. (RT 356:15-357:10 (Masters); e.g., Exh. 37.)

9 One member testified at the hearing about his frustrating efforts in trying to get
10 PacifiCare to process claims for two eye surgeries that were performed on him in July and
11 August 2006. (RT 1715:13-1716:10 (Mr. R); Exh. 135, pp. 9760, 9763.) That witness,
12 referred to in the transcript as Mr. R to protect his privacy, was diagnosed with a serious
13 condition in both eyes that his doctors explained could lead to permanent blindness without
14 eye surgeries. (RT 1714:15-1715:20.) Before those surgeries were performed, Mr. R's
15 doctor sought and received pre-approval from PacifiCare. (RT 1716:15-19.) Assuming that
16 PacifiCare would reimburse these claims as it was required to do, Mr. R paid for the
17 surgeries out-of pocket using his personal Visa credit card; the two surgeries cost in total
18 approximately \$3,500. (RT 1717:7-9; 1720:14-17; 1721:6-15; 1722:3-9; Exh. 135, pp. 9760,
19 9763; Exh. 242.)

20 Mr. R promptly submitted to PacifiCare claims for these surgeries, mailing them
21 within days of the dates of service. (Exh. 135, pp. 9886, 9888; RT 1720:20-24; 1722:17-21;
22 1723:21-24.) PacifiCare failed to acknowledge these claims. (RT 1724:8-13; 1724:20-23.)
23 Mr. R called PacifiCare to make sure it had received everything and to check the progress on
24 the claims. (RT 1724:25-1725:1.) PacifiCare initially claimed not to have received the
25 claims. (RT 1725:1-12.) Believing the claims to have been "apparently lost or misfiled" by
26 PacifiCare, Mr. R was forced to re-submit the claims three separate times by facsimile.
27 (RT 1723:10-16; 1725:7-12.)
28

1 Throughout August 2006, Mr. R called PacifiCare's customer service line on almost a
2 daily basis attempting to resolve these claims and to get them paid correctly. (RT 1726:2-4.)
3 Mr. R testified that for a long period, PacifiCare's phone lines were busy or no one would
4 pick up the phone; in some instances, the line wouldn't even ring. (RT 1726:10-1727:3;
5 1727:9-17.) Once, when Mr. R did reach someone at PacifiCare, the representative admitted
6 to Mr. R that the company was having problems with their phones and were switching phone
7 systems. (RT 1726:14-1727:3.) Mr. R further testified that the PacifiCare customer service
8 representatives he spoke with were unhelpful and provided incorrect information regarding
9 his claims. (RT 1726:4-10.) Mr. R also asked several times to speak to a supervisor, but no
10 one ever returned his calls. (RT 1727:23-1728:7.)

11 Over the course of the several months during which Mr. R was submitting and re-
12 submitting these claims, PacifiCare incorrectly denied them for multiple different reasons.
13 First, PacifiCare issued an EOB dated 9/14/2006 that denied one claim on the ground that
14 eye exams, glasses, contact lenses and routine eye refractions are not covered. (Exh. 140,
15 p. 9721; RT 1729:10-1730:3; Exh. 243; RT 1733:2-11.) That denial was wrong. Then,
16 PacifiCare denied one of the claims by EOB dated 1/13/2007 on the ground that it was
17 ineligible. (Exh. 140, p. 9734; RT 1730:4-20.) That denial was also wrong. Then,
18 PacifiCare denied a claim on the ground that the surgery was done outside the approval
19 dates. (Exh. 243; RT 1733:12-16.) That denial was wrong.

20 After months of trying to work with PacifiCare to resolve these claims, Mr. R filed a
21 complaint with CDI on December 21, 2006. (Exh. 135, p. 9535-9536; RT 1739:20-1740:17.)
22 Almost immediately thereafter, on December 27, 2006, PacifiCare, apparently
23 acknowledging that its previous denials were incorrect, reprocessed and paid Mr. R's claim
24 for one of his surgeries. (Exh. 140, p. 9725; RT 1741:10-20.) Because that claim was
25 submitted many months before, in July 2006 (Exh. 140, p. 9725; Exh. 135, p. 9886),
26 PacifiCare was required to pay interest on that late-paid claim in the amount of \$22.60
27 (Exh. 140, p. 9725; RT 1741:24-1742:2).

1 A few weeks later, on January 15, 2007, PacifiCare reprocessed and paid Mr. R's
2 claim for the other surgery. (Exh. 140, p. 9738; RT 1746:8-21.) Even though this claim was
3 also submitted to PacifiCare months before, in August 2006 (RT 1746:22-1747:1; Exh. 135,
4 p. 9888), PacifiCare refused to pay the statutorily required interest, contending that the
5 company did not receive the claim until January 5, 2007. (Exh. 138, p. 9750; Exh. 140,
6 p. 9738; RT 1747:2-5; RT 1748:2-8.) That contention was false. Mr. R had received denials
7 from PacifiCare on that claim prior to January 5, 2007. (RT 1748:18-1749:6.)

8 Mr. R testified that the total interest payment by PacifiCare of \$22.60 came nowhere
9 close to compensating him for the costs he incurred as a result of PacifiCare's delays and
10 wrongful denials. (RT 1742:3-17.) Among other things, Mr. R was forced to pay significant
11 interest charges on the credit card he used to pay for the surgeries, out-of-pocket costs for
12 facsimile transmissions to re-send PacifiCare claim materials multiple times, and the
13 significant time he spent re-submitting those documents and calling PacifiCare's customer
14 service line during a time when he was starting a new company. (RT 1742:3-14.) Mr. R and
15 his wife also experienced significant frustration at the delay in claims payment:

16 "I was very frustrated with my direct dealings with PacifiCare, had to elicit the
17 help of Costco, it was a lot of time, a lot of effort, a lot of trips to Kinko's."
18 (RT 1738:24-1739:2; see also RT 1749:7-15.)

19 Another witness at the hearing, Ms. W, testified that she had to pay a provider \$500
20 out of pocket to ensure that her son would receive a time-sensitive treatment by a provider
21 who was unwilling to provide treatment because PacifiCare had not timely paid \$15,000 in
22 claims from prior treatments. (RT 1034:24-1035:5.) Ms. W was balance-billed by a
23 different provider when PacifiCare did not remit payment within ninety days. (Exh. 144;
24 RT 1035:13-19.)

25 Dr. Mazer, a PacifiCare contracted provider, also testified about his frustrating
26 experience trying to get PacifiCare to correctly pay a claim. He testified that, in total, it took
27 approximately six months for PacifiCare to pay the claim, imposing "extremely burdensome"
28 costs on him and his office:

1 “If you can consider the amount of time that has to go into making phone calls,
2 drafting letters, researching claims, pulling claims from three years earlier, my
3 staff’s time, my review to decide what action to take, typing up letters,
4 transcribing them, proofing them, mailing them out, the overhead costs are
5 extremely burdensome, not to mention the frustration, not to mention the
6 extreme delay in collecting payment for services properly rendered in good
7 faith, expecting payment, and the damage it does to my ability to deal with a
8 patient, when they have financial issues hanging over their head.”
(RT 3051:17-3052:2 (Mazer).)

9 He also testified about how PacifiCare’s delays in claims payment interferes with his
10 relationships with his patients:

11 “[I]t interferes in many cases with the physician/patient relationship when I
12 have to go bill a patient for copayment six, nine, twelve months after service is
13 rendered.” (RT 3052:5-8 (Mazer).)

14 He described his experience with PacifiCare as “sheer unadulterated frustration.”
(RT 3036:13 (Mazer).)

15 In addition to the individual consumer complaints, the California Medical Association
16 (“CMA”) and the University of California (“UC”) systems filed complaints against
17 PacifiCare in 2007. (Exh. 5354; Exh. 165; Exh. 1019.) CMA alleged, among other things,
18 that following the acquisition, PacifiCare had engaged in widespread misconduct, including
19 not timely entering provider contract rates into its computer systems, failing to timely
20 process contract terminations, not responding to physicians’ payment disputes, and using
21 incorrect contract rates to pay claims, all of which results in claims not being fully and
22 correctly paid in a timely fashion. (Exh. 165, pp. 8506-8507.) In fact, CMA provided CDI
23 significant documentation in support of these allegations, which reflected that a large number
24 of providers were experiencing similar problems with PacifiCare. (E.g., Exh. 5354, p. 8206
25 [Dr. Watson contract not loaded in a timely manner], p. 8204 [Dr. Wood contract loading
26 delay].)

27 The UC systems also experienced problems with PacifiCare’s claims processing. As
28 discussed above, dating back to 2004 until March 2008, PacifiCare incorrectly paid
thousands of claims to the UCSF Medical Group. (See pp. 206-208, *infra*; Exh. 485,

1 p. 4073; RT 11863:23-11864:1 (Harvey); RT 4142:23-4146:22 (Martin).) Even though
2 PacifiCare admitted that it had incorrectly paid these claims (RT 4150:11-20; 4152:15-22
3 (Martin); Exh. 5157, p. 9586; RT 12612:22-12613:17 (Harvey)), it refused to reprocess
4 them, instead proposing a lump-sum settlement to resolve the underpaid claims (RT 4155:5-
5 4156:11 (Martin)). That settlement imposed significant administrative burdens on UCSF,
6 requiring it to engage in a time-consuming claim-by-claim reconciliation with PacifiCare
7 (Exh. 619, at pp. 1-3, ¶ 3-11; RT 4153:12-4154:17 (Martin)), and did not ultimately resolve
8 the incorrectly paid claims until well after the 30 working days required by statute.
9 (RT 12669:17-23 (Harvey).)

10 For over a year, PacifiCare also failed to fully and correctly pay thousands of UCLA
11 claims in a timely manner. (See p. 209; Exh. 613; Exh. 614; Exh. 615; Exh. 616.)
12 PacifiCare didn't respond to a significant number of appeal letters that UCLA initially sent
13 requesting that the insurer reprocess those claims correctly. (RT 3792:16-3794:19 (Rossie).)
14 In fact, as with the incorrectly processed UCSF claims, PacifiCare didn't reprocess these
15 UCLA claims, instead resolving the claims by settlement well after the 30 working days
16 required by statute. (RT 7072:17-7073:23, 7119:8-7127:9 (Rossie).)

17 From around March 2008 until August 2009, PacifiCare also failed to respond to
18 thousands of UCLA claims. Even though UCLA made multiple requests of PacifiCare to
19 process and pay these claims, the company failed to do so until after UCLA witness, James
20 Rossie, testified at the hearing in February 2010. (RT 7063:9:20 (Rossie); Exh. 5237;
21 Exh. 5388.) These claims were not reimbursed, contested, or denied within 30 working days,
22 in violation of the law.

23 c. Root Causes of PacifiCare's Violations

24 Through the course of its investigation of PacifiCare and during the hearing, CDI has
25 uncovered evidence demonstrating that several integration-related operational deficiencies
26 contributed to PacifiCare's failure to timely pay claims.

27 First, in June 2006, PacifiCare outsourced the handling of paper claims, which
28 constituted 45% of PLHIC's claim volume (RT 7419:17-24 (Berkel)), to Lason. PacifiCare

1 did not give Lason proper instructions for keying claims into the claims platform (Exh. 885)
2 and did not give Lason access to the systems that were necessary to identify whether a claim
3 should be keyed into the HMO or PPO platform. (Exh. 710; Exh. 573, p. 2770; Exh. 711,
4 p. 6591 [Akahoshi 6:43 p.m.]; RT 14315:6-19 (Murray).) Approximately 30% of PacifiCare
5 paper claims fell out of the auto-adjudication process into error queues because the claim
6 system did not recognize the member (Exh. 554, p. 0310 [Berkel 1:09 p.m.]), and “the
7 assumption would have been the member was not eligible when, in fact, they could have
8 been on another system.” (RT 6117:16-22 (Vonderhaar).) Approximately 1,500 PacifiCare
9 claims “looped” between the HMO and PPO platforms each day, sometimes looping eight or
10 nine times before getting to the right platform to be adjudicated. (Exh. 563; Exh. 881.) In
11 late 2007, PacifiCare acknowledged that eligibility matching problems were causing late-
12 paid claims and that it was “imperative” to give Lason a tool to fix these problems. (Exh.
13 554, p. 0310 [Berkel 1:09 p.m.]) However, that solution, which cost \$65,000 to implement,
14 met “resistance” (Exh. 554, p. 0310 [Parsons 2:08 p.m.]) and was not implemented until “late
15 2008, early 2009.” (RT 6118:7-11 (Vonderhaar); Exh. 711, p. 6591[Akahoshi 6:43 p.m].)

16 PacifiCare also identified the document-routing problems that followed the transition
17 to Lason, discussed above, as contributing to a 24% slowdown in claims processing as of
18 June 2007, compared with the prior year, and to violations of the timely payment laws.
19 (Exh. 750, p. 7699; Exh. 666, pp. 1103-1104; Exh. 342, p. 8514; RT 8473:8-17; 11249:24-
20 11250:18 (Berkel).)

21 When PacifiCare met with CDI in March 2007 to address consumer complaints and
22 compliance issues, the company was aware that serious errors in the transition of mail
23 routing to Lason were affecting claims timeliness, appeals, customer service, and provider
24 disputes. (Exh. 5258, p. 7105.) It did not provide this information to CDI. (RT 7568:20-
25 7569:3 (Berkel).) In March 2007, CDI asked PacifiCare to include Lason issues in its
26 corrective action plan. (Exhibit 747, p. 7114.) By mid-2007, PacifiCare knew that the
27 problems with Lason were serious and intractable (Exh. 5265, p. 1939 [July 2007: Berkel
28 calls correspondence routing “broken”]; Exh. 361 [July 2007: Failure to timely process

1 reworks attributed to Lason delays]; Exh. 526, p. 2771 [August 2007: “Issues again with
2 aging in Lason queues.”]; Exh. 575, p. 4003 [“Everytime we turn around there are issues
3 with Lason and DocDNA.”]), but did not “stop trying to handle the symptoms and really get
4 to try to understand the core of the issue” until the Lason Summit in October 2007, over a
5 year after the transition. (RT 6801:23-6802:14 (Vonderhaar).) By the time of a conference
6 United convened in March 2008 within the organization, called the “Front End Deep Dive,”
7 California regulators had been urging PacifiCare to address DocDNA misrouting and Lason-
8 related claim processing delays for an entire year. (Exh. 747; Exh. 370, p. 8614; Exh. 373.)
9 For example, PacifiCare promised to “completely update” its policies on correspondence
10 routing by mid-December 2007 (Exh. 161, p. 13), but did not do so until May 2008.
11 (Exh. 376, p. 8233; Exh. 5264, p. 6956.)

12 Internal emails show that PacifiCare and United staff were very frustrated with Lason
13 problems (Exh. 572; Exh. 575; Exh. 752; Exh. 5258, p. 7105), yet Ms. Berkel testified that
14 the Lason implementation was “a success,” that “the vast majority of things worked well
15 with Lason,” and they only had “routine issues” of the kind that arise “all the time.”
16 (RT 9788:18-9789:2; 9815:25-9816:2.) Ms. Vavra, PacifiCare’s Vice President of Vendor
17 Management, also testified that Lason “performed very well” and that she was “very proud”
18 of Lason’s performance in 2006 and 2007. (RT 13962:6-15; 13927:25-13928:5.)

19 PacifiCare’s transition to the United Front End (“UFE”) system for claims received
20 electronically also contributed to claims processing delays. Beginning in October 2006,
21 claims submitted through electronic data interchange (“EDI”) were routed from UFE to a
22 PacifiCare gateway, and then to a claims engine. (Exh. 562, p. 1168; Exh. 894, pp. 1795-
23 1796 [Vonderhaar 7:44 a.m]; RT 15367:17-22 (Soliman).) UFE had less stringent
24 acceptance criteria than PacifiCare’s gateway, so thousands of claims were received by UFE
25 but rejected by the gateway. (Exh. 567, pp. 1811-1812 [Paulson 1:33 p.m: see number 2;
26 Exh. 930, p. 1815 [Paulson 7:23 p.m.: see number 2]; Exh. 568, p. 3895 [Vonderhaar
27 9:44 a.m].) These claims simply “sat in a file” unattended and remained “lost,” in some
28 cases for months. (Exh. 894; Exh. 930; RT 15377:2-4 (Soliman); RT 14267:14-14268:3;

1 14269:1-9 (Way); RT 6813:25-6814:9 (Vonderhaar).) In one episode, EDI claims were lost
2 in this process sometime in the fourth quarter of 2006, but not found until the first and
3 second quarters of 2007. (Exh. 5265, p. 1947.) This issue delayed processing of a
4 significant percent of electronic claims (Exh. 566; Exh. 930) and contributed to claims
5 slowdown into August 2007. (Exh. 605; Exh. 666; Exh. 1066; see also RT 18471:11-13
6 (Wichmann).) Though PacifiCare was aware that UFE and the PacifiCare gateway had
7 different acceptance criteria, pre-implementation testing did not detect that these problems
8 would occur. (RT 15374:12-15375:1 (Soliman).) Further, PacifiCare did not initially
9 establish monitoring or reconciliation controls that would have detected if claims went
10 missing in this process (RT 15369:19-15370: 14 (Soliman); Exh. 566 [Paulson 11:16 a.m.]);
11 a simple claims-in, claims-out count would have likely been sufficient to have quickly
12 detected this problem and allowed PacifiCare to locate the claims and get them timely
13 processed. In March 2007, an automated audit system costing \$80,000 was proposed but
14 rejected as too costly; a manual audit was put in place instead. (RT 15378:16-15379:2;
15 15382:18-15383:6 (Soliman); RT 14269:10-14270:2 (Way).) As late as July 2007,
16 PacifiCare employees were still complaining of frequent problems with UFE's processing of
17 EDI claims. (Exh. 566.)

18 The corruption of provider demographic data by EPDE, mentioned above, also
19 contributed to late-paid claims. Because PacifiCare and United failed to conduct a full
20 inventory of structural differences between RIMS and NDB, the creators of EPDE failed to
21 account for the different ways the systems stored provider billing addresses. (Exh. 759,
22 p. 6084; RT 10845:3-10846:2; 10991:8-12 (McFann); RT 15102:1-10 (Lippincott).) The
23 EPDE feed reactivated outdated addresses in RIMS, and provider checks were often sent to
24 these old addresses and then returned to PacifiCare. By the time these claim payment checks
25 were sent to the providers' correct addresses, more than 30 working days had elapsed.
26 (Exh. 917, p. 6488.) Over 1,000 California providers had address errors serious enough to
27 result in returned checks. (Exh. 920; RT 15206:3-6 (Lippincott).)

1 PacifiCare was aware of these problems for months before seeking to implement
2 remedial actions. Immediately after EPDE was implemented in June 2006, providers began
3 complaining that their reimbursement checks were suddenly being sent to outdated
4 addresses. In November 2006, a PacifiCare employee reported multiple instances in which
5 providers' billing suffixes were corrupted in RIMS and suggested that a report be run to
6 identify all the billing addresses similarly affected, but that suggestion was apparently
7 ignored. (Exh. 495.) A month later, PacifiCare observed that NDB's overlay of RIMS data
8 had created "a huge mess" and that "a lot of our RIMS providers have been paid . . . to
9 wrong addresses." (Exh. 507, pp. 3923-3924.) In January 2007, 11,000 RIMS records were
10 changed to new billing addresses. Yet a member of the EPDE team tasked with identifying
11 required remedial actions decided that no review of the changed records was necessary:
12 "NDB is the source of truth for CA PPO. So regardless of what was in RIMS before, it's
13 good now." (Exh. 850, pp. 8066-8067 [Rao 2:23 p.m].) PacifiCare did not discover the
14 primary cause for returned checks until April 2007. (Exh. 917.) Even still, other EPDE
15 errors continued to affect provider addresses into 2008. (Exh. 602, pp. 1247-1248; Exh. 604,
16 p. 3767; RT 15214:4-8; 17308:11-21 (Lippincott).) Identification of the root cause was
17 "hampered by lack of trail of changes between NDB and PHS engines." (Exh. 342, p. 8529.)

18 PacifiCare's layoffs of experienced claims staff contributed to the delays in
19 processing claims. Included among late-paid claims are claims that were initially improperly
20 denied. CDI complaint investigations discovered instances in which PacifiCare reworked
21 such claims several months after the initial denial. Following the layoffs of Cypress staff,
22 there were "limited rework claims examiners" and PacifiCare had to rehire some of its laid-
23 off employees through a temp agency. Moreover, the departments involved in correcting
24 errors resulting from the EPDE feed, including billing address changes, were too
25 understaffed to respond effectively. (Exh. 920; Exh. 5265, p. 1948 ["The network
26 management and health care economics team of California had triple work load with the
27 same staff to accomplish 1/1/2008 Secure Horizons benefit planning/contract modeling"];
28 Exh. 717, pp. 5404-5405.)

1 **d. PacifiCare’s Positions at the Hearing**

2 At the hearing, Ms. Berkel sponsored an analysis of PacifiCare claims data that she
3 contended reflected that the company had paid 38,567 claims more than 42 calendar days
4 after receipt during the MCE review period. (Exh. 5369, p. 7875; RT 10050:9-10050:14;
5 11190:16-11190:21 (Berkel).)

6 Ms. Berkel further asserted that 3,633 of these 38,567 late-paid claims should not be
7 considered acts in violation because they were either overpaid claims, claims that had been
8 previously timely contested, or claims paid under self-directed accounts. (Exhibit 5369,
9 p. 7875; Exhibit 5252, p. 6937; RT 7640:8-7643:22.) Though CDI has not been provided
10 claims documentation sufficient to independently verify PacifiCare’s assertions, it accepted
11 PacifiCare’s representations, and withdrew its allegation that these 3,633 claims are acts in
12 violation of section 790.03, subdivisions (h)(2), (h)(3), (h)(4), and (h)(5) and section
13 10123.13, subdivision (a). (See Exh. 1177, ¶ 25.)

14 PacifiCare also contended that these 38,567 late-paid claims included 5,921 claims
15 that were processed more than 30 working days after receipt, but that PacifiCare did not owe
16 any money on, because the entire amount owed was applied to the member’s deductible.
17 (Exhibit 5369, p. 7875; RT 7640:23-7641:4; 10048:1-15; 10053:20-10054:15 (Berkel).)
18 PacifiCare interprets section 10123.13, subdivision (a) to require that insurers reimburse
19 claims within 30 working days only when the insurer pays money to the claimant.
20 (RT 10054:9-15 (Berkel).) Nothing in section 10123.13, subdivision (a) limits the
21 application of the 30-working-day requirement to instances in which money changes hands.
22 That section, and the various applicable subdivisions of section 790.03, require that insurers
23 process claims timely, whether coverage is affirmed and the insurer owes money, whether
24 coverage is affirmed and the entire allowed amount is applied to the deductible, whether
25 coverage is contested, or whether coverage is denied. Indeed, if PacifiCare’s novel
26 interpretation were to be accepted, it would mean that insurers could refuse to process claims
27 on which the entire amount is applicable to the member’s deductible indefinitely without
28 violating any laws. Such an absurd result finds no support in the law or in logic. These

1 5,921 late-paid claims constituted acts in violation of section 10123.13, subdivision (a) and
2 section 790.03, subdivision (h).

3 PacifiCare also contended that it had established and monitored various internal
4 “turnaround time” metrics that purported to measure the company’s processing of claims.
5 But an insurer’s compliance with its own internally developed and monitored metrics does
6 not constitute compliance with the law. (RT 6336:3-24 (Vonderhaar).) Further, the metrics
7 that PacifiCare proffered were of dubious reliability and cannot be relied upon to reflect
8 claims processing performance. As just one example, PacifiCare witnesses admitted that
9 claims that are paid incorrectly (or denied incorrectly) but done so within the timeliness
10 standards are counted as timely processed claims, even after PacifiCare determines that these
11 claims were incorrectly paid and needed to be readjudicated. (RT 6989:11-14; (Vonderhaar);
12 RT 9461:4-12 (Goossens); RT 20346:21-20348:20 (McNabb).)

13 PacifiCare also argued that certain tolerance levels described in the 2011 version of
14 the NAIC Market Regulation Handbook (Exh. 5648) should be applied in this hearing to
15 determine whether PacifiCare’s claims processing performance violated the law. But
16 nothing in section 733, subdivision (f) or any other law requires CDI to use those tolerance
17 levels, and CDI has never done so. (RT 13413:7-14; 13431:9-22 (Laucher); RT 22858:4-19
18 (Cignarale).) Section 733, subdivision (f) applies only to when the Department is
19 “conducting the examination,” not to when it is prosecuting an insurer for violations of law.
20 And it relates to financial examinations, not to market conduct examinations. (Exh. 872,
21 p. 17.)

22 Nor do the metrics set forth in the Undertakings to the California Department of
23 Insurance document (Exh. 5191) apply to this enforcement hearing to excuse some
24 percentage of violations committed by PacifiCare, as PacifiCare has contended. Those
25 Undertakings reflected unilateral commitments made by PacifiCare and United to then-
26 Commissioner Garamendi in 2005 to induce him to approve the acquisition (RT 8734:10-23;
27 RT 12534:19-12535:1; 12536:2-7 (Monk)) — an entirely separate process from this
28 proceeding. Indeed, those Undertakings set forth certain standards and thresholds that are

1 different from what all insurers are obliged to follow under the law. (Exh. 5191, pp. 9393-
2 9394.) And the Undertakings further set forth their own consequences for failure to meet
3 those standards and thresholds that are different from the consequences for violating laws or
4 regulations. PacifiCare is required to comply with the separate commitments it made in the
5 Undertakings, and, as are all insurers, it is required to comply with all applicable laws and
6 regulations.

7 **e. Harm Caused by PacifiCare’s Violations**

8 In enacting several provisions directly addressing the timely payment of claims, the
9 Legislature has expressed its determination that the late payment of claims is a serious
10 concern that harms consumers.

11 As Mr. Cignarale testified, the payment of claims “is, of course, central to the proper
12 functioning of the health insurance system. Failing to timely pay claims can impose
13 significant financial and administrative burdens on claimants.” (Exh. 1184, p. 101:10-12.)
14 Ms. Berkel also testified that late-paid claims can impose on providers administrative costs
15 that, she acknowledged, may not be fully recovered by the payment of statutory interest.
16 (RT 10039:11-10040:5.) The testimony of the patient and provider witnesses discussed
17 above confirm the serious level of harm caused by PacifiCare’s failure to timely process
18 claims. Mr. Cignarale also concluded that in the case of PacifiCare, “the harm caused by
19 late-paid claims was exacerbated by PacifiCare’s failure to promptly respond to inquiries and
20 complaints by both providers and consumers.” (Exh. 1184, p. 112:1-2.)

21 **3. Number of Acts in Violation**

22 Based on its electronic analysis and on PacifiCare’s representations during the MCE,
23 CDI initially cited the company for 42,137 acts in violation related to failing to timely
24 process claims (Exh. 1, pp. 3524, 3480, ¶ 2), which PacifiCare admitted it had committed
25 (Exh. 118, p. 3426).

26 As discussed above, PacifiCare produced additional data at the hearing reflecting that
27 it had paid 38,567 claims more than 42 calendar days after receipt during the MCE review
28 period. (Exh. 5369, p. 7875; RT 10050:9-10050:14; 11190:16-11190:21 (Berkel).) CDI has

1 determined that of those late-paid claims 34,934 constitute acts in violation of the applicable
2 late-pay statutes. The evidence reflects that tens of thousands of these claims were paid more
3 than a month after the 30-working-day period had elapsed. (Exh. 5190; RT 9595:17-21
4 (Washington).)

5 In addition, based on its investigation of consumer complaints against PacifiCare,
6 CDI identified 239 claims that were processed late, more than 30 working days after receipt
7 of the claim. (Exh. 22, p. 9512 [3 citations]; Exh. 29, p. 1031 [7 citations]; Exh. 38, p. 4087
8 [2 citations]; Exh. 41, pp. 9453-9454 [9 citations]; Exh. 46, p. 0979 [2 citations]; Exh. 48,
9 p. 9387 [3 citations]; Exh. 51, p. 0667 [1 citation]; Exh. 53, p. 2883 [6 citations]; Exh. 57,
10 pp. 8684-8685 [8 citations]; Exh. 58, pp. 9942-9943[5 citations]; Exh. 59, p. 9375 [2
11 citations]; Exh. 61, p. 9880 [1 citation]; Exh. 65, p. 8535 [1 citation]; Exh. 66, p. 9036 [1
12 citation]; Exh. 67, p. 9315 [1 citation]; Exh. 69, p. 1449 [1 citation]; Exh. 70 [1 citation];
13 Exh. 71, p. 8795 [1 citation]; Exh. 72, p. 8878 [1 citation]; Exh. 75, p. 9374 [1 citation];
14 Exh. 76, p. 8928 [1 citation]; Exh. 78, p. 6139 [2 citations]; Exh. 79, p. 6317 [1 citation];
15 Exh. 81, p. 5975 [1 citation]; Exh. 87, p. 7477 [11 citations]; Exh. 88 [1 citation]; Exh. 89,
16 p. 6802 [8 citations]; Exh. 91, p. 2318 [1 citation]; Exh. 92, p. 2610 [1 citation]; Exh. 93,
17 p. 2752 [1 citation]; Exh. 94, p. 9810 [3 citations]; Exh. 95, p. 0056 [8 citations]; Exh. 96 [1
18 citation]; Exh. 99 [1 citation]; Exh. 101 [1 citation]; Exh. 102, p. 4588 [2 citations];
19 Exh. 166, p. 1505 [7 citations]; Exh. 171, p. 5347 [1 citation]; Exh. 173, p. 8514 [2 citations];
20 Exh. 178, p. 1911 [12 citations]; Exh. 179, p. 9892 [6 citations]; Exh. 182, p. 8214 [6
21 citations]; Exh. 185, p. 4485 [5 citations]; Exh. 189, p. 7722 [7 citations]; Exh. 191, p. 2939
22 [8 citations]; Exh. 192, p. 2552 [2 citations]; Exh. 195, p. 1000 [2 citations]; Exh. 196,
23 p. 9653 [1 citation]; Exh. 202, p. 9682 [13 citations]; Exh. 203, p. 9632 [8 citations];
24 Exh. 204, p. 9655 [15 citations]; Exh. 206, p. 9686 [3 citations]; Exh. 209, p. 7064 [16
25 citations]; Exh. 211, p. 9710 [1 citation]; Exh. 212, p. 9569 [1 citation]; Exh. 213, p. 9665 [9
26 citations]; Exh. 214, p. 1174 [1 citation]; Exh. 217, p. 5846 [1 citation]; Exh. 219, p. 5970 [6
27 citations]; Exh. 220, p. 9807 [1 citation]; Exh. 221, p. 0284 [1 citation]; Exh. 223, p. 9967 [1
28 citation]; Exh. 224, pp. 2380-2381 [2 citations].)

1 Of those 239 untimely processed claims, there were 63 that fell outside of the MCE
2 period, and therefore were not included in the 34,934 figure. (Exh. 1209, ¶¶ 2, 3, 9, 14, 18,
3 28, 29, 30, 32, 33, 35, 36, 37, 42, 45, 46, 47, 48, 49, 50, 52, 53, 54; Exh. 22, p. 9512
4 [2 citations]; Exh. 29, p. 1031 [7 citations]; Exh. 46, p. 0979 [1 citation]; Exh. 53, p. 2883 [6
5 citations]; Exh. 57, pp. 8684-8685 [8 citations]; Exh. 70 [1 citation]; Exh. 71, p. 8795 [1
6 citation]; Exh. 72, p. 8878 [1 citation]; Exh. 75, p. 9374 [1 citation]; Exh. 76, p. 8928 [1
7 citation]; Exh. 78, p. 6139 [2 citations]; Exh. 79, p. 6317 [1 citation]; Exh. 81, p. 5975 [1
8 citation]; Exh. 87, p. 7477 [11 citations]; Exh. 91, p. 2318 [1 citation]; Exh. 92, p. 2610 [1
9 citation]; Exh. 93, p. 2752 [1 citation]; Exh. 94, p. 9810 [3 citations]; Exh. 95, p. 0056 [8
10 citations]; Exh. 96, [1 citation]; Exh. 99 [1 citation]; Exh. 101[1 citation]; Exh. 102, p. 4588
11 [2 citations].) Many of these claims were paid six or more months after receipt by
12 PacifiCare. (E.g., Exh. 22; Exh. 29; Exh. 53; Exh. 57; Exh. 72; Exh. 75; Exh. 78; Exh. 91;
13 Exh. 94; Exh. 95; Exh. 96; Exh. 101.)

14 Though not being charged as acts in violation in this action, PacifiCare also failed to
15 fully and correctly process in a timely manner thousands of claims submitted by UCSF and
16 UCLA.

17 **4. PacifiCare Knowingly Committed the Acts in Violation, And**
18 **Performed Them With Such Frequency as to Indicate a General**
19 **Business Practice**

20 All insurers are charged with constructive knowledge of when they receive claims and
21 when they pay claims; PacifiCare is no exception. Absent evidence that PacifiCare had some
22 reasonable basis to be unaware of when it received certain claims and when it paid claims,
23 PacifiCare knowingly paid these claims late, and therefore knowingly failed to acknowledge
24 and act reasonably promptly with respect to communications regarding claims and
25 knowingly failed to affirm or deny coverage within a reasonable time, in violation of the law.

26 In addition, many of these violations occurred after PacifiCare had actual knowledge
27 that the systems contributing to the violations were deficient. PacifiCare is further
28 chargeable with knowledge of the likely consequences of implementing these systems in the
hasty and slipshod manner in which they were implemented. (Exh. 1184, pp. 109:25-110:6.)

1 Separately, the tens of thousands of late-paid claims represent a frequency well in
2 excess of the number necessary to support an inference of a general business practice, as Mr.
3 Cignarale testified. (Exh. 1184, p. 110:6-9.)

4 **5. These Acts in Violation Were Willful**

5 PacifiCare's failure to timely pay claims was willful, as that term is used in
6 section 790.035 and the Regulations. Under section 790.035, an insurer is liable for a
7 penalty up to \$10,000 for each act, if either the act or practice was willful. Here, PacifiCare
8 continued to willingly utilize business processes that it knew were causing it to not affirm or
9 deny coverage within a reasonable time. For instance, PacifiCare observed a 24% slowdown
10 in claims processing and yet did not address the root causes for months. A company that
11 pays tens of thousands of claims over a month late is clearly willingly failing to effectuate
12 prompt payment of claims.

13 Moreover, PacifiCare recklessly designed new processes, including UFE, Lason's
14 correspondence routing and claim data entry processes, and EPDE in a manner that made
15 claims processing errors highly foreseeable. PacifiCare further failed to equip these
16 processes with appropriate quality control mechanisms, and failed to promptly investigate
17 and address the resulting problems. These acts represent a willful failure to adopt reasonable
18 claims processing standards. (Exh. 1184, p. 110:16-25.)

19 **6. The Issuance, Amendment, or Servicing of the Policy or** 20 **Endorsement Was Not Inadvertent**

21 There is no evidence that PacifiCare's failure to timely pay these claims constituted
22 an inadvertent issuance, amendment, or servicing of the policy. The "servicing of the
23 policy" in this instance is the issuance of payment on these claims, and PacifiCare has not
24 offered any evidence that it inadvertently issued payment on any of these claims.

25 (Exh. 1184, p. 110:13.)

26 **7. Applicable Unit-Penalty**

27 Mr. Cignarale began his penalty analysis for the untimely claims payment violations
28 with an assessment of the inherent severity of such acts, compared to the range of violations

1 subject to section 790.035. Based on his decades of regulatory experience with CDI, Mr.
2 Cignarale opined that the late-payment of claims is of “average seriousness,” accounting for
3 the fact that in some cases, the impact might be minimal if payment is late only by a day or
4 two:

5 “In comparison to the range of violations to which section 790.035
6 applies, I view this as being of average seriousness. Closing or denying a
7 claim because the insurer claims to need additional information is a wrongful
8 claim denial. In fact, a claimant receiving notification that a claim is being
9 closed or denied because the insurer needs information may be confused about
10 the status of that claim. The claimant may reasonably believe that the
11 insurer’s closure or denial of the claim is the final determination on that
12 claim.” (Exh. 1184, p. 101:6-12.)

13 Mr. Cignarale testified that this type of violation warrants initial placement at 50% of the
14 section 790.035 range, or \$5,000 per act for willful acts. (Exh. 1184, p. 101:15-17.)

15 He then reviewed the specific evidence in the record relating to these violations,
16 which were provided to him in the form of assumptions. He found slight mitigation based on
17 the “relative number of claims” factor (Reg. 2695.12, subd. (a)(7)); slight mitigation for the
18 remedial actions PacifiCare took, albeit belatedly (Reg. 2695.12, subd. (a)(8)); and slight
19 mitigation based on the frequency and detriment to public (Reg. 2695.12, subd. (a)(12)).
20 (Exh. 1184, pp. 111:15-112:15.)

21 Mr. Cignarale found aggravation based on his conclusion that PacifiCare failed to
22 exhibit a good faith attempt to comply (Reg. 2695.12, subd. (a)(12)). (Exh. 1184, p. 112:5-
23 12.) Particularly concerning to Mr. Cignarale was PacifiCare’s apparent belief that “a certain
24 number of violations were acceptable as long as [its internal claims timeliness] metrics were
25 met.” (Exh. 1184, p. 112:8-10.) PacifiCare’s refusal to invest in appropriate testing and
26 quality control measures, and its “alarming lack of urgency in addressing issues that the
27 company knew to be causing late-paid claims” also weighed into Mr. Cignarale’s analysis of
28 this factor. (Exh. 1184, p. 112:7-12.) As Mr. Cignarale also found, the harm caused by these
violations was greater than the typical case because of PacifiCare’s failures to timely respond
to inquiries and complaints by members and providers and because many of the late-paid

1 claims were extremely late. (Exh. 1184, p. 112, p. 1-4.) The delay in taking remedial
2 measures for these violations was also an aggravating circumstance (Reg. 2695.12,
3 subd. (a)(13)). (Exh. 1184, p. 112:16-25.)

4 The remaining penalty factors presented neither aggravating nor mitigating
5 circumstances. (Reg. 2695.12, subds. (a)(1), (a)(3), and (a)(9).)

6 On balance, Mr. Cignarale concluded that the section 2695.12 factors required an
7 increase of 10% in the unit-penalty, from \$5,000 to \$5,500 per willful act in violation,
8 resulting in an aggregate penalty of \$192,483,500 for these 34,997 acts. (Exh. 1184,
9 p. 112:26-113:2.)

10 **F. Failure to Pay Interest on Late-Paid Claims**

11 **1. Applicable Legal Requirements**

12 As discussed above, the UIPA requires that claims be processed within a reasonable
13 time after they are submitted. (Section 790.03, subds. (h)(2), (h)(3), (h)(4), and (h)(5).) It
14 also requires that claims be paid the full amount owed on them. Section 790.03,
15 subdivision (h)(5), for instance, specifically requires that insurers attempt in good faith to
16 effectuate settlements of claims that are not just prompt, but also fair and equitable.
17 Subdivisions (h)(2), (h)(3), and (h)(4), which pertain to the prompt and timely payment of
18 claims, similarly require that insurers fully and correctly pay those claims. Claims must be
19 paid in full, or else they are not promptly paid.

20 In 1986, the Legislature enacted section 10123.13, subdivision (a), which set a 30-
21 working-day standard as a reasonable time for insurers to process health claims. (See
22 pp. 170-171.) Three years later, in 1989, the Legislature enacted Assembly Bill 865
23 (“AB 865”), adding a separate requirement that insurers pay interest on health claims paid
24 after 30 working days:

25 “If an uncontested claim is not reimbursed by delivery to the claimant’s
26 address of record within 30 working days after receipt, interest shall accrue
27
28

1 and shall be payable at the rate of 10 percent per annum beginning with the
2 first calendar day after the 30-working day period.” (§ 10123.13, subd. (b).)²²

3 The Legislature’s intention in enacting AB 865 was clear: to add to the existing law the
4 requirement that insurers pay interest on late-paid claims. The final Senate Floor Analysis,
5 for example, reported that the existing law required insurers and health plans to reimburse
6 claims within 30 working days after receipt (Exh. 5682, p. 207 of 209), and that this bill
7 added to that law a separate requirement that insurers and plans pay interest on claims not
8 paid within that time:

9 “This bill requires every health care service plan, indemnity insurer, nonprofit
10 hospital service plan, which provides either individual or group coverage, to
11 be liable for the payment of interest at a rate of ten percent per annum on
12 monies owed to a professional or institutional provider on any submitted claim
13 which is uncontested.” (Exh. 5682, p. 207 of 209.)

14 In the signing letter to Governor Deukmejian, the bill’s author similarly explained:

15 “Current law requires insurers to reimburse claims within 30 days or 45 days
16 for HMO’s (Health Maintenance Organizations). The purpose of Assembly
17 Bill 865 is to encourage compliance with this law by providing a deterrent for
18 those who currently disregard it.” (Exh. 5682, p. 49 of 209.)

19 The bill, of course, was intended to strengthen, not weaken, existing law relating to the
20 timely payment of claims. It thus provided an automatic sanction against late paying insurers
21 that would not require state regulators to investigate, examine, and prosecute violations in
22 order to enforce the law. The interest requirement not only encourages compliance with
23 existing law, but also seeks to compensate, at least in part, those harmed by insurer delays —
24 a remedy that an enforcement action against an offending insurer would be unable to attain.
25 As reflected in the scores of letters from providers and provider groups in the legislative
26 history file, the prompt payment of claims to providers is “essential to their financial
27 viability.” (E.g., Exh. 5682, pp. 136 of 209, 139 of 209.)

28 ²²During the MCE, PacifiCare acknowledged that “interest is due when reimbursed
over 30 days of receipt of the claim.” (Exh. 1, p. 3525.) The company does not appear to
have recanted that admission at the hearing.

1 There is no indication in the language of the statute or the legislative history of any
2 intent to weaken the existing late-pay law by giving insurers the option of either paying
3 claims on time or paying them late with statutory interest. Rather, the interest requirement
4 represented the Legislature’s determination that in order to fully, fairly, and equitably settle
5 claims that are paid late, insurers must pay an added 10% interest to the amount owed on the
6 claim. By failing to pay statutory interest on claims, insurers are not paying the full amount
7 owed on a claim and are thus failing to attempt “in good faith to effectuate prompt, fair, and
8 equitable settlements of claims,” in violation of section 790.03, subdivision (h)(5). (See
9 Exh. 1184, p. 113:14-16.)

10 Similarly, an insurer that fails to pay statutorily required interest on late claims, is not
11 fully paying claims in a timely manner, in violation of section 790.03, subdivisions (h)(2),
12 (h)(3), and (h)(4). (See Exh. 1184, p. 113:12-14.) To the contrary, an insurer that pays
13 claims without statutory interest also violates subsection (h)(1) because it is misrepresenting
14 to claimants the amount owed on the claim. (Exh. 1184, p. 113:11-12.)

15 **2. PacifiCare’s Violations of Law**

16 During the 2007 MCE, CDI performed an electronic analysis of PacifiCare’s paid
17 claim population for the review period. That analysis uncovered thousands of claims that
18 were paid more than 30 working days after receipt but contained no payment of interest.
19 CDI’s analysis did not attempt to determine whether any of the interest payments that were
20 made were accurate; instead, CDI cited PacifiCare only in instances in which the company
21 paid a claim late and paid \$0 in interest. (RT 617:22-618:15 (Vandepas).)

22 In the company’s December 7, 2007, responses to the examination reports, PacifiCare
23 admitted that it failed to pay statutorily required interest on late-paid claims in 5,432
24 instances. (Exh. 118, pp. 3426-3427 [5,420 group claims and 12 individual claims].)
25 PacifiCare represented that it had completed a project on November 2, 2007, to reprocess
26 5,420 group claims to pay the required interest, and completed a project on October 22,
27 2007, to reprocess 12 individual claims to pay the required interest. (Exh. 118, pp. 3426-
28 3427.) During the MCE, PacifiCare further represented that it had manually adjusted these

1 claims to include interest totaling \$138,792.65, and purported to provide CDI with evidence
2 of those additional payments:

3 “The Company conducted a self-survey of the claims identified in the
4 data analysis review period (6/23/06-5/31/07) and manually adjusted the
5 claims to include interest totaling \$138,792.65. The Company provided
6 supporting data and proof of additional payments to the Department totaling
7 \$33.65 in the 12 individual claims identified and \$138,759.00 in the 5,420
group paid claims identified as not including interest with the reimbursement
paid over 30 working days of receipt of the claim.” (Exh. 1, p. 3525.)

8 PacifiCare’s representations that these claims had been fully remediated were false. At the
9 hearing, PacifiCare admitted that, contrary to its prior representations, many of these claims
10 had not been reprocessed and the claimants still had not been issued the statutorily required
11 interest. On June 10, 2010 — more than two years after PacifiCare had represented that
12 interest had been paid on all these claims — Ms. Berkel testified that the company had
13 reprocessed and paid interest on only 4,634 of those claims. (Exh. 5252, p. 6937; RT
14 7646:13-7647:17.) The remaining 813 claims, which were originally processed in 2006 and
15 2007 (RT 11271:8-11 (Berkel)), had still not been reprocessed and interest had not been paid,
16 as of June 10, 2010. (Exh. 5252, p. 6937; RT 7646:13-7647:17 (Berkel).) On August 31,
17 2010, Ms. Berkel testified that the company had completed its work on those 813 claims and
18 determined that 561 of them required additional payments of interest totaling \$4,049.34.
19 Those claims were finally paid with interest between June and July 2010 — approximately
20 three to four years after the claims were originally submitted. (Exh. 5369, p. 7873; RT
21 11183:13-11184:20 (Berkel).)

22 PacifiCare offered no explanation for its prior misrepresentations to CDI, and in fact
23 Ms. Berkel testified that she considered the company’s reprocessing of these 813 claims in
24 2010 to have been “self-initiated” (RT 11272:21-23), even though they were claims that
25 should have been reprocessed years before, during the MCE, when PacifiCare previously
26 (and falsely) represented that they had been reprocessed. Any suggestion that this belated
27 project to correctly pay these years-old claims was in any way “self-initiated” is false, and
28 such lack of repentance for providing incorrect information to CDI is inexcusable.

1 Ms. Berkel also offered at the hearing calculations purporting to show that PacifiCare
2 was 99.5% compliant with section 10123.13 by comparing the number of late-paid claims on
3 which PacifiCare failed to pay interest to the total number of paid claims during the MCE
4 period. (Exh. 5252, pp. 6937-6938; RT 7647:18-7648:22.) That calculation, like many of
5 PacifiCare’s proffered “compliance” percentages, is misleading and ultimately meaningless.
6 Using the total number of claims figure in the denominator, as PacifiCare does here, virtually
7 assures that any compliance rate is going to appear to be high.

8 To the extent that it would be relevant, the more appropriate measure of PacifiCare’s
9 compliance with the interest requirement would be to compare the number of claims on
10 which PacifiCare failed to pay interest to the number of claims that required interest. That
11 calculation would provide an actual measurement of how often PacifiCare was paying
12 interest when it was due, as Ms. Berkel admitted on cross examination. (RT 10076:7-10
13 (Berkel) [“Q. [By Strumwasser] Would you agree that this is a calculation of the percentage
14 of the claims that needed interest that got interest? A. Yes, I would.”].) PacifiCare contends
15 that during the MCE period, there were 23,658 claims paid late with interest (Exh. 5252,
16 p. 6937; RT 7645:7-18 (Berkel)), and 5,195 claims paid late without interest (Exh. 5369,
17 p. 7875). Thus, the total number of claims during the MCE that required interest was 23,658
18 plus 5,195, or 28,853. The rate of compliance with the interest requirement would, therefore,
19 be the total number of claims that PacifiCare paid with interest (23,658) divided by the total
20 number of claims requiring interest (28,853):

$$21 \quad 23,658 / (23,658 + 5,195) = 82\%.^{23}$$

22 When Ms. Berkel was presented on cross with this calculation and the result, she admitted
23 that the percentage did not represent satisfactory performance by PacifiCare: “No, I wouldn’t
24 say it is satisfactory, no.” (RT 10076:5-14; Exh. 724.)

26 ²³Because CDI did not test the accuracy of the amount of PacifiCare’s interest
27 payments, this compliance rate measures only whether some amount of interest was paid on
28 claims where interest was owed, and not whether the correct amount of interest was paid on
those claims.

1 Ms. Berkel testified that the reason that interest wasn't paid on these claims was that
2 the RIMS system did not automatically calculate interest on readjudicated claims, so an
3 examiner must manually calculate interest. (Exh. 5252, p. 6939; RT 7648:23-7649:8.) Ms.
4 Berkel therefore concluded that the root cause of these failures to pay interest was human
5 error. (RT 7648:23-7649:8.) That explanation, of course, addresses only PacifiCare's
6 failures to pay interest on rework claims and doesn't address the company's interest
7 violations on "new day" claims. (RT 10065:5-13.) PacifiCare does not appear to have made
8 any effort to determine the root cause of those failures for new day claims (RT 10066:10-16
9 (Berkel)), and has offered no evidence that it took appropriate corrective actions on those
10 claims.

11 And the supposed corrective actions PacifiCare claims to have taken with respect to
12 rework claims were ineffective for many months following their implementation. Ms. Berkel
13 testified that in response to these failure-to-pay-interest citations, the company provided its
14 claims examiners with an "interest calculator" in October 2007, and beginning in November
15 2007, provided additional training regarding interest payment guidelines. (RT 7649:9-17;
16 7650:5-19; Exh. 5252, p. 6940.) She further contended that the company implemented a
17 "Weekly Interest Focused Audit Program" in January 2008, in an effort to increase interest
18 payment accuracy. (Exh. 5252, p. 6940.) But, as Ms. Berkel herself admitted, these
19 corrective actions didn't appear to correct much. Ms. Berkel testified that several months
20 after implementation of these actions the company continued to struggle with paying interest:
21 "I know that we struggled struggled [sic] with people performing interest calculations."
22 (RT 10067:24-10068:3; see also RT 10068:4-9 ["Q. [By Strumwasser] So even after you
23 had the [interest calculator] template, you were having problems? A. Yes, we were."].) In
24 an October 2008 e-mail — approximately nine months after the implementation of all the
25 company's supposed corrective actions — Ms. Berkel reported that the company was "[s]till
26 struggling with RIMS PPO interest accuracy." (RT 10072:9-13; Exh. 712, p. 9316.)

27 Moreover, simply attributing the problem here to "human error," as PacifiCare does,
28 ignores the true root causes of these failures, thereby allowing the underlying issues to

1 remain unaddressed and the company’s problems with paying interest to persist. For
2 instance, the evidence adduced at the hearing revealed that PacifiCare’s flawed policies and
3 procedures for recording received dates in RIMS was a more significant contributing factor
4 to these interest violations. PacifiCare Claims Manager Lois Norket explained that when a
5 new claim is initially received by the company, the original received date is recorded in
6 RIMS for that claim. (RT 2368:11-16.) If that claim needs to be subsequently reworked,
7 however, the date that the rework request was received is recorded as the “received date” for
8 that rework claim. (RT 2368:15-18; 2369:9-12 (Norket).) Ms. Norket testified that it was
9 then up to that claims examiner to find the original received date of the claim and to
10 manually change it so that interest would be paid correctly:

11 “It would be up to the claims examiner to say, ‘Okay. I received the rework
12 request on April 1st, but we didn’t process it correctly,’ as in your example
13 you had earlier. ‘I need to go back and see what the original received date was
14 on the 01 worksheet and manually change it to be that date so the interest will
15 apply appropriately.’” (RT 2368:18-25; see also RT 2363:9-24.)

16 “Q. [By Strumwasser] Then, if the 02 claim number — and certainly the 02
17 claim number starts out its life with the date of the appeal, not the original
18 date, right?

19 A. It starts out that way, yes.

20 Q. So if nobody does anything, that’s how it’s going to get processed, right?

21 A. If the examiner doesn’t change that date, that’s correct.” (RT 2369:9-16.)

22 Therefore, if the claims examiner doesn’t manually change the received date on a
23 rework claim, the claim will be processed as though it was received by the company on the
24 date the rework request was received, not on the date that the claim was actually received,
25 and interest will be incorrectly calculated. For example, say a claim is initially received on
26 January 1 and is denied on January 15. The claimant appeals, and PacifiCare’s claims
27 department receives the request for rework on March 1. PacifiCare determines that it
28 incorrectly denied that claim, readjudicates it and pays the claimant on March 15. In
accordance with PacifiCare’s procedures for recording received dates, that rework claim will
be reflected in RIMS as having been received on March 1 and supposedly “timely” processed

1 on March 15 without interest, unless the claims examiner knows to manually change the
2 received date back to the original date of January 1.

3 Had the company critically considered the true root causes of its failures to pay
4 interest correctly, it could have discovered that a simple change to its policy of recording
5 received dates — that is, recording the original received date in RIMS for rework claims —
6 would have been far more effective in ensuring that claims were paid with appropriate
7 interest.²⁴ Instead, PacifiCare attributed the cause to “human error” and only sought to
8 address that issue, albeit ineffectively, by further training examiners and providing them with
9 “interest calculators,” as discussed above.

10 Indeed, the highly manual process PacifiCare had in place for calculating interest
11 relied heavily on claims examiners having institutional knowledge and understanding that it
12 was their responsibility to review and manually adjust claim received dates in order for the
13 correct amount of interest to be paid. As Ms. Vonderhaar testified, “[p]articularly on rework
14 claims, the interest is calculated manually. So you know, it’s just a human calculating
15 interest.” (RT 6851:24-6852:1.) While PacifiCare’s PPO claims operations were
16 functioning well in 2005 before the acquisition (RT 2318:3-7 (Norket)), shortly after United
17 acquired PacifiCare, it closed PacifiCare’s claims operations in the Cypress headquarters
18 office and laid off the PPO claims examiners there. (Exh. 283; RT 2293:16-25 (Norket);
19 RT 9016:12-24 (Monk).) As Ms. Berkel described those layoffs: “Historical knowledge is
20 intentionally severed.” (Exh. 5265, p. 1945.)

21 The bulk of PLHIC PPO claims processing was thereafter transferred to MedPlans.
22 (Exh. 528, p. 2687 [“Now that we have transitioned most of our PPO claims processing to
23 them”]; RT 6194:11-23 (Vonderhaar) [“They [MedPlans] were doing pretty much everything
24 else already.”]; see also RT 6188:16-24 (Vonderhaar).) As discussed above, PacifiCare was

25
26 ²⁴Of course, such a change in policy would have also made PacifiCare’s “compliance”
27 percentages for timely processing much lower, because the company’s claims data would
28 then accurately reflect the actual number of days between the originally received date and the
final adjudication date, not the number of days between the request for rework and the
adjudication date.

1 continually unsatisfied with MedPlans’s performance —complaining in 2006 that the quality
2 levels were cause for termination and in late 2007 that PacifiCare was having the same
3 problems again and again with Lason (Exh. 1032; Exh. 560, p. 4878; see pp. 30-32, *supra.*)
4 Yet, by 2007, PacifiCare was “absolutely dependent” on MedPlans for PPO claims
5 processing and continued to transfer work to the vendor despite its “unacceptable”
6 performance. (Exh. 560, pp. 4878-4879.) The transfer of PPO claims processing to
7 MedPlans — a vendor with serious and known performance problems — almost certainly
8 contributed to PacifiCare’s significant failures to appropriately pay interest on claims.

9 An insurer’s failure to pay interest on late-paid claims is akin to an underpayment of a
10 claim. It is, in fact, an underpayment of an amount that the Legislature has determined
11 insurers must pay on claims. As Mr. Cignarale testified, “[w]hen claimants are not paid
12 interest on late-paid claims, they are not being fully and accurately compensated what they
13 are owed.” (Exh. 1184, p. 113:21-23.) This, Mr. Cignarale further explained, may have
14 “adverse financial consequences similar to those occasioned by the underpayment of a
15 claim.” (Exh. 1184, p. 113:23-24.)

16 In some instances interest owed on a claim may be small, but in others it is
17 significant. The evidence in the record confirms that PacifiCare’s failure to pay interest can
18 have substantial effects on claimants. Ms. Berkel testified that of the claims that the
19 company failed to pay any interest on, the average amount of interest owed after these claims
20 were reprocessed was around \$30 per claim. (RT 10061:13-10062:2; Exh. 5252, p. 6938.)
21 Twenty-five of these additional interest payments exceeded \$1,000, and one claim, which
22 was originally submitted in 2004, was reprocessed 3 years later with an additional interest
23 payment of approximately \$21,000. (RT 10062:10-17; 11185:14-25 (Berkel).)

24 In addition to financial consequences to claimants, an insurer’s failure to pay
25 statutorily required interest also creates unnecessary administrative burdens on claimants
26 who may be forced to track down information about particular claims they had submitted and
27 to follow up with insurers to ensure that appropriate interest was paid. (Exh. 1184,
28 p. 113:20-27.) Particularly given the evidence of PacifiCare’s poor and ineffective customer

1 service, as described above, the administrative burdens of having to deal with PacifiCare to
2 get claims fully and correctly paid were likely significant. And in those instances that
3 PacifiCare has pointed to in which the interest payment was small (see Exh. 5639, p. 7874),
4 the administrative burdens imposed on claimants likely far exceeded the amount that the
5 interest payment compensated them for. (See Exh. 1184, p. 118:14-16.) Ms. Berkel herself
6 admitted that in some instances, the payment of interest would not cover the administrative
7 costs imposed by PacifiCare's delay in paying the claim. (RT 10039:11-10040:5.)

8 **3. Number of Acts in Violation**

9 PacifiCare admitted at the hearing that in total there were 5,195 late-paid claims on
10 which it failed to pay statutory interest in violation of the law. (Exh. 5369, p. 7874.) That
11 figure, as discussed above, represents only the number of claims that were paid late (more
12 than 30 working days after receipt) with \$0 in interest. CDI did not attempt to determine,
13 and PacifiCare did not disclose, the number of late-paid claims that were paid an incorrect
14 amount of interest. Given the serious problems PacifiCare was having paying interest, it is
15 likely that the number of acts in violation is significantly higher.

16 **4. PacifiCare Knowingly Committed the Acts in Violation, and** 17 **Performed Them with Such Frequency as to Indicate a General** 18 **Business Practice**

19 PacifiCare is chargeable with knowledge of the amounts it pays on claims, including
20 the amounts it pays — or in this case, doesn't pay — in statutory interest. There is no
21 evidence that PacifiCare had a reasonable basis to be unaware of these facts. By failing to
22 pay statutory interest on these claims, PacifiCare knowingly misrepresented pertinent facts,
23 knowingly failed to adopt and implement reasonable standards for the prompt investigation
24 and processing of claims, and knowingly did not attempt in good faith to effectuate prompt,
25 fair, and equitable settlements of claims.

26 Further, PacifiCare knew or should have known that it had not provided its examiners
27 with the tools and training necessary to correctly pay interest, making the resulting acts
28 knowing. (Exh. 1184, p. 116:9-18.)

1 Separately, the thousands of violations for failure to pay interest, by themselves,
2 represent a frequency that indicates a general business practice, as Mr. Cignarale testified.
3 (Exh. 1184, p. 116:18-20.) By PacifiCare’s own admission, it failed to pay any interest —
4 that is, it paid \$0 interest — on approximately 18% of claims that were owed interest. That
5 percentage would likely be significantly higher if it included the number of instances in
6 which PacifiCare paid the incorrect amount of interest on claims where interest was owed.

7 **5. The Acts in Violation Were Willful**

8 PacifiCare acted willfully — with a purpose and willingness — in failing to pay
9 statutory interest on these claims. The absence of proper interest was a knowable
10 consequence of paying a claim late and of the willing failure to adequately train and equip its
11 claims personnel. In failing to adequately train and equip its claims personnel, PacifiCare
12 willfully failed to adopt and implement reasonable standards for the prompt investigation and
13 processing of claims. (Exh. 1184, p. 117:3-7.)

14 Whether PacifiCare intended to violate the law or to injure another by failing to pay
15 statutory interest is irrelevant to this determination, as the Regulations make clear.
16 (Reg. 2695.2, subd. (y).)

17 **6. The Issuance, Amendment, or Servicing of the Policy or** 18 **Endorsement Was Not Inadvertent**

19 PacifiCare intended to service each of these claims when it issued payment on them.
20 (Exh. 1184, p. 116:24-26.) There was no inadvertent servicing on these policies.

21 **7. Applicable Unit-Penalty**

22 Mr. Cignarale opined that, in general, an insurer’s failure to pay interest on late-paid
23 claims is “less serious than the average violation,” and should be penalized at 20% of the
24 way from zero to the maximum, or \$2,000 per willful act in violation. (Exh. 1184, p. 114:3-
25 5.)

26 Mr. Cignarale considered the “relative number of claims” factor (Reg. 2695.12,
27 subd. (a)(7)) as slightly mitigating, though he also recognized that PacifiCare’s 82%
28 compliance rate for paying required statutory interest on late-paid claims was

1 “unsatisfactory.” (Exh. 1184, p. 117:16-24.) He also found mitigation in the remedial acts
2 taken (Reg. 2695.12, subd. (a)(8)) and in the harm caused by these violations (Reg. 2695.12,
3 subd. (a)(10)). (Exh. 1184, p. 117:25-118:6.)

4 Mr. Cignarale, however, also found that PacifiCare’s delay in remediating all the
5 claims was an aggravating factor (Reg. 2695.12, subd. (a)(13)). (Exh. 1184, p. 119:3-9.)
6 And Mr. Cignarale determined that under the totality of the circumstances, PacifiCare did not
7 exhibit a good faith attempt to comply (Reg. 2695.12, subd. (a)(12)), considering that factor
8 to be slightly aggravating. (Exh. 1184, p. 118:18-25.)

9 After applying the section 2695.12 factors, Mr. Cignarale found it appropriate to
10 reduce the unit-penalty by at most 15%, from \$2,000 to \$1,700 per act in violation, which
11 results in an aggregate penalty of \$8,831,500 for these 5,195 violations. (Exh. 1184,
12 p. 119:10-14.)

13 **G. Failure to Correctly Pay Claims**

14 **1. Applicable Legal Requirements**

15 Section 790.03, subdivision (h), as further defined by the Regulations, delineates
16 certain minimum standards for the settlement of claims. (Reg. 2695.1, subd. (a)(1).) At the
17 heart of these requirements is that claims be paid in the correct amount. To that end, several
18 provisions of section 790.03, subdivision (h) and the Regulations prohibit insurers from
19 incorrectly paying claims to claimants.

20 For instance, inaccurate claim payments, if committed knowingly or performed with
21 such a frequency as to indicate a general business practice, constitute acts in violation of
22 section 790.03, subdivision (h)(1). Inaccurate payments misrepresent the amount the insurer
23 has agreed to pay for services under a given policy, and the amount for which the patient is
24 responsible — both of which are pertinent facts relating to coverages. Incorrect payments
25 based on an untrue assertion that the provider is out-of-network (or in-network) also
26 misrepresent providers’ participation status, which is a pertinent fact relating to coverage.

27 Incorrect claim payments also violate section 790.03, subdivision (h)(3) because they
28 reflect failures to adopt and implement reasonable standards for prompt investigation and

1 processing of claims arising under insurance policies. Claims that are mispaid are not paid
2 fully and must be appealed and reprocessed before they are fully and correctly paid; that
3 causes such claims not to be promptly processed in violation of this subdivision.

4 They are also violations of section 790.03, subdivision (h)(5) because they are
5 instances of an insurer not attempting in good faith to effectuate prompt, fair, and equitable
6 settlement of claims in which liability has become reasonably clear. A claim that is
7 inaccurately paid represents a settlement of a claim that is unfair and inequitable. Because
8 that claim is not being paid correctly the first time, it is also a settlement of a claim that is not
9 prompt.

10 Regulation 2695.7, subdivision (g) further defines this requirement, prohibiting
11 insurers from “attempt[ing] to settle a claim by making a settlement offer that is
12 unreasonably low.” An insurer’s underpayment of a claim therefore violates this Regulation
13 because it represents an attempt to settle a claim with an unreasonably low settlement offer.

14 **2. PacifiCare’s Violations of Law**

15 **a. PacifiCare’s Admissions of Incorrect Payments**

16 In late 2006, CDI began receiving an influx of provider complaints about a number of
17 issues with PacifiCare’s claims handling. (RT 351:19-25 (Masters).) Among other
18 problems, providers were reporting to CDI that they were being reimbursed at non-
19 contracted rates, that claims checks were being sent to old and outdated addresses, and that
20 PacifiCare was using incorrect provider tax identification numbers to process claims.

21 (Exh. 5, p. 0705; Exh. 7.) Around the same time, providers from the CMA were similarly
22 complaining about PacifiCare’s failure to timely load contracts, to accurately load agreed-
23 upon rates, and to properly reflect providers’ contracted or non-contracted status.

24 (Exh. 1019, p. 7974; Exh. 165, pp. 8506-8507.) These failures resulted in, among other
25 things, claims being paid incorrect amounts.

26 When CDI questioned PacifiCare about these issues in early 2007, the company
27 indicated that it had changed its method of maintaining provider data, but portrayed the
28 changes as “not significant.” (Exh. 7 [see number 8].) The company was not forthcoming

1 about those changes and about what was being done to fix the problems that were resulting in
2 large numbers of incorrect payments. As Ms. Smith wrote to Ms. Henggeler in a March 20,
3 2007, e-mail:

4 “Company statements to date have been rather vague about exactly
5 what system fixes and verifications it has done, and when, regarding the
6 various programming and other system glitches that have led to the claims
7 processing problems post 6/23/06. The company personnel reporting info to
8 us do not seem to interact with their system department nor do they seem
9 familiar with systems procedures.” (Exh. 10, p. 7785; Exh. 7 [see number 8];
10 RT 111:21-112:7 (Smith).)

11 By the time of these inquiries, PacifiCare had conducted a “deep dive” to “review the
12 entire logic” and figure out “what’s going wrong” with EPDE (Exh. 950 [Rao 10:04 a.m.]),
13 but failed to disclose that information to the Department. Two months after CDI asked
14 PacifiCare to explain reports by providers about payments sent to outdated addresses, the
15 company discovered that the problem was caused by a systemic logic mismatch in EPDE,
16 but again failed to inform CDI. (Exh. 917, p. 6489; Exh. 5, p. 0705.)

17 In March 2007, PacifiCare told CDI that “the net financial impact of these three
18 challenges (retro-effective contract loads, fee schedule corrections and demographic errors)
19 is estimated to be approximately \$250K in provider underpayments requiring adjustments.”
20 (Exh. 8, p. 1870.) After CDI staff challenged this figure as unrealistic, the company admitted
21 that the figure did not, in fact, represent the “net financial impact” of those three operational
22 errors. (Exh. 9, p. 0620; Exh. 5348, p. 8450 [see number 4].)

23 When CDI examined PacifiCare’s contract loading processes during the MCE, it
24 found serious deficiencies. For instance, CDI found that the company “failed to institute
25 provider contract upload mechanisms, required as the result of provider contracting efforts,
26 to ensure timely initiation of contract terms. Consequently, provider claims were not
27 processed correctly as the result of delayed uploading.” (Exh. 118, p. 3422 [see number 10].)
28 PacifiCare did not dispute these findings. CDI further found that the company did not record
the dates on which contracts were loaded, and that there were “numerous gaps in date capture
and tracking.” (Exh. 118, pp. 3421-3422 [see number 9].)

1 PacifiCare similarly “acknowledge[d] that many provider contracts were loaded after
2 the effective date.” (Exh. 118, p. 3422.) PacifiCare further admitted that it had not
3 reprocessed all the claims mispaid as a result of contract loading delays:

4 “PacifiCare has admitted it did not consistently address problems in claims
5 adjudication when provider contract uploading was delayed or contracts were
6 back dated. Additionally, PacifiCare cannot verify that all claims submitted
7 prior to contract uploading or contract back date were reviewed for correct
8 payment and interest where applicable.” (Exh. 118, p. 3423.)

9 As a result of PacifiCare’s contract loading delays, claims were incorrectly processed
10 according to an outdated contract or, if the provider had no previous contract with
11 PacifiCare, would be incorrectly paid at non-contracted rates. (RT 2209:22-2210:9
12 (McFann).) This failure resulted in thousands of mispaid claims.

13 Internal correspondence and memoranda uncovered through the course of the hearing
14 further confirm the serious contract loading problems PacifiCare was experiencing during
15 this time. As discussed in above (pp. 44-47, *supra*), PacifiCare’s implementation of the
16 EPDE feed in 2006 resulted in manifold contract loading errors and massive corruption of
17 provider data records at the root of many of PacifiCare’s incorrect claims payments.

18 The company’s EPDE failures are traceable to the slapdash manner in which United
19 chose to implement the EPDE process. According to PacifiCare’s own employees, the
20 company failed to sufficiently test the end-to-end process for EPDE before implementing it.
21 As Mr. Lippincott said in a February 2007 e-mail reflecting on a number of issues that had
22 been identified: “This points out the need to take a more holistic approach to the ‘automated
23 data exchange process’ (of which EPDE is just one component) on future integrations,
24 specifically testing, pushing farther upstream and downstream with our test plans.”
25 (Exh. 921, p. 5189; see also Exh. 759, p. 6084 [“What Needs Improvement”: “Proactively
26 develop scenarios in testing environment . . .”].) As Ms. Berkel testified about the EPDE
27 process: “You know, I don’t know what testing was done. But sure, I would ask for more
28 testing with the benefit of hindsight, yes.” (RT 8231:2-9.)

1 The company also failed to analyze and resolve structural differences between NDB
2 and RIMS before launching EPDE. (Exh. 759, p. 6084; Exh. 1093, p. 12:10-13.) Ms.
3 McFann admitted that the company implemented the EPDE process before understanding
4 differences between NDB and RIMS:

5 “MR. STRUMWASSER: Q. Would you agree, Ms. McFann, that the feeding
6 of the data from NDB to RIMS commenced before United had a clear
7 understanding of these differences in rules with respect to check recipients?

8 A. I think that’s fair to agree to, yes.” (RT 10991:8-12)

9 That failure resulted in serious programming errors that led to claim payment errors.
10 (RT 10845:3-10846:10; 12774:5-12 (McFann); Exh. 917, p. 6488; Exh. 955.) For instance,
11 PacifiCare’s problem with sending reimbursement checks to outdated provider addresses is
12 directly traceable to the company’s failure to understand how the EPDE process would work
13 end-to-end. An internal PacifiCare analysis dated April 12, 2007 — nearly 10 months after
14 the EPDE process had been implemented — revealed the issue:

15 “Whenever there is a change to a provider record in NDB, the entire new
16 record is sent from NDB to RIMS in the nightly update process via the
17 Autoload program. When there are multiple billing address records within
18 RIMS, the EPDE/PHS Autoload program becomes confused and remits the
19 record to the default suffix. Often the default suffix contains an cancelled or
20 termed address.” (Exh. 917, p. 6488.)

21 That analysis further explained:

22 “This issue has potentially existed since June 22, 2006 when the first nightly
23 autoload from NDB to RIMS began. Issues with the EPDE/Autoload program
24 did not surface until approximately January 2007 upon investigation of several
25 returned checks. These issues were thought to be corrected; however, the true
26 root cause was just recently understood.” (Exh. 917, p. 6488.)

27 Internal document further establish that the company lacked “EPDE fee schedule
28 error report management” (Exh. 497, p. 9764 [Feng 1:04 p.m.: see number 2]), had “no
29 documented process flows” for contract loading (Exh. 787); lacked audit steps on fee
30 schedule construction (Exh. 491, p. 1252; RT 5022:4-5023:16 (McFann); RT 10296:4-12
31 (Berkel)), and lacked effective reconciliation measures (e.g., Exh. 977; Exh. 976) —
32 necessary controls that would have prevented many of the data corruption errors that instead

1 persisted for long periods. (Exh. 1093, pp. 10:24-11:19; RT 8247:8-13; 8253:1-25 (Berkel).)
2 Even more fundamental, PacifiCare, by its own account, lacked “a clear process on loading
3 fee schedules, updating cross walks” (Exh. 497, p. 9764 [Feng 1:04 p.m.: see number 2]),
4 which led to further failures in the EPDE process.²⁵

5 PacifiCare exhibited an alarming lack of urgency about remediating these
6 deficiencies. By August 2006, PacifiCare realized that the EPDE process was seriously
7 flawed (Exh. 435, p. 3699; Exh. 953, p. 4704; Exh. 775, p. 2803) and recognized the need for
8 stronger quality controls to prevent data defects, but took no remedial measures for months.
9 (Exh. 759, p. 6084; RT 16305:17-20; 16332:21-16333:22 (Lippincott).) Not until March
10 2007 did PacifiCare begin addressing the logic errors that caused data corruption (Exh. 921,
11 p. 5189 [Rao 5:40 p.m.]; Exh. 916, p. 9427), and it simply ignored known errors in RIMS.
12 (Exh. 956, p. 5196; Exh. 957, p. 8303; RT 16189:21-16190:10 (Lippincott).) PacifiCare
13 promised to remedy its contract-loading deficiencies following the market conduct exam
14

15
16 ²⁵In an apparent attempt to conceal the full extent of PacifiCare’s fee schedule
17 problems, Mr. Lippincott outright misrepresented the period during which the fee schedule
18 crosswalks were being used. On direct examination, Mr. Lippincott testified that while the
19 EPDE feed went live on June 23, 2006, fee schedule crosswalks weren’t deployed until
20 March of 2007. (RT 15006:3-20.)

21 But Ms. Berkel testified, on direct, that fee schedules were in fact being transferred as
22 of June 23, 2006. In reference to an entry on an August 9, 2006, e-mail that said: “Wrong
23 Fee Schedules for Certain CA PPO Providers,” Ms. Berkel explained: “[s]o when we began
24 using the interface on June 23rd, 2006, the interface supplied RIMS with fee schedule
25 numbers. So the interface only sends down the name. That name supplied in the interface
26 was incorrect.” (RT 7492:3-10; Exh. 5256, p. 2468.) Contemporaneous documents further
27 contradict the truth of Mr. Lippincott’s testimony. For instance, in a draft response Ms.
28 Berkel proposed sending to CDI in March 2007, she attempted to explain the company’s fee
schedule errors by reporting that “[w]hen NDB functionality was implemented on June 22,
2006, the older, incorrect fee schedule was updated to RIMS.” (Exh. 622, p. 678.) Other
documents show reworks for dates of service in 2006 that were attributed to the failure to
maintain the fee schedule crosswalk. (Exh. 509, pp. 6804, 6806-6807; see also
RT 10682:24-10683:3; 10861:14-21 (McFann) (admitting that the failure to maintain the
crosswalk resulted in mispaid claims).)

1 (Exh. 118, p. 3423) but had “not corrected our internal control framework” a year later.
2 (Exh. 637 [Berkel 9:52 a.m.])

3 Instead of seeking to correct the EPDE problems, PacifiCare leaders such as Mr.
4 Lippincott, who supposedly owned the end-to-end process, appeared more interested in
5 “trying to clear EPDE’s name” (Exh. 919, p. 5200), complaining about “how EPDE often
6 gets a ‘bad rap’ when there are issues with the entire end to end process” (Exh. 921, p. 5189).
7 As CDI expert Ronald Boeving concluded, efforts to “get issues with the end-to-end process
8 addressed and resolved” were “largely unsuccessful because of the focus on protecting the
9 reputation of the EPDE feed and an apparent reluctance to allocate resources to these quality
10 measures.” (Exh. 1093, p. 10:9-14.) Mr. Boeving opined that Mr. Lippincott’s failure to
11 own the EPDE problems in total and his decision instead to lay blame on components of the
12 process “violate[] the principle of end-to-end responsibility and control” and “makes it
13 impossible to solve problems on a root cause basis.” (Exh. 1093, pp. 9:28-10:3.) Mr.
14 Boeving further testified that “Mr. Lippincott should instead have attempted to accurately
15 identify and *fix* the problems with the end-to-end process.” (Exh. 1093, p. 10:8-9.)

16 The evidence in the record reflects that PacifiCare mispaid at least tens of thousands
17 of claims from 2006 to 2008. First, PacifiCare has admitted that it incorrectly processed
18 3,700 claims based on its failures to properly load provider contracts. (RT 2212:9-18
19 (McFann).) According to PacifiCare, these rework claims affected approximately 1,600
20 providers and required additional payments of around \$200,000 to \$250,000. (RT 207:11-
21 208:7 (Smith); Exh. 8, p. 1870; Exh. 5348, p. 8450 [see number 4].)

22 PacifiCare’s claims data further reflects that at least 78,320 PacifiCare claims that
23 were initially incorrectly paid had to be reprocessed during the MCE review period.
24 (Exh. 1156; Exh. 1165; Exh. 1166 [number of rework claims less claims representing
25 overpayment reimbursements equals 78,320]; Exh. 1167 [same].)

26 In addition, PacifiCare incorrectly paid thousands of PPO claims to the UCSF
27 medical group from January 1, 2006, through March 14, 2008. (RT 4153:13-4154:1
28 (Martin).) PacifiCare admitted that it had mispaid these claims, acknowledging that the

1 company had failed to load the correct fee schedule for that provider group. (RT 4150:11-
2 20, 4152:15-22 (Martin).) In fact, though PacifiCare never disclosed it, the company had
3 been paying UCSF based on the wrong fee schedule going back as far as 2004. Internal
4 PacifiCare correspondence reflect the company's efforts to conceal from UCSF that it had
5 *never even* built the original fee schedule that UCSF had agreed to in 2005. (Exh. 485,
6 p. 4073; RT 11863:23-11864:5 (Harvey).) In a February 2009 e-mail, George Liggett, a
7 United Director of Network Management (RT 4153:9-11), reported that the 2004 fee
8 schedule and the 2007 amendment agreed to with UCSF were not available in RIMS and
9 were never even built by PacifiCare. Mr. Liggett further reported that some UCSF providers
10 were paid according to an incorrect fee schedule, and some were not linked to any fee
11 schedule and therefore were paid at non-contracted rates. As a result, Mr. Liggett explained,
12 PacifiCare made underpayments and overpayments to UCSF providers:

13 “The UCSF MG PHS PPO Fee Schedules that were agreed to in the
14 original document (2004), and subsequent amendment (2007), were not
15 available as FS in RIMS and a request to build the FS was not submitted.
16 F200 was selected as the FS. Additionally not all UCSF providers were linked
17 to the FS so some claims were paid as non-par. As a result of the impact of
18 the FS load and the non-par load of providers, UCSF received both
19 underpayments and overpayments.” (Exh. 485, p. 4073; see also RT 4979:7-
20 25 (McFann).)

21 UCSF, however, was only aware of incorrect payments dating back to January 2006.
22 (RT 4153:13-4154:1 (Martin).) Accordingly, Mr. Liggett recommended to Ms. McFann,
23 Ms. Monk, and other United and PacifiCare employees that the company propose a lump-
24 sum settlement to supposedly “resolve” (the quotations were used by Mr. Liggett in the
25 original e-mail) the incorrect payments that UCSF was aware of — claims with dates of
26 service between 1/1/2006 to 3/14/2008 — “while simultaneously signing a document
27 (drafted by our settlements dept) that indicates that claims for all professional services,
28 including anesthesia that [sic] claims with 3/14/08 and earlier DOS as paid to date were as
both parties had intended and that no additional actions including member actions of any
kind will be taken by either party.” (Exh. 485, p. 4073; see also RT 4984:10-14 (McFann).)

1 Mr. Liggett thus proposed taking advantage of UCSF's ignorance that 2004 and 2005 claims
2 were also wrongly paid to deceive it into agreeing that PacifiCare correctly paid all claims
3 with dates of service before 3/14/08, and into agreeing not to bring any actions against
4 PacifiCare with respect to those claims. In fact, at the very same time, Mr. Liggett was
5 working with UCSF to determine what UCSF claims needed to be included in the settlement,
6 and the parties had concluded that the "correct population of claims ultimately was dates of
7 service from January 1, 2006 to March 14, 2008," even though Mr. Liggett knew full well
8 that PacifiCare had been incorrectly paying claims since at least 2004:

9 "Q. [By Gee] And do you remember when that happened?

10 A. I believe it was later in 2007 Anne Harvey actually, um, referred this
11 matter to George Liggett, who was the Director of Network Management.

12 Q. And how did this process work?

13 A. What George and I discussed was that we would have to isolate the
14 correct population of claims as the first step. And that he would generate
15 reports that would capture what they thought was the relevant population that
16 needed to be part of the reconciliation. And that we would then confirm
17 whether or not we felt that he had captured the right population. And then we
18 would, um, analyze what was actually approved versus what was, um, the
19 correct contract rate that should have been applied. And at some point reach a
20 figure.

21 Q. Ultimately, what did the parties agree was the correct population claims?

22 A. The correct population of claims ultimately was dates of service from
23 January 1, 2006 to March 14, 2008." (RT 4153:8-4154:1 (Martin).)

24 Such negotiating tactics amount to fraud and bad faith. As Mr. Liggett had proposed, a
25 lump-sum settlement was ultimately reached between the parties that covered only claims for
26 dates of service from January 2006 through March 14, 2008. (RT 12669:17-23 (Harvey);
27 Exh. 619.)

28 The number of wrongly paid 2004 and 2005 claims that were never remediated by
PacifiCare is unknown. The number of claims with dates of service from 2006 through
March 14, 2008, is in evidence and is undisputed by PacifiCare. Based on UCSF claims data
produced in response to a subpoena, PacifiCare incorrectly paid 3,124 claims to UCSF, of
which 2,133 were underpayments, and 991 were overpayments. (Exh. 619.)

1 PacifiCare also systematically underpaid thousands of claims to UCLA around the
2 same time, from the beginning of 2007 through March 14, 2008. (RT 3791:7-17 (Rossie).)
3 In response to a request from PacifiCare (RT 3859:9-14 (Rossie)), UCLA produced claim
4 data spreadsheets reflecting that PacifiCare underpaid at least 1,333 claims during that
5 period. (Exh. 613; Exh. 614; Exh. 615; Exh. 616.)

6 **b. PacifiCare’s Subsequent CTN Excuse**

7 In an effort to deflect blame for its poor claims handling, PacifiCare has cited the loss
8 of *United’s* CTN lease with Blue Shield as an excuse for PacifiCare’s failures to accurately
9 pay thousands of its own claims. PacifiCare is all over the map on its loss-of-the-CTN-
10 network defense, which, at bottom, is irrelevant to these violations.

11 For instance, PacifiCare contended at the hearing that Blue Shield’s termination of the
12 CTN lease was “unexpected,” a complete “surprise” that PacifiCare was apparently justified
13 in being unprepared for. (RT 10794:3-9 (McFann); Exh. 5341, p. 7857; RT 624:12-23
14 (Vandepas); Exh. 8, p. 1865.) But, as more fully described above, PacifiCare knew full well
15 that Blue Cross could, at any time on six months’ notice, terminate the CTN network (Exh.
16 758, p. 9291; RT 10791:19-10792:1 (McFann)), and in fact the elimination of the CTN lease
17 was the expected — indeed, intended — result of United’s acquisition of PacifiCare
18 (Exh. 426, p. 9021; RT 4872:15-4873:7 (McFann)). Even before receiving the formal
19 termination notice from Blue Shield, United had plans in place to transition off the CTN
20 network by June 2006. (E.g., Exh. 5343, p. 7737 [see bullet 2 under “Network”].) In fact,
21 according to a legal analysis performed by United’s lawyers and submitted to the Department
22 of Justice in connection with the acquisition, under the terms of the CTN agreement at the
23 time of the acquisition, United would have had to stop using the CTN contract within six
24 months even if Blue Shield did not exercise its termination rights:

25 “If the [CTN] agreement is not terminated (an “Option Event”), subject to
26 BSC’s right of first offer and first refusal, within six months from the
27 acquisition UHG must enter into an agreement to sell the PHS assets that
28 violate the exclusivity provision of the NAA. *See* Transition Agreement
§ 9.3.2. Since UHG is not prepared to sell the PHS assets (*i.e.*, the PHS
provider network), UHG’s access to the CareTrust network will terminate after

1 the PHS acquisition unless the NAA is renegotiated.” (Exh. 758, p. 9291,
2 fn. 7.)

3 Similarly, at the hearing, PacifiCare’s CTN-ate-my-homework defense consisted of
4 unsupported assertions that the CTN transition was a “tremendous undertaking,” requiring
5 the recontracting of 9,000 physicians. (RT 7372:25-7373:2 (Berkel); Exh. 5252, p. 6928.) In
6 reality, contemporaneous documents reflected the company portraying the loss of the CTN
7 network as “not a burning issue for us” and something “we do not want to over emphasize”
8 (Exh. 673, p. 9889), and reporting that “[t]he story [for the CTN transition] is a good one and
9 will only get better for our clients” (Exh. 674, p. 8610 [Kueter 5:30 a.m.]). In June 2006,
10 United further represented that its network “has very little disruption from the CTN” and that
11 “[o]n the actual date of network transition, we anticipate that our customers will have access
12 to substantially identical or even greater numbers of hospitals, specialists and primary care
13 physicians in California.” (Exh. 675, p. 3769.)

14 In fact, Ms. Berkel’s testimony that the CTN transition required the recontracting of
15 9,000 physicians was another PacifiCare misrepresentation. In actuality, United had
16 previously determined that it needed to contract with only about 4,000 of those doctors —
17 those who had actually seen a United member in the past year. United acknowledged that
18 these were the “doctors that truly matter.” (Exh. 676, p. 5921; see also Exh. 629, p. 1966.)

19 Putting aside PacifiCare’s flip-flops, as a matter of logic, the loss of CTN network for
20 United members should have had no negative impact on PacifiCare’s ability to pay its
21 members’ claims. As Ms. Monk admitted on cross, “PLHIC membership did not lose access
22 to CTN providers at that time [of the CTN transition].” (RT 9155:16-17.) Ms. Berkel
23 further testified that “[d]isruption [from the CTN transition] centered on providers needed to
24 fill UHC customer gap from CTN,” and had “by definition, nominal impact on PLHIC.”
25 (Exh. 5252, p. 6928.) PacifiCare’s CTN excuse doesn’t excuse anything. Like all insurers, it
26 is obligated to fully and correctly pay claims to claimants.
27
28

1 provider is out-of-network, patients feel anxious that they will end up owing more money
2 than they had anticipated. (RT 2699:1-8 (K. Griffin).)

3 The harm here was exacerbated by PacifiCare’s dismal customer service. The
4 evidence reflects that members and providers who attempted to contact PacifiCare regarding
5 incorrect payments often found they “couldn’t get anybody to answer the phone” or left
6 repeated messages without return calls. (Exh. 5354 at 8206 [see Dr. Watson]; RT 2668:22-
7 2669:12 (K. Griffin.); Exh. 286 [Harvey 8:55 p.m.].) Customer service staff provided
8 members and providers inaccurate information, improperly instructed callers to resubmit
9 already-submitted documents, and failed to return phone calls. (E.g., Exh. 287, p. 6168
10 [Mimick 5:05 p.m.]; Exh. 349, p. 6624; Exh. 289, p. 6599; Exh. 627, p. 0408; Exh. 5320,
11 p. 8939; Exh. 1033, pp. 5468-5469 [Berkel 12:59 a.m.]; RT 1727:21-1728:7 (Mr. R).)
12 Providers spent an inordinate amount of time pursuing appeals of wrongly denied or
13 improperly adjudicated PLHIC claims, and the lack of timely responses created significant
14 and unnecessary frustration. (E.g., Exh. 1019; RT 2674:15-21; 2668:14-2669:12 (K.
15 Griffin).)

16 As Mr. Wichmann described PacifiCare’s service in 2007: “In two words: We stink.”
17 (Exh. 945, p. 1059 [Wichmann 12:31 p.m.].) He further complained that the company
18 needed to “remediate PHS service which is a complete mess due to poor operational
19 integration.” (Exh. 945, p. 1059 [Wichmann 12:31 p.m.].) Consistent with Mr. Wichmann’s
20 assessment, PacifiCare/United were voted the “least effective and courteous member services
21 department” and the “most difficult to use/navigate” in a 2007 survey of California small
22 group brokers. (Exh. 5265, p. 1950.)

23 3. Number of Acts in Violation

24 PacifiCare has admitted that it incorrectly processed at least 3,700 claims due to
25 problems associated with late-loaded contracts, EPDE errors, and incorrect fee schedules.
26 (RT 2212:12-15 (McFann).) That number represents a small fraction of the total number of
27 mispaid claims during the market conduct period.

1 As discussed above, PacifiCare’s own claims data reflects over 78,000 incorrectly
2 paid claims that were reprocessed during the MCE review period. And PacifiCare wrongly
3 paid thousands more claims from the UCSF and UCLA medical groups. Although the ALJ
4 is not considering these additional claims as separate acts in violation, these uncharged
5 violations should be considered circumstances in aggravation when setting the penalty for the
6 charged violations. (E.g., *Grim, supra*, 53 Cal.3d at pp. 33-34; *Ralph Williams Ford, supra*,
7 30 Cal.App.3d at pp. 499-500.)

8 **4. PacifiCare Knowingly Committed the Acts in Violation, and**
9 **Performed Them with Such Frequency as to Indicate a General**
10 **Business Practice**

11 Insurers are charged with knowledge of the amounts they are supposed to pay and of
12 the amounts they in fact do pay to claimants. (Exh. 1184, p. 94:3-8.) Accordingly,
13 PacifiCare knew or should have known that it was mispaying each of these claims.

14 PacifiCare is further chargeable with knowledge that the integration activities it was
15 undertaking, such as the implementation of the EPDE process, would present an obvious risk
16 of incorrect payment of claims. PacifiCare thus knowingly failed to adopt and implement
17 reasonable standards for the prompt investigation and processing of claims. (Exh. 1184,
18 p. 94:8-11.)

19 Separately, the 3,700 admitted violations — with or without the additional 78,320 and
20 the thousands of UCSF and UCLA incorrect payments that are uncharged but in evidence —
21 represent a frequency sufficient to indicate a general business practice.

22 **5. The Acts in Violation Were Willful**

23 These inaccurate claim payments were part of a purposeful and willing failure to
24 engage in good faith attempts to promptly and fairly pay claims. PacifiCare purposely
25 transferred more responsibility for claims processing to a vendor whose performance was so
26 bad that it was grounds for terminating the contract, and PacifiCare paid that vendor in a
27 manner that created an incentive for sloppy adjudication. The reliance on MedPlans, along
28 with PacifiCare’s implementation of EPDE without adequate testing, training, or quality
controls, reflect a willing failure to adopt reasonable standards for processing claims.

1 It is simply not reasonable to continue to permit claims to be adjudicated by a
2 company that has shown unacceptable performance for several years. Nor is it reasonable to
3 launch a program to change provider data, on whose accuracy appropriate claim adjudication
4 depends, without fully understanding how that program will affect the data and without
5 instituting and maintaining rigorous quality controls to detect errors. Moreover, despite
6 mounting evidence that EPDE was in fact resulting in improper payments, PacifiCare
7 continued to refuse to adopt reasonable standards to correct the existing data or to prevent
8 data corruption in the future.

9 Finally, given the knowledge that these business practices — use of EPDE and
10 outsourcing to MedPlans — were resulting in large numbers of mispaid claims, PacifiCare
11 was apparently willing to continually misrepresent to claimants the amount owed to
12 providers. (Exh. 1184, p. 94:23-95:11.)

13 **6. The Issuance, Amendment, or Servicing of the Policy or** 14 **Endorsement Was Not Inadvertent**

15 There is no evidence of any inadvertent issuance, amendment, or servicing of the
16 policy with respect to these violations. PacifiCare did not inadvertently issue payment on
17 any of the claims at issue here. (Exh. 1184, p. 94:19-20.)

18 **7. Applicable Unit-Penalty**

19 Mr. Cignarale began his analysis of the appropriate unit-penalty by evaluating the
20 severity of this kind of violation, concluding that it is of “average seriousness” compared to
21 the range of violations to which section 790.035 applies:

22 “Paying claims is fundamental to what insurers are expected to do, and failures to pay
23 claims correctly are serious violations. Based on my experience, as a general matter,
24 incorrect payments on claims, whether they are underpayments or overpayments,
25 adversely affect providers. Of course, when claims are underpaid, claimants are not
26 being reimbursed the amounts they are entitled to. This can result in adverse financial
27 consequences. In addition, both underpayments and overpayments can create
28 significant administrative burdens on providers, forcing them, among other things, to
verify the claim payment amounts and to communicate with the insurer about the
claim payment errors. And an incorrect payment can result in the patient having to
pay more than the appropriate amount (for example when the provider is incorrectly

1 treated as out-of-network) or initially pay less than appropriate, resulting in belated
2 billing and potential provider-patient friction.” (Exh. 1184, p. 63:21-64:4.)

3 Consistent with his “of average seriousness” assessment, Mr. Cignarale stated that the
4 starting point for determining the unit-penalty should be 50% above the bottom of the range
5 from zero to the maximum, or \$5,000 for each willful act in violation. (Exh. 1184, p. 85:19-
6 23.) Mr. Cignarale then evaluated the evidence of the specific violations in this case. He
7 identified five factors under which there were grounds for adjustment of his starting point
8 based on evidence of the remaining charged violations, two mitigating and three aggravating.
9 First he explained that the CTN termination did not represent an extraordinary circumstance
10 (Reg. 2695.12, subd. (a)(1)), as that term is defined in the Regulations (Reg. 2695.2,
11 subd. (e)), because the termination was not outside the company’s control. (See RT 2486:3-6
12 (Stead).) The lease was terminated pursuant to a contractual provision that United had
13 agreed to and did not seek to renegotiate. Nor did the termination require the company to
14 renegotiate PLHIC contracts; that effort was undertaken voluntarily. (Exh. 1184, p. 95:14-
15 27.)

16 Mr. Cignarale acknowledged that some of the mispaid claims were related to
17 nonstandard fee schedules and were therefore complex to construct and load. (Reg. 2695.12,
18 subd. (a)(3).) Although the company should not have agreed to any fee schedules it could
19 not abide by, Mr. Cignarale nonetheless viewed this factor as slightly mitigating.
20 (Exh. 1184, p. 96:1-6.) He regarded PacifiCare’s remedial measures (Reg. 2695.12,
21 subd. (a)(8)), as evidence warranting slight mitigation, despite the ineffectiveness and
22 incompleteness of those measures. (Exh. 1184, p. 96:10-21.) Mr. Cignarale concluded that
23 the harm occasioned by PacifiCare’s mispaid claims (Reg. 2695.12, subd. (a)(10)) was
24 greater than in the ordinary case, citing the delay in correcting corrupted provider data and
25 the inadequacy of customer service to resolve payment problems. (Exh. 1184, pp. 96:24-
26 97:5.) Mr. Cignarale opined that PacifiCare’s actions with respect to claims payment
27 accuracy did not demonstrate a good faith attempt to comply with the law. (Reg. 2695.12,
28 subd. (a)(11).) By transferring more claims responsibility to a company with known quality
shortcomings, and deploying EPDE without adequate analysis, testing, or quality control,

1 PacifiCare recklessly invited claims payment errors in its desire to quickly realize synergies.
2 (Exh. 1184, pp. 97:6-98:2.) This is evidence in aggravation. As Mr. Cignarale observed,
3 PacifiCare's management was well aware of facts that apprised the company of violations
4 and the need to take remedial measures. (Reg. 2695.12, subd. (a)(12).) The company could
5 have foreseen, and did foresee, that MedPlans' piece rate payment system would result in
6 sloppy and inaccurate adjudication, and that the transfer of data from NDB to RIMS without
7 thorough analysis and testing would cause widespread claims problems. Not only did
8 PacifiCare display bad faith by failing to prevent these violations, but the company did not
9 timely address them when they arose. (Exh. 1184, p. 98:6-20.) On balance, Mr. Cignarale
10 determined that the evidence supported increasing the unit-penalty by 20%, from \$5,000 to
11 \$6,000 per act in violation. (Exh. 1184, p. 98:21-23.)

12 That recommendation, however, was predicated on the assumption that all 78,320
13 claims mispaid and reprocessed during the market conduct exam (Exh. 1166; Exh. 1167) as
14 well as the thousands of claims mispaid to UCLA and UCSF (Exh. 613; Exh. 614; Exh. 615;
15 Exh. 616; Exh. 619) would be charged and resolved in this proceeding.

16 The tens of thousands of uncharged violations warrant a departure from Mr.
17 Cignarale's recommended penalty for the charged violations. There can be no doubt that the
18 3,700 charged violations vastly understate the extent of PacifiCare's noncompliance in this
19 area. Incorrect rates of payment were the subject of the majority of provider complaints
20 throughout and beyond the MCE review period. (RT 351:19-25 (Masters); Exh. 5004,
21 p. 7576; Exh. 5, p. 0705; Exh. 7; Exh. 165, p. 8506.) The ALJ may consider these uncharged
22 violations as aggravating circumstances when setting the penalty. (E.g., *Grim, supra*, 53
23 Cal.3d at pp. 33-34; *Ralph Williams Ford, supra*, 30 Cal.App.3d at pp. 499-500; see also RT
24 10450:7-22.) The Department contends that the penalty for each charged act in violation
25 should be the maximum provided by statute, \$10,000, commensurate with the large number
26 of uncharged violations and PacifiCare's dishonesty and lack of good faith. This would
27 result in an aggregate penalty for this category of \$37,000,000, which is still far less than Mr.
28 Cignarale's original recommended penalty. (See Exh. 1184, pp. 71:2, 85:1, 99:4.)

1 **H. Failure to Acknowledge the Receipt of Claims**

2 **1. Applicable Legal Requirements**

3 Section 10133.66, subdivision (c) requires that insurers acknowledge to providers
4 when claims are received:

5 “The receipt of each claim shall be identified and acknowledged,
6 whether or not complete, and the recorded date of receipt shall be disclosed in
7 the same manner as the claim was submitted or provided through an electronic
8 means, by telephone, Web site, or another mutually agreeable accessible
9 method of notification, by which the provider may readily confirm the
insurer’s receipt of the claim and the recorded date of receipt within 15
working days of the date of receipt of the claim by the office designated to
receive the claim.

10 “If a claimant submits a claim to a health insurer using a claims
11 clearinghouse, its identification and acknowledgment to the clearinghouse
12 within the timeframes set forth above shall constitute compliance with this
section.”

13 This provision was enacted in 2005 as part of Senate Bill 634 (“SB 634”), which was
14 sponsored by the CMA (Exh. 5679, p. 107 of 310), a non-profit association representing
15 35,000 physicians (Exh. 5448, p. 1, ¶ 2 [Declaration of Long X. Do]). As the Legislative
16 Counsel’s Digest to SB 634 states: “This bill would impose additional requirements on
17 health insurers that enter into contracts with health care providers relative to the processing
18 and payment of claims” (Exh. 5679, p. 27 of 310.) One of those requirements imposed
19 on insurers was that they acknowledge to providers when claims are received within the time
20 and in the manner set forth in section 10133.66, subdivision (c).

21 Specifically, that provision imposes two requirements on insurers. First, they must
22 affirmatively identify and acknowledge to providers the receipt of claims. Second, they must
23 disclose to providers the recorded date of receipt of the claim in the same manner as the
24 claim was submitted or provided.

25 The first phrase of section 10133.66, subdivision (c) — “The receipt of each claim
26 shall be identified and acknowledged, whether or not complete” — requires insurers to
27 identify and acknowledge the receipt of claims, whether those claims are complete or not.
28 Identifying and acknowledging a claim requires an affirmative act. (RT 23568:14-19;

1 23954:2-15 (Cignarale); RT 994:19-995:6; 1004:2-13 (Vandepas).) To comply with this
2 requirement, therefore, an insurer must perform an affirmative act that identifies the claim
3 and that acknowledges the receipt of the claim to the provider. Simply making that
4 information available to providers and imposing the burden on them to contact the insurer to
5 find out if their claims have been received does not identify and acknowledge that a claim
6 has been received within the meaning of the statute.

7 To “acknowledge” a fact or condition is “to recognize,” rights, authority, status, or
8 validity or “to disclose” knowledge or agreement. (Merriam–Webster’s Online Dict. (2012)
9 < <http://www.merriam-webster.com/dictionary>> [as of April 14, 2012] “acknowledge,”
10 definition.) It is synonymous with “admit, agree, allow, concede, confess, fess (up), grant,
11 own (up to)” (*id.*, synonyms) — all affirmative acts that change the status of the
12 acknowledging party. One does not, as PacifiCare would have it (see pp. 229-231, *infra*)
13 acknowledge a claim by standing ready to confirm its receipt if asked, any more than one
14 “admits” or “owns up to” a fact by standing ready to make the concession should someone
15 pose the question. Legal usage is the same. Black’s Law Dictionary defines “acknowledge”
16 as to “own, avow, or admit; to confess; to recognize one’s acts, and assume the responsibility
17 therefore.” (Black’s Law Dict., p. 21, col. 2.) One does not make such an acknowledgment
18 by giving someone one’s phone number and saying “call if you’d like me to own, avow, or
19 admit.” Black’s gives three examples of “acknowledgement”: debts, instruments, and
20 paternity. (*Ibid.*) One does not “acknowledge” a debt by saying “call me if you want me to
21 admit whether I owe the money,” one does not “acknowledge” an instrument by certifying
22 that one stands ready to say in the future whether it was signed; one does not “acknowledge”
23 paternity by professing a willingness to say whether someone is one’s child.

24 The second clause of the statute reads:

25 “and the recorded date of receipt shall be disclosed in the same manner as the
26 claim was submitted or provided through an electronic means, by telephone,
27 Web site, or another mutually agreeable accessible method of notification, by
28 which the provider may readily confirm the insurer’s receipt of the claim and
the recorded date of receipt within 15 working days of the date of receipt of
the claim by the office designated to receive the claim.”

1 Thus, in addition to the requirement to affirmatively identify and acknowledge that the claim
2 is received, insurers must disclose to the provider the recorded date of receipt “in the same
3 manner as the claim was submitted or provided” by the provider. Then, the statute lists
4 examples of the various manners through which the recorded date of receipt may be
5 disclosed, as long as the claim was submitted or provided in that same manner:
6 (1) “electronic means,” (2) “by telephone,” (3) “Web site,” or (4) “another mutually
7 agreeable accessible method of notification, by which the provider may readily confirm the
8 insurer’s receipt of the claim and the recorded date of receipt.” For example, if a claim is
9 submitted or provided through an electronic means, then an insurer may disclose the
10 recorded date of receipt of that claim through that same electronic means. Or, if the insurer
11 and the provider mutually agree to another method of notification, by which the provider
12 may readily confirm the insurer’s receipt of the claim and the recorded date of receipt, then
13 the insurer may disclose the recorded date of receipt through that mutually agreeable
14 accessible method of notification.

15 The legislative history of SB 634 — specifically the final Senate and Assembly bill
16 floor analyses — makes clear that the bill “[r]equires insurers to acknowledge receipt of a
17 claim, in the same manner as the claim was received, within 15 working days of the date of
18 receipt.” (Exh. 5679, pp. 109, 159 of 310; Exh. 684, p. 2 of 4; RT 9325:4-14; 12397:12-
19 19 (Monk); RT 23923:10-19 (Cignarale).) That is to say, if a claim was received by the
20 insurer in paper form, it must be acknowledged in paper form.

21 Similarly, PacifiCare performed its own internal analysis of SB 634 when it was
22 enacted and determined that section 10133.66, subdivision (c) requires insurers to
23 acknowledge the receipt of claims via the same method of receipt of the claims. Based on its
24 analysis of the bill, PacifiCare further concluded that it was required to send to the provider
25 an acknowledgment letter stating that the company received the claim. As is its ordinary
26 practice with new laws and regulations, PacifiCare analyzed SB 634 and generated
27 implementation logs for the bill, which set forth the requirements of the law and the action
28 items that the company believes need to be taken to comply with the law. (RT 8891:12-

1 8892:8; 8893:18-8894:19; 9051:25-9052:3; 12452:11-20 (Monk); Exh. 5316; Exh. 812.)
2 Those implementation logs for SB 634 stated, in no uncertain terms, that to comply with
3 section 10133.66, subdivision (c), “the provider needs to be able to confirm via same method
4 of receipt of claim” (Exh. 5316, p. 7534; RT 9322:12-25 (Monk)), and “[a]n
5 acknowledgment letter stating we received the claim must be sent to the provider” (Exh. 812,
6 p. 7797).

7 Section 790.03, subdivision (h)(2) similarly requires insurers “to acknowledge and act
8 reasonably promptly upon communications with respect to claims arising under insurance
9 policies.” As discussed above, in enacting section 10133.66, subdivision (c), the Legislature
10 set forth the standard for acknowledging and acting reasonably promptly that insurers must
11 follow. That is to say, the Legislature determined that in order to acknowledge and act
12 reasonably promptly within the meaning of section 790.03, subdivision (h)(2), an insurer
13 must, within 15 working days: (i) identify and acknowledge the receipt of each claim; and
14 (ii) disclose the recorded date of receipt in the same manner as the claim was submitted or
15 provided. Failure to comply with those standards set forth by the Legislature constitutes
16 “[f]ailing to acknowledge and act reasonably promptly upon communications with respect to
17 claims,” in violation of section 790.03, subdivision (h)(2).

18 Subdivision (h)(3) also requires insurers “to adopt and implement reasonable
19 standards for the prompt investigation and processing of claims arising under insurance
20 policies.” Section 10133.66, subdivision (c) similarly reflects the Legislature’s
21 determination of what constitutes reasonable standards for the prompt investigation and
22 processing of claims with respect to acknowledging the receipt of a claim. Thus, an insurer
23 that does not comply with section 10133.66’s standards has failed to adopt and implement
24 reasonable standards for the prompt investigation and processing of claims, in violation of
25 section 790.03, subdivision (h)(3).

26 Regulation 2695.5, subdivision (e)(1) further defines section 790.03’s requirement to
27 acknowledge claims:
28

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

3 “(1) acknowledge receipt of such notice to the claimant unless payment is
4 made within that period of time. If the acknowledgement is not in writing, a
5 notation of acknowledgement shall be made in the insurer’s claim file and
6 dated. Failure of an insurance agent or claims agent to promptly transmit
7 notice of claim to the insurer shall be imputed to the insurer except where the
subject policy was issued pursuant to the California Automobile Assigned
Risk Program.”

8 This Regulation requires insurers to acknowledge the receipt of a claim in writing, unless the
9 insurer makes a notation of acknowledgment in the claim file. PacifiCare’s own analysis
10 confirms that Regulation 2695.5, subdivision (e) requires the company to send
11 acknowledgment letters to both members and providers. (Exh. 811; RT 12452:11-12453:16
12 (Monk).) PacifiCare’s implementation log for the Regulations reflects the company’s
13 understanding that the “action items that must be taken by PacifiCare” to comply with the
14 Regulation included “find[ing] out whether for non-participating provider claims, the ack
15 letters are sent to providers and members.” (Exh. 811, p. 7628 [“Action Item” column];
16 RT 12452:11-20 (Monk) [“Action Item” column contains “action items that must be taken by
17 PacifiCare to comply with the regulation or law”].) The log also reflects that in order to
18 comply with the Regulations, the company took actions to ensure that “Ack ltrs [were] sent
19 to members and providers.” (Exh. 811, p. 7628 [“Action Taken” column]; RT 12452:11-20
20 (Monk) [“Action Taken” column contains “actions that have already been taken to comply
21 with the regulation or law”].)

22 **2. PacifiCare’s Violations of Law**

23 **a. PacifiCare’s False Response to CDI’s Request for Data on**
24 **Acknowledgments**

25 During the 2007 MCE of PacifiCare, CDI uncovered tens of thousands of acts in
26 violation of the laws relating to the acknowledgment of claims. In its initial data call, CDI
27 requested that PacifiCare produce data on the dates that the company acknowledged the
28 receipt of claims that were processed during the MCE review period. (RT 11573:13-19

1 (David); Exh. 110, p. 4828 [“The field ‘date ack letter sent’ was requested by the Department
2 to be included, but is not available for reporting at this time.”]; RT 10000:9-15 (Berkel.)
3 PacifiCare responded to this request on September 20, 2007, explaining that those dates
4 were:

5 “not available for reporting at this time” because the “date acknowledgment
6 letters are sent out are not tracked in RIMS, and have to be queried manually.
7 At this time, if the Department chooses to have this information, it can be only
8 provided on an individual claim basis.” (Exh. 110, p. 4828 (emphasis
supplied).)

9 PacifiCare explicitly represented to CDI that acknowledgment letters were being sent during
10 the MCE period, but the dates of those letters could not be provided on an automated basis.
11 PacifiCare claims manager, Ms. Norket, similarly confirmed that this response was
12 representing that “there were acknowledgment letters” during this time, but that PacifiCare
13 could not provide the date of acknowledgment of those letters on an automated basis.
14 (RT 2393:3-8 (Norket); see also RT 633:14-634:14 (Vandepas).)

15 PacifiCare’s response to CDI was false. PacifiCare was unable to provide to CDI
16 dates of acknowledgment not because of how the company tracked that information, but
17 because the company had failed to send acknowledgment letters during that time. PacifiCare
18 knew at the time it issued this false September 20 response that its acknowledgment-letter
19 process was deficient but purposely withheld that information from CDI. In an internal e-
20 mail dated September 19, 2007, PacifiCare employee Suzanne Lookman reported that the
21 company had discovered a “gap” in its process for sending out acknowledgment letters: “It
22 appears that we may have a gap in the current process that will need to be addressed so that
23 ack letters are sent out consistently.” (Exh. 1139, p. 9768.) The problem, Ms. Lookman
24 explained, was that an acknowledgment letter would be generated only if the claim had
25 already been loaded in RIMS; if the claim was in a queue or in the Claims Exchange pre-
26 processing system, a letter would not be generated. (Exh. 1139, p. 9767.)

27 PacifiCare decided to conceal this gap in its acknowledgment process from CDI.
28 Francis Orejudos, the company’s representative responsible for responding to CDI referrals,

1 replied to Ms. Lookman’s September 19 e-mail, copying Ms. Norket, stating that “[a]t this
2 point I would rather not disclose the gap in our process for sending out ack letters, but simply
3 indicate that this data is not available for reporting. If the CDI probes further we can disclose
4 the below information.” (Exh. 1139, p. 9767.) PacifiCare employee Francis Orejudos then
5 proposed sending CDI a response that did not disclose the “gap” and that falsely represented
6 to CDI that acknowledgment letters were being sent but that PacifiCare was unable at that
7 time to provide the date of acknowledgment of those letters on an automated basis:

8 “The field ‘date ack letter sent’ was requested to be included in the Group
9 Claims Denied report, but it cannot be included at this time. The date
10 acknowledgment letters are sent out are not tracked in RIMS, and have to be
11 queried manually. At this time, if the Department chooses to have this
12 information, it can be only provided on an individual claim basis.”
(Exh. 1139, p. 9767.)

13 Mr. Orejudos’s proposed response was accepted by the PacifiCare team and submitted to
14 CDI. (Exh. 110, p. 4828.)

15 Even though CDI did “probe further,” PacifiCare never disclosed the gap in the
16 company’s acknowledgment letter process during the examination process; nor is there any
17 evidence that PacifiCare ever remediated the gap.

18 **b. PacifiCare’s Misrepresentations Regarding Dates of
19 Noncompliance and Promised Corrective Actions**

20 On October 12, 2007, CDI followed up on this issue with a referral requesting that
21 PacifiCare “[p]rovide a description of the measures taken to ensure compliance with CIC
22 § 10133.66(c).” (Exh. 113; RT 642:17-643:5 (Vandepas).) In response, PacifiCare admitted
23 on October 16, 2007, that acknowledgment letters were not being printed from July 2006
24 until January 2007. PacifiCare represented that the failure occurred because its vendor,
25 Duncan, failed to print these letters, and promised that this failure had been addressed with
26 Duncan and would no longer be an issue. (Exh. 113; RT 2340:17-2341:3, 2393:11-22
27 (Norket); RT 643:15-644:5 (Vandepas).) No mention was made of the gap PacifiCare had
28 then recently discovered. (Exh. 113.) Rather, internal correspondence revealed that
PacifiCare decided to purposely withhold additional pertinent information from CDI in

1 responding to this referral. In preparing the company’s response, Ms. Norket determined that
2 the cause of PacifiCare’s failure to send acknowledgment letters was the transition of
3 printing functions from PacifiCare’s internal department to a vendor called Duncan; this
4 transition, Ms. Norket concluded, was undertaken “as part of the UHC acquisition.”
5 (Exh. 149, p. 1026.) She, however, recommended to Jose Valenzuela, who had then taken
6 over responsibility from Mr. Orejudos for responding to CDI referrals, “tak[ing] out the part
7 about ‘as part of the UHC acquisition’ but that’s truly what happened.” (Exh. 149, p. 1026;
8 RT 2344:13-2345:3; 2346:3-10 (Norket); RT 1081:20-1082:6 (Valenzuela).) PacifiCare’s
9 final response to CDI, dated October 16, 2007, withheld that information. (Exh. 113,
10 p. 9893.)

11 PacifiCare’s October 16 response contained additional misrepresentations.
12 (RT 10095:25-10096:3 (Berkel) [“Q. [By Strumwasser] The information that the Company
13 provided the Department in this referral, it proves to be wrong, right? A. Yes, it is not
14 right.”].) First, the period of time — from July 2006 to January 2007 — that PacifiCare
15 represented the acknowledgment-letter process was broken was wrong. At the hearing,
16 PacifiCare admitted that it failed to send any acknowledgment letters to providers for *over*
17 *two years*, from January 1, 2006, when section 10133.66, subdivision (c) became effective,
18 until March 1, 2008. (RT 7877:12-7878:2 (Berkel).) PacifiCare contended at the hearing
19 that the dates in its October 16 response were incorrect because its staff was confused
20 between member and provider acknowledgment letters, and mistakenly provided the dates of
21 noncompliance for member letters. (RT 7705:10-20; 7706:7-18; 10097:2-5 (Berkel).) That
22 explanation is implausible. CDI’s referral clearly requested information about the
23 company’s compliance with section 10133.66, subdivision (c), which pertains to
24 acknowledgment of claims to providers, not members. (RT 10096:14-10097:1 (Berkel).)
25 Certainly, Ms. Norket understood that CDI’s referral was requesting information about
26 provider acknowledgment letters. (Exh. 153 [Norket preparing a sample *provider*
27 acknowledgment letter to submit to CDI]; Exh. 726 [PacifiCare’s submission to CDI of a
28 sample *provider* letter]; RT 10104:11-16 (Berkel) [“Q. [By Strumwasser] So on October 24,

1 less than two weeks after Ms. Norket was confused by member and provider
2 acknowledgment letters in response to [Exhibit] 113, she seems to understand that CDI
3 wants information about provider letters; right? A. Yes.”].)

4 Yet even if PacifiCare’s confusion between member and provider acknowledgments
5 were genuine, it still inexplicably provided incorrect dates for its noncompliance with the
6 member acknowledgment requirement. (RT 10097:6-9 (Berkel).) At the hearing, PacifiCare
7 witnesses admitted that the company had failed to send acknowledgment letters to members
8 from August 2006 until March 13, 2007. (RT 4358:2-7 (Oczkowski); RT 7706:25-7707:13;
9 11284:15-20; 11203:14-23 (Berkel).) In fact, Ms. Norket was informed in March 2007 —
10 approximately seven months before she drafted the company’s October 16 response
11 (RT 2340:17-21) — that Duncan had not been sending out claims acknowledgment letters
12 from July 2007 until March 2007. (Exh. 419, pp. 5408-5409; RT 10098:3-9; 10099:4-9
13 (Berkel).) Ms. Norket knew that the information she provided CDI in the October 16
14 response was wrong, for either member or provider letters.

15 PacifiCare’s October 16 response also falsely represented to CDI that PacifiCare
16 would be “submitting a request on 10/17/07 to have a weekly report generated to ensure
17 acknowledgement letters are sent timely and appropriately, and will allow us to generate
18 reports that link acknowledgement letter dates to claim numbers.” (Exh. 113, p. 9893.) Ms.
19 Norket admitted at the hearing, however, that no such weekly report was ever implemented.
20 (RT 2400:6-13 (Norket).) In fact, shortly after PacifiCare’s October 16 response, Ms. Norket
21 stated in a November 29, 2007, e-mail: “I don’t know why the response said a report had
22 been requested from Duncan. I did not initiate that, which was why I asked the question to
23 Jose on the CAP.” (Exh. 272 [Norket 11:02 a.m.].) Even though Ms. Norket was aware in
24 November that this promise made to CDI had not been kept, she never informed the
25 Department of that fact, and was unaware of anyone at PacifiCare who did. (RT 2400:14-
26 2401:4 (Norket).)

1 (Exh. 117, p. 3409; Exh. 118, p. 3427.) PacifiCare also contended that its “acknowledgment
2 letter process was not in compliance for July 2006 through December 2006,” and admitted
3 that it had violated section 10133.66, subdivision (c) for 81,270 claims. (Exh. 117, p. 3409;
4 Exh. 118, p. 3427.) It further represented that “[a]cknowledgment letters for individual
5 claims were corrected in July 2007.” (Exh. 117, p. 3410; Exh. 118, p. 3427.)

6 Based on PacifiCare’s representations during the MCE that the period that the
7 company’s acknowledgment-letter process was broken was from July 2006 until
8 January 2007, and based on PacifiCare’s admissions, CDI initially alleged 81,270 acts in
9 violation of the law. (Exh. 117, p. 3409; Exh. 118, p. 3427; Exh. 1, p. 3524.)

10 **e. March 2008 Settlement Meeting**

11 In March 2008, PacifiCare representatives met with CDI officials purportedly to
12 disclose the company’s previous misrepresentations regarding its acknowledgment letter
13 violations. Ms. Monk claimed that PacifiCare made a written and oral presentation at that
14 meeting that “provided CDI the exact dates when acknowledgment letters had been turned
15 off and when they had been restarted.” (RT 14629:23-14630:8 (Monk).)

16 That presentation, however, provided confusing and misleading information about
17 PacifiCare’s failures to send provider acknowledgment letters. Nowhere in the written
18 presentation did PacifiCare notify CDI that the company had previously misrepresented the
19 dates of its noncompliance and that the company had in fact failed to send provider
20 acknowledgment letters for over two years. Rather, it consisted of assertions of the
21 company’s compliance with that law (see, e.g., Exh. 817, p. 6518 [“From March 1, 2008 to
22 Current: Acknowledgment letters from the RIMS claims platform are sent within the legally
23 required timeframe.”]) and a misleading chart — titled “Acknowledgment Milestones” —
24 that incorrectly reflected the dates of noncompliance with the provider acknowledgment
25 statute (Exh. 817, p. 6520 [showing that provider acknowledgment letters were sent at all
26 times before June 1, 2006, which is false]).

27 Nor did PacifiCare disclose to CDI the number of claims it failed to acknowledge
28 based on the actual dates of the company’s noncompliance. PacifiCare had previously told

1 CDI that it had violated the acknowledgment statute on 81,270 claims based on the
2 company's false representations that its acknowledgment letter process was broken from July
3 2006 through December 2006. (Exh. 117, p. 3409; Exh. 118, p. 3427.) Even though the
4 period of noncompliance was actually over two years, from January 2006 to March 2008,
5 PacifiCare did not at that March 2008 meeting inform CDI of the actual number of
6 acknowledgment violations, and indeed has refused to correct that false representation to this
7 day. On the contrary, PacifiCare represented at that March 2008 meeting, as it does at this
8 hearing, that its web portal makes it compliant with the acknowledgment statute. (Exh 817,
9 p. 6516 ["Compliance with CIC 10133.66 — Acknowledgment Through Provider Portal"];
10 RT 14641:7-10 (Monk).) That representation was also false. As discussed below, PacifiCare
11 witnesses have admitted on cross examination that the company's portal does *not* satisfy the
12 requirements of the acknowledgment statute. (E.g., RT 8029:12-8030:9 (Berkel);
13 RT 14641:20-14642:1 (Monk).)

14 **f. PacifiCare's Positions at the Hearing**

15 Ms. Norket testified at the hearing in January and February 2010. She continued to
16 assert that acknowledgment letters were being sent beginning in February 2007:

17 "[By Strumwasser:] As far as you know, were acknowledgment letters sent out
18 in February 2007?

19 "A. That was the understanding that I had." (RT 2433:6-9.)

20 "Q. [By Strumwasser] To the best of your knowledge, when was the issue of failure
21 to send acknowledgment letters resolved?

22 "MR. VELKEI: Objection, vague.

23 "THE COURT: Overruled. Do you understand?

24 "THE WITNESS: You're referring to actual hardcopy acknowledgment
25 letters, correct?

26 "MR. STRUMWASSER: Q. Yes.

27 "A. From my understanding, when this was identified as an issue, they should
28 have started printing and being mailed in February of 2007. That's what I was
told." (RT 2437:18-2438:5.)

That testimony was false and misleading. Ms. Norket knew long before she testified that
neither member nor provider acknowledgment letters were being sent as of February 2007.

1 As discussed above, she was informed in March 2007 that member letters were not being
2 sent until March 2007 (Exh. 419, pp. 5408-5409), and she was aware in February 2008 that
3 provider acknowledgment letters had not been sent at any time from 2004 until February
4 2008. (Exh. 729.) Having been the person at PacifiCare responsible for the company’s
5 previous misrepresentations in its responses to CDI referrals — and if, as Ms. Berkel later
6 contended, Ms. Norket had simply been confused between member and provider letters when
7 she was responding to CDI’s referrals — it was incumbent on Ms. Norket to disclose the
8 accurate dates of PacifiCare’s noncompliance with respect to both member and provider
9 acknowledgments; instead, she continued to mislead CDI into thinking that all
10 acknowledgment letters were sent beginning in February 2007.

11 When Ms. Berkel testified in June 2010, she admitted that PacifiCare had failed to
12 send provider acknowledgment letters from January 2006 until March 1, 2008 (RT 7877:12-
13 7878:2; 7880:6-9), and had failed to send member acknowledgment letters from around
14 August 2006 until March 13, 2007 (RT 7706:25-7707:13; 11284:15-20; 11203:14-23). She
15 contended, however, that even though the acknowledgment-letter process was broken during
16 these periods, the company was complying with the law by maintaining a web portal and a
17 customer service telephone number. (RT 7687:15-7688:1; 7692:8-19; 7694:10-16; 8024:1-
18 15; Exh. 5252, p. 6949.) In taking that position, PacifiCare was backtracking on its previous
19 admissions that the company “is required to send an acknowledgment letter for claims
20 received, if the claim is not otherwise acknowledged by payment and/or issuance of an EOB
21 within 15 calendar days”; that the “acknowledgment letter process was not in compliance for
22 July 2006 through December 2006”; and that it had violated section 10133.66,
23 subdivision (c) for 81,270 claims (Exh. 117, p. 3409; Exh. 118, p. 3427).

24 PacifiCare’s new position is that section 10133.66, subdivision (c) permitted insurers
25 to passively “acknowledge” the receipt of claims by simply making that information
26 available if providers requested it. This position is directly contrary to PacifiCare’s prior
27 analysis that the law required insurers to send acknowledgment letters to providers.
28 (Exh. 812, p. 7797 [“An acknowledgment letter stating we received the claim must be sent to

1 the provider”].) PacifiCare further contended that its website and telephone line satisfied
2 section 10133.66, subdivision (c) for paper claims, even though the language of the statute,
3 the legislative history of the bill, and, again, PacifiCare’s own analysis of the law all make
4 clear that claims must be acknowledged in the same manner as they are received.

5 (Exh. 5679, pp. 109, 159 of 310 [the bill “[r]equires insurers to acknowledge receipt of a
6 claim, in the same manner as the claim was received”]; Exh. 684, p. 2; Exh. 5316, p. 7534
7 [“the provider needs to be able to confirm via same method of receipt of claim”].)

8 PacifiCare witnesses have since admitted that even under this new interpretation of
9 section 10133.66, subdivision (c), the company’s website does not satisfy the requirements
10 of the statute. First, Ms. Berkel admitted on cross examination that PacifiCare’s website was
11 not accessible to providers that were not contracted with PacifiCare. (RT 8029:12-15
12 (Berkel).) The statute, of course, requires insurers to acknowledge the receipt of claims from
13 *all* providers, not just PacifiCare-contracted providers. Ms. Berkel further admitted on cross
14 examination that the website did not provide information about the status of a claim until the
15 claim was fully adjudicated in RIMS; no information was available on PacifiCare’s website
16 for a claim still in a processing queue, or in Claims Exchange, or in the process of being
17 adjudicated in RIMS. (RT 8029:12-8030:9 (Berkel).) Thus, even contracted providers could
18 use PacifiCare’s website to review the status of a claim only after the claim was fully
19 adjudicated, at which time the provider would likely have already received an EOB or some
20 other notice of the company’s adjudication for the claim. So the only claims that can be
21 viewed on the website are those that no longer need to be acknowledged. Ms. Monk further
22 admitted that even after a claim was fully adjudicated in RIMS, the company’s website did
23 not provide information on the date that the claim was received (RT 14641:17-114642:1
24 (Monk)), as section 10133.66, subdivision (c) requires insurers to disclose. Thus,
25 PacifiCare’s representations to CDI that the company’s web portal made it compliant with
26 the acknowledgment law were false.

27 The purported availability of PacifiCare’s telephone line also does not satisfy
28 section 10133.66’s requirements. As discussed above, PacifiCare does not affirmatively

1 identify and acknowledge claims by phone, but rather imposes on the provider the burden of
2 calling the company in order to determine whether a claim has been received. In addition to
3 the fact that this does not comply with the law, PacifiCare never informed providers that they
4 must call the company's phone number in order to get information about when claims have
5 been received. Instead, PacifiCare has pointed to the fact that its number was available on
6 the back of member identification cards, and on certain materials that vaguely informed the
7 provider that general claims information was available by phone, apparently expecting that
8 providers would divine that they must call that number in order for PacifiCare to
9 acknowledge the receipt of claims. (Exh. 5135; RT 9365:25-6 (Sing) [admitting that nothing
10 on the member identification card informs providers that they can verify receipt of claims by
11 calling PacifiCare's phone number]; Exh. 5240; RT 9367:14-21 (Sing) [admitting that
12 nothing in the provider manual, which is only available to contracted providers, informs
13 providers that they may verify receipt of claims by calling number]; Exh. 5346.)

14 PacifiCare has not offered any testimony about, and does not appear to have
15 performed any analysis to determine, the root cause of its failure to send provider
16 acknowledgment letters. Internal PacifiCare documents that CDI reviewed and introduced at
17 the hearing indicate that PacifiCare intended to send these provider letters at least as early as
18 2004, but failed to do so because its claim system was set up incorrectly. (Exh. 727;
19 Exh. 729.) Apparently a parameter in the RIMS setup contained an "N" instead of the "Y"
20 that was required to generate the acknowledgment letters. No explanation was provided for
21 why PacifiCare didn't detect this failure for over four years. According to internal
22 PacifiCare documents, the persons responsible for the project to create provider
23 acknowledgment letters were unsure why this was setup incorrectly and why it wasn't caught
24 in testing. (Exh. 729 ["I contacted Jenny B. Cheng about the project in 2004. She said the
25 intent was to create an ack letter to the provider however it was probably Pam Eddy's
26 responsibility to turn on the function in the system. She was unsure why this wasn't done or
27 caught in testing. Failure to set the field from 'N' to 'Y' was obviously an oversight."].)

1 As to the member acknowledgment letters, PacifiCare has conceded that its failure to
2 send those letters for approximately eight months was caused by its outsourcing of certain
3 printing functions to a vendor called Duncan Printing Services. (Exh. 113; RT 7706:19-
4 7707:5 (Berkel).) In the transition of these functions to Duncan, Duncan repeatedly
5 recommended to PacifiCare that it invest in certain tools, such as Duncan’s Print Tracking
6 and Reconciliation System and the CodeLite program. (Exh. 412; Exh. 413; Exh. 415; RT
7 4339:2-19 (Oczkowski); Exh. 423, p. 5049; RT 4368:20-4369:2 (Oczkowski).) Jeffrey
8 Oczkowski, PacifiCare’s designated person most knowledgeable about Duncan issues,
9 testified that these tools would have allowed PacifiCare to track the documents that were sent
10 to Duncan. (RT 4336:15-4337:21 (Oczkowski).) Without those tools, PacifiCare faced
11 significant risks, such as “loss of data, [protected health information] breach, not meeting
12 timeframes as well as not being able to track mail if there is a disaster.” (Exh. 415, p. 6078;
13 RT 4348:10-25 (Oczkowski).)

14 But PacifiCare never implemented those tools. (Exh. 415, p. 6078; RT 4379:11-15
15 (Oczkowski); RT 1064:5-1065:2 (Berkel).) In fact, years after the transition, Duncan
16 employees were still complaining that they were unable to find anyone at PacifiCare to work
17 with them to implement these tracking tools. Following a 2008 internal company audit of
18 Duncan, United employee Kathleen Nichols reported: “Since PHS changed from IBM as
19 their print source in 2006 to Duncan, Duncan has not been able to find a person, department
20 from PHS that would be able to work with them to transfer the files to their systems.”
21 (Exh. 415, p. 6078 [Nichols 6:21 a.m.].) As Mr. Oczkowski testified: “Many people had left
22 PacifiCare. They weren’t there anymore. So there was no one there to work with us.” (RT
23 4349:1-16 (Oczkowski).)

24 Mr. Oczkowski testified that had PacifiCare implemented these monitoring and
25 tracking tools, the company would have detected the issue with the member acknowledgment
26 letters sooner. (RT 4369:13-21 (Oczkowski) [“We would have caught it sooner, yes.”]; Exh.
27 423, p. 5049; see also RT 10122:2-13 (Berkel).)

1 PacifiCare offered Valerie Bigam, a medical billing administrator at a managed
2 billing services organization, who testified that she personally doesn't want and doesn't use
3 acknowledgment letters. (RT 14953:13-14954:12.) But as Mr. Cignarale testified,
4 "[t]hat PacifiCare presented one witness to testify that her company doesn't want or use
5 acknowledgment letters does not mean that that is the view of all providers. The fact that the
6 Legislature saw fit to impose this requirement, and the fact that it did so in part at the behest
7 of representatives of providers, precludes the Department from treating it as if disobedience
8 is harmless." (Exh. 1184, p. 129:3-7.)

9 Some providers use acknowledgment letters, and some do not. Some providers find
10 receiving acknowledgment letters useful, and some do not. It is not up to PacifiCare to
11 declare violations of duly enacted laws harmless and, on that basis, to assert immunity.
12 Indeed, as PacifiCare's own expert testified, independent of the harm to the consumers,
13 violations of law cause harm to the regulatory process. (RT 21743:23-21744:7 (Kessler); see
14 also Exh. 1184, p. 129.) This harm is greater when, as here, the violator is unrepentant and
15 makes repeated misrepresentations in an attempt to conceal the full extent of the violations.

16 **3. Number of Acts in Violation**

17 Based on PacifiCare's representations during the MCE that the period that the
18 acknowledgment-letter process was broken was from July 2006 until January 2007, and
19 based on PacifiCare's admissions, CDI initially alleged 81,270 acts in violation. (Exh. 117,
20 p. 3409; Exh. 118, p. 3427.) At the hearing PacifiCare produced additional data for claims
21 paid during the MCE period, from June 23, 2006 to May 31, 2007. Among other things,
22 these new data identified which claims were submitted by paper and which by EDI.
23 (Exh. 5252, p. 6950.) Because PacifiCare has contended that claims submitted to it by EDI
24 claims were electronically acknowledged, which claim CDI has not contested, CDI used
25 these new data to exclude EDI claims from its count of acknowledgment violations. CDI
26 also excluded claims paid within 15 working days.

27 Based on PacifiCare's data and on PacifiCare's testimony, CDI has determined that
28 during the MCE review period, PacifiCare received 41,970 group claims that were submitted

1 by providers, that were paper claims, and that were not processed within 15 working days
2 (RT 10146:4-10; 10147:13-15 (Berkel); Exh. 731, p. 1; Exh. 733; Exh. 1180; Exh. 1181,
3 p. 1) and 13,505 individual claims that were submitted by providers and that were not
4 processed within 15 working days (RT 10146:16-20; 10147:13-17 (Berkel); Exh. 731, p. 1;
5 Exh. 733; Exh. 1180; Exh. 1181, p. 2). For each of these 55,475 claims, PacifiCare was
6 required to send an acknowledgment letter, but failed to do so. (See also Exh. 5252, p. 6950
7 [Total Claims Paid (1,119,599)-(Claims Paid within 15 Working Day (1,016,700) + All
8 Other EDI Paid Claims (47,417)) = 55,482.]

9 PacifiCare's data and testimony at hearing also revealed that during the MCE review
10 period, PacifiCare received 688 group claims that were submitted by members, that were
11 paper claims, and that were not processed within 15 calendar days (Exh. 1180; Exh. 1181, p.
12 3; Exh. 731, p. 2 [901 "RIMS Paper After 15 CalDays No Ack Letter Sent"]; RT 10144:1-15
13 (Berkel) [901 paper claims paid after 15 calendar days]), and received 300 group claims that
14 were submitted by members, that were paper claims, and that were not processed within 15
15 calendar days (Exh. 732; Exh. 733; Exh. 731, p. 2; RT 10143:6-22 (Berkel); Exh. 1180;
16 Exh. 1181, p. 4). For each of these 988 claims, PacifiCare was required, but failed, to send
17 an acknowledgment letter.

18 CDI also requested, but was denied, additional data sufficient to determine the
19 number of paper claims for which PacifiCare failed to send provider acknowledgment letters
20 from January 1, 2006, to June 22, 2006, and from June 1, 2007, through February 29, 2008.
21 (Exh. 664; RT 10450:7-17 (Berkel).) Accordingly, there are an unknown number of
22 additional acknowledgment violations during these periods that CDI has not alleged. The
23 number of such uncharged violations can reasonably be estimated. Based on the 55,475
24 violations during the 342-day MCE period (approximately 162 per day), it is reasonable to
25 infer that there are over 67,000 additional violations in the 172 days from June 1 to June 22,
26 2006, and the 243 days from July 1, 2007, to February 29, 2008. These uncharged violations
27 may be considered circumstances in aggravation when setting the penalty for the charged
28 violations. (E.g., *Grim, supra*, 53 Cal.3d at pp. 33-34; *Ralph Williams Ford, supra*, 30

1 Cal.App.3d at pp. 499-500; see also RT 10450:7-22 (Berkel) [remarks of ALJ recognizing
2 that failures to send acknowledgment letters during these periods could be considered an
3 aggravating factor that would potentially increase the per-violation penalty for the charged
4 violations].) Given that the uncharged violations took place over a longer period than the
5 MCE period, likely resulting in the actual number of violations being more than double the
6 number charged, a significant enhancement to the penalty for the 56,463 violations charged
7 is in order. However, the Department proposes that in this case the uncharged violations
8 simply serve as additional support for the penalty Mr. Cignarale has recommended.

9 **4. PacifiCare Knowingly Committed the Acts in Violation, and**
10 **Performed Them With Such Frequency as to Indicate a General**
11 **Business Practice**

12 Under Regulation 2695.2, subdivision (l), an act is “knowingly committed” if
13 “performed with actual, implied or constructive knowledge, including, but not limited to, that
14 which is implied by operation of law.” PacifiCare is chargeable with knowledge of the
15 actions it has and has not taken, and with the contents of its records. There can be no doubt
16 that PacifiCare had implied and constructive knowledge of its failure to issue
17 acknowledgment letters. (§ 790.03, subd. (h); see Exh. 1184, p. 126:16-18.) It is more than
18 reasonable to expect that an insurer knows, or should know, what correspondence is or is not
19 being sent on its behalf. PacifiCare has offered no excusable explanation for why it didn’t.

20 Of course, were there a need to look for a general business practice, 55,475-plus acts
21 in violation, occurring over the course of several years, are certainly sufficiently numerous to
22 indicate such a practice. In addition to that indirect evidence of a general business practice,
23 there is undisputed direct evidence here that these violations were performed pursuant to a
24 general business practice of PacifiCare. The bulk of the violations arose from an improperly
25 coded parameter in RIMS. The pertinent “business practice” for this purpose concerns the
26 manner in which the company customarily processes claims and discharges its
27 acknowledgment obligations. PacifiCare processed its claims on RIMS, and the general
28 business practice is literally coded into the RIMS logic. The insertion of an “N” that turned
off the sending of acknowledgments (Exh. 727, p. 2408; Exh. 729) established the general

1 business practice of not acknowledging provider paper claims. Similarly, the absence of a
2 process to print member acknowledgments (Exh. 113; RT 7706:19-7707:5 (Berkel)) was the
3 company’s general business practice leading to the violations during the period in which no
4 such letters were being printed, “which produce[d] consistent non-compliant results.”
5 (Exh. 1184, p. 126:16-20.) These acts in violation were both knowingly committed and were
6 consistent with PacifiCare’s general business practice. (§ 790.03, subd. (h).)

7 **5. The Acts in Violation Are Not Being Charged As Willful**

8 The bulk of the acknowledgment violations, the 55,475 provider claims, have been
9 traced to what might be called a single typographical error, the insertion of an “N” value in
10 the relevant RIMS parameter. (Exh. 727; Exh. 729.) While “PacifiCare should have known
11 that acknowledgment letters were not being sent out long before it discovered this failure,”
12 Mr. Cignarale was prepared to treat the acknowledgment violations as non-willful acts.
13 (Exh. 1184, p. 127:20-27.)

14 **6. The Issuance, Amendment, or Servicing of the Policy or**
15 **Endorsement Was Not Inadvertent**

16 These violations do not involve the issuance, amendment, or servicing of a policy.
17 The violation lies in the *failure* to acknowledge claims. One does not “service” a policy by
18 failing to take action the law requires — not as the word “servicing” is used in the insurance
19 industry and not in common language. As there was no servicing at all, there is no question
20 whether there was “inadvertent servicing.” (Exh. 1184, p. 126:26-27.)

21 Were it asserted that the failure to take required action represented “servicing” of a
22 policy, the question whether that failure was inadvertent would be a closer question. It may
23 be the case that PacifiCare’s error in entering an “N” instead of a “Y” in RIMS may have
24 been the result of a simple mistake back in 2004 when it was initially set up from which the
25 failures immediately thereafter might be said to be inadvertent. But for years, PacifiCare
26 failed to detect that it was not sending out provider acknowledgment letters. Multiple events
27 over the next four years should have caused PacifiCare to detect this failure, such as the
28 enactment of SB 634 in 2005, which PacifiCare concluded required it to send

1 acknowledgment letters to providers, and CDI's referrals during the MCE that specifically
2 requested information about PacifiCare's compliance with section 10133.66, subdivision (c).
3 As Mr. Cignarale testified, "PacifiCare's failure to send required acknowledgment letters to
4 providers for an approximately four-year period was the result of a reckless disregard for
5 compliance with the law that cannot be called simple 'inadvertence.'" (Exh. 1184,
6 p. 127:11-13.)

7 And certainly by September 19, 2007, PacifiCare was aware that it was committing
8 daily acts in violation of section 790.03 for failing to issue acknowledgments (Exh. 1139,
9 p. 9768) and, in fact, was actively concealing that fact. By December 7, 2007, the company
10 had admitted its duty to issue acknowledgment letters and its breach of that duty (Exh. 117,
11 pp. 3409-3410; Exh. 118, p. 3427) — albeit while misrepresenting the extent of the breach
12 — yet it did not actually issue acknowledgment letters to providers until March 1, 2008. (RT
13 7877:12-7878:2; 7880:6-9 (Berkel).)

14 **7. Applicable Unit-Penalty**

15 In formulating his recommendation for the appropriate penalty for the
16 acknowledgment violations, Mr. Cignarale started with the inherent severity of such acts,
17 compared to the range of violations subject to section 790.035. He explained:

18 "In comparison to the range of violations to which section 790.035
19 applies, I view failing to send acknowledgement letters for paper claims as less
20 serious than the average violation. As a general matter, it is not as serious as
21 violations that could cause a patient to be 10 denied medical care or as serious
as violations of the duty to correctly and timely pay claims."

22 "Failing to send acknowledgement letters can create administrative
23 burdens. For instance, claimants may be forced to track down whether and
24 when their claims were received by the insurer. Such failures also may make it
25 difficult for claimants to determine whether the insurer paid the appropriate
26 interest on late-paid claims. In some instances, claimants not having received
confirmation that their claims were received will send in an additional copy of
the claims. This practice further increases administrative burdens on both the
claimant and the insurer." (Exh. 1184, p. 120:7-17.)

1 He concluded that as a general proposition, such violations warrant initial placement 20% of
2 the way from zero to the maximum, or \$1,000 for a non-willful act. (Exh. 1184, p. 120:18-
3 22.)

4 Mr. Cignarale then considered each of the applicable factors enumerated in
5 Regulation 2695.12, subdivision (a). He found significant aggravation in the absence of
6 good faith (Reg. 2695.12, subd. (a)(11); Exh. 1184, p. 129:10-27) and in management
7 awareness and failure to take action (Reg. 2695.12, subd. (a)(13); Exh. 1184, p. 130:5-21).
8 Mr. Cignarale was particularly concerned about the multiple misrepresentations to CDI made
9 by PacifiCare during the MCE: These reflect “bad faith” by the insurer and an intent “to
10 conceal to full extent of PacifiCare’s noncompliance.” (Exh. 1184, pp. 12-16.) He also
11 found the high number of acts to be an aggravating factor (Reg. 2695.12, subd. (a)(7);
12 Exh. 1184, p. 128:10-18). He found nothing in the degree of harm or the frequency and
13 public detriment different from the generic acknowledgment violation and therefore
14 concluded that neither of those factors were aggravating or mitigating. (Reg. 2695.12,
15 subds. (a)(10) & (a)(13); Exh. 1184, pp. 129:1-9, 130:1-4.) He found slight mitigation in the
16 eventual taking of remedial action. (Reg. 2695.12, subd. (a)(8); Exh. 1184, p. 128:19-26.)
17 None of the other subdivisions of Regulation 2695.12, subdivision (a) were applicable.

18 Taken together, Mr. Cignarale found the 2695.12 factors to call for a significant
19 increase in the unit-penalty:

20 “On balance, I find that these factors represent a set of circumstances that are
21 significantly aggravating, as compared to the generic acknowledgment
22 violation. In particular, based on PacifiCare’s repeated misrepresentations to
23 and lack of candor with the Department; based on the length of time that these
24 violations persisted without PacifiCare detecting and remediating them; and
25 because there are likely a significant, but unknown, number of unalleged
26 violations, I think it appropriate to increase the per violation penalty by at least
27 50%, from \$1,000 to \$1,500 per act in violation.” (Exh. 1184, p. 130:22-28.)

28 He then made the declining-unit-penalty adjustment for the relatively large number of
violations. (Exh. 1184, pp. 48:20-49:15, 131:1-6.) The resulting aggregate penalty for this
category is \$79,607,250, or an average of \$1,410 per act in violation, about 23% of the range

1 for non-willful violations. The Department submits that this is the appropriate penalty for
2 the 56,463 acts in violation of section 790.03.

3 **I. Failure to Timely Respond to Provider Disputes**

4 **1. Applicable Legal Requirements**

5 Section 10123.137 requires insurers to establish a “fast, fair, and cost-effective
6 dispute resolution mechanism” available to both contracted and non-contracted providers.
7 (§ 10123.137, subd. (a).) That section further sets forth the requirement that insurers “shall
8 resolve each provider dispute consistent with applicable law and issue a written
9 determination within 45 working days after the date of receipt of the provider dispute.”
10 (§ 10123.137, subd. (c).)

11 Section 10123.137 thus reflects the Legislature determination that an insurer must
12 issue a written determination within 45 working days of receipt in order to “acknowledge and
13 act reasonably promptly” to a provider dispute, as required by section 790.03,
14 subdivision (h)(2). It similarly reflects the Legislature’s determination that a provider
15 dispute over a claim must be resolved within 45 working days in order to constitute the
16 “prompt investigation and processing of claims,” as required by section 790.03,
17 subdivision (h)(3).

18 Failures to respond to provider disputes within 45 working days therefore constitute
19 acts in violation of section 790.03, subdivisions (h)(2) and (h)(3) and section 10123.137,
20 subdivision (c).

21 **2. PacifiCare’s Violations of Law**

22 **a. Complaints of PacifiCare’s Violations and CDI’s
23 Investigation**

24 Beginning in November 2006, CDI began noticing a significant spike in complaints
25 from providers complaining about underpayments, improper denials, and the “frustration of
26 trying to work with PLHIC and their provider dispute program and not being able to get a
27 resolution.” (RT 349:21-350:4; 351:21-352:2 (Masters); Exh. 18.) By early 2007, the CMA
28 had also raised concerns with CDI about PacifiCare’s wholly deficient provider dispute
program: providers’ attempts to address their claim disputes had “fallen on deaf ears” and it

1 appeared that “there has been no effort to comply” with section 10123.137. (Exh. 165, pp.
2 8511-8512; see also Exh. 1019.)

3 PacifiCare’s own data confirms this sudden breakdown in processing provider
4 disputes. Though PacifiCare received no PPO provider disputes in June 2006 and only five
5 in July 2006, suddenly, in August — around the time several of United’s integration
6 activities were being implemented, such as the transferring of claim processing to MedPlans,
7 the use of EPDE to maintain provider data in RIMS, and the transition of mail routing to
8 Lason — provider disputes filed against PacifiCare rose to 226, then more than doubled the
9 next month to 575, and by October well exceeded 1,000. The number of disputes continued
10 to rise at a similarly alarming rate, ending up with more than 3,000 disputes in May 2007.
11 (Exh. 5046, p. 2229.) PacifiCare did not provide data beyond May 2007.

12 Given all the problems PacifiCare was having with provider disputes, CDI made a
13 simple request in January 2007 for information about PacifiCare’s internal guidelines for
14 processing such disputes. (Exh. 4, p. 7941 [“The Department requested information showing
15 compliance with SB 367 related to provider grievance process as a result of Dani Collier’s
16 January 25, 2007 response to the Department.”].) CDI made several additional requests
17 throughout February (Exh. 5, p. 0706 [Agenda #10]; Exh. 7 [see number 10]), but PacifiCare
18 continually failed to provide responsive information.

19 An internal e-mail, dated April 30, 2007, revealed that PacifiCare recognized at that
20 time that it needed to make “a number of changes” to its PDR policies and procedures “to be
21 in compliance with the law.” (Exh. 749, p. 2283 [number 6].) It wasn’t until June 13, 2007
22 — over four months after CDI had requested them, and apparently after PacifiCare had made
23 those “number of changes” to bring them into compliance with the law — that PacifiCare
24 finally produced copies of these procedures, without any mention that these procedures had
25 been updated or that the prior process was, by PacifiCare’s own account, noncompliant.
26 (Exh. 17, p. 7377; Exh. 5438, p. 4441.)

27 CDI examined PacifiCare’s provider dispute resolution (“PDR”) process during the
28 MCE and found serious deficiencies in many aspects of that process. Of 96 provider dispute

1 files the Department reviewed (Exh. 1, p. 3510), it found that PacifiCare had failed to issue a
2 written determination within the statutory period in 14 instances (Exh. 1, p. 3517); a number
3 of PacifiCare’s responses were late by many months. (E.g., Exh. 116, pp. 1331 [claim
4 number 19916317, 10-month delay to pay claim]; 1332 [claim number 19079205, over 9-
5 month delay to pay claim]; 1333 [claim number 19116747, over 9-month delay to pay
6 claim]; 1337-1338 [claim number 19762906-01, 10-month delay to pay claim]; 1345
7 [19512078-01, 127-day delay to pay claim].) CDI also found several instances in which
8 PacifiCare never even responded to the provider dispute. (E.g., Exh. 116, pp. 1328-1329
9 [claim number 4913865-0-9]; 1333 [claim number 19174954]; 1333-1334 [claim
10 number 19452834]; 1339-1340 [claim number 18929522-01].) For other disputes,
11 PacifiCare failed to record the receipt date, making it impossible to track the timeliness of the
12 company’s response. (E.g., Exh. 116, pp. 1322 [claim number 4905006-0-16]; 1344 [claim
13 number 19572969-01].)

14 During the exam, PacifiCare further admitted that it had received 16,563 provider
15 disputes during the MCE review period, and had failed to timely respond to 1,510 of those
16 disputes. (Exh. 1, pp. 3517-3518 [“Thus there were actually 1,510 disputes during the
17 window period that did not receive a written determination within 45 working days after the
18 dispute was received.”]; Exh. 118, p. 3418; RT 695:25-696:16 (Vandepas).)

19 **b. Root Causes of PacifiCare’s Violations**

20 PacifiCare’s own documents and testimony from its witnesses establish that the
21 company’s failure to timely process these provider disputes was primarily due to
22 PacifiCare’s sloppy implementation and lax oversight of the document routing and storage
23 functions outsourced to Lason. Both provider disputes and the documents sent in support of
24 providers’ appeals were lost or delayed in DocDNA, and supporting materials were not
25 properly indexed by Lason. (Exh. 882, p. 7640; Exh. 728, p. 6699; Exh. 718, p. 4396;
26 Exh. 118, p. 3418; RT 9965:7-14 (Berkel); RT 696:17-697:20 (Vandepas).) As an example
27 of PacifiCare’s flawed routing procedures, certain medical records unattached to a specific
28 claim, such as those sent by providers in connection with a dispute, were routed, *by design*,

1 to an “undetermined queue” (Exh. 882, p. 7640) that wasn’t monitored effectively. Because
2 “reporting for this queue [was] not well understood,” documents would languish there for
3 long periods (Exh. 373, p. 0560). From August 2006 until early 2007, thousands of
4 documents, including provider disputes and supporting material, were “locked” in DocDNA
5 and not uploaded to REVA for processing. (Exh. 341, p. 3978; RT 3273:7-19 (Murray).)
6 PacifiCare acknowledged that the impact of this failure would be “The requirement for CA
7 PPO Provider Disputes to be acknowledged with 15 days and resolved within 45 days will be
8 negatively impacted.” (Exh. 341, p. 3978.)

9 And even those provider disputes that somehow found their way to the proper queue
10 would not be timely worked. (Exh. 882, p. 7640.) In a January 2008 e-mail, Ms. Berkel
11 wrote: “We need to decide how we are going to look at the documents that arrive late in the
12 Provider dispute resolution unit and fix those issues. We are failing CA law and it is late
13 routing.” (Exh. 882, p. 7641.)

14 PacifiCare also failed to provide instructions for Lason to perform the data collection
15 necessary to move documents, such as provider disputes, from DocDNA to REVA, which
16 caused delays in processing those disputes. A PacifiCare issues list dated in September 2007
17 — over a year after routing functions were outsourced to Lason — reported that “[t]here are
18 no documented instructions and procedures that were provided to the Lason India staff to
19 work the Lason intake and REVA Matching Hold Queues. As a result, the TAT’s [sic] for
20 the queues was way out of alignment.” (Exh. 577, p. 8646 [number 3].)

21 In a December 2007 PowerPoint Presentation, PacifiCare expressed sufficient
22 dissatisfaction with Lason’s performance of this function to recommend bringing it back in-
23 house, noting that provider disputes were “highly complex” and “strictly regulated by CA
24 regulations, so this function will return to Transactions in San Antonio.” (Exh. 365, p. 6879
25 [number 2].) That recommendation was not approved, and instead PacifiCare decided to
26 continue to work with Lason “to see if quality can improve.” (Exh. 365, p. 6879 [number
27 2].)

1 Here, PacifiCare demonstrated egregious unresponsiveness to provider disputes. CDI
2 identified many instances in which PacifiCare failed to respond to disputes for many months,
3 as well as instances in which the company completely failed to respond at all. (E.g.,
4 Exh. 116, pp. 1331 [claim number 19916317, 10-month delay to pay claim], 1332 [claim
5 number 19079205, over 9-month delay to pay claim], 1333 [claim number 19116747, over 9-
6 month delay to pay claim], 1337-1338 [claim number 19762906-01, 10-month delay to pay
7 claim], 1345 [19512078-01, 127-day delay]; pp. 1328-1329 [claim number 4913865-0-9];
8 1333 [claim number 19174954]; 1333-1334 [claim number 19452834]; 1339-1340 [claim
9 number 18929522-01].) Many providers likely abandoned efforts to remedy claims
10 violations rather than persist in seeking responses from PacifiCare. For those who persisted,
11 their claims violations could have been remedied more quickly if PacifiCare had timely
12 responded to the dispute.

13 The harm here was exacerbated by PacifiCare’s dismal customer service. Not only
14 were providers’ formal written disputes not responded to timely, but when they tried to call
15 PacifiCare’s customer service, they received little help in resolving their disputes, and in fact
16 were often given inaccurate information, or told to resubmit already-submitted disputes.
17 (Exh. 289, p. 6599; Exh. 286; Exh. 287, p. 6168 [Mimick 5:05 p.m.]; Exh. 1019; Exh. 5320,
18 p. 8939; Exh. 1033, p. 5468 [Berkel 12:59 a.m.]; RT 2564:24-2565:25 (Sing); RT 2668:14-
19 2669:12; 2673:25-2674:21 (K. Griffin).) PacifiCare own employees complained about the
20 company’s poor customer service. Customer service representatives were dissuaded from
21 investing the time necessary to research caller complaints. (Exh. 678, pp. 2819, 2770, 2771,
22 2775, 2784, 2786, 2807, 2811, 2815, 2817, 2849, 2859, 2957, 2964, 2968, 2987, 2988, 3052,
23 3053, 3088, 3126, 3152, 3158, 3164, 3167, 3169, 3158, 3173.) Even staff in the Provider
24 Central Service Unit (“PCSU”), a unit supposedly specially equipped to follow provider
25 billing disputes through to resolution, couldn’t “answer simple questions as to how a claim is
26 paid” and refused to research complex claim disputes. (Exh. 261, p. 2541; Exh. 287, p. 6168
27 [Mimick 5:05 p.m.]
28

1 PacifiCare knew that its customer service unit played an integral part in tracking and
2 resolving provider billing disputes (Exh. 8, pp. 1880, 1883), yet the company nevertheless
3 knowingly degraded its customer service shortly after the acquisition. PacifiCare discarded
4 its previous customer service model, “Promise Made, Promise Kept,” in which a customer
5 service representative “takes that issue, that they own it until it’s completed” and adopted a
6 “model of how can we be more efficient, reduce call handle time,” with the goal of
7 “improving efficiencies.” (Exh. 352; RT 3392:3-3393:19; 3394:18-19 (Sing).) This focus
8 on improving efficiencies, Mr. Sing testified, undermined “follow-through processes and
9 ownership” of callers’ complaints (RT 3395:6-9) and “may have caused this type of service
10 issue where we had representatives who weren’t following through on an issue of this type.”
11 (RT 3392:20-3393:5.)

12 The evidence reflects that providers were forced to spend an inordinate amount of
13 time pursuing review of wrongly denied or improperly adjudicated PLHIC claims, creating
14 significant and unnecessary frustration (Exh. 1019, pp. 7975-7980; RT 2668:14-2669:12;
15 2674:15-21 (K. Griffin)) — precisely the harms the Legislature intended to avoid by
16 requiring that insurers adopt “a fast, fair, and cost-effective dispute resolution mechanism.”
17 (§ 10123.137, subd. (a).)

18 Finally, PacifiCare’s noncompliance improperly burdened CDI, thereby inflicting
19 significant harm to the regulatory process. Because of PacifiCare’s inability to timely or
20 fairly process provider disputes, the Department was forced to devote significant resources
21 — resources therefore not available for other CDI regulatory duties — to investigating
22 complaints from providers unable to obtain redress from PacifiCare.

23 **3. Number of Acts in Violation**

24 Of the 96 provider disputes CDI reviewed during the MCE, the Department identified
25 14 in which PacifiCare failed to respond within the statutorily required 45 days. PacifiCare
26 admitted that it failed to timely respond to 1,510 provider disputes received during the MCE
27 review period. (Exh. 118, p. 3418; Exh. 1, pp. 3517-3518.)
28

1 This number likely significantly undercounts the number of violations. First,
2 PacifiCare followed a practice of “closing” provider disputes when it believed that it had not
3 received supporting documentation within 30 days. (Exh. 5046, pp. 2227-2228, 2230.)
4 Because these documents often languished in DocDNA’s “undetermined queue” (Exh. 373,
5 p. 0560; Exh. 882, p. 7640) or otherwise failed to reach the rework team, it is likely that
6 PacifiCare improperly “closed” these disputes despite having timely received evidence
7 supporting the provider’s position. These wrongly “closed” disputes would not be included
8 among 1,510 figure admitted by PacifiCare.

9 In addition, although CDI has not cited PacifiCare for violating its obligation to
10 “resolve each provider dispute consistent with applicable law” (§ 10123.137, subd. (c)),
11 PacifiCare demonstrated a practice of violating section 10123.137 with respect to the
12 substance as well as the timing of its responses. (Exh. 116, pp. 1328-1329, 1333, 1340.) In
13 April 2008, *after* the company supposedly implemented corrective actions to improve PDR
14 processes, it handled only 75% of its provider disputes in compliance with the law.
15 (Exh. 741, pp. 6731-6732.)

16 **4. PacifiCare Knowingly Committed the Acts in Violation, and**
17 **Performed Them with Such Frequency as to Indicate a General**
18 **Business Practice**

19 PacifiCare is charged with knowledge of when it receives provider disputes and when
20 and how it responds to those disputes. (Exh. 1184, p. 134:10-11.) There is no evidence that
21 PacifiCare had a reasonable basis to be unaware of these basic facts that every insurer must
22 know to competently run its business.

23 PacifiCare was also fully aware of the steps it was taking when it altered the flow of
24 PDR documents, and is chargeable with the knowledge that carelessness and haste would
25 likely result in misrouting and mishandling of provider disputes. (Exh. 1184, p. 134:14-16.)
26 As the evidence quickly mounted in mid-2006 of problems with the handling of claims, the
27 increase in provider disputes was entirely foreseeable and the failure to devote sufficient
28 resources to handle them was knowing. (Exh. 1184, p. 134:16-18.)

1 Independently, as Mr. Cignarale concluded, the over 1,500 violations for this category
2 is sufficient to indicate a general business practice. (Exh. 1184, p. 134:18-20.)

3 **5. The Acts in Violation Were Willful**

4 These acts in violation were willful, as that term is defined by the Regulations. With
5 a willingness and purpose, PacifiCare transferred mail routing to Lason in a manner that
6 created risks of misrouting of correspondence, including provider disputes, and other
7 document mishandling errors that resulted in processing delays. As Mr. Cignarale
8 concluded, the design and implementation of the document-routing system, the lack of
9 oversight from PacifiCare management, and the serious delay in establishing quality control
10 mechanisms and redesigning the document routing procedures reflect a willful failure to
11 adopt reasonable standards related to claims and a willingness to not promptly respond to
12 communications from providers. (Exh. 1184, p. 135:3-10.)

13 **6. The Issuance, Amendment, or Servicing of the Policy or**
14 **Endorsement Was Not Inadvertent**

15 The servicing of the policy at issue here is PacifiCare’s sending out of written
16 responses to provider disputes. (Exh. 1184, p. 134:24-25.) There is no evidence that
17 PacifiCare inadvertently sent out those written responses, or that the company inadvertently
18 failed to send out such responses.

19 **7. Applicable Unit-Penalty**

20 Mr. Cignarale began his analysis of the appropriate unit-penalty by evaluating the
21 severity of this kind of violation, concluding that it is “moderately serious” (Exh. 1184,
22 p. 131:26):

23 “The prompt and accurate payment of claims is, of course, critical to the
24 provider, the patient, the insurer, and the healthcare system. The requirement
25 that insurers timely adjudicate provider disputes is a central feature of the
26 system established by the Legislature to guarantee appropriate and timely
27 claim processing. In my experience, the inability to obtain redress from the
28 insurer typically leads providers either to abandon efforts to get their claims
paid properly, or to turn to the Department for assistance. The former reaction
means that providers may not be getting reimbursed appropriately, and the
latter can mean that the Department is deluged with provider complaints.”
(Exh. 1184, p. 132:1-8.)

1 Consistent with his “moderately serious” assessment, Mr. Cignarale opined that the
2 starting point for determining the unit-penalty should be 40% above the bottom of the range
3 from zero to the maximum, or \$4,000 for willful acts in violation. (Exh. 1184, p. 132:9-12.)

4 Mr. Cignarale then evaluated the evidence he was asked to assume on the specific
5 violations in this case. He found evidence suggesting mitigating or aggravating
6 circumstances with respect to six of the twelve factors. He found the complexity of provider
7 disputes (Reg. 2695.12, subd. (a)(3)) slightly mitigating, although the regulatory framework
8 accounts for the complexity by permitting insurers 45 working days to respond. He regarded
9 the 14 instances of noncompliance the examiners discovered in their review of 96 provider
10 dispute files to be a high relative number of noncomplying acts (Reg. 2695.12, subd. (a)(7))
11 and an aggravating factor. Mr. Cignarale regarded the evidence relating to PacifiCare’s
12 remedial measures (Reg. 2695.12, subd. (a)(8)) as both mitigating and aggravating: although
13 he noted that the company took some measures, he “saw no evidence that some important
14 measures that were identified by the company, such as adding server space and bringing the
15 processing of provider disputes back in-house, were implemented,” and other measures were
16 taken only belatedly. (Exh. 1184, pp. 135:27-136:3.) Taken together, this evidence rendered
17 this factor neither aggravating nor mitigating.

18 Mr. Cignarale considered the harm specific to this case (Reg. 2695.12, subd. (a)(10)),
19 including provider frustration, “increased burden on the Department,” and “PacifiCare’s
20 inadequate customer service, which did not permit providers to resolve complaints
21 informally or to ascertain whether their written disputes were being processed,” to be
22 evidence in aggravation. (Exh. 1184, p. 136:6-18.) He concluded that PacifiCare did not
23 exhibit a good faith attempt to comply with the law (Reg. 2695.12, subd. (a)(12)) after
24 balancing “PacifiCare’s voluntary disclosure to CDI of the number of provider disputes
25 received during the market conduct period and how many were timely adjudicated” against
26 its delay in providing CDI a copy of the provider dispute resolution procedure and the
27 company’s “refusal to invest in appropriate testing and quality control measures for handling
28 documents.” (Exh. 1184, p. 136:19-27.) Mr. Cignarale viewed the fairly high frequency of

1 the violations (Reg. 2695.12, subd. (a)(12)) — 1,510 over an 11-month period — as
2 aggravating, but assumed that the detriment to the public was no more severe than in the
3 usual case. Finally, he found aggravation in PacifiCare’s “inattention and lack of urgency
4 about addressing problems that it knew to be causing violations of law” (Reg. 2695.12,
5 subd. (a)(13)). (Exh. 1184, p. 137:12-13.)

6 On balance, Mr. Cignarale’s review of these mostly aggravating circumstances led
7 him to increase his recommended unit-penalty by 10%, from the \$4,000 starting point to
8 \$4,400 for each of the 1,510 acts in violation. (Exh. 1184, p. 137:14-18.) This results in an
9 aggregate penalty for the PDR violations of \$6,644,000. (Exh. 1184, p. 137:17-18.)

10 **J. Illegally Closing or Denying Claims When Requesting Additional**
11 **Information**

12 **1. Applicable Legal Requirements**

13 An insurer’s practice of closing or denying a claim when it needs additional
14 information violates various laws, including the UIPA. A claim for which an insurer needs
15 additional information to process is “contested,” (RT 25547:9-25548:2 (Stead)), not denied
16 or closed.

17 Sections 10123.13, subdivision (a) and 10123.147, subdivision (a) specifically require
18 that claimants be notified within 30 working days if a claim is being contested or denied.
19 Though PacifiCare was contesting these claims, it wrongly notified claimants that the claims
20 were being closed or denied. (Exh. 1184, p. 138:4-7.)

21 Closing or denying a claim when requesting additional information therefore also
22 constitutes an act in violation of section 790.03, subdivision (h)(1), because informing a
23 claimant that a claim has been closed or denied, when it is in fact being contested, is a
24 misrepresentation of a pertinent fact relating to coverages. (Exh. 1184, pp. 137:27-138:2.)

25 PacifiCare has also violated section 790.03, subdivision (h)(3), which prohibits failing
26 to adopt and implement reasonable standards for the prompt investigation and processing of
27 claims. (Exh. 1184, p. 138:2-4.) Here, PacifiCare has adopted and implemented a standard
28 for the prompt investigation and processing of claims that is unreasonable. By closing or

1 denying a claim that needs further investigation, PacifiCare unreasonably delayed the
2 investigation and processing of the claim.

3 Similarly, PacifiCare's practice violates Regulation 2695.7, subdivision (d) because
4 by closing or denying the claim instead of leaving it open while the company awaits further
5 information amounts to failing to "conduct and diligently pursue a thorough, fair and
6 objective investigation." (Exh. 1184, p. 138:7-10.)

7 **2. PacifiCare's Violations of Law**

8 From at least December 2005 to sometime in 2007, PacifiCare's practice when it was
9 contesting a claim because it purportedly needed additional information was to close or deny
10 that claim. (Exh. 23, p. 3090; Exh. 24, p. 3086; Exh. 26, p. 3246; Exh. 30, p. 1045; Exh. 35,
11 p. 1049; Exh. 128, pp. 5095-5098, 5100, 5109, 5123, 5125; Exh. 330, pp. 1-2, 12.)

12 PacifiCare would inform members and providers on EOBs that their claim was being closed
13 or denied due to lack of required information. (RT 8090:18-8091:16 (Berkel); RT 2387:24-
14 2388:19 (Norket).) Specifically, several EOBs dated in 2006 contained a remark code "px"
15 that stated:

16 "This claim is being denied due to lack of required information. Please
17 forward the Certificate of Creditable Coverage from your prior carrier. If
18 unavailable, please submit names and addresses of doctors who have treated
19 you in the past year. Refer to your Certificate, 'Exclusionary period for pre-
20 existing conditions.'" (Exh. 23, p. 3090; Exh. 24, p. 3086; Exh. 30, p. 1045;
21 Exh. 35, p. 1049; Exh. 128, pp. 5109, 5123, 5125.)

22 Several EOBs dated in 2005 to 2007 contained a remark code "iq" that stated:

23 "Claim was closed due to lack of response to a prior request for other
24 insurance information. Services will be reconsidered and patient responsibility
25 will be calculated upon receipt. Please refer to your Certificate, 'Payment
26 Responsibility, Right to Receive and Release Information.'" (Exh. 128,
27 pp. 5095-5098, 5100.)

28 PacifiCare included this statement on its EOBs even when this was the first adjudication of
the claim, and no prior request for other information had ever been made. For instance, with
respect to Ms. W's son's claims, PacifiCare closed four separate claims on December 15,
2005, "due to a lack of response to a prior request for other insurance information" for a

1 claim with a date of service only two weeks before. (Exh. 128, pp. 5095-5098; RT 1017:5-
2 1018:6 (Ms. W).)

3 Based on complaints against PacifiCare filed with CDI, the Department cited
4 PacifiCare for two violations based on the company's denial of claims using the "px" remark
5 code when additional information was being requested. (Exh. 40, p. 4014; Exh. 41,
6 pp. 9454-9455; Exh. 1209, ¶¶ 7, 8.) In those violation letters, CDI explained:

7 "The claim was denied and closed rather than contested or delayed to request
8 additional information such as, a copy of the Certificate of Creditable
9 Coverage or prior Medical Records to properly determine if the claim was for
10 an actual pre-existing condition and not just a potential pre-existing condition.
11 This places an undue burden upon the provider/claimant and the insured to
12 appeal and overcome a denial rather than to provide reasonably necessary
13 information, requested by the insurer to make an informed determination to
14 accept or deny the claim." (Exh. 40, p. 4014; Exh. 41, p. 9454.)

15 CDI does not have data on the total number of PacifiCare EOBs that closed or denied
16 claims on this improper basis. Therefore, CDI is alleging 57 acts in violation based on the
17 violation letters, EOBs that are in evidence, and claim spreadsheets indicating "iq" or "px"
18 remark codes. (Exh. 40, p. 4014 [1 citation]; Exh. 41, pp. 9454-9455 [1 citation]; Exh. 23,
19 p. 3090 [1 citation]; Exh. 24, p. 3086 [1 citation]; Exh. 30, p. 1045 [1 citation]; Exh. 35,
20 p. 1049 [1 citation]; Exh. 128, pp. 5095 [1 citation], 5096 [1 citation], 5097 [1 citation], 5098
21 [1 citation], 5100 [1 citation], 5109 [1 citation], 5123 [1 citation], 5125 [1 citation];
22 Exh. 127, pp. 1-6 [at least 43 citations]; Exh. 1209, ¶¶ 168-172, 174.)

23 Closing or denying a claim because the insurer claims to need additional information
24 is a wrongful claim denial. That, by itself, represents serious harm.

25 PacifiCare's practice of closing or denying a claim may also cause claimants to be
26 confused about the status of their claim. A claimant receiving notification that a claim is
27 being closed or denied because the insurer needs information may reasonably believe that the
28 insurer's closure or denial of the claim is the insurer's determination on that claim, and many
will not submit the requested information. (Exh. 1184, p. 138:14-18.) This potential for
confusion by claimants also represents serious harm.

1 Here, the language that PacifiCare used on its EOBs is of particular concern. While
2 the “px” remark code language on the 2006 EOBs instructs the claimant to send in a COCC
3 or the names and addresses of prior doctors and to refer to the Certificate, it does not explain
4 that PacifiCare’s denial of the claim will be reconsidered upon receipt of that information.
5 This likely created confusion and may have resulted in claimants not submitting the
6 requested information because they believed that their claim had been denied. In that
7 instance, the incorrect denial would never be remediated and the claimant would never be
8 properly reimbursed for the claim, resulting in significant harm.

9 The language for the “iq” remark code on the 2005-2007 EOBs states that services
10 will be reconsidered and patient responsibility will be calculated upon receipt of the
11 requested information, but it does not explain what requested information the claimant is
12 being asked to submit. Rather, this language informs the claimant that the claim is being
13 closed due to lack of response to a prior request for other insurance information when there
14 has been no prior request for other insurance information. This is very confusing, and
15 similarly may have resulted in the claimant never sending in the requested information.
16 (Exh. 1184, pp. 141:16-142:5.)

17 **3. Number of Acts in Violation**

18 There is evidence in the record of at least 57 instances in which PacifiCare illegally
19 closed or denied a claim when it was requesting additional information, in violation of
20 section 790.03, subdivisions (h)(1) and (h)(2), section 10123.13, subdivision (a),
21 section 10123.147, subdivision (a), and Regulation 2695.7, subdivision (d). (Exh. 40,
22 p. 4014 [1 citation]; Exh. 41, pp. 9454-9455 [1 citation]; Exh. 23, p. 3090 [1 citation];
23 Exh. 24, p. 3086 [1 citation]; Exh. 30, p. 1045 [1 citation]; Exh. 35, p. 1049 [1 citation];
24 Exh. 128, pp. 5095 [1 citation], 5096 [1 citation], 5097 [1 citation], 5098 [1 citation], 5100
25 [1 citation], 5109, 5123 [1 citation], 5125 [1 citation]; Exh. 127, pp. 1-6 [at least 43
26 citations] Exh. 1209, ¶¶ 168-172, 174.)²⁶ Given that PacifiCare followed this practice for at
27

28 ²⁶The First Amended Accusation alleged 51 instances in which PacifiCare illegally closed or denied a claim on this ground (Exh. 1209, ¶ 172), and 6 separate instances in which

1 least several years, it is likely that the company issued many more EOBs that illegally closed
2 or denied such a claim.

3 In addition, PacifiCare's illegal practice of closing or denying claims, by itself,
4 constitutes one act in violation of section 790.03, subdivisions (h)(1) and (h)(2),
5 section 10123.13, subdivision (a), section 10123.147, subdivision (a), and Regulation
6 2695.7, subdivision (d). (Exh. 1209, ¶ 172.)

7 **4. PacifiCare Knowingly Committed the Acts in Violation, and**
8 **Performed Them with Such Frequency as to Indicate a General**
9 **Business Practice**

10 PacifiCare had actual or constructive knowledge of its practice of sending out EOBs
11 or EOPs that denied or closed claims when the insurer was requesting additional information.
12 PacifiCare has not argued, and has offered no evidence to suggest, that it had some
13 reasonable basis to be unaware of this practice.

14 Moreover, an insurer is chargeable with knowledge that the law requires it to contest,
15 not to deny, a claim for which it is requesting additional information; the affirmative act of
16 requesting additional information amounts to an admission that it lacked the information to
17 deny the claim. (Exh. 1184, p. 140:3-10.)

18 Separately, though the number of violations being charged in this action, by itself,
19 may not indicate a general business practice, these violations were performed pursuant to the
20 company's business practice of closing or denying claims when requesting additional
21 information. (RT 8090:18-8091:16 (Berkel); RT 2387:24-2388:19 (Norket); Exh. 1184,
22 p. 140:10-12.) Thus, there is no need to infer a general business practice from the number of
23 violations, for the evidence has established the existence of a general business practice.

24 **5. The Acts in Violation Are Not Being Charged As Willful**

25 PacifiCare knew or should have known that by denying and closing these claims, it
26 was misrepresenting pertinent facts and was failing to adopt and implement reasonable

27
28 PacifiCare failed to conduct a thorough investigation because it illegally closed or denied a
claim (Exh. 1209, ¶ 174).

1 standards for the prompt investigation and processing of claims. Nevertheless, CDI is not
2 charging these violations as willful acts in violation. (Exh. 1184, p. 140:20-23.)

3 **6. The Issuance, Amendment, or Servicing of the Policy or**
4 **Endorsement Was Not Inadvertent**

5 PacifiCare has offered no evidence that its servicing of these policies — that is, the
6 sending out of the EOBs and EOPs that illegally closed or denied these claims — was
7 inadvertent. (Exh. 1184, p. 140:16-17.) As a matter of logic, it would be hard to imagine
8 how sending out EOBs and EOPs that were consistent with a company’s policy — albeit an
9 illegal policy — could be inadvertent.

10 **7. Applicable Unit-Penalty**

11 Mr. Cignarale first opined that, in general, this type of violation is of “average
12 seriousness,” equating it to the wrongful denial of a claim. (Exh. 1184, p. 138:13-18.) The
13 starting point for these violations, Mr. Cignarale testified, should be at 50% of the way from
14 zero to the maximum, or \$2,500 per willful act. (Exh. 1184, p. 138:21-23.)

15 After considering the specific evidence in the record relating to these violations, Mr.
16 Cignarale found slightly aggravating circumstances warranting an increase in the unit-
17 penalty of 5%, from \$2,500 to \$2,625, per act in violation. (Exh. 1184, p. 142:16-19.)

18 Most troubling to Mr. Cignarale was PacifiCare management’s failure to detect and
19 remediate these violations sooner; in fact, there is no evidence that PacifiCare ever took
20 remedial measures. (Exh. 1184, p. 142:11-15.) The remaining penalty factors were neither
21 aggravating nor mitigating in Mr. Cignarale’s opinion.

22 The aggregate penalty for this category of violation should be \$152,250 for these 58
23 acts in violation.

24 **K. Sending Untimely Collection Notices on Overpaid Claims**

25 **1. Applicable Legal Requirements**

26 Section 10133.66, subdivision (b) sets forth various restrictions on an insurer’s ability
27 to demand from claimants reimbursement for purportedly overpaid claims:

28 “Reimbursement requests for the overpayment of a claim shall not be made,
including requests made pursuant to Section 10123.145, unless a written

1 request for reimbursement is sent to the provider within 365 days of the date of
2 payment on the overpaid claim. The written notice shall clearly identify the
3 claim, the name of the patient, and the date of service, and shall include a clear
4 explanation of the basis upon which it is believed the amount paid on the claim
5 was in excess of the amount due, including interest and penalties on the claim.
6 The 365-day time limit shall not apply if the overpayment was caused in
7 whole or in part by fraud or misrepresentation on the part of the provider.”

8 First, any request for reimbursement must be made in writing within 365 days of the date that
9 the allegedly overpaid claim was paid by the insurer. In addition, that written notice must
10 “clearly identify”: (i) the claim; (ii) the patient name; (iii) the date of service; and (iv) a clear
11 explanation of the basis upon which it is believed that the claim was overpaid. A request for
12 reimbursement by an insurer that does not comply with each of these requirements is illegal.
13 (See Exh. 1184, p. 143:7-9.)

14 Making demands for reimbursement that are untimely also violates section 790.03,
15 subdivision (h)(1) because the insurer is incorrectly representing to the claimant that it has
16 the right to collect those additional amounts. That is a misrepresentation of a pertinent fact.
17 (Exh. 1184, p. 143:1-4.) An insurer does not have the right to recover such overpayments if
18 it fails to request reimbursement within 365 days of payment of the claim, or if its written
19 notice fails to clearly identify one of the items of information listed in section 10133.66,
20 subdivision (b).

21 Sending untimely reimbursement demand letters further reflects a failure to adopt and
22 implement reasonable standards for the prompt investigation and processing of claims, in
23 violation of section 790.03, subdivision (h)(3). (Exh. 1184, p. 143:4-7.) By demanding that
24 claimants reimburse a previously paid claim, an insurer effectively re-opens that claim and
25 imposes on the claimant the burden of verifying that the claim was indeed overpaid and, if
26 so, sending reimbursement back to the insurer. If that demand is untimely, and the insurer
27 does not in fact have the right to seek reimbursement, then the insurer has not promptly
28 investigated the claim and wrongfully delays the complete processing of the claim.

1 **2. PacifiCare’s Violations of Law**

2 **a. January 2008: United Attempts to Collect on PLHIC**
3 **Historical Claims Paid Years Before**

4 In May 2007, United began integrating PacifiCare’s overpayment collection functions
5 into United’s Audit Recovery Operations (“ARO”) department. (RT 6608:5-10 (Bugiel);
6 Exh. 592, p. 0713.) In January 2008, United assigned several thousand PacifiCare PPO
7 claims to one of United’s debt recovery vendors, Johnson & Rountree Premium (“J&R”), to
8 collect alleged overpaid amounts on claims. (RT 2955:22-2957:18 (Cassady); Exh. 319.)
9 These claims, known as the PLHIC Historical Claims, had been paid years before, dating
10 back as far as January 2004. (E.g., Exh. 584, pp. 2 [line 93 reflecting claim paid date of
11 11/4/04], 3 [line 100 reflecting claim paid date of 12/13/04]; RT 2955:22-2956:18 (Cassady);
12 RT 1240:3-6 (Black).) But United considered its demands for reimbursement in 2008 to be
13 timely because it claimed that PacifiCare had previously sent initial letters demanding
14 repayment.

15 Almost immediately after this project was initiated, as early as January 4, 2008, J&R
16 began sending letters to providers demanding reimbursement on allegedly overpaid claims.
17 (E.g., Exh. 319, p. 2; RT 2957:13-18 (Cassady).) These letters were designated as “Second
18 Request” letters, and they asserted that the company had previously requested reimbursement
19 from the provider but had not received the refund. (Exh. 331, p. 1003; RT 2972:6-12
20 (Cassady).) The letters further warned providers: “If a response is not received, PacifiCare
21 may offset future payments by the refund amount requested.” (E.g., Exh. 331, p. 1003;
22 Exh. 793, p. 8627.)

23 **b. Early to Mid-2008: United Forced to Rescind “Invalid”**
24 **Requests for Reimbursement**

25 In early to mid-2008, the CMA forwarded to PacifiCare complaints from two
26 providers regarding these demands for repayment. One of the physicians, Dr. Theodore
27 Mazer, received a letter on April 8, 2008, requesting repayment of \$49.13 on a claim that
28 was initially paid by PacifiCare on October 18, 2005. In addition to being untimely by
several years, the letter contained several misrepresentations. The letter identified the

1 overpaid claim as a Secure Horizons claim (Exh. 331, pp. 1003-1004), which was wrong
2 (RT 3043:10-22 (Mazer)). The letter also indicated that it was a second request for
3 repayment (Exh. 331, p. 1003), which was also wrong; Dr. Mazer testified that he never
4 received a first request (RT 3043:23-3044:3). In fact, Dr. Mazer's office had previously
5 contacted PacifiCare in October 2005 to inform the company that they believed the claim to
6 be overpaid. PacifiCare promised to reprocess the claim at that time but never did.
7 (Exh. 331, p. 1005; RT 3045:13-3046:5.) Dr. Mazer never received anything from
8 PacifiCare on this claim until two-and-a-half years later when he received the J&R demand
9 letter. (RT 3043:23-3044:3.) At that point, it was far too late for PacifiCare to attempt to
10 recover the alleged overpayment, and its untimely attempt to do so was illegal.

11 PacifiCare contended that its records reflected that a first request for reimbursement
12 had previously been sent to Dr. Mazer, but the company was never able to locate the alleged
13 first request letter. (Exh. 592, pp. 0714-0715.) PacifiCare further acknowledged that the
14 claim at issue was not for a Secure Horizons member, as the letter incorrectly indicated.
15 (Exh. 592, p. 0715.) In response to Dr. Mazer's appeal of this request for reimbursement,
16 PacifiCare withdrew its request for reimbursement on April 22, 2008. (Exh. 592, p. 0715;
17 Exh. 332.)

18 The other CMA complaint came from Dr. Noelle Chiu, who had received a request
19 for repayment from PacifiCare on a claim that was initially paid on January 22, 2007.
20 (Exh. 592, p. 0715.) The provider, however, contended that he had previously, on his own,
21 repaid PacifiCare the overpaid amount. (Exh. 592, p. 0715.) PacifiCare subsequently
22 admitted that the provider was correct that he had previously reimbursed the company, and
23 that the company's records even reflected that the provider's check was cashed on April 17,
24 2007. (Exh. 592, p. 0715.)

25 PacifiCare investigated another provider complaint from Dr. Myron Bloom, which
26 was forwarded to PacifiCare by CDI, and determined that it could not locate the first request
27 letter, though it claimed that its records indicated that it was timely sent in 2005. (Exh. 592,
28 p. 0714.)

1 At the hearing, J&R employee Jacob Cassady testified that J&R was following
2 instructions from PacifiCare in sending out these collection letters, and that he had assumed
3 that timely first requests had been sent by PacifiCare. (RT 2957:2-12; 2979:6-11; see also
4 RT 6649:19-24 (Bugiel).) But Ms. Berkel admitted that the company “did not appropriately
5 look for the initial claim overpayment recovery letter before we instructed our vendor,
6 Johnson & Rountree, to initiate a second recovery letter on certain items, on some PLHIC
7 overpayment claim recoveries.” (RT 11250:24-11251:3 (Berkel).) Brian Bugiel,
8 PacifiCare’s designated person most knowledgeable about the J&R overpayment issues,
9 further testified that no one at United was assigned responsibility for verifying the existence
10 of these first request letters before instructing J&R to send the second request letters.
11 (RT 6721:18-6722:13.)

12 In a June 19, 2008, letter, PacifiCare informed CDI that it was at that time in the
13 process of auditing the PacifiCare Historical Claims to verify that a first request letter had
14 previously been sent within 365 days of payment for each claim. (Exh. 592, p. 0715.) This
15 verification, of course, is something that PacifiCare should have done *before* sending out
16 these untimely demand letters. Its failure to have such a basic and obvious control in place
17 resulted in the company sending out thousands of illegal collection notices and creating mass
18 confusion among the provider community that received them.

19 In the end of June 2008, PacifiCare had determined that of the 5,224 reimbursement
20 requests sent to providers, 2,912 were “invalid” and needed to be canceled. (Exh. 590,
21 p. 4553.) At that time, PacifiCare had located only several hundred first request letters. (RT
22 11914:13-22 (Bugiel).) Based on PacifiCare’s analysis, CDI alleged 2,912 acts in violation
23 for these untimely overpayment demands in the First Supplemental Accusation. (Exh. 290,
24 pp. 34-35, ¶¶ 136-144.)

25 **c. May 2010: PacifiCare’s Second Search for First Request**
26 **Letters**

27 In response to CDI’s allegations, PacifiCare redoubled its efforts to look for first
28 request letters. In advance of Mr. Bugiel’s testimony on May 13, 2010, PacifiCare again

1 attempted to search its files for additional first request letters. (RT 11891:22-25 (Bugiel).)
2 Mr. Bugiel claimed to have found “hundreds” of additional letters in this search. (RT
3 11892:5-11.) PacifiCare also produced to CDI data that reflected that there were 4,831
4 PacifiCare PPO claims for which J&R sent untimely overpayment demand letters.
5 (Exh. 584, Exh. 586; RT 11892:17-25 (Bugiel).)

6 **d. Mid-2010 to September 2010: PacifiCare’s Third Search for**
7 **Letters**

8 After his May 2010 testimony, Mr. Bugiel again went back to his office to look for
9 more first request letters on these claims. (RT 11893:18-11894:11 (Bugiel).) This time, Mr.
10 Bugiel came back claiming to have located thousands of such letters. (RT 11893:23-
11 11894:11 (Bugiel).) He produced a chart reflecting PacifiCare’s analysis of the overpayment
12 violations, some of which CDI accepts, some of which it rejects. (Exh. 5392, p. 1645.)

13 In this analysis, PacifiCare admitted that there were 1,934 claims for which
14 PacifiCare either was unable to find a first request letter or had sent an untimely first request
15 letter. (Exh. 5392, p. 1645 [1,374 “Remaining Claims” and 560 “Paid Before 1/1/06”];
16 RT 12715:5-19 (Bugiel).) PacifiCare, however, asserted that 560 of those claims are not
17 violations because they were initially paid before January 1, 2006, when section 10133.66,
18 subdivision (b) became effective. (Exh. 5392, p. 1645; RT 12715:5-19 (Bugiel); see also
19 Exh. 839 [spreadsheet of untimely first request letters].) PacifiCare’s position is that claims
20 that are *paid* before January 1, 2006, are not subject to the statute. (RT 12715:16-19
21 (Bugiel).) PacifiCare is wrong. The date of payment of the claim does not limit the statute’s
22 applicability. Rather, the statute makes the sending of reimbursement requests more than
23 365 days after date of payment the violative act:

24 “Reimbursement requests for the overpayment of a claim shall not be made,
25 including requests made pursuant to Section 10123.145, unless a written
26 request for reimbursement is sent to the provider within 365 days of the date of
payment on the overpaid claim” (§ 10133.66, subd. (b).)

27 And for each of those 560 violations, PacifiCare committed the violative act — sending an
28 untimely request for reimbursement — in 2008, well after the statute was in effect.

1 PacifiCare also contended that the data previously produced to CDI mistakenly
2 included non-California claims; of the 4,831 alleged violations, PacifiCare asserted that 204
3 related to non-California claims. (Exh. 5392, p. 1645.) No explanation was given for why
4 incorrect data were produced to CDI. PacifiCare further contended that there were 88 claims
5 in those data that were never pursued for overpayment recovery. (Exh. 5392, p. 1645.)
6 Again, PacifiCare offered no explanation for these incorrect data. In addition, according to
7 PacifiCare, there were 596 claims that were not pursued for secondary recovery, though
8 PacifiCare did not know whether a first request for recovery had been sent. (Exh. 5392,
9 p. 1645; RT 12712:4-7; 12712:16-19 (Bugiel).) Despite its concern about the reliability of
10 PacifiCare's data and, more generally, about the fact that a regulated entity has admittedly
11 provided incorrect information to the Department without explanation, CDI accepted these
12 representations and removed these 888 claims as violations. (Exh. 1177, p. 3, ¶ 12.)

13 PacifiCare claimed that it found 1,846 first request letters that were timely sent within
14 365 days of payment of the claim. (RT 12690:3-12 (Bugiel); Exh. 5392, p. 1645.)
15 PacifiCare produced to CDI an Excel spreadsheet that it maintained on these first request
16 letters. (Exh. 836; RT 12678:3-12679:3 (Bugiel).) That spreadsheet is of questionable
17 reliability. For example, PacifiCare's data reflect that a number of these first request letters
18 were sent the very same day as the claim was paid. (E.g., Exh. 840, p. 1, lines 6-9, 22-52.)
19 In some instances, the data showed that the first request letter was sent *before* the claim was
20 supposedly initially paid (e.g., Exh. 840, p. 1, lines 3-5, 10-21); according to PacifiCare's
21 data, therefore, the company sent out a request for reimbursement of an overpaid claim
22 before it even paid the claim. When Mr. Bugiel was presented with these data, he admitted
23 that the dates in the field purporting to be the date that the first request letter was sent may be
24 inaccurate; he testified that those dates may not be the date the letter was sent, but rather the
25 date additional information was requested from the provider in order to process the claim.
26 (RT 12699:17-12700:4.) In fact, Mr. Bugiel admitted that he had no evidence that any of the
27 first notification letters were actually sent on the dates reflected on the letter:
28

1 “Q. Now, Mr. Bugiel, what evidence do you have that any of these initial
2 notification letters were in fact sent out on the date that the letter is dated?

3 A. I have nothing that tells me that.” (RT 12700:5-8 (Bugiel).)

4 Thus, PacifiCare can provide no assurances of when these first request letters were sent.
5 They could have been sent months or years after they are dated, or they could have not been
6 sent at all. Mr. Bugiel’s admission casts doubt on each of the 1,846 purported first request
7 letters that PacifiCare has produced and seeks to use to prove that its requests were not
8 illegal.

9 PacifiCare also asserted that 163 of the alleged violations related to claims that
10 providers voluntarily repaid, so no overpayment letter would have been sent out.
11 (RT 12685:21-12686:4 (Bugiel); Exh. 837; Exh. 5392, p. 1645.) Upon review of these data,
12 however, CDI found a number of discrepancies, undermining PacifiCare’s assertion that
13 these claims were voluntarily repaid and further undermining the reliability of PacifiCare’s
14 data. CDI ran a filter on the Excel spreadsheet that PacifiCare had produced to cull out all
15 the “provider initiated” claims. The data in that spreadsheet, Exhibit 837 in evidence,
16 reflected that for nearly all the claims that PacifiCare contended the provider voluntarily
17 repaid, the company recovered no money from the provider and closed the claim in the full
18 amount of the recovery request. (E.g., Exh. 837, p. 1, lines 3, 8, 16-18, 21-23, 27, 30-45, 47-
19 53 [“Recovered Amount” column blank and “Amount Closed” column equal to “Claim
20 Audit Amount”].) Mr. Bugiel’s only explanation for this discrepancy was that the data
21 produced to CDI may be wrong. (RT 12687:4-12688:7.) The claims data also reflected a
22 supposedly provider initiated claim for which PacifiCare paid commission to a recovery
23 vendor, which obviously would not occur if the provider had initiated the refund. (Exh. 837,
24 p. 1, line 16.) Mr. Bugiel could not say whether or not an overpayment demand letter was
25 issued in that instance. (RT 12688:22-12689:1.) In fact, on cross examination, Mr. Bugiel
26 admitted that it was possible that overpayment letters were in fact sent to providers for these
27 163 supposed provider initiated claims:

28 “Q. So there were instances in which your spreadsheet would reflect that it
was a provider-initiated refund, but letters still did go out to the provider
seeking recovery of alleged overpayments; is that right?

1 A. It's possible, yes." (RT 12683:11-12683:16.)
2 PacifiCare never provided any evidence to explain these manifold inaccuracies in the data it
3 was relying upon.

4 In September 2010, while the hearing was in progress, PacifiCare produced to the
5 Department around 3,200 pages of documents that purported to be copies of these first
6 request letters that the company had located in 2010. (RT 11903:1-21 (Bugiel).) When the
7 Department reviewed those letters, it found further discrepancies. For instance, a number of
8 these letters referenced an attachment, but no attachment was produced. (E.g., Exh. 841,
9 pp. 8627, 8629.) A large number of these letters also failed to include information required
10 by law to be included on request for reimbursement letters, such as the claim number, the
11 name of the patient, the date of service, and a clear explanation of the basis upon which it is
12 believed the amount paid was in excess of the amount due. (Exh. 842; Exh. 843; Exh. 845;
13 Exh. 847.) Many of these letters also appeared to relate not to PLHIC PPO claims, but to
14 HMO and other claims outside of CDI's jurisdiction. (E.g., Exh. 841, pp. 8619, 8625.)

15 **e. February 2011: Search for Purported Attachments to First**
16 **Request Letters**

17 In an attempt to explain the discrepancies with the purported first request letters, Mr.
18 Bugiel had another search performed for additional documents associated with the
19 overpayment recovery letters. (Exh. 5531, pp. 1-2, ¶ 2.) The results of his search, however,
20 uncovered even more discrepancies, called into greater question PacifiCare's contention that
21 it had in fact sent these first request letters, and further undermined the reliability of
22 PacifiCare's document retention.

23 In February 2011, PacifiCare produced several hundred more pages of documents,
24 which PacifiCare contended were the missing attachments to some of the overpayment
25 recovery letters previously produced. (Exh. 5531, p. 2, ¶ 3.) The Department was again
26 forced to review these documents while the hearing was pending, and the Department again
27 found significant discrepancies that indicated that the purported attachments may not have
28 been attached to the letters at all. For example, in some instances, the letters had different
account numbers than the documents that PacifiCare contended were attached. (Exh. 1002.)

1 Mr. Bugiel couldn't explain that discrepancy. (RT 17093:22-17094:11.) Some of the
2 purported attachments had different headers and footers than the purportedly corresponding
3 letters. (Exh. 1003; Exh. 1004; Exh. 1005; Exh. 1006.) Mr. Bugiel couldn't explain those
4 discrepancies, either. (RT 17095:23-25.) Some of the attachments were also dated well
5 before or well after the date of the purportedly corresponding letters. (Exh. 1007; Exh. 1008;
6 Exh. 1009; Exh. 1010; Exh. 1011.) Mr. Bugiel also couldn't explain why these dates didn't
7 match. (RT 17103:8-11.)

8 Mr. Bugiel returned after a lunch break and attempted to explain some of the
9 discrepancies. He testified that he had spoken with Mark Davidson at PacifiCare's
10 overpayment recovery vendor, The Rawlings Company, about the attachment and letter dates
11 not matching. (RT 17127:4-13; 17129:17-21.) Mr. Bugiel testified that according to Mr.
12 Davidson, Rawlings hadn't been previously imaging attachments to letters, but "some event
13 occurred" in 2007 that caused them to regenerate and image prior attachments.
14 (RT 17128:22-17129:3; 17129:25-17130:10.) When Rawlings regenerated the prior
15 attachments in 2007, the date was changed, which Mr. Bugiel testified explained the date
16 discrepancies. (RT 17128:22-17129:3.) When Mr. Davidson testified, he claimed to have
17 never spoken to or even heard of Mr. Bugiel. (RT 19547:17-19548:20 [After having Mr.
18 Bugiel's name spelled and pronounced three different ways: "THE WITNESS: No, and in
19 none of the three ways does it in any way seem familiar to me."].) Mr. Davidson testified
20 that he did not recall telling anyone from PacifiCare that there was "some event that occurred
21 in 2007 that caused Rawlings to begin imaging the attachments." (RT 19546:13-19 ("A. I
22 don't recall telling anybody from PacifiCare such a thing, no."].) In fact, Mr. Bugiel's
23 explanation fails to explain why there are a number of purported attachments whose date
24 precedes the letter date. (E.g., Exh. 1007; RT 17143:5-7 (Bugiel).)

25 About the only relevant testimony Mr. Bugiel could competently give about the
26 attachments was to admit that many of them actually reflected that the company's demand
27 for reimbursement was illegally sent more than 365 days after payment. (RT 17112:12-
28 17113:5; Exh. 1012.) Based on CDI's analysis, which was not contested by PacifiCare, the

1 purported attachments reflected that PacifiCare had sent an additional 79 untimely demand
2 letters. (Exh. 1013.)

3 **f. Mid-2011: PacifiCare Brings Vendor to Try to Explain**
4 **Discrepancies**

5 Several months later, in April 2011, in yet another attempt to explain some of these
6 discrepancies between the letters and the purported attachments, PacifiCare filed a
7 declaration from Mr. Davidson. (Exh. 5562.) Mr. Davidson explained that the reason the
8 headers and footers on the letters and attachments didn't match was because the attachment
9 was generated independently of the letter. (Exh. 5562, p. 2, ¶¶ 5-6.)

10 Mr. Davidson also admitted that in four instances in which CDI questioned Mr.
11 Bugiel about letter and attachment discrepancies, the attachment that PacifiCare had
12 previously represented was connected to a first request letter was in fact the incorrect
13 document. (Exh. 5562, pp. 2, 5-6, ¶¶ 4, 16, 17, 18; Exh. 1002; Exh. 1014; Exh. 1015;
14 Exh. 1016.) Thus, even though upon being presented with these discrepancies Mr. Bugiel
15 had steadfastly testified that there was no question in his mind that they were the correct
16 letter and attachment, he was, according to Mr. Davidson, wrong. (RT 17093:22-17094:3
17 (Bugiel) ["Q. [By Gee] Does seeing this discrepancy create any question in your mind about
18 whether 3124 and 3123 [of Exhibit 1002] were indeed connected? A. No."]; RT 17118:16-
19 20 (Bugiel).)

20 Mr. Davidson also asserted that the Rawlings records confirmed that several of the
21 overpayment letters that CDI had questioned Mr. Bugiel about were in fact generated and
22 sent to the provider on or about the date of the letters. (E.g., Exh. 5562, pp. 2-4, ¶¶ 5, 10, 11,
23 12.) But in several instances, the Rawlings records that Mr. Davidson relied upon in his
24 declaration did not reflect that the letters had been sent, only that they had been printed.
25 (E.g., Exh. 1096, p. 3776; Exh. 1097, p. 3780; Exh. 1101, p. 3797; Exh. 1103, p. 3960;
26 Exh. 1105, p. 3928; Exh. 1107, p. 3920.) When Mr. Davidson was cross examined on this
27 topic, he then contended that the basis for his testimony was that the letters were printed and
28

1 that it was Rawlings’s standard practice to print the attachment and to mail both the letter and
2 attachment around the same time. (RT 19552:18-19553:4; 19554:7-22.)

3 On July 22, 2011, Mr. Davidson submitted a supplemental declaration, in which he
4 admitted that in the course of assembling the Rawlings records that CDI had requested, he
5 determined that three of the first request letters that had previously been produced to CDI,
6 and that PacifiCare had represented were sent to providers, had in fact not been sent.
7 (Exh. 5613, p. 2, ¶¶ 3-7; Exh. 1108; Exh. 1109; Exh. 1110; Exh. 1111; RT 19499:8-15
8 (Davidson).) In each of those three instances, a first request letter and attachment had been
9 generated, and they looked identical in format to the other letters and attachments that
10 Rawlings contends were sent. (Exh. 1108; Exh. 1109; Exh. 1110; Exh. 1111.) Mr. Davidson
11 ultimately admitted on cross examination that the existence of a copy of an overpayment
12 letter and attachment did not prove that they were in fact sent to a provider:

13 “Q. So Mr. Davidson, the last three exhibits or the last three overpayment
14 letters that we’ve looked at, Exhibits 1108, 1110, and 1111, were letters and
15 attachments that Rawlings located and produced to PacifiCare; is that right?

16 A. Correct.

17 Q. But, in fact, they were never sent to providers; is that right?

18 A. That is correct.

19 Q. So you would agree, would you not, that the existence of a copy of an
20 overpayment letter and invoice does not prove that they were in fact sent to the
21 provider?

22 A. Yes.” (RT 19592:19-19593:7.)

23 Accordingly, the fact that PacifiCare has located and produced a first request letter does not
24 prove in any way that that letter was actually sent. This admission — in addition to Mr.
25 Bugiel’s admission that he had no evidence that any of the letters were sent on the date of the
26 letter (RT 12700:5-8) — severely undermines PacifiCare’s contention that any of the
27 supposed first request letters it has produced establish that timely demand letters were in fact
28 sent. Add to that the complete unreliability of all the claims data PacifiCare produced
relating to these overpayment issues, and it is hard to believe any representation PacifiCare
has made here.

1 **g. Harm Caused by PacifiCare’s Violations**

2 In general, the primary harm caused by untimely overpayment demands is the
3 imposition of administrative burdens on claimants. As Mr. Cignarale testified, “[s]ending
4 untimely reimbursement requests can create significant administrative burdens on providers
5 who must track down and review old claims to verify that they were overpaid.” (Exh. 1184,
6 p. 143:16-18.) In this instance, PacifiCare sent demand letters on claims that had been paid
7 as much as four years before, thereby forcing providers to track down several-years-old
8 claims and to verify the amounts paid on those claims. (Exh. 1184, p. 152:1-2.) As Dr.
9 Mazer, testified:

10 “If you can consider the amount of time that has to go into making phone calls,
11 drafting letters, researching claims, pulling claims from three years earlier, my
12 staff’s time, my review to decide what action to take, typing up letters,
13 transcribing them, proofing them, mailing them out, the overhead costs are
14 extremely burdensome, not to mention the frustration” (RT 3051:12-23.)

15 In addition, untimely demands for reimbursement may force providers to collect
16 additional sums from patients years after treatment, which can harm members and adversely
17 affect the doctor-patient relationship. (Exh. 1184, p. 143:18-19.) Such late demands may
18 even cause patients to be denied medical care. For instance, the records produced by
19 Rawlings reflect an instance in which a patient had called Rawlings to complain that she
20 could no longer get treated by her doctor because of Rawlings’s overpayment collection
21 efforts:

22 “[S]he is upset tells me phs is fraud[.] phs has treated her like a criminal now
23 she can’t get treated by her dr. she is going to ins commissioner” (Exh. 1101,
24 p. 3797.)

25 Untimely reimbursement requests also have a negative financial impact on providers
26 because they are being asked to repay money that they may have already accounted for as
27 revenue. (Exh. 1184, p. 143:19-21.) Here, the evidence reflects that PacifiCare did in fact
28 collect alleged overpaid amounts on a large number of untimely requests but failed to repay
those amounts when it discovered the requests were untimely. PacifiCare’s data on the
overpayment letters produced in connection with Mr. Bugiel’s testimony reflected that in a

1 significant majority of the instances in which the company had sent an untimely first request
2 overpayment letter, it successfully collected from the provider the full requested amount.
3 (RT 12695:4-12695:10 (Bugiel); e.g., Exh. 839, p. 1, lines 6, 8-37, 39, 45-48, 54
4 [“Recovered Amount” column reflects full amount of request].) When asked about those
5 illegally requested funds, Mr. Bugiel admitted that PacifiCare had taken no remedial actions
6 to return those amounts to the providers:

7 “Q. When it was determined that overpayment demand letters were sent more
8 than 365 days after the date of payment in these instances, did PacifiCare or
9 United attempt to return the overpayment recoveries that it had received from
10 the providers?

11 A. The review that we did in 2008 was on anything that was open at the time.
12 For instances, where — such as what’s on Exhibit 839, we did not go back and
13 send the money back to the provider, no.

14 Q. How about for — in your searches in 2010? When you discovered that
15 there were letters sent more than 365 days after date of payment, did you
16 attempt to return those recoupments to those providers?

17 A. At this time, no.” (RT 12697:23-12698:11.)

18 Further, PacifiCare’s untimely reimbursement requests, and its failures to properly
19 maintain first request letters, imposed significant administrative burdens on the Department.

20 The Department was forced to examine PacifiCare witnesses for multiple days, to analyze
21 multiple PacifiCare claims databases, and to review thousands of pages of PacifiCare’s
22 documents comprising purported first notice letters, attachments to these letters, and internal
23 records of a PacifiCare recovery vendor — all while this hearing was continuing to proceed.

24 There were a significant number of discrepancies in PacifiCare’s data and in the documents it
25 produced, forcing the Department to piece together what actually happened using conflicting
26 information. Mr. Bugiel, the PacifiCare witness designated as the person most
27 knowledgeable on these issues, was unable to explain many of these discrepancies, and
28 PacifiCare never offered another witness or further evidence to address the many
inaccuracies in its data.

PacifiCare’s processes for data and document retention for these overpayment
demands are in disarray. The company produced data or documents purporting to show that

1 first notice letters were timely sent out; the Department would review them and find
2 discrepancies that the company couldn't explain; PacifiCare would then produce additional
3 data or documents to explain those discrepancies; but that additional information created
4 even more discrepancies, which PacifiCare again couldn't explain. (Exh. 1184, pp. 156:25-
5 157:2.)

6 **3. Number of Acts in Violation**

7 Because of the manifest unreliability of the data and documents PacifiCare has
8 produced to support its analysis, CDI would be justified in rejecting PacifiCare's entire
9 analysis and charging all 4,831 claims as acts in violation. Consistent with its conservative
10 approach, however, CDI has largely accepted PacifiCare's assertions and has alleged only
11 1,934 acts in violation. (Exh. 1209, pp. 29-30, ¶¶ 141-148.)

12 PacifiCare admitted that it sent 1,374 demand letters that were untimely. (Exh. 5392,
13 p. 1645; RT 12715:5-19 (Bugiel).) PacifiCare also admitted that it sent 560 untimely
14 demand letters on claims that were paid before January 1, 2006. (Exh. 5392, p. 1645;
15 RT 12715:5-19 (Bugiel).)

16 **4. PacifiCare Knowingly Committed the Acts in Violation, and** 17 **Performed Them with Such Frequency as to Indicate a General** 18 **Business Practice**

19 PacifiCare is chargeable with knowledge of the correspondence it sends out. Thus, it
20 knew or should have known whether it had timely sent first notice overpayment demand
21 letters, and it knew or should have known that thousands of the supposed second notice
22 letters were untimely sent. By sending those untimely letters, therefore, PacifiCare
23 knowingly misrepresented pertinent facts. (Exh. 1184, p. 150:7-11.)

24 In any event, the sheer number of illegal overpayment letters were of sufficient
25 frequency as to indicate a general business practice. Issuing over 1,900 untimely
26 overpayment demand letters over the course of five months, from January 2008 until around
27 May 2008 (Exh. 592, p. 0715), when PacifiCare claims that it stopped issuing these letters
28 for the PLHIC Historical Claims, amounts a high frequency. (Exh. 1184, p. 152:23-24.)

1 **5. The Acts in Violation Were Willful**

2 PacifiCare willfully — with a purpose and willingness — committed these acts in
3 violation. It willfully outsourced overpayment recoveries to J&R without adopting and
4 implementing proper controls to ensure that each overpayment demand was timely, which
5 resulted in these overpayment letters being sent untimely. PacifiCare admitted that it failed
6 to confirm or to require its vendor to verify that timely first notice letters were sent. This
7 failure reflects a willful refusal to adopt and implement reasonable standards for the prompt
8 investigation and processing of claims. (Exh. 1184, p. 150:20-25.)

9 Though it may not have intended to violate the law in failing to do so, the Regulations
10 make clear that such intent is unnecessary to find willfulness. (Reg. 2695.2, subd. (y).)

11 **6. The Issuance, Amendment, or Servicing of the Policy or**
12 **Endorsement Was Not Inadvertent**

13 For this category of violation, the “servicing of the policy” was the sending out of the
14 overpayment collection letters. There is no evidence that PacifiCare inadvertently sent any
15 of those letters. (Exh. 1184, p. 150:15-17.)

16 **7. Applicable Unit-Penalty**

17 Mr. Cignarale testified that, in general, an insurer’s sending of an untimely
18 reimbursement demand represents a “moderately serious” violation, noting that this type of
19 violation can create significant administrative burdens on providers, can interfere with the
20 doctor-patient relationship, and can have a negative financial impact on providers.
(Exh. 1184, p. 143:12-23.)

21 Consistent with his “moderately serious” assessment, Mr. Cignarale placed the
22 starting point for determining the unit-penalty at 30% of the way from zero to the maximum,
23 or \$3,000 per willful act. (Exh. 1184, p. 143:26-28.)

24 After evaluating the evidence of the specific violations in this case, Mr. Cignarale
25 found mostly aggravating circumstances.

26 As for the remedial measures factor (Reg. 2695.12, subd. (a)(8)), Mr. Cignarale
27 credited PacifiCare for canceling the overpayment requests on the claims for which it could
28 not find first request letters, but found that PacifiCare failed to take actions to remediate the

1 underlying causes that led to these violations. (Exh. 1184, p. 151:14-16.) In particular, he
2 took note of Mr. Bugiel’s testimony that there were no corrective action plans implemented
3 to address the sending of repeated requests for repayment on claims that had already been
4 repaid or to address the sending of second requests in absence of a documentable first request
5 within 365 days, and considered these failures to be an aggravating factor. (Exh. 1184,
6 p. 151:16-20.) Mr. Cignarale also considered it an aggravating factor that PacifiCare
7 successfully collected reimbursements from providers based on illegal overpayment requests,
8 yet did not attempt to repay those amounts. (Exh. 1184, p. 151:22-24.)

9 The harm caused by PacifiCare’s violations (Reg. 2695.12, subd. (a)(10)) was a
10 slightly aggravating factor for Mr. Cignarale given that these overpayment requests related to
11 several-year-old claims, which imposed significant and unnecessary administrative burdens
12 on providers. (Exh. 1184, p. 152:1-2.)

13 Also aggravating was Mr. Cignarale’s determination that PacifiCare failed to show a
14 good faith attempt to comply. (Reg. 2695.12, subd. (a)(11).) Though PacifiCare quickly
15 responded after provider complaints were filed with CDI and the CMA, the company’s
16 actions that led to the violations were not taken in good faith. Not verifying that a first
17 request letter was timely sent before sending second request letters is, Mr. Cignarale noted,
18 “such an obvious omission, especially when the claims are several years old, that I cannot
19 conclude that the company acted in good faith.” (Exh. 152, p. 152:13-20.) Mr. Cignarale
20 also considered the unreliability of the company’s claims data as evidence of bad faith.
21 (Exh. 1184, p. 152:20-22.) As CDI demonstrated at the hearing, these flawed data contained
22 so many discrepancies that no reasonable insurer would rely upon them in the conduct of its
23 business.

24 Mr. Cignarale also deemed PacifiCare’s failure to remediate these issues sooner an
25 aggravating factor. PacifiCare took action only after these illegal overpayment demands
26 were brought to its attention in mid-2008, but, with reasonable diligence, should have
27 detected these problems, including the numerous discrepancies in its data, far sooner.
28 (Exh. 1184, pp. 152:26-153:6.)

1 Mr. Cignarale found the remaining penalty factors to be neither aggravating nor
2 mitigating.

3 On balance, Mr. Cignarale concluded that these aggravating circumstances warranted
4 a 40% increase in the unit-penalty, from \$3,000 to \$4,200 per act in violation, for an
5 aggregate penalty of \$8,122,800 for these 1,934 acts in violation. (Exh. 1184, p. 153:7-10.)

6 **L. Failure to Maintain Complete Claim Files**

7 **1. Applicable Legal Requirements**

8 In order to ensure that claims are promptly and correctly processed and to promote
9 effective regulation, the UIPA imposes on insurers various requirements relating to the
10 maintenance of their claim files. Regulation 2695.3, subdivision (a) first makes every
11 licensee's claim files subject to examination by the Commissioner, and then requires that
12 those files contain "all documents, notes and work papers (including copies of all
13 correspondence) which reasonably pertain to each claim in such detail that the pertinent
14 events and the dates of the events can be reconstructed and the licensee's actions pertaining
15 to the claim can be determined."

16 Subdivision (b) specifies three additional requirements for insurers — that they:

17 "(1) maintain claim data that are accessible, legible and retrievable for
18 examination so that an insurer shall be able to provide the claim number, line
19 of coverage, date of loss and date of payment of the claim, date of acceptance,
20 denial or date closed without payment. This data must be available for all open
and closed files for the current year and the four preceding years

21 "(2) record in the file the date the licensee received, date(s) the licensee
22 processed and date the licensee transmitted or mailed every material and
relevant document in the file; and

23 (3) maintain hard copy files or maintain claim files that are accessible, legible
24 and capable of duplication to hard copy; files shall be maintained for the
current year and the preceding four years."

25 Thus, an insurer that fails to maintain in its claim files all documents pertaining to
26 claims and claim data for the claim number, line of coverage, and relevant dates violates this
27 provision of the Regulations.
28

1 Similarly, the failure to maintain a complete claim file, if committed knowingly or
2 with such frequency as to indicate a general business practice, violates section 790.03,
3 subdivision (h)(3), if that failure affects the prompt investigation and processing of claims.
4 (Exh. 1184, p. 153:17-20.) Such failures also violate section 790.03, subdivision (h)(2), if
5 they prevent the insurer from acknowledging and acting reasonably promptly upon
6 communications with respect to claims. (Exh. 1184, p. 153:20-22.)

7 **2. PacifiCare's Violations of Law**

8 In investigating the complaints filed by members and providers against PacifiCare,
9 CDI compliance officers identified at least 6 instances in which the company failed to
10 maintain important claim-related documents in its files.

11 For example, with respect to CSB-6223822, PacifiCare failed to produce the complete
12 claim file even after three separate requests from CDI. CDI determined that it had not been
13 provided with the complete file because the complainant had submitted claim-related letters
14 from PacifiCare that were missing from PacifiCare's file. (Exh. 180, p. 3519.)

15 With respect to CSB-6232755, PacifiCare was similarly unable to produce the
16 complete claim file, as CDI again discovered that claim-related documents were missing
17 based on a submission by the complainant. (Exh. 141, pp. 9705-9706.)

18 Based on its investigation of consumer complaints, CDI cited PacifiCare at least four
19 additional instances of failing to maintain a complete claim file. (Exh. 38, p. 4086; Exh. 57,
20 p. 8685; Exh. 79, p. 6318; Exh. 85, p. 4453.) In each instance, CDI sent a violation letter to
21 PacifiCare notifying the company that its failure violated the law. (Exh. 38; Exh. 57;
22 Exh. 79; Exh. 85; Exh. 141; Exh. 180.) PacifiCare did not respond to those letters to contest
23 the violations.

24 During the MCE, PacifiCare admitted that it failed in five instances to maintain all
25 documents, notes, and work papers in its claim files, in violation of Regulation 2695.3,
26 subdivision (a). (Exh. 1, p. 3537.) It also admitted that it failed in three instances to
27 maintain documents in its claim files that are accessible, legible, and capable of duplication
28 to hard copy, in violation of Regulation 2695.3, subdivision (b). (Exh. 1, p. 3538.)

1 PacifiCare also failed to maintain in its claim files claim dependent documents, such
2 as COCCs, in a number of instances. As a result, claims were improperly denied. In the case
3 of Ms. W, for instance, she testified that she faxed in a copy of the requested COCC multiple
4 times, but PacifiCare continued to deny her son’s claim on the ground that it had not received
5 the COCC. (RT 1025:11-1027:3.) CDI is charging this as one act in violation.

6 In addition, PacifiCare has admitted that, for several years, it was unable to locate in
7 its files documentation on claim overpayment demands in at least 2,605 instances.
8 According to PacifiCare, there were 1,846 overpayment letters that it couldn’t find in 2008 or
9 2009, but was able to locate in mid-2010 after several searches. (Exh. 5392, p. 1645;
10 RT 12690:3-12; 11893:23-11894:11 (Bugiel).) PacifiCare also contended that it located data
11 in mid-2010 indicating there were 163 claims on which the provider voluntarily repaid the
12 overpayment; it previously failed to provide such data to CDI. (Exh. 5392, p. 1645;
13 Exh. 837; RT 12685:21-12686:4 (Bugiel).) PacifiCare further contended that it located data
14 in mid-2010 reflecting that there were 596 claims that were not pursued for secondary
15 recovery; again, the company was unable to provide such data to CDI for several years.
16 (Exh. 5392, p. 1645.) These 2,605 acts in violation are not being charged in this action, but
17 they are aggravating evidence of the company’s overall lack of competence and general
18 inability to maintain complete claim files in compliance with the law.

19 The primary harm caused by an insurer’s failure to maintain claim files is that it
20 imposes burdens — in this case, significant burdens — on the Department, thereby
21 undermining effective regulation and frustrating the regulatory process. (Exh. 1184,
22 p. 154:15-18.) When CDI is forced to make multiple requests for complete documentation
23 and to reconcile data that are incomplete or contain inaccuracies, as was the case here, it
24 diverts time and resources from other regulatory matters. (Exh. 1184, pp. 156:15-157:2.)
25 Avoiding these burdens is precisely the purpose of Regulation 2695.3’s requirement that
26 insurers maintain complete claim files that are accessible and retrievable. (Exh. 1184,
27 p. 157:2-6.)

1 These failures also harm claimants, as the evidence here reflects. In a number of
2 instances described above, PacifiCare failed to provide CDI a complete claim file, which
3 delayed CDI's regulatory review and the ultimate resolution of a consumer's complaint.
4 PacifiCare's failure to maintain claim files here also resulted in it incorrectly denying claims,
5 which causes serious harm to consumers.

6 **3. Number of Acts in Violation**

7 PacifiCare committed 15 acts in violation for failing to maintain a complete claim
8 file. (Exh. 38, p. 4086; Exh. 57, p. 8685; Exh. 79, p. 6318; Exh. 85, p. 4453; Exh. 141,
9 pp. 9705-9706; Exh. 180, p. 3519; Exh. 1, pp. 3537, 3538; RT 1025:11-1027:3 (Ms. W).)

10 **4. PacifiCare Knowingly Committed the Acts in Violation**

11 PacifiCare committed these acts in violation knowingly as that term is used in
12 section 790.03, subdivision (h) as defined by the Regulations. PacifiCare, of course, is
13 charged with knowledge of the documents it maintains in its own claim files. (Exh. 1184,
14 p. 155:3-6.) There is no evidence that PacifiCare had a reasonable basis to be unaware of the
15 contents of its files.

16 **5. The Acts in Violation Are Not Being Charged As Willful**

17 CDI is not charging these acts in violation as willful.

18 **6. The Issuance, Amendment, or Servicing of the Policy or** 19 **Endorsement Was Not Inadvertent**

20 PacifiCare's failure to maintain complete claim files here do not constitute an
21 inadvertent issuance, amendment, or servicing of a policy. There was no evidence that any
22 of the missing first request letters was inadvertently omitted from the relevant claim file.
23 (Exh. 1184, p. 155:10-13.)

24 **7. Applicable Unit-Penalty**

25 Mr. Cignarale's penalty analysis of the evidence for this category focused on
26 PacifiCare's failure to maintain first request overpayment letters relating to the J&R
27 breakdown, which are no longer being charged in this action. Mr. Cignarale's testimony on
28 this category, however, remains instructive.

1 Mr. Cignarale first testified that he viewed this type of violation, in general, to be
2 “less serious than average” placing it at 10% of the way from zero to the maximum, or \$500
3 per non-willful act. (Exh. 1184, p. 154:8-23.) He noted that failing to maintain a claim file
4 may cause a claim to be incorrectly processed or to be paid untimely, or may result in
5 increased administrative burdens on claimants who are forced to re-submit information to
6 insurers multiple times. (Exh. 1184, p. 154:11-14.) They may also increase the burdens
7 imposed on the regulator when it must make multiple requests for documents in a claim file,
8 or must investigate a claim based on an incomplete file.

9 For the failure-to-maintain-documents violations that remain in this case, there is no
10 evidence of extraordinary circumstances (Reg. 2695.12, subd. (a)(1)), and no evidence that
11 the claims at issue were complex, or that maintaining the complete claim files for those
12 claims was complex (Reg. 2695.12, subd. (a)(3)). Nor is there sufficient evidence in the
13 record to assess the relative-number-of-claims factor. (Reg. 2695.12, subd. (a)(7).)

14 As to remedial measures taken, PacifiCare contended during the MCE, that it
15 “conducted additional training in October 2007 to address the specific requirements for
16 properly documenting a claim adjudication decision” (Exh. 1, p. 3538), but the company has
17 offered no evidence demonstrating that such training actually took place or that it effectively
18 remediated PacifiCare’s problems. And given the number of other misrepresentations to
19 CDI made by PacifiCare, CDI would be well justified in rejecting this assertion out of hand.
20 CDI will nevertheless credit PacifiCare with having taken remedial actions (Reg. 2695.12,
21 subd. (a)(7)), and with having done so promptly after the company became aware of these
22 acts (Reg. 2695.12, subd. (a)(13)). Those are mitigating factors.

23 The degree of harm occasioned by these violations (Reg. 2695.12, subd. (a)(10)) is
24 consistent with that which Mr. Cignarale testified presents in the typical case — incorrectly
25 processed claims, untimely processed claims, and increased administrative burdens on
26 claimants and CDI. (Exh. 1184, p. 154:8-18.) Accordingly, no adjustment is necessary.

1 There is no evidence that under the totality of circumstances, PacifiCare made a good
2 faith attempt to comply (Reg. 2695.12, subd. (a)(11)). This factor is neither aggravating or
3 mitigating.

4 CDI considers the frequency of the occurrence and/or severity of the detriment to the
5 public as neither aggravating nor mitigating. The number of charged violations is not of a
6 high frequency, though there is evidence in the record or thousands of violations that are not
7 being charged. Further, by imposing burdens on CDI, PacifiCare frustrated the regulatory
8 process and caused detriment to the public. CDI, however, is not seeking aggravation for
9 this factor, even though it would be justified.

10 On balance, these factors represent a set of circumstances that are mitigating. CDI
11 therefore requests a reduction of no more than 15% of the unit-penalty, from \$500 to \$425
12 per act in violation. Based on a unit-penalty of \$425, the aggregate penalty would be \$6,375
13 for these 15 acts in violation.

14 **M. Failure to Timely Respond to CDI Inquiries**

15 **1. Applicable Legal Requirements**

16 The law requires that insurers fully and accurately respond to CDI inquiries within a
17 reasonable time. Section 790.03, subdivision (h)(2) demands that insurers acknowledge and
18 act reasonably promptly upon any communications with respect to claims. Regulation
19 2695.5, subdivision (a) further defines that requirement, setting a 21-day deadline for
20 insurers to provide a complete written response to any inquiry from CDI:

21 “Upon receiving any written or oral inquiry from the Department of
22 Insurance concerning a claim, every licensee shall immediately, but in no
23 event more than twenty-one (21) calendar days of receipt of that inquiry,
24 furnish the Department of Insurance with a complete written response based
25 on the facts as then known by the licensee. A complete written response
26 addresses all issues raised by the Department of Insurance in its inquiry and
27 includes copies of any documentation and claim files requested. This section is
28 not intended to permit delay in responding to inquiries by Department
personnel conducting a scheduled examination on the insurer’s premises.”

2. PacifiCare's Violations of Law

1
2 When CDI receives a member or provider complaint against PacifiCare, it requests
3 the claim file and other documentation in order to review the complaint. In investigating
4 these complaints against PacifiCare, CDI compliance officers identified at least 29 instances
5 in which the company failed to provide a complete written response to such a CDI inquiry
6 within 21 days. (See Exh. 1209, ¶¶ 5, 8, 27, 38, 46, 55, 57, 58, 60, 61, 65, 66, 67, 69, 70, 71,
7 72, 73, 80, 98.)

8 For example, for CSB-6244025, CDI sent PacifiCare a letter dated March 2, 2007,
9 requesting the company's complete responses regarding the status of the claim at issue and a
10 copy of the complete claim file. PacifiCare's response failed to include the actual bill
11 submitted as well as other relevant claim information. (Exh. 38, p. 4086.)

12 For CSB-6242825, CDI sent PacifiCare a letter dated February 28, 2007, requesting
13 the company's complete responses regarding the status of the claim at issue and a copy of the
14 complete claim file. PacifiCare's response failed to include copies of the EOBs. (Exh. 41,
15 p. 9453.)

16 For CSB-6232755, CDI sent PacifiCare a letter dated January 2, 2007, requesting the
17 company's complete responses regarding the status of the claim at issue and the complete
18 claim file. PacifiCare failed to respond within 21 days, failed to provide the complete claim
19 file, and failed to provide a complete response. (Exh. 141, p. 9706.)

20 For CSB-6237500, CDI sent PacifiCare a letter dated January 26, 2007, requesting
21 the company's complete responses regarding the status of the claim at issue and the complete
22 claim file. PacifiCare failed to provide a complete response within 21 days. (Exh. 185,
23 p. 4485.)

24 For CSB-6233559, CDI sent PacifiCare a letter dated January 25, 2007, requesting
25 the company's complete responses regarding the status of the claim at issue and the complete
26 claim file. PacifiCare failed to respond within 21 days, failed to provide the complete
27 underwriting file as was requested, and failed to provide a complete response. (Exh. 188,
28 p. 0191.)

1 For CSB-6234573, CDI sent PacifiCare a letter dated February 7, 2007, requesting
2 the company's complete responses regarding the status of the claim at issue and the complete
3 claim file. PacifiCare failed to provide a complete response within 21 days. (Exh. 190,
4 p. 8697.)

5 For CSB-6244432, CDI sent PacifiCare a letter dated March 7, 2007, requesting the
6 company's complete responses regarding the status of the claim at issue and the complete
7 claim file. PacifiCare failed to provide a complete response within 21 days. (Exh. 201,
8 p. 9706.)

9 CDI cited PacifiCare at least 22 additional times throughout 2007, 2008, and 2009 for
10 failing to timely respond to CDI inquiries. (Exh. 69, pp. 1449-1450 [1 citation]; Exh. 83,
11 p. 6676 [2 citations]; Exh. 92, pp. 2610-2611 [1 citation]; Exh. 133, pp. 4956-4957 [2
12 citations]; Exh. 166, p. 1506 [2 citations]; Exh. 169, p. 6341 [2 citations]; Exh. 171,
13 pp. 5347-5348 [2 citations]; Exh. 180, p. 3519 [3 citations]; Exh. 181, p. 0542 [2 citations];
14 Exh. 182, p. 8215 [1 citation]; Exh. 184, p. 3139 [1 citation]; Exh. 189, p. 7723 [1 citation];
15 Exh. 223, p. 9968 [2 citations].)

16 In each instance, CDI sent a violation letter to PacifiCare notifying the company that
17 it had violated the law. (Exh. 38; Exh. 41; Exh. 69; Exh. 83; Exh. 92; Exh. 133; Exh. 141;
18 Exh. 166; Exh. 169; Exh. 171; Exh. 180; Exh. 181; Exh. 182; Exh. 184; Exh. 185; Exh. 188;
19 Exh. 189; Exh. 190; Exh. 201; Exh. 223.) PacifiCare did not respond to those letters to
20 contest the violations. During the MCE, PacifiCare further admitted that it failed to timely
21 respond to a CDI inquiry in one instance. (Exh. 1, p. 3539.)

22 These failures were caused by a sharp increase in regulatory complaints against
23 PacifiCare, especially in early 2007, as well as PacifiCare's failure to appropriately staff its
24 operations. In March 2007, Dr. Ed Sakamoto, the VP of Clinical Review and Policy
25 (Exh. 671, p. 1544) and the overall head of the member appeals department (RT 14517:3-7
26 (Cunningham)), reported that "the PPO work increased from 60 to 70 [DOI complaints] to
27 over 200 to a max of 220 in Feb. 07." (Exh. 670, p. 0432; RT 9100:11-17 (Monk).) He
28 noted that the majority of these issues were coming out of California and the Northwest.

1 (Exh. 670, p. 0432.) He blamed this large number of DOI complaints on United’s taking
2 over PacifiCare’s claims, customer service, membership accounting, and the mail room:
3 “Then United took over the PacifiCare Claims shop, Customer Service, Membership
4 Accounting, and the mail room — all of which generated large numbers of DOI complaints
5 and still do.” (Exh. 670, p. 0432.) Katrina Pelto, a Director in PacifiCare’s Appeals &
6 Grievances, Regulatory Compliance department, confirmed Dr. Sakamoto’s account. She
7 reported in March 2007 that the “PPO team’s volume has more than doubled within a year,”
8 attributing this twofold increase to the ongoing integration projects implemented by United:
9 “Ongoing transitions of United IT/staffing/work processes are contributing to increase and
10 are not anticipated to decrease.” (Exh. 671, p. 1545.)

11 At the same time PacifiCare was experiencing a significant increase in complaints
12 against it, the company’s appeals unit was being cut. As Dr. Sakamoto complained,
13 “Commercial staff is half of original staff post split with Ovations and the commercial
14 volumes increased dramatically, especially the PPO DOI cases — 91 cases per month to an
15 average of 267 cases per month from 176.” (Exh. 671, pp. 1544-1545 [March 21, 2007,
16 email from Sakamoto to Tanigawa].) He also noted that in late 2006, before the increase in
17 complaints, “[w]e were understaffed even at that time, but could not hire due to the ‘all-in’
18 budget limitations.” (Exh. 670, p. 0432.)

19 Ms. Monk admitted at the hearing that the “high volume” of complaints being filed
20 against PacifiCare in the February to April 2007 period adversely affected the company’s
21 ability to timely and accurately respond to CDI inquiries. (RT 9106:3-17.) PacifiCare
22 further admitted that case research on complaints was “not beginning until day 10-20 after
23 day of receipt,” which “leads to increased pressure on other depts. [that the appeals
24 department] rel[ies] on for research, less time for thorough research and investigation.”
25 (Exh. 671, p. 1546.) PacifiCare also admitted that the increase in inquiries from regulators
26 was “often due to lack of info provided in [the] first response to DOI” and that the company
27 had “ceased providing feedback on individual cases to various depts. whose error may have
28 caused the complaint in the first place.” (Exh. 671, p. 1546.)

1 While failing to timely respond to CDI inquiries, by itself, is not among the most
2 serious of violations, it is still a cause of concern. Responding to inquiries by CDI should be
3 a high priority for insurers, particularly when, as here, those inquiries relate to member and
4 provider complaints filed against the company. Failing to timely respond to such a CDI
5 inquiry delays regulatory review and resolution of a claim that is being appealed by a
6 member or provider, resulting in harm to the member or provider. (Exh. 1184, p. 159:1-3.)

7 Further, as reflected in Regulation 2695.5, timely responding to CDI inquiries is
8 necessary to ensure effective regulation. Delays in responding to CDI inquiries and in
9 providing documentation and claim files requested can significantly frustrate the regulatory
10 process. (Exh. 1184, p. 159:4-7.)

11 **3. Number of Acts in Violation**

12 PacifiCare failed to timely provide a complete written response to CDI in at least 29
13 instances. (Exh. 38; Exh. 41; Exh. 69; Exh. 83; Exh. 92; Exh. 133; Exh. 141; Exh. 166;
14 Exh. 169; Exh. 171; Exh. 180; Exh. 181; Exh. 182; Exh. 184; Exh. 185; Exh. 188; Exh. 189;
15 Exh. 190; Exh. 201; Exh. 223.)

16 **4. PacifiCare Knowingly Committed the Acts in Violation**

17 PacifiCare is charged with knowing the dates it receives inquiries from CDI and the
18 dates it provides a complete response to CDI. (Exh. 1184, p. 160:6-8.) CDI expects that all
19 insurers have actual knowledge of these dates, and an insurer's contention that it doesn't
20 reflects on the competence of that insurer. But at a minimum, PacifiCare had constructive
21 knowledge that it was sending these responses untimely.

22 **5. The Acts in Violation Are Not Being Charged As Willful**

23 Consistent with Mr. Cignarale's conclusions, CDI is not charging these acts in
24 violation as willful. (Exh. 1184, p. 160:16.)

25 **6. The Issuance, Amendment, or Servicing of the Policy or 26 Endorsement Was Not Inadvertent**

27 PacifiCare has not argued, and has offered no evidence demonstrating, that it
28 inadvertently sent any of these responses to CDI. (Exh. 1184, p. 160:11-13.)

1 Commissioner to conduct investigations of claims on behalf of an insurer. The
2 term ‘claims agent,’ however, shall not include the following: (1) an attorney
3 retained by an insurer to defend a claim brought against an insured; or,
4 (2) persons hired by an insurer solely to provide valuation as to the subject
5 matter of a claim.” (Reg. 2695.2, subd. (d).)

6 Failing to provide such training on the Regulations to any claims agent therefore violates
7 section 790.03, subdivision (h)(2) and Regulation 2695.6, subdivision (b). (See Exh. 1184,
8 p. 162:3-8.)

9 **2. PacifiCare’s Violations of Law**

10 PacifiCare’s Appeals & Grievances department is responsible for processing appeals
11 of claim adjudications that are filed by members. (RT 1541:16-18 (Mace-Meador);
12 RT 1057:24-1058:12 (Valenzuela).) As of May 2007, it comprised 11 Appeals Coordinators
13 and 3 Appeals Nurses. (Exh. 5046, p. 2222.) Each of these 14 appeals processors qualifies
14 as a claims agent under the Regulations.

15 In a PowerPoint presentation PacifiCare provided CDI at the entrance conference for
16 the 2007 MCE, PacifiCare represented that the Appeals Coordinators and Appeals Nurses in
17 the Appeals & Grievances department received training on the Fair Claims Settlement
18 Practices Regulations in May 2007. (Exh. 5046, p. 2222.) Heather Mace-Meador, a Director
19 of Appeals & Grievances, testified that this May 2007 training was provided at the
20 instruction of the company’s regulatory department. (RT 1545:17-1546:1.)
21 Ms. Mace-Meador, however, testified that prior to May 2007, her department had not
22 received such training:

23 “Q. Prior to 2007, was there any department-wide training on the Fair Claim
24 Practices Regulations in your unit?

25 A. No.” (RT 1546:2-5.)

26 As discussed above, PacifiCare outsourced overpayment recovery functions to J&R.
27 In addition to sending letters demanding reimbursement of alleged overpayments, J&R
28 handled certain appeals on behalf of PacifiCare, in accordance with its 2007 contract with
PacifiCare (Exh. 312, pp. 6-7 of 92, ¶ 4.17.3 [“Appeals Handling/Compliance”]). Mr.
Cassady, a business manager at J&R, testified that “whenever Johnson & Rountree is

1 attempting to collect a payment from a provider and the provider disputes the overpayment,
2 Johnson & Rountree functions as the appeals unit of the insurance company” though there
3 are certain types of appeals that J&R doesn’t handle. (RT 2924:10-18; see also RT 2891:15-
4 2892:7.) Mr. Cassady further testified that there were nine claims agents in J&R’s appeals
5 department. (2896:8-19.) Since each of these agents is responsible for processing claim
6 appeals for PacifiCare, section 790.03, subdivision (h)(2) and Regulation 2695.6, subdivision
7 (b) require that they receive training on the Regulations.

8 But Mr. Cassady was unaware if any of them had ever received training on the
9 Regulations; in fact, he was unfamiliar with the Regulations himself and did not believe any
10 copies of them existed at J&R’s offices. (RT 2926:17-24.) Mr. Bugiel, PacifiCare’s
11 designated person most knowledgeable about the J&R issues, was also unaware of whether
12 J&R employees had received training on the Regulations. (RT 3732:19-22.)

13 Failing to provide training on the Regulations is a very serious violation that may lead
14 to errors in processing claims, resulting in additional violations of law and in harm to
15 members and providers. (Exh. 1184, p. 162:11-13.) This is a basic requirement that should
16 not be difficult to comply with, and the failure to do so reflects a concerning disregard for
17 clear and unambiguous regulatory requirements. (Exh. 1184, p. 162:13-16.)

18 **3. Number of Acts in Violation**

19 PacifiCare failed to provide training on the Regulations to its 14 appeals processors
20 before May 2007. Though CDI would be well justified to charge an act in violation for each
21 year that each appeals processor was not provided this training, CDI has conservatively cited
22 PacifiCare for only 14 total acts in violation for these failures.

23 Similarly, PacifiCare has failed to provide the nine J&R appeals agents training on the
24 Regulations for a number of years, and as of the time Mr. Cassady and Mr. Bugiel testified in
25 2010, still does not appear to have provided such training. Yet CDI has conservatively
26 charged only nine acts in violation for these continuing failures.

1 **4. PacifiCare Knowingly Committed the Acts in Violation**

2 Because PacifiCare is charged with knowing that its claims agents weren't being
3 trained on the Regulations, it knowingly failed to adopt and implement reasonable standards
4 for the prompt investigation and processing of claims. (Exh. 1184, p. 163:6-8.)

5 **5. The Acts in Violation Are Not Being Charged As Willful**

6 Consistent with Mr. Cignarale's testimony, CDI is charging these acts as non-willful.
7 (Exh. 1184, p. 163:16.)

8 **6. The Issuance, Amendment, or Servicing of the Policy or**
9 **Endorsement Was Not Inadvertent**

10 There is no evidence that PacifiCare's failure to train these claims agents constitutes
11 an inadvertent servicing of the policy. (Exh. 1184, p. 163:12-13.)

12 **7. Applicable Unit-Penalty**

13 Mr. Cignarale began his unit-penalty analysis with a determination that failing to train
14 claims agents was a "very serious" violation:

15 "In comparison to the range of violations to which section 790.035
16 applies, I view this failure as very serious. This type of violation may lead to
17 errors in processing claims, which result in additional violations of law and
18 harm members and providers. Further, I consider the requirement to train
19 claims agents on the Regulations to be a basic requirement that should not be
20 difficult to comply with. In general, failure to do so reflects a concerning
21 disregard for regulatory requirements. However, the seriousness of the
22 violation might depend on whether the company, for example, simply
23 disregarded the requirement to train or instituted training that was inadequate;
24 as well as on the responsibilities of the employees whom it failed to train."
25 (Exh. 1184, p. 162:11-18.)

26 Based on this assessment, Mr. Cignarale opined that the starting point for this type of
27 violation should be 60% of the way from zero to the maximum, or \$3,000 for non-willful
28 acts in violation. (Exh. 162:21-23.)

29 Mr. Cignarale then evaluated the evidence of the specific violations in this case,
30 finding both aggravating and mitigating circumstances. He found that the harm caused by
31 these violations was greater than that of a typical case (Reg. 2695.12, subd. (a)(10)), noting
32 that these violations were based on the company's failure to provide any training whatsoever,

1 as opposed to providing inadequate training. (Exh. 1184, p. 164:3-6.) PacifiCare also failed
2 to train the entire Appeals & Grievances unit and the entire J&R appeals unit, which Mr.
3 Cignarale opined is more serious than failing to train one or a few employees in those units.
4 (Exh. 1184, p. 164:6-7.) Mr. Cignarale also observed that claims that get appealed are
5 typically more complicated than other claims making training all the more important, while
6 also acknowledging that fewer claims get appealed, leading to fewer opportunities for errors.
7 (Exh. 1184, p. 164:8-10.)

8 Mr. Cignarale also concluded that the 23 acts in violation, as an absolute number, is
9 “probably not a particularly high frequency” (Reg. 2695.12, subd. (a)(12)), though at the
10 same time, he recognized that providing training on the Regulations is “a basic requirement
11 that should be easy to comply with.” (Exh. 1184 p. 164:13-14.) Mr. Cignarale also testified
12 that he saw no evidence that the detriment to the public was severe. He therefore considered
13 the subdivision (a)(12) factor to be slightly mitigating. (Exh. 1184, p. 164:15-16.)

14 Mr. Cignarale found no mitigating or aggravating evidence relating to the other
15 factors. (Exh. 1184, pp. 163:20-164:19.)

16 Taking these circumstances into account, Mr. Cignarale concluded that an increase in
17 the unit-penalty of 10%, from \$3,000 to \$3,300 per act in violation, was appropriate. This
18 results in an aggregate penalty for this category of \$75,900 for these 23 acts in violation.
19 (Exh. 1184, p. 164:20-23.)

20 **O. Misrepresentations to CDI**

21 CDI has charged PacifiCare with nine acts in violation for making misrepresentations
22 of material fact during the 2007 MCE. Such misrepresentations constitute violations of
23 Regulation 2695.5, subdivision (a), which requires that insurers provide in response to CDI
24 inquiries “a complete written response based on the facts as then known by the licensee,” and
25 section 790.03, subdivision (e), which makes it an unfair and deceptive act to make any false
26 statement or to willfully omit any material fact pertaining to the business of the insurer with
27 the intent to deceive any examiner.

1 During course of the 2007 MCE, PacifiCare made multiple misrepresentations of fact
2 to CDI in response to CDI inquiries and referrals.

3 For instance, in response to an early referral, PacifiCare misrepresented to CDI that
4 the company was sending acknowledgment letters when, in fact, it was not. CDI had
5 requested that PacifiCare produce data on the dates that the company acknowledged the
6 receipt of claims, and PacifiCare responded that those data were “not available at this time”
7 because of the way the acknowledgment letter dates were tracked in RIMS. (Exh. 110,
8 p. 4828 [“The field ‘date ack letter sent’ was requested by the Department to be included, but
9 is not available for reporting at this time.”]; RT 10000:9-10000:15 (Berkel); RT 11573:13-19
10 (David).) As Ms. Norket testified, this response meant that “there were acknowledgment
11 letters” during this time, but that PacifiCare was simply unable to provide the dates of those
12 acknowledgment letters on an automated basis. (RT 2393:3-8.) That was false. PacifiCare
13 was unable to provide CDI dates of acknowledgment because the company was failing to
14 send acknowledgment letters at that time. (See pp. 221-223, 229, *supra*.)

15 Once PacifiCare was forced to admit that it had failed to send acknowledgment
16 letters, it then misrepresented the dates that its acknowledgment-letter process for providers
17 was not in compliance, claiming that the period of noncompliance was about a half year,
18 when in fact it was well over two years. In responding to a CDI referral, Ms. Norket
19 reported that the company failed to print acknowledgment letters from July 2006 until
20 January 2007. (Exh. 113, p. 9893.) In the company’s two December 7, 2007, letters
21 responding to the examination reports, Ms. Berkel similarly represented that the company
22 was not in compliance for July 2006 through December 2006. (Exh. 117, p. 3410; Exh. 118,
23 p. 3427.) In fact, PacifiCare failed to send acknowledgment letters to providers from January
24 2006 until March 2008. The company also failed to send acknowledgment letters to
25 members from July 2006 until March 2007. (See p. 229, *infra*.)

26 In October 2007, PacifiCare promised CDI that the company was having a weekly
27 report generated to ensure that acknowledgment letters were being sent timely and
28 appropriately. (Exh. 113, p. 9893.) No such weekly report was ever generated. In a

1 November 29, 2007, email, Ms. Norket stated: “I don’t know why the response said a report
2 had been requested from Duncan. I did not initiate that, which was why I asked the question
3 to Jose on the CAP.” (Exh. 272 [Norket 11:02 a.m.].) Even though Ms. Norket was aware in
4 November that this promise made to CDI had not been kept, she never informed the
5 Department of that fact, and was unaware of anyone at PacifiCare who did. (RT 2400:14-
6 2401:4 (Norket).)

7 In responding to a referral, PacifiCare purposely omitted the role of the UnitedHealth
8 Group acquisition in the acknowledgment-letter violations. Ms. Norket had determined that
9 the cause of PacifiCare’s failure to send acknowledgment letters was the transition of
10 printing functions from PacifiCare’s internal department to Duncan, which was undertaken
11 “as part of the UHC acquisition.” (Exh. 149, pp. 1026-1027.) She, however, recommended
12 omitting the part about “as part of the UHC acquisition” from the company’s response to
13 CDI, even though she acknowledged that “that’s truly what happened.” (Exh. 149, p. 1026
14 [Norket 8:11 a.m.]; RT 2344:13-2345:3; 2346:3-10 (Norket); RT 1081:20-1082:6
15 (Valenzuela).) PacifiCare’s final response to CDI withheld that information. (Exh. 113,
16 p. 9893.)

17 In responding to a referral dated October 17, 2007, PacifiCare failed to provide CDI
18 with copies of acknowledgment letters that had actually been sent by PacifiCare, doing so in
19 a manner intended to conceal the fact that the acknowledgment letters were still not being
20 sent. (Exh. 114; Exh. 115; see also p. 226.)

21 In responding to a CDI questionnaire about attrition at PacifiCare, PacifiCare
22 purposely decided not to disclose to CDI that the “biggest reason for turnover” was
23 “[d]issatisfaction with benefits and overtime.” (Exh. 363, p. 5972 [Norket 12:18 p.m.].) Ms.
24 Norket wrote to Mr. Orejudos that they “probably don’t want to mention this but it is the
25 biggest reason for turnover.” (Exh. 363, p. 5972 [Norket 12:18 p.m.].) Mr. Orejudos agreed
26 and this information was omitted from the response to CDI: “I think it is safe to indicate all
27 of the reasons you mention except, as you say, the second one regarding dissatisfaction with
28 benefits and overtime.” (Exh. 363, p. 5972 [Orejudos 10:37 a.m.].)

1 Misrepresentations to a regulator such as these represent a level of harm that is
2 “acutely serious,” as Mr. Cignarale testified. (Exh. 1184, p. 165:11-12.) Effective regulation
3 depends on the candor of regulatees. The Department simply does not have sufficient
4 resources to independently verify every representation made by its licensees; rather, the
5 Department must trust that the claims data provided by insurers are authentic and not
6 manipulated, must trust that claim files produced contain all relevant documentation, and
7 must trust that statements made by insurers are true and do not omit material information.
8 Intentional misrepresentations undermine and frustrate the regulatory process and cannot be
9 tolerated. Though harm to members and providers may not be as direct as, say, when a claim
10 is incorrectly denied or is untimely processed, it still obtains, indeed, in a more pervasive
11 manner as less effective regulation affects all consumers. (Exh. 1184, p. 165:13-20.)

12 Even though PacifiCare’s misrepresentations to CDI deserve punishment at the
13 highest level (Exh. 1184, p. 165:23-25), CDI is not seeking penalties under section 790.035
14 for these violations since it is asking that they be considered as aggravating factors in other
15 violation categories.

16 **P. Failure to Conduct Business in Company’s Own Name**

17 **1. Applicable Legal Requirements**

18 Section 880 requires that “every insurer shall conduct its business in this State in its
19 own name.” This requires, among other things, that insurers identify the legal name of the
20 underwriting company on all correspondence to members and providers, such as claim-
21 related letters and EOBs and EOPs. Each piece of correspondence that fails to do so
22 constitutes an act in violation of section 880.

23 An insurer that fails to conduct business in its own name also violates section 790.03,
24 subdivision (h)(1). (Exh. 1184, p. 166:5-9.) As reflected in section 880, the Legislature has
25 determined that the name of an insurer is a pertinent fact that is required to be used in the
26 conduct of an insurer’s business. Thus, failing to properly identify the insurer’s legal name
27 constitutes a misrepresentation of a pertinent fact.

1 [1 citation]; Exh. 201, p. 9706 [1 citation]; Exh. 206, p. 9686 [1 citation]; Exh. 207, p. 6686
2 [1 citation]; Exh. 220, p. 9806 [1 citation]; Exh. 223, p. 9967 [3 citations].)

3 In each instance, CDI sent a violation letter to PacifiCare notifying the company that
4 its failure violated the law. (Exh. 38; Exh. 134; Exh. 168; Exh. 175; Exh. 177; Exh. 180;
5 Exh. 183; Exh. 193; Exh. 198; Exh. 200; Exh. 201; Exh. 206; Exh. 207; Exh. 220; Exh. 221;
6 Exh. 223.) PacifiCare did not respond to those letters to contest the violations.

7 Identifying the insurer's name in business correspondence is a basic requirement that
8 should be easy to comply with. (Exh. 1184, p. 166:24-25.) An insurer's failure to comply
9 with it is a reflection of its overall competence and the level of importance it ascribes to
10 regulatory compliance.

11 As discussed above, this type of violation may also result in member and provider
12 confusion and may prevent a claimant from filing an appeal with the insurer or with the
13 appropriate regulatory agency, particularly when, as here, the company has several insurance
14 companies that share similar names. These risks present serious concerns. (Exh. 1184,
15 p. 166:14-16.) These risks were also exacerbated in this case because PacifiCare's EOPs
16 failed to contain the required notification of the right to appeal to CDI and CDI's contact
17 information. Indeed, Ms. Wetzel testified that the CMA and its physician members were
18 having difficulty in 2006 and early 2007 determining which regulator to file complaints with
19 because PacifiCare's EOBs and EOPs lacked the required notice and failed to identify the
20 status of the insured. (RT 17178:4-24.)

21 **3. Number of Acts in Violation**

22 PacifiCare committed at least 29 acts in violation of section 790.03, subdivision (h)(1)
23 and section 880 by failing to conduct business in its own name. (Exh. 1209, ¶¶ 5, 56, 59, 62,
24 63, 65, 68, 75, 78, 79, 80, 84, 85, 95, 96, 98.)

25 Given that these failures occurred on both letters and EOBs, which PacifiCare
26 generates using form templates, it is likely that it failed to conduct business in its own name
27 in far more instances than what is being charged here.

1 **4. PacifiCare Knowingly Committed the Acts in Violation**

2 PacifiCare is, of course, chargeable with knowledge of the contents of its
3 correspondence, particularly with respect to something as important as identification of the
4 company’s legal name. There is simply no excuse for non-compliance with such a basic
5 requirement, and any assertion that an insurer had a reasonable basis to be unaware that its
6 correspondence and EOBs failed to identify the company would be highly suspect.

7 **5. The Acts in Violation Are Not Being Charged As Willful**

8 CDI is not charging these violations as willful acts in violation.

9 **6. The Issuance, Amendment, or Servicing of the Policy or**
10 **Endorsement Was Not Inadvertent**

11 There is no evidence that these violations constitute an inadvertent issuance,
12 amendment, or servicing of the policy. PacifiCare intended to send each of these letters and
13 EOBs.

14 **7. Applicable Unit-Penalty**

15 As Mr. Cignarale testified, the failure to conduct business using the legal name of the
16 underwriting insurance company is a “less serious than average violation” that warrants
17 starting at 5% above the minimum penalty in the range, or \$250 per act, for the calculation of
18 the unit-penalty. (Exh. 1184, p. 166:13-21.)

19 CDI sees no mitigation based on the 2695.12 factors — no evidence of extraordinary
20 circumstances (Reg. 2695.12, subd. (a)(1)); no evidence that the claims involved were
21 complex (Reg. 2695.12, subd. (a)(3)); no evidence of mitigation based on the relative
22 number of claims factor (Reg. 2695.12, subd. (a)(7)); no evidence of remedial measures
23 (Reg. 2695.12, subd. (a)(8)); no evidence that PacifiCare made a good faith attempt to
24 comply (Reg. 2695.12, subd. (a)); and no evidence that the frequency of the occurrence and
25 the severity of the detriment was any less than the typical case (Reg. 2695.12, subd. (a)(12)).

26 In fact, as Mr. Cignarale testified, approximately 30 such acts in violations over the
27 course of a two-year period is a higher frequency than he would expect, which could be an
28 aggravating factor. (Exh. 1184, p. 166:24-26.) In addition, because of PacifiCare’s

1 concurrent failures to provide on its EOPs notification of the right to CDI review and CDI's
2 contact information, the harm caused by these violations is likely greater than the usual case.

3 CDI nevertheless does not seek aggravation based on the 2695.12 factors, and
4 proposes that these acts be penalized at the \$250 unit-penalty recommended by Mr.
5 Cignarale. This results in an aggregate penalty of \$7,250 for these 29 acts in violation.

6 **Q. Failure to Timely Respond to Claimants**

7 **1. Applicable Legal Requirements**

8 The law requires that insurers promptly respond to communications from a claimant
9 regarding a claim. Section 790.03, subdivision (h)(2) demands that insurers acknowledge
10 and act reasonably promptly upon any communications with respect to claims.

11 Regulation 2695.5, subdivision (b) further defines what "reasonably promptly" means in the
12 context of responding to communications from claimants; insurers must provide a complete
13 response "immediately, but in no event more than fifteen (15) calendar days after receipt of
14 that communication":

15 "Upon receiving any communication from a claimant, regarding a claim, that
16 reasonably suggests that a response is expected, every licensee shall
17 immediately, but in no event more than fifteen (15) calendar days after receipt
18 of that communication, furnish the claimant with a complete response based
19 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."

20 An insurer that fails to respond to such a communication from a claimant within 15 days, or
21 otherwise fails to provide a complete response to a claimant violates these provisions.

22 (Exh. 1184, p. 167:7-14.)

23 **2. PacifiCare's Violations of Law**

24 In investigating the complaints filed by members and providers against PacifiCare,
25 CDI compliance officers identified at least seven instances in which the company failed to
26 provide a complete written response to a communication from a claimant within 15 days.

27 For example, for CSB-6242825, PacifiCare received a facsimile from the claimant on
28 September 14, 2006, but never responded, requiring the claimant to call the company about

1 two months later, on November 9, 2006. (Exh. 41, p. 9455.) PacifiCare was cited for one
2 violation for this failure. (Exh. 41, p. 9455 [1 citation].)

3 For CSB-6268720, PacifiCare failed to respond to a provider's request to terminate
4 the contract effective January 1, 2006, until over eighteen months later, on August 31, 2007.
5 (Exh. 56, p. 9178.) PacifiCare further failed to respond to two requests for reconsideration of
6 claims sent by the provider on March 15, 2007, and May 14, 2007. (Exh. 56, p. 9178.)
7 PacifiCare was cited for three violations for these failures. (Exh. 56, p. 9178 [3 citations].)

8 Based on its investigation of consumer complaints, CDI cited PacifiCare at least three
9 additional times for failing to timely respond to claimants. (Exh. 38, p. 4087 [2 citations];
10 Exh. 218, p. 9673 [1 citation].) In each instance, CDI sent a violation letter to PacifiCare
11 notifying the company that its failure violated the law. (Exh. 38; Exh. 41; Exh. 56;
12 Exh. 218.) PacifiCare did not respond to those letters to contest the violations.

13 During the MCE, CDI further cited PacifiCare for failing to respond to members'
14 appeals within 15 days in 11 instances, though those citations are not being charged in this
15 enforcement action. (Exh. 1, p. 3538.)

16 In addition, PacifiCare admitted that the results of a December 2008 audit revealed
17 that it failed to fully respond to all the issues in a member appeal in two instances.
18 (Exh. 235; RT 1653:5-9 (Mace-Meador).) In fact, a manager in the Appeals & Grievances
19 department admitted that in "both of these cases we were way off in addressing all the
20 issues." (Exh. 235; RT 1653:10-12 (Mace-Meador).)

21 Responding to claim-related communications from claimants should be a high priority
22 for insurers. That is the essence of what insurers are supposed to do. Failing to timely
23 respond to such communications delays proper processing of claims and delays proper
24 payment of claims, resulting in direct harm to members and providers. (Exh. 1184,
25 p. 167:18-19.)

26 As is reflected in this record, such delays by insurers also cause significant frustration
27 and pain and suffering for members and providers:

1 “I was having to make these phone calls [to PacifiCare] during my work hours
2 and I was reprimanded. I was denied a raise. I was put on probation. And,
3 um, I had a complete meltdown at work the day this happened with him. And
4 I had to be sent home. My daughter had to pick me up. I couldn’t stop crying.
5 I couldn’t stop shaking. My heart was beating irregularly. And I was
6 embarrassed to go back.” (RT 1040:11-17 (Ms. W); see also RT 3036:13
7 (Mazer) [“sheer unadulterated frustration”].)

3. Number of Acts in Violation

8 CDI has charged PacifiCare with nine acts in violation for failing to timely respond to
9 communications from claimants. (Exh. 1209, ¶¶ 5, 8, 17, 93, 185.)

4. PacifiCare Knowingly Committed the Acts in Violation

10 PacifiCare is charged with knowing the dates it receives communications from
11 claimants and the dates it responds to those communications. At a minimum, PacifiCare had
12 constructive knowledge that it was sending these responses untimely.

5. The Acts in Violation Are Not Being Charged As Willful

13 CDI is not charging these violations as willful acts in violation.

6. The Issuance, Amendment, or Servicing of the Policy or Endorsement Was Not Inadvertent

14 There was no inadvertent issuance, amendment, or servicing of the policy with
15 respect to these violations. PacifiCare has not argued, and has offered no evidence
16 demonstrating, that it inadvertently sent any of these responses to claimants.
17

7. Applicable Unit-Penalty

18 Mr. Cignarale rated this category of violation as “less serious than average,” though
19 he recognized that delays in responding to claimants harms members and providers, and may
20 result in delays in processing claims. (Exh. 1184, p. 167:17-19.) Accordingly, he
21 recommended a \$1,000 unit-penalty for a typical non-willful violation for failing to timely
22 respond to claimants. (Exh. 1184, p. 167:22-24.)
23

24 PacifiCare has offered no mitigating evidence for these violations. Indeed, the fact
25 that PacifiCare was still failing to provide complete responses to claimants as late as
26 December 2008 could be an aggravating factor under Regulation 2695.12, but CDI
27 nevertheless proposes that PacifiCare be penalized at \$1,000 per act in violation, as
28

1 recommended by Mr. Cignarale. This results in an aggregate penalty of \$9,000 for these
2 nine acts in violation.

3 **R. Failure to Implement a Policy Regarding Recording the Date of Receipt of**
4 **Claims**

5 **1. Applicable Legal Requirements**

6 Section 790.03, subdivision (h)(3) requires insurers to adopt and implement
7 reasonable standards for the prompt investigation and processing of claims. This, at a
8 minimum, would include having in place a policy for claims examiners with respect to
9 recording the correct date that claims are received by an insurer.

10 Regulation 2695.3, subdivision (b) specifically requires insurers to maintain in the
11 claim file information regarding the date the licensee received any claims or claim-related
12 documents. Subdivision (a) of that Regulation further requires insurers to maintain in claim
13 files information in such detail that the dates of the events can be reconstructed and the
14 licensee's actions pertaining to the claim can be determined. (Exh. 1184, p. 168:14-19.)

15 The failure to have in place a policy instructing claims examiners to record the proper
16 date of receipt of a claim violates these provisions, and each instance in which an examiner
17 fails to properly record the date of receipt further constitutes an act in violation of these
18 provisions.

19 In addition, failing to record the correct date of receipt of a claim may result in other
20 violations of law, such as claims being paid late or the statutory interest being incorrectly
21 calculated. (Exh. 1184, p. 168:12-14.)

22 **2. PacifiCare's Violations of Law**

23 At the hearing, Ms. Mace-Meador, a Director of PacifiCare's Appeals & Grievances
24 department, was questioned about a member complaint against PacifiCare filed with CDI in
25 early 2007. (Exh. 224.) The member had complained about PacifiCare's delays in
26 processing two claims. (Exh. 224, p. 2393; RT 1566:22-1567:2; 1573:8-12 (Mace-Meador).)
27 The member had submitted the claims multiple times, but PacifiCare had no record of them.

1 (Exh. 224, pp. 2393, 2394; RT 1566:22-1567:2; 1570:22-1571:2; 1575:10-13 (Mace-
2 Meador).)

3 In internal correspondence regarding this complaint, PacifiCare employees expressed
4 confusion about the proper date to record as the date that the claim was received by the
5 company. (RT 1586:4-9 (Mace-Meador).) For instance, Linda Clark, an analyst in the
6 Regulatory Appeals department (Exh. 224, p. 2381), wrote on February 20, 2007:

7 “My question is this: The claims have been paid but the received date was
8 2/11/2006 (the date that appeals found the information)[.] Should we
9 reprocess the claims using [t]he 11/27/06 date since I have to include that
documentation with my letter to DOI?” (Exh. 224, p. 2387 [Clark 1:53 p.m.])

10 Ms. Mace-Meador instructed Ms. Clark to use the 11/27/06 date, and then noted that she
11 wanted to start having her Appeals team note the claim received date when submitting
12 overturn adjudications:

13 “Is CA the only state where the claim rcvd date is an important factor for
14 calculating interest? I want to have my Appeals team note the claim received
15 date when they are submitting the overturn for effectuation but I need to
16 confirm which states that rule applies to.” (Exh. 224, p. 2387 [Mace-Meador
12:22 p.m.])

17 On cross examination, Ms. Mace-Meador admitted that at the time of her February 20, 2007,
18 e-mail to Ms. Clark, her department did not have a policy for determining or documenting
19 the original receipt date of a claim:

20 “Q. [By Strumwasser] May I infer from the second sentence of that
21 paragraph that at the time you wrote this your department did not have a
22 standing instruction on what to use for the date the claim was received?

MR. KENT: Vague.

THE COURT: Overruled.

24 THE WITNESS: We did not have as part of our appeals research process
25 specific instructions on documenting or how to determine the original receipt
date of the claim.” (RT 1589:2-11.)

26 PacifiCare offered no evidence at the hearing indicating that such a policy was ever
27 implemented.

1 The harm caused by not having a policy in place for recording the proper date of
2 receipt of a claim is very serious. (Exh. 1184, p. 168:22-23.) Recording the correct received
3 date of a claim is a fundamental requirement underlying all of the provisions of the Insurance
4 Code and Regulations that seek to ensure the prompt payment of claims. If an insurer does
5 not have a consistent policy regarding the recordation of the received date, it calls into
6 question the accuracy of the claims data of that company.

7 For this reason, PacifiCare’s reliance on its “metrics” and “turnaround times” for
8 claims processing is misplaced. Its various assertions that it processed a high percentage of
9 claims within some number of days are meaningless if it hasn’t recorded the proper received
10 date for claims in the first place. PacifiCare’s reporting pursuant to the Undertakings,
11 specifically with respect to the “Claims processed within 30 calendar day” metric
12 (Exh. 5191, p. 9394), is highly suspect given the company’s lack of a policy for recording the
13 correct received date of a claim.

14 PacifiCare’s lack of such a policy also directly harms claimants. PacifiCare’s
15 Appeals & Grievance department reviews claims that need to be reprocessed for additional
16 payment and for interest. (E.g., Exh. 224; RT 1551:23-1552:15; 1663:1-8 (Mace-Meador).)
17 Determining the correct received date is vital to their function, and the failure to provide such
18 instructions to the entire department is a very serious problem that has the potential to cause
19 many claims payment errors. (Exh. 1184, p. 169:2-4 .)

20 This failure is all the more concerning given the company’s practice, with respect to
21 rework claims, of using the date the rework request was received as the “received date” in
22 RIMS. (RT 2368:15-25; 2369:9-16 (Norket).) As Ms. Norket explained, it would then be up
23 to the claims agent to determine the original received date and to manually change the date in
24 RIMS so that interest would be calculated appropriately. (RT 2368:18-25.) But without a
25 policy on what received date to use, claims agents in the Appeals & Grievances department
26 wouldn’t know what date to use so that interest could be calculated properly.

1 **3. Number of Acts in Violation**

2 Each of the claims for which PacifiCare failed to record the correct date of receipt
3 constitutes a separate act in violation. PacifiCare, however, has not produced sufficient data
4 to determine for how many claims the company recorded the wrong date of receipt.
5 Accordingly, one act in violation is being charged for PacifiCare’s lack of a policy on
6 recording the date of receipt. And one additional act in violation is being charged for
7 PacifiCare’s failure to record the received date in the case of the complaint described above.
8 (Exh. 224, pp. 2393, 2394; RT 1566:22-1567:2, 1570:22-1571:2, 1575:10-13 (Mace-
9 Meador).) It is likely that there are far more acts in violation that PacifiCare committed.

10 **4. PacifiCare Knowingly Committed the Acts in Violation**

11 It is without question that PacifiCare knows or should know about its policies or lack
12 of policies for recording the dates that claims are received, particularly given that the law
13 requires insurers to pay claims within a period of time after the date the claim is received.

14 **5. The Acts in Violation Are Not Being Charged As Willful**

15 CDI is not charging these violations as willful acts in violation.

16 **6. The Issuance, Amendment, or Servicing of the Policy or
17 Endorsement Was Not Inadvertent**

18 There is no evidence that PacifiCare’s failure to implement a policy regarding
19 recording the date of receipt constitutes an inadvertent issuance, amendment or servicing of
20 the policy.

21 **7. Applicable Unit-Penalty**

22 Mr. Cignarale testified that such a failure to implement a policy regarding recording
23 the date of receipt of a claim represents a “very serious” violation that as a general
24 proposition should be penalized at 65% of the way from zero to the maximum, or \$3,250 per
25 act for non-willful violations. (Exh. 1184, p. 168:22-169:9.)

26 PacifiCare has offered no evidence in mitigation for these violations. In fact, it has
27 provided no evidence that it ever remediated this failure by implementing a consistent policy
28 for its Member & Grievances department, which could be an aggravating factor. CDI,

1 however, conservatively seeks the \$3,250 unit-penalty recommended by Mr. Cignarale, for
2 an aggregate penalty of \$6,500 for these two acts in violation.

3 **S. Failure to Conduct a Thorough Investigation**

4 **1. Applicable Legal Requirements**

5 The UIPA imposes on insurers various requirements relating to the investigation and
6 processing of claims. Section 790.03, subdivision (h) requires that insurers adopt and
7 implement reasonable standards for the prompt investigation and processing of claims
8 (subdivision (h)(3)), and requires that insurers attempt in good faith to effectuate prompt,
9 fair, and equitable settlements of claims in which liability has become reasonably clear
10 (subdivision (h)(5)). Regulation 2695.7, subdivision (d) further specifies these obligations,
11 requiring that “[e]very insurer shall conduct and diligently pursue a thorough, fair and
12 objective investigation and shall not persist in seeking information not reasonably required
13 for or material to the resolution of a claim dispute.”

14 The UIPA also requires an insurer fails to conduct an adequate investigation of a
15 claim. For example, as a consequence of not conducting an adequate investigation into a
16 claim, an insurer may illegally misrepresent pertinent facts or insurance policy provisions in
17 violation of section 790.03, subdivision (h)(1), or may fail to affirm or deny claims within a
18 reasonable time in violation of section 790.03, subdivision (h)(4).

19 **2. PacifiCare’s Violations of Law**

20 In investigating member and provider complaints against PacifiCare, CDI compliance
21 officers identified and cited PacifiCare for failing to conduct and diligently pursue
22 investigations of claims in at least 37 instances. (See Exh. 1209, ¶¶ 2, 3, 7, 8, 11, 12, 18, 24,
23 33, 35, 36, 37, 42, 47, 48, 49, 54, 58, 67.)

24 For instance, PacifiCare routinely denied claims based on the *possibility* that the
25 treatment may have been provided for a pre-existing condition, even before the company
26 requested medical records that would have been necessary to adequately investigate and
27 determine whether the patient had such a pre-existing condition. (E.g, Exh. 29, p. 1032
28 [7 citations]; Exh. 79, pp. 6317-6318 [1 citation].)

1 In a number of other instances, PacifiCare continued to request from members and
2 providers medical information that was unnecessary and duplicative because the information
3 had already been provided; as a result of PacifiCare's failure to investigate, PacifiCare
4 repeatedly denied these claims improperly. (E.g., Exh. 22, p. 9513 [3 citations]; Exh. 76,
5 p. 8929 [1 citation]; Exh. 48, p. 9388 [3 citations]; Exh. 49, p. 3598 [1 citation]; Exh. 57,
6 p. 8684 [1 citation]; Exh. 166, p. 1506 [4 citations]; Exh. 182, p. 8215 [6 citations]; Exh. 93,
7 p. 2752 [1 citation].)

8 PacifiCare also required claimants to re-submit claims multiple times in order to get
9 them processed, in one instance causing an over 10-month delay in getting a claim processed
10 correctly. (Exh. 65, p. 8535 [1 citation]; Exh. 78, p. 6139 [1 citation]; Exh. 102, p. 4588
11 [1 citation involving a 10-month delay in payment].) PacifiCare also incorrectly denied
12 several claims and incorrectly rejected appeals, in many instances not correctly processing
13 the claims until the claimant filed a complaint with the Department.

14 CDI cited PacifiCare at least 6 additional times throughout 2007, 2008, and 2009 for
15 failing to conduct and diligently pursue investigations of claims. (Exh. 40, p. 4014
16 [1 citation]; Exh. 41, p. 9455 [1 citation]; Exh. 81, p. 5975 [1 citation]; Exh. 87, pp. 7477-
17 7478 [1 citation]; Exh. 94, p. 9810 [1 citation]; Exh. 95, p. 0057 [1 citation].)

18 In each instance, CDI sent a violation letter to PacifiCare notifying the company that
19 its failure violated the law. (Exh. 22; Exh. 29; Exh. 40; Exh. 41; Exh. 48; Exh. 49; Exh. 57;
20 Exh. 65; Exh. 76; Exh. 78; Exh. 79; Exh. 81; Exh. 87; Exh. 93; Exh. 94; Exh. 95; Exh. 102;
21 Exh. 166; Exh. 182.) PacifiCare did not respond to contest any of the violations.

22 In addition, based on the testimony of Ms. W, CDI has cited PacifiCare for failing to
23 conduct a thorough investigation in 13 instances. (Exh. 1209, ¶¶ 174-178.) Six of those
24 violations related to PacifiCare's illegal practice of closing or denying claims when it was
25 requesting additional information to process the claim, and the penalties sought for those six
26 acts in violation are included in part IV.J of this Brief, *supra*. (Exh. 1209, ¶ 174.) PacifiCare
27 also made numerous requests of Ms. W for additional medical information that she had
28 previously provided, in some instances multiple times. For instance, even though Ms. W had

1 submitted certain medical information to PacifiCare on January 3, 2006 (RT 1019:7-1019:23
2 (Ms. W)), PacifiCare illegally requested that Ms. W resubmit that same medical information
3 an additional two times in order to process her son's claim. (RT 1019:24-1020:6 (Ms. W).)
4 Similarly, on January 13, 2006, Ms. W submitted a COCC that PacifiCare had requested.
5 (RT 1026:2-8 (Ms. W).) Yet PacifiCare later requested that she resubmit a copy of that
6 COCC three more times. (RT 1026:20-1027:10 (Ms. W).) Then, in the summer of 2006,
7 PacifiCare made another unnecessary request for the medical records of Ms. W's son — the
8 same medical records that it had previously requested and that had been provided.
9 (RT 1036:11-20 (Ms. W).) The next year, on March 6, 2007, PacifiCare made yet another
10 request for the same medical records that it already had. (RT 1038:11-18 (Ms. W).) Each of
11 these unnecessary requests for medical information constitutes an act in violation of
12 section 790.03, subdivisions (h)(1), (h)(3), (h)(4), and (h)(5) and Regulation 2695.7,
13 subdivision (d).

14 After Mr. R had submitted claims for his eye surgeries in July and August 2006,
15 PacifiCare falsely claimed not to have received them, and required Mr. R to resubmit these
16 claims at least two additional times. (RT 1723:23:10-16; 1725:7-12 (Mr. R); Exh. 1209,
17 ¶ 179.) Each of these two requests for information already provided constitutes an act in
18 violation of section 790.03, subdivisions (h)(1), (h)(3), (h)(4), and (h)(5) and Regulation
19 2695.7, subdivision (d).

20 As the evidence here demonstrates, an insurer's failure to conduct a thorough
21 investigation is very serious. (Exh. 1184, p. 170:19-20.) It results in claims being
22 incorrectly processed, forcing members and providers to submit additional, unnecessary
23 information, to re-submit claims, to file appeals, to file complaints with CDI, all of which
24 delays payment, imposes administrative burdens, and creates significant frustration, as both
25 Mr. R and Ms. W testified. Failures to conduct and diligently pursue investigations also
26 result in members and providers being denied payment altogether, which can lead patients to
27 be denied medical treatment because they do not contest the insurer's incorrect adjudications
28

1 of the claims, or because they give up appealing the insurer's determinations on the claims.
2 (Exh. 1184, p. 170:23-27.)

3 **3. Number of Acts in Violation**

4 PacifiCare failed to conduct and diligently pursue investigations of claims in at least
5 52 instances, in violation of the UIPA and the Regulations. As discussed above, 6 of those
6 acts in violation related to the company's illegal practice of closing or denying claims when
7 requesting additional information, and the discussion of the appropriate penalty to impose for
8 those acts are discussed above in part IV.J, *supra*.

9 **4. PacifiCare Knowingly Committed the Acts in Violation**

10 PacifiCare certainly had actual or constructive knowledge of the thoroughness or lack
11 of thoroughness of its investigations. It knew or should have known that its investigations of
12 claims did not meet the standards required by law.

13 **5. The Acts in Violation Are Not Being Charged As Willful**

14 CDI is not charging these violations as willful acts in violation.

15 **6. The Issuance, Amendment, or Servicing of the Policy or**
16 **Endorsement Was Not Inadvertent**

17 There is no evidence that PacifiCare's failures to conduct a thorough investigation
18 into claims constitute an inadvertent issuance, amendment, or servicing of the policy.
19 PacifiCare cannot seriously contend that — and there is no evidence that — it inadvertently
20 denied claims based on the possibility of a pre-existing condition exclusion, or that it
21 inadvertently requested that consumers submit additional information, or that it inadvertently
22 requested that consumers re-submit claims.

23 **7. Applicable Unit-Penalty**

24 Mr. Cignarale testified that this type of violation is "very serious" that should be
25 penalized as a general matter, at \$3,250 per act in violation for non-willful violations.
26 (Exh. 1184, p. 170:19-171:5.)

27 PacifiCare has offered no evidence indicating any mitigating circumstances for these
28 violations. On the contrary, the evidence in the record demonstrates that PacifiCare's

1 failures to conduct thorough investigations in this case resulted in serious harm to consumers,
2 in particular, Mr. R and Ms. W. Though aggravation would be warranted, CDI seeks a
3 penalty of \$3,250 per act in violation, representing an aggregate penalty of \$149,500 for the
4 46 acts in violation being charged for this category.

5 **T. Misrepresentations of Pertinent Facts**

6 **1. Applicable Legal Requirements**

7 Not surprisingly, the UIPA makes it an unfair and deceptive business act or practice
8 for insurers to provide incorrect information to claimants regarding their insurance coverage.
9 (Exh. 1184, p. 171:12-14.) Section 790.03, subdivision (h)(1) prohibits insurers from
10 “[m]isrepresenting to claimants pertinent facts or insurance policy provisions relating to any
11 coverages at issue.”

12 Regulation 2695.4, subdivision (a) adds to that prohibition by imposing an affirmative
13 obligation on insurers to disclose “all benefits, coverage, time limits or other provisions of
14 any insurance policy issued by that insurer that may apply to the claim presented by the
15 claimant.” That subdivision further requires that insurers inform claimants whenever there is
16 a reasonable possibility that additional benefits under a policy might be owed and to
17 cooperate with claimants in determining the additional amounts owed: “When additional
18 benefits might reasonably be payable under an insured’s policy upon receipt of additional
19 proofs of claim, the insurer shall immediately communicate this fact to the insured and
20 cooperate with and assist the insured in determining the extent of the insurer’s additional
21 liability.”

22 An insurer that provides incorrect information to claimants relating to a claim thus
23 violates these provisions.

24 **2. PacifiCare’s Violations of Law**

25 In investigating member and provider complaints against PacifiCare, CDI compliance
26 officers identified a large number of instances in which the company provided false
27 information to members and providers in the processing of claims and appeals.
28

1 For example, for CSB-6267035, PacifiCare issued multiple EOBs to the insured and
2 provider that provided misinformation, such as incorrect remark codes and incorrect patient
3 responsibility amounts. (Exh. 22, p. 9513.) As a result, PacifiCare was cited for 18
4 violations. (Exh. 22, p. 9513 [18 citations].)

5 For CSB-6252108, PacifiCare sent a letter to the complainant falsely stating that
6 claims had never been received, even though the claim file revealed that the claims had been
7 received at least twice before. PacifiCare also issued an EOB that falsely informed the
8 insured that the services exceeded the maximum allowable benefit provision of the policy.
9 (Exh. 48, p. 9388.) As a result, PacifiCare was cited for two violations. (Exh. 48, p. 9388
10 [2 citations].)

11 For CSB-6268702, PacifiCare issued multiple EOBs that contained misinformation
12 regarding the contract status of the provider, the contract provider discounts, the amounts
13 payable by PacifiCare, and the patient financial responsibility. (Exh. 53, p. 2884.)
14 PacifiCare sent reconsideration letters that provided the same misinformation. (Exh. 53,
15 p. 2884.) As a result, PacifiCare was cited for 20 violations. (Exh. 53, p. 2884
16 [20 citations].)

17 For CSB-6253866, PacifiCare issued multiple EOBs that falsely stated that
18 authorization for services had not been obtained, even though the claim file reflected that
19 authorization for these services had been obtained and was documented in case entry notes
20 and in a letter. (Exh. 55.) As a result, PacifiCare was cited for five violations. (Exh. 55
21 [5 citations].)

22 For CSB-6279328, PacifiCare issued a denial letter misinforming the claimant that
23 the claims had not been received prior to June 20, 2007. But the claim file included a
24 PacifiCare letter dated April 14, 2007, confirming the receipt of the claims and all
25 information necessary to process the claims. (Exh. 78, pp. 6139-6140.) As a result,
26 PacifiCare was cited for one violation. (Exh. 78, pp. 6139-6140 [1 citation].)

27 For CSB-6223822, PacifiCare's customer service representative misinformed the
28 claimant regarding the applicable calendar year maximum during a telephone call on

1 March 10, 2006. PacifiCare acknowledged that this information was incorrect. (Exh. 180,
2 p. 3518.) As a result, PacifiCare was cited for one violation. (Exh. 180, p. 3518 [1 citation].)

3 CDI cited PacifiCare at least 33 additional times throughout 2006, 2007, 2008, and
4 2009 for misrepresenting pertinent facts. (Exh. 36 [1 citation]; Exh. 39, p. 2247 [1 citation];
5 Exh. 49, p. 3598 [14 citations]; Exh. 51, pp. 0667-0668 [4 citations]; Exh. 60, p. 9532
6 [1 citation]; Exh. 70 [1 citation]; Exh. 72, p. 8878 [1 citation]; Exh. 77 [1 citation]; Exh. 81,
7 p. 5975 [1 citation]; Exh. 85, p. 4453 [1 citation]; Exh. 90 [1 citation]; Exh. 94, p. 9811
8 [2 citations]; Exh. 133, p. 4956 [1 citation]; Exh. 205, p. 9659 [1 citation]; Exh. 207, p. 6686
9 [1 citation]; Exh. 222, p. 1292 [1 citation].)

10 In each of these instances, CDI sent a violation letter to PacifiCare notifying the
11 company that its misrepresentations violated the law. (Exh. 22; Exh. 36; Exh. 39; Exh. 48;
12 Exh. 49; Exh. 51; Exh. 53; Exh. 55; Exh. 60; Exh. 70; Exh. 72; Exh. 77; Exh. 78; Exh. 81;
13 Exh. 85; Exh. 90; Exh. 94; Exh. 133; Exh. 180; Exh. 205; Exh. 207; Exh. 222.) PacifiCare
14 never responded to contest the citations.

15 PacifiCare also made material misrepresentations to its member, Mr. R. In a
16 January 24, 2007, letter, PacifiCare misrepresented to Mr. R that it had not received a claim
17 for date of service August 7, 2006, until January 5, 2007, and on that basis refused to pay
18 interest on that late-paid claim. (Exh. 138, p. 9751.) But Mr. R testified that he had
19 submitted that claim multiple times in August 2006, within a day of having treatment.
20 (Exh. 135, p. 9888; RT 1722:17-21; 1723:21-24.) Mr. R further testified that he received
21 denials from PacifiCare on this claim prior to January 5, 2007, when PacifiCare contends it
22 first received the claim. (RT 1748:18-1749:6.) This misrepresentation constitutes at least one
23 act in violation of the law.

24 PacifiCare also misrepresented to Mr. R that his claim was for an uncovered service
25 under his policy. PacifiCare issued an EOB dated 9/14/2006 denying the claim on the
26 ground that “Eye exams, glasses, contact lenses and routine eye refractions are not covered.”
27 (Exh. 140, p. 9721; Exh. 243; RT 1729:10-1730:3; 1733:2-11 (Mr. R).) That denial was
28 wrong. PacifiCare ultimately admitted that the claim was covered under the policy after Mr.

1 R filed a complaint with CDI. (Exh. 138, pp. 9749-9750; Exh. 140, pp. 9725, 9738.) This
2 misrepresentation constitutes at least one act in violation of the law.

3 PacifiCare also misrepresented to Mr. R that his claim for date of service 8/7/2006
4 was “ineligible” for coverage. (Exh. 140, p. 9734; RT 1730:4-20 (Mr. R).) That was false.
5 As discussed, PacifiCare ultimately reprocessed and paid that claim. (Exh. 138, pp. 9749-
6 9750; Exh. 140, pp. 9725, 9738.) This misrepresentation constitutes at least one act in
7 violation of the law.

8 There is evidence that PacifiCare’s call center gave incorrect information and made
9 multiple misrepresentations to members and providers. For example, in September 2007, a
10 PLHIC customer service representative incorrectly told a PLHIC PPO member that he was
11 enrolled in a PLHIC HMO plan. (Exh. 349, pp. 6625 [vvandeweghe@sandiego.gov
12 2:36 p.m.], 6624 [Santillan 2:25 p.m.: “Ryan wasnt [sic] reading the system correctly for
13 HMO”].) Mr. Sing testified that the PacifiCare’s customer service representative incorrectly
14 told the member that he had HMO coverage. (RT 3373:21-23; 9433:18-9434:3.)

15 PacifiCare customer service also provided false information about whether Social
16 Security numbers are printed on PPO insurance cards. First, the customer service
17 representative told the member that Social Security numbers were no longer being printed on
18 PPO cards. (Exh. 349, p. 6625; RT 9436:17-21 (Sing).) Then, Ms. Santillan, another
19 PacifiCare employee, told the customer that they were. (Exh. 349, p. 6624 [Santillan
20 2:57 p.m.: “I was actually unsure if this SSN issue on PPO cards was still happening until
21 recently I received an email with copies of the SSN appearing in the ID# colum [sic] which
22 was an update by a customer service rep so yes apparantly [sic] this is still happening.”].)
23 Mr. Sing testified that Ms. Santillan gave the customer incorrect information and that in fact
24 Social Security numbers were not being printed on PPO cards at that time. (RT 9435:22-25;
25 9437:13-9438:3.)

26 The harm caused by providing to claimants incorrect information about claims can be
27 very serious. (Exh. 1184, p. 171:17-18.) The most harmful misrepresentations are those
28 misinforming consumers about eligibility, coverage and benefits, as these can lead to patients

1 deferring needed medical care because they believe it will not be reimbursed. (Exh. 1184,
2 p. 171:18-21.)

3 Such misrepresentations also can result in significant delays in claim reimbursements,
4 as the evidence here reflects. In many instances, PacifiCare's misrepresentations caused
5 claims to be paid many months late. Such delays have serious financial consequences for the
6 consumer.

7 **3. Number of Acts in Violation**

8 Based on CDI's investigation of member and provider complaints, CDI cited
9 PacifiCare in 80 instances for making misrepresentations of pertinent facts. (See Exh. 1209,
10 ¶¶ 2, 4, 6, 11, 12, 13, 14, 16, 21, 28, 30, 34, 35, 37, 40, 44, 48, 55, 65, 83, 85, 97, 180, 181,
11 182, 183.)

12 In addition, PacifiCare made multiple misrepresentations relating to coverage in the
13 processing of Mr. R's claims, three of which are being charged here. (Exh. 1209, ¶¶ 180-
14 182.)

15 PacifiCare's customer service also made a number of material misrepresentations to
16 customers, two of which are being charged here. (Exh. 1209, ¶ 183.)

17 **4. PacifiCare Knowingly Committed the Acts in Violation**

18 PacifiCare is chargeable with knowledge of the type of facts that it is accused here of
19 misrepresenting. For instance, the company should know whether a particular insured is on
20 an HMO or PPO plan; or whether a claim is for a covered or uncovered service; or the
21 correct dates that PacifiCare received a claim. In fact, an insurer that argues that it doesn't
22 know such fundamental aspects of its business is admitting that it doesn't have adequate
23 control over its operations and lacks sufficient competence to run its company.

24 **5. The Acts in Violation Are Not Being Charged As Willful**

25 CDI is not charging these violations as willful acts in violation.
26
27
28

1 **6. The Issuance, Amendment, or Servicing of the Policy or**
2 **Endorsement Was Not Inadvertent**

3 There is no evidence that PacifiCare’s misrepresentations constitute an inadvertent
4 issuance, amendment, or servicing of the policy.

5 **7. Applicable Unit-Penalty**

6 Mr. Cignarale testified that misrepresentations of pertinent facts or policy provisions
7 are “moderately serious to very serious” violations. (Exh. 1184, p. 171:17-18.) He
8 recommended a minimum penalty for such violations of \$1,500 per non-willful act, and for
9 violations that have more severe consequences for consumers, a \$3,250 per act penalty.
10 (Exh. 1184, p. 172:5-9.)

11 PacifiCare has offered no evidence in mitigation for these violations. In fact, based
12 on the testimony of Mr. R, PacifiCare has not remediated some of the misrepresentations
13 made to that patient. Despite that aggravating circumstance, and despite the fact that many
14 of these violations did result in severe consequences for consumers, CDI is seeking only a
15 \$1,500 unit-penalty for these violations, or an aggregate penalty of \$127,500 for these 85
16 acts in violation.

17 **V. AGGREGATE PENALTY**

18 The product of the various unit-penalties and the number of charged acts in violation
19 for that category can be summed to an aggregate penalty of \$910,159,088, as shown in the
20 following table:²⁷

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22
23
24
25
26 ²⁷ This table differs from that on pages 172-173 of Exhibit 1184 principally because it
27 omits rows for violation categories in the Department’s Fourth Supplemental Accusation that
28 Mr. Cignarale considered but that the ALJ has ruled will not be accepted as charged
 violations. The table here also includes categories for which Mr. Cignarale did not make a
 recommendation in Exhibit 1184.

Violation Category	Number of Acts in Violation	Average Unit Penalty	Penalties for Category
PacifiCare's Incorrect Denial of Claims Due to Failure to Maintain COCCs on File	1,799	\$6,132	\$11,031,350
PacifiCare's Incorrect Denial of Claims Based on an Illegal Preexisting Condition Exclusionary Period	3,862	\$1,852	\$7,151,550
PacifiCare's Failure to Provide Notice to Providers of Their Right to Appeal to CDI	462,805	\$720	\$332,990,250
PacifiCare's Failure to Provide Notice to Insureds of Their Right to Request an Independent Medical Review	336,085	\$672	\$225,749,563
PacifiCare's Failure to Accurately Pay Claims to Providers other than UCSF and UCLA	3,700	\$10,000	\$37,000,000
PacifiCare's Failure to Pay Timely Claims	34,997	\$5,500	\$192,483,500
PacifiCare's Failure to Pay Interest on Late-Paid Claims	5,195	\$1,700	\$8,831,500
PacifiCare's Failure to Acknowledge Receipt of Claims	56,463	\$1,410	\$79,607,250
PacifiCare's Failure to Timely Respond to Provider Disputes	1,510	\$4,400	\$6,644,000
PacifiCare's Illegal Practice of Closing or Denying Claims When Requesting Additional Information	58	\$2,625	\$152,250
PacifiCare's Sending Untimely Collection Notices on Overpaid Claims	1,934	\$4,200	\$8,122,800
PacifiCare's Failure to Maintain Complete Claims Files	15	\$425	\$6,375
PacifiCare's Failure to Respond to CDI Inquiry Within 21 Calendar Days	29	\$450	\$13,050
PacifiCare's Failure to Train Claims Agents on the Fair Claims Settlement Practice Regulations	23	\$3,300	\$75,900
PacifiCare's Misrepresentations to CDI	8		\$0
PacifiCare's Failure to Conduct Business in Its Own Name	29	\$250	\$7,250
PacifiCare's Failure to Timely Respond to Claimants	9	\$1,000	\$9,000
PacifiCare's Failure to Implement a Policy Regarding Recording the Date of Receipt of Claims	2	\$3,250	\$6,500
PacifiCare's Failure to Conduct a Thorough Investigation	46	\$3,250	\$149,500
PacifiCare's Misrepresentations of Pertinent Facts	85	\$1,500	\$127,500
Total	908,654		\$910,159,088

However, the Department is not recommending that PacifiCare be ordered to pay this amount and is instead requesting that the aggregate penalty be reduced to \$325 million. The reasons for the recommended reduction were set out by Mr. Cignarale. (Exh. 1184, pp. 172:10-178:11.)

1 First, Mr. Cignarale explained that where the indicated penalty is large, it is
2 appropriate to consider the company's financial condition and ability to pay the indicated
3 amount. Attention to the financial condition of a licensee is among the Commissioner's
4 critical responsibilities, and just as he or she may prevent a solvent insurer from taking action
5 that would jeopardize that solvency (see § 1065.1), the Commissioner may stay his or her
6 own hand to avoid a similar jeopardy. (See generally *Arthur Andersen v. Superior Court*
7 (1998) 67 Cal.App.4th 1481, 1484 ["Commissioner has the statutory responsibility of
8 monitoring insurance companies to ensure their ability to pay insurance claims"]; *Caminetti*
9 *v. Guar. Union Life Ins. Co.* (1942) 52 Cal. App. 2d 330, 333 [vital interest of state,
10 policyholders in ability of insurer to pay claims empowers Commissioner to take action even
11 with respect to an insurer not then insolvent].) This does not, of course, preclude the
12 Commissioner, in appropriate circumstances, from imposing a penalty that would render an
13 insurer insolvent, but it does mean that the possibility of insolvency is an appropriate
14 consideration in imposing a penalty.

15 In PLHIC's case, Mr. Cignarale testified, on the basis of information provided by the
16 Department's Financial Surveillance Bureau ("FSB") that PLHIC had, as of June 30, 2011,
17 \$728.8 million in surplus and \$221.2 million in net written premium. (Exh. 1184, p. 173:18-
18 23.) They performed two industry-standard financial tests of PLHIC's capital needs,
19 revealing that the company required between \$20.8 million and \$73.8 million to support its
20 business. Choosing the more conservative number, Mr. Cignarale concluded that PLHIC
21 could absorb aggregate penalties up to \$655 million without impairing its ability to function
22 as an insurance company. (Exh. 1184, pp. 173:23-174:2.)

23 Mr. Cignarale also compared the indicated penalty to PLHIC's profits during the
24 three years, 2006 through 2008, in which it went from being a successful insurance company
25 to its removal from the California PPO market. He found that PacificCare reported a net
26 income of \$600.5 million in those three years, which amounted to a return on statutory
27 surplus of 46.83%. (Exh. 1184, p. 174:3-15.) That was more than double the returns
28

1 enjoyed by the four companies having the largest number of insured lives. (Exh. 1184,
2 pp. 174:16-175:22; Exh. 1184E.)

3 With these guideposts in mind, Mr. Cignarale recommended reducing the aggregate
4 penalty to \$325 million. (Exh. 1184, p. 175:27-28.) This figure will leave PLHIC with half
5 of the amount by which its surplus exceeds the amount required to support its 2011-level
6 operations (Exh. 1184, pp. 175:28-176:2) and a little more than half of its profits from 2006-
7 2008 (Exh. 1184, p. 176:2-3), leaving it a rate of return comparable to its peer companies
8 (Exh. 1184, p. 174:20-23; Exh. 1184E [PLHIC's rate of return 48.83%, roughly twice the
9 23.34% for the peer group]).

10 Mr. Cignarale was careful to confirm that the \$325-million penalty would suffice to
11 achieve the purpose of deterrence. (Exh. 1184, pp. 176:25-179:11.) Relying on his “years of
12 experience with our enforcement program,” he noted insurance companies’ common
13 assumption that the Department cannot be expected to pursue penalties to a litigated
14 conclusion, a state of mind that impairs CDI’s ability to obtain agreement to penalties
15 commensurate with the gravity of violations. (Exh. 1184, pp. 176:27-177:8, 178:19-179:11;
16 Exh. 1082B; Exh. 1082C; Exh. 1082D; Exh. 1184F.) In making this assessment,
17 Mr. Cignarale also drew on a point on which the two expert economists, Dr. Zaretsky and
18 Prof. Kessler, agreed: that the lower the perceived likelihood of detection and enforcement,
19 the higher the penalty must be to achieve deterrence. (Exh 1184, p. 177:9-17.) Given the
20 absence of a history of penalty cases litigated to conclusion, and given PacifiCare’s own
21 emphasis on its claimed reliance on past settlements as an indicator of potential exposure to
22 penalties, Mr. Cignarale viewed these facts “as confirmation that companies doubt that large
23 numbers of serious violations will result in correspondingly large penalties.” (Exh. 1184,
24 p. 177:17-22.)

25 Because one measure of an appropriate penalty, in order to achieve deterrence, is that
26 the amount be “large enough to hurt” (*City & County of San Francisco v. Sainez* (2000) 77
27 Cal.App.4th 1302, 1318), Mr. Cignarale was asked whether an aggregate penalty of \$325
28 million satisfies that test, and he opined that it was. (Exh. 1184, p. 178:13-18.)

1 Perhaps most fundamentally, as Mr. Cignarale observed, the appropriate aggregate
2 penalty must take into account the profit-maximizing motives and management indifference
3 to compliance that led to so many of these violations. (Exh. 1184, p. 177:23-27.)

4 “Many of the violations found in this case appear to have been the
5 product of PLHIC’s owners placing the pursuit of synergies for Wall Street
6 above expressed concerns for operations, and others appear to have occurred
7 in a culture of attention to profits and indifference to compliance. A case can
8 certainly be made for a much larger aggregate penalty that does not allow
9 PLHIC’s owners to reap the full extent of the profits they sowed in the
10 violations.” (Exh. 1184, p. 177:23-27.)

11 Given the increasing concentration of insurance markets and the economic incentives to
12 reduce costs and increase profits by the hasty, careless cutting of corners, Mr. Cignarale
13 deemed it essential that companies see the realistic prospect of large penalties for large-scale
14 noncompliance lest violations of the UIPA be seen as good business practices.

15 **VI. CONCLUSION**

16 An aggregate penalty of \$325 million is amply supported on this record. It represents
17 less than \$360 per act in violation of the law — less than 4% of the statutory maximum.
18 That such a measured amount aggregates to \$325 million merely reflects the magnitude of
19 the noncompliance and the enormous sums implicated by the licensee’s conduct. It is an
20 outcome that will provide a proper ending to the otherwise profitable demise of PacifiCare
21 Life and Health Insurance Company. The Department respectfully requests that PLHIC be
22 ordered to pay penalties in this amount.
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1 Date: May 31, 2012

Respectfully submitted,

2 STRUMWASSER & WOOCHEER LLP

3 CALIFORNIA DEPARTMENT OF
4 INSURANCE LEGAL DIVISION

5 By: _____
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8 *Insurance*

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